Title:	Assertive Community Treatment- Step Down (ACT-SD)	**Code:**	H0040 U5
Type:		**Group Code:**	
Effective Date:		**Units:**	1 unit = 15 minutes

Service Description

ACT Step-Down (ACT-SD) is the next lower level of care under ACT Team and supports individuals who no longer need the full array of ACT Team services but are not yet prepared to move to office-based care. ACT-SD provides longer-term clinical case management supports of moderate intensity. The service also promotes continuity of care and ease of service access across ACT Team and ACT-SD, including the retention of their ACT Team prescriber until transition to office-based care is appropriate.

The service is appropriate for individuals who have participated in ACT-Team for at least six (6) months and need:

- Ongoing, less intensive supports, rather than the full array of ACT Team supports, to prevent decompensation, or short-term support in transitioning successfully to office-based care or another lower level of care

Population to be Served

This service is available to members, ages 18 and older, with severe and persistent mental illness. This service bridges the gap between ACTT and the next lower levels of care.

Treatment Program Philosophy, Goals and Objectives

ACT-SD is a clinical case management model with a foundation in wellness management and recovery practices. Unlike ACT Team, which consists of multiple services bundled together in a single program and requiring a multidisciplinary team, ACT-SD is limited to the services below:

- Psychiatric Services (Psychiatrist, Psychiatric Nurse Practitioner or Physician Assistant)
  - Psychiatric assessment, medication and symptom management, and brief supportive therapy
  - Coordination with other providers for both physical and psychiatric care needs
  - Service recipients are seen by the psychiatric care provider at least every three (3) months
- Nursing (RN) - Provision of injectable antipsychotic medications
- Clinical Case Management (QP, preferably also a certified peer support specialist)
  - Person-centered planning and crisis planning
  - Community-based service delivery and monitoring
  - Benefits management
  - Medication coordination and delivery
  - Supportive therapy (more formal therapy may be delivered, conditioned on QP's training and license)
  - Family psycho-education o Advocacy

- Supportive housing, including tenancy supports
- Peer supports
- Wellness management and recovery, which includes "manualized" curricula, such as Illness Management and Recovery (IMR); Wellness Management and Recovery (WMR); Wellness Recovery Action Plans (WRAP); Psychiatric Advance Directives (PADs)

Crisis Services: The Home ACT Team, i.e., not just identified ACT-SD team members, shall provide "first responder" crisis response 24 hours a day, 7 days a week, 365 days a year to beneficiaries experiencing a crisis, as available. The provider agency may triage the situation telephonically and determine whether face-to-face crisis response is needed. Mobile Crisis will be used as a back-up service if the Home ACT Team is not available.

- Team members will directly receive all crisis calls from beneficiaries without routine triaging by a third party.
- Team members who are on-call will have access to necessary information, such as all beneficiaries' crisis plans.
- Many crisis calls will likely be handled on the phone directly with the beneficiary or by coordinating with other providers or natural supports (e.g., hospital staff, residential workers, housing provider, family members).
- As needed, licensed team members will be available to provide on-site assessment, de-escalation, and follow-up. Team members are not responsible for finding a disposition for a consumer once he or she is already in an ED or hospital setting.
- Psychiatric coverage shall be available 24 hours per day. It is also necessary to arrange for and provide psychiatric back-up for all hours that the psychiatric care provider is not regularly scheduled to work.
- First responder crisis response by the ACT Team is considered a component of the ACT-SD service and is included in the ACT-SD per diem.

ACT Re-Entry: ACT-SD service recipients may be stepped back up to ACT Team services when the comprehensive service array is determined by the ACT-SD psychiatrist to be medically necessary given an acute exacerbation of illness or significant reduction in functional status that is not adequately addressed by ACT-SD within four weeks. In such cases, the goal will be for ACT Team to stabilize the individual and return to ACT-SD, once determined medically appropriate.

Expected Outcomes

Given the provision of ACT-Step Down services, it is expected that service recipients will demonstrate continued stabilization within the community, for example, absence or very limited use of psychiatric inpatient service, absence of incarcerations and growth in life areas valued by the service recipient, including:

- Maintenance of current areas of functioning and wellness, as desired and valued by the service recipient
- Increased use of wellness self-management and recovery tools, which includes independence around medication management
- Vocational/educational gains
- Increased length of stay in independent, community residence
- Increased functioning in activities of daily living, such as independence around money management and transportation
- Increased use of natural supports and development of meaningful personal relationships
- Improved physical health

Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required

Provider Requirements ACT Step-Down is provided by organizations that meet all the following requirements:

- Meets the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the requirements of 10A NCAC 27G, and the NC Medicaid requirements for Assertive Community Treatment (ACT) Team outlined in NC Medicaid Clinical Policy 8A-1 Assertive Community Treatment (ACT) program. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services.
- Enrolled with Partners Health Management as a Medicaid provider of ACT Team
- Established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina
- Has achieved full certification status with a rating of at least 3.7 on the Tool for Measurement of ACT (TMACT)
- Has been approved by Partners Health Management to provide ACT-SD services

Staffing Requirements: ACT Step-Down is provided by identified ACT Team staff within the provider organization. The ACT-SD team consists of the following staff. (The staffing full-time equivalents provided below are applicable to large ACT Teams serving 75 to 120 beneficiaries. Lesser FTEs for the psychiatrist and QP may be approved by NC Medicaid for mid-size teams.)

- Psychiatric Care Provider (Psychiatrist, Psychiatric Nurse Practitioner or Physician Assistant) at 0.20 FTE (8 hours/week)
- A Qualified Professional/Clinical Case Manager at 1 FTE, who meets the qualifications of Qualified Professional (QP) as specified in 10A NCAC 27G .0104. Certification of the QP by the NC Peer Support Specialist Program is preferred (CPSS).
- A registered ACT Nurse at 0.025 FTE (1 hour a week) to provide injections or medication monitoring as needed. New ACT-SD teams with fewer than 20 members must be staffed as above, with the following exceptions to prescriber time based on the number of members enrolled in service.
    - 1 - 6 members: 2 hours/week
    - 7 - 13 members: 4 hours/week
    - 14 - 20 members: 6 hours/week

Most ACT-SD services are provided by the ACT-SD psychiatric care provider and the QP. The ACT-SD psychiatric care provider must also serve on the home ACT Team and cannot be exclusively assigned to ACT-SD recipients. To honor service recipient choice, ACT Team staff may also assist with ACT-SD services, except for providing ongoing specialty services, such as substance abuse treatment by the substance abuse specialist, vocational services from the vocational specialist, and nursing services, excluding provision of injections, from the RN.

Service Type/Setting: ACT Step-Down serves the needs of two distinct groups: those in need of ongoing supports, but at a less intensive and comprehensive level than ACT Team and those who need support to transition successfully to a lower level of care. ACT-SD as an ongoing, longer term support for those individuals who have achieved a level of stability that is within their satisfaction, but whose history indicates a high risk of decompensation. These individuals are often at risk of harm to self or others, hospitalizations, and/or homelessness if continual community-based support is not provided Psychiatric outreach and focused medication supports provided through ACT-SD are critical to these individuals' continuing stabilization. ACT-SD is a graduated transition is for those individuals who have demonstrated more limited use of the breadth of ACT services, primarily due to improved functioning, but would benefit from time-limited support as services are titrated down and the individual connects to a lower level of care. Such individuals may have attachments to the ACT Team staff, which are generating anxiety about the prospect of transition, resulting in acute exacerbations in symptoms. ACT-SD services are provided primarily in the community and are available anytime throughout the week, as directed by the needs cited in the person-centered plan.

Wellness Management and Recovery services are the foundation of ACT-SD, which help service recipients assume greater responsibility and ownership for their own self-care. Recipients of ACT-SD are expected to receive at least three (3) face-to-face contacts each month. At least one contact takes place in the individual's residence. ACT-SD is billed on an event basis, also referred to as a "per diem." An ACT-SD event is a 15- minute face-to-face contact, defined as lasting at least eight minutes. A maximum of two events may be billed per month. All other contacts, activities, meetings, and travel time are accounted for in the event rate and are not directly billable. Only one event may be billed per beneficiary per day.

Program Requirements: All individuals receiving ACT Step-Down services will be reviewed at least weekly as part of the ACT program's daily team meeting. Staff time utilized for ACT-SD is accounted for through use of additional staff or splitting positions. ACT program team members cannot serve on both the ACT Team and ACT-SD team at the same time. Staff must be dedicated to either ACT Team or ACT-SD during a single time span. This is accomplished by adding additional FTEs to the ACT program as described in the ACT-SD definition. For example, an ACT program that provides ACT Team to 100 individuals and ACT-SD to 20 individuals will be staffed as follows to account for the addition of ACT-SD:

- 1 psychiatric care provider FTE, minimum (.8 FTE for ACT Team + .2 FTE for ACT-SD)
- 4 QP/AP FTEs, minimum (3 FTEs for ACT Team + 1 FTE for ACT-SD)
- 3.025 RN FTEs, minimum (3 FTEs for ACT Team + .025 FTE for ACT-SD) ACT program staff may serve on both ACT Team and ACT-SD during different times of the day; for example, the same staff person may be scheduled to serve on ACT Team from 8 a.m. to 4 p.m. and on ACT-SD from 4 p.m. to 6 p.m.

The ACT-SD provider ensures that the ACT Team staffing ratios are met or exceeded. In addition, the time that any staff spends providing services to ACT-SD consumers will be tracked and counted only toward fulfilling requirements for ACT-SD. This time will not be counted toward ACT Team consumer contact and service requirements.

The Home ACT Team will provide first responder crisis services when available. If the ACT Team is not available, Mobile Crisis will be accessed.

Individuals identified for ACT-SD may continue with select ACT Team specialty services (e.g., receiving vocational or substance abuse services) during the initial transition phase, prior to the ACT-SD team being able to transition specialty services to other non-ACT providers.

Large ACT Team providers are permitted to serve no more than 20 individuals through their ACT-SD program at any given time.
Mid-size teams may be approved by Partners Health Management as needed to provide ACT-SD to 10 to 15 individuals.

Utilization Management

An ACT-SD unit is an event.
An event is a 15-minute face-to-face contact defined as lasting at least eight minutes.
Only two units may be billed per month, although individuals are expected to be seen by the ACT-SD Team face-to-face at least three times per month.

Utilization Management
Prior Authorization for ACT-SD is required. Initial authorization for services may not exceed six months. Re-Authorization must be conducted every six months.

Entrance Criteria ACT-Step Down is provided to individuals 18 years of age or older with severe and persistent mental illness who meet the following criteria:

- Qualified for and received ACT services for at least six (6) months
- ACT Team as a comprehensive, bundled service program is determined to be no longer medically necessary given the individual's person-centered goals
- ACT-SD is determined to be the appropriate level of care compared to other available alternative interventions or programs within the Partners Health Management service array.
- In need one of the following:
    - Ongoing, community based psychiatric outreach and supports to ensure stability and avoid significant negative consequences such as mortality, victimization, hospitalization, homelessness, or violence that will compromise recovery, or
    - A strategic, titrated transition to less intensive services to minimize risk of relapse and/or psychiatric decompensation. Determination is based on an individual's attachment to the team, and related anxiety

about transition despite improvements in functioning; and/or a person-centered plan that indicates a time-limited continuation of psychiatric outreach and supports, while the individual, who is operating at a greater level of independence continues to use limited ACT team specialty services.

Individuals who meet any of the criteria below are not appropriate for transition to ACT-SD:

- High use of acute psychiatric hospital or psychiatric emergency services, (two or more crisis episodes during the past 12 months requiring emergency behavioral health response)
- Coexisting mental health and active substance use disorders for more than six months that are of ongoing severity
- High risk or recent history (past six months) of criminal justice involvement, such as arrest, incarceration, probation, or
- Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness

Continued Stay Criteria: The ACT Transition Readiness (ATR) tool will be used to guide the determination of whether an ACT-SD recipient continues to meet the entrance criteria above. There are no specific limitations on length of stay.
Discharge Criteria:

I. The individual has made significant progress toward rehabilitation goals and discharge to a lower level of care is indicated.
II. Recipient requires a more intensive level of care or service such as ACT Team. A discharge SAR should be submitted at the time of discharge.

Service Orders: A Master's level behavioral health professional licensed in the state of North Carolina with at least two years of post-master's degree experience with the population served orders this service.

Documentation Requirements: The same documentation requirements that apply to ACT Team apply to ACT Step-Down.

Treatment Plan: Everyone receiving ACT Step-Down services is required to have a Person-Centered Plan (PCP) that is fully complete prior to or on the first date of service. The PCP must meet all the requirements, including an enhanced crisis plan, as outlined in the NC PCP Instruction Manual. The amount, duration, and frequency of the service must be included in the PCP.

Service Documentation: A full service note that meets the requirements per APSM 45-2 is required for each contact or intervention (such as individual session, case management, crisis response) for each date of service. Each service note must include the following information:

- Recipient's name
- Service record number
- Medicaid identification number (as applicable)
- Name of service provided
- Full date of service
- Place of service
- Type of contact (face to face, telephone call, collateral, etc.)
- Purpose of contact as it relates to the goal(s) on the PCP
- Description of the interventions provided
- Time spent providing interventions (i.e. duration)
- Assessment of effectiveness of intervention and/or the recipient's progress towards the goal(s)
- Signature and credentials of the staff member(s) providing the service

Discharge Planning: Beginning at the time of admission, all interventions/activities regarding discharge planning and transition with the member, family/caregiver, and child and family team will be documented. A documented discharge plan shall be discussed with the individual and included in the service record.

Service Exclusions/Limitations:

Concurrent Billing: As ACT Step-Down is not intended to be an all-inclusive, bundled service program (unlike ACT Team), some services may be provided by non-ACT service providers concurrently with ACTSD. An ACT-SD recipient is limited to no more than two of these additional services. The services that may be provided concurrently with ACT-SD if deemed medically necessary include:

- Psychosocial Rehabilitation (PSR)
- Supported Employment/Individual Placement and Support (IPS)
- Outpatient Therapy (e.g., DBT, CBT for psychosis, substance abuse counseling)
- Opioid Treatment
- Detoxification Services
- Facility Based Crisis
- Substance Abuse Residential Treatment
- Adult mental health residential programs (for example, supervised living low or moderate; or group living low, moderate, or high)
- Mobile Crisis

Determination of medical necessity for each of the concurrent services will consider services expected to be provided by ACT-SD and whether traditional ACT Team would better meet the needs of each consumer requesting the additional service.

- In Lieu Of services are not included in the Medicaid state plan and are provided only when they are expected to be a cost-effective alternative to state plan services which result in as good as or better outcomes than would the state plan service
- In Lieu Of services may be provided to individuals who participate in NC Innovations or other home and community-based waiver programs, such as CAP/C and CAP/DA, if the alternative services are not duplicative of waiver services.
- If a request for authorization of this service is denied, or if an authorization of this service is terminated, suspended, or reduced, then appeal rights will be provided in accordance with applicable law.

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