Department:	Medical Management	**Original Approval:**	03/29/2016
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Title:	Program of Assertive Community Treatment (PACT) Program Criteria		
Approved By:	UM Committee		

SCOPE

Apple Health Integrated Managed Care (IMC) (previously called FIMC) and Behavioral Health Services Only (BHSO) enrollees 18 years of age and older.

BACKGROUND

The Program for Assertive Community Treatment (PACT) is a person-centered, recovery-oriented, mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

PACT serves individuals with severe and persistent mental illness who also experience difficulties with daily living activities and tasks and, because of the limitations of traditional mental health services, may have gone without appropriate services. Consequently, this group of enrollees is often over represented among individuals who are homeless or are in jails and prisons, and have been unfairly thought to resist or avoid involvement in treatment.

PACT services are delivered by a group of transdisciplinary mental health staff who work as a team and provide the majority of treatment, rehabilitation, and support services enrollees need to achieve their goals. The team is:

- Directed by a team leader and a psychiatric prescriber,
- Includes a sufficient number of staff from the core mental health disciplines,
- Has at least one peer specialist, and
- A program or administrative support staff who work in shifts to cover 24 hours per day, seven days a week and to provide intensive services (multiple contacts may be as frequent as two to three times per day, seven days per week, which are based on enrollee need and a mutually agreed upon plan between the enrollee and PACT staff).

Many, if not all, staff share responsibility for addressing the needs of all enrollees requiring frequent contact.

PACT services are individually tailored with each enrollee and address the preferences and identified

goals of each enrollee. The approach with each enrollee emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.

The PACT team is mobile and delivers services in community locations to enable each enrollee to find and live in their own residence and find and maintain work in community jobs rather than expecting the enrollee to come to the program. Seventy-five percent or more of the services are provided outside of the program offices in locations that are comfortable and convenient for enrollees.

PACT services are delivered in an ongoing, rather than time limited, framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many enrollees benefit from the availability of a longer-term treatment approach and continuity of care. This allows enrollees opportunity to re-compensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

Services in the PACT program include, but are not limited to:

- **Activities of Daily Living Services** to support activities of daily living in community-based settings include individualized assessment, problem solving, skills training/practice, sufficient side-by-side assistance and support, modeling, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist consumers to gain or use the skills
- **Co-Occurring Disorders Services**
- **Crisis Assessment and Intervention**
- **Education Services** for PACT consumers whose high school, college or vocational education could not start or was interrupted. Services provide support to enrolling and participating in educational activities.
- **Family and Natural Supports' Psychoeducation and Support**
- **Medication Prescription, Administration, Monitoring and Documentation**
- **Peer Support Services** to validate consumers' experiences and to guide and encourage consumers to take responsibility for and actively participate in their own recovery, as well as services to help consumers identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce consumers' self-imposed stigma.
- **Service Coordination**
- **Social and Community Integration Skills Training** serve to support social/interpersonal relationships and leisure-time skill training and include supportive individual therapy (e.g.) problem solving, role- playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure consumers' time, increase their social experiences, and provide them with

opportunities to practice social skills and receive feedback and support

- **Support Services** to include skills training for accessing services, and providing direct assistance when necessary, to ensure that consumers obtain the basic necessities of daily life.
- **Symptom Management and Psychotherapy**
- **Vocational Services** including work-related services to help consumers value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers.
- **Wellness Management and Recovery Services** are a combination of psychosocial approaches to working with the consumer to build and apply skills related to his or her recovery, including development of recovery strategies, psychoeducation about mental illness and the stress-vulnerability model, building social support, reducing relapses, using medication effectively, coping with stress, coping with problems and symptoms, and getting needs met within the mental health system and community.

DEFINITIONS

Comprehensive Assessment: The organized process of gathering and analyzing current and past information with each enrollee and the family and/or support system and other significant people to evaluate:

1. Mental and functional status;
2. Effectiveness of past treatment;
3. Current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and
4. The range of individual strengths (e.g., knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the enrollee

and his/her recovery planning team in pursuing goals.

The results of the information gathering and analysis are used to:

1. Establish immediate and longer-term service needs with each enrollee;
2. Set goals and develop the first person-centered treatment plan with each enrollee; and
3. Optimize benefit that can be derived from existing strengths and resources of the individual and his/her family and/or natural support network in the community.

Co-Occurring Disorders Services: Include integrated assessment and stage-based treatment for individuals who have a co-occurring mental health and substance use disorder. This type of treatment is based on a harm reduction model (vs. a traditional or abstinence-only substance abuse treatment model).

Individual Treatment Team (ITT): A group or combination of three to five PACT staff members who, together, have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned by the team leader and the psychiatric prescriber to work collaboratively with an enrollee and his/her family and/or natural supports in the community by the time of the first person-centered treatment planning meeting or thirty days after admission. The core members are the primary practitioner, the psychiatric prescriber, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each enrollee.

Initial Assessment and Person-Centered Treatment Plan: The initial evaluation of: 1) the enrollee's mental and functional status; 2) the effectiveness of past treatment; 3) the current treatment, and rehabilitation and support service needs, and 4) the range of individual strengths that can act as resources to the person and his/her ITT in pursuing goals. The results of the information gathering and analysis are used to establish the initial treatment plan to achieve individual goals and support recovery. Completed the day of admission, the enrollee's initial assessment and treatment plan guides team services until the comprehensive assessment and full person-centered treatment plan is completed.

PACT Primary Practitioner: Leads and coordinates the activities of the individual treatment team (ITT) and is the ITT member who has primary responsibility for establishing and maintaining a therapeutic relationship with a enrollee on a continuing basis, whether the enrollee is in the hospital, in the community, or involved with other agencies. In addition, he or she is the responsible team member to be knowledgeable about the enrollee's life, circumstances, and goals and desires.

Peer Support and Wellness Recovery Services: Include services which serve to validate enrollees' experiences, provide guidance and encouragement to enrollees to take responsibility for and actively participate in their own recovery, and help enrollees identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce enrollees' self-imposed stigma. Such services also include *counseling* and support provided by team members who have experience as

recipients of mental health services for severe and persistent mental illness.

Person-Centered Treatment Plan: The culmination of a continuing process involving each enrollee, their family and/or natural supports in the community, and the PACT team, which individualizes service activity and intensity to meet the enrollee's specific treatment, rehabilitation, and support needs. The written treatment plan documents the enrollee's strengths, resources, self-determined goals, and the services necessary to help the enrollee achieve them. The plan also delineates the roles and responsibilities of the team members who will work collaboratively with each enrollee in carrying out the services.

Program of Assertive Community Treatment (PACT): A self-contained mental health program made up of transdisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services enrollees need to achieve their goals. PACT services are individually tailored with each enrollee through relationship building, individualized assessment and planning, and active involvement with enrollees to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The PACT team is mobile and delivers services in community locations rather than expecting the enrollee to come to the program. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for enrollees. The enrollees served have severe and persistent mental illness that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services.

Transdisciplinary Approach: Specifies that team members share roles and systematically cross discipline boundaries. The primary purpose of this approach is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided.

INDICATIONS/CRITERIA

Medicaid Members	***Continue to criteria for approval below.***
Medicare Members	

PROGRAM ADMISSION CRITERIA

Individuals must meet the following admission criteria:

I. Severe and persistent mental illness listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fifth Edition, or 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.

A. Individuals must have a primary mental health diagnosis.

B. Individuals with a sole diagnosis of a substance use disorder, mental retardation, brain injury or Axis II disorders **are not** the intended group of enrollees for PACT services.

C. Individuals who have not been able to remain abstinent from drugs or alcohol **will not be excluded** from PACT services.

II. Significant functional impairments as demonstrated by at least one of the following conditions:

A. 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); or

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

III. **Continuous high-service** needs as demonstrated by at least one of the following:

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. Co-occurring substance use disorder of significant duration (e.g., greater than six months);
D. Significant difficulty meeting basic survival needs or residing in substandard housing, homelessness, or at imminent risk of becoming homeless;

E. Residing in an inpatient or supervised community residence, 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; or
F. Difficulty effectively utilizing traditional office-based outpatient services or other less-intensive community-based programs (e.g., consumer fails to progress, drops out of service).

IV. Documentation of admission shall include:
   A. The reasons for admission as stated by both the consumer and the PACT team;and
   B. A Level of Care Utilization System (LOCUS) composite score of at least 20 and no more than 22 is required for treatment at this level.

PROGRAM CONTINUED STAY CRITERIA

I. The following documentation must be completed and provided:

   A. An initial assessment and treatment plan must be done the day of the consumer's admission to PACT by the team leader or the psychiatric prescriber, with participation by designated team members.

   B. A comprehensive assessment must be completed by each respective team specialist and/or a PACT team member with skill and knowledge in the area being assessed. The assessment is based upon all available information, including that from consumer interview/self-report, family and/or natural supports, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. A comprehensive assessment shall be initiated and completed within one month after a consumer's admission according to the following requirements:

      1. In collaboration with the consumer, the ITT will complete a psychiatric and social functioning history time line.

      2. In collaboration with the consumer, the comprehensive assessment shall include an evaluation of the following areas:

         a. **Psychiatric History, Mental Status, and Diagnosis:** The psychiatric prescriber is responsible for completing the psychiatric history, mental status, and diagnosis assessment. (Using information derived from the evaluation, a psychiatric prescriber or a clinical or counseling psychologist shall make an accurate diagnosis listed in the American Psychiatric Association's DSM IV.) The psychiatric prescriber presents the assessment findings at the first treatment planning meeting.

         b. **Physical Health:** A registered nurse is responsible for completing the physical health assessment. The registered nurse presents the assessment findings at the first treatment planning meeting.

         c. **Use of Drugs and Alcohol**: A team member with experience and training in dual diagnosis substance abuse assessment and treatment is responsible for completing the drug and alcohol assessment. The chemical dependency specialist presents the assessment findings at the first treatment planning meeting.

         d. **Education and Employment:** A team member with experience and training in vocational assessment and services is responsible for completing the

education and employment assessment. Included in this area is the assessment of community inclusion and integration as it relates to education and employment. The vocational specialist presents the assessment findings at the first treatment planning.

e. **Social Development and Functioning**: A team member who is interested and skillful in attainment and restoration of social/interpersonal skills and relationships and who is knowledgeable about human development is responsible for completing the social development and functioning assessment. Included in this area is the assessment of the individual's social and interpersonal inclusion and integration within the community. The team member who does the assessment presents the assessment findings at the first treatment planning meeting.

f. **Activities of Daily Living (ADL)**: Nurses and other clinical staff with training or experience in this area (e.g., occupational therapists) are responsible to complete the ADL assessment. Other staff members with training to do the assessment and who have interest in and compassion for consumers in this area may complete the ADL assessment. The team member who does the assessment presents assessment findings at the first treatment planning meeting.

g. **Family Structure and Relationships**: Members of the consumer's ITT are responsible to carry out the family structure and relationships assessment. The staff members working with the family present the assessment findings at the first treatment planning meeting.

h. **Strengths and Resources**: Members of the consumer's ITT are responsible for engaging the consumer in his or her own narrative in order to identify individual strengths and resources as well as those within the individual's family, natural support network, service system, and community at large. These may include: skills, talents, personal virtues and traits, interpersonal skills, interpersonal and environmental resources, cultural knowledge and lore, family stories and narratives, knowledge gained from struggling with adversity, knowledge gained from occupational and parental roles, spirituality and faith, and hopes, dreams, goals, and aspirations.

C. A person-centered treatment plan will be developed through the following treatment planning process:
   1. Developed in collaboration with the consumer and his/her preferred natural supporters, and/or guardian, if any, when feasible and appropriate;
   2. Identify service needs/issues, strengths/ weaknesses, and specific measurable goals;
   3. Include the following key areas in the enrollee's person-centered treatment plan

unless they are explored and designated as “not of current interest” by the consumer:

a. Psychiatric illness or symptom reduction;
b. Housing
c. Activities of Daily Living (ADL’s)
d. Daily structure and employment;
e. Family and social relationships;
f. Physical health; and
g. Other life areas, goals and aspirations as identified by the consumer (e.g., community activities, empowerment, decision-making).

4. The consumer’s own words are reflected in the treatment plan.
5. The primary practitioner and the ITT, together with the consumer, are responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the consumer's course of treatment (e.g., significant change in consumer’s condition or goals) or at least every 180 days. Additionally, the primary practitioner shall prepare a summary (i.e., treatment plan review) which thoroughly describes in writing the consumer’s and the ITT’s evaluation of his/ her progress/goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last treatment plan.

II. While the assessment process involves the input of most, if not all, team members, the enrollee's psychiatric prescriber, primary practitioner, and ITT members will do the following:

A. Assume responsibility for preparing the written narrative of the results and formulation of the psychiatric and social functioning history time line and the comprehensive assessment, ensuring that a psychiatric and social functioning history time line and comprehensive assessment are completed within one month of the consumer's admission to the program.

B. After the assessment formulation is complete, the ITT will solicit feedback from the consumer and obtain their signature indicating their degree of participation in the assessment process. A copy of the signed assessment shall be made available to the consumer.

III. The primary practitioner and ITT members will be assigned by the team leader in collaboration with the psychiatric prescriber by the time of the first treatment planning meeting or thirty days after admission.

PROGRAM DISCHARGE CRITERIA

I. Discharges from the PACT team occur when consumers and PACT staff mutually agree to the termination of services. This shall occur when enrollees:
   A. Have successfully reached individually established goals for discharge and when the consumer and program staff mutually agree to the termination of services; OR
   B. Move outside the geographic area of PACT's responsibility. In such cases, the PACT

team shall arrange for transfer of mental health service responsibility to a PACT program or another provider wherever the consumer is moving. The PACT team shall maintain contact with the consumer until this service transfer is completed; OR

C. Demonstrate an ability to function in all major role areas (i.e., work, social, self-care) without requiring ongoing assistance from the program for at least one year without significant relapse when services are withdrawn; OR

D. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable person-centered treatment plan with the consumer.

II. In addition to the discharge criteria listed above based on mutual agreement between the consumer and PACT staff, an enrollee discharge may also be occur due to any one of the following circumstances:

a. Death; OR

b. Inability to locate the consumer for a prolonged period of time; OR

c. Long-term incarceration; OR

d. Long-term hospitalization where it has been determined based on mutual agreement by the hospital treatment team and the PACT team that the consumer will not be appropriate for discharge for a prolonged period of time.

III. If the consumer is accessible at the time of discharge (i.e., according to circumstances listed III.B.1 above), the team shall ensure consumer participation in all discharge activities, as evidenced by documentation as described below:

A. The reasons for discharge as stated by both the consumer and the PACTteam;

B. The consumer's biopsychosocial status at discharge;

C. A written final evaluation summary of the consumer's progress toward the goals set forth in the person-centered treatment plan;

D. A plan developed in conjunction with the consumer for follow-up treatment after discharge; and

E. The signature of the consumer, the consumer's primary practitioner, the team leader, and the psychiatric prescriber.

IV. When clinically necessary, the team will make provisions for expedited re-entry of discharged consumers as rapidly as possible and will prioritize them on the admission and/or waiting list.

SPECIAL CONSIDERATIONS

None.

LIMITATIONS/EXCLUSIONS

Please refer to a product line's certificate of coverage for benefit limitations and exclusions for these services:

PRODUCT LINE	LINK TO CERTIFICATE OF COVERAGE
MEDICARE ADVANTAGE	http://healthfirst.chpw.org/for-members/resource-library/handbooks-and-guides
WASHINGTON APPLE HEALTH	http://chpw.org/our-plans/apple-health/
INTEGRATED MANAGED CARE	http://chpw.org/our-plans/apple-health/

Citations & References

CFR		
WAC	182-552-1000	
RCW		
Contract Citation	☒ WAH	
	☒ IMC	
	☐ MA	
Other Requirements		
NCQA Elements		

Revision History

Revision Date	Revision Description	Revision Made By
03/20/2016	Policy creation	Jane Daughenbaugh, RN
03/29/2016	Approval	MMLT
02/27/2017	Minor editing	Cyndi Stilson, RN
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