

Partners in Recovery

ACT Admission/Transfer & Discharge

PROCEDURE DOCUMENT

CMC or Department Name: Partners in Recovery Direct Care Clinics								
CMC or Department Procedure Name and Number: ACT Admission/Transfer & Discharge								
Date of Inception:								
Previous Approval Date:	N/A							
Current Approval Date:								
Operational Scope:	<input checked="" type="checkbox"/> Clinical	<input type="checkbox"/> QI	<input type="checkbox"/> Network	<input type="checkbox"/> Customer Service	<input type="checkbox"/> Claims	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other

PROCEDURE PURPOSE:

This Desktop Procedure addresses the steps for admitting and/or discharging recipients from Assertive Community Treatment Team (ACT) services. Please refer to the procedure attachment titled “Assessing ACT Appropriateness Tool” for more assistance on determining need.

I. TRANSFER TO ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM SERVICES Needs Based Service Level Assessment

- A. Clinical team must assess the person for service level intensity change and appropriateness to receive ACT services, using the following criteria:
 1. Person **must** have a qualifying SMI DSM IV diagnosis: Schizophrenia, Schizoaffective Disorder, Major Mood Disorder, or Major Thought Disorder. Priority is given to people with Schizophrenia, other Psychotic Disorders, and Bipolar Disorder).
 2. Person **must** have severe functional impairment (example – GAF no higher than 60)
 3. In addition, the person **must qualify with either (i) or (ii):**
 - a) Significant functioning impairments, which may include:
 1. inability to consistently perform practical daily living tasks for basic adult functioning in the community
 2. inability to be consistently employed at a self sustaining level or inability to consistently carry out homemaker roles
 3. inability to maintain a safe living environment
 - b) One or more indicators of continuous high-service needs (greater than 8 hours per month), which may include:
 1. high use of psychiatric hospitals
 2. high use of emergency services
 3. persistent or very recurrent major symptoms
 4. high risk or recent criminal justice involvement
 5. inability to meet basic survival needs
 6. residing in substandard housing

7. homeless or unstable housing
 8. residing in inpatient bed or supervised community residence, but clinically assessed to be able to live in a more independent situation if intensive services are provided
 9. requiring a residential institutional placement if intensive services are not available
 10. inability to participate/benefit from traditional, office-based services
- B. Person must agree to receive ACT team services or clinical team can recommend a trial engagement/assessment period with the ACT team services. (See applicable Grievance/Appeal policies).
- C. Documentation of the transfer to ACT services should include:
1. Reason for transfer as stated by both the person and the clinical team
 2. Signature of the person, Clinical Coordinator or Clinical Director, and Behavioral Health Medical Practitioner.

II. TRANSFER FROM ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM SERVICES Needs Based Service Level Assessment

- A. Clinical team must assess the person for service level intensity change and appropriateness to transfer from ACT services, using the following criteria:
1. Person has successfully reached individually established goals for discharge, as mutually agreed upon by person and ACT team staff
 2. Person has successfully demonstrated an ability to function in all major role areas without on-going assistance from the ACT team services, without significant relapse when services are withdrawn, and/or when the person requests transfer and the ACT team mutually agrees (ex: person has been stable for a period no less than two years, person has a history of hospitalization but no recent crisis episodes, six months or more in recovery without additional supports or professional care)
 3. Person moves outside of Maricopa County (see Inter-RHBA Transfer and Closure policies).
 4. Person declines or refuses services and requests transfer, despite the teams best efforts to develop an acceptable treatment plan with the person
 5. By virtue of diagnosis or intensity of service needs, the person would be better served by an alternative program of care.
- B. Person must agree to transfer from ACT team services or clinical team can recommend a trial engagement/assessment period to transfer from ACT team services (See applicable Grievance/Appeal policies).
- C. When persons are transferred from ACT team services, the following criteria should be followed:
1. A gradual transfer period
 2. A plan to maintain continuity of treatment at appropriate levels of intensity to support the person's continued recovery
 3. A plan for persons to easily return to the ACT team if needed
- D. Documentation of the transfer from ACT services should include:
1. Reasons for transfer as stated by both the person and the ACT team.
 2. A written summary of the person's progress toward the goals set in the treatment plan.
 3. A plan in development driven by the person for follow up treatment and support services following transfer from the ACT team.
 4. The signature of the person, the Clinical Coordinator or Clinical Director, and Behavioral Health Medical Practitioner.

Form Attachments:
Assessing ACT Appropriateness Tool

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Assessing ACT Appropriateness Tool

When assessing a consumer for ACT appropriateness, please consider the following:

- 1) Has the person been hospitalized frequently for psychiatric reasons within the last year (please include any urgent care settings as well as private hospitals)
- 2) Has the person been incarcerated frequently in the last year?
- 3) Does the person require frequent crisis services? This does not include calling crisis frequently, but is more related to utilization of mobile teams and UPC.
- 4) Does the person have a qualifying SMI Diagnosis? Is the GAF 60 or below? Is the behavioral component secondary?
- 5) Does the person have an inability to perform daily tasks of living that makes it difficult for them to live independently? (Can they cook, clean, budget, maintain personal hygiene, understand safety concerns? Persons that would be appropriate for ACT would either have some of the skills above or none at all. They may be in need of retraining in the areas of daily living, or may need to be taught for the first time).
- 6) Is the person interested in working or becoming involved in daily activities but due to their psychosis, have the inability to remain employed or continue volunteering? Does it appear that the person would be able to participate in the above if there was extra support available to them in the community?
- 7) Does the person continue to have persistent and recurrent symptoms related to their mental illness? Would medication monitoring assist them in this area?
- 8) Are they either homeless or living in poor living conditions?
- 9) Are they currently inpatient or living in a Supervisory Care Home (SCH) setting and the clinical team feels that intensive services provided in their home, would assist them in living independently?
- 10) Does the clinical team think that a Provider Affiliated Housing (PAH) or Supported Independent Living (SIL) placement would be a good setting for them? These are services that ACT Teams can and do provide.
- 11) Does the person have a difficult time coming into the clinic for services due to their psychosis? Does the clinical team believe that they would improve if the services came to them in the community?
- 12) Is the person willing to engage in ACT services, knowing that the majority of ACT services will be provided in their home/community and contact with the team may be as frequent as daily?

*****PLEASE REMEMBER THAT THE PERSON'S NEEDS MUST MEET MORE THAN ONE OF THESE CONSIDERATIONS*****