# Program of Assertive Community Treatment

PACT is a service delivery model for providing comprehensive community- based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation, and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

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 to support the member's ability to utilize behavioral health and medical services, manage functional difficulties, or otherwise realize recovery and resiliency goals.

## Admission Criteria (must meet all of the following):

1. The Member must demonstrate behavioral symptoms consistent with a DSM diagnosis which requires and can reasonably be expected to respond to planned therapeutic interventions
2. The services must be recommended by a Tennessee licensed behavioral health clinician who is actively treating the member at the time of the recommendation, in addition to meeting all other prongs of the TennCare Medical Necessity Criteria.
3. The member's current condition cannot safely, efficiently, and effectively be assessed and/or treated in a less intensive level of care due to acute changes in the member's symptomatology and/or psychosocial and environmental factors (i.e., the factors leading to admission).
4. 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
5. Co-occurring medical conditions can be safely managed.
6. 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 this 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.

7. Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.
8. 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 symptoms and behaviors identified as meeting authorization requirements (i.e.Admission Criteria) have measurably decreased and functioning has improved to a point that care can be transitioned to less intensive level of care (e.g. Standard CM, Outpatient treatment, etc.).
2. There is lack of measurable progress or participation by the member and/or there is no clinical intervention that will likely change the lack of participation.
3. The member is unwilling or unable to participate in treatment.

**Program Service Expectations:**

1. The PACT team will be multidisciplinary and include at least one physiatrist, registered nurse, and PACT Team Coordinator.
2. PACT will be supervised by a licensed master's level or higher clinician in a behavioral health discipline at least once monthly. Evidence of supervision will be made available to UnitedHealthcare Community Plan upon request.
3. PACT services should not occur in conjunction with other intensive community-based treatment case management services (e.g. CTT or CCFT).

4. The initial evaluation should be completed 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.
5. The PACT Team Coordinator in conjunction with the PACT 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.
6. The responsible provider in conjunction with the PACT Treatment team and, whenever possible, the member develops a multidisciplinary service plan that addresses the following:
    a. Behavioral health illness or symptom reduction;
    b. Housing;
    c. Activities of Daily Living;
    d. Daily structure and employment;
    e. Family and social relationships.
7. The service plan includes a crisis intervention plan.
8. The Program Assertive Community Treatment team provides services such as the following to the member's family with the member's consent:
    a. Education about the member's condition and its treatment;
    b. Education about the member's strengths;
    c. Education about the family's role in the member's treatment;
    d. Assistance with resolving conflicts;
    e. Interventions aimed at promoting the family's collaboration with the PACT team.
9. 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 may include:
    a. The member's signs and symptoms have worsened.
    b. The member response to a new medication needs to be monitored.
    c. The member is experiencing an acute serious life event.
10. The PACT team psychiatrist assesses the member's signs and symptoms, prescribes appropriate medication, and monitors the member's response to the medication.
11. The PACT team provides ongoing support and liaison services for members who are hospitalized or incarcerated.
12. The PACT team reaches out and maintains contact with the member when the member becomes isolated or is admitted to a higher level of care.
    a. The service plan is reviewed and modified as necessary commensurate with the member's needs, or no less than quarterly.

13. The provider and, whenever possible, the member will develop an initial discharge plan at the time of admission, and estimates the length of treatment and ensure an appropriate discharge plan is in place prior to discharge
14. If member moves outside of the provider's geographic service area, the PACT team shall arrange for transfer of mental health services to another provider within the new geographic area if the enrollee is still a member of the plan.