Policy: The Division of Mental Health and Developmental Services and its two statewide mental health agencies that provide Program for Assertive Community Treatment (PACT) will ensure statewide comparability, consistency and parity in their provision of PACT Services.

Purpose: PACT Services are intended to focus service delivery to persons with serious mental illness who tend to have frequent/repeated hospital admissions, jail admissions and who are homelessness.

Scope: Statewide

Procedures:

This Policy pertains only to MHDS Mental Health Agencies having PACT Programs.

I. Definition

Often referred to as Assertive Community Treatment (ACT) around the country, the Nevada MHDS Program for Assertive Community Treatment (PACT) focuses on serving individuals who have serious mental illness and who, consequently, have the greatest difficulty with basic daily activities, keeping themselves safe, caring for their basic physical and emotional needs or maintaining a safe and affordable place to live and who require interventions that have not been effective through traditional, less intensive services.

PACT provides intensive support to people with mental illness who have a history of high use of emergency, hospital and law enforcement services. The teams, which can consist of, but are not limited to, psychiatrists, clinical social workers, mental health counselors, marriage and family therapists, psychologists, psychiatric nurses, service coordinators, consumer service advocates and alcohol/substance abuse counselors, who work in an interdisciplinary manner to support consumers living in the community adhere to their medication regimens and work towards mental illness recovery and employment rehabilitation.

II. Statewide PACT Criteria for Admission, Continuing Stay, Discharge (including Step-down/Transition from PACT services) and Exclusions to PACT Services.

A. Admissions

Individuals seeking admission into the PACT program are required to meet all of the following criteria:

1. Is at least 18 years of age.

2. Has met criteria for one or more of the following Axis I major mental disorders as defined by the DSM-IV TR/DSM-V:

    a. Schizophrenia (295.xx) including subtypes Disorganized, Catatonic, Paranoid, Undifferentiated, Residual, etc.

    b. Mood Disorder (296.xx) including Bipolar Disorder, Depressive Disorder, Mood Disorder NOS, etc.

    c. Schizoaffective Disorder (295.70)

    d. Other Psychotic Disorders including Delusional Disorder, Brief Psychotic Disorder, Schizophreniform Disorder and Psychotic Disorder NOS.

    e. This, however, does not include Substance-Induced Psychotic Disorder, Psychotic Disorder Due to a General Medical Condition or Shared Psychotic Disorder

    f. This does not include individuals who have, as their *primary* diagnosis, Axis II (Developmental Disability, Personality Disorder).

3. The severity of the Axis I disorder has substantially impaired the individual such as his/her being unable to successfully and independently acquire and/or maintain skills necessary to perform essential activities in at least two of the following major life areas:

    a. Employment/Vocational
    b. Housing
    c. Social and community integration
    d. Symptom management
    e. Daily living skills
    f. Economic self-sufficiency/Financial
    g. Education

4. The individual has, due to the severity of their mental illness, exhibited a pattern of utilization as evidenced by no less than three (3) inpatient psychiatric hospitalizations within the last two years, or has a history of chronic psychiatric hospitalization suggesting a similar future pattern is likely to continue without intensive intervention.

5. The individual, due to the severity of their mental illness, exhibits a lack of motivation and/or insight into their illness as evidenced by a history of non-compliance with prescribed treatment goals and objectives including medications.

6. The individual has, due to the severity of their mental illness, demonstrated a pattern of serious impairment or regression such that less intensive levels of service (e.g. Service Coordination, outpatient medication clinic) have not proven successful in achieving long-term stability and recovery.

7. Hospitalization would be required if not for the intervention and services of the PACT team

8. The individual has failed less intensive levels of service (e.g., service coordination).

7. The individual has been authorized for admission into the PACT program by the primary treating PACT physician/psychiatrist and/or Qualified Mental Health Professional (QMHP).

B. Continuing Stay

In order to continue in the PACT program, the individual must meet one of the following criteria:

1. Lower levels of care have proven ineffective and the individual continues to experience period of decompensation that without the intervention of the PACT team would clearly lead either to a loss of housing, other benefits, and/or the ability to perform ADL's, and/or would result in the necessity for a higher level of care.

2. The individual has experienced a period of relative stability as a result of PACT intervention, but is judged by the team to be too fragile to transition to a lower level of care at this time.

3. The individual has been unsuccessful at a lower level of care, such as Step Down.

C. Discharge (or Step-down/Transition from PACT services)

Individuals who:

1. Have the ability to function well with less intensive or comprehensive services/supports in place.

2. Are stable in their recovery and rehabilitation and no longer require PACT level of care services

3. Despite repeated attempts from staff to try to locate them, individuals who are out of contact/out of touch for 90 days or more.

4. Expire

5. Move out of the geographic area of responsibility.

6. Move permanently to a nursing facility

7. Refuse services

D. Exclusions

1. Primary diagnosis of a Developmental Disability

2. Primary Substance or Drug Abuse disorder by diagnosis and/or history

3. Primary diagnosis of Dementia, Organic Brain Syndrome, or Alzheimer's Disease

4. Primary medical or metabolic condition.

III. PACT Client Contact and Service Provision

As a minimum, based on the PACT consumer's immediate clinical and medical needs, the PACT team shall have contact with a client at least once time per week. Individuals who are in transition to a lower level of care may be exempted from this requirement.

Additional service/intervention contacts will be tailored to the clinical needs of the consumer, which may vary over time, based on individual consumer needs.

PACT Team members who provide service/intervention contacts with consumers must meet the requirements of being a 1) Qualified Mental Health Professional (QMHP), Qualified Mental Health Associate (QMHA) or Quality Behavioral Aide (QBA). (Please reference the Medicaid Services Manual Chapter 400, which out lines specific mental health professional requirements and designations for being a QMHP, QMHA or QBA).

Based PACT services provided to MHDS' consumers include but may not be limited to the following:

A. Assessments based on Joint Commission and other regulatory requirements;

B. Treatment Plan Development and monitoring;

C. Psychosocial needs

D. Medical Needs (e.g., administering medications, injections, etc.)

E. Linking clients to appropriate services, such as potential social security eligibility/benefits, food stamp eligibility/benefits, Medicaid eligibility/benefits, etc.

F. Avocation, monitoring and education

IV. PACT Documentation Requirements

The following PACT documentation requirements will be in effect:

A. An individual medical record will be maintained for each client enrolled in the PACT program.

B. Manual entry of documentation, when required, shall be legible. Signatures accompanying manual entries shall include job classification and/or associated license or degree (e.g., RN, PCW, MHC, etc.).

C. Assessment: Specific assessments (e.g., Level of Care Utilization System or LOCUS) will be completed by the primary care coordinator.

D. Consent: Specific consent forms (e.g., Release of Information, Client Rights and Responsibilities, etc.) will be completed no less than annually.

E. Service Plan Development and Quarterly Review: A formal plan of service will be developed for each consumer enrolled in the PACT program. At a minimum this plan will:

1. Be written by the primary service coordinator or designated member of the PACT team with input from the consumer as well as from other service providers and natural supports as relevant or appropriate.

2. Identify specific consumer strengths, needs, treatment goals/objectives and intervention strategies. Needs, goals, objectives and intervention strategies will be relevant to the client's current clinical status and, as appropriate, reflect the client's preference and goals.

3. Identify and address co-occurring or co-morbid disorders.

4. Be completed at least annually and reviewed/updated at least every 90 days or when deemed clinically necessary due to significant changes in the consumer's status or level of functioning.

5. Be reviewed and signed by, at the minimum, the consumer, the PACT psychiatrist or licensed designee and the primary service coordinator.

F. Progress Note Documentation

1. A progress note shall be written in connection with each PACT-related service as it is provided directly to or on behalf of the consumer. Typical services include monitoring, coordination, education, provision of care, linking of community services, advocacy, assessment and service plan development.

2. Progress note documentation will reflect progress or lack thereof towards identified treatment goals and objectives.

3. Progress note documentation shall be completed within the period specified by the governing agency's policy.

4. Progress note documentation shall be completed using the one of the following formats DAP, DAPE, SOAP, etc.).

5. Unless otherwise specified, entry of progress note documentation shall be completed using Avatar, the MHDS Electronic Medical Record.

6. Progress note content reflecting specific face-to-face client contact must include:

    a. Date, time and location of the contact;

    b. Name of the consumer, staff or other persons present or involved with the contact;

c. Purpose and outcome of the contact including referrals and recommendations to other service providers, plan for resolution or present problems and/or concerns;

d. Specific Interventions;

e. Assessment of current status including overall level of functioning, status of co-occurring or co-morbid conditions and level of current risk (e.g., suicidal/homicidal, danger of hospitalization, or incarceration);

f. Assessment of the client's overall level of satisfaction with services and progress.

V. Preparation, Storage and Administration of Medications for PACT consumers

A. The preparation, administration, handling, and storage of medications for the PACT Program will be consistent with professional and legal regulations governing medications and in accordance with standards of nursing and pharmacy practices.

B. ONLY a Nevada licensed R.N. or L.P.N. may administer medications upon the order of a Nevada licensed physician, (M.D. or D.O.) a Licensed Advanced Practitioner, or a Licensed Physician Assistant under the supervision of a psychiatrist.

C. ONLY a Nevada licensed pharmacist or a Nevada licensed physician, or advanced practitioner as defined above, may dispense medications.

D. A nonprofessional may not dispense or administer any medications.

E. Medication orders:

1. Medications shall be given only on the order or prescription of a physician or advanced practitioner. Verbal orders for the administration of some medications may be taken only by a registered nurse, and must be countersigned by the physician/practitioner within twenty-four (24) hours.

2. Any questions arising from a medication order, including the interpretation of illegible physician / practitioner orders shall be referred to the physician/practitioner writing the order.

3. Pharmaceutical calculations shall be double-checked by another nurse, if possible; and verified by a pharmacist, if there is still doubt.

4. A copy of an up-to-date Physician Desk Reference (PDR) and the Poison Control phone number shall be maintained by the PACT Program.

F. Medication Errors and Adverse Drug Reactions:

1. If an error occurs in the administration of medications, the program supervisor and the physician or advanced practitioner shall be notified immediately and a Medication Error Report must be completed. (Reference Policy PF-CC-17 on "Medication Errors").

2. Such errors and subsequent actions shall be documented in the patient's chart.

3. All Adverse Drug Reactions shall be reported using the appropriate forms and procedures (Reference Policy PF-CC-18 on "Adverse Drug Reactions"

VI. PACT Data Collection and Reporting

The fidelity of the MHDS Statewide PACT programs will be maintain as evidenced by the ongoing evaluation of the PACT program

MHDS' Mental health agencies operating PACT programs will collect, analyze and report the following PACT Data:

A. Number of consumers served in the PACT Program.

B. Within the calendar month, percentage of PACT clients who received a) two or fewer services, b) three to five services and c) six or more services.

C. Number of consumers who step down to lower, less restrictive levels of care in the community (e.g., from group home to Supportive Living Arrangements).

D. Number of hospital readmissions (at 30 days and 90 days) from previous admission. If readmitted to an inpatient psychiatric hospital, the total length of stay days hospitalized.

E. Number of jail episodes/days

F. Housing: Consumers who find and keep independent housing and total days in independent housing.

G. Employment: consumers who find and keep jobs and total days in jobs.

H. Consumer Satisfaction Surveys

I. Percentage of individual service plans that are signed by the physician and current/within established time frames.

VII. Measures of Success (How Do we Know that PACT is Working and doing what it is intended to do)

Measures of Success to the PACT program include, but not be limited to, evidence of

A. Increased number of consumers who step down to lower levels of care in the community (e.g., group home to Supportive Living Arrangements).

B. Increased total numbers of consumers who find and keep jobs and total days in jobs.

C. Increased total numbers of consumers who find and keep independent housing.

D. Decreased total number of hospital readmissions over one year (If hospitalized was length of stay days to be less than 30 days).

E. Decreased total number of Jail Episodes/Days over one year.

F. High total and cumulative scores of Consumer Satisfaction Surveys

G. Acceptable percentage of service plans signed and completed within established guidelines.

H. Frequency of Client interactions as stipulated in PACT service guidelines per clinical need.

VIII. PACT Performance Improvement Plan

MHDS PACT programs will assure program integrity by having an ongoing Performance Improvement Plan for monitoring, evaluating and improving the quality and consistency of PACT.

A. The PACT Program Coordinator shall be responsible for implementing the integrated PACT Services Performance Improvement Plan. The following monitors shall be used as indicators for monitoring, evaluating and improving the quality of PACT services.

1. Monitor – Client Satisfaction with PACT Services

   a. Indicator: Client's perception of their overall satisfaction with the services they receive through the PACT Program shall be measured through responses to questions on the PACT Client Satisfaction Survey derived from above referenced aspects of care.

2. Monitor – Improved Client Quality of Life

   a. Indicator: The PACT Program will demonstrate the progress of their clients through the maintenance of appropriate living situations in the community and a documented improvement in skill levels that allow the client to live in a progressively less restrictive environment.

   b. Data monitored through residential / SLA contracts and service coordinator documentation.

3. Monitor PACT clients admitted to POU/Inpatient care.

   a. Indicator: The program will also show a reduction in total private and public psychiatric hospitalization bed days and hospital emergency usage.

   b. PACT supervisor shall maintain data for PACT clients admitted to POU/Inpatient psychiatric care.

4. Monitor – Clinical Record Review

   a. Indicator: 10% of clinical records shall be reviewed at least quarterly for completeness, accuracy, and timely completion of all necessary information.

   b. The review shall be performed by the PACT program supervisors using an agency approved medical record review form.

5. The Client Satisfaction Survey shall be distributed annually to all PACT consumers who come in for services during the annual survey period. The purpose of the survey shall be to assess

client's satisfaction with the P.A.C.T. services they have received.

a. The PACT Program Coordinator shall review questionnaires which are then incorporated into a periodic Performance Improvement Plan report.

b. Results shall be shared with the PACT team members.

c. Standard: The desired performance level is 50% participation.

B. Corrective Action. Results of the monitoring and evaluation activities, as described in this P.I. plan are used primarily to study and improve processes that affect client service outcomes. However, when the clinical performance of a provider is a relevant issue, P.I. monitoring and evaluation activities are utilized in evaluating individual capabilities and competencies. When specific sources of non-process related problems are identified, the following corrective action steps may occur:

1. Worker participates in supervisory conference to discuss areas that need corrective action and to seek a commitment to improve action(s).

2. Follow-up monitoring occurs to assess effectiveness of implemented correction action(s).

3. As needed, further training, and/or review of procedures, and employee work performance standards, is undertaken.

C. Reporting

Results of PIP monitoring activities shall be reported to the:

1. PACT team members
2. Community Services Director
3. Agency Director

4. Office of Performance Improvement.

The PACT Performance Improvement Plan shall be reviewed and evaluated every two years to determine it's effectiveness in monitoring and improving the quality of services offered by the PACT Program.

IX. PACT Program Evaluation

The fidelity of the MHDS Statewide PACT programs will be maintained as evidenced by the ongoing evaluation of the PACT program through the outline course of data collection, process and outcome measures, and performance improvement criteria as adapted from the ACT fidelity Scale and General Organizational Index.

X. PACT Appeals

A. Appeals Process

1. When an individual has concerns or a complaint related to safety, service delivery or access, he/she may make a complaint directly and verbally to any MHDS PACT Program employee, or may submit such to any MHDS PACT Program employee supervising personnel in writing and an internal appeals process may be utilized if the complaint or concern is not remediated to the satisfaction of the individual involved. The appeals process is as follows.

   a. The Community Services Director shall review the case, and if necessary, meet with the involved parties and make a determination within five (5) working days.

   b. The MHDS PACT Program's Agency Director shall review the a concern and resolution within five working days and make a determination;

   c. The Administrator of the Division of Mental Health and Developmental Services shall review the concern and resolution within five (5) working days and make a determination.

   d. The individual may present his/her case to the Local Govern Board at the next scheduled meeting.

2. When an individual has concerns or a complaint related to safety, service delivery or access, he/she may make a complaint directly and verbally to any MHDS Statewide PACT Program employee, may submit such to any MHDS Statewide PACT Program employee in writing and an external appeals process may be utilized. The external appeals process is as follows:

   a. The individual may contact the State of Nevada licensing body, which is State of Nevada, Department of Health and Human Services, Division of Health, Bureau of Health Care Quality and Compliance.

b. The individual may contact the certifying body, which is The Center for Medicare and Medicaid Services.

c. The individual may contact the accrediting body, which is the Joint Commission.

d. The individual may contact the Office of Civil Rights (ORC).

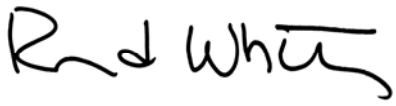
3. Address and telephone numbers are available at the Official web sites of each agency. Addresses and telephone numbers are also posted in all clinics and in the lobby of the Hospital.

XI. Billing and Payment of PACT Services for Medicaid-eligible persons

A. Medicaid Eligible – There are four primary Medicaid-billable PACT Services: Injections, Medication Management, Psychiatric Evaluation and Targeted Case Management. Consumers with Medicaid or any combination of Medicaid and another payer will be considered as having provided payment in full.

1. All others - Consumers with Medicare and supplemental insurance will be responsible for full payment of all applicable co-insurance, co-payments, and deductibles unless the sliding fee scale has been applied based on the consumer's ability to pay. These consumers will be assessed for ability to pay using a sliding fee scale. Payments made in accordance with the fee schedule will be considered payments in full. All third-party payers, such as commercial insurance companies, are billed at the agency's full cost of services that is established on a regular basis through a cost allocation agreement and analysis.

Under this statewide MHDS Division Policy MHDS Statewide PACT Program agencies will maintain internal PACT policies, procedures and criteria that are designed to lead to the best and optimal service provision for persons with serious mental illness and who have had (are at risk of) repeated hospital and jail admissions, or who are homeless. These internal policies, procedures and criteria's will be compliant with MHDS Division Policy and still maintain and assure statewide comparability and consistency



ADMINISTRATOR

EFFECTIVE DATE: 11/16/12
DATE REVISED: N/A
SUPERSEDES: New
APPROVED BY MHDS ADMINISTRATOR: 11/16/12
APPROVED BY MHDS COMMISSION: 11/16/12