



This information is provided for quick reference for Certified Peer Specialists as part of their training and ongoing education. For billing codes and questions, please consult the most current “Provider Manual for Community Health Provider for The Department of Behavioral Health and Developmental Disabilities,” which is published and regularly updated by DHBDD.

Assertive Community Treatment														
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Assertive Community Treatment	Practitioner Level 1, In-Clinic	H0039	U1	U6			\$32.46	Practitioner Level 1, Out-of-Clinic	H0039	U1	U7			\$32.46
	Practitioner Level 2, In-Clinic	H0039	U2	U6			\$32.46	Practitioner Level 2, Out-of-Clinic	H0039	U2	U7			\$32.46
	Practitioner Level 3, In-Clinic	H0039	U3	U6			\$32.46	Practitioner Level 3, Out-of-Clinic	H0039	U3	U7			\$32.46
	Practitioner Level 4, In-Clinic	H0039	U4	U6			\$32.46	Practitioner Level 4, Out-of-Clinic	H0039	U4	U7			\$32.46
	Practitioner Level 5, In-Clinic	H0039	U5	U6			\$32.46	Practitioner Level 5, Out-of-Clinic	H0039	U5	U7			\$32.46
	Practitioner Level 3, Group, In-Clinic	H0039	HQ	U3	U6		\$6.60	Practitioner Level 3, Group, Out-of-Clinic	H0039	HQ	U3	U7		\$6.60
	Practitioner Level 4, Group, In-Clinic	H0039	HQ	U4	U6		\$4.43	Practitioner Level 4, Group, Out-of-Clinic	H0039	HQ	U4	U7		\$4.43
	Practitioner Level 5, Group, In-Clinic	H0039	HQ	U5	U6		\$3.30	Practitioner Level 5, Group Out-of-Clinic	H0039	HQ	U5	U7		\$3.30
	Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039	GT	U1			\$32.46	Multidisciplinary Team Meeting	H0039	HT				\$0.00
	Practitioner Level 2, Via interactive audio and video telecommunication systems	H0039	GT	U2			\$32.46							
Unit Value	15 minutes							Utilization Criteria		TBD				
Service Definition	ACT is an Evidence Based Practice that is person-centered, recovery-oriented, and a highly intensive community based service for individuals who have serious and persistent mental illness. The individual's mental illness has significantly impaired his or her functioning in the community. ACT provides a variety of interventions twenty-four (24) hours, seven days a week. The service utilizes a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work,													

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substance abuse, and vocational rehabilitation; additionally, a Certified Peer Specialist is an active member of the ACT Team providing assistance with the development of natural supports, promoting socialization, and the strengthening of community living skills. The ACT Team works as one organizational unit providing community based interventions that are rehabilitative, intensive, integrated, and stage specific. Services emphasize social inclusiveness through relationship building and the active involvement in assisting individuals to achieve a stable and structured life style. The service providers must develop programmatic goals that clearly articulate the use of best/evidence-based practices for ACT recipients using co-occurring and trauma-informed service delivery and support. Practitioners of this service are expected to maintain knowledge and skills according to the current research trends in best/evidence-based practices. ACT is a unique treatment model in which the majority of mental health services are directly provided internally by the ACT program in the recipient's natural environment. ACT services are individually tailored with each individual to address his/her preferences and identified goals, which are the basis of the Individualized Recovery Plan (IRP). Based on the needs of the individual, services may include (in addition to those services provided by other systems):

1. Assistance to facilitate the individual's active participation in the development of the IRP;
2. Psycho educational and instrumental support to individuals and their identified family;
3. Crisis planning, Wellness Recovery Action Plan (WRAP), assessment, support and intervention;
4. Psychiatric assessment and care; nursing assessment and care; psychosocial and functional assessment which includes identification of strengths, skills, resources and needs;
5. Curriculum-based group treatment;
6. Individualized interventions, which may include:
 - a. Identification, with the individual, of barriers that impede the development of skills necessary for independent functioning in the community; as well as existing strengths which may aid the individual in recovery and goal achievement;
 - b. Support to facilitate recovery (including emotional/therapeutic support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment);
 - c. Service and resource coordination to assist the individual with the acquisition and maintenance of recovery capital (i.e. gaining access to necessary internal and external rehabilitative, medical and other services) required for recovery initiation and self-maintenance;
 - d. Family counseling/training for individuals and their families (as related to the person's IRP);
 - e. Assistance to develop both mental illness and physical health symptom monitoring and illness self-management skills in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living (may include medication administration and/or observation and assistance with self- medication motivation and skills) and to promote wellness;
 - f. Assistance with accessing entitlement benefits and financial management skill development;
 - g. Motivational assistance to develop and work on goals related to personal development and school or work performance;
 - h. Substance abuse counseling and intervention (e.g. motivational interviewing, stage based interventions, refusal skill development, cognitive behavioral therapy, psycho educational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence drug use, relapse prevention planning and techniques etc.);
 - i. Individualized, restorative one-to-one psychosocial rehabilitation and skill development, including assistance in the development of interpersonal/social and community coping and functional skills (i.e. adaptation/functioning in home, school and work environments);
 - j. Psychotherapeutic techniques involving the in depth exploration and treatment of interpersonal and intrapersonal issues, including trauma issues; and
 - k. Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs; and
 - l. Individuals receiving this intensive level of community support are expected to experience increased community tenure and decreased frequency and/or duration of hospitalization/crisis services. Through individualized, team-based supports, it is expected that individuals will achieve housing stability, decreased symptomatology (or a decrease in the debilitating effects of symptoms), improved social integration and functioning, and increased movement toward self-defined recovery.

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Admission Criteria

1. Individuals with serious and persistent mental illness that seriously impairs the ability to live in the community. **Priority** is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders, or bipolar disorder, because these illnesses more often cause long-term psychiatric disability;
- AND**
2. Individuals with significant functional impairments as demonstrated by the need for assistance in 3 or more of the following areas which despite support from a caregiver or behavioral health staff continues to be an area that the individual cannot complete:
 - a. Maintaining personal hygiene;
 - b. Meeting nutritional needs;
 - c. Caring for personal business affairs;
 - d. Obtaining medical, legal, and housing services;
 - e. Recognizing and avoiding common dangers or hazards to self and possessions;
 - f. Persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives;
 - g. Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting or childcare tasks and responsibilities);
 - h. Maintaining a safe living situation (e.g., evicted from housing, or recent loss of housing, or imminent risk of loss of housing);
- AND**
3. Individuals with **two or more of the following issues** that are indicators of continuous high-service needs (i.e. greater than 8 hours of service per month):
 - a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic, Psychiatric Residential Treatment Facility (PRTF) or crisis residential (e.g., 3 or more admissions in a year) or extended hospital or PRTF stay (60 days in the past year) or psychiatric emergency services.
 - b. Persistent, recurrent, severe, or major symptoms that place the individual at risk of harm to self or others (e.g., command hallucinations, suicidal ideations or gestures, homicidal ideations or gestures, self-harm).
 - c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse.
 - d. High risk for or a recent history of criminal justice involvement related to mental illness (e.g., arrest and incarceration).
 - e. Chronically homeless (e.g., 1 extended episode of homelessness for a year, or 4 episodes of homelessness within 3 years).
 - f. Residing in an inpatient bed (i.e., state hospital, community hospital, CSU) or in a 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.
 - g. Inability to participate in traditional clinic-based services (must provide evidence of multiple agency trials if this is the only requirement met on the list).
- AND**
4. Meets one or more of the criteria below:
 - a. Individual is transitioning from a state forensic or adult mental health unit after an extended length of stay and the hospital's treatment team determines that due to the individual's history and/or potential risk if non-compliant with clinic-based community services a period of ACT is clinically necessary prior to transition to less intensive services;
 - b. Within the last 180 days, the individual has been incarcerated 2 or more times related to a behavioral health condition; or
 - c. Within the last 180 days, individual has been admitted to a psychiatric hospital or crisis stabilization unit 2 or more times.

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	<p>d. Past (within 180 days of admission) or current response to other traditional, community-based intensive behavioral health treatment has shown minimal effectiveness/unsuccessful treatment (e.g. Psychosocial Rehabilitation, ICM, etc.). The individual has been unsuccessfully treated in the traditional mental health service system at a level of greater than 8 hours of service per month. The recipient may have experienced chronic homelessness and/or criminal justice involvement; and may have had multiple and/or extended stays in state psychiatric/public hospitals. Admission documentation must include evidence to support this criterion.</p>
Continuing Stay Criteria	<p>Individual meets two (2) or more of the requirements below:</p> <ol style="list-style-type: none"> 1. Individual has been admitted to an inpatient psychiatric hospital, received services from a temporary observation unit or crisis service center, and/or received in-person crisis intervention services from ACT or Mobile Crisis one or more times in the past six (6) months; 2. Individual has had contact with Police/Criminal Justice System due to behavioral health problems in the past six (6) months; 3. Individual has displayed inability to maintain stable housing in the community due to behavioral health problems (i.e. individual fails to maintain home with safe living conditions such as insect infestation, damaging property, etc.) during the past six (6) months; 4. Individual continues to demonstrate significant functional impairment s and/or difficulty developing a natural support system which allows for consistent maintenance of medical, nutritional, financial, and legal responsibilities without incident in the past six (6) months. Examples include, but are not limited to: <ol style="list-style-type: none"> a. Natural Supports: Inability to identify, engage, and maintain relationships with friends and/or family support; b. Medical: Unable to comply with medical recommendations which results in significant health risk (such as inability to identify the need for medical attention, refusal to engage with traditional healthcare systems for medical needs (e.g. PCP appointments, etc.), demonstrated inability to manage medication even with available supports, continued use of alcohol or illicit drugs despite adverse consequences; c. Activities of Daily Living: Inability to maintain personal hygiene. Persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives. Failure to recognize and avoid common dangers or hazards to self and possessions; d. Nutritional/Financial: Consistent pattern of misuse of benefits such as SNAP, TANF, WIC, etc. such as documented evidence of selling food benefits for money or drugs and creating the frequent condition of lack of nourishment; e. Legal Responsibilities: Inability to comprehend illegal and legal actions, consistent engagement of high-risk illegal behaviors, or failure to comply with mandated community supervision or court orders. 5. Individual has displayed persistent, recurrent, severe, or major symptoms that place him/her at risk of harm to self or others (e.g. command hallucinations, suicidal ideation or gestures, homicidal ideation or gestures, self-harm) in the past six (6) months. 6. Documented efforts of attempts to transition an individual within the prior 6 months have resulted in unsuccessful engagement in traditional clinic-based behavioral health services and the subsequent need for ACT level intensity of services continues.
Discharge Criteria	<ol style="list-style-type: none"> 1. No individual should be considered for discharge prior to 45 days of consecutive outreach and documentation of attempted contacts (calls, visits to various locations, collateral/informal contacts etc.). 2. An adequate continuing care plan has been established; and one or more of the following: <ol style="list-style-type: none"> a. Individual no longer meets admission criteria; or b. Goals of the Individualized Recovery Plan have been substantially met; or c. Individual requests discharge and is not in imminent danger of harm to self or others; or d. Transfer to another service/level of care is warranted by a change in individual's condition; or e. Individual requires services not available in this level of care.
Service Exclusions	<ol style="list-style-type: none"> 1. ACT is a comprehensive team intervention and most services are excluded, with the exceptions of: <ol style="list-style-type: none"> a. Peer Supports; b. Residential Supports; c. Community Transition Planning (to be utilized as a person is transitioning to/from an inpatient setting, jail, or CSP); d. Group Training/Counseling (within parameters listed in Section A);

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	<ul style="list-style-type: none"> e. Supported Employment; f. Psychosocial Rehabilitation; g. SA Intensive Outpatient (If an addiction issue is identified and documented as a clinical need unable to be met by the ACT team Substance Abuse counselor, and the individual's current treatment progress indicates that provision of ACT services alone, without an organized SA program model, is not likely to result in the individual's ability to maintain sobriety ACT teams may assist the individual in accessing this service, but must ensure clinical coordination in order to avoid duplication of services. If ACT and SAIOP are provided by the same agency, the agency may update the existing authorization to include group services to be utilized by the SAIOP program; and h. Group therapy is not a service exclusion when the needs of an individual exceed that which can be provided by the ACT team, the individual may participate in SA group treatment provided by a Tier 1 or Tier 2 provider or SA-IOP provider upon documentation of the demonstrated need. i. Specialized evidence-based practices are not service exclusions (excluded) when the needs of an individual exceed that which can be provided by the ACT team (e.g. specialized treatment for PTSD, eating disorders, personality disorders, and/or other specific clinical specialized treatment needs). In this case, the Individual's recovery plan (IRP) must reflect the necessity for participation in such services along with medical record documentation of the unique need and resulting collaboration between service providers to ensure coordination towards goals and to prevent any duplication of services/effort. <ol style="list-style-type: none"> 2. On an individual basis, up to eight (8) weeks of some services may be provided to ACT consumers to facilitate a smooth transition from ACT to these other community services. A transition plan must be adequately documented in the IRP and clinical record. These services are: <ul style="list-style-type: none"> a. Case Management/Intensive Case Management. b. Psychosocial Rehabilitation Individual/Group. c. AD Support Services. d. Behavioral Health Assessment. e. Service Plan Development. f. Diagnostic Assessment. g. Physician Assessment (specific to engagement only). h. Individual Counseling (specific to engagement only). 3. ACT recipients who also receive a DBHDD Residential Service may not receive ACT-provided skills training which is a part of the "residential" service. The ACT provider shall be in close coordination with the Residential provider such that there is no duplication of services supports/efforts. 4. Those receiving Medicaid I/DD Waivers who meet the admission criteria above may be considered for this service as long as his/her waiver service plan is not so comprehensive in nature as to be duplicative to the ACT service scope.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition/substance use disorder co-occurring with one of the following diagnoses: developmental disability, autism, organic mental disorder, substance-related disorder. 2. Individuals may be excluded if there is evidence that they are unable to participate in the development of their Individual Recovery Plan as a result of significant impairment due to an I/DD diagnosis.
Required Components	<ol style="list-style-type: none"> 1. Assertive Community Treatment must include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings 80% of the time by a mobile multidisciplinary team. The team must provide community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings which will be documented in the served individual's medical record. 2. Ideally, and in accordance with the Dartmouth Assertive Community Treatment Scale (DACTS), the Treatment Team meeting must be held a minimum of 4 times a week with time dedicated to discussion of support to a specific individual, and documentation in the log of the Treatment Team Meetings as indicated in the Documentation Requirements section below. Each individual must be discussed, even if briefly, in each Treatment Team Meeting. The Treatment Team Meetings are to review the status of all individuals and the outcome of the most recent staff contacts, develop a master staff work schedule for the day's activities, and all ACT team members are expected to attend; exception of nonattendance can be made and documented by the Team Leader. The psychiatrist must participate at least one time/week in the ACT team meetings. 3. Each ACT team will identify an Individual Treatment Team (ITT) for each enrolled ACT individual.

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4. Individuals will be provided assistance by the ACT team with gaining skills and resources necessary to obtain housing of the individual's choice, including completion of the housing need and choice survey (<https://dbhddapps.dbhdd.ga.gov/NSH/>) upon admission and with the development of a housing goal, which will be minimally updated at each reauthorization.
5. Services and interventions must be individually tailored to the needs, goals, preferences and assets of the individual with the goals of maximizing independence and recovery as defined by the individual.
6. At least 80% of all service units must involve face-to-face contact with individuals. Eighty percent (80%) or more of face-to-face service units must be provided outside of program offices in locations that are comfortable and convenient for individuals (including the individual's home, based on individual need and preference and clinical appropriateness).
7. During the course of ACT service delivery, the ACT Team will provide the intensity and frequency of service needed for each individual. ACT teams are expected to achieve fidelity with the DACTS Model. To achieve a score of "4" in the Frequency of Contact Measure within DACTS, ACT Teams must provide a median of **3-3.99** face-to-face contacts per week across a sample of agency's ACT individuals. This measure is calculated by determining the median of the average weekly face-to-face contacts of each individual in the sample. At least one of these monthly contacts must include symptom assessment/management and management of medications.
8. During discharge transition, the number of face-to-face visits per week will be determined based on the person's mental health acuity with the expectation that these individuals participating in ACT transitioning must receive a minimum of 4 face-to-face contacts per month during the documented active transition period.
9. Service may be delivered by a single team member to 2 ACT individuals at the same time if their goals are compatible, however, this cannot be a standard practice. Services cannot be offered to more than 2 individuals at a time (exception: Item A.8.).
10. ACT recipients can receive limited Group Training/Counseling (up to 20 units/week) when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy (DBT), Motivational Enhancement, Integrative Dual Diagnosis Treatment (IDDT), etc. For this to be allowable, the ACT participants must have clinical needs and recovery goals that justify intervention by staff trained in the implementation of the specific curriculum-based therapy.
 - a. This group may be offered to no less than 3 individuals and no more than 10 ACT participants at one time.
 - b. Only ACT enrolled-individuals are permitted to attend these group services.
 - c. Acceptable group practitioners are those on the ACT team who meet the practitioner levels as follows:
 - i. Practitioner Level 1: Physician/Psychiatrist.
 - ii. Practitioner Level 2: Psychologist, CNS-PMH.
 - iii. Practitioner Level 3: LCSW, LPC, LMFT, and RN. In addition, and only performing these functions related to the treatment of substance use disorders: MAC, CAADC, GCADC-II or -III, and CAC-II.
 - iv. Practitioner Level 4: LMSW, APC, AMFT, and Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state. In addition, and only performing these functions related to the treatment of substance use disorders: GCADC-I (with Bachelor's Degree), CAC-I (with Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee (with Bachelor's Degree and under supervision).
 - v. Practitioner Level 5: GCADC-I (without Bachelor's Degree), CAC-I (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee (without Bachelor's Degree and under supervision) (practitioners at this level may only perform these functions related to treatment of addictive diseases).
 - d. Ideally, 50% of individuals with co-occurring substance use disorders will participate in a substance abuse group at least once per month with their ACT provider. If there are 2 practitioners leading the group who are the same practitioner level (i.e. two U3 practitioners), then each may split the responsibility for documentation and singly sign a note. In this situation, there must be evidence in the note of who was the co-leader of that group to document the compliance expectations for two practitioners.
 - e. If a group is facilitated by two practitioners who are not the same U-level (i.e. one is a U3 and one is a U4), then these co-leaders may split the responsibility for documenting group progress notes. If the lower-leveled practitioner writes the progress note, the upper level person's practitioner level

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	<p>can be billed if the higher practitioner-leveled person co-signs the note. If the higher level practitioner writes the note, then he/she shall document the co-leaders participation and can solely sign that note.</p> <p>f. There is no penalty to a provider for using the "in-clinic" code when a group is provided in a community-based setting, as there is no code currently available to document "out-of-clinic" groups.</p>
Staffing Requirements	<p>1. Assertive Community Treatment Team members must include:</p> <p>a. (1 FT Employee required) A fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must have at least 2 years of documented experience working with adults with a SPMI and one of the following qualifications to be an "independently licensed practitioner." It is expected that the practicing ACT Team Leader provides direct services at least 10 hours per week with the remaining work hours encompassing team-focused activities. The Team Leader must be a FT employee and dedicated to only the ACT team.</p> <ul style="list-style-type: none"> i. Physician ii. Psychologist iii. Physician's Assistant iv. APRN v. RN with a 4-year BSN vi. LCSW vii. LPC viii. LMFT ix. One of the following as long as the practitioner below is under supervision in accordance with O.C.G.A. § 43-10A-11: <ul style="list-style-type: none"> • LMSW* • APC* • AMFT* <p>* If the team lead is not independently licensed, then clinical supervision duties should be delegated appropriately in accordance with expectations set forth in O.C.G.A. Practice Acts.</p> <p>b. (Variable: .2-1.0 FTE required) Depending on individual enrollment, a full or part time Psychiatrist who:</p> <ul style="list-style-type: none"> i. provides clinical and crisis services to all team consumers; ii. delivers services in the recipient's natural environment when the individual is unable or unwilling to access a traditional service setting (this allowance is only for psychiatrists. Also, adherence to the 80% of the entire team's services provided in non-office settings requirement above is still maintained); iii. works with the team leader to monitor each individual's clinical and medical status and response to treatment; and iv. directs psychopharmacologic and medical treatment (at a minimum, must provide monthly medication management for each individual); v. must provide a minimum of 14 hours per week of direct support to the ACT team/ACT consumers; vi. the psychiatrist must participate in at least one time/week in the ACT team meetings; and vii. The psychiatrist (including Physician Extender) to ACT individual ratio must not be greater than 1:100. Specifically: <ul style="list-style-type: none"> • With 1-50 consumers, the requirement for the ACT team is to employ a Psychiatrist/Physician Extender minimally .35-.5 FTE (14 hrs./wk-20 hrs./wk.) providing support to the team and; • With 51-65 consumers, the requirement for the ACT team is to employ a Psychiatrist/Physician Extender minimally .36-.65 FTE (14.4 hrs./wk-26 hrs./wk.) providing support to the team and; • With 66-75 consumers, the requirement for the ACT team is to employ a Psychiatrist/Physician Extender t minimally .47-.75 FTE (18.8 hrs./wk-30 hrs./wk.) providing support to the team; and • With 76-100 consumers, the requirement for the ACT team is to employ a Psychiatrist/Physician Extender minimally .54 FTE-1 FTE (21.6 hrs./wk-40 hrs. /wk.) providing support to the team.

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- Teams utilizing a physician extender (APRN, NP, or PA) for part of the Psychiatrist time outlined above must maintain enough Psychiatrist time (not including physician extenders) to obtain a score of at least 3 on the DACTs on the Psychiatrist staffing item (.40FTE Psychiatrist per 100 consumers). The Psychiatrist's FTE and the physician extender's FTE combined would yield at least a 4 (.70 combined FTE per 100 consumers) on the DACTS. The physician extender's FTE that fulfills this requirement could not also be counted as fulfilling the FTE requirements for the RNs for the team (i.e. no portion of an FTE may be counted twice).
 - The ACT Team Psychiatrist would see each new admission to the ACT Team in a face-to-face appointment and would review each case with the physician extender on a monthly basis.
 - The physician extender would be expected to participate in ACT team meetings at least once per week as would the supervising Psychiatrist be expected to participate in an ACT team meeting at least once per week.
- c. (1-2 Fulltime Employee/s) RN/s who provide nursing services for all individuals, including health and psychiatric assessments, education on adherence to treatment, prevention of medical issues, rehabilitation, nutritional practices and works with the team to monitor each individual's overall physical health and wellness, clinical status and response to treatment
- i. With 1-50 consumers, the requirement for the ACT team is to employ a Registered Nurse minimally .7-1 FTE (28 hrs./wk-40 hrs./wk.) providing support to the team;
 - ii. With 51-65 consumers, the requirement for the ACT team is to employ a Registered Nurse minimally .73 FTE-1.3 FTE (29.2 hrs./wk-52 hrs./wk.) providing support to the team;
 - iii. With 66- 75 consumers, the requirement for the ACT team is to employ a Registered Nurse(s) .93 FTE-1.5 FTE (37.2 hrs./wk-60 hrs./wk.) providing support to the team and; and
 - iv. With 76-100 consumers, the requirement for the ACT team is to employ a Registered Nurse (s) 1.3 FTE -2 FTE (52 hrs. /wk-80 hrs. /wk. providing support to the team.
- d. A substance abuse practitioner who holds a CAC-I (or other SA certification equivalent or higher) and assesses the need for and provides and/or accesses substance abuse treatment and supports for team consumers.
- i. With 1-50 consumers, the requirement for the ACT team is to employ a SA practitioner minimally .7-1 FTE (28 hrs./wk-40 hrs./wk.) providing support to the team; and
 - ii. With 51-65 consumers, the requirement for the ACT team is to employ a SA practitioner minimally .73 FTE-1.3 FTE (29.2 hrs./wk-52 hrs./wk.) providing support to the team; and
 - iii. With 66- 75 consumers, the requirement for the ACT team is to employ a SA practitioner .93 FTE-1.5 FTE (37.2 hrs./wk-60 hrs./wk.) providing support to the team; and
 - iv. With 76-100 consumers, the requirement for the ACT team is to employ a SA practitioner 1.3 FTE -2 FTE (52 hrs. /wk-80 hrs. /wk. providing support to the team.
- e. (1 FT employee) A full-time practitioner licensed to provide psychotherapy/counseling under the practice acts or a person with an associate license who is supervised by a fully licensed clinician, and provides individual and group support to team consumers (this position is in addition to the Team Leader).
- f. (1 FTE) One FTE Certified Peer Specialist who is fully integrated into the team and promotes individual self-determination and decision-making and provides essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation and community self-help activities. CPSs must be supervised by an independently licensed/credentialed practitioner on the team.
- g. (2 FTEs) Two paraprofessional mental health workers who provide rehabilitation and support services under the supervision of a Licensed Clinician. The sum of the FTE counts for the following two bullets must equal at least 2 FTEs.
- i. (1 FTE) One of these staff must be a Vocational Specialist. A Vocational Specialist is a person with a minimum of one-year verifiable training and/or experience in vocational counseling.

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	<ul style="list-style-type: none"> ii. (1 FTE) Other Paraprofessional. 2. It is critical that ACT team members build a sound relationship with and fully engage in supporting the served individuals. To that end, no more than 1/3 of the team can be “contracted”/1099 team members. 3. The ACT team maintains a small consumer-to-clinician ratio, of no more than 10 individuals per staff member. This does not include the psychiatrist, program assistant/s, transportation staff, or administrative personnel. Staff-to-individual ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served. 4. Documentation must demonstrate that multiple members across disciplines from the ACT team are engaged in the support of individuals served by the team including direct and indirect service delivery for each intervention (excluding the substance abuse practitioner, if substance related issues have been ruled out). 5. At least one ACT RN must be employed by an ACT team. The RN works with a team at least 32 hours/week (up to 40 hours/week) and is a full-time employee of the agency (not a subcontractor/1099 employee).
Clinical Operations	<ul style="list-style-type: none"> 1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. 2. ACT Teams must incorporate assertive engagement techniques to identify, engage, and retain the most difficult to engage individuals which include using street outreach approaches and legal mechanisms such as outpatient commitment and collaboration with parole and probation officers. 3. Because ACT-eligible individuals may be difficult to engage, the initial treatment/recovery plan for an individual may be more generic at the onset of treatment/support. It is expected that the IRP be individualized and recovery-oriented after the team becomes engaged with the individual and comes to know the individual. The allowance for “generic” content of the IRP shall not extend beyond three months. 4. Because many individuals served may have a mental illness and co-occurring addiction disorder, the ACT team may not discontinue services to any individual based solely upon a relapse in his/her addiction recovery. 5. ACT is expected to actively and assertively participate in transitional planning via in person or, when in person participation is impractical, via teleconference meetings between stakeholders. The team is expected to coordinate care through a demonstrable plan for timely follow up on referrals to and from their service, making sure individuals are connected to resources to meet their needs in alignment with their preferences. The team is responsible for ensuring the individual has access to services and resources such as housing, pharmacy, benefits, a support network, etc. when being discharged from a psychiatric hospital; released from jail; or experiencing an episode of homelessness. ACT providers who are a Tier 1 or Tier 2+ Provider may use Community Transition Planning to establish a connection or reconnection to the individual and participate in discharge planning meetings while the individual is in a state operated hospital, crisis stabilization unit, jail/prison, or other community psychiatric hospital. 6. Each ACT provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities. 7. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods that shall be taken by the ACT team for supporting and responding to ACT enrolled individuals who require emergency psychiatric admission/hospitalization and/or crisis stabilization. <ul style="list-style-type: none"> a. The ACT team is required to respond to the crisis needs of ACT enrolled individuals, both directly and via collaboration with Mobile Crisis Response Service (MCRS). ACT teams will receive a phone call from MCRS when a GCAL call has been received for ACT enrolled consumers in crisis. Upon receipt of the call, the ACT team must; <ul style="list-style-type: none"> i. Respond to the MCRS call within 15 minutes of receipt; and ii. Engage in discussion w/ MCRS regarding clinical and/or crisis needs and location of individual; and iii. Agree upon appropriate intervention/response which shall be provided within 1 hour of completion of call, either in the form of ACT team responding in person, MCRS team responding in person or another agreed upon in-person response. b. ACT teams are required to respond with face-to-face evaluation and/or intervention to at least 85% of all crisis calls coming through GCAL involving their respective ACT enrolled individuals over the course of fiscal year. 8. The organization must have an Assertive Community Treatment Organizational Plan that addresses the following descriptions: <ul style="list-style-type: none"> a. Particular rehabilitation, recovery and resource coordination models utilized, types of intervention practiced, and typical daily schedule for staff.

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- b. Staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
 - c. Hours of operation, the staff assigned, and types of services provided to individuals, families, and/or guardians.
 - d. How the plan for services is modified or adjusted to meet the needs specified in the Individualized Recovery Plan.
 - e. Inter-team communication plan regarding individual support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.).
 - f. A physical health management plan.
 - g. How the organization will integrate individuals into the community including assisting individuals in preparing for employment.
 - h. How the organization (team) will respond to crisis for individuals served.
9. The ACT team is expected to work with informal support systems at least an average of 2 to 4 times a month with or without the individual present to provide support and skill training as necessary to assist the individual in his or her recovery. For individuals who have no identified informal supports, team members should document attempts to engage, identify, or build support networks at least 2 to 4 times per month. Informal supports are defined as persons who are not paid to support the individual (i.e., family, friends, neighbors, church members, etc.). Monthly maximum billing for informal support contacts without an individual being present shall not exceed 4 hours.
10. For the individuals which the ACT team supports, the ACT team must be involved in all hospital admissions and hospital discharges. The agency will be reviewed for fidelity by the standard that the ACT team will be involved with 95% of all hospital admissions and hospital discharges. This is evidenced by documentation in the clinical record.
11. The entire ACT team is responsible for completing the ACT Comprehensive Assessment for newly enrolled individuals. The ACT Comprehensive Assessment results from the information gathered and are used to establish immediate and longer-term service needs with each individual and to set goals and develop the first individualized recovery plan. Because of the complexity of the mental illness and the need to build trust with the served individual, the comprehensive mental health, addiction, and functional assessments may take up to 60 days. Enrolled individuals will be re-assessed at 6-month intervals from date of completion of the comprehensive assessment. It is expected that when a person identifies and allows his/her natural supports to be partners in recovery that they will be fully involved in assessment activities and ACT team documentation will demonstrate this participation. The ACT Comprehensive Assessment shall (at a minimum) include:
- a. Psychiatric History, Mental Status/Diagnosis.
 - b. Physical Health.
 - c. Substance Abuse assessment.
 - d. Education and Employment.
 - e. Social Development and Functioning.
 - f. Family Structure and Relationships.
12. Treatment and recovery support to the individual is provided in accordance with a Recovery Plan. Recovery planning shall be in accordance with the following:
- a. The Individual Treatment Team (ITT) is responsible for providing much of the individual's treatment, rehabilitation, and support services and is charged with the development and continued adaptation of the person's recovery plan (along with that person as an active participant). The ITT is a group or combination of three to five ACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned by the team leader to work collaboratively with an individual and his/her family and/or natural supports in the community by the time of the first recovery/resiliency planning meeting or thirty days after admission. The key members are the primary practitioner and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each individual. ITT members are assigned to take separate service roles with the individual as specified by the individual and the ITT in the IRP.
 - b. The Recovery Plan Review is a thorough, written summary describing the individual's and the ITT's evaluation of the individual's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered IRP.
 - c. The Recovery Planning Meeting is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of these meetings is for the staff, as a team, and the individual and his/her family/natural supports, to thoroughly prepare for their work together. The

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	<p>group meets together to present and integrate the information collected through assessment in order to learn as much as possible about the individual's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each individual and his/her goals and aspirations and for each individual to become familiar with each ITT staff person. The IRP shall be reevaluated and adjusted accordingly (at least quarterly) via the Recovery Planning Meeting prior to each reauthorization of service (Documentation is guided by elements G.2. and G.3. below).</p> <p>13. In order to maintain compliance with the DACTS fidelity model, each ACT team may enroll a maximum of 8 individual admissions per month. Allowing teams to meet and maintain the expectation of an active average daily census of at least 75 individuals.</p> <p>14. It is expected that 90% or more of the individuals have face to face contact with more than one staff member in a 2-week period.</p>
Service Accessibility	<p>1. Services must be available by ACT Team staff skilled in crisis intervention 24 hours a day, 7 days a week with emergency response coverage, including psychiatric services. Answering devices/services/Georgia Crisis and Access Line do not meet the expectation of "emergency response".</p> <p>2. The team must be able to rapidly respond to early signs of relapse and decompensation and must have the capability of providing multiple contacts daily to individuals in acute need.</p> <p>3. An ACT staff member must provide this on-call coverage.</p> <p>4. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.</p> <p>5. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. The ACT Physician may use telemedicine to provide this service by using the code above with the GT modifier. Telemedicine is not to be utilized as the primary means of delivery of psychiatric services for ACT consumers and should not exceed 50% of psychiatric contacts.</p>
Billing & Reporting Requirements	<p>1. ACT teams are expected to submit all requisite information in order to establish eligibility for the initial authorization, and if an individual meets eligibility they receive a 12-month authorization for ACT services. During the first 12-months, consumers receive an automatic-authorization for the first 4 authorizations for ACT services. ACT teams are required to submit information that the ASO system references as a "reauthorization" every 90 days for collection of consumer outcome indicators. This data collection is captured from information submitted by ACT teams during initial and subsequent authorization periods. There is no clinical review taking place during this 90-day data collection process, the 90-day data collection-reauthorization meets the need of data collection only. At these intervals, the use of the term "reauthorization" is merely a data collection process and not a clinical review for eligibility every 90 days ACT teams are expected to submit all requisite information in order to establish continued eligibility for the concurrent review, this reauthorization review for medical necessity time frame is 180 days and begins after the initial 12 months of authorized services and occurs no less than every 6 months thereafter.</p> <p>2. All submissions for initial authorization must be entered into the ASO system within three days of establishing eligibility for ACT services.</p> <p>3. ACT teams are expected to submit all initial authorizations for service and all 6 month concurrent authorizations in a timely manner. All continuing stay reauthorization must be submitted in advance of the expiration of the current authorization.</p> <p>4. All time spent between 2 or more team practitioners discussing a served individual must be reported as H0039HT. While this claim/encounter is reimbursed at \$0, it is imperative that the team document these encounters (see Documentation Requirements below) to demonstrate program integrity AND submit the claim/encounter for this so this service can be included in future rate setting.</p> <p>5. The following elements (at a minimum) shall be documented in the clinical record and shall be accessible to the DBHDD monthly as requested:</p> <ol style="list-style-type: none"> Served individual's employment status; Served individual's residential status (including homelessness); Served individual's involvement with criminal justice system/s; Served individual's interactions with crisis support services (including acute psychiatric hospitals, emergency room visits, crisis stabilization program interactions, etc.). <p>6. ACT may not be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or crisis stabilization program with greater than 16 beds), jail, or prison system.</p>

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	<ol style="list-style-type: none"> 7. The ACT team can provide and bill for Community Transition Planning as outlined in the Guideline for this service. This includes supporting individuals who are eligible for ACT and are transitioning from Jail/Prison. 8. When group services are provided via an ACT team to an enrolled ACT-recipient, then the encounter shall be submitted as a part of the ACT type of care defined in the Orientation to Services section of Part I, Section 1 of this manual. 9. Each ACT program shall provide monthly outcomes data as defined by the DBHDD.
Documentation Requirements	<ol style="list-style-type: none"> 1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section IV of the Provider Manual and in keeping with this section G. 2. All time spent between 2 or more team practitioners discussing a served individual must be documented in the medical record as H0039HT. While this claim/encounter is reimbursed at \$0, it is imperative that the team document these encounters to demonstrate program integrity AND submit the claim/encounter for this so this service can be included in future rate setting. HT documentation parameters include: <ol style="list-style-type: none"> a. If the staff interaction is specific to a single individual for 15 minutes, then the H0039HT code shall be billed to that individual (through claims or encounters). b. If the staff interaction is for multiple individuals served and is for a minimum single 15-minute unit and: <ol style="list-style-type: none"> i. The majority of time is for a single individual served, then the claim/encounter shall be submitted attached to the individual's name who was the focus of this staffing conversation; or ii. The time is spent discussing multiple individuals (with no one individual being the focus of the time), then the team should create a rotation list (see below) in which a different individual would be selected for each of these staffing notes in order to submit claims and account for this staffing time; and c. An agency is not required to document every staff-to-staff conversation in the individual's medical record; however, every attempt should be made to accurately document the time spent in staffing or case conferencing for individual consumers. The exceptions (which shall be documented in a medical record) are: <ol style="list-style-type: none"> i. When the staffing conversation modifies an individual's IRP or intervention strategy; and ii. When observations are discussed that may lead to treatment or intervention changes, and/or that change the course of treatment. 3. The ACT team must have documentation (e.g., notebook, binder, file, etc.) which contains all H0039HT staffing interactions (which shall become a document for audit purposes, and by which claims/encounters can be revoked-even though there are no funds attached). In addition to the requirements in Section G.2.above, a log of staff meetings is required to document staff meetings as outlined in Section A.2. The documentation notebook shall include: <ol style="list-style-type: none"> a. The team's protocol for submission of H0039HT encounters (how the team is accounting for the submissions of H0039HT in accordance with the above); b. The protocol for staffings which occur ad hoc (e.g. team member is remote supporting an individual and calls a clinical supervisor for a consult on support, etc.); c. Date of staffing; d. Time start/end for the "staffing" interaction; e. If a regular team meeting, names of team participants involved in staffing (signed/certified by the team leader or team lead designee in the absence of the team leader); f. If ad hoc staffing note, names of the team participants involved (signed by any one of the team members who is participating); g. Name all of individuals discussed/planned for during staffing; and h. Minimal documentation of content of discussion specific to each individual (1-2 sentences is sufficient). 4. If the group location is documented in the note as a community-based setting (despite the absence of an "out-of-clinic" code for group reporting), then it will be counted for reviews/audits as an out-of-clinic service. 5. All expectations set forth in this "Additional Service Components" section shall be documented in the record in a way which demonstrates compliance with the said items.