

# Best Practices in Assertive Community Treatment



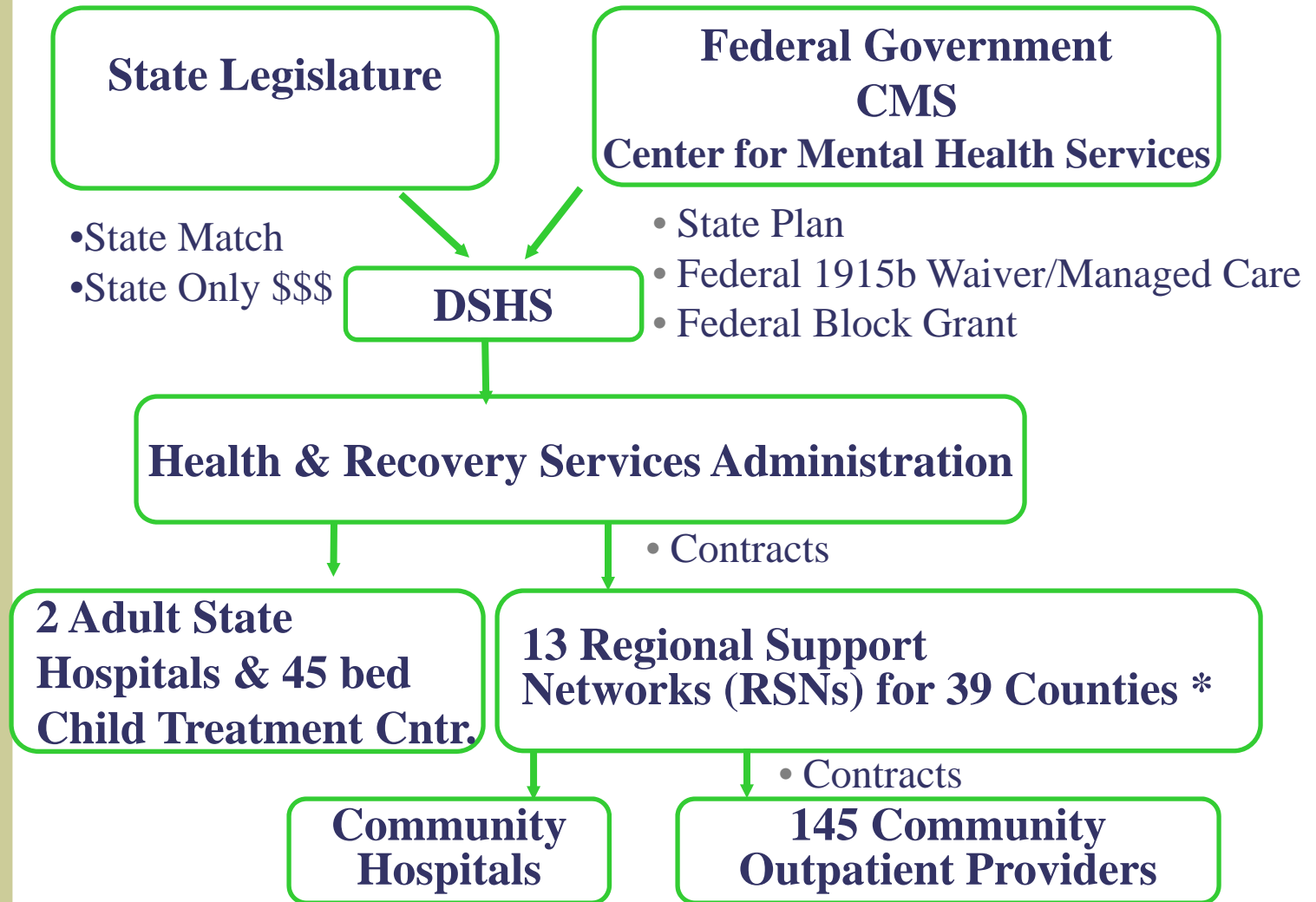
**National Association of State Medicaid Directors  
Fall 2009 Conference**

Washington State  
Department  
of Social  
& Health  
Services

**Doug Porter**  
Assistant Secretary  
Health and Recovery Services Administration

November 11, 2009

# Washington Mental Health Structure



# Genesis of PACT Implementation in Washington State

## Challenges Facing the 2006 Legislature

- Decreasing community psychiatric inpatient capacity
- State hospital waiting lists
- Court rulings in September 2005
  - No wait for transfer of community hospital patients on 90/180 involuntary treatment orders
  - Failure to follow proper procedures for assessing “liquidated damages” to RSNs exceeding allocation of state hospital beds
- Variable inpatient utilization and lengths of stay
  - Long lengths of stay in Washington’s state hospitals
  - Significant disparities in lengths of stay when comparing state hospitals
  - Significant disparities between RSNs in per capita inpatient utilization



# Critical Policy Catalysts Addressed in the 2006 Legislative Session

## Summary of Statutory and Budget Changes

- Clarified roles of State & RSNs related to community and state hospital care
- Affirmed State's authority to charge RSNs for state hospital bed days which exceed allocation and state hospital appropriation
- Time limited investment in State Hospital capacity to deal with inpatient access issues
- Investment in enhanced community resources to reduce reliance on state hospitals
  - \$10.4 million annually for PACT (100% State Funded)
  - \$6.5 million annually for community alternatives for individuals in a residential program run by the state hospital
- Long term planning



# PACT Implementation and Dissemination Strategies

- HRSA Contracts with University of Washington for technical assistance in developing Washington PACT Standards and Training PACT Teams in October 2006
- HRSA contracts with 6 western RSNs for 7 teams beginning in July 2007
- HRSA contracts with 3 eastern RSNs for 3 teams beginning in October 2007
- Each PACT team staggers consumer admissions (4-6 per month) until full capacity reached
- State Hospital patients have priority for admission to PACT
  - Over half of the enrolled PACT consumers are directly referred from State Hospitals/ approximately 75% have prior state hospital admissions
  - 120 state hospital beds opened on a temporary basis were phased out as PACT teams phase in with final ward closed in October 09



# PACT Implementation and Dissemination Strategies (cont'd)

- Washington arranges for PACT teams to shadow high fidelity PACT teams in Tulsa, Oklahoma prior to start-up
- Extensive Individualized PACT Start-Up and Booster Training provided through the University of Washington (UW) and national consultants
- Additional Training in Core Content Areas provided by UW:
  - Motivational Interviewing & Dual Disorders Treatment
  - Supported Employment
  - Strengths-Based Assessment & Person-Centered Planning
  - Safety & Therapeutic Boundaries
  - Team Leader retreat & ongoing team role break-out sessions
- Ongoing program-level and clinical consultation provided by UW
- State Website to Support PACT Teams



# Key Features of the Program/Service Design

- WA-PACT Standards adapted from National ACT Program Standards (Allness & Knoedler, 2003) in consultation with Deborah Allness
- Strengthened requirements related to Person-Centered Planning, Recovery Focus, and use of Evidence Based Practices
- Fidelity assessment through T-MACT- enhancement of the Dartmouth Assertive Community Treatment Scale (DACTS)



# Key Features of the Program/Service Design

## Minimum Staffing

Position	Urban	Rural
Team leader	1 FTE	1 FTE
Psychiatric prescriber	16 Hours for 50 Consumers	16 Hours for 50 Consumers
Registered Nurse	3 – 5 FTE	1.5 – 2 FTE
Peer Specialist	1 FTE	1 FTE
Master's level*	4 FTE	2 FTE
Other level*	1 – 3 FTE	1.5 – 2.5 FTE
Program/Administrative Assistant	1-1.5 FTE	1 FTE

### Notes:

- 1 or more members expected to have training and experience in vocational services
- 1 or more members expected to have training and experience in substance abuse services



# PACT Funding Mechanisms

- \$1.3m per year in state funds contracted for each of 6 urban PACT teams serving 90 -100 individuals
- \$650,000 per year in state funds contracted for 4 rural PACT teams serving up to 42-50 individuals
- All teams received a full quarter year budget for development, startup and training costs
- All teams required to submit annual budgets, meet minimum staffing levels, and adhere to Washington PACT Standards
- \$200,000 - \$300,000 per year in state funds contracted with the University of Washington for:
  - Development of Washington PACT Standards
  - Development of Washington PACT Fidelity Scale and Protocols
  - Ongoing Training and Technical Assistance of PACT Teams
  - Conducting Fidelity Reviews and Writing Fidelity Reports



# Why Washington Chose to Fund PACT With Medicaid

- Fidelity- PACT was not in Washington's State Plan or Waiver and closest service modality (High Intensity Treatment) was significantly less than fidelity model (see slides 11-13)
- Time- Implementation was driven by response to lawsuit and did not allow time for modification of the state plan or waiver
- Statewide- Funding only provided for teams in 9 of 39 Washington Counties creating potential challenges with CMS related to access
- Control- State lacked ability to require funds built into RSN capitation rates would actually be used for PACT



# Comparison between PACT & Washington's High Intensity Treatment Modality

	PACT Standards- State Funded	High Intensity Treatment - Medicaid
Staff Qualifications	➤ <b><u>Specific staffing requirements</u></b> including psychiatrist or ARNP, 3-5 RNs, cd specialist, vocational specialist, peer specialist and other mental health professionals. No less than 8 of the staff on an urban team must be MHPs.	➤ <b><u>No staffing requirements</u></b> other than team under direction of a mental health professional
Team Size	➤ Minimum for urban team - <b><u>10 to 12 FTE</u></b> clinical staff	➤ <b><u>No standard</u></b> for minimum team size
Staff Ratios	➤ Maximum of <b><u>1 to 10</u></b> staff to consumer ratio not including prescriber (rural teams are 1-8)	➤ Maximum of <b><u>1 to 15</u></b> staff to consumer ratio
Peer Specialist	➤ Each team <b><u>required</u></b> to have minimum of 1 peer specialist	➤ <b><u>No requirement</u></b> for peer specialist
Coordination	➤ <b><u>Standards</u></b> for daily team meetings & communication	➤ <b><u>No standards</u></b>



# Comparison between PACT & Washington's High Intensity Treatment Modality (cont'd)

	PACT Standards- State Funded	High Intensity Treatment - Medicaid
Admission & Discharge Criteria	➤ <b><u>Detailed standard</u></b> admission and discharge criteria	➤ <b><u>No standard</u></b> admission and discharge criteria
24/7 coverage	➤ Yes- after hours services <b><u>provided by PACT clinicians</u></b> familiar with the consumers	➤ Yes- after hours services can be <b><u>provided by non-PACT clinicians</u></b> unfamiliar with the consumers
Frequency of contact	➤ Minimum average of <b><u>3 contacts per week</u></b>	➤ <b><u>No minimum standards</u></b>
Place of Treatment- Outreach Standards	➤ <b><u>75%-85%</u></b> of service contacts in non-office-based settings (e.g. consumer's home)	➤ <b><u>No minimum standards</u></b>
Brokering of Services	➤ Team required to provide all core services and <b><u>not refer out</u></b>	➤ <b><u>No requirement</u></b> preventing team from referring out
Advisory Group	➤ <b><u>Required</u></b> - 51% must be consumers & family members	➤ <b><u>Not</u></b> Required



# Comparison between PACT & Washington's High Intensity Treatment Modality (cont'd)

	PACT Standards- State Funded	High Intensity Treatment - Medicaid
Minimum Core Services Provided by Team	<ul style="list-style-type: none"> <li>➤ Service Coordination</li> <li>➤ Crisis Assessment &amp; Intervention</li> <li>➤ Symptom Management and Psychotherapy</li> <li>➤ Wellness Management &amp; Recovery</li> <li>➤ Medication, Administration, Monitoring and Documentation</li> <li>➤ Co-Occurring Disorders Services</li> <li>➤ Supported Education Services</li> <li>➤ Vocational Services</li> <li>➤ Activities of Daily Living Services</li> <li>➤ Skills Training</li> <li>➤ Services to Ensure Consumers Access other Critical Services</li> <li>➤ Family &amp; Natural Supports</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b><u>No minimum defined service package.</u></b> Modality states: Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan.</li> </ul>



# Options for Moving WA-PACT Into Medicaid

## Option 1: Amend State Plan and Waiver and administer PACT as FFS

### Benefits:

- State Plan amendment can be written to ensure fidelity model
- Funds budgeted for PACT will not be re-directed

### Challenges:

- Inability to control growth of the program
- Not integrated with RSNs and current continuum of care
- Increases administrative responsibilities during time of staff reductions
- Issues related to bundled services



# Options for Moving WA-PACT Into Medicaid

## Option 2: Build Medicaid costs of PACT into RSN capitation rates utilizing current High Intensity Treatment modality

### Benefits:

- Does not require state plan or waiver amendment
- Maintains PACT within the RSN delivery system

### Risks:

- No ability to ensure fidelity to the model
- No ability to ensure funding built into capitation will continue to be used for PACT- this is exacerbated by budget driven RSN rate cuts pressuring them toward less costly services



# Options for Moving WA-PACT Into Medicaid

## Option 3: Amend waiver to include PACT as a b3 modality and build the Medicaid costs into RSN b3 capitation rates

### Benefits:

- Waiver amendment can be written to ensure fidelity model
- Maintains PACT within the RSN delivery system
- Ability to control expenditures

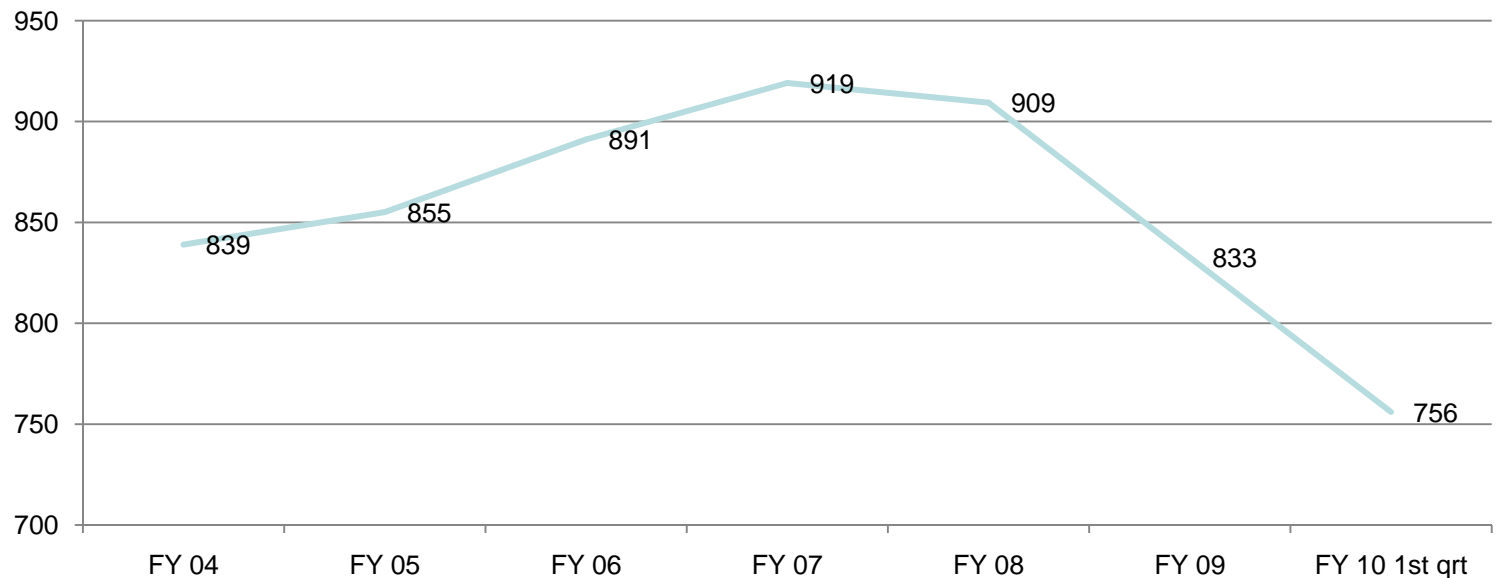
### Risks:

- Feasibility due to CMS efforts to limit growth of b3 services
- PACT would become an “optional” service



# Changes in Census Since PACT Implementation

## Civil Average Daily Census at Washington State Hospitals



### Notes:

1. State Hospital ADC numbers do not capture the fact that ,prior to PACT, there was an average of up to 40 persons per day waiting for a state hospital bed. Currently there is no wait list for a civil bed.
2. Other initiatives to reduce census occurred simultaneous to PACT making it difficult to assess the real impact of PACT on hospital census- an evaluation of PACT outcomes including hospital recidivism will be available in 2010



# Lessons Learned and Ongoing Challenges

- Housing- no resources were allocated as part of the implementation plan and the lack of affordable housing and competition for resources has created challenges for all teams
- Challenges in recruiting qualified professional staff have resulted in need for temporary waivers to the minimum standards
- Initial turnover high for some teams during startup as some staff hired were not a good match- need to be able to train new staff
- Continuing challenges incorporating Evidence-Based Practices & promising practices into services such as:
  - Supported Employment
  - Integrated Dual Disorders Treatment (IDDT)
- Need to transition teams from focusing on working in crisis-mode to providing proactive and sustainable treatment interventions
- Ongoing technical assessment and monitoring required to ensure service plans are strength based and person centered



# Additional Resources

- Further information including the Washington PACT Standards and TMACT fidelity scale can be found online at:  
[http://www1.dshs.wa.gov/mentalhealth/sti\\_pact.shtml](http://www1.dshs.wa.gov/mentalhealth/sti_pact.shtml)
- A January 2009 article on Psychiatric Services on Washington State's Initiative to Disseminate and Implement High-Fidelity ACT Teams can be found online at:  
[http://www.dshs.wa.gov/pdf/hrsa/mh/bjorklund\\_psychiatric\\_services.pdf](http://www.dshs.wa.gov/pdf/hrsa/mh/bjorklund_psychiatric_services.pdf)
- Further questions regarding Washington's PACT Program:

Andy Toulon

Phone: (360) 725-1784

email: [andrew.toulon@dshs.wa.gov](mailto:andrew.toulon@dshs.wa.gov)

