Best Practices in Assertive Community Treatment

National Association of State Medicaid Directors
Fall 2009 Conference

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Health and Recovery Services Administration

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Washington Mental Health Structure

State Legislature
- State Match
- State Only $$$

Federal Government
CMS
Center for Mental Health Services
- State Plan
- Federal 1915b Waiver/Managed Care
- Federal Block Grant

Health & Recovery Services Administration
- Contracts

2 Adult State Hospitals & 45 bed Child Treatment Cntr.

13 Regional Support Networks (RSNs) for 39 Counties *
- Contracts

Community Hospitals

145 Community Outpatient Providers

* Limited mental health services for individuals not meeting eligibility for RSN services offered through ffs and physical managed care plans
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

<table>
<thead>
<tr>
<th>Position</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team leader</td>
<td>1 FTE</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Psychiatric prescriber</td>
<td>16 Hours for 50 Consumers</td>
<td>16 Hours for 50 Consumers</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>3 – 5 FTE</td>
<td>1.5 – 2 FTE</td>
</tr>
<tr>
<td>Peer Specialist</td>
<td>1 FTE</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Master’s level*</td>
<td>4 FTE</td>
<td>2 FTE</td>
</tr>
<tr>
<td>Other level*</td>
<td>1 – 3 FTE</td>
<td>1.5 – 2.5 FTE</td>
</tr>
<tr>
<td>Program/Administrative</td>
<td>1-1.5 FTE</td>
<td>1 FTE</td>
</tr>
</tbody>
</table>

**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

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

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

<table>
<thead>
<tr>
<th>Minimum Core Services Provided by Team</th>
<th>PACT Standards- State Funded</th>
<th>High Intensity Treatment - Medicaid</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Service Coordination</td>
<td>No minimum defined service package. Modality states: Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan.</td>
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<tr>
<td></td>
<td>Crisis Assessment &amp; Intervention</td>
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<td></td>
<td>Symptom Management and Psychotherapy</td>
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<td></td>
<td>Wellness Management &amp; Recovery</td>
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<tr>
<td></td>
<td>Medication, Administration, Monitoring and Documentation</td>
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<td></td>
<td>Co-Occurring Disorders Services</td>
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<td></td>
<td>Supported Education Services</td>
<td></td>
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<tr>
<td></td>
<td>Vocational Services</td>
<td></td>
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<tr>
<td></td>
<td>Activities of Daily Living Services</td>
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<tr>
<td></td>
<td>Skills Training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Services to Ensure Consumers Access other Critical Services</td>
<td></td>
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<tr>
<td></td>
<td>Family &amp; Natural Supports</td>
<td></td>
</tr>
</tbody>
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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

• 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

• Further questions regarding Washington’s PACT Program:

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