

**Berks County/Community Care  
Assertive Community Treatment (ACT) Team  
Referral, Admission, Discharge Process**

3-2-09 Final

**Overview:** Assertive Community Team (ACT) is a voluntary, primary, direct service which provides comprehensive and intensive outpatient mental health and addictions treatment in addition to rehabilitative and support services to persons with a serious and persistent mental illness and addiction problems. These individuals are not able to benefit from traditional community mental health and drug and alcohol services. ACT services are targeted for those persons who have not achieved and maintained health and stability in the community and for whom without these services would continue to experience hospitalization, incarceration and psychiatric emergencies. Guided by CSP and Recovery Principles, ACT services merge clinical, rehabilitative and support staff expertise within one service delivery team with minimal referral of consumers to other program entities for these interventions.

**Referral Process:**

- Referral source discusses the referral with the consumer
- Referral source completes the Assertive Community Treatment (CTT) referral form.
- All referrals are faxed to Community Care Behavioral Health at 1-866-418-0366. Community Care will then fax to Wolf Hrubyk, Berks County MH/MR as appropriate for adult team referrals. Referrals will be reviewed for admission/eligibility for ACT. Community Care may contact the referral source with a request to provide additional information. Community Care will contact the referral source with the outcome of the medical necessity review.
- Community Care may take up to 10 days to review the referral and render a decision. A Physician Advisor will be consulted on any case in which an Exception to the eligibility criteria is considered.
- If the individual does not meet the admission/eligibility criteria for ACT, Community Care will recommend an alternative and appropriate level of support and treatment necessary to address the needs of the consumer being referred.
- Berks County and Community Care will collaborate to prioritize approved referrals. The team may assume no more the 6 new referrals per month. Some of the factors that will be taken into consideration will be risk of homelessness, number of contacts with crisis intervention services, repeated hospitalizations, severity of symptoms, and adherence to the reinvestment guidelines documenting the priority population.
- Open referrals and the client's current status will be discussed on a weekly basis between Community Care and the ACT Team Leader. Approved referrals will be faxed to the attention of the program's administrative assistant for distribution to

the Team Leader. ACT will have 30 days to complete the assessment process. The provider will be authorized for 150 units for the engagement to begin. ACT can request additional hours if necessary.

- The referral source and/or ACT will identify if the individual will need to continue receiving any existing services during the transition to ACT. Services funded by Community Care, like IMC, RC, may overlap for 30 days, to ease the transition. Any overlap of service beyond 30 days must be reviewed and approved the Community Care. An Interagency meeting may prove helpful in designing the transition plan or to clarify the need for ongoing concurrent services.
- The provider can request an assignment to a lower level of support anytime after the 30 days of initial assignment if upon full assessment the medical necessity criteria are not met. If a request is made, an ACT team meeting will occur, to which Community Care and the county are invited, to discuss the current clinical situation and rationale for the change. . Additional clinical information may be requested and a Community Care Peer Advisor will be consulted.

#### **Engagement Process:**

- Upon receipt of an approved referral, ACT is given an initial authorization for 30 days, 150 units to start the engagement process .If a longer engagement period is needed, ACT will call Community Care to request another 30 day authorization.
- The referral source or the ICM will obtain the initial Consent to Engage with Reading Act and send this directly to the ACT program.
- Once the member officially signs on for ACT that they agree to this plan of services, the ACT team is then responsible for managing the clinical care. Upon signed agreement into ACT services, an initial assessment is completed the day of admission. There is a six week period to get a comprehensive assessment completed, followed by an additional 2 week period to complete the individualized treatment plan.
- Requests for ongoing concurrent services include the clinical rationale and will be reviewed by a Physician Advisor. It is expected an interagency meeting has occurred to discuss this request/plan.
- For all clients still not engaged after the 90 day period, and all options have been exhausted, the team, in collaboration with Community Care, utilizes their clinical judgment as to whether to continue attempts to engage client. (See section on Discharge process). Community Care will notify the county of a discharge and the services offered to the member.

#### **Continued Stay review process:**

- Once the member has engaged in the ACT program, continued stay reviews are completed to determine if medical necessity criteria are met. Members in the program shall have a current authorization.
- ACT is responsible for scheduling this telephonic review with the Community Care Care Manager prior to the end of the most recent authorization.
- The first continued stay review is entered for 60 days, allowing time for the team to complete the comprehensive assessment and individualized treatment plan

Subsequent continued stay reviews may be authorized for up to 90 days of service with 450 units on average (150 per month).

- The ACT team is responsible for tracking units delivered, projecting any shortage of units, and if needed, calling Community Care prior to the end of that authorization with rational/justification for additional units.

#### **Discharge Process:**

- When the consumer and team determine that ACT services are no longer needed, based on the attainment of goals, lesser levels of service are explored, appropriate referrals made, and a telephonic discharge review is completed with Community Care. Overlap of services for 30 days may be appropriate to allow for transition to these other levels of service. An inter-disciplinary meeting may prove helpful to coordinate referrals and admission to other services, without interruption.
- When the consumer moves out of the county it is expected that ACT has facilitated the referral to other services. A telephonic discharge review is completed with Community Care.
- When the consumer, and/or guardian choose to withdraw from services (or never fully engaged in services, or refused to sign the consent to treatment) the ACT program documents all attempts made by the program to engage/reengage the consumer with the services. Community Care and the county participate in the ACT treatment team meetings at which discharge under these circumstances is being considered. ACT offers referrals to the consumer and the Care Manager will assist as needed/warranted. A telephonic discharge review is completed with Community Care.
- Consumers active with the ACT team who are incarcerated during an episode of treatment will require close monitoring of the incarceration period. Community Care is to be notified immediately of any consumer incarcerated. Consumers usually lose eligibility with Community Care while incarcerated. (Community Care cannot pay for services when the eligibility has ended) Each case is investigated. The county is also informed. A team meeting is held as warranted. Any consumer with an anticipated sentence of 6 months or more should be discharged from the program. A team meeting is held and the appropriate liaison invited:
  - Adults (over 18): SAM has contract with MHMR for liaison to Berks County Prison. Coordinate activity with this SAM prison liaison.
  - Under 18 – Concern Professional Services is contracted by MH/MR to provide outpatient and case management services at Youth Center. Coordinate activity with this agency.

A telephonic discharge review is completed with Community Care.

**BERKS COUNTY HEALTH CHOICES REFERRAL FOR:**

**ASSERTIVE COMMUNITY TREATMENT (ACT) check one**  
**Fax to Community Care at 1-866-418-0366**

- Reading Hospital Adult Team (Age 18 and older)**  
       **Berks Counseling Center Transitional Age Team (Must be age 16-25)**

**Demographic, Identifying and Contact Information:**

(All the following information is required to activate a referral)	Referral Date _____
Name: _____	DOB: _____
MA ID# : _____	SS#: _____
Current Address: _____	
Current Phone #'s: _____	
Case Manager: Name: _____	Phone #: _____
Who is making the referral? _____	Phone #: _____
Provider/Facility: _____	
Referral discussed with consumer? _____	
Response: _____	
Primary Language Spoken: _____	
<b>Release of Information signed for referral to Berks County MH/MR, Community Care, and to Reading Hospital ACT Team, if approved. YES NO</b>	

Consumer Eligibility:

Adults, age 18 years of age or older, (age 16 -25 for Transitional Age) who have serious and persistent mental illness. A person shall be considered to have a serious and persistent mental illness when all of the following criteria for diagnosis, treatment history, and functioning level (A, B, C and D) are met.

**A. Diagnosis:**

Primary diagnosis of schizophrenia or other psychotic disorders such as schizoaffective disorder, or bipolar disorder as defined in the DSM IV-R (or subsequent update). Individuals with a primary diagnosis of a substance use disorder, mental retardation, or brain injury are not the intended consumer group.

List Current Diagnosis

- Axis I: \_\_\_\_\_  
Axis II: \_\_\_\_\_  
Axis III: \_\_\_\_\_  
Axis IV: \_\_\_\_\_  
Axis V: \_\_\_\_\_

Medications	Dose	Frequency

Attach additional sheet if need

B. Functioning level: GAF ratings of 40 or below. Rating \_\_\_\_\_

C. Consumer who meets at least two (2) of the following criteria:

- a. As of the referral date, at least two (2) psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months that can include admissions to the psychiatric emergency services

List Hospitalizations for mental health in the last 12 months:

Facility/Hospital	Dates	Outcome/Disposition

- b. Intractable (i.e. persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal):

List life threatening /self harm Behaviors:

<u>Method</u>	<u>Date</u>	<u>Disposition</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Describe severe major symptoms:

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- c. Co-occurring mental illness and substance use disorders with more than six months duration at the time of contact

List Substances Abused/Dependent/Treatment History if known

<u>Type</u>	<u>Frequency</u>	<u>Date Last Used</u>
1.		
2.		
3.		
4.		

- d. High risk or recent history of criminal justice involvement which may include frequent contact with law enforcement personnel, incarcerations, parole or probation;

List Incarcerations/Criminal Justice System involvement in the last 12 months:

<b>Incarceration/Law Enforcement</b>	<b>Date of Encounter</b>	<b>Outcome/Disposition</b>

Probation/Parole; Name of Officer; Length of service, Reason:

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- e. Literally homeless, imminent risk of being homeless, or residing in unsafe housing;

Describe in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- f. Residing in an inpatient or 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.



**Medical Conditions and Activities of Daily Living:**

**Medical Conditions:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Activities of Daily Living: Check all that apply**

Visually Impaired       Hearing Impaired       Language Barrier

Independent with ADL's

Primary Language: \_\_\_\_\_

ADL Dependent Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Outcome of Community Care/Berks County Review**

Referral received on: \_\_\_\_\_

Review Date \_\_\_\_\_

**Outcome:**

Not approved; Referral Source Notified on \_\_\_\_\_

Approved for Referral to  
 Reading Adult ACT

Berks Counseling Center Transitional Age ACT

Initial Authorization given for \_\_\_\_\_ units from \_\_\_\_\_ to \_\_\_\_\_

**BERKS COUNTY HEALTH CHOICES REFERRAL FOR:**

**ASSERTIVE COMMUNITY TREATMENT (ACT) check one**  
**Fax to Community Care at 1-866-418-0366**

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Axis I: \_\_\_\_\_

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<u>Method</u>	<u>Date</u>	<u>Disposition</u>
1. _____	_____	_____
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3. _____	_____	_____
4. _____	_____	_____

**Describe severe major symptoms:**

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**c. Co-occurring mental illness and substance use disorders with more than six months duration at the time of contact**

List Substances Abused/Dependent/Treatment History if known

Type

Frequency

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**e. Literally homeless, imminent risk of being homeless, or residing in unsafe housing;**

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**f. Residing in an inpatient or 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.**



**Medical Conditions and Activities of Daily Living:**

**Medical Conditions:**

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2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Activities of Daily Living: Check all that apply**

Visually Impaired     Hearing Impaired     Language Barrier

Independent with ADL's    Primary Language: \_\_\_\_\_

ADL Dependent Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## HUD's Continuum of Care

The Department of Housing and Urban Development (HUD) allocates HUD homeless assistance grants to organizations that participate in local homeless assistance program planning networks. Each of these networks is called a **Continuum of Care (CoC)**. HUD introduced the CoC concept to encourage and support local organizations in coordinating their efforts to address housing and homeless issues and reduce homelessness.

CoC committees at the city, county and state level coordinate their efforts to produce annual plans that identify the needs of local homeless populations, the resources that are currently available in the community to address those needs, and additional resources needed to fill identified gaps. The CoC process is a community-based approach that encourages the creation of collaborative, comprehensive systems to meet the diverse of needs of local homeless populations.

## How HUD Funding is Allocated

HUD funding for homeless assistance programs is distributed according to the results of two community planning efforts, called Consolidated Plans and Continuum of Care Plans.

**HUD Definition: A Consolidated Plan provides the framework for states and localities to identify housing, homeless, community and economic development needs and resources and to develop a strategic plan to meet those needs.**

The Consolidated Plan provides for state and local jurisdictions to develop housing and community development priorities, including a focus on homelessness. The plan lays out a three- to five-year strategy to implement formula-funded grant programs, including the **Emergency Shelter Grants Program (ESG)**, which solely funds projects for the homeless.

Under the ESG program, funds are distributed to state and local jurisdictions that have an approved Consolidated Plan. Funding allocation follows a formula based on factors including the population of a jurisdiction and the level of community need.

A Consolidated Plan provides an assessment of homeless individuals' needs within a jurisdiction, as well as plans for using ESG funds to address those needs.

**HUD Definition: A Continuum of Care Plan is a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness.**

The majority of HUD's homeless assistance funds are awarded through the Continuum of Care planning process, which complements and overlaps the Consolidated Plan. CoC funds are allocated through three major programs: **Supportive Housing Program (SHP)**, **Shelter Plus Care Program (S+C)**, and **Section 8 Moderate Rehabilitation for Single Room Occupancy (SRO)**.

To receive funds through these programs, state and local governments submit a CoC plan each year that draws upon extensive community participation and includes identification of local funding priorities. The CoC application specifically identifies veterans as a sub-population targeted for assistance.

*Typically, each year approximately 15% of the total HUD McKinney-Vento homeless appropriation is allocated for ESG. The majority of funds for homeless assistance are allocated through the Continuum of Care planning process.*

## CoC Planning Cycle

Homeless veteran service providers and other local organizations working in the homeless services field can use the CoC plan as a tool for planning and building partnerships. The CoC planning process is conducted annually and involves the full range of agencies in the homeless assistance community. The planning cycle follows these basic steps:

1. The planning cycle begins with the organization of the planning process, including identification of a working group and establishment of roles, responsibilities, goals, and a timetable.
2. The committee then collects data about the needs of the local population and sub-populations and the resources available to meet those needs.
3. A gap analysis is conducted to identify needs, existing community capacity, additional resources needed, and the priority of each sub-population.
4. The gap analysis is used to set funding priorities and develop short- and long-term strategies.
5. The final CoC plan is then prepared, criteria established for project selection, and projects are identified for funding and monitoring.



*Helping others reach toward  
a better life....*

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