Assertive Community Treatment

Documentation Requirements	1. Providers must document services in accordance with the general requirements found in Part II, Section III: Documentation Requirements of this Provider Manual, as well as with the service-specific requirements delineated in this section below. 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: 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: 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: 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 item #2 of this section (above), a log of staff meetings must be documented as outlined in the Staffing Requirements section of this service guideline (above), item #2. The documentation notebook shall include: 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 staffing 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. 6. ACT Treatment team meeting logs/staffing logs should be retained for a minimum of one (1) year, and in accordance with professional standards and the provider agency's policy.

Assisted Outpatient Treatment Program

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

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TBD	TBD	TBD												
Service Definition	Assisted Outpatient Treatment (AOT) is the practice of providing court-ordered community-based mental health treatment under a civil commitment to individuals living with serious mental health condition if it is determined that they may be a danger to themselves or others. AOT facilitates engagement in treatment services and supports that may allow an individual to live independently in the community of their choice while living with a mental health diagnosis or co-occurring substance use disorder. It also helps providers focus their attention to work diligently to keep the enrolled individual engaged in effective treatment, and to support them in reaching their personal recovery goals. This Program is a time-limited, multi-faceted treatment model for adults who are court-ordered through a Probate Court petition to enroll in an Assisted Outpatient Treatment Program for required structure and support to achieve and sustain recovery from behavioral health conditions. These services enable individuals served to: • Maintain residence in their community, • Continue to work and go to school, • Stay connected to friends and family life, • Transition to voluntary treatment past court involvement. All behavioral health services described in this manual are available to individuals in the AOT Program, subject to clinical necessity and the requirements of the particular service being considered. Intellectual and Developmental Disability services may also be available to individuals in the Program who have a co-occurring intellectual or developmental disability, subject to the eligibility requirements for those services.													
Admission Criteria	An individual can be enrolled in the Assisted Outpatient Treatment Program if: 1. A petition has been signed by a probate judge of the county of the individual's residence, **AND** 2. AOT service is available in the county the individual resides: **AND** 3. The individual meets the following criteria: a. The person is 18 years of age or older; **and** b. The person is suffering from a mental health or co-occurring substance use disorder which has been clinically documented by a health care provider licensed to practice in Georgia; **and** c. There has been a clinical determination by a physician or psychologist that the person is unlikely to survive safely in the community without supervision; and d. The person has a history of lack of compliance with treatment for his or her mental health or co-occurring substance use disorder, in that at least one of the following is true: i. The person's mental health or co-occurring substance use disorder has, at least twice within the previous 36 months, been a substantial factor in necessitating hospitalization or the receipt of services in a forensic or other mental health unit of a correctional facility, not including any period during which such person was hospitalized or incarcerated immediately preceding the filing of the petition; or ii. The person's mental health or co-occurring substance use disorder has resulted in one or more acts of serious and violent behavior toward himself or herself or others or threatens or attempts to cause serious physical injury to himself or herself or others within the preceding 48 months, not including any period in which such person was hospitalized or incarcerated immediately preceding the filing of the petition; **and** e. The person has been offered an opportunity to participate in a treatment plan by the department, a state mental health facility, a community service board, or a private provider under contract with the department and such person continues to fail to engage in treatment; **and** f. The person's condition is substantially deteriorating; **and**													

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	g. Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure such person's recovery and stability; **and** h. In view of the person's treatment history and current behavior, such person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would likely result in grave disability or serious harm to himself or herself or others; **and** i. It is likely that the person may benefit from assisted outpatient treatment.
Continuing Stay Criteria	An individual may remain in the AOT Program as long as: 1. There is a current court-order from the probate court ordering them to remain enrolled; **and** 2. The individual's condition continues to meet the admission criteria; **and** 3. Progress notes document progress towards goals identified in the IRP (e.g., developing social networks and lifestyle changes, increasing educational, vocational, social and interpersonal skills, meeting court program requirements, and establishing a commitment to a recovery program), but overall goals have not yet been met; **and** 4. There is a reasonable expectation that the individual can achieve their IRP goals in the necessary reauthorization timeframe.
Discharge Criteria	An individual may be discharged from the AOT Program if: 1. An adequate continuing care or discharge plan is established, **and** 2. Linkages are in place, **and** 3. The individual is no longer under court-order to be enrolled.
Service Exclusions	1. Individuals who are not under court-order from the probate court to be enrolled in the AOT Program are not eligible. 2. When higher intensity services are utilized, documentation must indicate efforts to minimize duplication of services and effectively transition individuals to appropriate services of lower intensity when appropriate.
Clinical Exclusions	1. Individuals who do not meet the eligibility requirements for each service for which admission is sought. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with one of the following diagnoses: Developmental Disability, Autism, Neurocognitive Disorder, Substance Use Disorder.
Required Components	1. While a court order may have been issued for this program, the provider must assess, determine, and complete an order for the unique services and supports needed by the individual, in keeping with standards set forth in Part II of this manual. 2. The program incorporates information from a court ordered evaluation, provider assessments and the individual's personal goals into the treatment planning process and resulting IRP. 3. While this is a court-ordered program, all aspects of programmatic and service delivery are subject to the stipulations set forth in the Service Definition for each service delivered, as well as to all requirements in Part II of this manual. 4. The program must operate at a site approved to bill DBHDD/Medicaid for services. However, limited individual or group activities may take place off- site in natural community settings as is appropriate to each individual's recovery plan. Program must have in place appropriate accreditation and licenses for all established service sites. 5. The program provides individual treatment compliance and status reports as needed prior to and during court staffing/judicial review meetings. Any decrease in engagement levels should be reported to identified court as soon as possible for court review (incidents to be reported to the court include but are not limited to missed appointments, inappropriate behavior toward staff or other participants, damage to property, non-compliance with provider policies). 6. Provider will develop written agreements, partnerships, and memoranda of understanding (MOU) with key justice, mental health and substance use disorder treatment providers, recovery community advocates and support partners, consumer groups on an ongoing basis for the purpose of cooperative wrap around services and for developing sustainable activities. 7. In cases where an individual is in an inpatient facility, prior to discharge from the facility, an AOT team member shall engage with the individual and explain the AOT process and program expectations. The individual must have a **written** document with the outpatient appointment date and time and the AOT program expectations (Participant Handbook) upon discharge.

	8. All individuals enrolled in the AOT Program shall receive a *Participant Handbook* and *Assisted Outpatient Treatment Enhancement Program Framework* upon enrollment to the AOT program. 9. All participants and significant family members (caregivers) shall be given the opportunity and encouraged to complete the *AOT Participant/Family Satisfaction Survey* upon discharge from the AOT program. 10. At a minimum, the entire AOT Team shall meet to discuss and status all individuals enrolled in the AOT Program. Other service providers from the agency or community may be invited to supply relevant information on the status of any individual enrolled.
Staffing Requirements	The AOT Team will maintain a maximum caseload of 25 participants to allow for frequent contact with the individual. The AOT team, working with the treating psychiatrist and other appropriate staff, monitors the individual's engagement in treatment and observes for behavior changes similar to previous behavior that preceded a psychiatric decompensation. Every AOT Team includes the following staff: 1. Team Lead Clinician (1 FTE) Duties shall include, but not limited to: a. Assisting the individual in identifying and resolving personal, social, vocational, intrapersonal, and interpersonal concerns. b. Providing services (or be responsible for the oversight of service provision) to address goals/issues such as promoting recovery, and the restoration, development, enhancement, or maintenance of: i. Illness and medication self-management knowledge and skills (e.g., symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed); ii. Problem solving and cognitive skills; iii. Healthy coping mechanisms; iv. Adaptive behaviors and skills; v. Interpersonal skills; and vi. Knowledge regarding mental health conditions, substance use disorders, and other relevant topics that assist in meeting the individual's or the support system's needs; and vii. Use best/evidence-based practice modalities which may include (as clinically appropriate): Motivational Interviewing/Enhancement, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, and others as appropriate to the individual and clinical issues to be addressed. c. Conducting a monthly IRP review and, with input from the Team, to determine progress made, barriers to success, and whether the individual continues to meet criteria for court-ordered treatment criteria. Findings should be submitted through the 30-Day Review report. d. Submit reports and updates to the court, as requested, or presented at status hearings conducted by the probate judge. e. Monitoring each AOT enrolled individual, and determine appropriate actions, when warranted. f. Completing identified documentation in a timely manner. 2. Case Manager (1 FTE) The case manager monitors the individual's stability and ensures that care is provided in the least restrictive setting consistent with the individual's needs. Duties shall include, but not limited to: a. Engagement & Needs Identification: The case manager engages the individual in a recovery-based partnership that promotes personal responsibility and provides support, hope, and encouragement. The case manager assists the individual with developing a community-based support network to facilitate community integration and maintain housing stability. Through engagement, the case manager partners with the individual to identify and prioritize housing, service and resource needs to be included in the IRP. b. Care Coordination: The case manager coordinates care activities and assists the individual as he/she moves between and among services and supports. Care coordination requires information sharing among the individual, his/her Tier 1 or Tier 2 provider, specialty provider(s), residential provider, primary care physician, and other identified supports in order to:

	i. Ensure that the individual receives a full range of integrated services necessary to support a life in recovery that includes health, home, purpose, and community; ii. Ensure that the individual has an adequate and current crisis plan; iii. Reduce barriers to accessing services and resources; iv. Minimize disruption, fragmentation, and gaps in service; and v. Ensure all parties work collaboratively for the common benefit of the individual. c. Referral & Linkage: The case manager assists the individual with referral and linkage to services and resources identified on the IRP including housing, social supports, family/natural supports, entitlements (SSI/SSDI, Food Stamps, VA), income, transportation, etc. Referral and linkage activities may include assisting the individual to: i. Locate available resources; ii. Make and keep appointments; iii. Complete the application process; and iv. Make transportation arrangements when needed. d. Monitoring and Follow-Up: The case manager visits the individual in the community to jointly review progress made toward achievement of IRP goals and to seek input regarding his/her level of satisfaction with treatment and any recommendations for change. The case manager monitors and follows-up with the individual in order to: i. Determine if services are provided in accordance with the IRP; ii. Determine if services are adequately and effectively addressing the individual's needs; iii. Determine the need for additional or alternative services related to the individual's changing needs or circumstances; and iv. Notify the treatment team when monitoring indicates the need for IRP reassessment and update. 3. Certified Peer Specialist (1 FTE): The Certified Peer Specialist provides interventions which promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills. Duties shall include, but not limited to: a. Conduct activities between and among individuals who have common issues and needs, that are individual motivated, initiated and/or managed; b. Assist individuals in living as independently as possible; c. Promote self-directed recovery by exploring individual purpose beyond the identified mental health condition; and d. Explore possibilities of recovery by: i. Tapping into individual strengths related to illness self-management (including developing skills and resources and using tools related to communicating recovery strengths, communicating health needs/concerns, self-monitoring progress); ii. Emphasizing hope and wellness, by helping individuals develop and work toward achievement of specific personal recovery goals (which may include attaining meaningful employment if desired by the individual); and iii. Assisting individuals with relapse prevention planning.
Clinical Operations	1. An individual may have a variable length of stay. The level of care and length of stay should be determined by individual's multiple assessments and progress toward meeting goals of the IRP. It is recommended that the individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care. 2. Each individual should participate in setting individualized goals for themselves and in assessing their own skills and resources related to recovery. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place individually or in groups. 3. Each individual must be provided assistance in the development/acquisition of needed skills and resources necessary to achieve recovery and/or reduction in use of substances and maintenance of recovery. 4. Court Status Meetings time may be billable as a collateral contact via Case Management with or without the person being present if the following are considered:

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	a. If the Court Status Meeting addresses multiple individuals being supported by the Assisted Outpatient Treatment Program, the only time which can be billed is the specific discussion and planning related to the individual being served; b. Court Status Meeting time and documentation must comply with the expectations set forth in the unique Case Management (CM) service definition (Assistance to the person and other identified recovery partners in the facilitation and coordination of the Individual Recovery Plan (IRP), identification, with the person, of strengths which may aid him/her in achieving and maintaining recovery from mental health challenges as well as barriers that impede the development of necessary skills, linkage and referral, monitoring and follow-up, etc.). For example, if this service is being billed via CM and the individual served is not participating, the intervention and billing would comply with the Required Components section of the CM service which allow 50% of billable contact to be non-face-to-face.
Service Accessibility	1. Service are available during the day and evening hours. 2. Demographic information collected shall include a preliminary determination of hearing status to determine referral to the Office of Deaf Services. 3. To promote access, providers may use telemedicine as a tool to provide direct interventions to individuals enrolled in this service. See Part II. Community Service Requirements for All Providers, Section I: Policies and Procedures, 1. Guiding Principles, B. Access to Individualized Services, item 16 of this Provider Manual for definitions and requirements specific to the provision of telemedicine.
Documentation Requirements	1. Entry of required data shall be entered monthly to monitor performance and outcomes as well and approve the amount requested via the monthly invoices. 2. Every admission and assessment must be documented. 3. Agency must adhere to documentation requirements set forth for each unique service delivered in accordance with Part 1 of this Manual. 4. The program will document the following data for the required timelines in the Data Collection Worksheet found at the SharePoint site below: https://gets.sharepoint.com/:x:/r/sites/DBHDDExtranet/JSU/_layouts/15/Doc.aspx?sourcedoc=%7B4A2DA5E0-AA84-4D4F-B4D2-12CC977C72F0%7D&file=AOT%20Data%20Collection%20Worksheet%20-%20Provider%20Temp.xlsx&action=default&mobileredirect=true a. AOT Participant Information (demographic data): Shall be completed within 30 days of enrollment for each participant. b. 12 Months Pre-AOT (historical data): All efforts to gather as much data as possible should be sought using connections with sheriff's departments, provider medical records, other ERF records, family, etc. Additional information, other than that used to determine eligibility criteria should be entered as discovered. c. During AOT (ongoing status and significant events): All incident categories listed in the spreadsheet should be entered within 24 hours of the event. d. 12 Months Post-AOT (continued monitoring of participant's progress): Significant events should be monitored and recorded within 24 hours of discovery. e. 30-Day Review (ongoing reviews): This review must be completed on each enrolled participant no less than every 30 days. Copy of review may be submitted to the partnered probate court upon request of the court. f. Determination of Renewal (request for continued enrollment or discharge): The request for discharge may completed at any time the individual meets discharge criteria but if renewal of the current court-order is warranted, the request shall be completed no less than 45 days prior to current court-order expiration date and submitted to the court no less than 30 days prior to expiration. g. Request for Immediate Court Action/Conference: Shall be completed and submitted to the court when indications of nonengagement increase or a significant incident occurs that warrants court intervention. 5. Mandatory documentation of weekly team status meetings shall be documented and downloaded to the appropriate Team folder on the SharePoint site above.
Billing & Reporting Requirements	The individual medical record must include documentation of services described in the Service Operations section. 1. Provider is required to complete progress notes for every contact with individual as well as for related collateral contacts. 2. Progress notes must adhere to documentation requirements set forth in this manual.
Additional Medicaid Requirements	Providers should bill DBHDD State Fee-For-Service, Medicaid, or private insurance for behavioral health services rendered.