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Clark County Regional Support Network Policy Statement

Policy No.: CM14
Policy Title: Referral & Authorization into PACT Programs
Effective Date: July 1, 2007

Policy: Program for Assertive Community Treatment (PACT) is a specialized, limited-capacity program intended to provide integrated, high-intensity outpatient services to consumers requiring this level of care. These programs require a detailed delineation of roles and processes related to referral and authorization.

Reference: Washington State Program of Assertive Community Treatment (PACT) Program Standards. CCRSN Policy & Procedure: QM05-A Level/Element of Care Clinical Guidelines;

Procedure:

Overview of Roles and Referral Triggers

1. The RSN PACT Program Manager (PPM) shall provide ongoing oversight of all PACT programs and serve as the primary interface with the Lead Care Manager (LCM) to discuss and coordinate referrals and other matters related to clinical and capacity management. The PPM is responsible for acceptance into PACT.
2. The Lead Care Manager shall provide ongoing oversight of authorizations to all PACT programs and serve as the primary interface with the PACT Program Manager to discuss and coordinate referrals and other matters related to clinical, authorization, and capacity management.
3. A waiting list shall be maintained for all PACT programs, other than the YORP program, and the PPM shall maintain the waiting list. The PPM and LCM shall review the waiting list regularly to coordinate referral, treatment while awaiting PACT services, and placement into PACT programs.
4. Overall coordination of referrals into any CCRSN PACT Program shall be the primary responsibility of the CCRSN PACT Program Manager (or designee) and the Lead CCRSN Care Manager (or designee) assigned to review PACT services.
5. With the exception of non-traditional PACT programs that target special populations of consumers, admission criteria shall include a severe and persistent mental illness resulting in substantial functional impairment. Priority shall be given to people with schizophrenia, other psychotic disorders, and bipolar disorder. Clinical criteria for functional impairment for PACT

are detailed in the CCRSN Element/Level of Care Guidelines (QM05-A). Admission into the program shall be based on the combination of clinical need, the severity of other cases awaiting admission into PACT, current and anticipated PACT service capacity, and the availability of other intensive non-PACT programs such as Intensive Case Management.

6. Referral triggers to PACT include, but are not limited to, those listed below. Those persons and/or systems that will most likely make referrals based on that respective trigger(s) are listed in parentheses. In addition, CCRSN Network providers may be the first to make a referral based one or more of the triggers below.
 - a. Highest priority: Consumers who are near discharge/being released from WSH or PALS (CCRSN Hospital Liaison)
 - b. At least two community hospitalizations within past year, with particular weight given to number of bed days and involuntary detentions (CCRSN Hospital Liaison; CCRSN Care Manager)
 - c. Multiple crisis contacts/diversions (Clark County Crisis Services; CCRSN Care Managers)
 - d. Patterns of arrests related to psychiatric instability (Legal System)
 - e. Housing problems related to psychiatric instability (Housing Authority)
 - f. Consumers appearing in CCRSN monthly Utilization Management reports, including (CCRSN Utilization Management Committee):
 - i. Consumers readmitted for psychiatric hospitalization (voluntary & involuntary)
 - ii. Consumers with four or more crisis contacts in last month
 - g. Cases reviewed in weekly CCRSN Continuity of Care meetings (CCRSN Hospital Liaison; CCRSN Network Providers)
 - h. Trends observed by RSN Care Managers in course of day-to-day work (CCRSN Care Manager)
 - i. Mental Health Court, Justice System, and other system referrals (Mental Health Court Program Coordinator)

Referral Pathways & Authorization Procedures

1. One or more of the referral sources noted above make a PACT referral to the PPM using the PACT Referral Form,
2. The PPM reviews the referral information and gathers additional clinical, historical and/or collateral information from providers, and other sources, and makes an initial assessment as to the person's appropriateness for PACT participation.
3. The PPM presents and discusses the case with the LCM. Possible dispositions:
 - a. PPM & LCM agree person meets criteria for PACT participation:

	Person ready and able to enter PACT	Person not ready and able to enter PACT (e.g., pending discharge from WSH)
Opening exists in appropriate PACT	LCM enters authorization for services. PPM facilitates entry into PACT	<ul style="list-style-type: none"> • For consumers currently in WSH or PALS - consumer accepted into the program and PPM works with Hospital Liaison and WSH/PALS to expedite discharge to PACT • For other consumers - LCM makes note that consumer will be approved when ready and able. PPM tracks status of person and facilitates entry into program when person ready and able.
Opening does not exist in appropriate PACT	PPM & LCM work together to assure person referred to appropriate alternate program(s) LCM tracks status of person in alternate program. PPM places person on waiting list tracks status of person. When PACT opening becomes available, PPM & LCM review current status of person and make decision as to current appropriateness for entry into PACT.	LCM makes note that consumer will be approved when ready and able. PPM tracks status of person and facilitates entry into program when person ready and able

- b. PPM & LCM agree person is not suitable for PACT participation - PPM & LCM discuss best appropriate referral options and LCM expedites referral into alternate program(s)/Level of Care.

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