NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

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Memorandum

To: Mainstream Medicaid Managed Care Plans, HIV Special Needs Plans, and Health and Recovery Plans, Assertive Community Treatment (ACT) Teams & Inpatient Article 31 Facilities

From: Thomas E. Smith, MD, Deputy Chief Medical Officer, NYSOMH

Subject: Inpatient Setting Continuity of Care Expectations for ACT Individuals

Date: December 7, 2018

The intent of this memo is to outline continuity of care expectations for Assertive Community Treatment (ACT) recipients admitted to an inpatient setting. Individuals served on ACT Teams have a Serious Mental Illness (SMI) and a treatment history that has been characterized by frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, alcohol/substance use, and lack of engagement in traditional outpatient services. Therefore, discharge planning from inpatient settings is crucial to this population to prevent recurrent readmissions and to ensure individuals can adhere to recommendations for follow-up care.

In some cases, ACT staff may be unaware when individuals are admitted to an inpatient setting. An individual's ACT enrollment may not be evident to inpatient staff thus preventing communication and coordination between the two entities. Medicaid Managed Care Organizations (MMCOs) should bridge this information gap by communicating with ACT Teams and inpatient staff upon receiving notification of a hospitalization.

Medicaid Managed Care Organization Expectations

MMCOs are expected to use Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) or other internal data systems (such as claims, UM/UR) at least monthly to update their internal records to ensure MCO staff are aware of members in ACT (refer to OMH guidance memo "Using PSYCKES to identify members with Assisted Outpatient Treatment (AOT) orders and/or who receive Assertive Community Treatment (ACT) services" issued, 12/9/2016).

When informed that a member in ACT has been admitted to an inpatient facility, MMCOs must have processes in place to alert ACT Teams. MMCOs will be involved in the discharge planning process and make determinations on any requests for authorization (if applicable). ACT Teams should be notified of hospitalizations as soon as possible and while the member is still in the hospital to allow for participation in discharge planning.

MMCOs may request documentation from ACT Teams such as Service Plans or crisis/relapse prevention plans to assist in the discharge planning process. MMCOs should inform inpatient staff that the individual is an ACT recipient while providing appropriate ACT Team contact information for the purposes of coordination and discharge planning.

ACT Team Expectations

It is expected that the ACT Team, MMCO and inpatient staff will coordinate to provide for warm hand-off and/or immediate engagement with the ACT Team as part of the inpatient discharge process for ACT recipients. A warm hand-off is a best practice to ensure optimal transition to the ACT Team when an individual is being discharged/transitioned from an inpatient setting.

Inpatient Staff Expectations

Inpatient staff should identify the member's MMCO and determine the individual's ACT enrollment through the MMCO or PSYCKES. Inpatient staff should establish contact with the ACT Team upon an ACT recipient's admission to the inpatient facility. Inpatient staff should update the ACT Team regularly regarding the individual's treatment progress and consult with the ACT Team regarding discharge planning.

In most cases, an ACT recipient will require a warm hand-off to successfully transition back to the community. The inpatient staff should inform the ACT Team of the member's date and time of discharge well in advance so that the ACT Team can make the necessary arrangements.

Please let us know if you have any questions. Questions can be sent to OMH-Managed-Care@omh.ny.gov.

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