Florida Assertive Community Treatment (FACT)

Requirement: Contractual

Frequency: Annual Monitoring
Monthly & Quarterly Reports

Due Date: 10th of each month

OVERVIEW

The Florida Assertive Community Treatment (FACT) teams utilize a transdisciplinary approach to deliver comprehensive care and promote independent, integrated living for individuals with serious mental illness. FACT teams primarily provide services to participants where they live, work, or other preferred settings, and are available 24 hours a day, 7 days a week.

FACT is recovery-oriented, strengths-based, and person-centered. FACT teams provide a comprehensive array of services for program participants, such as: helping find and maintain safe and stable housing; furthering education or gaining employment; education about mental health challenges and treatment options; assisting with overall health care needs; assisting with co-occurring substance abuse recovery; developing practical life skills; providing medication oversight and support; and working closely with individuals' families and other natural supports.

This document provides guidance as to the programmatic expectations for a Network Service Provider implementing FACT teams. The programmatic goals are to prevent recurrent hospitalization and incarceration, as well as improve community involvement and overall quality of life for program participants.

Program Description

FACT team core elements include a transdisciplinary clinical team approach with a fixed point of responsibility for directly providing the majority of treatment, rehabilitation and support services to identified individuals with mental health and co-occurring disorders. Program characteristics include:

- The provider is the primary provider of services and fixed point of accountability,
- Services are primarily provided out of office,
- Services are flexible and highly individualized,
- There exists an assertive, "can do" approach to service delivery; and
- Services are provided continuously throughout duration of the individual's participation.

A typical FACT participant may present with diagnoses such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, and personality disorders. Challenges associated with these disorders are often compounded by co-occurring substance use issues, physical health problems, and mild intellectual disabilities. These individuals are at high risk of repeated psychiatric admissions and have typically experienced prolonged inpatient psychiatric hospitalization or repeated admissions to crisis stabilization units. Many are involved in the criminal justice system and face the possibility of incarceration.

The FACT team delivers services on a long-term basis with continuity of care over time. Emphasis is on recovery, choice, outreach, relationship-building, and individualization of services. Enhancement funds are available to assist with housing costs, medication costs, and other needs identified in the recovery

planning process. The number and frequency of contacts is set through collaboration rather than service limits. The team is available on nights, weekends, and holidays. Service intensity is dependent on need and can vary from minimally once weekly to several contacts per day. This flexibility allows the team to quickly ramp up service provision when a program participant exhibits signs of decompensation prior to a crisis ensuing. FACT teams must provide a minimum of 75% of all services and supports in the community. This means providing services in areas that best meet the needs of the individual, such as the home, on the street, or in another location of the participant's choosing.

The FACT team is expected to assist program participants in attaining recovery goals, thereby enabling transition to less intensive community services. The team conducts regular assessment of need for services and uses explicit criteria for participant transfer to less intensive service options. Transition is gradual, individualized and actively involves the participant and the next provider to ensure effective coordination and engagement. There are no mandated minimum or maximum lengths of stay in the program.

The team approach to delivering services and lack of service limits makes FACT a unique service.

Program Goals

The FACT program goals are to:

Implement with fidelity to the Assertive Community Treatment (ACT) model,
Promote and incorporate recovery principles in service delivery,
Eliminate or lessen the debilitating symptoms of serious mental illness and co-occurring substance use that the individual may experience,
Meet basic needs and enhance quality of life,
Improve socialization and development of natural supports,
Support with finding and keeping competitive employment,
Reduce hospitalization,
Increase days in the community,
Collaborate with the criminal justice system to minimize or divert incarcerations,
Strengthen parenting skills for those who have children, and
Lessen the role of families and significant others in providing care.

NETWORK SERVICE PROVIDER RESPONSIBILITIES AND EXPECTATIONS

Staffing Requirements

Minimum Staffing Standards

FACT staffing configurations combine practitioners with varying backgrounds in education, training, and experience. This diverse range of skills and expertise enhances the team's ability to provide comprehensive care based on individual needs. The ratio of participants to direct service staff members should not exceed 10:1. Hours of operation and staff coverage provide services seven days per week with overlapping shifts, operating a minimum of twelve hours per day on weekdays and eight hours each weekend day and holiday. The team operates an after-hours on-call system with a FACT team professional.

The minimum staffing patterns are:

# of Participants	Minimum Direct Service[1] FTE	Minimum Total FTE
105	10.3	12.3
100	10.0	11.8
95	9.7	11.5
90	9.4	11.2
85	9.1	10.9

Within the guidelines of the prescribed staff to participant ratio presented in the previous staffing chart, teams may exercise a degree of flexibility in team composition. However, a FACT team must minimally include:

- One full-time Team Leader,
- One part-time[1] Psychiatrist or Psychiatric Advanced Practice Registered Nurse (APRN),
- One nurse for every 35 participants, one of whom must be a full-time Registered Nurse (RN) required to be on duty Monday through Friday,
- One full-time Peer Specialist,
- One full-time Substance Abuse Specialist,
- One full-time Vocational Specialist,
- One full-time Case Manager, and
- One full-time[1] Administrative Assistant.

[1]Direct services staff does not include the psychiatric care provider or administrative staff.

Staff Roles and Credentials

The provider must maintain a current organizational chart indicating required staff and displaying organizational relationships and responsibilities, lines of administrative oversight, and clinical supervision.

Team Leader

The team leader must be a full-time employee with full clinical, administrative, and supervisory responsibility to the team with no responsibility to any other programs during the 40-hour workweek and possess a Florida license in one of the following professions:

- Licensed Clinical Social Worker, Marriage and Family Therapist, or Mental Health Counselor licensed in accordance with Chapter 491, F.S.
- Psychiatrist licensed in accordance with Chapter 458, F.S
- Psychologist licensed in accordance with Chapter 490, F.S.

The Team Leader is a practicing clinician providing FACT services and clinical supervision at least 50 percent of the time. The Team Leader is responsible for administrative, clinical, and quality oversight of the team. Preferably, the Team Leader is certified as a clinical supervisor. The Team Leader receives clinical supervision from the Psychiatrist or Psychiatric APRN and administrative supervision from the Chief Executive Officer or designee.

Psychiatrist or Psychiatric APRN

The Psychiatrist or Psychiatric APRN provides clinical consultation to the entire team as well as psychopharmacological services for all participants. They also monitor non-psychiatric medical conditions and medications, provides brief therapy, and provides diagnostic and medication education to participants, with medication decisions based in a shared decision-making paradigm. If participants are hospitalized, they communicate directly with the inpatient psychiatric care provider to ensure continuity of care. The Psychiatrist and Psychiatric APRN also conducts home and community visits with participants as needed. The Psychiatrist must be board eligible. If the team employs a Psychiatric APRN, there must be access to a board eligible Psychiatrist for weekly consultation. A minimum of 0.32 hours of psychiatric services must be available for each FACT recipient per week (e.g., 32 hours for 100 FACT participants: 16 hours for 50 FACT participants).

Nurse

The FACT team must have one nurse per 35 participants. The team must have a minimum of one full-time registered nurse (RN). Additional nurses may be RNs or licensed practical nurses (LPN), licensed in accordance with Chapter 464, F.S.

Nurses perform the following critical roles:

- Manage the medication system,
- Administer and document medication treatment,
- Screen and monitor participants for medical problems/side effects,
- Communicate and coordinate services with other medical providers,
- Engage in health promotion, prevention, and education activities (i.e., assess for risky behaviors and attempt behavior change related to their physical health),
- Educate other team members on monitoring of psychiatric symptoms and medication side effects, and
- With participant agreement, develop strategies to maximize the taking of medications as prescribed (e.g., behavioral tailoring, development of individual cues and reminders).

Peer Specialist

There must be at least one full-time Peer Specialist. The Peer Specialist shall have lived experience with receiving mental health services for severe mental illness. Their life experience provides expertise that professional training cannot replicate.

Peer Specialists are fully integrated team members who provide individualized support services and promote self-determination and decision-making. Peer Specialists provide essential expertise and consultation to the entire team to promote a culture in which each team member's point of view and preferences are recognized, understood, respected, and integrated into care.

Peer Specialists must be certified in accordance with Chapter 397, F.S. at the time of employment, or within one year of employment.

Substance Abuse Specialist

There must be at least one Substance Abuse Specialist with a bachelor's or master's degree in psychology, social work, counseling, or other behavioral science with two years of experience working with individuals

with co-occurring disorders. Bachelor's level substance abuse specialists must be certified as a Certified Addiction Professional in accordance with Chapter 397, F.S. at the time of employment, or within one year of employment.

The Substance Abuse Specialist provides integrated treatment for co-occurring mental illness and substance use disorders to participants who have a history of substance abuse. The services include:

- Substance use assessments that consider the relationship between substance use and mental health,
- Assessment and tracking participants' stages of change readiness and stages of treatment,
- Outreach and motivational interviewing techniques,
- Cognitive behavioral approaches and relapse prevention, and
- Treatment approaches consistent with the participants' stage of change readiness

The Substance Abuse Specialist also provides consultation and training to other team staff on integrated assessment and treatment skills relating to co-occurring disorders.

Vocational Specialist

There must be at least one Vocational Specialist who has a bachelor's degree and a minimum of one year of experience providing employment services. The Vocational Specialist provides supported employment services as described in the Substance Abuse and Mental Health Services Administration's Supported Employment Evidence-Based Practices (EBP) KIT, which may be downloaded at: https://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-Kit/SMA08-4364. Current training and practitioner tools may also be accessed on the Individual Placement and Support (IPS) Employment Center website at http://www.ipsworks.org/.

The Vocational Specialist also provides consultation and training to other team staff on supported employment approaches.

Case Manager

This position requires a minimum of a bachelor's degree in a behavioral science and a minimum of one year of work experience with adults with psychiatric disabilities. The Case Manager provides the rehabilitation and support functions under clinical supervision and are integral members of individual treatment teams. This includes social and communication skills training and training to enhance participant's independent living. Examples include on-going assessment, problem solving, assistance with activities of daily living, and coaching.

Administrative Assistant

An Administrative Assistant is responsible for organizing, coordinating, and monitoring the non-clinical operations of FACT. Functions include direct support to staff, including monitoring and coordinating daily team schedules and supporting staff in both the office and field. Additionally, the Administrative Assistant serves as a liaison between participants and staff, including attending to the needs of office walk-ins and calls from participants and natural supports. The Administrative Assistant actively participates in the daily team meeting.

Staff Communication and Planning

The FACT team conducts daily organizational staff meetings at regularly scheduled times as established by the Team Leader. The team completes the following tasks during the daily meeting:

Conduct a brief, clinically-relevant review of all participants and contacts (i.e. phone calls, home visits, transporting, etc.) in the past 24 hours and document this information,
Maintain a weekly schedule for each participant including all treatment and service contacts to be carried out to reach the goals and objectives in the participant's recovery plan,
Maintain a central file of all weekly schedules,
Develop a daily staff schedule consisting of a written timetable for all treatment and service contacts to be divided and shared by the staff working that day based on:

- The weekly schedule for each participant;
- emerging needs; and
- need for pro-active contacts to prevent future crises; and
- revision of recovery plans as needed and add service contacts to the daily staff assignment schedule per the revised recovery plans.

Treatment Planning Meeting

The FACT team conducts treatment planning meetings under the supervision of the Team Leader. The treatment planning meetings must occur with sufficient frequency and duration to make possible for all staff to:

- Be familiar with each participant and their goals and aspirations.
- Participate in the ongoing assessment and reformulation of any problems that arise.
- Problem-solve treatment strategies and rehabilitation options.
- Ensure participant input in the development and revision of the recovery plan.
- Fully understand the rationale in order to carry out each participant's recovery plan.

Program Enrollment

The FACT Team should actively recruit new enrollees who could benefit from FACT team, including assertive outreach to referral sources outside of usual community mental health settings (e.g., state mental health treatment facilities, community hospitals, crisis stabilization units, emergency rooms, prisons, jails, shelters, and street outreach).

The FACT team engages recipients, providing them with information about the FACT program:

- To screen them for eligibility
- To allow them to make an informed decision regarding participation in FACT services

Once a recipient expresses interest in, and desire for, participation in FACT services and meets eligibility requirements, the FACT team enrolls them in the program. The team should maintain a stable service environment when determining the total of new enrollees each month.

The maximum number of participants (including Florida Medicaid recipients and individuals who are not Medicaid recipients) served by a FACT team is 120, unless approved by the Department of Children and Families (DCF).

Target Population

When enrolling and maintaining capacity level, the FACT team must prioritize enrolling participants directly discharged from a state mental health treatment facility.

Clinical Eligibility Requirements

The individual must have a diagnosis within one of the following categories as referenced in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th Edition or the latest edition thereof:

- Schizophrenia Spectrum and Other Psychotic Disorders,
- Bipolar and Related Disorders,
- Depressive Disorders,
- Anxiety Disorders,
- Obsessive-Compulsive and Related Disorders,
- Dissociative Disorders,
- Somatic Symptom and Related Disorders, and
- Personality Disorders.

- The individual must meet **one** of the following seven (7) criteria:
  - More than three crisis stabilization unit or psychiatric inpatient admissions within one year,
  - History of psychiatric inpatient stays of more than 90 days within one year,
  - History of more than three (3) episodes of criminal justice involvement within one year,
  - Referred by one of the state's correctional institutions for services upon release,
  - Referred from an inpatient detoxification unit with documented history of co-occurring disorders,
  - Referred for services by one of Florida's state hospitals, or
  - High risk for hospital admission or readmission.
- The individual must meet at least **three** of the following six characteristics:
  - Inability to consistently perform the range of practical daily living tasks required for basic adult interactional roles in the community without significant assistance from others. Examples of these tasks include:
    - Maintaining personal hygiene,
    - Meeting nutritional needs,
    - Caring for personal business affairs,
    - Obtaining medical, legal, and housing services, and
    - Recognizing and avoiding common dangers or hazards to self and possessions.
  - Inability to maintain employment at a self-sustaining level or inability to consistently carry out the homemaker role (e.g., household meal preparation, washing clothes, budgeting or child-care tasks and responsibilities),
  - Inability to maintain a safe living situation (repeated evictions, loss of housing, or no housing),
  - Co-occurring substance use disorder of significant duration (greater than six months), or co-occurring mild intellectual disability,
  - Destructive behavior to self or others, or
  - High-risk of or recent history of criminal justice involvement (arrest and incarceration).

As long as the above admission requirements are met, substance use disorders and mild intellectual disabilities, as defined in the DSM-5, cannot be used as a basis to deny FACT services. Individuals will continue membership with their Managed Medical Assistance (MMA) Program or Long-term Care (LTC) Program for provision of medical services. FACT will be solely responsible for comprehensive behavioral health services. FACT will coordinate care with individual's MMA or LTC Program.

Services and Supports

The FACT approach to performing services is based on recovery orientation and promotes empowerment. The guiding principles include participant choice, cultural competence, person-centered planning, rights of persons served, stakeholder inclusion, and voice.

Using this approach, the FACT team must provide the following services:

Crisis Intervention
A FACT team member will be available 24/7, to assist with crisis intervention including referrals or supportive counseling when needed. Psychiatric backup/on-call support must be available during all off-hour periods.

- **Comprehensive Assessment**
  Within 60 days of admission to FACT, the team completes assessments to guide care.
  Natural Support Network Development
  Natural support network development is the process of establishing and/or strengthening personal associations and relationships, typically developed in the community, that enhance the quality and security of life for recipients. A natural support network may include family relationships; friendships reflecting the diversity of the neighborhood and the community; 9 association with fellow students or employees in regular classrooms and workplaces; and associations developed through participation in clubs, organizations, and other religious and civic activities.
  Case Management
  The primary case manager, along with the team, coordinates care, advocates on behalf of the participant, and provides access to a variety of services and supports, including but not limited to:
    - Primary health care (medical and dental),
    - Basic needs such as housing and transportation,
    - Educational and employment services, and
    - Legal services.

  For recipients enrolled in Medicaid managed care plans, the FACT team case manager will coordinate non-FACT services with the recipients' plan coordinators.
- **Enhancement Funds**
  Funding is used to increase or maintain a person's independence and integration into their community. It may be used for costs related to housing, medications, employment, education, and specialized treatment not paid by any other means. Detailed guidelines on the use of enhancement funds may be found in Appendix B, and shall follow F.A.C. 65E-14.021(4)(k)4.b.(V).
- **Family Engagement and Education**
  With consent of the participant, families are engaged in the treatment process and are educated on topics related to their family member's recovery goals, diagnosis, and illness management.

- **Psychiatric Services**
  Psychiatric services must be provided by a psychiatrist or psychiatric APRN. Services include psychiatric evaluation, prescribing and/or administering and reviewing medications and their side effects, including pharmacological management, as well as supports and training to the recipient.
- **Rehabilitation Services**
  Rehabilitation services are provided by FACT team members. These services provide structured, community-based services delivered in an individual or group setting. These services utilize behavioral, cognitive, or supportive interventions to improve a recipient's potential for establishing and maintaining social relationships and obtaining occupational or educational achievements. Rehabilitation services are provided to restore a recipient's skills and abilities necessary for independent living. Activities include:
    - Development and maintenance of necessary daily living skills, such as independent living and social skills
    - Food planning and preparation
    - Money Management
    - Maintenance of the living environment
    - Training in appropriate use of community services
      - Housing Services
      - Pre-vocational and transitional employment rehabilitation training
      - Social support and network enhancement
    - Work readiness assessments
    - Job development on behalf of the recipient
    - Job matching
    - On-the-job training and support.
- **Substance Use and Co-occurring Services**
  Both mental health and substance use needs are addressed through integrated screening and assessment, stage of change readiness determination, and therapeutic interventions consistent with the participant's readiness to change behaviors. The treatment approach is based on motivational interviewing and is non-judgmental, stresses engagement, and does not make sobriety a condition of continued treatment.
- **Supported Employment**
  Services are individualized to assist recipients to obtain and maintain integrated, paid, competitive employment. Services include vocational assessment, job placement, and ongoing coaching and support (including on-site support).
- **Therapy**
  Clinicians provide and coordinate individual, group, and family therapy services. The type, frequency and location of therapy provided are based on individual needs and utilize empirically supported techniques for that individual and their symptoms and behaviors.
- **Wellness Management and Recovery Services**
  The team assists participants to develop personalized strategies for managing their wellness, set and pursue personal goals, learn information and skills to develop a sense of mastery over their psychiatric illness, and help them put strategies into action in their everyday lives.
- **Transportation**
  Staff assists with transportation to medical appointments, court hearings, or other related activities outlined in the care plan.

- **Supported Housing**
  The team assists the participant in accessing affordable, safe, permanent housing of their choice through provision of multiple housing options with assured tenancy rights regardless of progress or success in services.
- **Competency Training**
  For participants who are adjudicated incompetent to proceed, the team will provide competency restoration training and assist the participant through the legal process.

Initial Assessment and Recovery Plan

The Team Leader in coordination with the Psychiatrist or Psychiatric APRN performs an initial assessment and develops an initial plan of care on the day of the participant's admission to the program. The participant and designated team members will be actively involved in the development of the plan. This is intended to ensure that immediate needs for medication, treatment, and basic needs are not delayed. The required components of an initial assessment, at a minimum, include:

- A brief mental status examination,
- Assessment of symptoms,
- An initial psychosocial history,
- An initial health/medical assessment,
- A review of previous clinical information obtained at the time of admission,
- A preliminary identification of the participant's housing, financial and employment status, and
- A preliminary review of the participant's strengths, challenges, and preferences.

Comprehensive Assessment

The Team Leader assigns the individual's treatment team, including the Psychiatrist and Psychiatric APRN and primary case manager on the day of admission. The team is responsible for preparing a written comprehensive assessment within 60 days of the participant's admission to the program. The comprehensive assessment must meet the following requirements:

- Each assessment area is completed by the team member with skill and knowledge in the area being assessed and is based upon all available information.
- At minimum, the comprehensive assessment minimally includes:
  - Psychiatric history and diagnosis,
  - Mental status,
  - Strengths, abilities, and preferences,
  - Physical health,
  - History and current use of drugs or alcohol,
  - Education and employment history and current status,
  - Social development and functioning,
  - Activities of daily living,
  - Family and social relationships and supports, and
  - Recommendations for care.

- To supplement the comprehensive assessment, the team completes a psychiatric/social functioning history timeline is completed no later than 120 days after the first day of admission.
- The team updates assessments at least annually and uses the updated assessments to update the recovery plan. All necessary areas essential for planning are included in the updated assessment.

Comprehensive Recovery Plan

The team completes a comprehensive recovery plan as an expansion of the initial plan within 90 days of admission, following completion of all assessments. The Comprehensive Recovery Plan shall adhere to the following guidelines:

- Planning is person-centered and actively involves the participant, guardian (if any), and family members and significant others the participant wishes to participate.
- The plan is reviewed and updated minimally every six (6) months during planned meetings, unless clinically indicated earlier, by the treatment team and the participant.
- The plan is based on assessment findings and:
    - Identifies the participant's strengths, resources, needs and limitations,
    - Identifies short and long-term goals with timelines,
    - Identifies participant's preferences for services,
    - Outlines measurable treatment objectives and the services and activities necessary to meet the objectives and needs of the participant, and
    - Targets a range of life domains such as symptom management, education, transportation, housing, activities of daily living, employment, daily structure, and family and social relationships, should the assessment identify a need and the individual agrees to identify a goal in that area.

Administrative Tasks

The FACT team performs administrative tasks that include the following:
Establishment and maintenance of written policies and procedures for:

- Personnel,
- Program organization,
- Admission and discharge criteria and procedures,
- Assessments and recovery planning,
- Provision of services,
- Medical records management,
- Quality assurance/quality improvement,
- Risk management, and
- Rights of persons served.

Accurate record keeping reflecting specific services offered to and provided for each FACT participant, available for review by the Managing Entity and Department staff,
Coordination of services with other entities to ensure the needs of the participant are addressed,
Providing staff training and supervision to ensure staff are aware of their obligations as an employee, and

A plan for supporting participants in the event of a disaster including contingencies for staff, provision of needed services, medications, and post-disaster related activities.

FACT Transfers

When a FACT participant plans to move out of the area, the Managing Entity is responsible for coordinating transfers to the new location. The originating Managing Entity will contact the receiving Managing Entity to determine if there is capacity to accept the transfer and a proposed date of transfer. Once this has been established, the originating FACT team must, with consent, send the receiving FACT team a comprehensive referral packet.

FACT teams are obligated to accept any transfers if the team has capacity. Both the originating and receiving teams will make every effort to ensure the participant has stable housing. Upon arrival, the receiving team shall review the participant's clinical records, conduct an initial assessment and admission process, assess the person's current medication regime, consult with the program Psychiatrist and conduct a new comprehensive assessment or develop a new recovery plan.

When an individual meets criteria and there is capacity, the team must accept and enroll all referrals from the Departments' Substance Abuse and Mental Health regional office and the Managing Entity.

Discharge Process

During the daily meetings, FACT teams will assess participants for the continued need for FACT services. If it is determined that the participant could be successful in a lower level of care, the team starts addressing transition goals with the participant. This process may take time and early engagement with potential new service providers to acclimate the participant. Each team is responsible for discharging no less than twelve individuals each year.

Discharges fall into these categories:

The participant moves out of the geographic areas of the FACT team's service area.

The participant demonstrates an ability to perform successfully in major role areas (i.e., work social, and self-care) over time without requiring assistance from the program and no longer requires this level of care (i.e. successful completion).

The participant requests discharge or chooses not to participate in services, despite the team's repeated efforts to develop a recovery plan acceptable to the participant.

Following a six (6) month period in which the participant has been admitted to a state mental health treatment facility and there is no anticipated date of discharge.

The participant has been adjudicated guilty of a felony crime and subsequently sent to a state or federal prison for a sentence that exceeds one (1) year. Otherwise the participant remains enrolled with the FACT Team.

The participant was admitted to a nursing facility for long term care due to a medical condition, and there is no anticipated date of discharge. Exceptions to this discharge criteria shall be staffed with the Managing Entity (LSFHS) Adult System of Care Manager for approval.

The participant dies.

The FACT team staff are unable to locate a participant for a period of 45 days. All efforts to locate the participant shall be documented during the 45-day timeframe.

The team must document the discharge process in the participant's medical record, including:

The reason(s) for discharge.

The participant's status and condition at discharge.

A final evaluation summary of the participant's progress toward the outcomes and goals set forth in the recovery plan.

A plan developed in conjunction with the FACT participant for treatment upon discharge and for follow-up that includes the signature of the primary case manager, Team Leader, Psychiatrist/Psychiatric APRN, and the participant or legal guardian. If the FACT participant or guardian is not available to sign the discharge plan, the reason will be documented in the plan.

Documentation of referral information made to other agencies upon discharge.

Documentation that the participant was advised he or she may return to the FACT team if they desire and space is available.

FACT Advisory Committee

Advisory committees are a group of volunteer stakeholders that come together to support and guide a FACT team. The advisory committee's primary function is to promote quality and assist in the oversight of the program through monitoring, problem solving, and mediating grievances or complaints made by participants or their families. Details regarding implementation and operation of the advisory committee, including a FACT Model Fidelity Review sample, can be found in Appendix C.

Reports

FACT teams are responsible for submitting the following reports to the managing entity in a timely and accurate manner:

- **FACT Enhancement Reconciliation Report**
  This quarterly report displays the team's monthly expenditures of enhancement funds and is due to the Network Manager quarterly by the 10th of the month.
- **FACT Report**
  This report displays the team's monthly census and aggregate client data for types of housing, employment/volunteer status, crisis stabilization admissions, state hospitalizations, educational status, and types of discharges. Network Service Providers must submit the **Template 29 - FACT Report** found at following link using the applicable fiscal year: http://www.myflfamilies.com/service-programs/samh/managing-entities due by the 10th of each month following service delivery to the Network Manager and Adult System of Care Manager .

- **Vacant Position(s) Reports**
  This monthly report displays positions required by this program and whether the positions were filled or vacant for the reporting month. This report is due to the Network Manager and Adult System of Care Manager as vacancies occur.
- **FACT/Disability Rights Florida Mental Health Transitional Voucher Report**
  See Incorporated Document 34 - Transitional Voucher. This report is due to the Network Manager and Adult System of Care Manager by the 10th of each month with your monthly invoice data. The Template for this report is incorporated herein.
- **FACT Referral Report**
  This report displays the new admissions and referrals received for the month and is due to the Network Manager and Adult System of Care Manager monthly by the 10th of each month. The Template for this report is incorporated herein.
- **Outcome Measure Data Collection Tool**
  This report will be completed in July to include data for each individual enrolled on the team. It will then be updated with each admission and discharge as needed and submitted to the Network Manager and Adult System of Care Manager by the 10th of each month. The Template for this report is incorporated herein.

Outcome Measures

The team is required to meet the following numerical targets for the target population "Adults with Serious and Persistent Mental Illness" as established in the General Appropriations Act:[1]

Percent of adults with severe and persistent mental illnesses who live in stable housing environment that is *equal to or greater than* 90 percent or the most current General Appropriations Act working papers transmitted to the Department of Children and Families; and,

Average annual days worked for pay for adults with a severe and persistent mental illness that is equal to or greater than 40 days worked for pay or the most current General Appropriations Act working papers transmitted to the Department of Children and Families.

FACT teams must incorporate the following performance measures:

- Fewer than 10 percent of all individuals enrolled will be admitted to a state mental health treatment facility while receiving FACT services.
- Within thirty (30) days of discharge from the program, fewer than 10 percent of all individuals will be readmitted to a state mental health treatment facility.
- 75 percent of all individuals enrolled will either maintain or show improvement in their level of functioning, as measured by the Functional Assessment Rating Scale (FARS).

FACT teams must also incorporate the following process measures:

- 90 percent of all initial assessments shall be completed on the day of the person's enrollment with written documentation of the service occurrence in the clinical record.
- 90 percent of all comprehensive assessments shall be completed within 60 days of the person's enrollment with written documentation of the service occurrence in the clinical record.

[1] See ME Contract Exhibit E – Minimum Performance Standards at http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities/2016-contract-docs

- 90 percent of all individuals enrolled shall have an individualized, comprehensive recovery plan within 90 days of enrollment with written documentation of the service occurrence in the clinical record.
- 90 percent of all individuals enrolled shall have a completed psychiatric/social functioning history timeline within 120 days of enrollment with written documentation of the service occurrence in the clinical record.
- 50 percent of all individuals enrolled shall receive work-related services toward a goal of obtaining employment within one year of enrollment with written documentation of the service occurrence in the clinical record.
- 90 percent of all individuals enrolled shall receive housing services toward a goal of obtaining independent, integrated living within one year of enrollment with written documentation of the service occurrence in the clinical record.
- 90 percent of staffing requirements will be maintained monthly.

MANAGING ENTITY RESPONSIBILITIES AND EXPECTATIONS

The Managing Entities are responsible for:

- Oversight of FACT requirements including report and invoice approvals,
- Provision of technical assistance to teams as needed,
- Participation in and oversight of advisory committees,
- Assistance with the timely and efficient transfers from state mental health treatment facilities to teams,
- Identification of need for additional FACT teams, and
- Monitoring of the program including:
    - Medical record reviews,
    - Personnel records review,
    - Policy and procedure reviews,
    - Staff credentials review,
    - Participant interviews, and
    - Follow up with corrective action plans, if indicated.

Managing Entities shall determine the eligibility of Network Service Providers and non-Network Service Providers to provide services funded with FACT Enhancement Funds.

- Such determination will be based on licensure or certification in good standing, history of licensing or certification complaints, appropriateness of services, staff training and qualifications, evidence of staff and organizational competency, interviews with organization staff, and other knowledge of significance unique to the individual provider.
- Treatment providers must be licensed by the Department, Agency for Health Care Administration (AHCA), or a related professional license.
- Recovery support providers must provide documentation of applicable professional

certifications, excluding providers which are licensed by the Department, are licensed by AHCA, certified by the Florida Association of Recovery Residences (FARR), or are active affiliates of the Oxford House, Inc. network.

Managing Entities shall include adherence to the requirements, in section II of this document, in all subcontracts for FACT services.

DEFINITION OF KEY TERMS

The following definitions facilitate a common understanding of key terms used in this Incorporated Document:

Comprehensive assessment means an organized process of gathering information to evaluate a person's mental and interactional status and his or her treatment, rehabilitation, and support needs that will enhance recovery. The results of the assessment are used to develop an individual recovery plan for the person.

Culturally competent services means acknowledging and incorporating variances in normative acceptable behaviors, beliefs and values in determining an individual's mental wellness/illness and incorporating those variances into assessments and treatment that promotes recovery.

Empowerment means the process where the provider of services encourages the individual to make choices in matters affecting their lives and to accept personal responsibility for those choices. The empowerment process will include, but is not limited to: 1) freedom of choice regarding services; 2) influence over the operation and structure of service provision; 3) participation in system-wide human recovery planning; and 4) participation in decision-making at the community level.

Engage as it relates to new admissions means the process of identifying, recruiting and considering a person for enrollment in FACT. A person being considered for FACT who is in a state mental health treatment facility, local hospital or crisis stabilization unit (CSU) cannot be enrolled until discharge takes place. Team members will begin to visit the person in the hospital and participate in developing the discharge plan, but will not officially assume responsibility to provide treatment services until the person is discharged. A person already enrolled in a FACT program continues to be enrolled even though hospitalization via a CSU, local hospital or state mental health treatment facility occurs. Even though a person going through the engagement process has not formally been enrolled in a FACT team, the FACT team must keep a written record on:

- Activities that took place during the engagement process,
- The person's response to engagement activities, and
- The name of the FACT staff member conducting the engagement activities.

Functional Assessment Rating Scale (FARS) means the rating scale adopted by the Mental Health Program Office that is to be administered consistent with the most current version of the Department's pamphlet 155-2 as it is developed.

Incompetent to proceed, pursuant to s. 916.106, F.S., means the condition of a defendant being unable to proceed at any material stage of a criminal proceeding due to mental impairment. Those stages shall include a trial of the case and pretrial hearings involving questions of fact on which the defendant might be expected to testify. It shall also include an entry of a plea, proceedings for violations of probation or violations of community control, sentencing, and hearings on issues regarding a defendant's failure to comply with court orders. It also considers conditions or other

matters in which the mental competence of the defendant is necessary for a just resolution of the issues being considered.

Initial assessment and recovery plan means the initial evaluation of a person's mental health status and initial practical resource needs (e.g., housing, finances). The initial recovery plan is completed on the day of admission and guides services until the comprehensive assessment and recovery plan are completed.

Mental illness means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse.[2]

Not guilty by reason of insanity, pursuant to s. 916.15, F.S., means a ruling by a court acquitting a defendant of criminal charges because of a mental defect sufficient under the law to preclude conviction.

Psychiatric/social functioning history timeline means the process that helps to organize, chronicle and evaluate information about significant events in a person's life, experience with mental illness, and treatment history.

Psychotropic medication means any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or anti-anxiety agents.

- **Recovery** means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

  Recovery Plan means the culmination of a continuing process involving the participant, family or other supports upon consent, and the FACT team. The plan reflects individualized service activity and intensity to meet person-specific needs that promote recovery. The plan documents the person's goals and the services necessary to achieve them. The plan must reflect the individual's preferences for services and choices in the selection of living arrangements. The plan delineates the roles and responsibilities of the FACT team members who will carry out the services.

  Recovery Plan Review means a written summary describing the person's progress since the last recovery-planning meeting; it outlines interactional strengths and limitations at the time the recovery plan is rewritten.

- **Rehabilitation** means services and supports that promote recovery, full community integration and improved quality of life for persons diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Rehabilitation services are collaborative, person directed and individualized. They focus on helping individuals develop skills and access resources

[2] Chapter 394.455(18), F.S.

needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.[63]

Florida Assertive Community Treatment (FACT) will be administered according to DCF Guidance 16, which can be found at following link using the applicable fiscal year: http://www.myflfamilies.com/service-programs/samh/managing-entities/.

[3] Allness, Deborah J., and William H. Knoedler. *A Manual for ACT Start-up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illnesses.* Arlington, VA: NAMI, 2003. Print.

APPENDIX A - FACT ENHANCEMENT GUIDELINES

Introduction

One of the goals of FACT is to promote and respect self-determination, recovery, and full community inclusion. Participation in FACT provides the individual with the opportunity to select the services and commodities that they deem necessary for recovery for the purpose of consumption, employment, volunteering, or training/education, and facilitates achievement of the individual's recovery plan.

An integral part of participation is accepting responsibility for choosing, spending, recording, and learning how best to use limited funds to achieve a desired state of mental wellness and productivity. The program believes that individuals are capable of purchasing needed services and commodities that will help them on their road to recovery. Individual choice drives this system of purchasing.

The program provides access to public funds to purchase adjunct services or commodities not directly provided by the FACT team. Funding is used to increase or maintain a person's independence and integration into their community. Funding may be used for costs related to housing, pharmaceuticals, tangible items needed for employment/education or other meaningful activity, and specialized treatment (not paid by any other means).

Definitions

1. Assistive Care Services or "ACS" means a state payment for services provided by qualified residential care facilities. Funds transferred from the Department of Children and Families to Medicaid draw down federal Title XIX matching funds. This Medicaid optional state plan service is for low-income people who live in qualified assisted living facilities (ALFs), adult family-care homes (AFCHs) and residential treatment facilities (RTFs).
2. "Commodities" means supplies, materials, goods, merchandise, equipment, information technology, and other personal property. The definition does not include pharmaceuticals, medical treatment, glasses, hearing aids, or lab work.
3. "Indigent Drug Program" or "IDP" means the provision of psychotropic medications for individuals served by the Department who have a mental illness, reside in the community and who do not have other means of purchasing prescribed psychotropic medications.
4. "OSS" means Optional State Supplementation, a state program to supplement payments to eligible individuals residing in Assisted Living Facilities, Adult Family-Care Homes, family placement, or any other specialized living arrangement.
5. "Payer of Last Resort" means using FACT enhancement funds after exhausting all other potential sources of funds.
6. "Recovery Plan" means an individual's service/treatment plan.
7. "Services" means pharmaceuticals, lab work, treatment, housing assistance, or other assistance given to benefit a person.
8. "SSDI" means Social Security Disability Income that is paid to a person and certain members of the person's family if the person is "insured", meaning the person has worked the required number of quarters and paid social security taxes.

9. "SSI" means Supplemental Security Income, a federal income supplement program funded by general tax revenue designed to provide cash to help aged, blind and disabled people who have little or no income to meet basic needs for food, clothing and shelter.

Guidelines on the Use of Funds

1. Ensuring FACT team enhancement funds is the payer of last resort:

Participants must take responsibility in locating other sources of funding for services or commodities prior to requesting FACT enhancement funds for the purchase. FACT staff, in collaboration with the member, must determine if there is another payer source, such as Medicaid, Medicare, OSS, SSI, SSDI, IDP, or ACS. The primary case manager must submit a certification form with the monthly invoice. The certification states that due diligence was exercised in searching for alternative funding to pay for the commodity or service prior to the use of enhancement funds. If the commodity or service is ongoing, certification is only required for the original purchase. Examples of ongoing purchases include utility and phone bills, refills of existing prescriptions, or any other like commodity or service.

2. Price Quotes:

Participants are required to provide three price quotes from different vendors for any single commodity costing in excess of $1,000.00. These price quotes may be in the form of vendor circulars or advertisements, vendor website items and price descriptions, in-store price comparisons, and telephone price quotes. Telephone should only be considered if other means of securing a price quote are not possible. Quotes received over the phone and in-store must be verified/witnessed by staff and documented (includes date and time). Documentation of the price quotes must be filed (may be separate file from clinical record) and available for audit when requested.

3. Emergency purchase:

An emergency is considered an unexpected event that causes immediate danger to the health, safety, or welfare of the individual. In such cases, there might not be time to secure three price quotes (e.g., towing vehicle from roadway). An emergency purchase without three quotes must be justified and documented to be considered for payment or reimbursement. Emergency purchases must be documented in the clinical record, and if deemed an ongoing need, must be added to the recovery plan.

4. Recovery plan:

The member's recovery plan must incorporate the purchase of any commodity or service. The member's recovery plan must explain how the purchase will promote one or more of the member's recovery goals.

5. Dental services, hearing aids, and eyeglass purchases:

Medically necessary (recommended by medical practitioner) professional hearing, dental, and vision services will be paid by the program after all other resources have been exhausted. Decorative or cosmetic purchases, such as color contacts, may not be paid for with FACT enhancement funds.

6. Payment/Reimbursement rate:

Commodities and services purchased are paid or reimbursed at a negotiated rate between the participant and FACT case manager and is dependent on the participants' ability to pay.

7. Making the purchase:

The accepted purchase price (quotes and receipt) must be dated subsequent to the incorporation of the

purchase into the recovery plan. For approved purchases, the participant can either:

a) Make the purchase using his or her own funds and later, be reimbursed, or

b) Provide an original, itemized estimate of the needed purchase that shows the name of the vendor, the anticipated purchase date, the item, and the amount of the purchase (along with documentation of price quotes).

The amount paid or reimbursed will include the actual price of the item and may include tax, if applicable. Tips are not reimbursed. It is the participants' responsibility for ensuring the quality of the item purchased. If a purchased item is defective, inoperable, or unusable, it is the participants' responsibility to resolve the matter with the vendor.

Criteria for purchase approval (Must be able to answer "yes" to all questions):

1. Does the purchase directly relate to identified needs outlined in the participants' recovery plan?
2. Does the purchase promote independence?
3. Will the purchase enhance employability or recovery for the individual?
4. Have all other options been explored and exhausted prior to requesting the purchase with FACT enhancement funds?
5. Is the amount of the proposed expenditure reasonable?
6. Is the budget to fulfill the request available?
7. Is the date on the receipt for the purchase subsequent to the effective date of the current recovery plan?
8. Is the receipt original?
9. Does the receipt contain vendor information printed on the receipt (name of vendor, address, phone number, etc.)?

Examples of purchases that may be authorized if all criteria above are met:

1. Co-pays for adjunct services purchased with Medicaid or Medicare funds.
2. Housing subsidy. Enhancement funds may be used for payments to Assisted Living Facilities (above OSS rate), but all available options that could best meet the individual's needs should be considered (such as Therapeutic Family Care homes, permanent supportive housing, rental subsidies for current lease).
3. Medication.
4. Transportation or mileage reimbursement.
5. Services related to developing employability.
6. Smoking cessation activities under the supervision of a medical doctor.
7. Non-cosmetic dental work.
8. Hearing aids.
9. Non-cosmetic eyeglasses and non-disposable contacts once per year, unless otherwise noted by a licensed eye care professional.
10. Facial cosmetic and make-up products for the purposes of camouflaging medical conditions, such as facial scars, burns, etc., and for the purposes of seeking or participating in employment.
11. Tutoring.
12. Face-to-face and distance learning educational classes.
13. Time-limited assistance to secure or maintain a more independent living arrangement.
14. Time-limited assistance with vehicle repair for purposes of employment, education and/or transportation or other recovery goal with the intent to increase independence for the person served. Alternative transportation (bus, bike, cab use) should be considered in lieu of vehicle repair if the cost

to repair in in excess of $1,000.00 or the budget does not permit the expenditures.

15. Specialized treatment not provided by FACT team and not paid for by any other means (e.g. eating disorders, behavioral analyst, health club/gym). Approval must be obtained from Managing Entity for expenditures exceeding $1,000.00.
16. Support tools promoting the safety and security of the individual, including fire alarms, disability aids such as char, shower or stair rails when explicitly justified by the individual's recovery plan and no other resource is available.

Examples of disallowed purchases:

1. Rent reimbursement for an expired rental lease.
2. Motel room(s) beyond 21 days. Motel rooms for more than 21 days may be authorized if the FACT team makes an ongoing and consistent effort to find more permanent housing, and this is fully documented in the recovery plan.
3. Purchase of automobiles, sport utility vehicles (SUVs), minivans, motorcycles, recreational scooters or recreational vehicles.
4. Long distance telephone service.
5. Major repairs or renovations of rental property.
6. Pay-per-View or enhanced programming cable service.
7. Television, Video Cassette Recorders (VCRs), Digital Video Disc (DVD) or Blu-Ray players, video game consoles, stereos, MP3 Players or other types of entertainment appliances.
8. Designer sunglasses.
9. Beauty aids such as spa services, including but not limited to, facials, makeup applications, aromatherapy massage, body waxing, manicure, pedicure, therapeutic body wraps, micro dermabrasion, tanning booth sessions, wigs and hair pieces, or cosmetics (aside from the purposes described above).
10. Ongoing or continuous purchase of over-the-counter medications in excess of 7 days per episode for allergies and flu-like symptoms.
11. Acupuncture without a prescription/order/referral from the program psychiatrist.
12. Petty cash for general use.
13. Purchase or rental of firearms.
14. Purchase of alcoholic beverages.
15. Purchase of contraband or illegal products or services.
16. Purchase of tobacco products.
17. Purchase of pets.
18. Purchase or rental of boats.
19. Purchase or lease of burglar alarms.
20. Purchase or lease of cell phones.
21. Purchase or lease of diving equipment.
22. Internet service.
23. Purchase for 3rd parties.
24. Purchase of pornographic books, magazines, or videos.
25. Payment of credit card interest or balances.
26. Payment of court-ordered costs, fines, restitution, or other similar debts.

HEALTH SYSTEMS

Participant Certification and Assurances

FACT team participants are not guaranteed access to enhancement funds. Purchase approval is dependent on the following guidelines:

- All other options have been explored and exhausted prior to requesting the purchase with FACT enhancement funds.
- The purchase directly relates to identified needs outlined in the participant's recovery plan.
- The purchase promotes independence.
- The purchase enhances employability or recovery for the individual.
- The amount of the proposed expenditure is reasonable.
- The budget to fulfill the request is available
- The date on the receipt for the purchase must be after the effective date of the current recovery plan.
- Individual must provide an original receipt.
- The receipt must contain vendor information printed on the receipt (name of vendor, address, phone number, etc.).

1. By signing below, I agree to adhere to these guidelines and understand that I am responsible for the outcome of all purchases that I make under this program.
2. I agree not to hold the FACT enhancement program responsible if I make purchases that are beyond the scope of purchases incorporated into my recovery plan amount, and understand that the program is not responsible for the choices I make regarding my personal finances.

The FACT participant receives a signed copy of these guidelines. The original signed document remains part of the participant's clinical record.

I, _____, have received, reviewed, and agree to the Florida ACT Enhancement Funds guidelines.

HEALTH SYSTEMS

Certification Statement as Payer of Last Resort

(Required only on initial purchases of commodities and services)

Name of FACT Participant: _____

Date of Purchase: _____

Name of Vendor: _____

Cost of Item/Service: _____

Item(s)/Services Purchased: _____

_____

Relationship to Recovery Plan (Complete the following table):

Recovery Plan Goal	**Relationship to Purchase**
What goal on the recovery plan does this purchase relate?	
How will this purchase assist in meeting the goal?	
How many more times is this service estimated to be needed?	

I, _____, primary case manager and/or member of the above-named individual's Treatment Team, certify that this purchase is made to support the person's recovery plan. I further certify that all other resources have been explored and exhausted prior to purchasing this service/commodity with payer of last resort enhancement funds.

_____

Signature Date

APPENDIX B

FACT ADVISORY COMMITTEES

A FACT Advisory Committee (Committee) is a group of volunteer stakeholders that come together to ensure the FACT team's work is consistent with SAMHSA's Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT.[4] The Committee's primary functions are to promote quality FACT programs and assist in the oversight of the program through monitoring, problem solving, and mediating grievances. Committees are independent of the provider operating the team and therefore have no role in the governance of the team. Committees may, at their discretion, develop additional procedures beyond those identified below.

Purpose:

The purpose of a FACT Committee is to guide and support local FACT team activities by monitoring on-going operations; promoting the team's work in the community; and ensuring the team provides each participant quality and recovery-oriented services.

Membership:

The contracting managing entity (ME) approves individual membership to the Committee. Committees have a minimum of 10 members that consist of at least 26 percent people with psychiatric disabilities and 25 percent family members. Other members may represent stakeholders such as local homeless coalitions, local law enforcement agencies, jail personnel, county commissioners, other providers, hospital representatives, Medicaid, faith-based entities and advocacy groups. Membership that is representative of the local cultural and linguistic populations is strongly encouraged. The Committee must be committed to promoting recovery and empowerment.

The provider operating the FACT team is responsible for recruiting Committee members. Names of nominated individuals are submitted to the contracting ME for approval of membership. Membership may be rescinded if, in the view of the contracting ME an adversarial relationship has developed between the provider, Committee and the contracting managing and a good faith effort on the part of the ME to resolve the adversarial environment has failed.

Membership Qualifications:

Committee members should be knowledgeable about psychiatric disabilities and the challenges that people with these disabilities face living in the community. Members should be good problem solvers with a positive attitude and be objective and seek to understand the views of all stakeholders. People in recovery and their families are strong candidates for membership.

Membership Requirements:

Committee members become familiar with the Program Standards for ACT Teams and the FACT Handbook. Committees meet quarterly or more frequently if desired and members agree to serve at least a 2-year term, staggering termination to maintain a core of experienced members on the Committee. Although Committee Bylaws are not required, it is suggested the Committee elect a Chairperson. If a Chairperson is elected, the Committee must establish a protocol for such election including term of office, method of election, including use of proxy votes and specific duties of the Chairperson. Minutes of Committee meetings are recorded and submitted to the provider's Chief Executive Officer, the FACT Team Leader, and Managing Entity staff.

Approving and Rescinding Membership:

The contracting ME may use the following criteria in approving and rescinding membership on Committees. These guidelines are subject to change based upon the accumulation of practices, data and issues that may evolve over the course of time and experience.

Approving Membership

- Expressed willingness to volunteer time;

[7] The Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT may be accessed at: https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344

- Expressed interest in Florida's adult community mental health service delivery system;
- Expressed willingness to learn the ACT model of service intervention;
- Expressed willingness to participate in public forums;
- Meets at least one of the membership groups identified as representative of community stakeholders; and
- Has been approved by the contracting ME.

Rescinding Membership

- Repeated unexcused absence from Committee meetings (as determined by the Chair); or
- Creating an adversarial environment that is prolonged for three months or more and such environment diminishes the supportive, collaborative relationship that must exist between the contracting ME, the provider and the Committee.

FACT Advisory Committee Member Roles:

1. Advocating on behalf of individuals with psychiatric disabilities.
2. Becoming knowledgeable of the ACT model.
3. Identifying community resources for the team such as affordable housing, employment opportunities, and social outlets/supports.
4. Promoting awareness of the team in the community through community dialogues when requested.
5. Providing support, guidance and assistance to the FACT team.
6. Monitoring ACT fidelity by administering the "FACT Model Fidelity Review" on an annual basis.[5]
7. Participating in planned technical assistance site visits conducted by the ME to FACT teams.
8. Mediating complaints or grievances between meetings. It is the responsibility of the Chair to convene a mediating panel made up of three Committee members.
9. Spending at least one day observing a daily organizational meeting, recovery planning meeting or accompanying a team member on a field visit (with consent).[6]
10. Reviewing and commenting on the FACT team's enhancement expenditures and monthly FACT ad hoc data reports.
11. Developing a schedule of activities for the year.
12. Serving as a resource to the team to problem-solve local issues that may be barriers to successful outcomes.
13. Participating in the development of a protocol for communications between the team, its administration and the ME to be approved by the ME prior to implementation.[7]

Providers' Role Relating to FACT Advisory Committees:

1. Attending Committee meetings by the FACT team leaders and the provider's Chief Executive Office/Executive Director or designee.
2. Providing FACT enhancement expenditures and FACT monthly ad hoc data reports.
3. Providing any grievances/complaints and their outcome.
4. Forwarding of grievances/complaints not resolved at the team level within two weeks from date of filing to the team's Committee Chair who will convene a grievance mediating panel.
5. Participating in the development of a communication protocol between the team, its administration, the Committee and the ME for approval from the ME prior to implementation.
6. Providing the Committee with the necessary administrative support to ensure that documents are provided and minutes of meetings are distributed.

Managing Entity's Role Relating to FACT Advisory Committees:

1. Inviting the Chair of the Committee to participate in on-site technical assistance and programmatic monitoring

[8] [5] The FACT Model Fidelity Review is a modified form of the PACT Model Fidelity Review published by the National PACT Center and contains recommended standards. The protocol is attached to this Appendix C, revised May 2014.

[6] Due to the size of Advisory Committees, no more than 2 members should schedule attendance at any one meeting at any given time and with prior agreement by the team leader.

[7] A suggested format is attached but may be modified at the discretion of the entities developing the protocol.

completed by the ME.
2. Attending Committee meetings.
3. Participating in the development of a communication protocol between the team, its administration, the Committee and the ME. Upon completion, prepare an approval memo to the team, its administration and the Committee that the protocol is approved for implementation.
4. Serving as a liaison and resource person to the Committee for system issues that impact the team's successful outcomes.

Confidentiality

By law, Committee members do not have access to the medical record of FACT participants without the specific, written agreement of the individual. Committee members who may also serve on other councils or entities that, in the course of their duties, have statutory authority to access and review medical records are prohibited from sharing the findings of such reviews with other Committee members without the specific, written agreement of the individual. The specific agreement must be time-limited and can be changed by the individual at any time.

FACT Advisory Committee Agenda Template

Committee meetings address the following items:

- Call to Order and roll call;
- Report of Committee Activities;
- Report on Enhancement Expenditures;
- Report on the FACT Quarterly Data; and
- Report on Grievances Mediated and Outcomes.

Other Business
Next Meeting Date
Adjournment

Suggested Format for Communications Protocol

See Below

Instructions for Completing the FACT Model Fidelity Review

This is a quality improvement exercise and not intended to serve as a contractual compliance activity. Committee members conducting this survey are prohibited from reviewing individual clinical records. Feedback to the team leader at the end of the review will be helpful for continuous quality improvement. This activity will require 7 exercises:

1. Reviewing the staffing chart;
2. Reviewing position descriptions;
3. Reviewing policies and procedures;
4. Touring the entire team office space;
5. Interviewing the team leader;
6. Observing a daily organizational meeting; and
7. Reviewing the posted 2-month schedule of treatment team meetings.

Using the attached FACT Model Fidelity Review instrument, please complete the following:

1. Check either "Y" for yes or "N" for no at the time of the review;
2. Please note any discrepancies from the standards on a separate page; and
3. Using the results of the survey, prepare a summary of findings to share with the team leader.

FACT Advisory Committee Communication Protocol

Purpose: The purpose of this protocol is to ensure that a mechanism of communication is in place that enables the Committee, the provider, the contracting ME and the team to conduct its business while promoting the goals of the FACT initiative. This protocol is not intended to restrict any form of communication between individuals or entities but is intended to establish an agreement between the entities referenced above as to a preferred schedule of time for such communications.

Hours of Communication: It is agreed by all parties that business relating to the mission and intent of the Committee can best be served by calling between the hours of _____ and _____ Monday through Friday. Weekends and holidays will not be used for conducting routine business.

Communication Contacts: It is agreed by all parties that the following persons and phone numbers will be designated the primary and secondary contacts:

Primary Contacts:

For the Committee _____ Phone _____

For the FACT Team _____ Phone _____

For the Managing Entity _____ Phone _____

Secondary Contacts:

For the Committee _____ Phone _____

For the FACT Team _____ Phone _____

For the Managing Entity _____ Phone _____

Mitigating Factors: It is agreed by all parties that certain situations may arise that require the parties to prepare, locate, copy and fax or e-mail information. When a request is made for written information, it is agreed that an appropriate response time to complete the request is ____ days from the date of the request.

Agreements: The parties, by their signature, will make a good faith effort to communicate with each other within the agreed upon parameters established above.

For the Committee _____ Date _____

For the Team _____ Date _____

For the Provider _____ Date _____

For the ME _____ Date _____

FACT MODEL FIDELITY REVIEW

Standard	Element	Y	N
A. Staff Composition	Look at staffing chart for documentation		
	The ratio of participants to direct service staff members should not exceed 10:1		
	Psychiatrist or Psychiatric APRN @ a minimum of 0.80 (FTE) hours of services for each 100 participants per week		
	1 Administrative Assistant		
	1 FTE Team Leader (licensed professional)		
	1 Nurse for every 35 participants – at least one must be a FTE RN		
	1 FTE Case Manager		
	1 FTE Substance Abuse Specialist		
	1 FTE Peer Specialist		
	1 FTE Vocational Specialist		
B. Key Staff Roles	Look at position descriptions for documentation		
1. Team Leader	Leads daily organizational team meeting		
	Available to team for clinical supervision		
	Provides 1:1 supervision to staff		
	Functions as a practicing clinician		
	Assigns team members including a primary case manager to each new participant		
2. Psychiatrist or APRN	Conducts psychiatric & health assessments		
	Supervises psychiatric/psychopharmacological treatment of all enrolled participants		
	Monitors non-psychiatric medical conditions & medications		
	Supervises medication management system with nurses		
	Provides brief therapy and diagnostic/medication education to enrolled participants		
	Provides crisis intervention on-site		
	Provides family interventions and psychoeducation		
	Attends daily organizational & recovery planning meetings		
	Provides clinical supervision to staff including RN and LPNs		
	If participant is hospitalized, actively collaborates with inpatient care providers to ensure continuity of care		
	If APRN, must have continual access to and weekly consultation with a board-certified Psychiatrist		
3. Nurses	RN, LPN and MD manage medication system		
	Administer and document medication treatment		
	Screen and monitor for medical problems and side effects		
	Coordinate services with other health providers		
	Provide education on health promotion & prevention, education side effects, and strategies for medication compliance		
4. Vocational Specialist	Serves as mentor to staff for employment assessment and planning		
	Maintains liaison with DVR and training agencies		
	Provides full range of work services (job development, assessment, job support, career counseling)		
5. Peer Specialist	Position is integrated within the team		
	Shares roles with other team members		
	Provides individual and group support services		

Standard	Element	Y	N
6. Substance Abuse Specialist	Serves as mentor to staff for assessing, planning and treating substance use		
	Provides supportive treatment individually & in groups (i.e., CBT, motivational interviewing, relapse prevention)		
	Completes substance use assessments that consider the relationship between substance use and mental health		
C. Program Size & Intensity	Look at policies for documentation		
	Participants are contacted face-to-face an average of 3 times per week, based on the participant's individual needs		
	Clinically compromised participants are contacted multiple times daily		
D. Admission & Discharge Criteria	Look at policies for documentation		
	Admission criteria specify target population		
	Discharge criteria include demonstrated ability to perform successfully in major role areas over time		
	Discharges mutually determined by participant and team		
	Team assumes long-term treatment orientation		
E. Office Space	Tour office space for documentation		
	Easily accessible to participants and families		
	Common workspace, layout promotes communication		
	In office medication storage area		
F. Inter-Agency Relationships	Interview Team Leader and ask for evidence of collaboration for documentation		
	Active collaboration with other human services providers		
	Active participant-specific liaison with SSA, health care providers, other agency assigned workers		

Standard	Element	Y	N
G. Hours of Operation	Look at policies for documentation		
	Staff on duty 7 days per week		
	Program operates 12 hours on weekdays		
	Program operates at least 8 hours on weekend days and holidays		
	Team members are on-call all other hours for 24 hour coverage		
	Team members available by phone and face-to-face with back-up by Team Leader and Psychiatrist or APRN		
H. Team Communication & Planning	Look at policies, observe daily organizational meeting and ask to see 2-month posting of treatment team meetings for documentation		
	Organizational team meeting held daily M-F		
	Meeting completed within 45-6O minutes		
	Member status reviewed via daily log and staff report		
	Team leader facilitates discussion & recovery planning		
	Services & contacts scheduled per recovery plans and triage		
	Staff assignments determined		
	Daily staff assignments prepared schedule		
	Service provision monitored and coordinated		
	All staff contacts with participants are logged		
	Recovery planning meetings held weekly		
	Recovery planning meetings held by senior staff		
	Recovery planning meetings schedule posted 2 months ahead		
I. Policy and Procedure Manual	Look at policies for documentation		
	Admission and discharge criteria and procedures		
	Job descriptions, performance appraisals, training plan		
	Program organization & operation (program hours, on-call, service intensity, staff communication, team approach & staff supervision)		
	Assessment and recovery planning		
	Medical records management		
	Service Scope		
	a. Case management		
	b. Crisis assessment & intervention		
	c. Symptom assessment, management & supportive therapy		
	d. Medication prescription, administration, monitoring & documentation		
	e. Substance abuse services		
	f. Work related services		
	g. Activities of daily living		
	h. Social, interpersonal relationships & leisure time		
	i. Support services		

	j. Education & support to families & other supports		
	Enrolled participant rights		
	Program performance improvement and evaluation		
	80% of participants live in independent community living		
	Legal advocacy provided as needed		

NOTES:

HEALTH SYSTEMS

MONTHLY VACANT POSITION(S) REPORT

FACT Program/Contract No. _____

Network Service Provider:_____

Month:_____

Position Number	Position Title	Date Position Became Vacant	Number of Vacant Calendar Days