



Office of
Mental Health

Program Operations: Applying Program Guidance to Build Effective Workflows and Strengthen the Team Approach

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Learning Objectives:

By the End of this Session, Participants will be able to:

1. Recognize and use the NYS ACT Program Guidelines, Standards of Care and other OMH Guidance Documents to help train new staff and drive high-quality ACT.
2. Identify common signs of model drift within your ACT Team.
3. Apply ACT Guidance to ensure that you are following ACT Fidelity: Multidisciplinary practice, team workflows, billing, providing high-quality care.
4. Use available ACT Resources, guidance documents, and fidelity tools to strengthen your ACT Teams.

The goal isn't to memorize ACT, its to know the model, know your role and know where to look if you don't know the answer.

Why Does Assertive Community Treatment Exist?

- ❑ Post deinstitutionalization- cr. 1965-1975: stein, test and colleagues recognized that people coming out of the hospital from an inpatient setting- stabilized inpatient- they learned skills, managed their meds and symptoms but then struggled to maintain those same skills once d/c'ed.
- ❑ They developed a community-based program that supported people post hospital d/c to help keep skills fresh, have a warm hand off into the community and to continue with rehabilitation goals and prevent recidivism. This was the start of ACT as we know it today.
- ❑ ACT was designed to bring intensive treatment, rehabilitation, skill development and multidisciplinary care into people communities and homes.
- ❑ The basic efficacy of assertive community treatment in reducing hospitalization and improving patient functioning has been tested and retested not only in the U.S. but also in other countries
- ❑ ACT wasn't designed to be traditional Case Management; it was designed to be treatment and rehabilitation on wheels.

The Foundation of NYS ACT: ACT Guidelines & Standards of Care

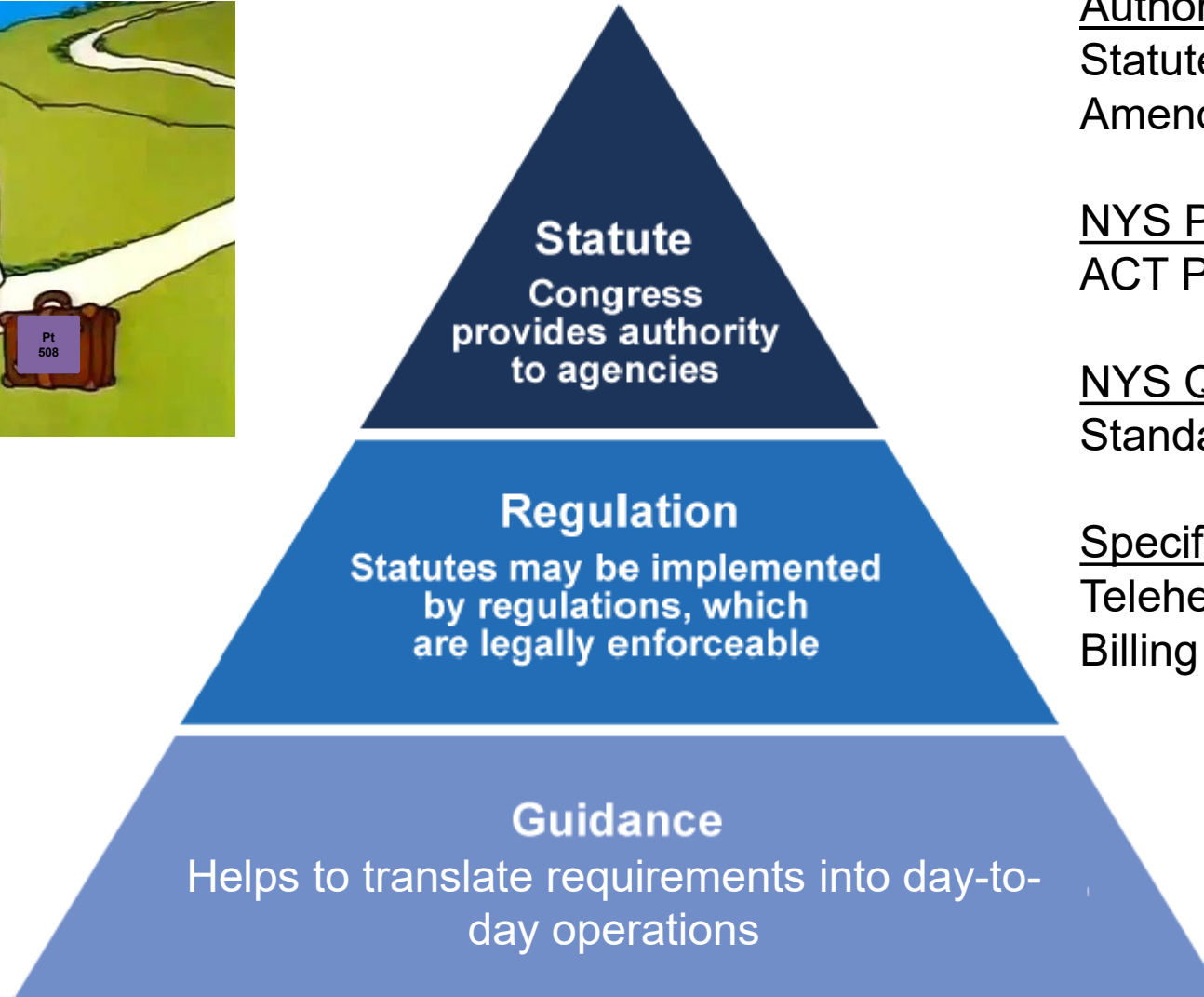
Foundational Knowledge

Medicaid State Plan: A contract between the state and federal governments wherein the State agrees to administer the Medicaid program in accordance with federal law – Section 1902(a)(30)(A) of the Social Security Act and other applicable federal statutes and regulations.

The Medicaid State Plan is a compilation of pages approved by the federal government's Centers for Medicare & Medicaid Services (CMS) and includes the State's policies and procedures pertaining to Medicaid covered services, eligibility requirements and reimbursement methodologies. The Plan is the basis for obtaining federal funds for services allowing States to claim Federal matching funds for its program activities.

- State Plan Amendment
 - Part 508 Regulation
 - Assertive Community Treatment Program Guidelines
 - Standards of Care

I'm Just a Bill: So where does ACT Guidance Come From?



Authority:

Statute | Regulation | State Plan Amendment (SPA)

NYS Program Framework:

ACT Program Guidelines

NYS Quality:

Standards of Care (SOC)

Specific Practice Guidance:

Telehealth| Service Dollar| Collateral| Billing

We don't need to know every answer; just where to find them.

- ACT is complex, we are supporting individuals with the highest behavioral/physical health needs in the state.
- The [ACT Guidance documents](#) are here to help make sense of things; **you don't need to KNOW** all the info all the time.
 - ACT [SPA/Regulations](#)
 - ACT Guidelines: Understand the model, know your role, recognize the basics of ACT
 - SOC: Are we providing good quality ACT? If not, how can I make sure I am?
- **These aren't just guidance documents: They're knowledge enhancing tools!**

Office of Mental Health

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Assertive Community Treatment (ACT)

OVERVIEW

Assertive Community Treatment (ACT) takes a "whole team" approach to treating serious mental illness. It allows people to receive services in their community (rather than a more restrictive hospital setting). ACT aims to reduce the reliance on hospitals by providing round-the-clock services to the people who need it most. ACT uses a person-centered, recovery-based approach to care.

ACT services include:

- mental health treatment
- integrated dual disorder treatment
- family education
- community integration
- peer support
- vocational support

The goal of ACT is to help people become independent and integrate into the community as they experience recovery.

ACT GUIDANCE

- [ACT Program Guidelines \(updated 2025\)](#) 
- [Flexible ACT Program Guidelines Addendum](#) 
- [Forensic ACT Program Guidelines Addendum](#) 
- [Forensic ACT with TAP Program Guidelines Addendum](#) 
- [Rural ACT Program Guidelines Addendum](#) 
- [Older Adult ACT Program Guidelines Addendum](#) 
- [Young Adult ACT Program Guidelines Addendum](#) 
- [Inpatient Setting Continuity of Care Expectations for ACT Individuals](#) 
- [ACT Utilization Management Guidance \(updated 3/2023\)](#) 
- [Service Dollar Guidance](#) 
- [ACT Standards of Care \(reissued 2026\)](#) 
- [ACT Billing Memo 8/29/19](#) 
- [ACT Collateral Update Memo 9/1/19](#) 
- [Training Memo \(updated 1/2026\)](#) 
- [Forensic ACT Assessment Memo](#) 
- [IPS Initiative Guidance for ACT and CORE PSR](#) 

Know the Program Guidelines and SOC: Know ACT

Know the Model:

Understand what ACT is designed to do-

- Why does ACT Exist?
- What makes ACT different?
- What does high-quality ACT ACTually look like?
- How does this evidence based/multidisciplinary team work?

Know Your Role:

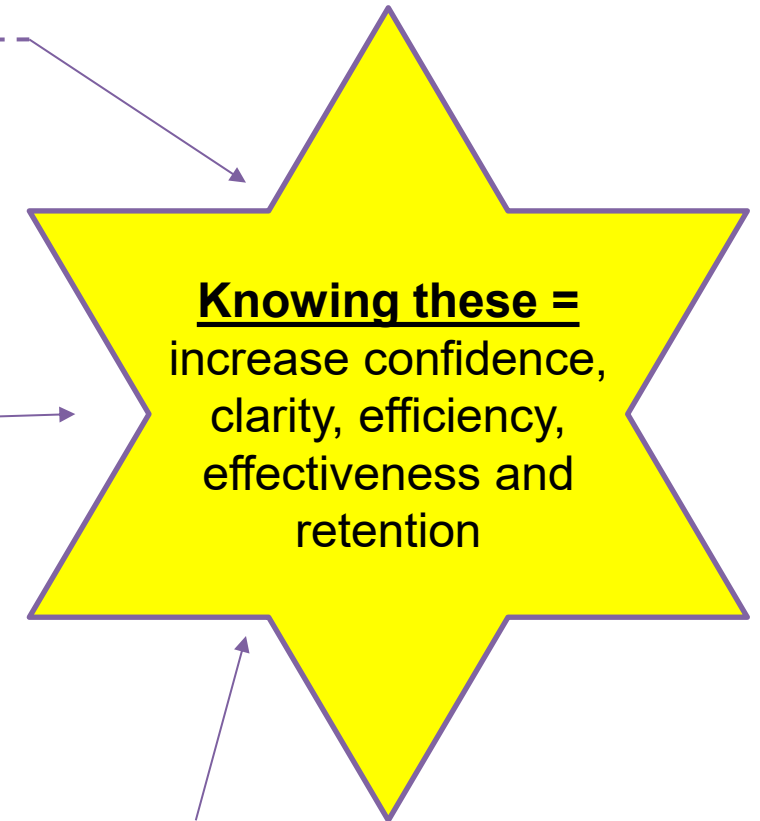
Understand how YOU contribute to ACT-

- Know your specialty role
- Understand your responsibilities
- Bring your expertise to the team
- Connect your expertise to participant goals

Know where to Look:

You don't have to memorize these tools-

Program Guidelines | ACT SOC | ACT Institute LMS | Field Office Liaisons



ACT Guidelines = Scaffolding and Structure

The Guidelines help to establish the scaffolding for NYS ACT; team composition and competencies, medically necessary services, supervision, multidisciplinary work, treatment, rehabilitation, team processes...

Adult Assertive Community Treatment (ACT) Program Guidelines

2. Overview

The purpose of Assertive Community Treatment (ACT) is to deliver comprehensive and effective services to individuals who are diagnosed with SMI and whose needs have not been well met by more traditional service delivery approaches.

ACT is grounded in a recovery-oriented practice and provides an integrated set of evidence-based treatment, rehabilitation, case management, and support services delivered by a mobile, multidisciplinary behavioral health treatment team. ACT supports individual recovery through a highly individualized approach that provides individuals with the tools to obtain and maintain housing, employment, relationships, and relief from symptoms and medication side effects. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of daily team meetings.

ACT integrates the principles of person-centered, culturally responsive, trauma-informed care, addressing the impact of discrimination/stigma, and cross-system collaboration into its service philosophy. ACT provides services with consideration of cultural/linguistic preference through the use of the cultural formulation interview process and cultural assessment. An essential aspect of ACT is recognizing the importance of family, community-based, and faith-based supports.

Standards of Care = Quality ACT

- The SOC are OMH's articulation of core expectations for quality, safety, access, and accountability.
- SOC's help teams and agencies ensure high quality services, the SOC translate the services and model into a clear guide and help inform what ACT looks like.
- The SOC take regulations and provide additional context for the provision of high-quality services
- Guide how OMH evaluates whether care is meaningful, safe, and effective. SOC help guide licensing to help inform surveyors- "Is this ACT?"
- The SOC outline Core and Exemplary performance indicators for ACT teams to follow. *(they're kind of like having a cheat sheet)*

ACT ADULT AND YOUNG ADULT STANDARDS OF CARE SURVEY TOOL MAY 2026

NYS Office of Mental Health Office of Mental Health		
Standard of Care Focus	EXEMPLARY (In addition to Core)	CORE (Absence of a preponderance of core indicators may require a performance improvement plan)
Intake		
ACT SOC 1.11 Intake	1. ACT team members engage with a person prior to admission into ACT and well in advance of hospital discharge or jail release assisting with coordination of discharge planning.	1. Following referral, the ACT Team locates individuals and engages them in services. 2. The team makes an admission decision no later than seven (7) business days of initial contact with the individual. ACT Team clearly documents their admission decision and notifies SPOA of their decision. Delays in admission are clearly documented in the individual's record.
Assessment and Evaluation		
ACT SOC 2.11 Initial Assessment	1. The entire team meets to review clinical assessments of new admissions to formulate multidisciplinary team review and to inform planning recommendations. 2. Each individual is screened using the Columbia-Suicide Severity Rating Scale (C-SSRS).	1. An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 business days of admission. 2. An Initial Assessment is completed within 60 calendar days of admission to inform the initial Service Plan: a. Staff with appropriate expertise complete the assessments. b. The team reviews and develops clinical formulations under the guidance of the MD, Team Leader or designated clinical supervisor. c. Person-specific risk factors and patterns are identified, as well as effective and ineffective coping strategies, level of independence in critical areas, supports and interventions. d. There is evidence that exploration of personalized recovery goal(s) occurred during the assessment. 3. Standardized screening and assessment instruments are used for: a. Risk b. Substance Use c. Health (reviewed by MD, NP or RN)
ACT SOC 2.12 Ongoing Assessment and CAIRS	1. The team's CAIRS BASF and FUAF data is entered within 2 weeks of the due date. 2. The team uses PSYCKES to identify and monitor individuals who could benefit from clinical review, and inform treatment planning. 3. The team uses RHIOs/QEs to identify ER/hospitalizations.	1. There is evidence that the team enters individual data into CAIRS the Baseline Assessment Form (BASF) is completed within 30 days of admission. 2. The CAIRS Follow-Up Assessment Form (FUAF) is updated at least every six months. 3. The FUAF and comprehensive assessment is completed every six months and informs the service plan review. 4. Specific comprehensive assessments are completed as needed, specifically in areas of Risk, SUD, Medical, and Psychiatric.

Service Plans		
ACT SOC 3.11 Service Plan	1. Individuals develop WRAP plans. 2. The team uses systematic tools to determine readiness for change. 3. The team uses tools that reflect a rehabilitation process: e.g.: identifying a personal goal, assessment of strengths, barriers and strategies, and timelines to achieve the goal. 4. Recipients receiving rehabilitation services actively practice and utilize social and communication skills. 5. Treatment planning and review occurs with family/supports present if the person consents. 6. A copy of the plan is shared with family with consent and medical/other providers where appropriate.	1. Every individual has a person-centered service plan developed in partnership, within 60 days of admission, with documented involvement of the individual, physician and the team leader or designated clinical supervisor involved in the treatment. 2. The plan is signed by the staff person completing the plan and an LPHA on the ACT Team. If the plan is not signed by the individual, the team documents in progress notes that the plan was reviewed and agreed upon by the individual. 3. The service plan reflects: a. A recovery orientation, including life goals, such as educational, vocational, residential, social, or recreational pursuits. b. Evidence of shared decision making with individual, team, family support and/or collateral. c. Activities to be carried out from an AOT order, where applicable. d. Future orientation and documentation of specific and individualized discharge criteria. 4. The plan is shared with individual, and family, medical and other providers, with consent. 5. Clinical interventions are not solely focused on engagement and treatment adherence, but include: a. Building and testing skills, and fostering independence b. Strengthening and building community links and supports 6. There is evidence that the team and individual have identified barriers associated with reaching goals and strategies to assist in overcoming these barriers. 7. At least one of the documented services is a Community Integration and Re-integration service: a. Care coordination;

**ACT Hasn't Changed; the World
has: Rapidly**

Two things happened almost simultaneously: **WHY IS THIS SO MUCH HARDER?**

- **The workforce Changed:** higher turnover/vacancies, COVID disruption, loss of veteran staff and historical ACT knowledge.  Rapid onboarding, turnover, new staff training new staff, new staff with less experience overall. Huge Impact on ACT Teams.
- **The Landscape changed:** EVERYTHING got rapidly more expensive, services have become more complicated to access, systems are larger, understaffed and difficult to navigate, community resources are stretched, participants have increasingly complex behavioral, social and physical healthcare needs.
- You have to learn to work within this changed system.

When Survival Mode Becomes Model Drift:

Not ACT	ACT
Does Kim have her visits?	Quality case review of participant
Just let me handle it, we don't have time for this.	Cross specialty collaboration.
"I'm a case manager"	"I'm the Vocational Specialist"
Long-Term Maintenance	Recovery and Transition
I dropped food off to Jon	I helped Jon find where to access info on the local pantry and brought him.
I brought Dion his meds.	I supervised a med fill with Dion and helped him fill an organizer for one week.
That's how we've always done it	Have we checked the SOC on this?

ACT Teams, just like people, adapt to survive. Eventually and overtime, those adaptations become normal practice. It can be easy to forget that ACT is an evidence-based model and we have to follow fidelity.

SO... What Should ACT Look Like?

Daily Team Meeting: Where ACT Comes Together Like a Symphony

- What Daily Team Meeting ISN'T-
 - "Whose got 6 visits, lets skip them"
 - No input from specialists: eg- JG is using but SUD Spec doesn't comment
 - Arguing about what's best for a specific client
 - One person leading all the discussions
- What is Daily Team Meeting ACTually?
 - **A brief and clinically relevant review of every individual on the team.**
 - Brief review of prior on-call contacts since the last staff meeting.
 - Updates and revisions to the daily staff assignment schedule.
 - **Inter-team collaboration and consultation**
 - Service plan reviews and revisions, as needed
- Daily Team Meeting is ➡ The war room: its: Clinical case review, operational planning, group supervision, team problem solving...



Core ACT Specialty Roles:

Specialist Competencies:

- **Substance Use Specialist** • Substance use assessment and identification of SUD, including tobacco, alcohol, and opioid use disorders • Principles and practices of harm reduction • Knowledge and application of stage-wise treatment • Knowledge and application of motivational interviewing strategies and stage-matched treatments for all SUD • Training and/or experience in integrated mental health and substance use services
- **Vocational Specialist** • Knowledge of models of supported employment/Individual Placement and Support (IPS) • Knowledge of psychosocial rehabilitative services • Ability to complete a vocational assessment to determine mental health needs in the workplace or education (e.g., career profile) • Skills development related to choosing, securing, and maintaining employment and educational goals
- **Family Specialist** • Family needs assessment • Family intervention strategies • Cognitive behavioral techniques • Training and/or experience in psychoeducation and/or other family support services

Stay Curious, Learn Your Craft, & Teach the People Around You

Knowing your specialty is important, your expertise increases your team's knowledge, and you help to cross train your colleagues along the journey. This helps your participants grow and recover, you are their guide, in more ways than one. **THIS IS SYNERGY.**

AI LMS:

Required &
Recommended
Trainings,
Support Calls,
Instagram!

CEU's/CME's:

MD, RN,
LMSW, LMHC,
CASAC

Podcasts:

Psychiatry and
Psycho Therapy,
In Recovery,
GET REAL:
Talking Mental
Health and
Disability

Other:

National ACT
Support Calls
and Listserv,
Books,
TedTalks

Knowledge Check! Scenario 1

“Cross what now?”

During morning meeting, staff report that Denise has become increasingly irritable, confused, and suspicious over the past several days, they mention her apartment smells like urine and that Denise complained yesterday about pain when urinating. The nurse says, “*I’ll call her PCP and handle it*” and the team moves on because there are 40 more participants to review.

Q: How could the RN have handled this situation more ACT-like?

What has your team taught you and how has it helped you in practice?



Assess, Collaborate and Treat: ACT in ACTion

Assessment and Treatment Planning:

- Treatment Planning is a Team Activity
- Daily Team Meeting is where the team thinks together, treatment planning is where all that work thinking comes together on paper.
 - After point staff meet with the individual to complete assessments and the tx plan the team should meet to review.
 - During the tx plan meeting: each relevant specialty should have representation in tx planning, based on participant needs, strengths, and preferences.
 - For Example: If the individual has an identified SUD, the team should ensure weekly visits with the participant to provide SU services that are linked and aligned with the tx plan.
 - Assessments should be used to guide treatment planning and should highlight the participants voice, choice and perspective.
 - Regardless of specialty needs, each team member should regularly meet with every participant to provide general ACT services: psychoeducation, case management, appointment coordination, rehabilitative interventions....

Finding the Golden Thread: Example

Assessment Findings/Clinical Formulation

Wants: to finish bachelor's degree in Computer Science

Needs: assistance with applying to a college and financial assistance

Barriers: symptoms of Bipolar elevate in classroom settings and when experiencing high levels of stress. Previous attempts have resulted in lengthy hospitalizations. When doing well Patrick will stop taking his medications

Service Plan

Goal: I will obtain a bachelors degree in Computer Science

Objective: I will apply to three Computer Science programs by June 2027.

Intervention: ACT staff will provide Patrick with one CS program to review monthly and assist him with identifying pros and cons.

Intervention: ACT staff will assist Patrick with obtaining his transcripts from SUNY Cortland through reviewing the request process, utilizing service dollars to pay for transcripts, and offering follow up support monthly.

Objective: I will utilize my Crisis/Relapse Prevention Plan to avoid hospitalizations when possible for the next six months.

Intervention: ACT staff will assist Patrick with identifying and utilizing coping skills during times when he is experiencing an increase in Bipolar symptoms and stress through the development of his Crisis/Relapse Prevention Plan twice a month.

Intervention: The RN will meet with Patrick quarterly to administer his IM medication and educate him on the purpose of taking his oral medications as prescribed.

Finding the Golden Thread: Example

Patrick Javarone

Date: 9/2/2026

Start Time: 2:33pm **End Time:** 3:03pm

Location: Home

Goal: I will obtain a bachelors degree in Computer Science

Objective: I will apply to 3 Computer Science programs by 2027

Intervention: ACT staff will provide Patrick with one CS program to review monthly and assist him with identifying pros and cons.

Writer met with Patrick in his home to discuss his goal of obtaining a bachelor's degree. Patrick explained that he researched the previous program writer provided him and realized it didn't seem like it would be a good fit due to it being an accelerated program requiring him to attend full-time. Writer and Patrick discussed how attending full-time in the past caused Patrick to experience high levels of anxiety and stress which resulted in Patrick experiencing a manic phase. Patrick stated he did much better during semesters when he attended part-time. Writer reiterated Patrick's identified con while providing him with a new program that allows for part-time admission. Writer provided Patrick with a brief description of the program that includes a hybrid approach. Patrick expressed excitement around the hybrid approach acknowledging that it would allow him an in-person experience while giving him some independence with online learning. Writer reiterated Patrick's identified pro of a mix of in person and the ability to complete school tasks on his own time with online classes. Patrick and writer discussed follow up for our next meeting scheduled 10/2/2026 to review Patrick's program research and possible decision. Writer informed Patrick that he can reach out prior to then if he has any questions or wants to talk through his thoughts. Before ending the session, Patrick did inquire about next steps with obtaining his transcripts. Writer and Patrick scheduled a time to meet next week to start that process.

Wait, is that model drift again??

As ACT Teams start up, grow, evolve and maintain, they should be asking themselves:

- Is there actual treatment and rehabilitation happening?
- Are we helping to develop skills or maintaining?
- Are we task managing or helping participants learn skills.

Guardrails:

TMACT	Tool for Measurement of ACT
NYSAF	NYS ACT Fidelity Tool
SOC	ACT Standards of :Care
Adult ACT Guidelines	Framework of ACT

ACT Program Guidelines Section 5.12.3

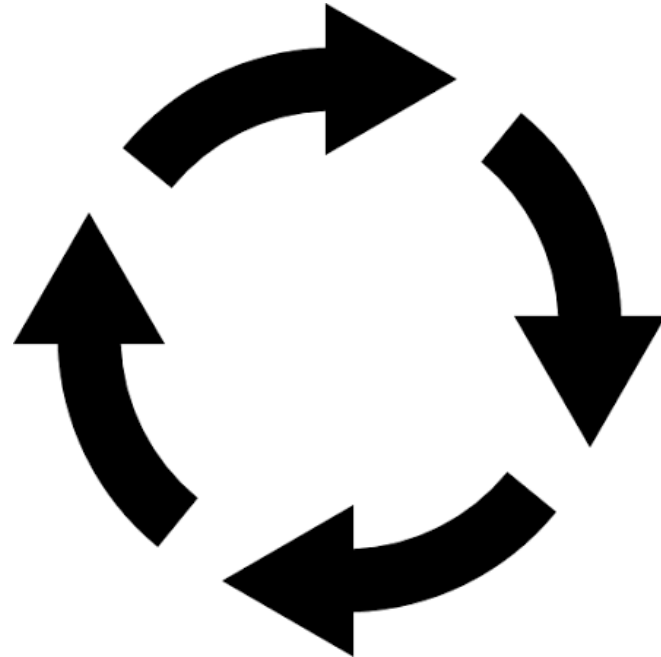
The Agency will develop a process to systematically monitor, analyze, and improve the performance of the ACT team in assisting individuals to achieve their treatment outcomes. This includes the development of a quality improvement plan consistent with the mission, principles, and values of the ACT program. The plan will include:

- x. Self-assessment of fidelity to the ACT model (using the TMACT or available soon the NYS ACT Fidelity Tool).

Knowledge Check: Scenario 2

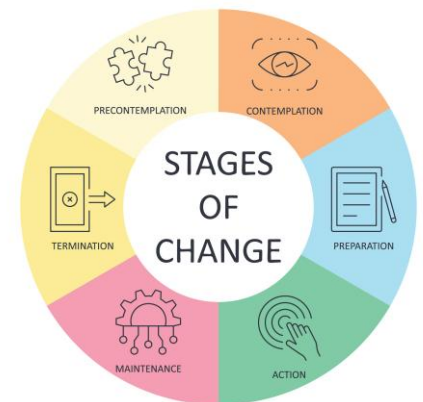
Jordan has been enrolled in ACT for 18 months. The team consistently meets minimum billing standards. Most contacts involve setting up transportation, grocery shopping, appointment reminders, benefits coordination, and housing applications. Jordan's service plan identifies goals related to managing anxiety, returning to work, and reducing cannabis use. The Vocational Specialist and SUD Specialist regularly see Jordan, but their notes primarily document the same general care-management activities as other team members.

Q: Are they meeting the clinical needs of the participant?



SUD/IDDT Deep Dive

- Co-Occurring Disorder Treatment is a part of the ACT Bundled Rate:
 - SUD Specialists have the responsibility to not only assess for SUD but also to treat SUD. (SOC Section 4.14)
- Substance Use assessment- Recent substance use, history of substance use, planned interventions, understanding what stage of change the participant is at helps to understand the treatment:
 - Do we provide harm reduction and continue to educate, are they ready to work toward THEIR recovery?? Do they understand their illness? Do they have the tools to succeed?
 - IDDT- IDDT- integrated treatment that aims to help participants understand how their mental health and substance use is intertwined. How does one impact the other and vice versa. (Pg. 11 ACT Program Guidelines | AI LMS)
 - Skill building, relapse prevention, understanding mental health symptoms and how they relate to substance use,
 - Providing additional supports: recovery centers, groups, work, family specialist interventions, SUD counseling.



ACT Treatment doesn't have to ALWAYS be 1:1: Groups You Say?!

SUD/IDDT:

- Co-occurring disorder tx
- Recovery focused skill building
- Harm Reduction/Relapse Prevention
- Self exploration

Family Psychoeducation:

- Education and coping strategies
- Strengthening natural supports
- Teaching communication skills
- Understanding positive vs negative supports/setting boundaries

Rehabilitation and Skill Development:

- Problem solving in real world situations
- Wellness self management-diet/nutrition/hiking/walks
- Independent living skills
- Community living skills

Peer Led Recovery Support:

- Developing self-advocacy skills
- Psychiatric Advanced Directives
- Effectively communicating needs
- Navigating Community Resources

Knowledge Check: Scenario 3

Scenario 3 “Lets Just Refer out”

You are the **new Team Leader of an established ACT team** after the team’s longtime Team Leader recently left. During morning meeting, the team discusses **David**, who has been enrolled in ACT for three months. David lives with schizophrenia and a co-occurring substance use disorder; he regularly uses alcohol and cannabis, with occasional stimulant and convenient store drug use.

The SUD Specialist reports:

“His substance use is pretty significant. I’ve talked to him about it; he needs actual substance use treatment. I’m going to refer him to an OASAS clinic. We can’t give him what he needs here, he wont even really talk to me about drug use.”

The team appears ready to move on to the next participant.

Q: You’re the new Team Leader. What do you say?



Maximizing Contacts and Billing

Billing: What ACTually Counts

Medicaid Reimbursement Rates for ACT

- **Full Rate** (Rate Code 4508): At least six (6) contacts in a month (up to three (3) of these contacts may be with collaterals)
- **Partial Rate** (Rate Code 4509): Less than six (6) contacts but at least two (2) contacts per month
- **Inpatient Hospital rate** (Rate Code 4511): for individuals in the hospital

[OMH Telehealth Guidance](#)

[Inpatient Billing](#)

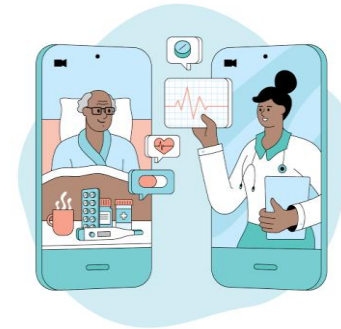
https://omh.ny.gov/omhweb/medicaid_reimbursement/

[Collateral Memo](#)



Telehealth: Know the Rule Before you Use the Tool:

- To utilize Telehealth as a modality:
 - Must be included on an agency's Operating Certificate
 - Must follow Telehealth requirements per Part 596 and [Telehealth Services Guidance for OMH Providers - April 2023](#)
 - Assessing appropriateness of Telehealth use with individual
 - Confidentiality and Privacy of Health Information
 - Documentation and the Electronic Health Record
 - Informed Consent
- May be used to supplement in-person services to:
 - Optimize engagement (e.g., for screening so individual can learn about choices in services),
 - Temporarily provide care in circumstances where in-person engagement is not possible (e.g., risk of infection),
 - Engage others in the individual's care (e.g., family therapy sessions, **collateral contacts**, etc.).



Telehealth: Know the Rule Before you Use the Tool: Billing Requirements

ACT Teams may not use Telehealth (TH) to provide all of the minimum contacts required for ACT billing. A contact is defined as a minimum of a 15-minute interaction for both in-person and Telehealth, with the individual or collateral.

Full billing:

- At least 3 contacts must be provided in-person with the individual;
- A maximum of 3 contacts may be provided using TH; and
- Where collateral contacts are provided, a maximum of 2 collateral contacts may be provided using TH.

Partial billing:

- At least 2 contacts must be provided in-person with the individual; and
- Any additional contacts with the individual may be provided using TH.

Inpatient billing:

- At least 1 contact must be provided in-person and the other contact may be provided using TH;
- In the month of admission/discharge, the full payment rate reimbursement is permitted for any month in which at least 6 contacts are provided, including 4 or more community-based contacts, consistent with the standards stated above for full billing, combined with a minimum of 2 inpatient contacts, and
- In the month of admission/discharge, the partial payment rate reimbursement is permitted when a minimum of 1 in-person community contact, combined with a minimum of 1 in-person inpatient contact, is provided.

Collaterals and Natural Supports

Collateral Persons: Members of the individual's family or household, family of choice, or others who regularly interact with the individual (e.g., landlord, criminal justice staff, employer), are directly affected by or can affect the individual's condition, and who are identified in the service plan as having a role in the individual's treatment. Contacts made with a defined collateral person are provided for the direct benefit of the individual receiving services. Collateral contacts are conducted in accordance with, and for the purpose of, advancing the individual's service plan and for coordination of services with other community mental health and medical providers.

Contact: A face-to-face interaction (duration of at least 15 minutes) between a member of an ACT team and an individual or collateral during which at least one (1) ACT service is provided.

[ACT Collateral Memo](#): expands the definition to include shelter staff.



The ACT Billing Toolbox: Creating Flexibility Within a Rigid Structure

- Daily Team Meeting Contact Logs
- Monthly, Weekly, and Daily contact tracking
- AOT and High-Risk Logs
- Readiness for Transition
- Inpatient Billing & Billing combinations in month of admission or discharge
- Collateral Contacts
- Case Conferencing with your participant
- Telehealth Allowances

The ACT Billing Toolbox: Creating Flexibility Within a Rigid Structure

Workflow Practice	Billing Impact
Daily team meeting	Ensures services are assigned and coordinated, reducing missed billable contacts.
Staff scheduling	Maximizes productivity and face-to-face community contacts.
Daily assignment of Participants (i.e., assigning runs each day)	Promotes equitable caseload distribution, ample number of visits and timely service delivery.
Community-based outreach	Supports ACT's expectation that the majority of services occur in the community and are billable.
Timely documentation	Claims cannot be supported without complete documentation.
Integrated treatment planning	Demonstrates medical necessity and supports billed interventions.
Coordination among disciplines	Prevents duplication while increasing opportunities for billable multidisciplinary interventions.
Supervision and chart review	Improves documentation quality and reduces billing errors.
Missed-contact follow-up	Maintains engagement and supports continuity of care.
Monitoring productivity/Contact Logs/Visit Tracking Tools	Helps leadership identify workflow barriers before they affect revenue.

Knowledge Check! Scenario 4

Scenario 3: “She’s Doing Great”

Maria has been on ACT for six years. She has stable housing, hasn’t been hospitalized in three years, manages her medications with minimal assistance, regularly attends a community art group, and has developed several natural supports. She still receives six ACT contacts each month because *“she likes the team and doesn’t want to leave.”* Her treatment plan has looked largely the same for the past two years.

During treatment planning, A new member of the ACT Team asks whether the team should begin discussing transition. An older, more seasoned staff member responds, *“Why mess with something that’s working?”*

Q: As a team, how would you handle this scenario?

Big ACT Takeaways:

BIG ACT TAKEAWAYS:

1. Stewardship
2. Think Strategically
3. Be dynamic
4. Rely on your team
5. Find your Passion
6. ACT is Rehabilitation
7. Others?

Questions?



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