MSA MEDICAL SERVICES ADMINISTRATION

# Bulletin

**Michigan Department of Community Health**

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**Distribution:** Prepaid Inpatient Health Plans (PIHP), Community Mental Health Service Programs (CMHSP)

**Issued:** May 1, 2014

**Subject:** Revisions to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual, Assertive Community Treatment Program Section

**Effective:** June 1, 2014

**Programs Affected:** Medicaid

This bulletin revises the Assertive Community Treatment (ACT) Program section of the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual. These changes were developed after extensive discussion, research, input and revisions from Assertive Community Treatment Subcommittee of the State-Wide Practice Improvement Steering Committee, Michigan Department of Community Health (MDCH) staff, representatives of Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Service Programs (CMHSPs) and consumers.

## ASSERTIVE COMMUNITY TREATMENT PROGRAM

ACT is a therapeutic set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team that includes case management, psychiatric services, counseling/psychotherapy, housing support, Substance Use Disorder (SUD) treatment and employment and rehabilitative services provided in the beneficiary's home or community.

ACT provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources (such as food, housing, medical care and supports) to allow beneficiaries to function in social, educational, and vocational settings.

ACT is an individually tailored combination of services and supports that may vary in intensity over time, and is based on individual need. ACT includes availability of multiple daily contacts and 24-hour, 7 days per week crisis availability provided by the multi-disciplinary ACT team that includes psychiatric and skilled medical staff. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of each beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team staff.

The PIHPs and the CMHSPs offer a continuum of adult services including case management, outpatient therapy, and psychiatric services that can be used in varying intensities and combinations to assist beneficiaries in a recovery-oriented system of care. Beneficiaries' level of need and preferences must be considered in the admission process. ACT is the most intensive non-residential service in the continuum of care within the service array of the public mental health system.

**TEAM APPROVAL**

Medicaid providers wishing to become providers of ACT services must obtain approval from MDCH and meet the program components outlined below. Provider programs with more than one ACT team must have individually approved and registered ACT teams. All ACT teams are subject to MDCH re-approval every three years.

**TARGET POPULATION**

The intensity of ACT services are intended for beneficiaries with a primary Axis I diagnosis of serious mental illness, and who, without ACT, would require more restrictive services and/or settings. ACT is not an appropriate service for a beneficiary with a primary Axis II personality disorder, a primary SUD, or a primary developmental disability diagnosis. A beneficiary with a primary Axis I diagnosis may also be diagnosed with a secondary Axis II disorder or co-occurring substance use disorder and benefit from ACT services.

ACT services are targeted to beneficiaries demonstrating acute or severe psychiatric symptoms that are seriously impairing the beneficiaries' ability to function independently, and whose symptoms impede the return of normal functioning as a result of the Axis I diagnosis. Areas of impairment are significant, and are considered individually for each beneficiary.

These areas of difficulty may include:

- Maintaining or having interpersonal relationships with family and friends
- Accessing needed mental health and physical health care
- Addressing issues relating to aging, especially where symptoms of serious mental illness may be exacerbated or confused by complex medical conditions or complex medication regimens
- Performing activities of daily living or other life skills
- Managing medications without ongoing support
- Maintaining housing
- Avoiding arrest and incarceration, navigating the legal system, and transitioning back to the community from jail or prison
- Coping with relapses or return of symptoms given an increase in psychosocial stressors or changes in the environment resulting in frequent use of hospital services, emergency departments, crisis services, crisis residential programs or homeless shelters
- Maintaining recovery as part of the challenges of a co-occurring substance use disorder
- Encountering difficulty in past or present progress toward recovery despite participation in long term and/or intensive services

**ESSENTIAL ELEMENTS**

**Team-Based Service Delivery**
ACT is a team-based mental health service that includes shared service delivery responsibility that provides consistent continuity of care. Case management, psychiatric services, counseling/psychotherapy, peer support services, housing support, substance use disorder treatment, employment and rehabilitative services are interwoven with treatment and rehabilitative services, and services are provided by all members of the ACT team in the beneficiary's home or community. ACT team responsibilities for consumer treatment include obtaining housing, benefits, employment services and rehabilitative services for beneficiaries who request them.

All ACT staff must obtain a basic knowledge of ACT programs and principles acquired through participation in MDCH-approved ACT-specific initial training, and subsequent participation in at least one MDCH-approved ACT-specific training annually thereafter. All initial training of ACT staff must occur within six months of hire for work in ACT. Physicians/Nurse Practitioners must participate in the MDCH-approved Physician/Nurse Practitioner training one time, with additional ACT training/participation for Physicians/Nurse Practitioners encouraged, but not mandatory.

Team meetings occur Monday through Friday on business days and are attended by all ACT staff members on duty. Physicians and/or Nurse Practitioners are expected to participate in ACT team meetings at least weekly. Agendas for daily team meetings include the status of all beneficiaries, updates from on-call, clinical and case management needs, crisis management, schedule organization, and finalized plans for ACT staff deployment into the community.

A minimum of 80% of ACT contacts provided by the team are in the beneficiary's home or other agreed upon community location. Treatment groups identified in the Individual Plan of Service (IPOS), such as Family Psychoeducation, Dialectical Behavior Therapy, Alcoholics Anonymous, etc. are excluded from the 80% community visit standard regardless of where the group is held.

The average number of visits per day/week/month/etc. is provided by the whole team — not individual ACT team members — to an individual consumer will comprise 80% of home or community contacts.

**Team Composition and Size**
The ACT team requires a sufficient number of qualified staff to assure the provision of an intensive array of services on a 24-hour basis. Teams must have at least three staff members, but generally are comprised of 4-9 staff members, with the expected team average of 6-7. The minimum ACT staffing requirements are below. ACT teams that need to operate with as few as 3 members or more than 9 must have MDCH approval. The scope of services for individual ACT staff members require that some staff will work in the community more often than others.

- A full-time team leader with a minimum of a Master's degree in a relevant discipline and with appropriate licensure or certification to provide clinical supervision to the ACT team staff, plus a minimum of two years post-degree clinical experience with adults who have serious mental illness is required. The ACT team leader is a Qualified Mental Health Professional (QMHP) or Mental Health Professional (MHP). The ACT team leader also provides direct services to beneficiaries in the community within their scope of practice.

- A full-time Registered Nurse (RN) is required on the ACT team. The RN provides integrated behavioral and physical healthcare, including managing medication, assessing and coordinating physical/medical care, and providing direct services to the beneficiary in the community.

- A physician (MD or DO) who provides psychiatric coverage for all beneficiaries served by the ACT team is required. The physician is considered a part of the ACT team, but is not counted in the staff-to-beneficiary ratio. The physician participates in the team meeting at least weekly and is assigned to the ACT team at least 15 minutes per beneficiary per week in a capacity that allows for immediate access to the physician so that emergency, urgent or emergent situations may be addressed. The expectation is that some beneficiaries will need more physician time and some beneficiaries will need less time during any given week. The physician may delegate psychiatric activities to a nurse practitioner, but the nurse practitioner must be supervised by that physician. Typically, although not exclusively, physician activities may include team meetings, beneficiary appointments during regular office hours, psychiatric evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telemedicine. The physician must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a Drug Enforcement Administration registration.

- A nurse practitioner may perform clinical tasks delegated by and under the supervision of the physician. The nurse practitioner must hold a specialty certification as a nurse practitioner in Michigan, a current license to practice nursing in Michigan, and a master's degree in psychiatric mental health nursing. If the ACT team includes a nurse practitioner, he/she may substitute for a portion of the physician time, but may not substitute for the ACT RN. The nurse practitioner is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, nurse practitioner activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telemedicine.

- A case manager with a minimum of a Bachelor's degree in a human services discipline with appropriate licensure to provide the core elements of case management, with at least 1 year of experience providing services to adults with a mental illness is required. This individual shall be a Qualified Mental Health Professional (QMHP).

  If the case manager has a Bachelor's degree, but is without the specialized training or experience, the case manager must be supervised by a QMHP.

- A QMHP, with a clinically prepared Master's Degree, shall provide individual/family counseling.

- Up to 1 Full-Time Equivalent (FTE) Peer Support Specialist (PSS) may substitute for 1 QMHP to achieve the 1:10 required staff-to-beneficiary ratio. Under the supervision of the ACT team leader, a PSS may provide documentation in beneficiary records.

- Paraprofessional staff hired before July 1, 2008 to work with ACT teams may be counted in the staff-to-beneficiary ratio.

- If the ACT team provides substance abuse services, there must be a designated Substance Abuse Treatment Specialist who has 1 or more credentials through the Michigan Certification Board of Addiction Professionals (MCBAP). If the ACT team provides co-occurring treatment or substance abuse treatment, the Organization must have a substance abuse treatment license issued by the State of Michigan.

- Additional staff positions reflect the needs of the population and shall minimally be a QMHP.

**Staff-to-Beneficiary Ratio**
The staff-to-beneficiary ratio shall be no less than 1:10, e.g., a maximum of 10 beneficiaries to each ACT staff. With the exceptions of the limitations on paraprofessionals and peer support specialists described above, the ratio includes all ACT team members excluding the clerical support staff and physicians or nurse practitioners.

**Fixed Point of Responsibility**
The ACT team is the fixed point of responsibility for the development of the IPOS using the person-centered planning process and for supporting beneficiaries in all aspects of recovery and community living. The process addresses all services and supports to be provided to or obtained for the beneficiary by the team including consultation with other disciplines and/or coordination of other supportive services as appropriate.

**Availability of Services**
Availability of ACT services must include:

- Twenty-four hour/seven-day crisis response coverage (including psychiatric availability) that is handled directly by members of the ACT team. For 3-member teams, "on call" services may be a part of the larger organizations on-call system if approved by MDCH.

- The capacity to provide a rapid response to early signs of relapse, including the capability to provide multiple contacts daily with beneficiaries in acute need or with emergent conditions.

- The ACT team has the ability to provide needed services to the beneficiary, 7 days a week as per the IPOS.

**Individual Plan of Service**
ACT services and interventions must be consistent and balanced through medical necessity and the preferences of the beneficiary while embracing person-centered principles, wellness and mental health recovery with a goal of maximizing independence and a progression into less intensive services.

Beneficiaries with co-occurring substance use disorders must have both mental health and substance use disorders addressed in the IPOS.

Beneficiaries who need a less intensive service than ACT, such as case management, have documentation in the IPOS detailing the transition plan to the new service and a plan to return to ACT should the need occur.

**In Vivo Settings**
ACT teams provide a wide array of clinical, medical and rehabilitative services during face-to-face interactions designed to promote the beneficiary's growth in recovery. ACT services and supports are focused on acquiring needed mental health services, SUD treatment services, physical health care, performing activities of daily living , obtaining and/or maintaining employment, developing leisure activities, developing and maintaining meaningful relationships, maintaining housing, avoiding arrest and incarceration, navigating the legal system, transitioning successfully into the community from jail or prison, and relapse prevention.

Services for ACT beneficiaries may include those defined elsewhere in this chapter, as well as others that are consistent with individual preferences, professionally accepted standards of care, and that are medically necessary.

ACT services may be used as an alternative to hospitalization as long as beneficiary health and safety issues can be reasonably well-managed with ACT supports that do not require 24-hour-per-day supervision.

**ELIGIBILITY CRITERIA**

Utilization of ACT in high acuity conditions and situations allows beneficiaries to remain in their community of residence and may prevent the use of more restrictive alternatives which may be detrimental to a beneficiary's existing natural supports and occupational roles. This level of care is appropriate for beneficiaries with a history of serious mental illness who may be at risk for inpatient hospitalization, intensive crisis residential or partial hospitalization services, but can remain safely in their communities with the considerable support and intensive interventions of ACT. In addition to meeting the following criteria, these beneficiaries may also be likely to require or benefit from continuing mental health treatment. The ACT acute service selection guideline covers criteria in the following domains.

**Diagnosis**
The beneficiary must have a serious mental illness, as reflected in a primary, validated, current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) diagnosis (not including V Codes).

**Severity of Illness**
Psychiatric Status

- Prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness), which may manifest as intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions, ruminations, severe phobias, depression, etc., and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions, rituals, impaired reality testing and/or impairments in functioning and role performance.

Self-Care/Independent Functioning

- Disruptions of self-care, limited ability to attend to basic physical needs (nutrition, shelter, etc.), seriously impaired interpersonal functioning, and/or significantly diminished capacity to meet educational/occupational/parental role performance expectations.
- Drug/Medication Conditions-Drug/medication adherence and/or a co-existing general medical condition that needs to be simultaneously addressed along with the mental illness and that cannot be carried out at a less intensive level of care. Medication use requires monitoring or evaluation for adherence to achieve stabilization, to identify atypical side effects or concurrent physical symptoms and medical conditions.
- Risk to Self or Others-Symptom acuity does not pose an immediate risk of substantial harm to the person or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged. Harm or danger to self, self-mutilation and/or reckless endangerment or other self-injurious activity is an imminent risk.

Intensity of Service

ACT team services must be medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in the community, to improve the beneficiary's condition and/or allow the person to function without more restrictive care, and the person requires at least one of the following:

- An intensive team-based service to prevent elevation of symptom acuity, to recover functional living skills and maintain or preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regimen and symptom stabilization necessary for recovery.
- The beneficiary's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest regression and forestall the need for inpatient care in a 24-hour protective environment.
- The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports.
- Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations.
- Frequent monitoring of medication regimen and response is necessary and adherence is doubtful without ongoing monitoring and support.
- Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects.

Discharge

Cessation or control of symptoms is not sufficient for discharge from ACT. For beneficiaries who have progressed forward on their journey toward recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to a less intensive service, such as case management. Recovery must be sufficient to maintain functioning without the support of ACT as identified through the person-centered planning process as described below:

- The beneficiary no longer meets severity-of-illness criteria and has demonstrated the ability to meet all major role functions for a period of time sufficient to show clinical stability.

Beneficiaries who meet medical-necessity criteria for ACT services usually require and benefit from long-term participation in ACT. ACT is not a service that is appropriate for short-term stabilization and then transition into another program.

If a beneficiary requests transition to other service(s) because he/she believes maximum benefit has been reached in ACT, consideration for transition into less intensive services must be reviewed during the person-centered planning process. If clinical evidence supports the beneficiary's desire to transition, this evidence and the transition plan must be detailed in a revised IPOS developed through the person-centered planning process. The plan must identify what supports and services will be made available, and contain a provision for re-enrollment into ACT services, if needed.

- Engagement of the individual in ACT is not possible, as deliberate, persistent and frequent assertive team outreach including face-to-face engagement attempts and legal mechanisms, when necessary, have been consistent, unsuccessful, and documented over many months, and an appropriate alternative plan has been established with the beneficiary.
- Beneficiary has moved outside of the geographic service area. Contact continues until service has been established in the new location.

**Manual Maintenance**

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

**Questions**

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

**Approved**

Stephen Fitton, Director
Medical Services Administration