

Bulletin

January 29, 2008

Minnesota Department of Human Services -- P.O. Box 64941 -- St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Tribal Health Services Directors
- Social Services Supervisors and Staff
- Adult Mental Health Initiatives
- Local MH Advisory Council Chairs
- MCO Contact Persons
- Advocacy Groups
- ACT and ARMHS Providers

ACTION/DUE DATE

Please read for information and implement changes.

EXPIRATION DATE

January 29, 2010.

DHS issues guidance on Assertive Community Treatment (ACT) services

TOPIC

Assertive Community Treatment services in adult mental health.

PURPOSE

To provide guidance on Assertive Community Treatment services, including: program standards, admission criteria, service delivery and documentation, outcome data reporting, and other requirements.

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SIGNED

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Assistance Commissioner
Chemical and Mental Health Administration

Introduction

The purpose of this bulletin is to provide an overview of the principles of Assertive Community Treatment (ACT) and to describe policy and procedural requirements for this Medical Assistance (MA) funded service available to eligible Minnesotans.

It is our intention to update this bulletin periodically and to expand the range of topics, as needed, to assure that relevant and accurate information is readily available about ACT programs.

Assertive Community Treatment – An Overview

As an evidence-based psychiatric rehabilitation practice, ACT provides a comprehensive approach to service delivery to consumers with serious mental illness who have demonstrated their need for this most intensive level of nonresidential community service. ACT uses a multidisciplinary team that typically includes a psychiatrist, a mental health professional who serves as the team leader, and one or more nurses, substance abuse specialists, supported employment specialists, peer recovery specialists, and other mental health professionals, practitioners, or rehabilitation workers. The team is responsible for providing virtually all needed community services to a designated group of recipients.

ACT is designed for individuals whose symptoms of mental illness cause the most substantial levels of disability and functional impairment. Due to the severity of their symptoms and functional issues, individuals who receive ACT services are in the greatest need of rehabilitative services in order to live successfully in the community and achieve their personal recovery goals. Multiple barriers to successful functioning are common in this group and may include, among other difficulties: co-occurring substance abuse or dependence, homelessness, unemployment, out-of-control illness management, frequent and persistent use of hospital emergency departments and inpatient psychiatric treatment, and problems with the legal system.

The overall mission of ACT is to assist individuals in achieving their recovery and rehabilitation goals. In order to accomplish this mission, an ACT team necessarily also strives to stabilize the individuals' community functioning; shorten the appropriate use of inpatient psychiatric care; and prevent inappropriate inpatient care, homelessness, and other adverse consequences.

Using the principles and methods of Illness Management and Recovery (IMR), Integrated Dual Disorders Treatment (IDDT), Supported Employment (SE), psychiatric rehabilitation, and other best practices, ACT helps individuals to develop the skills necessary for life in the community. ACT services are planned in close collaboration with the individual recipients and – if the recipients wish – with their families or other members of their informal support networks. Services are customized to fit each individual's unique set of preferences, strengths, and needs. The needs addressed may relate to any area of functioning affected by the person's mental illness, including symptom management, housing, finances, employment, education, medical and dental care, substance abuse, family and social life, and activities of daily living.

Key Components of Assertive Community Treatment

The defining characteristics of ACT include the following:

- Team approach. A multidisciplinary team of mental health professionals, mental health practitioners, and other qualified staff work closely together, blending their knowledge, expertise, and skills. Team members practice recognized rehabilitation principles in their work with service recipients.
- Small caseload. The staff-to-recipient ratio is approximately one-to-ten.
- Shared caseload. Team members do not have individual caseloads; instead, the team as a whole is responsible for assuring that each individual receives the services he or she needs to live in the community and reach his or her personal goals.
- Fixed point of responsibility. Rather than sending individuals to a variety of different providers, the team itself provides virtually all of the needed services. If using another provider cannot be avoided (e.g., medical care), the team is responsible for making certain that the individual receives the services she or he needs.
- In vivo services. Services are delivered primarily in natural settings – where they are needed and where skill training is most likely to be effective – not in office or clinic settings.
- Time unlimited services. Services are provided as long as they are medically needed, not on the basis of predetermined timelines.
- Flexible service delivery. The team meets daily to discuss how each individual recipient is doing and adjusts the service mix as necessary to be responsive to any observed changes.
- 24/7 crisis services. Crisis services are available 24 hours a day, 7 days a week. Team members anticipate and, whenever possible, prevent crisis situations; however, someone from the team is always available on an on-call basis to address unavoidable crises that may arise during evenings, weekends, and holidays.

ACT in Minnesota

Legislative Authority

Legislative authority for ACT in Minnesota can be found in two statutes, which cover adult rehabilitative mental health services (ARMHS) and ACT, respectively. The first of these (Minnesota Statutes, section 256B.0623), enacted in 2001, established Medical Assistance (MA) or Medicaid coverage for adult rehabilitative mental health services (ARMHS). The second (Minnesota Statutes, section 256B.0622), enacted in 2003, added ACT as a type of “intensive nonresidential rehabilitative service” consistent with the ARMHS statute. Intensive nonresidential rehabilitative service delivery is defined in the statute (Minnesota Statute, section 256B.0622, subdivision 2) as services “provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment ... and other evidence-based practices, and directed to recipients with a serious mental illness who require intensive services.”

Evidence-based practices are defined as “nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.”

An eligible provider of ACT services must have a contract with the host county to provide intensive adult rehabilitative mental health services and must be certified by the Minnesota Department of Human Services (DHS) as being in compliance with both the ARMHS and ACT requirements (Minnesota Statutes, section 256B.0622, subdivision 4).

The ACT statute (Minnesota Statutes, section 256B.0622, subdivision 5) includes a number of additional requirements:

- ACT services must be provided by staff who are qualified, trained, and supervised in accordance with the ARMHS statute (Minnesota Statutes, section 256.0623, subdivisions 5 and 6).
- The clinical supervisor of an ACT team must be an active member of the treatment team, and the team must meet with its clinical supervisor at least weekly to discuss participants' progress and make rapid adjustments to meet their needs. The team meeting must include person-specific case reviews and general treatment discussions among team members. Person-specific case reviews and planning must be documented in the individual service recipients' treatment records.
- Treatment staff must have prompt access – in person or by telephone – to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of participants.
- The initial functional assessment must be completed within 10 days of intake and updated at least every three months or prior to discharge, whichever comes first.
- The initial individual treatment plan must be completed within 10 days of intake and reviewed and updated at least monthly with the participant.

Subdivision 7 of the ACT statute (Minnesota Statutes, section 256B.0622) further specifies the following requirements:

- The ACT team must use team treatment, not an individual treatment model.
- The clinical supervisor must function as a practicing clinician at least on a part-time basis.
- The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position.
- Services must be available at times that meet client needs.
- The treatment team must actively and assertively engage and reach out to the recipient's family members and significant others, after obtaining the recipient's permission.
- The treatment team must establish ongoing communication and collaboration between the team, family, and significant others and educate the family and significant others about mental illness, symptom management, and the family's role in treatment.

- The treatment team must provide interventions to promote positive interpersonal relationships.

Revised Minnesota ACT Standards

DHS has reviewed and updated the program standards for ACT in Minnesota. Revised Minnesota ACT Standards are now available on the DHS website (http://www.dhs.state.mn.us/dhs_id_019807.pdf).

Among other modifications, the revised standards:

- place increased emphasis on the ACT teams' rehabilitative work with service recipients;
- highlight the requirement that a provider be ARMHS certified as a prerequisite for delivering ACT services in Minnesota;
- include clear guidance on assessment, service planning and implementation, and documentation in a Medicaid-funded rehabilitation environment;
- make explicit the teams' obligation to notify DHS promptly when key staff vacancies occur and to fill those vacancies in a timely fashion;
- establish clear admission and utilization management criteria that are consistent with statutory requirements and with federal expectations for this most intensive level of nonresidential rehabilitation service;
- emphasize that ACT teams must have the final decision on recipient admissions, subject to federal and state requirements for Medicaid-reimbursable rehabilitation services;
- clarify the use of ACT services for individuals with certain diagnoses and co-occurring disorders;
- set the expectation that ACT teams will have alternative sources of funding available to serve otherwise-eligible consumers who do not qualify for Medicaid or other Minnesota Health Care Programs;
- underline the expectation that ACT teams will directly provide virtually all major community mental health services needed by recipients, using non-Medicaid funding sources as necessary;
- incorporate the statutory requirements for timely initial and ongoing assessment and service planning;
- encourage ACT teams to hire qualified persons in recovery as regular staff members with full professional status and responsibilities, including Certified Peer Specialists when that credential becomes available;
- provide direction on team structure and operation, including the expected staff-to-consumer ratio; and
- reinforce the expectation that ACT teams will participate in all program evaluation, training/technical assistance, and quality improvement activities mandated or requested by DHS.

Services Provided by ACT Teams

In Minnesota, ACT services are provided by a multidisciplinary staff using a total team approach and assertive outreach for rehabilitation and treatment in a recipient's natural environment. The team includes a clinical and rehabilitative supervisor who is a mental health professional and other staff consistent with the Dartmouth Assertive Community Treatment Scale (DACTS), which establishes national fidelity standards for ACT. The DACTS is available on the DHS website (http://www.dhs.state.mn.us/dhs_id_027778.pdf).

ACT teams are expected to provide direct services that incorporate the principles and methods of Illness Management and Recovery (IMR), Integrated Dual Disorders Treatment (IDDT), Supported Employment (SE), psychiatric rehabilitation, and other best practices. It is important to note that certain SE-related activities are not Medicaid reimbursable and must, therefore, be supported by other funds. Supplemental ACT Grants provided by DHS to ACT teams may be used for this purpose, among others (http://www.dhs.state.mn.us/dhs16_137959.pdf).

ACT, IMR, IDDT, SE, and other federally recognized evidence-based practices are described in detail in implementation resource kits (or "toolkits") developed by the Center for Mental Health Services. These kits are available online from the Substance Abuse and Mental Health Services Administration (<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp>).

Psychiatric rehabilitation has been defined by the national organization in this area of practice as service delivery that promotes "recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice." (U.S. Psychiatric Rehabilitation Association, <http://www.uspra.org/i4a/pages/index.cfm?pageid=4124>).

As a reference on program start-up, assessment, service planning and implementation, and other issues, teams are encouraged to become familiar with *A manual for ACT start-up: Based on the PACT model of community treatment for persons with severe and persistent mental illnesses (2003 edition)* by Deborah J. Allness and William H. Knoedler, published by and available from the National Alliance on Mental Illness (<http://www.nami.org/>). Many of the concepts and methods presented in this manual will be useful for ACT teams in Minnesota.

Services Not Eligible for Medicaid Reimbursement

Because ACT is defined in Minnesota as a rehabilitation service, ACT interventions that do not have a clear rehabilitative purpose should not be billed to Medicaid. Assessment, service planning, intervention, and documentation requirements for rehabilitation services are discussed later in this bulletin.

The following services are not eligible for Medicaid reimbursement as ACT services:

- recipient transportation services;
- services billed by a provider who is not enrolled to provide Medicaid-reimbursed ARMHS;
- services provided by volunteers;
- direct billing of time spent “on call” when not providing services to recipients;
- activities which are primarily social or recreational in nature, rather than rehabilitative;
- job-specific skills services, such as on-the-job training;
- performance of household tasks, chores, or related activities such as laundering clothes, moving the recipient’s household, housekeeping, and grocery shopping for the recipient;
- outreach services, such as recruitment of potential recipients, community relations, or program marketing;
- a mental health service that is not medically necessary; and
- any services provided by a hospital, board and lodge facility, or residential facility to an individual who is a patient in or a resident of that facility, including services provided by an Institution for Mental Diseases.

Eligibility Criteria and Admission Policy

An eligible ACT service recipient is an individual who:

- (1) is age 18 or older;
- (2) is diagnosed with a mental illness;
- (3) because of a mental illness, has substantial disability and functional impairment in three or more of the areas listed in Minnesota Statutes, section 245.462, subdivision 11a, so that self sufficiency is markedly reduced as indicated by:
 - (a) an assessment of level four or higher on the Level of Care Utilization System, Adult Version 2000, published by the American Association of Community Psychiatrists;
 - (b) ratings of four or higher in three or more areas of functioning listed in the DHS functional assessment tool (<http://edocs.dhs.state.mn.us/lfserver/Legacy/DM-0008-ENG>); or
 - (c) equivalent ratings on a comparable functional assessment tool approved by DHS.
- (4) because of a mental illness, has one or more of the following:
 - (a) a history of two or more inpatient hospitalizations in the past year;
 - (b) significant independent living instability such that the person would be in a long term residential or hospital placement without intensive community-based rehabilitation, treatment and support services;
 - (c) homelessness as defined in Minnesota Statutes, section 116L.361, subdivision 5; or
 - (d) very frequent use of mental health and related services yielding poor outcomes, such as contacts with the criminal justice system, recent housing evictions or frequent use of emergency departments; and

- (5) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services (including services that are potentially available given existing funding sources), or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

Given the severity of the mental illnesses and the functional impairments of individuals who qualify for ACT-level services, the final decision to admit a referred individual must rest with the ACT provider. Accordingly, the referral of a prospective recipient to an ACT provider should be accompanied by sufficient diagnostic and functional assessment information, hospital and other facility records, and additional background documentation to provide a full picture of the person; the person's clinical, rehabilitative, and supportive needs; and the reasons for the referral.

Professional experience in Minnesota and elsewhere indicates that no more than twenty percent of the individuals served by an ACT team should have a primary diagnosis of borderline personality disorder. A team that seeks to admit a substantial number of individuals with this diagnosis must have prior approval from DHS, and all team members must be trained and skilled in the provision of Dialectical Behavior Therapy.

Many individuals who are eligible for ACT also present with co-occurring mental illness and substance use problems. Accordingly, team members are expected to become proficient in the principles and practices of Integrated Dual Disorders Treatment.

Requirements for Medicaid Reimbursable Rehabilitation Services

ACT teams are expected to adhere to professionally recognized best practices for rehabilitation assessment, service planning, and service delivery. Teams are also expected to comply with all federal and DHS documentation requirements for rehabilitation services reimbursed by Medicaid (also known in Minnesota as Medical Assistance or MA).

Medicaid-reimbursed services must be medically necessary. ACT teams are expected to satisfy this requirement in several interrelated ways, including:

- evidence of a *diagnostic assessment* that leads to a diagnosis of serious mental illness;
- evidence of a comprehensive *functional assessment* covering the major areas of functioning that are affected by the person's symptoms of mental illness;
- evidence that the services are rendered by an *eligible provider*, as previously outlined;
- evidence that the services are authorized and supervised by a properly licensed *mental health professional*;
- evidence that the services follow a *rehabilitation plan* that is based on the recipient's own *recovery goals or vision*;

- evidence that the team's *interventions* are sufficient in amount, duration and intensity to have a reasonable likelihood of bringing about progress or preventing relapse; and
- evidence that the team's *progress or encounter notes* clearly document the interventions provided and their connection to the rehabilitation plan.

ACT service documentation includes the following major components:

- A *diagnostic assessment* establishes the presence of a serious mental illness, providing a basis for the medical necessity of ACT-level services and a foundation for the functional assessment, interpretive summary, and rehabilitation plan. The diagnostic assessment is provided by the team psychiatrist or by another team member who is a properly licensed mental health professional.
- A comprehensive *functional assessment* describes the person's functioning in the major life domains. It describes both the person's impairments, which are caused by the symptoms of mental illness, and the person's strengths. On an ACT team, the functional assessment is created through a collaborative effort that involves all team members who know the person. The functional assessment must include substantial input from the recipient and should also, with the latter's permission, include relevant information from family members and other key members of the recipient's social network. The functional assessment should be written primarily in narrative form and should never be merely a checklist.
- An *interpretive summary* synthesizes the diagnostic and functional assessments, includes information about the recipient's preferences and goals, and establishes priorities for the work of the team.
- A *rehabilitation plan* or *treatment plan* provides overall direction for the team's work with the person and includes several elements:
 - the recipient's personal *recovery goals* or *recovery vision*, which guide the service delivery process;
 - major *rehabilitation goals*, which typically identify one- to two-year targets for the rehabilitative process and may serve as intermediate steps toward the achievement of the recipient's personal recovery goals or vision;
 - *objectives* describing the concrete skills and behaviors that will be learned by the recipient as a result of the team's rehabilitative interventions during the next three to six months; and
 - *interventions* planned for the next three to six months to help the recipient reach the objectives.
- *Encounter or progress notes* describe the interventions conducted by the team. Although there are various acceptable ways of writing these notes, they should include actual start and stop times and should address, at a minimum, the following essential topics:
 - the *goal* from the rehabilitation plan that was addressed in the encounter,
 - the *intervention* that was provided by the staff member,
 - the *response* to that intervention by the recipient,
 - the *plan* for the next encounter with the recipient, and

- other *significant observations*.

ACT as a Covered Service in Minnesota Health Care Programs

Since January 1, 2005, ACT has been a covered service in the MA fee-for-service benefit set. Effective January 1, 2008, the Minnesota Legislature added ACT to the benefit sets for General Assistance Medical Care (GAMC), Prepaid Medical Assistance Program (PMAP), and MinnesotaCare. DHS has worked closely with stakeholders to develop effective procedures for the transition of ACT into these additional Minnesota Health Care Programs.

Required Program Outcomes Status Report

All Minnesota ACT teams are required to participate in the Program Outcomes Status Report (POSR) program evaluation system operated by DHS. POSR includes information on homelessness, inpatient hospital utilization, employment, residential status, substance use, and incarceration. It measures quarterly changes in each of these areas at a recipient-specific level.

The information is used to assess program efficacy, to determine how recipients benefit from changes in the mental health service delivery system, and to help guide policy and planning decisions by the state and service management decisions by counties, initiatives, and providers.

ACT Center

In 2005, DHS established an ACT Center, operated under contract by Ramsey County, to assist teams with start-up and developmental issues. Among other services, the center offers experiential training for prospective ACT providers and others at a “shadow team,” training sessions conducted in-person or by interactive videoconferencing, and customized consultation to developing teams. To schedule a visit, contact the Mental Health Program Consultant for your county or regional initiative.

Further Information or Technical Assistance

If you have questions or comments about any aspect of Assertive Community Treatment in Minnesota, or if you would like to make arrangements for technical assistance in this area of community mental health service delivery, please contact:

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Special Needs

This information is available in other forms to people with disabilities by contacting us at (651) 431-2225 (voice). TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.