

Minnesota Assertive Community Treatment Standards

Revised January 19, 2010

#	Category	Standard	Provisional Standard	Recommendations and Guidelines
1	Certification to Provide Adult Rehabilitative Mental Health Services	<p>The ACT program is operated by an entity that is in compliance with Minnesota Statutes 256B.0623 (Adult Rehabilitative Mental Health Services), as evidenced by a current ARMHS certification issued by DHS. It is the responsibility of the ACT program to ensure that the ARMHS certification of its parent organization continues without interruption.</p>	None.	
2	Team Leader	<p>Full-time Mental Health Professional with one year of appropriate prior supervisory experience. The team must notify DHS within two business days of a vacancy in this position and must follow DHS policy with regard to re-filling the position and ensuring adequate interim coverage. For this standard and throughout this document, full-time equivalent (FTE) employment means 40 paid hours per week.</p> <p>The Team Leader divides his/her time in approximately equal portions between supervisory/administrative and direct service roles. She/he shares the team's professional leadership role with the Psychiatrist, including responsibility for admission, utilization management, and step-down/discharge decisions; supervises the staff in their team functions as well as clinically and rehabilitatively; takes the lead role in assuring that assessments, rehabilitation planning, and documentation adhere to professional and Medicaid standards; organizes and leads productive team meetings; and oversees the team's internal functions and external relationships.</p>	<p><u>Provisional Standard</u> The Team Leader is a full-time Mental Health Practitioner with one year of appropriate prior supervisory experience; in this instance, the Mental Health Professional provides the team's required clinical and rehabilitative supervision and must spend at least one-half time as a member of the team. <i>Note:</i> The Provisional Standard only applies for up to 12 months from the inception of the ACT program, at which time there must be a full-time equivalent Mental Health Professional assigned to the team and providing the required clinical and rehabilitative supervision; the Team Leader may continue to be a Mental Health Practitioner as long as the Mental Health Professional remains a full-time equivalent member of the team and provides the required clinical and rehabilitative supervision.</p>	

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3	Psychiatrist	<p>A minimum of 16 hours per week per 50 consumers, or the equivalent. The team must notify DHS within two business days of a vacancy in this position and must follow DHS policy with regard to re-filling the position and ensuring adequate interim coverage. Backup coverage must be arranged when the Psychiatrist is on vacation or is unavailable for any reason.</p> <p>The Psychiatrist functions as a full member of the team; shares the team's professional leadership role with the Team Leader, including admission, utilization management, and step-down/discharge decisions; prescribes psychiatric medication for all of the team's consumers, except when this is not possible or not medically indicated; supervises the nursing functions of the team's RNs and LPNs, including the medication management system; is available to meet all of the team's consumers, even those for whom he/she does not prescribe; coordinates care with other health care providers; attends two or more team meetings per week, either face-to-face or by ITV or conference call, with at least one-half of those meetings being face-to-face; performs diagnostic/functional assessments consistent with Medicaid regulations; and participates in the team's service planning meetings.</p>	<p><u>Provisional Standard A.</u> <i>For teams in Designated Mental Health Professional Shortage Areas:</i> A minimum of 10 hours per week per 50 consumers, or the equivalent.</p> <p><u>Provisional Standard B.</u> <i>For teams in Designated Mental Health Professional Shortage Areas and/or that demonstrate an inability to acquire the required level of Psychiatrist time:</i> A minimum of 16 hours per week per 50 consumers, or the equivalent; Psychiatrist may be replaced by Psychiatric Nurse Practitioner, or Clinical Nurse Specialist with psychiatric specialty, with prescriptive privileges and working under the direction of a Psychiatrist.</p>	

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4	Registered Nurse	<p>One FTE per 50 consumers; must have one year of prior mental health experience, preferably in community-based settings. The team must notify DHS within 4 business days of a vacancy in this position and must follow DHS policy with regard to re-filling the position and ensuring adequate interim coverage.</p> <p>The Registered Nurse collaborates with the Psychiatrist or other prescriber to manage the team's medication system; to administer and document medication treatment; to conduct health assessments; to coordinate care with other health care providers; and to provide training to the team's staff and consumers on psychiatric symptoms, medications, and side effects. In addition, as time permits, the Registered Nurse performs general ACT staff functions.</p>	None.	
5	Substance Abuse Specialist	<p>One FTE per 50 consumers; must have one year of training or experience in substance abuse treatment and must qualify as a Mental Health Practitioner or Rehabilitation Worker.</p> <p>The Substance Abuse Specialist takes the lead in screening, assessing, planning, treating, and monitoring progress in the substance abuse area for the team's consumers. She/he provides training to the team's staff to help them gain competency in substance abuse and its treatment, using the concepts and methods of integrated dual disorders treatment. In addition, as time permits, he/she performs general ACT staff functions.</p>	None.	

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6	Vocational Specialist	<p>One FTE per 50 consumers; must have one year of training or experience in vocational rehabilitation and support and must qualify as a Mental Health Practitioner or Rehabilitation Worker.</p> <p>The Vocational Specialist takes the lead on vocational issues for the team's consumers, including assessment, planning, job development, placement, coaching, and support. She/he serves as the team's liaison with vocational rehabilitation counselors; in addition, he/she provides training to the team's staff to help them gain competency in the evidence-based practice of supported employment. As time permits, she/he performs general ACT staff functions.</p>	None.	
7	Other Direct Service Staff	Other direct service staff must qualify as Mental Health Professionals, Mental Health Practitioners, Mental Health Rehabilitation Workers, or Certified Peer Specialists.	None.	Teams are encouraged to employ qualified persons in recovery as regular staff members with full professional status and responsibilities.

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8	Admission Criteria and Procedure	<p>An eligible 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 MN Statutes 245.462, subd. 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 4 or higher in three or more areas of functioning listed in the DHS Functional Assessment Tool located at 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 MN Statutes 116L.361, subd. 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.</p>	None.	<p>ACT services are not an appropriate substitute for the basic components of a community mental health service array that are needed and potentially available in a local area, given existing funding sources. ACT teams must have alternative sources of funding available to serve otherwise-eligible consumers who do not qualify for Medicaid or other Minnesota Health Care Programs; a general guideline is that the county or initiative sponsor should set aside adequate funds to support no fewer than 10% of the team's consumers. No more than six consumers are admitted per month. The final decision regarding admission to an ACT program rests with the service provider, consistent with these guidelines and with federal and state requirements. Referral information should include a description of the current clinical/rehabilitative picture, thorough background material, and clear reasons for referral. An ACT provider may exercise a preference for local residents based on a clinical "close to home" rationale but must, for Medicaid-eligible individuals, allow free choice of providers; admissions of persons from other counties may not be prohibited. The provider may decline a referral or discharge a consumer due to (a) the provider's inability to meet the person's needs or (b) the provider's decision to focus on a different clinically defined target population or specialty group. It is recommended that no more than 20 percent of the consumers served by an ACT team have a primary diagnosis of borderline personality disorder; ACT teams that serve this population are expected to be trained in Dialectical Behavior Therapy.</p>

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9	Team Structure and Operation	<p>After initial start-up, the team ranges in size from 4 to 10 full-time equivalent staff, excluding the medication prescriber(s) and office personnel; the expected staff-to-consumer ratio is 1-to-10; assuming that the Team Leader provides one-half FTE direct service, a team of 4 FTEs serves no fewer than 35 consumers, and a team of 10 FTEs serves no more than 95. Except for necessary administrative functions, the staff work as a team and do not have individual caseloads.</p> <p>The team meets at least four times per week to review the entire roster of consumers and to exchange information about the interventions conducted, the consumers' responses to those interventions, and the planned next steps. Additional team meetings are scheduled, as necessary, for assessment, service planning, staff training, and administrative purposes. Team members are expected to be available to work outside of regular office hours – including evenings, weekends, and holidays – to meet consumers' needs.</p>	<p><u>Provisional Standard A.</u> With DHS approval, the staff-to-consumer ratio may be 1-to-8 for a rural team, defined as one whose primary service area (a) is outside of the Twin Cities Metropolitan Area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties) and (b) includes no city or town with a population of 70,000 or more.</p> <p><u>Provisional Standard B.</u> With DHS approval, the staff-to-consumer ratio may be 1-to-8 for a special-purpose team whose participants are individuals with exceptionally challenging service needs, such as refugees for whom English is not the primary language or persons who, at the time of admission, are homeless as defined in MN Statutes 116L.361, subd. 5.</p> <p><u>Provisional Standard C.</u> With DHS approval, a team experiencing demographic changes or other conditions that prohibit adherence to this standard may continue to receive Minnesota Health Care Programs reimbursement for a period of up to nine months, as long as service to consumers is not adversely affected.</p>	

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10	Crisis Services	<p>The team provides crisis assessment, crisis intervention, and nonresidential crisis stabilization for the consumers it serves. A team member is on call for emergencies or crisis situations 24 hours a day, 365 days a year, and the Team Leader and Psychiatrist are available for backup. If the team shares the initial contact and screening functions with an established crisis service, there must be a formal agreement with the service, and – with the consumers' permission – individual crisis plans must be made available to the crisis service.</p>	None.	
11	Utilization Management and Discharge Criteria	<p>The team has formal utilization management procedures in place and applies them regularly – at a minimum, once every six months – to determine each consumer's continuing need for ACT-level services. When consumers no longer meet the eligibility criteria for ACT, they are assisted in making a transition to less intensive or "stepped down" services that better meet their needs. Priority for continuing ACT services is given to consumers who have substantial disability and functional impairment in three or more major areas of adult role functioning and/or who require intensive community services consistent with those described at Level Four – Medically Monitored Non-Residential Services – of the Level of Care Utilization System (Adult Version 2000), published by the American Association of Community Psychiatrists, or a similar level of service need as determined by another recognized utilization management tool.</p>	None.	

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12	Assertive Outreach and Engagement	The team is persistent in its efforts to reach out to consumers and to help them become actively engaged in rehabilitation and recovery.	None.	Guidelines are as follows: At least 60% of the team's face-to-face contacts with consumers occur outside of the office; on the average, the number of face-to-face contacts is three or more per consumer per week, for a total duration of 85 minutes or longer per consumer per week; except for planned discharges and "step-down" arrangements, at least 80% of the team's consumers are retained annually.
13	Diagnostic and Functional Assessment	Qualified team members conduct timely diagnostic and functional assessments. An <u>initial diagnostic assessment</u> is completed within five days after the second visit with the consumer or 30 days after admission, whichever occurs first; if a diagnostic assessment is available reflecting the consumer's current status and was completed within 180 days prior to admission, an update will suffice. An <u>initial functional assessment</u> is completed within 10 days after admission by the Team Leader, Psychiatrist, or other Mental Health Professional, and addresses the consumer's functional impairments that are affected by symptoms of mental illness, as well as the consumer's strengths and preferences. A <u>comprehensive assessment</u> is completed within 30 days after admission by appropriately qualified staff, supervised by the Team Leader, Psychiatrist, or other Mental Health Professional, and includes a description of the person's symptoms of mental illness and their impact on deficits or barriers in the major areas of adult functioning, as well as a description of the consumer's strengths and resources for recovery. The functional assessment must be updated at least every three months or prior to discharge, whichever occurs first. A current <u>interpretive summary</u> of findings, consumer preferences, and priorities for the team's work with the consumer links the assessment to the service plan.	See Team Leader standard. No other provisional standards apply.	

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14	Service Planning	<p>Guided by the consumer's own personal recovery goals, qualified ACT team members prepare outcome-oriented rehabilitation and treatment plans and update them on a timely basis – at least once every six months as a full team and monthly with each consumer, or more often as changes occur. Consistent with the provision of high-quality services to meet consumers' needs, team members are expected to become proficient in the principles and practices of current and emerging evidence-based practices and to adhere to guidelines developed by the state and by national experts. The team meets as often as necessary to conduct rehabilitation and treatment planning, under supervision of the Team Leader, Psychiatrist, or other Mental Health Professional. Each consumer's initial service plan must be completed within 10 days of admission and reviewed and updated at least monthly with the consumer. The plan is formally reviewed no less than once every six months by the entire ACT team or – when large teams are divided into smaller units for planning and other organizational purposes – by the consumer's individual team, which includes the Team Leader, the Psychiatrist, and other staff who have regular contact with the consumer. Consumers must be included in the rehabilitation and treatment planning process, and their level of participation must be documented.</p>	<p>See Team Leader standard. No other provisional standards apply.</p>	<p>Consumers' attendance at their rehabilitation and treatment planning meetings is encouraged but not required.</p>
15	Documentation of Services	<p>Diagnostic and functional assessments, rehabilitation and treatment plans, and interventions conducted by the team are documented using methods consistent with federal regulations; state statutes, rules, and policies; and professional best practices.</p>	<p>None.</p>	

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16	Full Responsibility for Services	The team directly provides rehabilitative services, psychiatric and nursing services, supportive counseling, housing support, integrated dual disorders treatment, supported employment, illness management and recovery, case management, and other community mental health services as needed by particular consumers.	None.	Necessary vocational, housekeeping, or other services that are not Medicaid-reimbursable are supported by alternative sources of funds, as appropriate and available. In order to avoid duplication, ACT and other comprehensive services – such as foster care with shift staff – are used concurrently only for brief transitional periods as part of a rehabilitation plan that includes proposed timeframes and clear strategies for eliminating the duplication.
17	Work with Informal Support System	With the consumers' permission, the team provides consultation and support to members of the consumers' social networks, including family, friends, landlords, employers, and other relevant acquaintances.	None.	As a guideline, the team averages two or more contacts per month per consumer with members of informal support systems.
18	Program Evaluation and Quality Improvement	The team participates in all program evaluation and quality improvement activities mandated or requested by DHS.	None.	Program evaluation and quality improvement activities may include (1) consumer demographic and outcome data, prepared by the team and submitted to DHS; (2) site visits conducted by DHS or its representatives; (3) evaluations using the Dartmouth Assertive Community Treatment Scale or other instruments, which – at DHS's discretion – may be self-administered by the team; (4) training and technical assistance activities; and (5) other program evaluation or quality improvement activities mandated or requested by DHS.