

Enhanced Benefit Services for Mental Health and Substance Abuse Effective March 20, 2006

Assertive Community Treatment Team (ACTT) Medicaid Billable Service

Service Definition and Required Components

The Assertive Community Treatment Team is a service provided by an interdisciplinary team that ensures service availability 24 hours a day, 7 days per week and is prepared to carry out a full range of treatment functions wherever and whenever needed. A service recipient is referred to the Assertive Community Treatment Team service when it has been determined that his/her needs are so pervasive and/or unpredictable that they can not be met effectively by any other combination of available community services. Typically this service should be targeted to the ten percent (10%) of MH/DD/SA service recipients who have serious and persistent mental illness or co-occurring disorders, dual and triply diagnosed and the most complex and expensive treatment needs. The service objectives are addressed by activities designed to: promote symptom stability and appropriate use of medication; restore personal, community living and social skills; promote and maintain physical health; establish access to entitlements, housing, work and social opportunities; and promote and maintain the highest possible level of functioning in the community. ACT Teams should make every effort to meet critical standards contained in the most current edition of the National Program Standards for ACT Teams as established by the National Alliance for the Mentally Ill or US Department of Health and Human Services, Center for Mental Health Services.

This service is delivered in a team approach designed to address the identified needs of specialized populations and/or the long term support of those with persistent MH/DD/SA issues that require intensive interventions to remain stable in the community. These service recipients would tend to be high cost, receive multiple services, decompensate to the point of requiring hospitalization before seeking treatment, seek treatment only during a crisis, or unable to benefit from traditional forms of clinic based services. This population has access to a variety of interventions twenty four (24) hours, seven days per week by staff that will maintain contact and intervene as one organizational unit.

This team approach involves structured face-to-face scheduled therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, personal care, domestic, psychosocial, problem solving, etc. in preventing, overcoming, or managing the recipient's level of functioning and enhancing his/her ability to remain in the community.

This service includes interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength based and focused on promoting symptom stability, increasing the recipient's ability to cope and relate to others and enhancing the highest level of functioning in the community.

ACTT provides ongoing assertive outreach and treatment necessary to address the service recipient's needs effectively. Consideration of geographical locale may impact on the effectiveness of this service model. This model is primarily a mobile unit, but includes some clinic based services.

A service order for ACTT must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Assertive Community Treatment services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G . These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

ACTT services may be provided to an individual by only one organization at a time. This organization is identified in the Person Centered Plan and is responsible for obtaining authorization from the LME for the PCP. ACTT providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, street locations, etc.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions. For ACTT, the case management component may be billed when provided thirty (30) days prior to discharge when a recipient resides in a general hospital or a psychiatric inpatient setting and retains Medicaid eligibility.

Organizations that provide ACTT services must ensure service availability 24 hours per day, 7 days per week, 365 days per year and be capable of providing a full range of treatment functions including crisis response wherever and whenever needed to recipients who are receiving ACTT services.

Staffing Requirements

Assertive Community Treatment services must be provided by a team of individuals. Individuals on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that individuals obtain the basic necessities of daily life; and education, support, and consultation to individuals' families and other major supports. Each ACT team staff member must successfully participate in the DMH approved ACTT training. The DMH approved training will focus on developing staff's competencies for delivering ACTT services according to the most recent evidenced based practices. Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days per week.

Each ACT team shall have a staff-to-individual ratio that does not exceed one full-time equivalent (FTE) staff person for every 10 individuals (not including the psychiatrist and the program assistant ACT teams **that serve approximately 100 individuals** shall employ a minimum of 10 FTE multidisciplinary clinical staff persons including:

Team Leader: A full-time team leader/supervisor that is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the ACTT team. The team leader at a minimum must have a master's level QP status according to 10A NCAC 27G.0104.

Psychiatrist: A psychiatrist, who works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 individuals. The psychiatrist provides clinical services to all ACTT individuals; works with the team leader to monitor each individual's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.

Registered Nurses: A minimum of two FTE registered nurses. At least one nurse must have a QP status according to 10A NCAC 27G.0104 or be an Advanced Practice Nurse (APN) according to NCGS Chapter 90 Article I, Subchapter 32M. The other nurse must have at minimum an AP status according to 10A NCAC 27G.0104. By July 1, 2005 it is expected that all team nurses will be have QP Status or be an APN.

Other Mental Health Professionals: A minimum of 4 FTE QP or AP (in addition to the team leader), with at least one designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling. At least one-half of these other mental health staff shall be master's level professionals.

Substance Abuse Specialist: One FTE who has a QP status according to 10A NCAC 27G.0104. and is one of the following: CCS, CCAS, or CSAC.

Certified Peer Support Specialist: A minimum of one FTE Certified Peer Support Specialist. A Certified Peer Support Specialist is an individual who is or has been a recipient of mental health services. Because of life experience with mental illness and mental health services, the Certified Peer Support Specialist provides expertise that professional training cannot replicate. Certified Peer Support Specialists are fully integrated team members who provide highly individualized services in the community and promote individual self-determination and decision-making. Certified Peer Support Specialists also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

Remaining Clinical Staff: The additional clinical staff may be bachelor's level and Paraprofessional mental health workers who carry out rehabilitation and support functions. A bachelor's level mental health worker has a bachelor's degree in social work or a behavioral science and work experience with adults with severe and persistent mental illness. A Paraprofessional mental health worker may have a bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with severe and persistent mental illness or with individuals with similar human services needs. These Paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

Program/Administrative Assistant: One FTE program/administrative assistant who is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACTT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for individual and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and individuals.

Smaller teams **servng no more than 50 individuals** shall employ a minimum of 6 to 8 FTE multidisciplinary clinical staff persons, including one team leader (MHP), one registered nurse, one FTE peer specialist, one FTE program assistant, and 16 hours of psychiatrist time for every 50 individuals on the team. One of the multidisciplinary clinical staff persons should be a CCS or CCAS, CSAC.

Service Type/Setting

ACTT is a direct and indirect periodic service where the ACTT staff provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. ACTT are intended to be provided on an individualized basis.

ACTT services are primarily provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions. For ACTT, the case management component may be billed when provided thirty (30) days prior to discharge when a recipient resides in a general hospital or a psychiatric inpatient setting and retains Medicaid eligibility.

ACTT may include telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals. ACTT activities include person-centered planning meetings and meetings for treatment/Person Centered Plan development.

Program Requirements

The ACT team shall have the capacity to provide multiple contacts a week with individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on individual need and a mutually agreed upon plan between individuals and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all individuals requiring frequent contact. The ACT team shall provide an average of three contacts per week for all individuals.

Program services are primarily delivered face-to-face with the consumer and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

A minimum of eighty percent (80%) or more of staff time must be face-to-face with the recipient. The remaining units may either be phone or collateral contacts; and

Each team shall set a goal of providing seventy-five percent (75%) of service contacts in the community in non office-based or non facility-based settings.

To ensure appropriate ACT team development, each new ACT team is recommended to titrate ACTT intake (e.g., 4-6 individuals per month) to gradually build up capacity to serve no more than 100-120 individuals (with 10-12 staff) and no more than 42-50 individuals (with 6-8 staff) for smaller teams.

The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. It is recommended that ACT team schedules should follow the standards established in the National Program Standards for ACT Teams.

Utilization Management

Authorization by the statewide vendor or by the LME if approved by DHHS is required. Utilization review must be conducted every thirty (30) days and is so documented in the Person Centered Plan and service record.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

The recipient is eligible for ACTT services when:

A. They have a severe and persistent mental illness listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fourth Edition, or DSM IV, of the American Psychiatric Association) that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. (Individuals with a primary diagnosis of a substance abuse disorder or mental retardation are not the intended recipient group.)

B. They have a significant functional impairments as demonstrated by at least one of the following conditions:

1. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

C. Have one or more of the following problems, which are indicators of a need for continuous high level of services (i.e., greater than eight hours per month):

1. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.
2. Intractable (i.e., persistent or very recurrent) severe major psychiatric symptoms (e.g. affective, psychotic, suicidal).
3. Coexisting mental health and substance abuse disorder of significant duration (e.g., greater than 6 months).
4. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).
5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness or imminent risk of becoming homeless.
6. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided,

- or requiring a residential or institutional placement if more intensive services are not available.
7. Difficulty effectively utilizing traditional office-based outpatient services. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder) and bipolar disorder. Individuals with other major psychiatric disorders may be eligible when other services have not been effective in meeting their needs.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on attempts to reduce ACTT services in a planful way; or the tenuous nature of the functional gains; or any one of the following apply:

- A.** Recipient has achieved positive life outcomes that supports stable and ongoing recovery and these services are needed to meet additional goals.
- B.** Recipient is making satisfactory progress toward meeting goals.
- C.** Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- D.** Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions or indicating a need for more intensive services.
- E.** Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions. If the recipient is functioning effectively with this service and discharge would otherwise be indicated, ACTT services should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn.

The decision should be based on any one of the following:

- A.** Past history of regression in the absence of ACTT is documented in the service record or attempts to titrate ACTT downward have resulted in regression,
- OR**
- B.** In the event there is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains. The presence of a DSM IV diagnosis would necessitate a disability management approach.

Discharge Criteria

- A.** Discharges from the ACT team occur when recipients and program staff mutually agree to the termination of services. This shall occur when recipients:
 1. Have successfully reached individually established goals for discharge, and when the recipient and program staff mutually agree to the termination of services.
 2. Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, and when the recipient requests discharge, and the program staff mutually agree to the termination of services.
 3. Move outside the geographic area of ACTT's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACTT program or another provider wherever the recipient is moving. The ACT team shall maintain contact with the recipient until this service transfer is implemented.
 4. Decline or refuse ACTT services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the recipient.

B. Documentation of discharge shall include:

1. The reasons for discharge as stated by both the recipient and the ACT team.
2. The recipient's biopsychosocial status at discharge.
3. A written final evaluation summary of the recipient's progress toward the goals set forth in the treatment plan.
4. A plan developed in conjunction with the recipient for follow-up treatment after discharge.
5. The signature of the recipient, the recipient's service coordinator, the team leader, and the psychiatrist.

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Documentation Requirements

Minimum standard is a daily full service note that includes the consumer's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

Expected Outcomes

The individual will have increased ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, need for emergency and inpatient psychiatric services will be reduced; severe psychiatric symptoms will be reduced, criminal justice involvement will be decreased, ability to meet basic needs such as food, clothing, housing will be increased.

Service Exclusions/Limitations

An individual can receive ACTT services from only one ACTT provider at a time. ACTT is a comprehensive team intervention and most other services are excluded. Opioid Treatment can be provided concurrently with ACTT. ACTT services can be billed for a limited period of time in accordance with the PCP for individuals who are receiving Community Support, CST, Partial Hospitalization, SAIOP, SACOT, PSR, or SA residential services for the purpose of facilitating transition to the service admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the ACTT professional and discharge planning. ACTT services can be provided for individuals residing in adult MH residential programs (e.g. Supervised Living Low or Moderate, Group Living Low, Moderate or High).

Note:

For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

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