SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM

Assertive Community Treatment (ACT) is a therapeutic set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team that includes case/care management, psychiatric services, counseling/psychotherapy, housing support, Substance Use Disorders 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 which 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 Prepaid Inpatient Health Plans (PIHPs) and the Community Behavioral Health Services Programs (CMHSPs) offer a continuum of adult services including case/care 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. The beneficiary's 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 behavioral health system.

4.1 TEAM APPROVAL

Medicaid providers wishing to become providers of ACT services must obtain approval from MDHHS 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 MDHHS re-approval every three years.

4.2 TARGET POPULATION

The intensity of ACT services is intended for the beneficiary with a primary 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 diagnosis of a personality disorder, a primary diagnosis of a Substance Use Disorder, or a primary diagnosis of intellectual or developmental disability. A beneficiary with a primary diagnosis of a serious mental illness may also be diagnosed with a personality 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 beneficiary's ability to function independently, and whose symptoms impede the return of normal functioning as a result of the diagnosis of a serious mental illness. 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 to meet 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.

4.3 ESSENTIAL ELEMENTS [CHANGES MADE 4/1/20 & 7/1/20]

Team-Based Service Delivery	ACT is a team-based behavioral health service that includes shared service delivery responsibility that provides consistent continuity of care. Case/care 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. All ACT staff must obtain a basic knowledge of ACT programs and principles acquired through participation in MDHHS-approved ACT-specific initial training, and subsequent participation in at least one MDHHS-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/Physician's Assistants/Clinical Nurse Specialists must participate in the MDHHS-approved Physicians/Nurse Practitioners/Physician's Assistants/Clinical Nurse Specialists training one time, with additional ACT training/participation for Physicians/Nurse Practitioners/Physician's Assistants/Clinical Nurse Specialists encouraged, but not mandatory. Team meetings occur Monday through Friday on business days and are attended by all ACT staff members on duty. Physicians, Nurse Practitioners, Physician's Assistants or Clinical Nurse Specialists 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/care 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, 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. 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 *A minimum of 80% of ACT contacts provided by the team are in the beneficiary's home or other agreed-upon community location.*	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. The minimum ACT staffing requirements are below. The scope of services for individual ACT staff members requires that some staff will work in the community more often than others. An ACT team operates minimally with 4 FTE staff and with no more than 9 FTE staff members. Teams average 6-7 FTE staff. If an ACT team believes it is necessary to operate outside of team requirements, consult with MDHHS regarding feasibility. If appropriate, a waiver request may be submitted to the PIHP. If approved, the PIHP will submit the request to MDHHS for consideration of approval. ▪ A full-time team leader whose experience includes at least two years post-degree clinical work with adults who have a serious mental illness, and is fully licensed, minimally possessing a master's degree in a relevant discipline, with appropriate licensure to provide clinical supervision to the ACT team staff. The ACT team leader leads the team, provides clinical supervision to team members, and provides direct services to beneficiaries in the community within their individual scope of practice. The fully licensed ACT team leader also meets the requirements of a MHP. **(revised 4/1/20)**

The average number of visits per day/week/month/etc. provided by the whole team, not individual ACT team members, to an individual consumer will comprise 80% of home or community contacts. *Telepractice is the use of telecommunications and information technologies for the provision of psychiatric services to ACT consumers and is subject to the same service provisions as psychiatric services provided in person. The telepractice modifier, 95, must be used in conjunction with ACT encounter reporting code H0039 when telepractice is used.* *All telepractice interactions shall occur through real-time interactions between the ACT consumer and the physician/nurse practitioner/physician's assistant/clinical nurse specialist from their respective physical location. Psychiatric services are the only ACT services that are approved to be provided in this manner.*	▪ 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 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, physician's assistant or clinical nurse specialist, but the nurse practitioner, physician's assistant or clinical nurse specialist 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 telepractice. The physician (MD or DO) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a Drug Enforcement Administration (DEA) registration. ▪ A physician assistant may perform clinical tasks under the terms of a practice agreement with a participating physician. The physician assistant must hold a current physician assistant license and a controlled substance license in Michigan. The physician assistant is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, physician assistant activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice. ▪ A nurse practitioner or clinical nurse specialist may perform clinical tasks delegated by and under the supervision of the physician. The nurse practitioner/clinical nurse specialist must hold a specialty certification as a nurse practitioner/clinical nurse specialist 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/clinical nurse specialist, he/she may substitute for a portion of the physician time, but may not substitute for the ACT RN. The nurse practitioner/clinical nurse specialist is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, nurse practitioner/clinical nurse specialist activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice. ▪ A case or care manager, possessing minimally a bachelor's degree in a human services discipline, who possesses appropriate licensure to provide the core elements of case or care management with at least one year of experience providing services to adults with a mental illness, and is a QMHP. If the case or care manager has a bachelor's degree but is without one year of experience working with adults with serious mental illness or co-occurring disorders and otherwise meets the requirements of the QMHP, documentation of clinical supervision is provided in the beneficiary record. **(revised 4/1/20)**

Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements for the provision of telepractice services. *Treatment Groups identified in the IPOS, such as Family Psychoeducation, Alcoholics Anonymous, etc., are excluded from the 80% community visit standard regardless of where the group is held.* *The scope of services for individual ACT staff members require that some staff will work in the community more often than others.*	▪ Individual/family/group counseling provided by a MHP, including a limited-licensed master's degree social worker who is supervised by a licensed master's degree social worker. **(revised 4/1/20)** ▪ Up to one Full Time Equivalent (FTE) Peer Support Specialist (PSS) may substitute for one 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. This supervision is documented in the beneficiary record. ▪ Up to one FTE paraprofessional staff to work with ACT teams may be counted in the staff-to-beneficiary ratio. Paraprofessional staff may have a bachelor's degree or related training in a field other than behavioral sciences (e.g., certified occupational therapy assistance, home health care); or have a high school equivalency and work or life experience with adults with severe mental illness or co-occurring substance use disorders. ▪ If the ACT team provides substance use disorder services, there must be a designated Substance Abuse Treatment Specialist who has one or more credentials through the Michigan Certification Board of Addiction Professionals (MCBAP). If the ACT team provides co-occurring treatment or substance use disorder treatment, the Organization must have a substance use disorder treatment license issued by the State of Michigan. Additional staff positions reflect the needs of the population, such as the ability to obtain housing, employment services and rehabilitative services for beneficiaries who request them, and shall minimally be a QMHP.
Staff-to-Beneficiary Ratio	The ACT team's staff-to-beneficiary ratio shall be at least one FTE ACT staff to a maximum of 10 ACT beneficiaries, a 1:10 staff-to-beneficiary ratio. Teams serving large service areas, highly complex beneficiaries, or very high acuity beneficiaries may find a lower staff-to-beneficiary ratio better meets beneficiary needs and retains team capacity to quickly address emerging or acute treatment needs and adjust service contacts. With the exceptions of the limitations on paraprofessionals and certified peer support specialists described above, the staff ratio includes all ACT team members, excluding the clerical support staff and physicians, nurse practitioners, physician assistants, **(revised 4/1/20)** and clinical nurse specialists.
Fixed Point of Responsibility *H0039 indicates provision of ACT service; place of service is indicated as hospital.* ***(text added 7/1/20)***	The ACT team is the fixed point of responsibility for the development of the individual plan of service (IPOS) using the person-centered planning process and for supporting beneficiaries in all aspects of 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. Care continuity is maintained with pre-admission screening, team contact during inpatient psychiatric hospitalizations, and team participation in transition and discharge planning. **(text added 7/1/20)**

Availability of Services *Pre-admission screens for ACT beneficiaries must be reported by including the TG modifier with the ACT encounter code of H0039.*	Availability of ACT services must include: ▪ 24-hour/7-day crisis response coverage (including psychiatric availability) that is handled directly by members of the ACT team. ▪ The ACT team is responsible for performing the required pre-admission screen for all beneficiaries enrolled in an ACT program seeking inpatient psychiatric admission. ▪ 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 (IPOS)	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 behavioral 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 behavioral health and substance use disorders addressed in the IPOS. Beneficiaries who need a less intensive service than ACT, such as case/care 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 behavioral health services, substance misuse 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.

4.4 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 or 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 psychiatric rehabilitation.

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 Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) diagnosis (not including ICD-9 V-codes and ICD-10 Z-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 which needs to be simultaneously addressed along with the psychiatric illness and which 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 beneficiary 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 are 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 beneficiary to function without more restrictive care, and the beneficiary requires at least one of the following: ▪ An intensive team-based service is needed 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 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 *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/care management.*	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/care 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 beneficiary 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.