APPENDIX 3

ASSERTIVE COMMUNITY TREATMENT (ACT)

Purpose

Assertive Community Treatment (ACT) is a best practice community-based treatment for members with severe mental illness (SMI). ACT services are based in the community and assist members with decreasing psychiatric hospitalizations and involvement with law enforcement while increasing their community living skills. The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes ACT as an evidence-based best practice for adults and transition age youth (i.e., 18-26 years) that is no more expensive than other community-based care and has high satisfaction scores among individuals who receive the service and their family members.[1]

Service Definition and Tool for Measurement of ACT

ACT is an intensive non-residential treatment and rehabilitative mental health service provided in accordance with the fidelity model of the Tool for Measurement of ACT (TMACT; Monroe-DeVita, Moser, & Teague, 2011). The primary intention of the TMACT is to evaluate current practice, compare to best practice standards, conduct a needs assessment to guide recommendations and inform broader training needs and to highlight areas of strength. ACT provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for members with SMI who require a higher level of community care and have not been well supported in lower level of care options.

ACT utilizes a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance use disorders, peer support, and integrated treatment and skill building to achieve and maintain educational or vocational success. Because an ACT team often works with individuals who may passively or actively resist services, an ACT team is expected to thoughtfully carry out planned assertive engagement techniques including rapport-building strategies, facilitating meeting basic needs and motivational interviewing techniques. These techniques are used to identify and focus on the individual's life goals and what he or she is motivated to change. Likewise, it is the team's responsibility to monitor the individual's mental

[1] SAMHSA. ACT: The Evidence. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services, 2008.

status and provide needed supports in a manner consistent with the individual's level of need and functioning.

The ACT team delivers all services according to a recovery-based philosophy of care. The team promotes self-determination, respects the person receiving ACT as an individual in his or her own right and engages peers in promoting hope that the individual can recover from mental illness and regain meaningful roles and relationships in the community.

Services are offered 24 hours per day, seven days per week, in a community-based setting that may include the member's home, a shelter, or even on the street. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of daily team meetings. Typically, members served through ACT have a serious and persistent psychiatric disorder and a treatment history characterized by frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, substance use, and lack of engagement in traditional outpatient services. Crisis intervention and planning are critical components of this service.

One of the fundamental charges of ACT is to be the first line (and generally sole provider) of all the behavioral health services that members may need. Thus, a higher frequency and intensity of community-based contacts and a low member-to-staff ratio is required. Services are flexible and appropriately adjusted based on the member's evolving needs over time.

Medical Necessity

Eligibility Criteria

ACT services require prior authorization and shall be covered for a member with diagnoses of schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder, as defined by the current edition of the Diagnostic and Statistical Manual (DSM). These illnesses more often cause long-term psychiatric disability; Members with other psychiatric illnesses are eligible depending on the level of the long-term disability from their mental illness. Diagnosis must reflect a serious and persistent mental illness and the need for treatment, and the covered treatment must be medically necessary for meeting the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the member.

Members ages 18 - 21 must meet medical necessity under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

Members with a primary diagnosis of a substance use disorder, intellectual developmental disorder (intellectual disability), borderline personality disorder, dementia, and traumatic brain injury are not eligible for ACT.

The member has significant functional impairment as demonstrated by at least one of the following conditions:

1. Significant difficulty consistently performing the range of routine 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; attending to personal hygiene) or persistent or recurrent difficulty performing daily living tasks without 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 head of household responsibilities (e.g., meal preparation, household tasks, budgeting, or childcare tasks and responsibilities).

3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing or utilities).

In addition, has one or more of the following problems which are indicators of continuous high service needs:

1. High use of acute psychiatric hospitalization (two or more admissions during the past 12 months) or psychiatric emergency services.

2. Intractable (persistent or recurrent) severe psychiatric symptoms (e.g., affective, psychotic, suicidal, etc.).

3. Coexisting mental health and substance use disorders of significant duration (more than six months).

4. High-risk or recent history of criminal justice involvement (e.g., detention, incarceration, probation, frequent contacts with law enforcement, etc.).

5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness.

6. Residing in an inpatient or supervised community residence but clinically assessed as 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 using traditional office-based outpatient services.

Continued Stay

The member shall be approved for continued stay if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the member's

treatment plan, or the member continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains.

Additionally, one of the following applies:

1. The member demonstrates a high level of impairment and barriers to rehabilitative services are significant, yet number of protective strengths and ability to access resources remain low, which result in the member being unable to effectively meet treatment goals with a lower level of care.

2. The member is making satisfactory progress toward meeting goals, and there is documentation that supports continuation of ACT will be effective in addressing the goals outlined in the treatment plan.
3. The member is making moderate progress, but the specific interventions in the treatment plan need to be modified so that greater gains, which are consistent with the member's pre-morbid or potential level of functioning, are possible.

4. The member fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the treatment plan (e.g., the member's diagnosis must be reassessed to identify any unrecognized co-occurring disorders and treatment recommendations should be revised based on the findings).

5. If the member is functioning effectively with ACT and discharge would otherwise be indicated, the ACT team services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision must be based on either of the following:
    a. The member has a documented history of regression in the absence of ACT team services or attempts to titrate ACT team services downward have resulted in regression.
    b. There is an epidemiologically sound expectation that symptoms will persist, and ongoing outreach treatment interventions are needed to sustain functional gains.

Discharge Criteria

Member shall meet at least one of the following:

1. The member and team determine that ACT services are no longer needed based on the attainment of goals as identified in the person-centered plan and a less intensive level of care would adequately address current needs, thus enabling member to meet treatment goals. Standards for transitioning to less intensive services should be consistent with the standards noted in Operations and Structure 9 (OS9) on the TMACT OS subscale.

2. The member moves out of the catchment area, and the ACT team has facilitated the referral to either a new ACT provider or other appropriate mental health service in the new place of primary private residence and has assisted the member in the transition process. The ACT team shall maintain documentation of the referral process.

3. The member and, if appropriate, the legally responsible person choose to withdraw from services and documented attempts by the program to reengage the member have not

proven to be successful. Best practice engagement efforts are advised for approximately six months for those individuals the team has assessed as likely needing this service.

In general, when teams adhere to ACT admission criteria, they are less likely to work with members who are unable to benefit from the service. ACT teams must take care in methodically assessing and adjusting service efforts and goals to adequately capture the needs of the member. Those who meet ACT admission criteria will have persistently high needs but are most likely to gain the benefits sustained during the course of the service. If a member is not demonstrating significant progress, periods of reassessment and adjustments to the treatment plan over time are required to adapt to the specific needs of the individual.

Staff Composition and Qualifications

ACT teams require an adequate number of staff members with sufficient individual competence to carry out the array of services and to establish quality supportive relationships with members. In addition, ACT staff must have attitudes and values that are compatible with ACT philosophy — compassion and respect for members with SMI and their experiences, understand and believe in recovery concepts and clients determining their own goals, and member and family involvement in all activities that shape the quality of ACT services.

An ACT team is a multidisciplinary group of clinical professionals providing coordinated services, where staff are fully integrated onto the team with limited appointments to other service lines within the organization. With the exception of psychiatric medical providers, ACT team members shall have, at minimum,16 hours per week of dedicated time to ACT services and team requirements.

An ACT team is staffed with various specialties that have an opportunity to work within their specialty areas, while also supporting all other areas of practice within the team approach. The team delivers care in an organized way, with individual treatment teams used to coordinate and support the team-based approach.

ACT teams may utilize several psychiatric care providers to address the medical needs of members; however, these providers must be fully integrated into the functioning of the team. There is an expectation of indirect time coordinating care with fellow team members, providing clinical leadership to the team in collaboration with the team lead, participating in daily team meetings, and other coordinated efforts as described in this manual.

ACT teams are led by a team leader who is exclusively dedicated with no responsibilities to other roles outside of the ACT team. Only one qualified professional shall assume the role as team leader.

Staffing for ACT teams includes the below roles and team members and the subsequent expectation of time devoted to ACT (i.e., proportion of time where “1.0” is a full-time position):

Team Size and Staff Ratios

Certification as an ACT team with fidelity to the TMACT is required. In compliance with TMACT fidelity (scoring at least a 3.0) or having provisional certification for no more than 18 months, ACT teams may provide any component of the services list from above and must employ and utilize the qualified practitioners necessary to maintain fidelity.

Required staffing ratios are based on team size as noted in the table below. Other than the team leader role and required staffing, team composition is flexible based on the narrative descriptions of the team member, as follows.

ACT service providers must meet the following requirements:

ASSERTIVE COMMUNITY TREATMENT TEAM STAFFING REQUIREMENTS		
	Small Teams (Up to 50 members)[1]	**Large Teams** (51–129 members)[1]
Staff to Member Ratio Includes all team members except psychiatric care provider and program assistant.	1 team member per 8 or less members.	1 team member per 9 or less members.
Team Leader This position must be occupied by only one individual.	One full-time team leader.	One full-time team leader.
Psychiatric Care Provider Prorating of FTE allowed given number of members actually served. No more than two psychiatric care providers may assume this role.	• At least 16 hours each week for 50 members (or equivalent if fewer members). • The psychiatrist works a minimum of eight hours each week; a nurse practitioner or physician assistant may cover the balance of the requirement as per the member caseload size.	• At least 32 hours each week per 100 members, or equivalent *(ex., a team serving 75 members is expected to have a minimum of 24 hours of psychiatric care provider time; a team serving 120 members is expected to have a minimum of 40 hours of psychiatric care provider time).*
Nurses Prorating of FTE allowed given number of members actually served. No more than two individuals can share a 1.0 FTE.	1.0 FTE nurse who is an RN ***or*** APRN with a minimum of 1 year experience working with adults with serious mental illness and working knowledge of psychiatric medications.	3.0 FTE Nursing. • At least two Nurses are an RN ***or*** APRN, with at least one having a minimum of 1 year experience working with adults with serious mental illness and working knowledge of psychiatric medications. • The remaining 1.0 nurse can be an RN or LPN.
Substance Use Disorder Professional No more than two individuals can share this position.	1.0 FTE licensed or certified professional (LAC, MAC, or master's level CAC).	1.0 FTE licensed or certified professional (LAC, MAC, or master's level CAC).

Certified Peer Support Specialist No more than two individuals can share this position.	1.0 FTE Certified Peer Support Specialist	1.0 FTE Certified Peer Support Specialist
Vocational Specialist This position is to be occupied by only one person.	1.0 FTE; minimum of bachelor's degree in a human services field, at least one year experience working with adults with SMI, and at least six months experience providing employment or educational supports.	1.0 FTE; minimum of bachelor's degree in a human services field, at least one year experience working with adults with SMI, and at least six months experience providing employment or educational supports.
Program Assistant	1.0 FTE office-based program assistant dedicated solely to supporting the ACT team.	1.0 FTE office-based program assistant dedicated solely to supporting the ACT team.
Additional Staff Any additional staffing should reflect the intended program size, number of beneficiaries served, and needs of the team.[2]	At least 1 FTE ACT team member.	At least 1 FTE ACT team Member.

[1] Admitting and discharging members from the team caseload may temporarily result in noncompliance with the maximum caseload. Teams are expected to meet an annual average not to exceed 50 and 120 members, respectively.

[2] The additional team member position may have specific areas of expertise and training, to include: supportive housing, psychiatric rehabilitation (i.e., assistance with ADLs, money management, benefits, etc.), empirically-supported therapy (i.e., Trauma-Focused CBT, CBT for psychosis, etc.), family liaison work, and forensic/legal issues. If teams are targeting a specific clinical population, it is recommended they hire additional staff reflecting the expertise and training needed for the targeted clinical population (ex., a second substance use counselor for teams serving primarily members with co-occurring substance use disorders).

It is an expectation that ACT teams have caseloads of at least 30 members to meet and maintain TMACT and ACT fidelity requirements.

The service components that are eligible for Medicaid reimbursement must be delivered by providers who are Medicaid-approved (as per definitions in this manual, see "Eligible Providers" section for further information), and within professional scope for those services.

Team Leader

In collaboration with the psychiatric care provider(s), the ACT team shall be staffed with one full-time team leader whose primary responsibility is to provide clinical leadership and oversight to the ACT program and manage the team operations and staffing. The team leader shall be a licensed mental health professional holding any of the following licenses: Licensed Psychologist, Licensed Independent Social Worker-Clinical Practice (LISW-CP), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed

Psychiatric NP, and/or Clinical Nurse Specialist certified as an advanced practice psychiatric clinical nurse specialist.

The team leader shall have three years of clinical experience with serious mental illness, with a minimum of two years post-graduate school.

The full-time team leader is responsible for:
1. Overseeing the administrative operations of the team.
2. Providing clinical oversight of services in conjunction with the psychiatric care provider as well as clinical supervision for staff team members.
3. Supervising staff team members to assure the delivery of best and ethical practices.
4. Providing direct services to ACT service members where a therapeutic relationship is developed between ACT service members and the team leader.

The team leader is exclusively dedicated to the ACT team, with no responsibilities to other roles outside of the ACT team. Only one qualified professional (QP) shall assume the role as team leader.

Psychiatric Care Provider
The psychiatric care provider's minimal full-time equivalent (FTE) is determined by the number of service members. Part-time psychiatric care providers shall have designated hours to work on the team, including sufficient blocks of time on consistent days in order to carry out their clinical, supervisory, and administrative responsibilities. The role of a psychiatric care provider is to be filled by a psychiatrist(s), APRN, or shared by a psychiatrist, an NP, or a PA under the supervision of the psychiatrist. APRNs with prescription authority and a Drug Enforcement Administration (DEA) registration are also authorized to prescribe medications and can fill this role. This position does not count towards the ACT team's staff-to-member ratio.

No more than two psychiatric care providers may share this role. If a physician assistant is one of the psychiatric care providers, then the team psychiatrist must assume at least half of the minimum FTE require given the team size. All psychiatric care providers are to be integrated on the team by providing direct services to the members.

The ACT team psychiatrist shall be board-eligible or certified by the American Board of Psychiatry and Neurology and licensed to practice in the State. The ACT team's psychiatric nurse practitioner shall be currently licensed as an APRN in the State with at least three years of fulltime experience treating individuals with SPMI, and/or the ACT team's PA shall be currently licensed as a PA in the State with at least three years fulltime experience treating individuals with SPMI.

Nurse
The nurse's minimal FTE is determined by the number of service members. An ACT team shall be staffed minimally with one RN that has a minimum of one year experience working with

adults with SMI and a working knowledge of psychiatric medications, regardless of team size. Additional nursing staff can include RNs, APRNs, or LPNs. No more than two staff can share a 1.0 FTE.

Qualified Mental Health Professional (QMHP)

The QMHP position shall be staffed with a minimum LISW-CP, LMFT, LPC, or Licensed Psychologist and one year of experience working with the population to be served. Interventions and services provided should be grounded in evidence-based practices (EBPs) tailored to meet the needs of ACT members and can include:

- Individual and group interventions
- Completion of screening and assessments for referrals; updating biopsychosocial assessment as necessary
- Using assertive engagement and outreach techniques and motivational interviewing to engage members in services
- Leading Instructional Continuity Plan (ICP) development and revisions
- Working with a member's natural supports
- Family and member psychoeducation

NOTE: LMSWs meet criteria for the QMHP position when the ACT team is a function of (and employed by) a State agency, as per State statute. Private providers must utilize an LPHA for the QMHP position, as described in the Eligible Providers section of this manual.

Mental Health Provider (MHP)

ACT Teams may include either a Mental Health Professional and/or a Mental Health Services Provider:

- Mental Health Professional – A masters or doctoral degree in a human services field and minimum of one year experience working with the population to be served.
  and/or
- Mental Health Services Provider — Must have a minimum of a bachelor's degree in a human service field and three years of experience working with the population to be served.

If either of the providers is licensed (e.g., LBSW, LMSW, LPC-A, LMFT-A), years of experience may be reduced to one year for the mental health services provider and waived for the mental health professional. Interventions and services provided should be grounded in psychiatric rehabilitation; reflect the education, experience, and scope of practice of the staff; and can include:

Licensed or Certified Substance Use Disorder Professional

The ACT team shall be staffed with a 1.0 FTE substance use disorder professional who shall be a Licensed Addiction Counselor (LAC), Master Addiction Counselor (MAC), or a master's level Certified Addictions Counselor (CAC). No more than two substance use specialists may share this role.

Vocational Success Specialist
While all ACT team members may provide ongoing support to members who are employed or seeking employment, the team shall be staffed with a full-time vocational success specialist. The vocational success specialist shall have a minimum of a bachelor's degree in a human services field, at least one year experience working with adults with SMI, and at least six months experience providing employment or educational supports. Preference is for someone who has at least one year of experience providing employment services or has advanced education that involved field training in vocational services.

The vocational success specialist shall provide evidence-based employment strategies. Members receiving ACT shall have immediate access to vocational services from the ACT team. The primary intent of vocational services is management of symptoms and behaviors that allows for competitive employment — defined as jobs that pay at least minimum wage, which anyone can apply for and are not set aside for persons with disabilities. This may include temporary and seasonal jobs, entrepreneurial efforts, and/or self-employment.

Vocational success specialists shall also determine the benefit of any outside referrals for members to receive vocational services beyond that of the ACT team; referrals may include those to the South Carolina Vocational Rehabilitation Department (SCVRD) or programs with specific vocational preparation groups, for example, such as those provided by Goodwill Industries. The vocational success specialist will coordinate and collaborate with any outside providers as necessary for the benefit of the member and to enhance job development opportunities and business networking opportunities as appropriate.

In cases where the ACT team cannot provide needed supports for the member to obtain or maintain employment, or to support educational goals (e.g., need for adaptive technology to support employment, reimbursement of tuition and fees for education or certification related to employment goals), such referrals are relevant and not contraindicated.

Certified Peer Support Specialist (CPSS)
Each ACT team has at least 1.0 FTE CPSS. No more than two individuals can share this position. Those providing Peer Support Services must be certified and in good standing as a Certified Peer Support Specialist in South Carolina through SC SHARE. *Further information about training and certification for CPSSs are found in the service requirements section of this manual.*

The CPSS is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of members.

Additional Staff

Additional clinical staff may be necessary to meet the needs of the ACT team, and may include Mental Health Professionals, Mental Health Services Providers, or QMHPs. These individuals shall have the knowledge, skills, and abilities required by the population and age group to be served to carry out rehabilitation and support functions. Activities of these additional staff may include a range of psychosocial rehabilitative interventions and case coordination tasks. Specialization is encouraged in areas such as psychiatric rehabilitation, therapy, and additional supports in the areas of substance use counseling, housing, vocational services, etc.

Program Assistant

The full-time office-based program administrative assistant position is assigned to solely support the ACT team. This position does not count towards the ACT team's staff-to-member ratio.

The ACT program assistant provides a range of supports to the team by organizing, coordinating, and monitoring all non-clinical operations of the ACT team, including:

- Managing medical records.
- Operating and coordinating the management information system.
- Maintaining accounting and budget records for member and program expenditures.
- Entering and tracking team performance and member outcome data as well as running reports on such data.
- Providing support to the team by receiving calls and responding to office walk-ins, triaging, and coordinating communication between the team and individuals.
- Actively participating in the daily team meeting, assisting with organizational record-keeping, and scheduling activities.

Staff Competencies, Services, and Supports

The ACT team shall have staff with sufficient individual competence, professional qualifications, and experience to provide the care coordination, service coordination, crisis assessment and intervention, and symptom assessment and management. The intensity of intervention and support shall vary to meet the changing needs of members with SMI, to support members in community settings, and to provide a sufficient level of service as an alternative to hospitalization or more restrictive levels of care.

ACT services are delivered continuously and *titrated*, meaning that when a member needs more services, the team provides them. Conversely, when the member needs less services, the team lessens service intensity. Services provided by an ACT team include but are not limited to the following:

INTERVENTIONS AND ACTIVITIES PROVIDED BY ACT TEAMS	
Assertive Engagement	• Use collaborative and motivational interventions that promote members' development of intrinsic motivation to receive services from the ACT team. • Short-term use when collaborative approaches fail and risks are high.

	• Therapeutic limit-setting interventions that promote' development of motivation to receive services from the ACT team.
Assessment and Service Plan Development	• Identify or update primary psychiatric and co-occurring disorders, symptoms, and related functional problems, particularly as they relate to impediments to members' desired life roles, as a part of the comprehensive clinical assessment. • Assess transition readiness on an ongoing basis using standardized tools. Update and revise, in partnership with the member, an individualized, comprehensive, goal-oriented Person-Centered Plan. • Identify individualized strengths, resources, preferences, needs, and goals; include identified strengths in the treatment plan goals and action steps. Create specific and clinically thoughtful interventions for team delivery, which are then cross-walked to a members' weekly/monthly schedule which guides day-to-day team planning. • Identify risk factors for harm to self or others; develop collaborative safety plan for risk abatement. • Monitor response to treatment, rehabilitation, and support services. • Develop person-centered, functional crisis plans.
Empirically Supported Interventions and Psychotherapy	• Provide cognitive-behavioral interventions targeting specific psychological and behavioral problems (ex., anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms). • All psychotherapy services shall be provided by a trained, master's level provider; all psychotherapy services must be supervised according to guidelines provided in provider qualifications section of this manual.
Relationship Building and Social Supports	• Restore and strengthen the member's unique social and familial relationships. • Provide psychoeducational services (ex., provide accurate information on mental illness & treatment to families and facilitate communication skills and problem solving). • Coordinate with child welfare, family agencies, or other entities involved. • Support member's parenting and provide skills necessary to manage day-to-day parenting and interfamilial interaction. • Teach coping skills to families in order to support member's recovery. • Enlist family support in member's recovery. • Facilitate the member's natural supports through access to local support networks and trainings, such as NAMI's Family-to-Family. • Help members expand network of natural supports.
Health	• Provide preventative health education. • Provide and coordinate medical screening and follow up. • Schedule routine and acute medical and dental care visits and assist member in attending these visits.

	• Sex education and counseling. • Health and nutrition counseling.
Housing	• Assist members in obtaining safe, clean, affordable housing that follows the member's preferences in level of independence and location, consistent with an evidenced-based Supportive Housing model. • Locate housing options with a focus on integrated independent settings. • Apply for housing subsidies and housing programs. • Assist the member in developing amicable relationships with local landlords. • Assist the member in negotiating and understanding the terms of their lease and paying rent and utilities. • Provide tenancy support and advocacy for the member's tenancy rights at the individual's home at least monthly. Examples of these interventions include utility management, cleaning, and relationships with other tenants and the landlord. • Assist with relocation, when necessary. • Teach skills in purchasing and repairing household items. • Provide tenancy support services to members transitioning to the community from institutional or congregate care settings.
Integrated Treatment for Dual Mental Health/Substance Use Disorders	• Non-confrontational support that promotes harm reduction or abstinence, depending on the member's stage of change readiness. • Assess stages of change readiness and related stage of treatment. • Provide outreach and engagement to those in a pre-contemplation or contemplation stage of change readiness. • Use motivational interviewing for those in a contemplation and preparation phase of change readiness. • Provide active substance use counseling and relapse prevention, using cognitive behavioral interventions, for those in later stages of change readiness. • Educate on substance use & interaction with mental illness. • Provide individual & group modalities for dual disorders treatment. • All staff providing substance use treatment must be appropriately qualified/certified.

Staff Training and Continuing Education

ACT team staff shall have training in relevant topics regarding the population served and provision of ACT services. Teams shall also develop procedures for cross-training to support team members, provide adequate coverage, and to relieve staff when necessary due to time away. Training topics will vary depending on staff experience and knowledge base; thus, team leaders and/or provider organizations should take into account the needs of the whole team when ensuring the team has what it needs to be effective providers of ACT.

Along with initial training, ACT teams shall strive to participate in continuing education on a yearly basis to ensure teams are aware of current trends, best practices, and relevant updates to the model.

ACT teams may find pertinent resources for initial training and continuing education through the following:

UNC Institute for Best Practices - UNC Center for Excellence in Community Mental Health

SAMHSA Assertive Community Treatment Tool Kit

Center for Practice Innovations > Initiatives > ACT Assertive Community Treatment > Training

Service Documentation

Each provider is responsible for developing the IPOC in collaboration with the member and/or other relevant collateral supports involved in care. The IPOC shall be updated as necessary based on the flexible and adaptable nature of ACT services; documentation in clinical services notes must support the need for changes to the IPOC, demonstrating progression of the member and/or difficulties encountered that may necessitate shifting or changing treatment goals.

Clinical Service Notes (CSNs) must be completed for each individual service rendered, regardless of whether the service is responsible for drawing down the ACT per diem of that day (i.e., it is not the first service delivered on the same date, thus is encompassed in the per diem rate to be billed for that day). Teams shall also document coordinated case discussions and/or clinical staffing of individual members in their record.

ACT teams shall adhere to requirements for IPOC/CSN completion as well as other requirements related to documenting services as described in Section 6 of this manual.

Billing Guidance

ACT services are delivered continuously and titrated, meaning that when a member needs more services, the team provides them. Conversely, when the member needs less services, the team lessens service intensity; therefore, frequency of service will vary from week to week and month to month depending on the needs of the member.

ACT requires prior authorization prior to service delivery and is billed using the following procedure code and modifier, determined by team size:

ASSERTIVE COMMUNITY TREATMENT (ACT)			
Procedure Code	**Modifier/Description**	**Prior Authorization**	**Coverage Limitations**
H0040	U1 – Small Teams U3 – Large Teams	YES	• Encounter = 1 unit (all-inclusive per diem). • 1 unit per day, per member, no more than 15 units per month, per member. • Encounter must include minimum 15 minutes of ACT service provision.

Reimbursement methodology is based on a per diem rate that is all-inclusive of activities that are necessary to deliver ACT services. ACT per diems can be billed only on days when an ACT team provider has performed a face-to-face service with the member or a family member. Only one per diem may be billed per member, per day with no more than 15 per month.

For an ACT team per diem to be generated, a 15-minute or longer face-to-face contact that meets all requirements outlined below must occur. A 15-minute contact is defined as lasting at least eight minutes. Group contacts alone are not permitted as a face-to-face contact for generating an ACT per diem rate. Providers may not bill for services included in the ACT per diem and also bill for that service outside of the per diem for enrolled members.

The expectation of SCDHHS is that ACT teams will actively strive to reach fidelity and will adhere to the best practice guidelines, philosophy, and intent of the model. Teams that do not follow a practice model that aligns with the TMACT may be rendering services that do not meet South Carolina's service definition for ACT.

Reimbursement of Employment Services

ACT includes non-job-specific vocational training, employment assessments, and ongoing support to assist a member in maintaining employment. Strategies from the Individual Placement and Support (IPS) model are recommended, with a focus on managing one's symptoms for the purpose of obtaining/maintaining meaningful employment. ACT may also pay for the medical services that enable the member to function in the workplace (such as psychiatric and/or psychological evaluation and treatment), rehabilitation planning, recovery strategies, therapy, and supportive counseling that enable the member to be successful in a work environment.

Billing Limitations

Medically necessary care consistent with the fidelity model should be delivered even if beyond the minimum number of units permitted to be billed under this reimbursement strategy.

In addition to general preclusions to Medicaid reimbursement as identified in this manual (i.e., "Billing Guidance" section), the following activities may not be billed:

- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in purely recreational activities unless tied to specific rehabilitative activities conducted in the community (to assist the member with social skills building, modeling prosocial behavior in specific environments, orienting the member to appropriate social norms in certain settings, etc.). *Documentation must appropriately demonstrate the goals addressed and therapeutic interventions rendered.*
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation of the member or family/other collateral supports. Services rendered in a moving vehicle are considered transportation.
- Covered services that have not been rendered.
- Services provided before the department, or its designee (including the Managed Care Organization) has approved authorization.
- Services not identified on the member's authorized ACT Treatment Plan.
- Services not in compliance with the ACT service manual and not in compliance with fidelity standards.
- Services provided to children, spouse, parents, or siblings of the eligible member under treatment or others in the eligible member's life to address problems *not directly related* to the eligible member's issues and not listed on the eligible member's ACT participant-directed treatment plan.
- Services provided that are not within the provider's scope of practice.

Billable Place of Service

There is no place of service restrictions. The ACT team is expected to meet with the member in their environment at times of the day/week that honor the member's preferences and will require the team to meet members at home, in homeless shelters, streets, and/or hospitals, etc..

Note: Other than psychiatry services, when necessary based on emergent needs or other unforeseen circumstances, ACT is not intended to be provided via telehealth but primarily in-person.

Indirect Costs

All other contacts or activities related to provision of ACT services, but that are not directly billable to Medicaid independently, are incorporated into the rate methodology that accounts for the all-inclusive, bundled ACT reimbursement rate. Such activities include the following examples:

- Team (or other) meetings, travel time, training, time spent on fidelity reviews, supervision;

- Pre-session research and/or information gathering required to assist the member or understand a particular resource (such as activities related to job development) or consultation from a subject matter expert.

Special Restrictions in Relationship to Other Services

The following services must not be provided concurrently with ACT, as they are incorporated into the all-inclusive, bundled rate for ACT services:

- Individual or Family Psychotherapy
- Outpatient Medication Management
- Outpatient Psychiatric Services
- Psychosocial Rehabilitation after a 30-day Transition Period
- Partial Hospitalization
- Medicaid-Funded Evidence-Based Supported Employment or Long-term Vocational Supports
- ACT cannot be provided to members in a nursing facility.

The following services may be provided concurrently with ACT services when deemed medically necessary:

- Opioid Treatment
- Withdrawal Management Services
- Facility-Based Crisis Stabilization (i.e., walk-in crisis stabilization center or unit for purpose of diversion from Emergency Department, 23-hour stay); Hospital-Based Crisis Stabilization (i.e., ED diversions to specialized outpatient hospital units for triage and transition to appropriate services).
- Non-Medicaid funded Evidence-Based Supportive Employment of Long-Term Vocational Supports
- Group Psychotherapy
  - As long as medical necessity is met, an ACT team may facilitate a time-limited group for members served when a specific goal is identified on the IPOC; for an ACT member to attend a group facilitated outside of the ACT team, there must be justification of why the goal cannot be met by the providers on the ACT team, as documented in a CSN or progress summary at the time of referral.

ACT Model Fidelity

The below table shows the staff to member ratios as well as FTEs for small and large teams:

Staff*	Small Team	Large Team
Staff to Member Ratio	1:8	1:9
FTE Base Fidelity	6.0	7.0
FTE High Fidelity	7.0	10.0

**All team members are included in the FTE number except the program assistant.*

Provisional Fidelity Level

A new ACT team can be certified at a provisional fidelity level for six months if it has submitted the required documentation to the State approved fidelity evaluation team. At that time, the ACT team must undergo a mock fidelity review by the State approved fidelity evaluation team and achieve an average TMACT fidelity score of 2.0 or greater. In order to achieve a provisional fidelity level, the team must also achieve minimum fidelity rating scores on certain aspects of TMACT fidelity:

- A minimum average rating of 3.0 across the following items from the OS subscale must be achieved:
  - OS1 — Low ratio of consumers to staff
  - OS5 — Program size
  - OS6 — Priority service population
  - OS10 — Retention rate
- A minimum average rating of 3.0 on the entire CT subscale must be received.
- A minimum rating of 3.0 on CP subscale CP1 community-based services must be received.

ACT teams may remain at the provisional fidelity level for no more than 24 months. Once the two years of provisional fidelity is completed, the State Medicaid Authority may place any ACT team not reaching basic fidelity on a corrective action plan not to exceed 90 days. During that time, the team may **not** bill using H0040,and will bill the appropriate RBHS code(s) for the services rendered.

Basic Fidelity Level

ACT teams must have an overall TMACT fidelity score of at least 3.0 to meet the basic fidelity level. The team must also achieve the following minimum fidelity rating scores on certain aspects of TMACT fidelity:

- A minimum average rate of 3.0 across the following items from the OS subscale must be achieved:
  - OS1 — Low ratio of consumers to staff
  - OS5 — Program size
  - OS6 — Priority service population
  - OS10 — Retention rate
- A minimum average rating of 3.0 on the CT subscale must be received.
- A minimum rating of 3.0 on CP subscale CP1 — community-based services item must be received.

ACT teams remain at the basic fidelity level for 18 to 24 months before rater reevaluation.

Moderately High Fidelity Level

ACT teams scoring an overall TMACT fidelity score of at least 3.5 when all other requirements are met (e.g., a face-to-face service with the client or family member) are considered moderately high fidelity. In addition to the average score, teams must meet the following specific TMACT requirements:

- A minimum average rate of 3.5 across the following items from the OS subscale must be achieved:
  - OS5 — Program size
  - OS9 — Transition to less intensive services
  - OS10 — Retention rate
- A minimum rating of 4.0 on OS subscale OS6 — Priority service population must be received.
- A minimum average rating of 4.0 on the CT subscale must be received.
- A minimum rating of 4.0 on CP subscale CP1 — community-based services item must be received.
- A minimum average rating of 3.0 on the Person-Based Planning (PP) subscale must be received.

ACT teams remain at the moderately high-fidelity level for 30 to 36 months before rater reevaluation.

High Fidelity Level

ACT teams scoring a TMACT fidelity score of at least 4.2 when all other requirements are met (e.g., a face-to-face service with the client or family member) is considered high fidelity. In addition, teams must meet the following specific TMACT requirements (similar to level two teams):

- A minimum average rate of 4.0 across the following items from the OS subscale must be achieved:
  - OS5 — Program size
  - OS9 — Transition to less intensive services
  - OS10 — Retention rate
- A minimum rating of 5.0 on OS6 — Priority service population.
- A minimum average rating of 4.0 on the CT subscale must be received.
- A minimum rating of 4.0 on CP1 — community- based services item must be received.
- A minimum average rating of 3.7 on the following subscales:
  - PP subscale
  - Specialist team subscale
  - EBPs subscale

ACT teams remain at the high fidelity level for 30-36 months before rater reevaluation.

The following chart is a quick reference guide indicating the fidelity level by scoring range and length of time at each level of fidelity before reevaluation. Teams are due for re-evaluation at the end of that timeframe.

NOTE: TMACT re-evaluation timeframes start from the date the team receives their final score, not from date of rater evaluation. Additionally, start-up teams are allowed 6 months before the initial TMACT fidelity rating and the start of the 24-month timeframe for provisional fidelity.

Fidelity Level	TMACT Scoring Range	Timeframe for Reevaluation
Provisional	2.0 - 2.9	24 months
Basic	3.0 - 3.6	18-24 months
Moderately High	3.7 - 4.1	30-36 months
High	4.2 - 5.0	30-36 months