Appendix A

Team Admission and Treatment Policies	
Michigan Medicaid Requirements	**National Standard for ACT Teams**
Fidelity Component: Admission criteria	
Diagnosis Clients have a mental illness, as reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V Codes), including personality disorders.	Diagnosis Clients with severe and persistent mental illness listed in the diagnostic nomenclature (DSM-IV) that seriously impair their functioning in community living.
Target population ACT services are targeted to persons with serious mental illness who require intensive services and supports and who, without ACT, would require more restrictive services and/or settings and include persons: 1. with difficulty managing medications without ongoing with support, or with psychotic/affective symptoms despite medication compliance. 2. with a co-occurring substance disorder. 3. with socially disruptive behavior that puts them at high risk for arrest and inappropriate incarceration or those exiting a county jail or prison. 4. who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential, or homeless shelters. 5. ***who are older with serious mental illness and complex medical/medication conditions***.	Target population Clients with significant functional impairments as demonstrated by at least one of the following conditions: 1. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal). 2. Coexisting substance abuse disorder of significant duration (e.g., greater than 6 months). 3. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration). 4. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services. a. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless. b. 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**.** c. ***Difficulty effectively utilizing traditional office-based outpatient services.***
Severity of Illness 1. 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 role performance expectations. 2. ***Drug/Medication Conditions - Drug/medication compliance and/or coexisting 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.*** 3. ***Medication use requires monitoring or evaluation for adherence to achieve stabilization, to identify atypical side effects or concurrent physical symptoms and medical conditions***. 4. ***Risk to Self or Others - Symptom acuity does not pose an immediate risk of substantial harm to the person 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***.	Severity of Illness 1. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community …or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives. a. Significant difficulty maintaining consistent employment at a self-sustaining level or significant. b. difficulty consistently carrying out the homemaker role. c. Significant difficulty maintaining a safe living situation.

Bold Italics indicates differences between the two standards.

Team Admission and Treatment Policies	
Michigan Medicaid Requirements	**National Standard for ACT Teams**
Fidelity Component: Time limits on treatment	
Individualized Plan of Service • ACT services and interventions must be consistent and balanced through o ***medical necessity and*** o ***preferences of the beneficiary while*** o ***embracing person-centered principles and recovery, with*** o the goal of maximizing independence and progression into less intensive services. • ***Beneficiaries with co-occurring substance use disorders must have both mental health and substance use disorders addressed in their individual plan of service. Treatment in the same program is preferred***.	Discharges from the ACT team occur when clients and program staff mutually agree to the termination of services. This shall occur when clients: • Have successfully reached individually established goals for discharge, and when the client and program staff mutually agree to the termination of services. • ***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 client requests discharge, and the program staff mutually agree to the termination of services.*** • ***Move outside the geographic area of ACT's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACT program or another provider wherever the client is moving. The ACT team shall maintain contact with the client until this service transfer is implemented.*** • ***Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the client.***

Team Caseload	
Michigan Medicaid Requirements	**National Standard for ACT Teams**
Fidelity Component: Caseload	
	Each new ACT team shall stagger client admissions (e.g., 4-6 clients per month) to gradually build up capacity to serve no more than 100-120 clients (with 10-12 staff) on any given urban team and no more than 42-50 clients (with 6-8 staff) on any given rural team.
	• ***The urban program shall employ a minimum of 10 to 12 FTE multidisciplinary clinical staff persons including the team leader, 1 FTE peer specialist, one to 1.5 FTE program assistants, and 16 hours of psychiatrist time for every 50 clients on the team.*** • ***The rural program shall employ a minimum of 6 to 8 FTE multidisciplinary clinical staff persons, including one team leader, one FTE peer specialist, one FTE program assistant, and16 hours of psychiatrist time for every 50 clients on the team.***
Fidelity Component: Staff to consumer ratio	
The staff-to-beneficiary ratio shall be no more than 1:10, i.e., a maximum of 10 beneficiaries to each member of the team. The ratio includes the team coordinator and all other team members who provide direct services, and excludes the physician, peers who do not meet paraprofessional or professional criteria, and clerical support staff.	Each ACT team shall have the organizational capacity to provide a minimum staff-to-client of at least one full-time equivalent (FTE) staff person for every 10 clients (not including psychiatrist and the program assistant) for an urban team. ***Rural teams shall have the organizational capacity to provide a minimum staff-to-client ratio of at least one full-time equivalent person for every 8 clients (not including the psychiatrist and the program assistant).***

Bold Italics indicates differences between the two standards.

Placement of Treatment	
Michigan Medicaid Requirements	**National Standard for ACT Teams**
Fidelity Component: In Vivo treatment	
According to the beneficiary's preference and clinical appropriateness, ***the majority of services*** are provided in the beneficiary's home or other community locations rather than the team office.	Each new urban team shall set a goal of providing ***75 percent*** of service contacts in the community in non-office-based or non-facility-based settings, while each new rural team shall set a goal of providing ***85 percent*** of service contacts in the community in non-office-based or non–facility based settings.
ACT teams provide a wide array of clinical, medical, or rehabilitative services during face-to-face interactions that are designed to help beneficiaries to live independently facilitate the movement of beneficiaries from dependent settings to independent living. These services and supports are focused on maximizing independence and the beneficiary's quality of life, such as maintaining employment, social relationships and community inclusion. For beneficiaries with co-occurring substance use disorders, individualized treatment will be integrated by the team as part of the overall treatment approach. Services may include those defined elsewhere in this section, as well as others that are consistent with preferences, professionally accepted standards of care, and are medically necessary.	An essential ingredient in the way that services are delivered in the ACT program is "assertive outreach". The majority of treatment and rehabilitation interventions take place "in the community," that is, in the client's own place of residence and neighborhood, at employment sites in the community, and in the same sites of recreation and leisure activities that all citizens use (e.g., parks, movie houses, and restaurants). The rationales for use of assertive outreach is to enable the provision of psychosocial services "in vivo," where clients need to use them. The latter factor eliminates the need for transfer of learning, which has been difficult to achieve for many persons with serious mental illnesses.

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Team Functioning	
Michigan Medicaid Requirements	**National Standard for ACT Teams**
Fidelity Component: Case Review	
Team meetings occur ***Monday through Friday*** and are attended by all members on duty. The status of all beneficiaries is briefly reviewed and documentation of daily team meetings includes all individuals discussed and all staff members present. The daily schedule is organized and contacts scheduled.	Daily staff meeting held at ***regularly scheduled times*** under the direction of the team leader (or designee) to: 1) briefly review the service contacts which occurred the previous day and the status of all program clients; 2) review the service contacts which are scheduled to be completed during the current day and revise as needed; 3) assign staff to carry out the day's service activities; and 4) revise treatment plans and plan for emergency and crisis situations as needed.

ACT services and interventions must be consistent and balanced through medical necessity and preferences of the beneficiary while embracing person-centered principles and recovery, with the goal of maximizing independence and progression into less intensive services. Beneficiaries with co-occurring substance use disorders must have both mental health and substance use disorders addressed in their individual plan of service. Treatment in the same program is preferred.	The ACT team shall conduct treatment planning meetings under the supervision of the team leader and the psychiatrist. These treatment planning meetings shall:
	• Convene at regularly scheduled times per a written schedule set by the team leader.
	• ***Occur and be scheduled when the majority of the team members can attend, including the psychiatrist, team leader, and all members of the ITT.***
	• ***Require individual staff members to present and systematically review and integrate client information into a holistic analysis and prioritize issues.***
	• ***Occur with sufficient frequency and duration to make it possible for all staff:***
	  ○ ***to be familiar with each client and their goals and aspirations;***
	  ○ ***to participate in the ongoing assessment and reformulation of issues/problems;***
	  ○ ***to problem-solve treatment strategies and rehabilitation options;***
	  ○ ***to participate with the client and the ITT in the development and the revision of the treatment plan; and***
	  ○ ***to fully understand the treatment plan rationale in order to carry out each client's plan.***

Fidelity Component: Contact with Consumer	
• The ACT program is an individually tailored combination of services and supports that may vary in intensity over time based on the beneficiary's needs and condition. Services include ***multiple daily contacts and 24-hour, seven-days-per-week crisis availability*** provided by a multi-disciplinary team which includes psychiatric and skilled medical staff.	• The ACT team shall have the capacity to provide multiple contacts a week with clients 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 client need and a mutually agreed upon plan between clients and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all clients requiring frequent contact.
• 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 shall have the capacity to rapidly increase service intensity to a client when his or her status requires it or a client requests it. • The ACT team shall provide a ***mean (i.e., average) of three contacts per week for all clients***.

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Team Functioning	
Michigan Medicaid Requirements	**National Standard for ACT Teams**
Fidelity Component: Team Availability	
Availability of services must include: • Twenty-four-hour/seven-day crisis response coverage (including psychiatric availability) that is handled directly by members of the team.	Urban Teams • The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. • Regularly scheduling mental health professionals for on-call duty to provide crisis and other services the hours when staff are not working. ACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to clients by telephone or in person. • Regularly arranging for and providing psychiatric backup all hours the psychiatrist is not regularly scheduled to work. If availability of the ACT psychiatrist during all hours is not feasible, alternative psychiatric backup should be arranged (e.g., mental health center psychiatrist, emergency room psychiatrist). Rural Teams • The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. • ACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to clients by telephone or in person. • When a rural team does not have sufficient staff numbers to operate an after-hours on-call system, the staff should provide crisis services during regular work hours. During all other hours, the team may arrange coverage through a reliable crisis intervention service. The crisis-intervention service should be expected to go out and see clients who need face-to-face contact.
Fidelity Component: Shared Caseload	
ACT is a team-based service that includes shared service delivery responsibility. Case management services are interwoven with treatment and rehabilitative services, and are provided by all members of the team. Substance abuse treatment provided within the context of the ACT team must meet the criteria located in the Substance Abuse Services Section of this chapter.	• ***Each client will be assigned a service coordinator (case manager)*** who coordinates and monitors the activities of the client's individual treatment team and the greater ACT team. The service coordinator is also the first staff person called on when the client is in crisis and is the primary support person and educator to the individual client's family. • Members of the client's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is not working. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

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Team Staffing	
Michigan Medicaid Requirements	**National Standard for ACT Teams**
Fidelity Component: Team Leader	
A team coordinator with a minimum of a master's degree in a relevant discipline with appropriate licensure or certification to provide clinical supervision, plus a minimum of two years clinical experience with adults with serious mental illness. The team coordinator also provides direct services to beneficiaries in the community. The coordinator is assigned full-time to the ACT team.	A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the ACT team. The team leader has at least a master's degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatrist.
Fidelity Component: Nurse	
A registered nurse (RN) is required (in addition to the physician). The nurse oversees medication and provides direct services to the beneficiary in the community.	On an urban team***, five FTE*** registered nurses (or at least ***3 FTE*** registered nurses) and on a rural team, ***2 FTE*** registered nurses. ***A team leader with a nursing degree cannot replace one of the FTE nurses.***
Fidelity Component: Psychiatrist	
A physician who provides psychiatric coverage for all beneficiaries served by the team. The physician is considered part of the team and meets with the team on a frequent basis. The physician (MD or DO) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a DEA registration.	A psychiatrist, who works on a full-time or part-time basis for a ***minimum of 16 hours per week for every 50 clients.*** The psychiatrist provides clinical services to all ACT clients; works with the team leader to monitor each client's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services
Fidelity Component: Peer Specialist	
Peer support staff, a valuable resource to both the recipients and members of the team, is not counted in the staff-to-beneficiary ratio.	***A minimum of one FTE*** peer specialist on either an urban team or a rural team. A person who is or has been a recipient of mental health services for severe and persistent mental illness holds this position.
Fidelity Component: Team members	
• Other staff not licensed, certified, or registered (i.e., paraprofessional staff, possessing at least a bachelor's degree in an unrelated field with one year experience working with adults with mental illness, or a high school diploma with two years experience working with the mentally ill population) are considered a part of staff-to-beneficiary ratio.	• The remaining 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. • ***On an urban team, a minimum of 4 FTE master's level or above mental health professionals (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. On a rural team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader) with at least one FTE who has designated responsibility for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling.*** • ***Substance Abuse Specialist: One or more mental health professionals with training and experience in substance abuse assessment and treatment shall be designated the role of substance abuse specialist.***

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Team Staffing	
Michigan Medicaid Requirements	**National Standard for ACT Teams**
Responsibility for Treatment	
Michigan Medicaid Requirements	**National Standard for ACT Teams**
Fidelity Component:	
• The ACT team is the fixed point of responsibility for the development of the individual plan of service 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 or obtained by the team including consultation with other disciplines and/or referrals to other supportive services as appropriate. • ACT teams provide a wide array of clinical, medical, or rehabilitative services during face-to-face interactions that are designed to help beneficiaries to live independently or facilitate the movement of beneficiaries from dependent settings to independent living. • These services and supports are focused on maximizing independence and the beneficiary's quality of life, such as maintaining employment, social relationships and community inclusion. • ***For beneficiaries with co-occurring substance use disorders, individualized treatment will be integrated by the team as part of the overall treatment approach.*** • ***Services may include those defined elsewhere in this section, as well as others that are consistent with preferences, professionally accepted standards of care, and are medically necessary.***	The ACT multidisciplinary staff individually plans and delivers services targeted to help clients 1) address the complex interaction between symptoms and psychosocial functioning, and 2) achieve personal goals. ***Accepted current practice interventions which are provided in assertive community treatment include: supportive counseling and psychotherapy, including cognitive behavioral therapy, personal therapy, and psychoeducation; integrated substance abuse and mental health treatment, including motivational enhancement therapy; evidence-based pharmacological treatment using practice guidelines (algorithms); supported employment; peer counseling and consultation; collaboration with families and family psychoeducation; and treatment of trauma and posttraumatic disorders.*** *The following services are identified with specific activities:* • *Service Coordination* • *Crisis Assessment and Intervention* • *Symptom Assessment and Management* • *Medication Prescription, Administration, Monitoring and Documentation* • *Dual Diagnosis Substance Abuse Services* • *Work-Related Services* • *Activities of Daily Living* • *Social/Interpersonal Relationship and Leisure-Time Skill Training* • *Peer Support Services* • *Support Services Support services or direct assistance to ensure that clients obtain the basic necessities of daily life ,including but not necessarily limited to: Medical and dental services, safe, clean, affordable housing., financial support and/or benefits counseling ,social service, transportation , legal advocacy and representation* • *Education*, **Support, and Consultation to Clients' Families and Other Major** *Supports*

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