Mercer

Government Human Services Consulting

Assertive Community Team Documentation

South Carolina

September 26, 2023

welcome to brighter

A business of Marsh McLennan

Contents

Mercer

Section 1

Assertive Community Treatment Documentation

All Assertive Community Treatment (ACT) Providers shall maintain a clinical record for each Medicaid-eligible beneficiary that fully describes the extent of the treatment services provided. The clinical record must contain documentation sufficient to justify Medicaid participation and should allow an individual not familiar with the beneficiary to evaluate the course of treatment. The absence of appropriate and complete records, as described below, may result in recoupment of payments by South Carolina Department of Health and Human Services (SCDHHS). An index as to how the clinical record is organized must be maintained and made available upon request. Each Provider shall have the responsibility of maintaining accurate, complete, and timely records, and ensure the confidentiality of the beneficiary's clinical record.

There are several types of meetings that are held by the ACT team for planning the care and intervention of the caseload served by the team. These meetings have specific documentation required, and these administrative tasks are part of the per diem rate that has been established for the ACT service. Documentation of these meetings should be available both for fidelity reviews and any post payment reviews that may be conducted by the payer of services rendered.

Medical Necessity

ACT services require prior authorization and shall be covered for a beneficiary 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. These illnesses more often cause long-term psychiatric disability. Beneficiaries with other psychiatric illnesses may be eligible depending on the level of the long-term disability from their mental illness. Documentation of need for the service must be completed on the SCDHHS prior authorization form for services. The Provider should include any additional information to support the request for services, including any applicable assessments or other documentation. Documentation that supports medical necessity may include, but not be limited to:

- Psychiatric evaluations and updates
- Biopsychosocial assessments and updates
- Inpatient hospital assessments and discharge summaries
- Referral and transfer documentation from lower levels of care (LOC)

Additional information may be requested if insufficient evidence of the beneficiary's need for ACT is provided. ACT providers should ensure that any documentation submitted to support

Mercer

medical necessity clearly meets the requirements identified above. Failure to demonstrate medical necessity can result in a delay in prior authorization approval.

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 beneficiary.

Beneficiaries ages 18–21 must meet medical necessity under Early and Periodic Screening, Diagnostic and Treatment. Beneficiaries with a primary diagnosis of a substance use disorder, intellectually/developmentally disabled, borderline personality disorder, and traumatic brain injury are not eligible for ACT.

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

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

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

- High use of acute psychiatric hospitalization (two or more admissions during the past 12 months) or psychiatric emergency services.
- Intractable (persistent or recurrent) severe psychiatric symptoms (e.g., affective, psychotic, suicidal, etc.).
- Coexisting mental health and substance use disorders of significant duration (more than six months).
- High risk or recent history of criminal justice involvement (e.g., detention, incarceration, probation, frequent contacts with law enforcement, etc.).
- Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness.
- Residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive

Mercer

services are provided or requiring a residential or institutional placement if more intensive services are not available.

- Difficulty effectively using traditional office-based outpatient services.

Assessment

Assessing a beneficiary for ACT services will be a combination of assessments from all the providers on their team, specific to their discipline. Each assessment must be conducted by a qualified clinical professional operating within one's scope of practice. The professional must be specifically trained to render and review the assessment tool to make a clinically appropriate diagnosis and treatment intervention to be incorporated into the Individual Plan of Care (IPOC). For example, a comprehensive assessment may include an assessment by the psychiatrist, a nursing assessment, a substance use assessment, a mental health assessment, and an employment assessment.

The content of each assessment should be a part of a holistic review of the beneficiary and their needs across the spectrum of ACT services. The comprehensive assessment should include a psychiatric and social functioning timeline that includes significant events in the beneficiary's life. Each assessment should follow the guidance included in the rehabilitative behavioral health services (RBHS) provider manual for each practitioner type and should not be billed independently, but rather would be a part of the overall ACT per diem rate. If all assessments were conducted on the same day, the ACT Team would bill on per diem for all activities.

Peer Support Specialists can consider using the Temple University Community Participation Measure (TUCPM), which is included in the Peer Facilitated Community Inclusion Toolkit. The TUCPM is a 26-item measure designed to help a beneficiary explore their community participation goals and was deigned to be facilitated by a Peer Support Specialist.

IPOC & IPOC Components

An IPOC must be completed for a beneficiary of ACT services. When a client is referred for ACT services and the referral source does not provide the IPOC, the ACT team must develop the IPOC. IPOC documentation must meet all SCDHHS requirements and include IPOC components as described in the RBHS provider manual in Section 2 on pages 2–57. The initial IPOC should be guided by the conclusions and recommendations from the initial assessment. All team members should participate in the development of the IPOC. Treatment of the beneficiary should be conducted in a coordinated care manner by the entire team, and the approach to treatment planning should be similar, with a coordinated and person-centered treatment plan. A sample IPOC can be found in Appendix B with a case scenario.

IPOC Team Meetings

These meetings occur after the comprehensive assessment is completed and focus on the development and updates to the IPOC. Meetings should be held with the beneficiary and occur as needed including issues that may arise, prior to discharge, and when a beneficiary goes through a transition. At minimum, the IPOC shall be reviewed and updated quarterly. A

Mercer

progress note should be included in the beneficiary's chart that includes meeting attendees and outcomes.

The agenda for these meetings may include:

- Orientation and review of ACT services
- Review of goals and revision of goals if needed
- A written summary describing the beneficiary and the ACT team's evaluation of the beneficiary's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last IPOC was written
- Discussion with the beneficiary regarding their treatment preferences
- Discussion of how the ACT team will reach recovery goals and treatment needs
- Revision of the IPOC as indicated

Transition Plan Documentation

ACT teams should formally assess beneficiaries' needs for ACT services at least once every six months. One potential tool to accomplish this is the ACT Transition Readiness Scale, a tool that establishes criteria to help determine whether a beneficiary is ready to be placed on a completion track to transition to a less intensive LOC. Any tool used for assessment of continued need should be included in documentation submitted for continued stay. A beneficiary may be placed within the completion track if they are assessed at a "1" or "2" on all the scaled items. See Appendix C for a sample ACT Transition Readiness Scale. Other tools may be used, but the same basic elements should be reviewed every six months. For more information on the ACT Transition Readiness Scale and how to rate from a "1" to a "5" please see The Assertive Community Treatment Transition Readiness Scale© User's Manual.

At a minimum, if another tool is used to assess the continued need for services, the elements that are considered should be:

- Housing Stability
- Treatment Participation
- Psychiatric Medication Adherence
- Psychiatric Hospitalizations/Crisis Management Episodes
- Forensic Involvement
- Substance Use Stage of Treatment
- High Risk Behaviors
- Activities of Daily Living
- Beneficiary Interest in Transitioning

Mercer

Clinical Service Notes

The Clinical Service Notes (CSNs) for each beneficiary served by the ACT Team should reflect the same information as required for other services by the same types of professionals in the RBHS manual. There is no separate template for an ACT note. Each intervention should be documented by the professional who conducted the intervention just as they would document any individual session or service. For team members that are not specified in the RBHS manual, each professional should still complete a CSN with the elements noted below.

A CSN is required for each contact or service, for each date of service, for each beneficiary, and must be written and signed by the qualified staff who provided the service. Every CSN must be individualized to reflect treatment/service and interventions with a specific beneficiary, for each date of service, for each service rendered to the beneficiary and/or family. If CSNs are not completed and maintained in accordance with the requirements in the RBHS manual, payments to the provider shall be subject to recoupment.

The CSN must include the following information:

- The beneficiary's name and Medicaid ID number.
- The date of service.
- The name of the intervention, such as individual therapy, medication management, or vocational rehabilitation.
- The date of service in a month, day, and year format.
- Document the start time and end time for each service delivered, not including any travel time.
- Location where the service was rendered.
- Be typed and/or handwritten — documentation must be legible.
- Be kept in chronological order.
- Abbreviations must be decipherable — if abbreviations are used, the Provider must maintain a list of abbreviations and their meanings, and the list must be made available to SCDHHS upon request.
- Be signed, credentialed or functional titled, and signature dated (month/date/year) by the qualified staff who provided the service. The signature verifies that the services were provided in accordance with these standards.
- Be completed and placed in the beneficiary's record immediately following the delivery of the service, but no later than five business days from the date of rendering the service.

Mercer

Each CSN must address the following items to provide a pertinent clinical description and to ensure that the ACT intervention conforms to the service description and authenticates the charges:

- The focus and/or reason for the session or interventions which should be related to treatment objective(s) and/or goal(s) on the IPOC, unless there is an unexpected event that needs to be addressed.
- The detailed summary of the interventions (e.g., action steps, tools used, techniques utilized, etc.) and involvement of qualified staff with the beneficiary and/or family during each contact or session/meeting.
- The individualized response of the beneficiary and/or beneficiary's family, as applicable, to the interventions and/or treatment rendered at each contact or session/meeting.
- The general progress of the beneficiary to include observations of their conditions/mental status. Progress should reflect detailed individualized information about the beneficiary over the course of treatment and shall not reflect general categories of progress or general statements of progress in treatment (e.g., Phrases such as "moderate" or "not making progress", without providing detailed information to support the identification of these will not meet this standard).
- The plan for working with the beneficiary. This should reflect the plan of action for the next and foreseeable future sessions/meetings with the beneficiary (e.g., statements such as "will continue to meet with person as per IPOC" will not meet this standard).

An example of documentation for an employment specialist can be found in Appendix A, with a corresponding case summary. A sample supervision note is also included. The supervision note should reflect the same principles as listed above, with a focus on the care coordination of the individual receiving treatment among staff members.

Crisis/Afterhours Documentation

ACT is a 24/7/365 service, and ACT staff must be available to address any crisis situations that may occur either via telephone, telehealth, or in person. Just as other CSNs should be completed the same way as they are required to be for other services in the RBHS manual, Crisis Management interventions must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

A CSN must be completed upon contact with the beneficiary and should include the following:

- Start time and stop time, as well as the duration, not including any travel time.
- Summary of the crisis or the symptoms that indicate the beneficiary is in a crisis.

Mercer

- Content of the session, including safety risk assessment and safety planning.
- Active participation and intervention of the staff.
- Response of the beneficiary to the treatment. Beneficiary's status at the end of the session.
- A plan for what will be worked on with the beneficiary.
- Resolution of the crisis.

Staff Meetings and Documentation

Staff Competencies, Services, and Supports

Training for ACT Providers should include both the required trainings documented in the RBHS manual as well as additional trainings specific to the provision of ACT. In addition, practitioners will be required to maintain continuing education trainings required for licensure, which will vary by profession. Guidance on professional licensure training can be found at the applicable professional licensure board, such as for social workers and psychiatrists.

For team trainings, a log of trainings should be maintained. Training records must indicate:

- The name of the training course
- The instructor's name and signature
- The training agency or on-line training resource
- The date(s) of the training
- The hours of the training
- Signed attestation for those in attendance (signatures must be legible)
- The outline and content of the training
- The completion of certification criteria, as applicable

Trainings required by SCDHHS before an ACT Team may begin providing services include:

- Confidentiality/Protected Health Information
- Beneficiary Rights
- Prohibition of Abuse, Neglect, & Exploitation
- Overview of Provider's Policy and Procedures
- Ethics & Professional Conduct
- Overview of Behavioral Health
- Health & Safety/Emergency Preparedness

Mercer

- Workplace Violence
- Cultural Competency/Diversity
- Fraud, Waste, & Abuse
- Overview of Service Documentation Expectations & Completion
- Medicaid Billing

Providers must ensure that all staff involved in the direct care of a beneficiary successfully complete a training program from a certified trainer in the use of restraints and seclusion prior to ordering or participating in any form of restraint.

Training should be aimed at minimizing the use of such measures, as well as ensuring the beneficiary's safety. For more information on selecting training models, review the Project Rest Manual of Recommended Practice, available at Project Rest Manual of Recommended Practice.

Additional Training recommended for ACT Teams specifically include the following:

- Benefits Counseling
- Cognitive Behavioral Therapy for Psychosis
- Culturally and Linguistically Appropriate Services
- Individual Placement and Support-Supported Employment (IPS-SE) evidence-based practices (EBP)
- Family Psychoeducation
- Functional Assessments and Psychiatric Rehabilitation
- Integrated Dual Disorders Treatment EBP
- Limited English Proficiency, Blind or Visually Impaired, and Deaf and Hard of Hearing Accommodations
- Medication Algorithms
- National Alliance on Mental Illness Psychoeducational Trainings
- Psychiatric Advanced Directives
- Recovery Oriented Systems of Care: Policy and Practice
- Social Security Income (SSI)/Social Security Disability Income Outreach, Access, and Recovery/Steppingstones to Recovery
- Permanent Supportive Housing EBP, such as the Substance Abuse and Mental Health Services Administration EBP Tool

Mercer

- The Pathway's Model to End Homelessness for People with Mental Illness and Addiction
- Evidence-based Models and Trauma Informed Care
- Wellness and Integrated Health Care, Wellness Management and Recovery Interventions

Daily Team Meetings

The ACT daily team meeting is a gathering of all scheduled ACT staff to facilitate team cohesiveness, team collaboration, and support recovery of beneficiaries with severe mental illness and co-occurring substance use disorders. The daily team meeting has two basic components: format and pace. The meeting format is simple.

All ACT team members discuss any contact they have had with a beneficiary or beneficiary's natural support, any interventions provided, and any response to interventions in the last 24 hours and planned in the next 24 hours. The team leader keeps the pace of the meeting by focusing on the roster of names of beneficiaries enrolled in ACT services. The team leader keeps the discussion focused on the 24-hour cycle. This close look at yesterday and today is very important. It helps keep the pace of the meeting.

Programmatic Monthly Report

On a monthly basis, the ACT team should produce a monthly report, which should include the following information:

- Team census
- Referral sources
- Beneficiary outcome data:
- ER visits
- Inpatient
- Law enforcement
- Employment
- School
- Homelessness
- Living arrangements
- Discharge dispositions
- Graduated
- Dropped out/refused/unable to locate

Mercer

Appendix A

Employment Specialist and Supervision Note

Case Study:

Brad is a 47-year-old white male who has a diagnosis of schizophrenia. He has been receiving ACT for two years, and this was the first time he had received ACT services. Since receiving ACT services, Brad has moved into his own apartment and just started dating. He worked closely with his psychiatrist and finally found medications that help him effectively manage his symptoms.

The current goals in Brad's treatment plan are:

- Keep living in my apartment
- Find a job I like
- Find fun things to do in my neighborhood, like pickle ball

Career Profile Activity Note:

Name: Brad X

Medicaid ID: #123456

Date of Service: August 21, 2023

Start Time: 10:00 AM

End Time: 11:30 AM

Intervention: Vocational Specialist Activity

Location: Client's Apartment

Today I met with Brad, and we discussed some of his options for employment as well as some of his concerns. Brad reads and writes at an 11th grade level and does have his GED. He physically can complete tasks like lift fifty pounds, walk with no limitations. He does utilize public transportation and lives near a bus stop. The bus transportation is reliable and goes to several nearby locations with potential employment opportunities. Brad is on SSI and is concerned that employment will impact his benefits.

Brad is good with people and would like to work with the public. He does not want to seek any kind of management position. He does not have a criminal history, which will assist in his obtaining employment. Brad appeared upbeat and excited about becoming employed and seeking opportunities. He appears to be ready to pursue active employment.

Brad and I worked on developing a resume and will continue to explore employment options. He will work on filling out applications for Target and Food Lion, both of which are located

Mercer

near his home, and we will review in our next session. I also referred Brad to the benefits specialist on the team to discuss his options, as he can retain his SSI while he is employed.

Kathy Nichols

Employment Success Specialist

August 21, 2023

Supervision Note:

Name: Kathy Nichols

ACT Role: Employment Success Specialist

Date: August 23, 2023

Start Time: 1:00 PM

End Time: 2:00 PM

Reviewed caseload currently assigned 12 beneficiaries. Six beneficiaries are currently working, three are actively searching and have submitted applications, two are in the process of completing their career profile, and one beneficiary has not returned calls/been available for appointments. Kathy indicates that she is providing on-site job supports for two beneficiaries, and four beneficiaries have requested off-site job supports.

Kathy indicated she's having difficulty keeping up with job development tasks as she has had to pick up more case management tasks due to staff being on leave.

Reviewed career profile and documentation in Brad X's chart, all reviewed documentation aligns with the IPS model.

Reviewed topics for next month's in-service. Kathy is assigned to lead and has prepared a 30-minute overview of zero exclusion. She selected this due to three new staff starting within the past two months and has observed during daily team meetings discussion around readiness to work.

ACT Team Lead to coordinate with other staff to ensure that Kathy is not assuming additional coverage that impacts her ability to complete job development tasks.

Stacy Smith, LCSW

Team Lead

August 23, 2023

Mercer

Appendix B

IPOC

Cecilia is a 30-year-old African American female, and she has a diagnosis of schizoaffective disorder, as well as a diagnosis of Marijuana Use. She currently lives in an adult care home and has lived there for the past five years. At the adult care home, staff does most daily living tasks (e.g., laundry, cooking, cleaning). Cecilia receives $60 a month, and she does not have direct access to the money. Cecilia has been identified as an eligible participant to move into independent living in the community, and she should have access to community behavioral health services that will help her succeed.

Beneficiary Identification:

Name: Cecilia Y.

Medicaid ID: 456789

Presenting Problem(s):

Lack of medication adherence – Cecilia does not take her medication daily as scheduled, leading to psychotic episodes requiring crisis intervention services.

Crisis interventions – Cecilia has had three crisis interventions in the past two months as she has been decompensating due to not taking her medication regularly. She has been able to deescalate and has been referred for partial hospitalization but has not been compliant with attendance.

Active substance use – Cecilia actively uses marijuana at least three times a week.

Lack of independent housing – Cecilia resides in an adult care home but has requested to transition to independent living.

Lack of independent living skills – Cecilia does not consistently maintain her personal hygiene or perform other tasks such as eating regularly without the supervision of staff. She also does not do her own laundry, cooking, or cleaning.

Need for vocational skills – Cecilia has expressed an interest in pursuing vocational skills and will require benefits counseling once stabilized.

Psychiatric Diagnosis(es):

Schizoaffective Disorder

Marijuana Use

Goals and Objectives:

Long term goal: “I want to have my own apartment, get a cat, and find a boyfriend.”

Mercer

Date	Problem	Short Term Goal	Objectives	Method and Frequency of Intervention	Timeframe for Completion
	Lack of adherence to medication	Cecilia will take all medication as prescribed.	Cecilia will take her medication daily with prompts. Cecilia will be able to verbalize why it is important to take her medications as prescribed. Cecilia will discuss with Registered Nurse (RN) and psychiatrist any side effects leading to non-adherence with medication.	Daily medication reminders from peer support specialist or RN. Medication management from psychiatrist and RN as needed, to include education and discussion of side effects.	Review in 90 days.
	Active marijuana use	Cecilia will maintain abstinence from marijuana.	Cecilia will attend two Narcotics Anonymous meetings a week. Cecilia will be able to verbalize three ways marijuana use impacts her mental health and community living skills.	Intervention by substance use specialist and peer support specialist as needed, with a minimum of weekly sessions for the first 90 days.	
	Lack of independent housing	Cecilia will obtain independent housing.	Cecilia will obtain all the necessary documents to apply for housing, such as her identification card/driver's license and background check. Cecilia will apply for three housing opportunities a week.	Mental Health Professional and Peer Support Professional interventions at least weekly.	

Mercer

Date	Problem	Short Term Goal	Objectives	Method and Frequency of Intervention	Timeframe for Completion
	Lack of independent living skills	Cecilia will develop independent living skills.	Cecilia will be able to do her own laundry once per week. Cecilia will shower daily. Cecilia will eat vegetables at least once per day.	Mental Health Professional and Peer Support Professional interventions at least weekly.	
	Lack of employment	Cecilia will begin to explore supported employment.	Cecilia will be able to identify three strengths. Cecilia will identify three areas where she might be interested in seeking employment, such as retail or working with animals.	Engagement with employment specialist for assessment and development of employment plan.	

Contact Information:

Emergency contacts:

Guardian: Lucy Jones (555)555-1111

Sister: Kelly Thomas (555)555-2222

Discharge Plan:

Upon discharge, Cecilia should be living independently, able to perform daily tasks of self-care, and be active in her community, either through employment, volunteer work, or other community engagement. She should be adherent to her medication and engaged in her physical and mental health care and follow up. She should be stable in her housing and other social determinant of health needs, including food security and access to transportation.

Cecilia should be assessed at the time of discharge for lower LOC needs, which may include outpatient services, psychosocial rehabilitation, or another form of support.

Mercer

Beneficiary Signature: Cecilia Y.

Provider Signature: Stacy S.

Mercer

Appendix C

ACT Transition Assessment Scale

Assessment Item	Score
Stable Housing: Client has been stably housed in the community for 12 months.	1
Treatment Participation: Participates independently and can access services.	1
Psychiatric Medication Use: Takes medication most of the time but may need some verbal assistance.	2
Psychiatric Hospitalization/crisis management: No psychiatric inpatient admissions, and no ER visits in past 12 months.	1
Forensic Involvement: Had no arrests and spent no days incarcerated in past 12 months.	1
Substance Use Stages of Treatment: Client has been in recovery for past 12 months.	1
High-risk Behaviors: No high-risk behaviors in at least the past year.	1
Activities of Daily Living: Able to perform self-care tasks (bathing, toileting, cooking, food shopping). Able to use public transportation independently, able to cook, and food shop for self.	1
Community Integration: Client works 20 hours a week and attends church weekly.	1
Consumer Interest/ Motivation: Client has agreed to a transition plan to outpatient care and has the necessary skills and supports to be successful after transitioning from ACT.	1

Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com