131st Legislature
Senate of Maine
Senate District 2

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LD 328, "An Act to Improve Mental Health in Maine"

Joint Standing Committee on Health and Human Services
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Senator Baldacci, Representative Meyer and Distinguished Members of the Joint Standing Committee on Health and Human Services

I am Senator Trey Stewart, and I represent District 2, which includes several communities in Aroostook County and Northern Penobscot County I am pleased to be here this morning to present to you LD 328, "*An Act to Improve Mental Health in Maine* "

As members of the Health and Human Services Committee, you are well aware of the mental health crisis our state faces Thank you for the long hours and hard work you all put in for the people of Maine

This proposal started as a concept draft, and I have attached the proposed amendment to my testimony LD 328 and the accompanying language ensures high-quality, evidence-based Assertive Community Treatment (ACT) services for Maine residents with psychotic disorders and high needs by aligning MaineCare regulations with the Dartmouth Assertive Community Treatment Scale fidelity items

The ACT model emphasizes a team-based approach, with a multidisciplinary team providing intensive, individualized services to clients in the community The Dartmouth ACT Scale is used to evaluate the degree to which an ACT program adheres to the model and identify areas where improvements may be needed The Dartmouth ACT Scale includes 144 items, which are organized into 10 domains, including team structure, client participation, and staff qualifications Overall, the Dartmouth ACT Scale is a useful tool for ensuring that ACT programs are providing high-quality, evidence-based services to individuals with severe and persistent mental illness

Maine's mental health continuum of care has faced a detrimental shortage of ACT due to stagnant rates Now, in large part due to the rate reform work of this Committee, the rates have improved That means providers can start increasing the availability of ACT However, in order to truly meet the fidelity of the ACT service, we must update the rules to ensure the most impact That is what this proposal does by aligning MaineCare regulations with the Dartmouth Assertive Community Treatment Scale fidelity items

Assertive Community Treatment (ACT) has been proven to be effective in improving outcomes for clients, reducing hospitalizations, and promoting recovery, however, many individuals still do not have access to this critical service Therefore, policies that increase access to ACT are essential to improving mental health outcomes for individuals and for the State of Maine as a whole

Thank you very much for your time and attention and I appreciate your thoughtful consideration of this proposal

An Act to Improve Mental Health in Maine

Be it enacted by the People of the State of Maine that the Section 17.04-3 of the MaineCare Benefits Manual is amended to read as follows:

17 04-3 **Assertive Community Treatment** Assertive Community Treatment (ACT) uses an integrated team of multi-disciplinary practitioners to provide individualized intensive, twenty-four (24) hours a day, seven (7) day a week, three hundred and sixty-five (365) days a year treatment for members with serious mental illness and high needs Services should be primarily community rather than office-based and include assertive interventions like street outreach to engage members who have struggled to maintain services Due to persistent member acuity connected with ACT eligibility criteria, ACT services should be viewed as time-unlimited and authorized for no-less than 12 months of service at a time ACT teams must average three meaningful contacts per member, per week, per calendar month when measured monthly across a client panel Members must receive at least one (1) meaningful contact per member, per week, to bill for services Meaningful contact includes

1 Face-to-face contact,

2 Telehealth according to the rules set forth in section 4 of the MaineCare Benefits Manual,

3 Assertive outreach and engagement including to meet medication services requirement in 17 04-4

4 Contact through a closed door

Programs are allowed to bill for a full week of service if the single meaningful contact requirement is met in the following scenarios

- The week of program intake or discharge,
- The week a member is admitted to or discharged from a hospital, crisis residential placement, or carceral facility

Average meaningful contacts = total meaningful contacts per calendar month across a client panel/total number of client weeks

Client weeks=the number of full weeks per month a client is enrolled in a program

Programs should not count the week of program intake or discharge, or the week of admission or discharge from a hospital, crisis placement, or carceral facility when calculating client weeks and average meaningful contacts per month

ACT Teams who fall below the monthly average of three contacts per member per week across a client panel for three months within a rolling twelve (12) month period must establish a corrective action plan with the department

17 04 **COVERED SERVICES** (cont)

ACT teams must assume clinical responsibility for all members on the team and must offer all of the following services and support

- Individual assessment and individual support plan development,
- Development and implementation of a comprehensive crisis management plan and provision of follow-up services, including emergency face-to-face contact, if necessary, to assure services are delivered and the crisis is resolved,
- Use and promotion of informal and natural supports to assist the member with integration in the community,
- Contacts with the member's parent, guardian, other family members, and providers of services or natural supports, as appropriate, to ensure continuity of care and coordination of services within and between inpatient and community settings,
- Individual, group and family outpatient therapy, supportive counseling or problem-solving activities in order to maintain and support the member's
- recovery and provide the support necessary to help the member manage the
- symptoms of the member's illness and co-occurring substance use disorder,
- Linking and evaluating the efficacy of services and natural supports, and formulating changes to the individual support plan as necessary,
- Medication services, including medication management and administration, which minimally includes

    1) one (1) face-to-face contact per month with the psychiatrist, or a psychiatric and mental health nurse practitioner (NP) If assertive outreach is used to meet this requirement it must be clearly documented in the member record

    2) capacity to administer medications daily in a member's home or community by an appropriately licensed or certified ACT team professional

- Employment assistance including facilitating formal and informal opportunities for career exploration and assisting the member in obtaining and maintaining competitive employment, and
- Housing assistance

A The minimum overall staffing ratio for an ACT team is one (1) staff person to ten (10) members Administrative staff are excluded from calculation of the staffing ratio ACT team staff must include,

17 04 **COVERED SERVICES** (cont)

1 a Team Leader, who may be one of the staff listed below but must be an independently licensed professional The team leader must spend at least twenty five percent (25%) of his or her work hours providing direct service to the members The team leader must be at least one (1 0) FTE (full time equivalent),

2 a psychiatrist or a psychiatric and mental health clinical nurse specialist (CNS), or a psychiatric and mental health nurse practitioner (NP), who is at least one-half (5) FTE for every fifty (50) members and provides clinical leadership to the team in conjunction with the Team Leader,

3 a registered nurse or licensed practical nurse, who is at least one (1 0) FTE for every fifty (50) members,

5 a certified rehabilitation counselor or employment specialist, who spends at least ninety percent (90%) of his or her time on employment related activities and who is at least one (1 0) FTE for every fifty (50) members,

6 a Certified Intentional Peer Support Specialist (CIPSS),

Certified Intentional Peer Support Specialist (CIPSS) – (for adult services) is an individual who has completed the Maine Office of Behavioral Health (OBH) curriculum for CIPSS, and receives and maintains that certification

The CIPSS is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with BHH members

Peer support staff may function as a CIPSS without CIPSS certification for the first nine (9) months of functioning as a CIPSS, but may not continue functioning as a CIPSS beyond nine (9) months without (a) having received provisional certification by completion of the Core training, and (b) continuing pursuit of full certification as a CIPSS and maintaining certification as an Intentional Peer Support Specialist according to requirements as defined by SAMHS

The CIPSS shall coordinate and provide access to Peer Support Services, peer advocacy groups, and other peer-run or peer-centered services, maintain updated information on area peer services, and shall assist the member with identifying and developing natural support systems

7 a substance use disorder counselor who is at least one-half (5) FTE for every fifty (50) members

B Multidisciplinary teams **may also** include any of the following,

1 a licensed occupational therapist,

2 an MHRT/C,

3 a licensed psychologist,

4 a conditional or fully licensed social worker, clinical professional counselor, or marriage and family therapist,

5 A certified medical assistant

SUMMARY

This bill brings MaineCare regulations into alignment with Dartmouth Assertive Community Treatment Scale fidelity items, ensuring high-quality, evidence based Assertive Community Treatment (ACT) services for Maine residents with psychotic disorders and high needs