Alliance for Addiction and Mental Health Services, Maine
The unified voice for Maine's community behavioral health providers
Malory Otteson Shaughnessy, Executive Director

Testimony in support of LD 582

Resolve, To Support the Fidelity and Sustainability of Assertive Community Treatment

Sponsored by Representative Colleen Madigan
April 15, 2021

Good afternoon Senator Claxton, Representative Meyers, and members of the Joint Standing Committee on Health and Human Services. I am Malory Shaughnessy, a resident of Westbrook, and Executive Director of the Alliance for Addiction and Mental Health Services.

We offer our thanks to Representative Madigan for submitting this legislation, and I am here on behalf of the Alliance to speak **in support of** LD 582, **Resolve, To Support the Fidelity and Sustainability of Assertive Community Treatment.**

Within the Alliance membership, we have all but one provider of this service in the entire state of Maine, so this is a service that we discuss regularly. Assertive Community Treatment (ACT) is an evidence-based practice that improves outcomes for people with severe mental illness who are most at-risk of psychiatric crisis, hospitalization, homelessness, and involvement in the criminal justice system. ACT is one of the oldest and most widely researched evidence-based practices in behavioral healthcare for people with severe mental illness. **As an evidence-based practice, providing this service takes an added level of documentation and adherence to fidelity of the model (DACTS Fidelity Scale) for it to be most effective**.

ACT services are provided by a multi-disciplinary team of practitioners and are available twenty-four hours a day. The team is made up at a minimum of a Team Leader who must be an independently licensed professional, a psychiatrist (or a psychiatric and mental health clinical nurse specialist, or a psychiatric and mental health nurse practitioner), a registered nurse, a certified rehabilitation counselor or employment specialist, a Certified Intentional Peer Support Specialist and a substance use counselor. They may also include a psychologist, licensed clinical social worker or licensed professional counselor.

This legislation makes a few changes to this team makeup. It creates a clear definition of "medical assistant" and "psychiatric provider" to allow for more flexibility while still adhering to evidence-based criteria.

This team is very extensive. All of which are professionals, likely have some student loans, receive benefits, and need a wage that is competitive -- or they will move to another position that does pay a competitive wage and has competitive benefits.

In March of 2019, **this HHS committee gave a majority Ought to Pass to LD 1135**, sending it to the House and Senate, **where it received a majority vote to pass to engrossment**. LD 1135 was a similar bill to this one before you today, it made a few improvements to the ACT services and also called for a 25% reimbursement rate increase. It was held over on the Appropriations table to the second session of the Biennium – **where sadly it died on the Appropriations table when the legislature shut down on March 17th, 2020 due to the Covid Pandemic**.

Here we are two years later from this initial passage and admission that this service needed increased rates. **In these two years, other providers of these services have ended their programs, and we have lost two ACT teams in the Portland area alone**, sending many clients with serious mental illness to be absorbed by other providers, creating disruption and some loss of access.

The department has stated that there needs to be some methodology for any increases. Well, the dollar had an average inflation rate of 1.92% per year between 2005 and today, producing a cumulative price increase of 35.63%. **The reimbursement rate for ACT services has not increased appreciably since 2005. That was over 15 years ago**. A 25% increase today is on the low side if using inflationary factors as methodology.

The Department's Comprehensive Rate Setting Evaluation recommends that the Department conduct a rate study to develop new rates as a high priority across the entire spectrum of behavioral health policy (Section 17 being one of these). **We are saying this need to happen sooner than later.**

Section 5-2 allows individuals to receive services as long as medically necessary, whereas currently there seems to be an informal 5-year maximum service length.

Section 5-3 provides for an initial authorization of one year, and then renewal authorizations annually. Currently it is a 90-day reauthorization period – this for a serious and persistent mental illness. Really? This is uncalled for and an administrative burden.

Section 5-4 would allow for reimbursement for documented efforts to coordinate care if the client does have to be temporarily admitted to a hospital, ends up in jail, or transitions to lower levels of care. This coordination of care and "following the client" is integral to the fidelity of the model of care.

Section 5-6 is aimed at ensuring that medical eligibility to receive services under the program reflects an evidence-based understanding of the diagnoses and circumstances in which ACT is most effective. This service has many times been used as a catch-all for mental health diagnoses that are not actually evidence based to succeed in this service due to there being no other more intensive outpatient mental health services in Maine to meet the higher needs of some patients. With the implementation of a series of new Intensive Outpatient services for mental health diagnoses, this practice should end. A great eligibility guideline is available from Case Western. The Alliance does not often advocate for a reduction in eligibility, but ACT is truly geared to those with Schizophrenia Spectrum; Bipolar Spectrum with Psychosis; or Major Depressive Disorder with Psychosis.

The bill also requires the department to conduct a study to transition to a per member, per month payment model, reforming the criteria and operation of the program to ensure its fidelity to the evidence-based model. Under this per member per month (PMPM) rate, ACT teams would meet with clients an average of three times per week over the course of the new authorization period of one year. Sometimes with more intensity as needed, and then at times allowing for some space for the client to acclimate to newly found stabilization. These contacts would include face to face contact, contact through a closed door, and outreach attempts at the home and in the community.

Medical best practice or evidence-based measures as relates to physical health conditions such as cancer, heart disease, or diabetes are rarely questioned. We should not question supporting fidelity to a proven model of care for severe mental illness either.

There are years of research that show that this service has a very good return on the investment in not only dollars saved through avoidance of incarceration and hospitalizations, but in lives saved, circumstances enhanced, and communities improved.

We need you to give this legislation an Ought to Pass vote and make sure we do not lose access to these critical services. Thank you and I am happy to answer any questions you may have.

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*With 35 members, the **Alliance** is the state association for Maine's community based mental health and substance use treatment providers. The **Alliance** advocates for the implementation of sound policies and evidence-based practices that serve to enhance the quality and effectiveness of our behavioral health care system. All Mainers should have full access to the continuum of recovery-oriented systems of care for mental illness and substance use disorder – from prevention through treatment and into peer recovery support.*

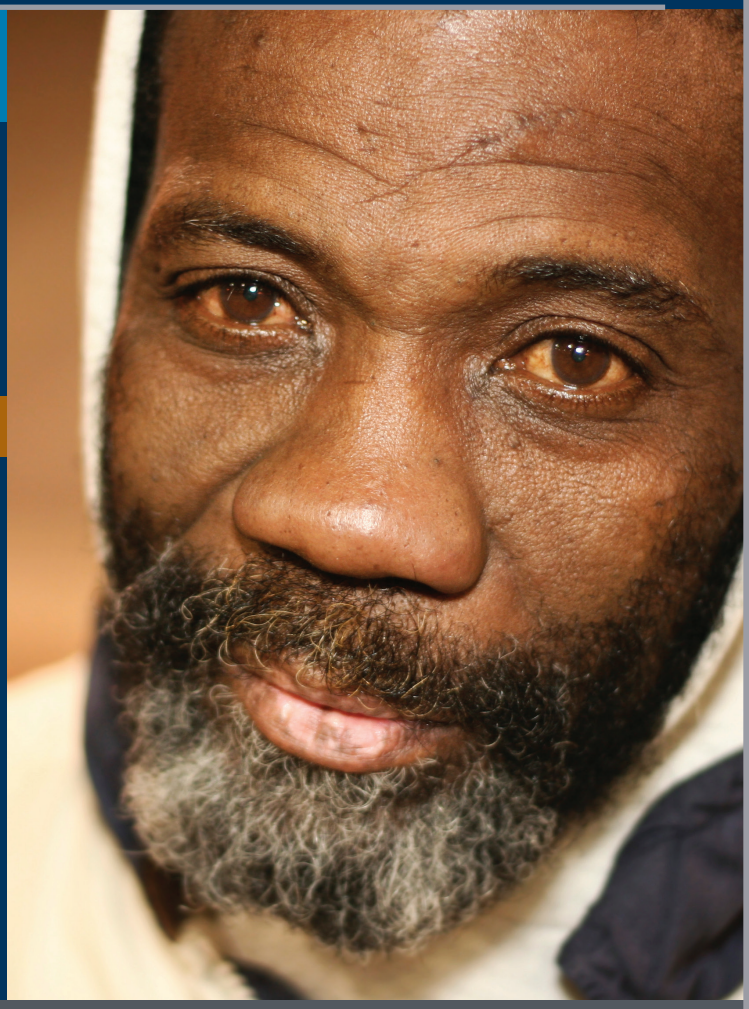
ACT ASSERTIVE COMMUNITY TREATMENT

the evidence-based practice

MAKING THE CASE

Assertive Community Treatment (ACT) is an evidence-based practice that improves outcomes for people with severe mental illness who are most at-risk of

- Homelessness
- Psychiatric hospitalization
- Institutional recidivism



Recovery Relationships

ACT services are delivered by a multidisciplinary team of providers who conduct assertive outreach in the community.

Team members develop consistent, caring, person-centered relationships with clients. These relationships have a positive impact on outcomes and quality of life.

People who receive ACT services tend to utilize fewer intensive, high-cost services such as emergency department visits, psychiatric crisis services, and psychiatric hospitalization. They also experience more independent living and higher rates of treatment retention.

CENTER FOR EVIDENCE-BASED PRACTICES

& its Ohio Assertive Community Treatment Coordinating Center of Excellence

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ASSERTIVE COMMUNITY TREATMENT

the evidence-based practice

OUTCOMES[1]

Assertive Community Treatment (ACT) began over 40 years ago and has been studied widely. Research shows that ACT has consistent, positive effects upon individuals who have the most severe symptoms and experience the greatest impairment. ACT consistently

- Reduces hospitalization
- Increases housing stability
- Improves quality of life

Importance of Fidelity[2]

Research also shows that fidelity to the ACT model has a positive effect upon hospitalization rates. People with mental illness who receive services from ACT teams that achieve higher levels of fidelity to the model tend to experience a greater reduction in hospital days.

SYSTEMS CHANGE

ACT services implemented by your organization will likely have a positive impact upon outcomes and costs in other systems in your community. Therefore, it is important to communicate this. Consultants from our Center will work with you to engage key stakeholders from the beginning of the implementation process.

Other organizations and systems that will likely experience improved outcomes and reduced costs because of your ACT services include the following:

- Courts
- Hospitals
- Local mental health authorities
- Managed care companies

INTEGRATED TREATMENT

ACT is a person-centered, recovery-based model that is often integrated with other evidenced-based practices and best practices, including

- Integrated Dual Disorder Treatment (IDDT)
- Supported Employment/ Individual Placement and Support (SE/IPS)
- Illness Management and Recovery (IMR)
- Family Psychoeducation

Integrated Dual Disorder Treatment (IDDT) is an evidence-based practice for people with co-occurring severe mental illness and addiction to alcohol and other drugs. The integration of ACT and IDDT is increasingly popular and effective. Research shows that individuals who receive integrated ACT-IDDT services experience a reduction in mental-health symptom severity and frequency of mental health problems. There are also significant improvements in their housing status.[3]

CONSULTING & TRAINING

Our Center provides technical assistance (consulting, training, and evaluation) to mental health organizations in Ohio and other states across the country that are providing ACT services, plan to implement ACT services, and wish to integrate ACT with IDDT. Our Center also provides technical assistance for ACT and integrated ACT-IDDT in the Netherlands.

STATE OF OHIO

Our Center provides technical-assistance services for ACT and ACT-IDDT to behavioral healthcare organizations in Ohio through our ACT Coordinating Center of Excellence (CCOE) initiative, which is supported by the Ohio Department of Mental Health and Addiction Services (OhioMHAS).

RECOMMENDED READING

1. Phillips, S.D., Burns, B.J., Edgar, E.R., Mueser, K.T., Linkins, K.W., Rosenheck, R.A., Drake, R.E., & McDonel Herr, E.C. (2001). Moving Assertive Community Treatment into standard practice. *Psychiatric Services,* 52(6), 771-9.
2. Latimer, E. (1999). Economic impacts of Assertive Community Treatment: A review of the literature. *Canadian Journal of Psychiatry*, 44, 443-454.
3. Young, S.M., Barrett, B., Engelhardt, M.A., & Moore, K.A. (2014). Six-month outcomes of an Integrated Assertive Community Treatment Team serving adults with complex behavioral health and housing needs. *Community Mental Health*, 50: 474-9.

Visit our website for more information: www.centerforebp.case.edu/practices/act

Implement and integrate behavioral healthcare innovations

v:2014-10.01

The **Center for Evidence-Based Practices at Case Western Reserve University** is a partnership between the **Jack, Joseph and Morton Mandel School of Applied Social Sciences** and the **Department of Psychiatry at the Case Western Reserve School of Medicine**. The partnership is in collaboration with and supported by the **Ohio Department of Mental Health and Addiction Services (OhioMHAS)**.

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Ohio Medicaid ACT Eligibility Criteria:

Based on OAC 5160-27-04: Mental Health Assertive Community Treatment Service (current draft – 8/29/2017). CEBP added notes in text boxes with examples or possible sources of information/documentation as to whether the recipient meets that criterion or not.

(F) A medicaid recipient is eligible to receive ACT when determined… to have met all of the following:

1) **Diagnosis(es):**
   - **<u>Eligible diagnoses:</u>** Schizophrenia Spectrum; Bipolar Spectrum; Major Depressive Disorder with Psychosis, and

<u>Examples or possible sources:</u> Hospital Discharge Summaries; Diagnostic Assessment; Social Security Disability Determination letter; Provider-developed ACT Referral form

2) **The recipient has:**
   - **Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI) determination or**

   - **Adult Needs and Strengths Assessment (ANSA)**
     <u>Eligible scores:</u>
     - Score of two or greater on at least one of the items in the *"Mental Health Needs"* or *"Risk Behaviors"* sections or
     - Score of three on at least one of the items in the "*Life Domain Function*" section, and

<u>Source:</u> Verification in disability system; Social Security Disability Determination letter ANSA rating sheet

3) **Institutional Utilization and other functional criteria** – The recipient has one or more of the following:

(a) Two or more admissions to a psychiatric inpatient hospital setting during the past twelve months, or
(b) Two or more occasions of utilizing psychiatric emergency services during the past twelve months, or
(c) Significant difficulty meeting basic survival needs within the last twenty-four months, or
(d) History within the past two years of criminal justice involvement including but not limited to arrest, incarceration, or probation, and

Examples or possible sources:

- **Psychiatric inpatient:** State or psychiatric hospital or psychiatric unit admission and discharge dates; Hospital Discharge Summaries.
- **Psychiatric emergency services:** hospital emergency department (whether or not admitted); mobile crisis encounter; crisis intervention encounter; stay at crisis residential unit.
- **Difficulty meeting basic survival needs:**
  - Substandard housing: house known to be drug trafficking/use house; infested with pests; lack of working utilities, plumbing, and/or HVAC; in area that compromises person's safety; cardboard box under a bridge.
  - Homelessness: literal homelessness (e.g. streets, park bench, under bridge); shelters; lack of permanent residence (e.g. couch surfing).
  - Imminent risk of homeless: landlord has threatened eviction; family is moving out of area; family refusing to continue housing the person; neighbors have called police at least twice complaining of client behavior; has exhausted all available system/community housing resources, supports; has been banned from housing resources/supports.
  - Person has "moved" more than twice in the last 12 months.
  - Other examples: too paranoid to go to grocery store; not eating regularly; inappropriate dress for the weather; lacking safe cooking skills; inability to pay utilities on time to keep them connected.

- Sources: DA; progress notes or psychiatric prescriber notes; hospital admission notes; crisis encounter notes
- **Criminal Justice involvement:** names, dates, correctional facility(ies) and/or charges; date of start and end of probation or parole; NGRI status; NCST status
- Provider-developed ACT Referral form
- Provider-developed ACT Assessment form

- ANSA rating sheet:
    - Life Domain Functioning: 1 or higher on Residential Stability; 2 or higher on Legal or Medication Compliance; or 3 or higher on Sexuality or Self-Care
    - Mental Health Needs: 2 or higher on any item
    - Risk Behaviors: 2 or higher on any item except Gambling

4) The recipient experiences one or more of the following:

a. Persistent or recurrent severe psychiatric symptoms, or
b. Coexisting substance use disorder of more than six month in duration, or
c. Residing in an inpatient or supervised residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or
d. At risk of psychiatric hospitalization, institutional or supervised residential placement if more intensive services are not available or,
e. Has been unsuccessful in using traditional office-based outpatient services; and

Examples or possible sources:

- **Persistent or recurring symptoms:** acute and chronic affective or psychotic symptoms (see slides with lists of symptoms); suicidal ideation or attempt in last 12 months
- **Substance use disorder:** hospital discharge summaries; diagnostic assessment; ANSA Mental Health Needs "Substance Use" score of 2 or greater

- **Residing in an inpatient or supervised residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided:** person is currently residing in inpatient or supervised residence (e.g. group home, family care home, other residential treatment or setting where formal services are provided); person requests move to independent living situation (though assessed to need more supports to be safe/successful); has received a PASS-R recommendation to move into lesser restrictive setting (or other formal assessment that demonstrates the person is not in an appropriate level of care – due to lack of better options).
- **At risk of psychiatric hospitalization, institutional or supervised residential placement if more intensive services are not available:** alcohol or other drug use (with or without diagnosis) has adversely impacted functioning, housing, community tenure, ability to care for needs, or has resulted in hospitalization, exacerbation of symptoms, and/or interfered with treatment engagement. Threatening behavior. Discontinues medications against medical advice. "Nuisance to community", vagrancy or loitering.
- **Unsuccessful in using traditional office-based outpatient services:** has been terminated from less intensive services for non-adherence or not keeping appointments; history of not keeping appointments and/or not engaging in treatment; has been banned from premises for inappropriate behaviors; has "fired" previous service providers; transient.
- Provider-developed ACT Referral form
- Provider-developed ACT Assessment form
- ANSA rating sheet:
    - Mental Health Needs: 2 or higher on any item
    - Risk Behaviors: 2 or higher on any item except Gambling
    - Life Domain Functioning: 1 or higher on Residential Stability; 2 or higher on Legal or Medication Compliance; or 3 or higher on Sexuality or Self-Care

And

5) **The recipient is eighteen years of age or older at the time of ACT enrollment.**