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Western Interstate Commission
For Higher Education

Behavioral Health Program

South Dakota Quality Assurance Scale:

Assertive Community Treatment Fidelity and Rural Considerations

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Outline for Today

- Brief Overview of ACT
- ACT fidelity tools
- Challenges of rural ACT
- Adapting ACT for rural implementation
- Overview of South Dakota Quality Assurance Scale

Assertive Community Treatment (ACT)

- Community-based program for adults with serious (and persistent) mental illness
- Focus on independent living, employment and community tenure with assertive outreach
- “Team” staff approach
- Designated as an EBP

Research Support

- Effective at reducing hospital use and increasing community tenure.[1]
- Many practice guidelines endorse it as an evidence-based practice for the treatment of schizophrenia.[2]
- Improvements in stable housing, symptom management, and quality of life.[1]
- Especially effective and cost-effective for clients who returned repeatedly to psychiatric hospitals.[3]
- Extensions to homeless clients with SMI aimed at reducing homelessness are also generally effective, especially when integrated with evidence-based housing models.[4]

[1]Bond, G.R., Drake, R.E., Mueser, K.T. & Latimer, E. (2001). Assertive Community Treatment for people with Severe Mental Illness: Critical Ingredients and Impact on Patients. Dis-Manage-Health-Outcomes, 9, 141-159. https://doi.org/10.2165/00115677-200109030-00003.
[2]Dixon LB, Dickerson F, Bellack AS, et al. (2010). The 2009 Schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophr Bull, 36*, 48–70. doi: 10.1093/schbul/sbp115.
[3]Dieterich M, Irving CB, Park B, et al. (2010). Intensive case management for people with severe mental illness. *Cochrane Database Syst Rev, 10,* 1-248. doi: 10.1002/14651858.CD007906.pub2.
[4]Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis. *American Journal of Public Health*, *94*(4), 651–656.

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ACT Guidelines

- Small Caseload (consumer/provider ratio of 1:10)
- Community-Based Services
- Team Approach
- Frequent Program Meetings
- Practicing Team Leader (direct services)
- Full Staffing with Continuity
- Psychiatrist (1 FTE per 100 consumers)

ACT Guidelines, Cont'd…

- Minimum of 2 Nurses per 100 Consumers
- Minimum of 2 Substance Abuse Staff per 100 Consumers
- Minimum of 2 Vocational Staff per 100 Consumers
- Program Size: Sufficient to consistently provide the necessary staffing diversity and coverage

More About Staffing…

- Psychiatrist (can be part-time)
- Team Leader
- Nurse(s)
- Peer Staff
- Specialists: Vocational & Substance Abuse
- Social Workers/Counselors (Masters level)
- Paraprofessionals – Community Partners

ACT Treatment Responsibilities

- Full Responsibility for Individualized Treatment Services – case management, psychiatric services, counseling, housing support, substance abuse treatment, and employment/rehabilitation services
- Community-Based Services
- Crisis Services (24/7)
- Hospital Admissions
- Hospital Discharge Planning – Continuity of Care
- Time Unlimited/Indefinite Services

Anticipated ACT Outcomes

- Increased Independent Living – decreased homelessness
- Improved Employment Status
- Decreased Substance Use
- Decreased Hospitalization Days
- Enhanced Quality of Life, Increased Socialization, Reduced Symptom Severity/Distress
- Targeted Programs may Decrease Incarceration Days
- Increased Staff Morale and Retention

ACT Fidelity Tools

Dartmouth Assertive Community Treatment Scale (DACTS)

ACT Fidelity Scale

Human resources: Structure and composition

Criterion	Ratings / Anchors				
	1	2	3	4	5
H1 Small caseload: Consumer/provider ratio = 10:1	50 consumers/team member or more	35 – 49	21 – 34	11 – 20	10 consumers/team member or fewer
H2 Team approach: Provider group functions as team rather than as individual ACT team members; ACT team members know and work with all consumers	Less than 10% consumers with multiple team face-to-face contacts in reporting 2-week period	10 – 36%	37 – 63%	64 – 89%	90% or more consumers have face-to-face contact with >1 staff member in 2 weeks
H3 Program meeting: Meets often to plan and review services for each consumer	Service-planning for each consumer usually 1x/month or less	At least 2x/month but less often than 1x/week	At least 1x/week but less than 2x/week	At least 2x/week but less than 4x/ week	Meets at least 4 days/ week and reviews each consumer each time, even if only briefly
H4 Practicing ACT leader: Supervisor of Frontline ACT team members provides direct services	Supervisor provides no services	Supervisor provides services on rare occasions as backup	Supervisor provides services routinely as backup or less than 25% of the time	Supervisor normally provides services between 25% and 50% time	Supervisor provides services at least 50% time
H5 Continuity of staffing: Keeps same staffing over time	Greater than 80% turnover in 2 years	60 – 80% turnover in 2 years	40 – 59% turnover in 2 years	20 – 39% turnover in 2 years	Less than 20% turnover in 2 years
H6 Staff capacity: Operates at full staffing	Operated at less than 50% staffing in past 12 months	50 – 64%	65 – 79%	80 – 94%	Operated at 95% or more of full staffing in past 12 months
H7 Psychiatrist on team: At least 1 full-time psychiatrist for 100 consumers works with program	Less than .10 FTE regular psychiatrist for 100 consumers	.10 – .39 FTE for 100 consumers	.40 – .69 FTE for 100 consumers	.70 – .99 FTE for 100 consumers	At least 1 full-time psychiatrist assigned directly to 100- consumer program
H8 Nurse on team: At least 2 full-time nurses assigned for a 100-consumer program	Less than .20 FTE regular nurse for 100 consumers	.20 – .79 FTE for 100 consumers	.80 – 1.39 FTE for 100 consumers	1.40 – 1.99 FTE for 100 consumers	2 full-time nurses or more are members for 100-consumer program

DACTS

- Also called SAMHSA ACT Fidelity Scale.
- Recommended in the SAMHSA Evidence-Based Practices Assertive Community Treatment KIT.
- One of the longest histories of any quality assurance measure[1]
  - Undergone extensive psychometric testing.
  - Demonstrated discriminant and predictive validity
  - Widely adopted by many State and local agencies throughout the United States and internationally.
  - Found to differentiate between established ACT teams, as monitored and trained by ACT trainers, and other types of intensive case management and brokered case management[1]
- Regarding predictive validity, several studies using precursors to the ACT Fidelity Scale have found strong correlations between ACT fidelity and consumer outcomes.[2,3,4]

[1]Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry, 68*(2), 216-232.
http://dx.doi.org/10.1037/h0080331
[2]Latimer, E. (1999). Economic impacts of assertive community treatment: A review of the literature. Canadian Journal of Psychiatry, 44, 443–54.
[3]McGrew, J.H., Bond, G.R., Dietzen, L.L. (1994). Measuring the fidelity of implementation of a mental health program model. Journal of Consulting and Clinical Psychology, 62, 670-678.
[4]McHugo, G. J., Drake, R. E., Teague, G. B., & Xie, H. (1999). Fidelity to assertive community treatment and client outcomes in the New Hampshire Dual Disorders Study. Psychiatric Services, 50, 818–824.

DACTS continued

- 28 program-specific items.
  - Each item is rated on a 5-point scale ranging from 1 (“not implemented”) to 5 (“fully implemented”).
- DACTS items fall into three subscales:
  - (1) Human Resources;
  - (2) Organizational Boundaries;
  - (3) Nature of Services.

Tool for Measurement of Assertive Community Treatment (TMACT)

ITEM		RATINGS / ANCHORS				
		(1)	(2)	(3)	(4)	(5)
Person-Centered Planning & Practices (PP) Subscale						
PP1	STRENGTHS INFORM TREATMENT PLAN: 1) The team is oriented toward consumers' strengths and resources, and 2) consumers' strengths and resources inform treatment planning development.	Strengths are not assessed (No Criteria #1 or #2).	Team variably attends to consumers' strengths and resources, and strengths/resources do not inform planning (Partial #1 only).	Team is clearly attentive to consumers' strengths and resources, documenting such in plans, but consumers' strengths and resources do not typically inform plan development (Full #1 and No credit #2) OR Team is variably attentive to strengths and uses this information to inform plans, but less systematically (Partial #1 and Partial #2).	Team is clearly attentive to consumers' strengths and resources, documenting such in plans, and consumers' strengths and resources informed plan development for some (Full #1 and Partial #2).	Team is highly attentive to consumers' strengths and resources, and gathers such information for the purpose of treatment planning (Full #1 and Full #2).
PP2	PERSON-CENTERED PLANNING : The team conducts treatment planning according to the ACT model, using a person-centered approach, including: (1) development of formative treatment plan ideas based on initial inquiry and discussion with the consumer (prior to the formal treatment planning meeting); (2) conducting regularly scheduled treatment planning meetings; (3) attendance by key staff, the consumer, and anyone else s/he prefers (e.g., family), tailoring number of participants to fit with the consumer's preferences; (4) meeting driven by the consumer's goals and preferences; and (5) provision of guidance and support to promote self-direction and leadership within the meeting, as needed. For teams that use an Individual Treatment Team (ITT), treatment planning meetings should include members from this group.	No more than 1 element of person-centered planning OR 2 elements provided, but both are not fully provided.	2 elements of person-centered planning are FULLY provided OR 3 elements are provided at least PARTIALLY.	4 elements of person-centered planning provided (i.e., 1 absent) OR provides 5 elements, with 3 or more PARTIALLY provided.	ALL 5 elements of person-centered planning are met, with up to 2 PARTIALLY provided.	ALL 5 elements of person-centered planning are FULLY provided (see under definition).
PP3	INTERVENTIONS TARGET A BROAD RANGE OF LIFE DOMAINS: The team attends to a range of life domains (e.g., physical health, employment/education, housing satisfaction, legal problems) when planning and implementing interventions. (1) The team specifies interventions that target a range of life domains in treatment plans and (2) these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to consumers' needs.	The team does not plan for and/or deliver interventions that reflect a breadth of life domains.	Team minimally plans for and/or delivers interventions that reflect life domains (PARTIAL credit for one criterion only) OR Team plans for but does not deliver a breadth of services (Full #1 only).	Team plans for and delivers interventions that reflect a breadth of life domains, but less systematically (PARTIAL #1 and PARTIAL #2) OR a larger breadth of services are planned for, but not in turn delivered (FULL #1 and PARTIAL #2).	Team delivers interventions that reflect a range of life domains to all consumers (FULL #2), but interventions targeting a breadth of life domains are not systematically specified in treatment plans (PARTIAL #1) OR FULL #1, but lacking Symmetry—see under definition).	Team specifies interventions that target a range of life domains in treatment plans and these interventions are carried out in practice (FULL criteria #1 and #2 with Symmetry - see under definition).

TMACT

- Based on DACTS
  - Differences variously reflect important but previously omitted features of ACT, refinements in measurement, and evolution of the model.
- More sensitive to change[1]
  - More nuanced measure of ACT program fidelity and sets a higher bar for ACT program performance.
- Higher fidelity scores on the TMACT were associated with reductions in state hospital and acute crisis unit stays.[2]

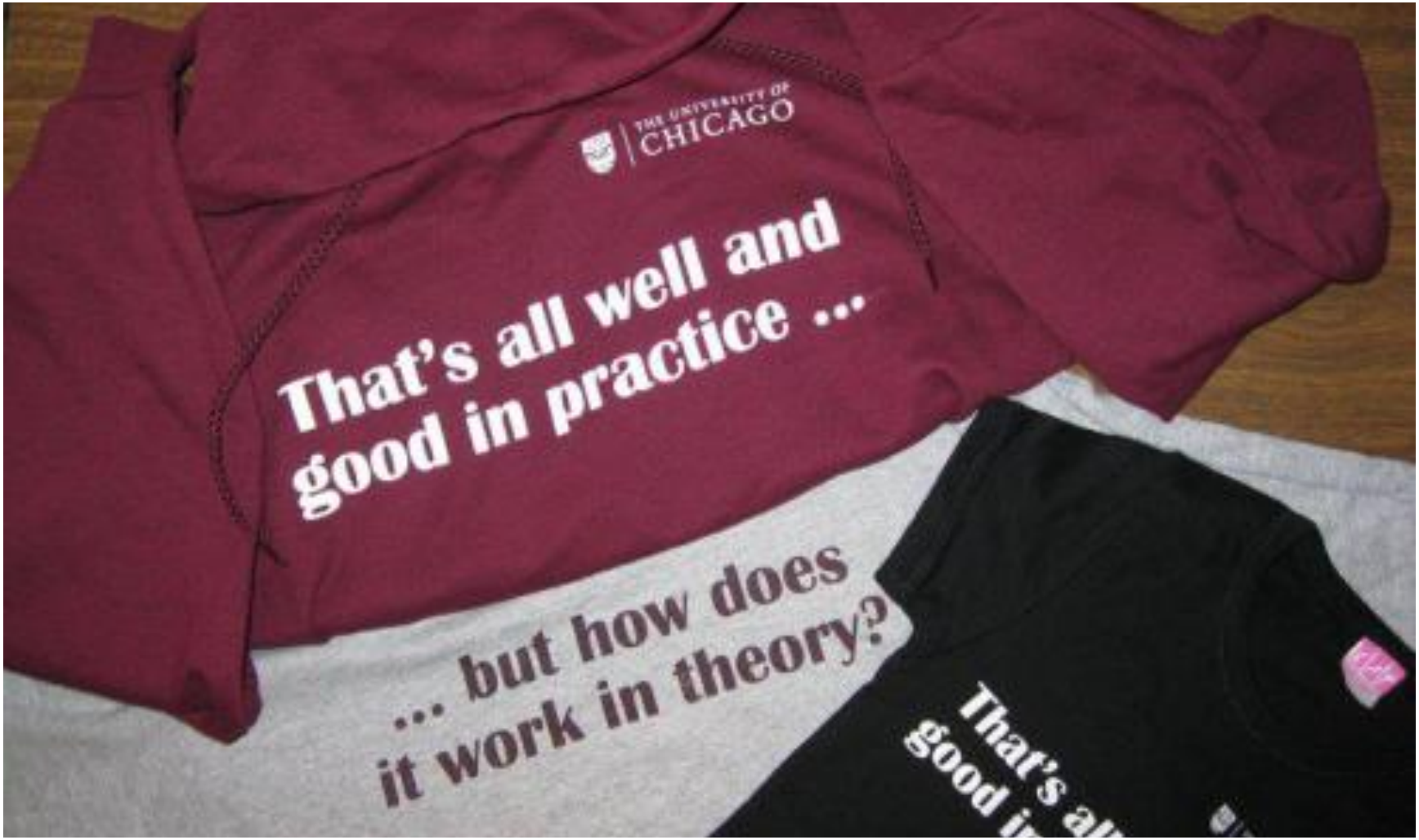
[1]Monroe-DeVita, M., Teague, G. B., & Moser, L. L. (2011). The TMACT: A new tool for measuring fidelity to assertive community treatment. *Journal of the American Psychiatric Nurses Association*, *17*(1): 17-29.

[2]Cuddeback, G. S., Morrissey, J. P., Domino, M. E., Monroe-DeVita, M., Teague, G. B., & Moser, L. L. (2013). Fidelity to recovery-oriented ACT practices and consumer outcomes. *Psychiatric Services*, *Psychiatric Services*, 64, 318-323.

TMACT continued

- 47 program-specific items.
  - Each item is rated on a 5-point scale ranging from 1 (“not implemented”) to 5 (“fully implemented”).
  - Standards used for establishing the anchors for the “fully-implemented” ratings were determined by a combination of expert opinion and the empirical literature.
- TMACT items fall into six subscales:
  - (1) Operations and Structure (OS);
  - (2) Core Team (CT);
  - (3) Specialist Team (ST);
  - (4) Core Practices (CP);
  - (5) Evidence-Based Practices (EP); and
  - (6) Person-Centered Planning and Practices (PP).

Challenge: Translating Research into Practice



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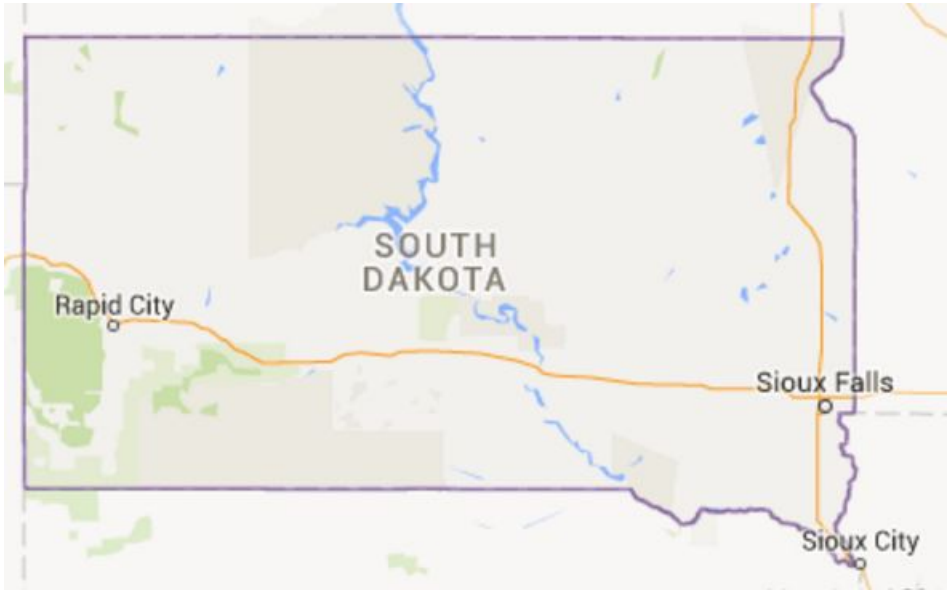
Challenge: Translating Research into Practice, Continued

- What's different in small/rural counties?
  - Workforce and Staffing
  - Number of Persons with SMI/SPMI – lack of "economies of scale"
  - Geography and Travel (time/distance)
  - Smaller Resource Pools

What are Rural Folks Doing?

Identifying and implementing the core components of an EBP, such as ACT, in a rural area can result in good clinical outcomes for rural consumers.

ACT in South Dakota



Lewis & Clark Behavioral Health Services

Behavior Management Systems BMS Cares.org

CACS Building Better Tomorrows

Southeastern Directions for Life

Community Counseling Services
Providing personal counseling and services to South East South Dakota

Northeastern Mental Health Center

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Adapting ACT for Rural Implementation

- Workforce and Staffing
  - Availability of specific clinicians
  - Level of staffing necessary for small teams
    - 24/7 coverage with small teams
  - Shared staffing with other programs and agencies

South Dakota

Fully staffed team important, but difficult. Refer consumers to other resources, such as substance abuse specialists.

Michigan

Teams usually average about 6-7 staff

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Implementing ACT for Rural Implementation

- Number of persons with SMI/SPMI
  - Size of Teams

South Dakota

Size of program is usually around 50 consumers

Colorado

Rural team may only have 25 consumers enrolled at one time

Adapting ACT for Rural Implementation

- Geography and Travel

Colorado

Fewer number of contacts, duration is longer

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Adapting ACT for Rural Implementation

- Smaller Resource Pools
  - Lack of an economy of scale
  - Benefits of collaborating and sharing resources more visible
  - Consumers better known to smaller communities

South Dakota

Collaboration with local partners – consumers known to everyone

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Colorado ACT Scale

COLORADO ASSERTIVE COMMUNITY TREATMENT FIDELITY SCALE (CO-ACT)

CATEGORY How well does the program meet the criteria for the component?	1 Does not meet criteria.	2 Most of the criteria are not met most of the time.	3 Some of the criteria are met, but it is not consistent.	4 Meets most of the criteria most of the time.	5 Meets and exceeds criteria all the time.
(H1) TEAM APPROACH: Small Case Load: Client: staff ratio should be no greater than 12:1, and ideally 10:1 or less	35-40 Clients/clinician or more.	25-35	15-25	11-15	10 clients/clinician or fewer.
(H1-CO) TEAM APPROACH: Team size of at least three FTE members.	Has not been above the 3 FTE requirement during the FY.	Has had 3 FTE for less the 6 months but more than 2 months.	Is below 3 FTE requirement for more than a month.	Has dropped below the 3 FTE requirement for less than 2 weeks during FY.	Always has at least 3 FTE team members, even during employee transitions.
(H2-CO) TEAM APPROACH: Shared case loads for both treatment planning and treatment provision – Provider group functions as team rather than as individual practitioners: clinicians know and work with all clients.	Fewer than 10% of clients with multiple staff face-to-face contacts in reporting quarterly period.	10-36%	37-63%	64-89%	90% or more clients have routine face tot face contact with more than 1 staff during a quarter.
(H3) TEAM APPROACH: Daily team meetings attended by all members.	Program service planning for each client usually occurs once/month or less frequently.	At least twice/month but less often than once/week.	At least once/week but less often than twice/week.	At least twice/week but less often than 4 times/week.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.
(H4) PRACTICING TEAM LEADER: ACT team has a designated team leader/coordinator who provides direct services and whose responsibilities are limited to the ACT team.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup, and/or has other responsibilities.	Supervisor provides services routinely as backup, or less than 25% of the time.	Supervisor normally provides services between 25-50% of the time.	Supervisor provides services at least 50% of the time.
(H6-10-CO) The ACT team is multi-disciplinary (e.g., mental health counselors, social workers, vocational counselors, substance abuse counselors, Housing specialist, Payee specialist).	Team is strictly comprised of mental health professionals.		Team has 1.5 FTE mental health and .5 CAC or Voc.		Team has one FTE mental health clinician and either one FTE CAC or Vocational Counselor.
(H7) PSYCHIATRIST On Staff:	No direct psychiatrist responsible to the Team.	Less than 0.15 FTE psychiatrist available to staff.	0.20 FTE per 40 clients or 0.15 FTE per 25 clients: available to staff bi-weekly.	0.20 FTE per 40 clients or 0.15 FTE per 25 clients: available to staff weekly.	0.25 FTE per 40 clients or 0.2 FTE per 25 clients: available to staff weekly.
(H8) REGISTERED NURSE IS ON STAFF (preferably full-time).	Program for 40 clients has less than .1 FTE regular nurse.	.1-.4 FTE per 40 clients.	.4-.7 FTE per 40 clients.	.7-.9 FTE per 40 clients who attends ½ of staff meetings.	1 FTE RN for 40 clients who attends all staff meetings.

SD IMPACT Quality Assurance Scale

SD IMPACT Quality Assurance Scale

HUMAN RESOURCES: STRUCTURE AND COMPOSITION						
Criterion		*Ratings/Anchors*				
		1	2	3	4	5
H1	*Small caseload:* Consumer/provider ratio = 10:1	50 consumers/team members or more	35-49	21-34	11-20	10 consumers/team member or fewer
H2	*Team approach:* Provider group functions as team rather than as individual ACT team members; ACT team members show and work with all consumers	Less than 10% consumers with multiple team face-to-face contacts in reporting 2-week period	10-36%	37-63%	64-89%	90% or more consumers have face-to-face contact with >1 staff member in 2 weeks
H3	*Program meeting:* Meets often to plan and review services for each consumer	Service-planning for each consumer usually 1x/month or less	At least 2x/month but less often than 1x/week	At least 1x/week but less than 2x/week	At least 2x/week but less than 4x/week	Meets at least 4 days/week and reviews each consumer each time, even if only briefly
H4	*Practicing ACT leader:* Supervisor or Frontline ACT team members provides direct services	Supervisor provides no services	Supervisor provides services on rare occasions as backup	Supervisor provides services routinely as backup or less than 25% of the time	Supervisor normally provides services between 25% and 50% time	Supervisor provides services at least 50% time
H5	*Continuity of staffing:* Keeps same staffing over time	Greater than 80% turnover in 2 years	60-80% turnover in 2 years	40-59% turnover in 2 years	20-39% turnover in 2 years	Less than 20% turnover in 2 years
H6	*Staff capacity:* Operates at full staffing	Operated at less than 50% staffing the past 12 months	50-64%	65-79%	80-94%	Operated at 95% or more of full staffing in past 12 months
H8	*Nurse on team:* At least 2 full-time nurses assigned for 100-consumer program	Less than .20 FTE regular nurse for 100 consumers	.20-.79 FTE for 100 consumers	.80-1.39 FTE for 100 consumers	1.40-1.99 FTE for 100 consumers	2 full-time nurses or more are members for 100-consumer program

HUMAN RESOURCES: STRUCTURE AND COMPOSITION						
Criterion		*Ratings/Anchors*				
		1	2	3	4	5
H11-SD	*Program size:* Of sufficient absolute size to consistently provide necessary staffing diversity and coverage (Please see Appendix A: Supplemental Grid for Teams With a Caseload Cap Different Than 50 or 100 Consumers)	100-Consumer Team: Includes fewer than 5.5 FTE direct clinical staff.	5.5 - 6.9 FTE	7.0 - 8.4 FTE	8.5 - 9.9 FTE	100-Consumer Team: Includes at least 10.0 FTE direct clinical staff.
		50-Consumer Team: Includes fewer than 5.5 FTE direct clinical staff.	5.5 - 5.9 FTE	6.0 - 6.4 FTE	6.5 - 6.9 FTE	50-Consumer Team: Includes at least 7.0 FTE direct clinical staff.

ORGANIZATIONAL BOUNDARIES						
Criterion		*Ratings/Anchors*				
		1	2	3	4	5
O1	*Explicit admission criteria:* Has clearly identified mission to serve a particular population. Has and uses measurable and operationally defined criteria to screen out inappropriate referrals	Has no set criteria and takes all types of cases as determined outside the program	Has a generally defined mission but admission process dominated by organizational convenience	Tries to seek and select a defined set of consumers but accepts most referrals	Typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure	Actively recruits a defined population and all cases comply with explicit admission criteria
O2	*Intake rate:* Takes consumers in at a low rate to maintain a stable service environment	Highest monthly intake rate in the last 6 months = greater than 15 consumers/month	13-15	10-12	7-9	Highest monthly intake rate in the last 6 months no greater than 6 consumers/month
SD-1	Clients are assessed for specialty service needs (e.g. psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services).	Less than 20% of caseload are assessed for specialty service needs and the need is documented.	20-39% of the caseload are assessed for specialty service needs and the need is documented.	40-59% of the caseload are assessed for specialty service needs.	60-79% of the caseload are assessed for specialty service needs and the need is documented.	80% or greater of caseload are assessed for specialty service needs and the need is documented.

ORGANIZATIONAL BOUNDARIES						
Criterion		*Ratings/Anchors*				
		1	2	3	4	5
SD-2	Of those in need of specialty services (e.g. psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services), clients are provided these services by the team or are actively referred to other providers for these services.	Less than 20% of those with specialty service needs are provided specialty services or are actively referred (documented in the patient chart).	20-39% of those with specialty service needs are provided specialty services or are actively referred (documented in the patient chart).	40-59% of those with specialty service needs are provided specialty services or are actively referred (documented in the patient chart).	60-79% of those with specialty service needs are provided specialty services or are actively referred (documented in the patient chart).	80% or greater of those with specialty service needs are provided specialty services or are actively referred (documented in the patient chart).
O3-SD	*Full responsibility for treatment services:* In addition to case management, actively coordinates or provides psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services (please see Appendix B: Definition of Active Coordination of Services).	Actively coordinates/provides no more than case management services	Actively coordinates/ provides 1 of 5 additional services and refers externally for others	Actively coordinates/ provides 2 of 5 additional services and refers externally for others	Actively coordinates/ provides 3 or 4 or 5 additional services and refers externally for others	Actively coordinates/ provides all 5 services to consumers

ORGANIZATIONAL BOUNDARIES						
Criterion		*Ratings/Anchors*				
		1	2	3	4	5
O4	*Responsibility for crisis services:* Has 24-hour responsibility for covering psychiatric crises	Has no responsibility for handling crises	Emergency service has after hours program-generated protocol for program consumers	Is available by phone, mostly in consulting role	Provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement	Provides 24-hour coverage
O5	*Responsibility for hospital admissions:* Is involved in hospital admissions	Is involved in fewer than 5% decisions to hospitalize	ACT team is involved in 5-34% of admissions	ACT team is involved in 35-64% of admissions	ACT team is involved in 65-94% of admissions	ACT team is involved in 95% or more of admissions
O6	*Responsibility for hospital discharge planning:* Is involved in planning for hospital discharges	Is involved in fewer than 5% of hospital discharges	5-34% of program consumer discharges planned jointly with program	35-64% of program consumer discharges planned jointly with program	65-94% of program consumer discharges planned jointly with program	95% or more discharges planned jointly with program
O7	*Time-unlimited services (graduation rate):* Rarely closes cases but remains the point of contact for all consumers as needed	More than 90% of consumers are expected to be discharged within 1 year	From 38-90% of consumers expected to be discharged within 1 year	From 18-37% of consumers expected to be discharged within 1 year	From 5-17% of consumers expected to be discharged within 1 year	All consumers served on a time-unlimited basis, with fewer than 5% expected to graduate annually

NATURE OF SERVICES						
Criterion		*Ratings/Anchors*				
		1	2	3	4	5
S1	*Community-based services:* Works to monitor status, develop community living skills in community rather than in office	Less than 20% of face-to-face contacts in community	20-39%	40-59%	60-79%	80% of total face-to-face contacts in community
S2	*No dropout policy:* Retains high percentage of consumers	Less than 50% of caseload retained over 12-month period	50-64%	65-79%	80-94%	95% or more of caseload is retained over a 12-month period
S3	*Assertive engagement mechanisms:* As part of ensuring engagement, uses street outreach and legal mechanisms (probation/parole, OP commitment) as indicated and available	Passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms	Makes initial attempts to engage but generally focuses on most motivated consumers	Tries outreach and uses legal mechanisms only as convenient	Usually has plan for engagement and uses most mechanisms available	Demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate
S4	*Intensity of services:* High total amount of service time, as needed	Average 15 minutes/week or less of face-to-face contact for each consumer	15-49 minutes/week	50-84 minutes/week	85-119 minutes/week	Average 2 hours/week or more of face-to-face contact for each consumer
S5	*Frequency of contact:* High number of service contacts, as needed	Average less than 1 face-to-face contact/week or fewer for each consumer	1-2x/week	2-3x/week	3-4x/week	Average 4 or more face-to-face contacts/week for each consumer

NATURE OF SERVICES						
Criterion		*Ratings/Anchors*				
		1	2	3	4	5
S6-SD	*Frequency of Contact with Natural Supports:* The team has access to consumers' natural supports. These supports either already existed, and/or resulted from the team's efforts to help consumers develop natural supports. Natural supports include people in the consumer's life who are NOT paid service providers (e.g. family, friends, landlord, employer, clergy).	For less than 25% of consumers, the natural support system is contacted by team at least 1 time per month.	26% - 50%	51% - 75%	76% -89%	For at least 90% of consumers, the natural support system is contacted by team at least 1 time per month.
S9	*Dual Disorders (DD) Model:* Uses a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence	Fully based on traditional model; confrontation; mandated abstinence; higher power, etc.	Uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehab; recognizes need to persuade consumers in denial of who don't fit AA	Uses mixed model: e.g., DD principles in treatment plans; refers consumers to persuasion groups; uses hospitalization for rehab.; refers to AA, NA	Uses primarily DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; rarely hospitalizes for rehab. or detox except for medical necessity; refers out some SA treatment	Fully based DD treatment principles, with treatment provided by ACT staff members

Human Resources (H): Structure and Composition

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
H1	*<u>Small caseload:</u>* Consumer/provider ratio = 10:1	50 consumers/team members or more	35-49	21-34	11-20	**10 consumers/team member or fewer**

- Low consumer-to-staff ratio ensures adequate intensity and individualization of services

Human Resources (H): Structure and Composition

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
H2	*Team approach:* Provider group functions as team rather than as individual ACT team members; ACT team members show and work with all consumers	Less than 10% consumers with multiple team face-to-face contacts in reporting 2-week period	10-36%	37-63%	64-89%	**90% or more consumers have face-to-face contact with >1 staff member in 2 weeks**

- Entire team shares responsibility for each consumer
- Each team member contributes expertise as appropriate
- Ensures continuity of care
- Creates supportive organizational environment for team members

Human Resources (H): Structure and Composition

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
H3	*Program meeting:* Meets often to plan and review services for each consumer	Service-planning for each consumer usually 1x/month or less	At least 2x/month but less often than 1x/week	At least 1x/week but less than 2x/week	At least 2x/week but less than 4x/week	**Meets at least 4 days/week and reviews each consumer each time, even if only briefly**

- Daily meetings allow team members to discuss consumers, solve problems, and plan treatment and rehabilitation efforts
- Ensures all consumers receive optimal service

Human Resources (H): Structure and Composition

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
H4	*Practicing ACT leader:* Supervisor or Frontline ACT team members provides direct services	Supervisor provides no services	Supervisor provides services on rare occasions as backup	Supervisor provides services routinely as backup or less than 25% of the time	Supervisor normally provides services between 25% and 50% time	**Supervisor provides services at least 50% time**

- Research shows this factor is strongly related to consumer outcomes
- Better able to model appropriate clinical interventions
- Remain in touch with consumers served by the team

Human Resources (H): Structure and Composition

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
H5	*Continuity of staffing:* Keeps same staffing over time	Greater than 80% turnover in 2 years	60-80% turnover in 2 years	40-59% turnover in 2 years	20-39% turnover in 2 years	**Less than 20% turnover in 2 years**

- Enhances team cohesion
- Enhances therapeutic relationships between consumers and providers

Human Resources (H): Structure and Composition

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
H6	*Staff capacity:* Operates at full staffing	Operated at less than 50% staffing the past 12 months	50-64%	65-79%	80-94%	**Operated at 95% or more of full staffing in past 12 months**

- Necessary to maintain consistent, multidisciplinary services
- Based on what is considered a full team - how many positions are filled

Human Resources (H): Structure and Composition

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
H8	*Nurse on team:* At least 2 full-time nurses assigned for 100-consumer program	Less than .20 FTE regular nurse for 100 consumers	.20-.79 FTE for 100 consumers	.80-1.39 FTE for 100 consumers	1.40-1.99 FTE for 100 consumers	**2 full-time nurses or more are members for 100-consumer program**

- Critical ingredient to successful ACT programs
- Function as full members of the team – home visits, treatment planning, team meetings
- Help administer medications
- Educate the team about medication issues – cross-training is important

Human Resources (H): Structure and Composition

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
H11-SD	*Program size:* Of sufficient absolute size to consistently provide necessary staffing diversity and coverage (Please see Appendix A: Supplemental Grid for Teams With a Caseload Cap Different Than 50 or 100 Consumers)	100-Consumer Team: Includes fewer than 5.5 FTE direct clinical staff.	5.5 - 6.9 FTE	7.0 - 8.4 FTE	8.5 - 9.9 FTE	**100-Consumer Team: Includes at least 10.0 FTE direct clinical staff.**
		50-Consumer Team: Includes fewer than 5.5 FTE direct clinical staff.	5.5 - 5.9 FTE	6.0 - 6.4 FTE	6.5 - 6.9 FTE	**50-Consumer Team: Includes at least 7.0 FTE direct clinical staff.**

- Maintain adequate staff size and disciplinary background to provide comprehensive, individualized services to each consumer
- Integrated approach to mental health services – range of treatment issues addressed from variety of perspectives

Appendix A. Supplemental Grid for Teams With a Caseload Cap Different Than 50 or 100 Consumers, from TMACT OSS Criterion.

Supplemental Grid for Teams With a Caseload Cap Different Than 50 or 100 Consumers					
	Rating				
Caseload Cap Size	1	2	3	4	5
125	Fewer than 5.5 FTE	5.5 - 7.4 FTE	7.5 - 9.4 FTE	9.5 - 11.4 FTE	At least 11.5 FTE
120	Fewer than 5.5 FTE	5.5 - 7.3 FTE	7.4 - 9.2 FTE	9.3 - 11.1 FTE	At least 11.2 FTE
115	Fewer than 5.5 FTE	5.5 - 7.2 FTE	7.3 - 9.0 FTE	9.1 - 10.8 FTE	At least 10.9 FTE
110	Fewer than 5.5 FTE	5.5 - 7.1 FTE	7.2 - 8.8 FTE	8.9 - 10.5 FTE	At least 10.6 FTE
105	Fewer than 5.5 FTE	5.5 - 7.0 FTE	7.1 - 8.6 FTE	8.7 - 10.2 FTE	At least 10.3 FTE
100	Fewer than 5.5 FTE	5.5 - 6.9 FTE	7.0 - 8.4 FTE	8.5 - 9.9 FTE	At least 10.0 FTE
95	Fewer than 5.5 FTE	5.5 - 6.8 FTE	6.9 - 8.2 FTE	8.3 - 9.6 FTE	At least 9.7 FTE
90	Fewer than 5.5 FTE	5.5 - 6.7 FTE	6.8 - 8.0 FTE	8.1 - 9.3 FTE	At least 9.4 FTE
85	Fewer than 5.5 FTE	5.5 - 6.6 FTE	6.7 - 7.8 FTE	7.9 - 9.0 FTE	At least 9.1 FTE
80	Fewer than 5.5 FTE	5.5 - 6.5 FTE	6.6 - 7.6 FTE	7.7 - 8.7 FTE	At least 8.8 FTE
75	Fewer than 5.5 FTE	5.5 - 6.4 FTE	6.5 - 7.4 FTE	7.5 - 8.4 FTE	At least 8.5 FTE
70	Fewer than 5.5 FTE	5.5 - 6.3 FTE	6.4 - 7.2 FTE	7.3 - 8.1 FTE	At least 8.2 FTE
65	Fewer than 5.5 FTE	5.5 - 6.2 FTE	6.3 - 7.0 FTE	7.1 - 7.8 FTE	At least 7.9 FTE
60	Fewer than 5.5 FTE	5.5 - 6.1 FTE	6.2 - 6.8 FTE	6.9 - 7.5 FTE	At least 7.6 FTE
55	Fewer than 5.5 FTE	5.5 - 6.0 FTE	6.1 - 6.6 FTE	6.7 - 7.2 FTE	At least 7.3 FTE
50	Fewer than 5.5 FTE	5.5 - 5.9 FTE	6.0 - 6.4 FTE	6.5 - 6.9 FTE	At least 7.0 FTE
45	Fewer than 5.5 FTE	5.5 - 5.8 FTE	5.9 - 6.2 FTE	6.3 - 6.6 FTE	At least 6.7 FTE
40	Fewer than 5.5 FTE	5.5 - 5.7 FTE	5.8 - 6.0 FTE	6.1 - 6.3 FTE	At least 6.4 FTE
35	Fewer than 5.5 FTE	5.5 - 5.6 FTE	5.7 - 5.8 FTE	5.9 - 6.0 FTE	At least 6.1 FTE
30	Fewer than 5.5 FTE	5.5 FTE	5.6 FTE	5.7 FTE	At least 5.8 FTE

Organizational Boundaries (O)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
O1	*Explicit admission criteria:* Has clearly identified mission to serve a particular population. Has and uses measurable and operationally defined criteria to screen out inappropriate referrals	Has no set criteria and takes all types of cases as determined outside the program	Has a generally defined mission but admission process dominated by organizational convenience	Tries to seek and select a defined set of consumers but accepts most referrals	Typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure	**Actively recruits a defined population and all cases comply with explicit admission criteria**

- Examples of criteria: pattern of frequent hospital admissions, frequent use of emergency services, co-occurring substance-use disorders, homelessness, involvement with the criminal justice system, not adhering to medications as prescribed
- Best suited to consumers who do not effectively use less intensive mental health services

Organizational Boundaries (O)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
O2	*Intake rate:* Takes consumers in at a low rate to maintain a stable service environment	Highest monthly intake rate in the last 6 months = greater than 15 consumers/month	13-15	10-12	7-9	**Highest monthly intake rate in the last 6 months no greater than 6 consumers/month**

- Low growth rate of consumer population is necessary to provide consistent, individualized and comprehensive services

Organizational Boundaries (O)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
SD-1	Clients are assessed for specialty service needs (e.g. psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services).	Less than 20% of caseload are assessed for specialty service needs and the need is documented.	20-39% of the caseload are assessed for specialty service needs and the need is documented.	40-59% of the caseload are assessed for specialty service needs.	60-79% of the caseload are assessed for specialty service needs and the need is documented.	**80% or greater of caseload are assessed for specialty service needs and the need is documented.**

- Providing multidisciplinary services is key to the model
- Clients must be assessed for need

Organizational Boundaries (O)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
SD-2	Of those in need of specialty services (e.g. psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services), clients are provided these services by the team or are actively referred to other providers for these services.	Less than 20% of those with specialty service needs are provided specialty services or are actively referred (documented in the patient chart).	20-39% of those with specialty service needs are provided specialty services or are actively referred (documented in the patient chart).	40-59% of those with specialty service needs are provided specialty services or are actively referred (documented in the patient chart).	60-79% of those with specialty service needs are provided specialty services or are actively referred (documented in the patient chart).	**80% or greater of those with specialty service needs are provided specialty services or are actively referred (documented in the patient chart).**

- If client has specialty service need, must be provided or actively referred
- Need must be documented

Organizational Boundaries (O)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
O3-SD	*Full responsibility for treatment services:* In addition to case management, actively coordinates or provides psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services (please see Appendix B: Definition of Active Coordination of Services).	Actively coordinates/provides no more than case management services	Actively coordinates/ provides 1 of 5 additional services and refers externally for others	Actively coordinates/ provides 2 of 5 additional services and refers externally for others	Actively coordinates/ provides 3 or 4 or 5 additional services and refers externally for others	**Actively coordinates/ provides all 5 services to consumers**

- Integrated approach allows services to be tailored to each consumer
- Care must be intentionally and actively coordinated (see Appendix B for definition)

Appendix B. Definition of Active Coordination of Services

Care coordination is defined as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care" (from McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination). Rockville (MD): Agency for Healthcare Research and Quality (US); 2007 Jun. (Technical Reviews, No. 9.7.) 3, Definitions of Care Coordination and Related Terms. Available from: https://www.ncbi.nlm.nih.gov/books/NBK44012/). Active coordination includes any strategies to improve communication and collaboration among different service providers. Examples include case managers attending appointments with clients, service providers attending team meetings, providers meeting in person or by phone for consultation at least bimonthly, etc. For the purposes of item O3-SD, if the provider attends one team meeting a week the provider will be considered part of the team and the service will be considered as provided by the team.

Organizational Boundaries (O)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
O4	*Responsibility for crisis services:* Has 24-hour responsibility for covering psychiatric crises	Has no responsibility for handling crises	Emergency service has after hours program-generated protocol for program consumers	Is available by phone, mostly in consulting role	Provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement	**Provides 24-hour coverage**

- Immediate response can help minimize distress
- Maintains continuity of care

Organizational Boundaries (O)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
O5	*Responsibility for hospital admissions:* Is involved in hospital admissions	Is involved in fewer than 5% decisions to hospitalize	ACT team is involved in 5-34% of admissions	ACT team is involved in 35-64% of admissions	ACT team is involved in 65-94% of admissions	**ACT team is involved in 95% or more of admissions**

- Enhances appropriate use of psychiatric hospitalization
- Maintains continuity of care

Organizational Boundaries (O)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
O6	*<u>Responsibility for hospital discharge planning:</u>* Is involved in planning for hospital discharges	Is involved in fewer than 5% of hospital discharges	5-34% of program consumer discharges planned jointly with program	35-64% of program consumer discharges planned jointly with program	65-94% of program consumer discharges planned jointly with program	**95% or more discharges planned jointly with program**

- Maintains community supports and continuity of service

Organizational Boundaries (O)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
O7	*Time-unlimited services (graduation rate):* Rarely closes cases but remains the point of contact for all consumers as needed	More than 90% of consumers are expected to be discharged within 1 year	From 38-90% of consumers expected to be discharged within 1 year	From 18-37% of consumers expected to be discharged within 1 year	From 5-17% of consumers expected to be discharged within 1 year	**All consumers served on a time-unlimited basis, with fewer than 5% expected to graduate annually**

- Time-unlimited services encourage the development of stable, ongoing therapeutic relationships

Nature of Services (S)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
S1	*Community-based services:* Works to monitor status, develop community living skills in community rather than in office	Less than 20% of face-to-face contacts in community	20-39%	40-59%	60-79%	**80% of total face-to-face contacts in community**

- Contacts in natural settings are more effective
- Allows for more accurate assessment of functioning
- Home visits for medication delivery, crisis intervention, and provision of other services

Nature of Services (S)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
S2	*No dropout policy:* Retains high percentage of consumers	Less than 50% of caseload retained over 12-month period	50-64%	65-79%	80-94%	**95% or more of caseload is retained over a 12-month period**

- Outreach efforts help build relationships and ensure consumers receive ongoing services

Nature of Services (S)

Criterion		*Ratings/Anchors*				
		1	2	3	4	5
S3	*Assertive engagement mechanisms:* As part of ensuring engagement, uses street outreach and legal mechanisms (probation/parole, OP commitment) as indicated and available	Passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms	Makes initial attempts to engage but generally focuses on most motivated consumers	Tries outreach and uses legal mechanisms only as convenient	Usually has plan for engagement and uses most mechanisms available	**Demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate**

- Assertive outreach is a critical feature of the ACT model
- Retention of consumers is a high priority for ACT teams
- Persistent, caring attempts to engage consumers in treatment help foster trusting relationships

Nature of Services (S)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
S4	*Intensity of services:* High total amount of service time, as needed	Average 15 minutes/week or less of face-to-face contact for each consumer	15-49 minutes/week	50-84 minutes/week	85-119 minutes/week	**Average 2 hours/week or more of face-to-face contact for each consumer**

- High intensity of services is often required to help consumers with serious symptoms maintain and improve their function within the community

Nature of Services (S)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
S5	*<u>Frequency of contact:</u>* High number of service contacts, as needed	Average less than 1 face-to-face contact/week or fewer for each consumer	1-2x/week	2-3x/week	3-4x/week	**Average 4 or more face-to-face contacts/week for each consumer**

- Associated with improved consumer outcomes
- ACT teams are highly invested in their consumers
- Frequent contact to provide ongoing, responsive support as needed

Nature of Services (S)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
S6-SD	*Frequency of Contact with Natural Supports:* The team has access to consumers' natural supports. These supports either already existed, and/or resulted from the team's efforts to help consumers develop natural supports. Natural supports include people in the consumer's life who are NOT paid service providers (e.g. family, friends, landlord, employer, clergy).	For less than 25% of consumers, the natural support system is contacted by team at least 1 time per month.	26% - 50%	51% - 75%	76% -89%	**For at least 90% of consumers, the natural support system is contacted by team at least 1 time per month.**

- Developing and maintaining community supports further enhances consumers' integration and functioning

Nature of Services (S)

Criterion		*Ratings/Anchors*				
		1	2	3	4	**5**
S9	*Dual Disorders (DD) Model:* Uses a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence	Fully based on traditional model; confrontation; mandated abstinence; higher power, etc.	Uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehab; recognizes need to persuade consumers in denial of who don't fit AA	Uses mixed model: e.g., DD principles in treatment plans; refers consumers to persuasion groups; uses hospitalization for rehab.; refers to AA, NA	Uses primarily DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; rarely hospitalizes for rehab. or detox except for medical necessity; refers out some SA treatment	**Fully based DD treatment principles, with treatment provided by ACT staff members**

- The co-occurring disorders model attends to the concerns of both SMI and substance abuse for maximum opportunity for recovery and symptom management

Critical Components of ACT

Critical Components of ACT

- South Dakota Perspective
  - Team Approach
  - Communication
  - Community-Based Services
  - Assertive Consumer Engagement
  - Tailored Individual Treatment

South Dakota

SD plans to continue its IMPACT program and to evaluate programs using the modified SD-specific quality improvement scale.

Critical Components of ACT

- Michigan Perspective
  - Team Approach
  - Frequent Client Contact
  - Assertive Consumer Engagement/Intense Program
  - Tailored Individualized Treatment
  - Community-Based Services

Critical Components of ACT

- Colorado Perspective
  - Multidisciplinary Team
  - Low Caseload
  - Community-Based Services
  - Frequent Client Contact

Critical Components of ACT

- Research Perspective
  - Meta-analysis – relationship between ACT fidelity and reduction of hospital use used two broad indices to find critical ingredients:
    - Staffing: e.g., low client-staff ratio, optimal team size, and inclusion of psychiatrist and nurse in the team.
    - Organization: e.g., ACT team provides care directly, rather than brokering, daily team meeting, and 24-hour access.[1]

[1]Burns, T., Catty, J., Dash, M., Roberts, C., Lockwood, A., & Marshall, M. (2007). Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ : British Medical Journal*, *335*(7615), 336. http://doi.org/10.1136/bmj.39251.599259.55.

Critical Components of ACT

- Results:
  - *Organization* predicted significant reductions in hospital use, while *staffing* did not.
  - This study provided empirical support for the organizational components of ACT, but cast doubt on the necessity of multidisciplinary staffing standards.[1]
- Multidisciplinary Concept:
  - Now transformed into team members' need to learn new competencies continuously as evidence-based practices emerge.[2]

[1]Burns, T., Catty, J., Dash, M., Roberts, C., Lockwood, A., & Marshall, M. (2007). Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ : British Medical Journal*, *335*(7615), 336. http://doi.org/10.1136/bmj.39251.599259.55.
[2]Bond, G. R., & Drake, R. E. (2015). The critical ingredients of assertive community treatment. *World Psychiatry*, *14*(2), 240–242. http://doi.org/10.1002/wps.20234.

Fidelity – Rural Considerations

- What is absolute and what is not?
- What modifications impact program outcomes?
- Monitoring fidelity versus/and outcomes.
- When is the program no longer ACT?

"Finding the proper balance between adaptation and retention of important features remains a fundamental challenge."[1]

[1]Fekete, D. M., Bond, G. R., McDonel, E. C., Salyers, M., Chen, A., & Miller, L. (1998). Rural assertive community treatment: A field experiment. *Psychiatric Rehabilitation Journal, 21*(4), 371-379. http://dx.doi.org/10.1037/h0095286.

ACT is an Investment

Thank You

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