ACT Day to Day Operations

Leah Appell RN, MSN
IMPACT Team Leader
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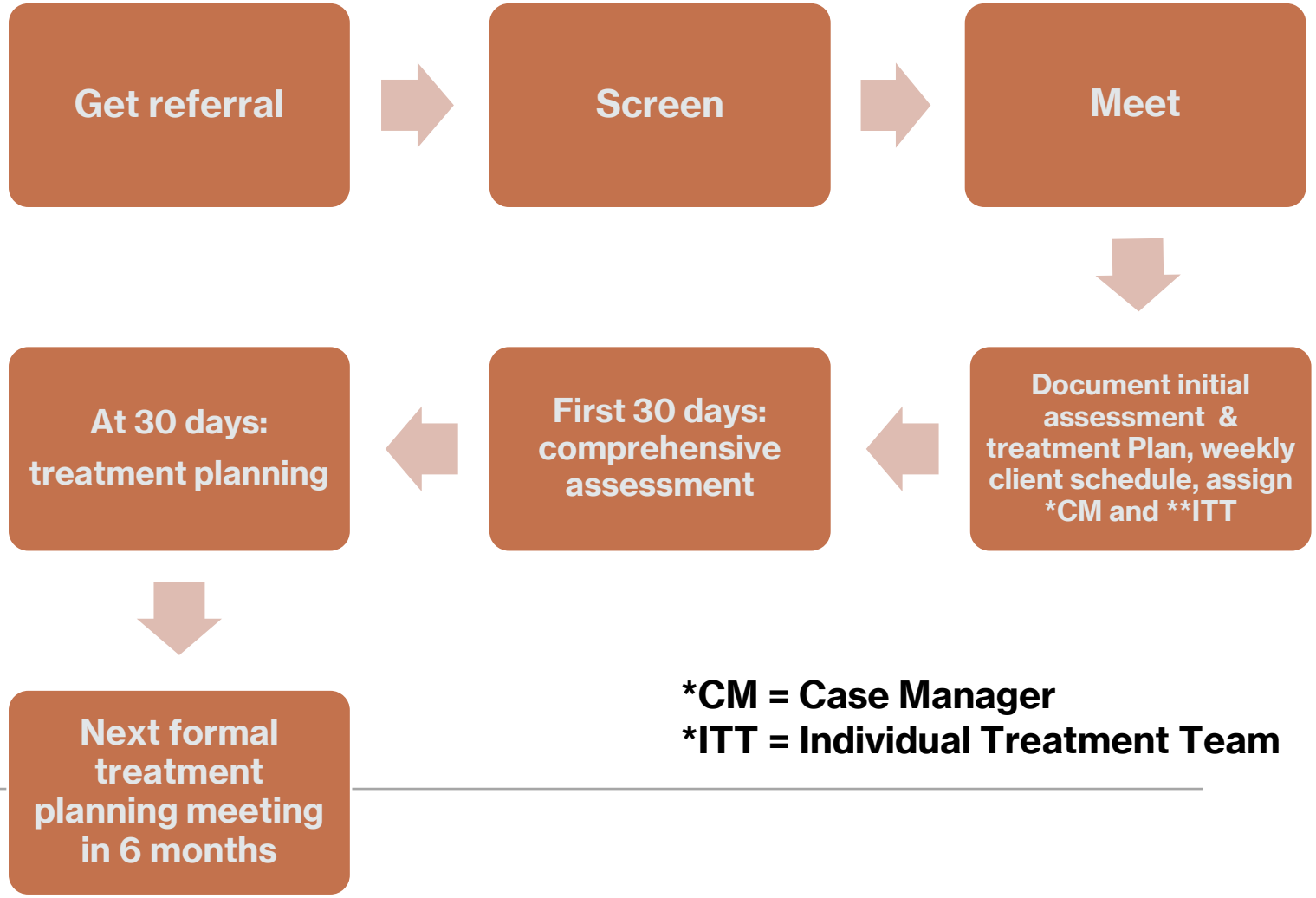
Overview of Topics

- Referrals/Admissions (March)
- Daily Operations--Scheduling (March)
- Discharges (March)
- Shared Case Management (April)
- Treatment Planning (April)

Referrals/Admissions



*CM = Case Manager
*ITT = Individual Treatment Team

Admission

Example of IMPACT Admission Criteria

Primary diagnosis: (must have one of the following)

- **Schizophrenia**
- **Schizoaffective Disorder**
- **Bipolar Affective Disorder**
- **Major Depressive Disorder (recurrent, with significant functional deficits)**

- **High cost/treatment failure in spite of traditional community-based services such as a visiting counselor from a supported community living program (Hillcrest, CMHC, or Life Skills) or a visiting nurse: (as evidenced by one of the following)**
  - **Two or more admissions in the preceding 12-24 months (or)**
  - **More than three weeks of hospitalization in the preceding 12 months (or)**
  - **More than 3 months in residential care in the preceding 12 months (or)**
  - **Decompensation or high risk of decompensation with traditional treatment due to treatment noncompliance, or severe life stress such as homelessness.**
- **Iowa City Region – 30 minute 'windshield time', or 25-mile radius**
- **Payor Source (Medicaid, mental health region assistance, private pay option)**

Admission
Referral

- Comes from many sources
- Clients, families, care providers, hospitals, residential facilities, jail, department of corrections, etc.
- Important to build relationships with referral sources, remind them of your presence every once in a while. ☺

Admission
Screening

- Do they meet criteria?
  - Diagnosis
  - Utilization
  - Location
  - Funding

- ProTip: On-paper vs. In-person

Admission

Admission Meeting

- Typically arranged by current provider and team leader
- Attended by client, current provider, ACT Team Leader, psychiatrist (ideally) or another ACT staff, appropriate natural supports
- Client's perspective, reason for referral
- Provide information about ACT
- Confirm meets admission criteria
- Obtain releases of information (family/supports, records)
- Agree upon weekly schedule (provisional) and exchange contact information with client, family, ACT
- Review emergency procedures
- Pro Tip: Good time to explore history of violence/self injury and safety in the home

Admission
Presentation to Team & Initial Assessment and Treatment Plan

- Presentation to entire team, history/plan
- Completed by team leader or psychiatrist/provider at time of admission
  - Reason for referral
  - Diagnosis, medication
  - What is known about psychiatric, medical and social history, immediate needs
- Designate case manager and individual treatment team
- Weekly client schedule (provisional)
- This is the acting treatment plan for the first 30 days

Admission
Comprehensive Assessments

- Completed within the first 30 days in the program
- Primary responsibility for completion lies with the assigned case manager and individual treatment team (ITT)
- Assessment takes place in the community settings – home, car, etc. – while working with the client to meet initial needs.

Components of the Comprehensive Assessment

- Physical health assessment (RN)
- Drug and alcohol use (CADC or other designee)
- Social development and functioning (counselor, case manager)
- Activities of daily living (OT or other designee)
- Education and employment (Employment specialist)
- Family structure and relationships (Case manager)

Time intensive...but yields great returns!

Client-Centered Approach

Comprehensive assessment and individualized treatment planning (using a client-centered approach) is the core organizational structure to deliver ACT services in the community.

- **Client-Centered** "...requires staff members to change from the distant and in-control professional to using themselves as an active, side-by-side partner to figure things out..."
- Typically, easy to understand philosophically, but hard to put into practice
- Staff responsibility: Ongoing high-quality relationship + engagement in planning + optimism/encouragement

Barriers to Client-Centered Approach

- Misperception of paperwork (it's a framework)
- Preconceived notions of being "in charge" and "knowing best"
- Insufficient professional training
- Undervaluing the time involved

Day to Day Operations:
Scheduling

- Terms: Daily Team meeting, Shift Manager,Weekly Client Schedule, Daily Staff Assignment Schedule
- **Team Meeting** (aka “The Secret Sauce”): Each client is discussed, team members should have a good idea of how clients are doing and what special issues need attention that day.
  - “You are being paid to have an opinion.”
- **Shift Manager** coordinates the scheduling for the day (typically a rotating responsibility)

Scheduling

- Visits are listed in the **weekly client schedule**
- A client's weekly schedule card should include:
  - Weekly visit schedule
  - Purpose for each visit and staff who sees them
  - Upcoming appointments
  - Lab work/Injection due dates

*Should represent the client's "mini team" and delineated case manager. Visits should be tied to individual treatment goals.

Weekly Client Schedule Example

Weekly Schedule Card **Name** Jon R

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
A.M.							
8							
9	med monitor-call			med monitor-call			
10		Meds face to face			Meds face to face		
11			Grocery shopping				
12							
P.M.							
1				To Library/job search			
2	Visit to Mom				ADL education skill building		
3					Weekend plan		
					Mediset		
4							
		Call for check in	Call for check in				
5							

Pro-Tip: Schedule cards should be reviewed with each treatment plan (at the least)

Scheduling

Daily Staff Assignment Schedule

- Includes the client visits (transferred from their individual cards)
- Includes any acute needs which arose in morning report (ex) med set-ups, appointments, labs
- Shift Manager reviews/reads aloud the schedule for each staff

Daily Staff Assignment Schedule Example #1

ACT Daily Staff Schedule
Date _____10/4/15_____

On Call ___Kelley_____
Off _____

	Jasmine (3)	JT (1)	Kelley (4)	Fred (2)	Holly	Sara
8 a.m.	Kelly H -check in and med mon.		John -check in and med mon.			
9 a.m.	Samm T to grocery	Tamra to YWCA	Notes	Ethan -morn routine Tilly- housing authority	Jan to grocery and pharmacy	OFFICE
10 a.m.			Karen D -benefits mtg		Jan med education	
11 a.m.	Check in at Hurley Hse	Scott G to payee		Tilly to look at apts.	Robert- mtg with landlord	Meeting with Tommy and family (office)
12 p.m.		Sam check in/meds			Robert to PCP (bus home)	
1 p.m.	Tim T for apartment cleaning and Post Office	Tabitha for cleaning and ADLs	Zone 4 check in with others	Life Changes group	Marissa to Walgreens interview	OFFICE
2 p.m.			Tina med check	Carl for apt hunt		
3 p.m.	Jessica for therapy	Dan G for therapy	Della- check in and med check	Sam H to guardian	Dan S with Dr. Kale	
4 p.m.	Jessica to sister's	Dan G to pantry and AA	Sam to PCP	Daniel- check in and med check		John- check in and med monitor

ON CALL: Kelley

VACATION:

ON THE LOOK OUT FOR: Sara K, Jerry P

EVENING TASKS:

ANY EXTRA TIME: see/call John

Daily Staff Assignment Schedule Example #2

MONDAY										
TIME	**ASSIGN**	**BELINDA**	**FINN**	**COLLEEN**	**JANET**	**JOHN**	**LEAH**	**SUSAN**	**MICAH**	**THERESA**
0800			Holly				Polly			
0830		Rounds	Rounds	Rounds	Rounds	Rounds	Rounds	Rounds	Rounds	Rounds
1000		Bob		Frieda	Larry			Pete	Sadie	Michelle
1030				Jamie		August		Aiden		
1100		Judy			Jerry	May			Annabelle	Randy
1130				Halle				Cam		
1200			Nick	Paul	Carrie	Patty			Tommy	Shannon
1230		Mary Lou				Tom		Lucy		
1300				Robert	Barry			Henry		Katie
1330			Betty			Frank			Steve	
1400		Sam		June	Terry			Nolan		Ben
1430						Harry				Harper
1500		Gloria	Chuck						Owen	
1530										
1600										
1930	Bob-pc									
	Nolan-pc									
TUESDAY AM:			Holly					Polly		

Discharge

- Discharge Criteria
- Planning/Transitions
- Discharge documentation

Discharge

Discharge Criteria

- Discharge from IMPACT

1. An individual reaches individually established goals for discharge, and the individual and program staff mutually agree to the termination of services; or
2. An individual requests discharge, demonstrates the ability to function in all major role areas without ongoing assistance from the program and without significant relapse when services are withdrawn, and the program staff agree to the termination of services; or
3. An individual moves outside the geographic area of the team's responsibility. In such cases, the team shall arrange for transfer of responsibility for mental health services to an ACT program or another provider wherever the individual is relocating, and the team shall maintain contact with the individual until the service transfer is implemented; or
4. An individual declines or refuses services and requests discharge despite the team's best efforts to develop an acceptable treatment plan with the individual.

Other things to consider:

- Symptom stable for 12 months on current medication regimen
- Ability to manage medication regimen independently
- Ability to independently perform activities of daily living (ADL) including personal ADLs such as grooming and hygiene
- Ability to manage instrumental ADLs such as money management, shopping, cooking, transportation and home upkeep
- Ability to independently engage in a satisfying level of work and leisure activities
- Personal preference for care other than the PACT program

Discharge Planning/Transitions

- Assessing readiness
  - Using ACT Transition Readiness Scale (ATRS) tool
  - Family/supports consultation/meeting
- Referrals/Handoff to next provider
- Assurance of readmission to ACT if things go poorly post-transition
- Discharge documentation by MD/provider and/or the case manager (hx, course in ACT, current medications and plan)
- Notification internally/externally (billing)

References

- A Manual for ACT Start-Up: Based on the PACT Model, By Deb Allness MSSW and William Knoedler MD. NAMI Publishing, 2003 edition.
- ACT Resources from Case Western Center for EBP
  - https://case.edu/socialwork/centerforebp/practices/assertive-community-treatment/assertive-community-treatment-resources
- ACT Transition Readiness Scale
  - https://mco.eastpointe.net/DocumentBrowser/file/ACT_Team_ATR_Information/ATR%20User's%20Manual%202011.pdf