Yolo County Health and Human Services Agency

BEHAVIORAL HEALTH SERVICES

Local Mental Health Board
Mental Health Director's Report
February 22, 2016

Jill Cook

As a part of Yolo County's Talent Exchange Program, Jill has been placed on temporary assignment at the County Administrator's Office as Deputy County Administrator. This assignment is expected to last 3-4 months. We are extremely happy for Jill and know that she will do great things at the CAO.

Student Mental Health

Please find attached Rand Study on investment in student mental health outcomes.

ACT Evaluation

Please see attached fidelity assessment of Turning Point Assertive Community Treatment program.

Partnership Healthplan of California (PHC)

We submitted an application to PHC last month and expected to hear whether or not we were funded on January 29. Due to the number of applicants PHC received, they have delayed their decision until February 25.

External Quality Review Organization (EQRO)

Once a year EQRO comes to each County to evaluate their Mental Health Plan and make suggestions for systems improvements surrounding access to care, timeliness of services, and quality of care. This visit started today (February 22) and lasts through tomorrow. We will be sharing the report with LMHB once we receive it.

Drug Medi-Cal Organized Delivery System

As we've discussed before the 1115 Drug Medi-Cal Waiver is being implemented statewide. The State has adopted a phased approach to implementation. The bay area counties were phase one, southern California was Phase II, and Yolo County is in Phase III. Phase III officially begins March 30. We have already begun meeting with our providers to begin developing our Yolo County implementation plan. This waiver will allow for Medi-Cal coverage for services such as detoxification and residential and intensive outpatient treatment modalities.

Substance Abuse Prevention and Treatment Site Visit

Similar to the EQRO visit, the Department of Health Care Services conducts a site visit for our Substance Abuse Block Grant responsibilities. This site visit will also last two days and will occur in April. The focus of this review primarily surrounds policies and procedures and mechanisms for monitoring our contract providers.

Mental Health Services Act FY 16/17 Plan Update

You will soon begin receiving invitations to participate in stakeholder meetings for the FY16/17 plan update. Additionally, Research Development Associates (RDA) will join the LMHB for approval of plan before submission. A scheduled of related event will be shared in the near future.

RAND FINDS INVESTMENT IN STUDENT MENTAL HEALTH PAYS OFF

CalMHSA investment means more graduates

Approximately **329** more UC, CSU and California Community College grads annually make a big impact

More graduates means more earnings

Lifetime Earnings

- UC Graduate: $2 million
- CCC Graduate: $1.4 million
- High School Graduate: $700,000

More earnings means more societal benefits

$1 invested in students

- $6.49* → society
- $0.98 → state government

Societal benefits justify continued investment

$56.1 million added to society

$8.5 million returns to state government

*Among community college students, the net benefit is estimated to be $11.39 for each dollar invested.

According to a recent RAND evaluation, student mental health programs decrease college drop out rates and contribute to graduate success. Students, schools and all of California will benefit from each dollar invested in prevention and early intervention programs by the California Mental Health Services Authority (CalMHSA).

EachMindMatters

Funded by counties through the voter-approved Mental Health Services Act (Prop. 63).

EachMind MATTERS California's Mental Health Movement

CalMHSA

63

Introduction

As an evidence-based psychiatric rehabilitation practice, Assertive Community Treatment (ACT) provides a comprehensive approach to service delivery to consumers with severe mental illness (SMI). ACT uses a multidisciplinary team, which typically includes a psychiatrist, a nurse, substance abuse and vocational specialists, peer counselor, and at least two case managers. ACT is characterized by (1) low client to staff ratios; (2) providing services in the community rather than in the office; (3) shared caseloads among team members; (4) 24-hour staff availability, (5) direct provision of all services by the team (rather than referring consumers to other agencies); and (6) time-unlimited services. When done to fidelity, the ACT model consistently shows positive outcomes for individuals with psychiatric disabilities. This flexible, client-driven comprehensive treatment has been shown to reduce risk and improve mental health outcomes.

The ACT service-delivery model relies on a multidisciplinary team of professionals who work closely together to serve consumers with the most challenging and persistent mental health needs. The ACT team works as a unit rather than having individual caseloads in order ensure that consumers receive the services and support necessary to successfully live in the community and provide direct services to consumers *in vivo*; this means the ACT team must have a flexible service delivery model, providing consumers the services they need in the places and contexts they need them, as opposed to primarily in an office setting.

ACT is a nationally recognized evidence based practice with evidence dating back to the 1970s. According to outcomes from 25 randomized controlled trials, compared to usual community care, ACT more successfully engages clients into treatment, substantially reduces psychiatric hospital use, increases housing stability, and moderately improves symptoms and subjective quality of life. Perhaps more importantly, research also suggests there are no negative outcomes associated with the ACT service delivery model. Recent research seeking to identify which client populations ACT is most effective for demonstrates that ACT is strongly effective and cost-effective for clients with a high frequency of psychiatric hospitalizations and less effective and not cost-effective for clients with a low frequency of psychiatric hospitalizations.

In Yolo County, Turning Point Community Programs administers ACT. It is funded by the Mental Health Services Act (MHSA) Community Services and Supports component as a Full Service Partnership program. ACT offers adults with serious mental illness a full service partnership program that addresses mental health, housing needs, and community reintegration. Clients in the program have access to any team member; small caseloads for more individualized attention; nursing services and psychiatry; housing supports; and 24-hour availability. A small proportion of ACT consumers are concurrently engaged in assisted outpatient treatment with ACT as the court-ordered services.

Fidelity Assessment Process

Yolo County Health and Human Services Agency (HHSA), in partnership with Turning Point Community Programs (TPCP), was interested in learning about the ACT program successes and outcomes with the intention to identify opportunities to strengthen ACT services. HHSA contracted with Resource

Development Associates (RDA) to conduct a fidelity assessment that explores the extent to which TPCP's ACT program is in alignment with the ACT model and the outcomes that ACT consumers have achieved during their participation, including available data regarding expected ACT outcomes (e.g. reduction in hospitalization, incarceration, homelessness).

RDA applied the ACT Fidelity Scale, developed at Dartmouth University[1] and codified in a SAMHSA toolkit.[2] This established assessment process sets forth a set of data collection activities and scoring process in order to determine a fidelity rating as well as qualifications of assessors.

Roberta Chambers, PsyD, and John Cervetto, MSW conducted the ACT Fidelity Assessment. Both raters have extensive experience in community mental health programs as well as quality improvement and evaluation.

The fidelity assessment began with a series of project launch activities. This included:

1. Project launch call with HHSA to confirm desired outcomes for the fidelity assessment and identify contact persons for each of the activities.
2. Project launch call with HHSA and TPCP to introduce the fidelity assessment and desired outcomes, describe the assessment process, and confirm logistics for the assessment site visit.
3. Data request to HHSA and TPCP in advance of the site visit to obtain descriptive data about consumers enrolled in ACT over the 12 months preceding the site visit.

The assessors conducted a full-day site visit at TPCP's ACT team office in Davis, CA on December 8, 2015. During the site visit, the assessors engaged in the following activities:

- ACT program meeting observation
- Interviews with five (5) ACT team members including the Team Leader, Clinical Director, Nurse, and two (2) Personal Service Coordinators
- Review of available documentation
- Consumer focus group
- Family member focus group
- Debrief with the Team Leader and Clinical Director

Concurrently, RDA obtained data from HHSA and conducted descriptive analyses of the demographics and service utilization patterns of consumers enrolled in ACT.

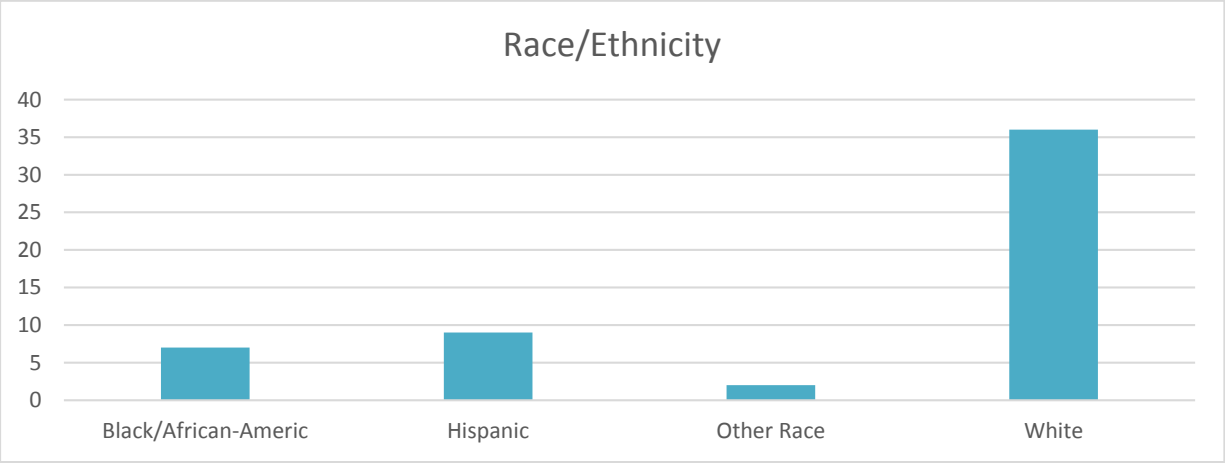
Following the site visit and data analysis, the assessors each completed the fidelity rating scale independently and then met to seek consensus on each individual rating as well as identify recommendations to strengthen TPCP's ACT program fidelity rating. The results of that discussion and the fidelity assessment are presented in the proceeding Results and Discussion sections.

[1] http://www.dartmouth.edu/~implementation/page15/page4/files/dacts_protocol_1-16-03.pdf
[2] Substance Abuse and Mental Health Services Administration. *Assertive Community Treatment: Evaluating Your Program.* DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services Administration, U.S Department of Health and Human Services, 2008.

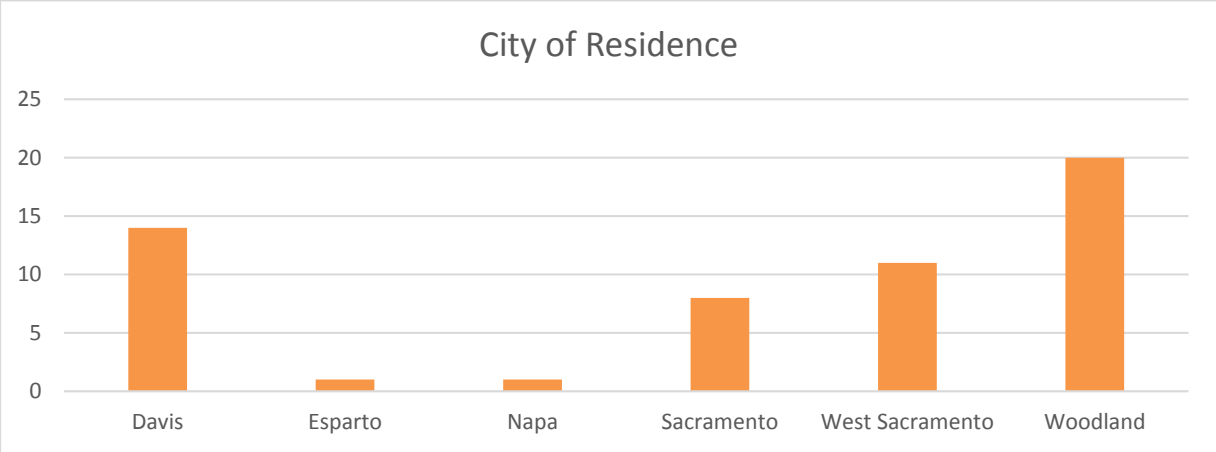
ACT Program

ACT Consumer Information

In 2015, fifty-five (55) consumers were enrolled in the ACT program. Twenty-eight (28) were female and twenty-seven (27) were male. ACT consumers ranged from age 21- 68 years old with a mean age of 40 years old. The majority of ACT consumers were white with smaller proportions of Latino and African American consumers.

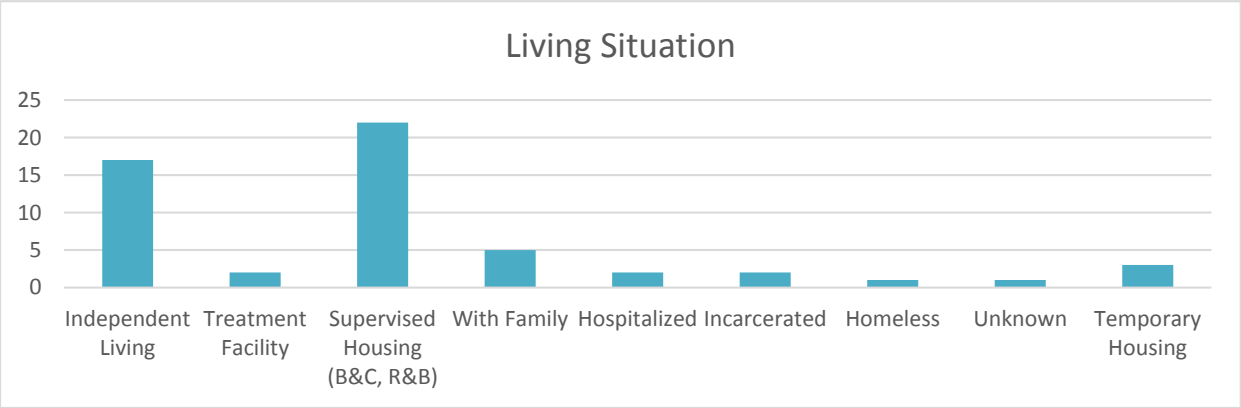


Additionally, the majority of consumers lived in the cities of Woodland, Davis, and West Sacramento. A smaller number of consumers reported out-of-county addresses.



All ACT consumers had a diagnosis of a serious mental illness and experienced significant impairments in functioning, including a history of psychiatric hospitalization, homelessness, and difficulty participating in regular, ongoing outpatient services. Additionally, 60% of ACT consumers (33 individuals) had a diagnosed co-occurring disorder.

The majority of ACT consumers live in stable housing environments. The highest percentages of consumers live in supervised living arrangements, including board and care and room and board environments, as well as in independent settings.



Two (2) of the 55 ACT consumers were employed at the time of assessment.

ACT Service Utilization

A subset of ACT consumers received services that were in addition to ACT participation, including crisis and hospitalization services and other FSP and mental health services, as shown in the service utilization table. It is important to note that emergency department utilization is not included in these data nor are substance abuse treatment encounters.

Service Utilization	# of Consumers
Hospital Inpatient	14
IMD/MHRC	5
Crisis Residential Treatment	6
Community Intervention Program	1
FSP Services	4
Other Outpatient Mental Health	6

For the fourteen (14) consumers who were hospitalized during 2015, the majority of had less than 25 inpatient bed days throughout the year. Notably, there were seven (7) consumers who had more than 25 hospital inpatient days with two (2) having more than 90 inpatient bed days. Please note that this data represents inpatient bed days across all hospital admissions for each consumer and does not suggest continuous hospital stays.

# of Days Hospitalized	# of Consumers
0-25	7
26-50	3
51-75	2
76-100	1
100+	1
Total	**14**

ACT Team Staffing

The ACT program is staffed with an interdisciplinary team that includes the following positions and full time equivalencies (FTEs):

- Team Leader (1.0)
- Clinical Director (1.0)
- Psychiatrist (.2)
- Licensed Psychiatric Technician/Nurse (1.0)
- Personal Service Coordinators (5.0)
- Program Assistant (1.0)

ACT staff work together as a team and share responsibility for supporting all ACT consumers with their recovery and psychosocial needs.

Fidelity Assessment Results

The ACT program was rated on the three domains set forth in the ACT Fidelity Scale, including:

- Human Resources: Structure and Composition
- Organizational Boundaries
- Nature of Services

Each domain has specific criterion rated on a 5 point Likert scale with clearly defined descriptions for each rating. The following chart provides an overview of the domains, criterion, and TPCP's ACT program rating. The proceeding section provides descriptions, justifications, and data sources for each criterion and rating.

Domain	Criterion	Rating
Human Resources: Structure and Composition	Small caseload	5
	Team approach	5
	Program meeting	5
	Practicing ACT leader	4
	Continuity of staffing	3
	Staff capacity	5
	Psychiatrist on team	2
	Nurse on team	4
	Substance abuse specialist on team	1
	Vocational specialist on team	1
	Program size	5

Domain	Criterion	Rating
Organizational Boundaries	Explicit admission criteria	5
	Intake rate	5
	Full responsibility for treatment services	4
	Responsibility for crisis services	5
	Responsibility for hospital admissions	1
	Responsibility for hospital discharge planning	4
	Time-unlimited services	4
Nature of Services	In vivo services	5
	No drop-out policy	5
	Assertive engagement mechanisms	5
	Intensity of services	3
	Frequency of contact	2
	Work with support system	4
	Individualized substance abuse treatment	1
	Co-occurring disorder treatment groups	1
	Co-occurring disorders model	3
	Role of consumers on treatment team	1
ACT Fidelity Score		**3.5**

Human Resources: Structure and Composition

Small Caseload: 5

Small caseload refers to the consumer-to-provider ratio, which is 10:1 for ACT programs. TPCP's ACT program received a rating of 5 for this criterion as they have 9.2 FTEs for 55 consumers and clearly exceeds the 10:1 ratio. This was assessed through personnel records.

Team Approach: 5

Team approach refers to the provider group functioning as a team rather than as individual team members with all ACT team members knowing and working with all consumers. TPCP's ACT program received a rating of 5 for this criterion as more than 90% of consumers had face-to-face interactions with more than one team member in a two (2) week period. This was assessed through consumer records and further supported through the morning meeting observation, staff interviews, and consumer and family focus groups.

Program Meetings: 5

Program meetings is regarding the team meeting often to plan and review services for each consumer. TPCP's ACT program received a rating of 5 for this criterion as they team meets at least four (4) times per week and reviews every consumer in each meeting. Assessors observed the program meeting during the

site visit and observed the team discussion for every consumer as well as confirmed the frequency of program meeting through available documentation and staff interviews.

Practicing ACT Leader: 4

Practicing ACT leader refers to the supervisor of frontline staff providing direct service to consumers. Full fidelity requires that the supervisor provide direct service at least 50% of the time. TPCP's ACT program is set-up to share supervisory responsibility between the Team Leader and Clinical Director. Through interviews with both supervisory staff, they reported that each provide direct service about 40% of the time. These direct services include both formal and informal interactions and may or may not include formal progress notes. As such, this rating is solely based on staff interviews.

Continuity of Staffing: 3

Continuity of staffing refers to staff retention. Full fidelity requires no more than 20% turnover within a two (2) year period. Currently, there are ten (10) positions on the ACT team with 8 staff discontinuing ACT team employment in the time frame, resulting in an annualized turnover rate of 40%. This results in a rating of 3 based on the scoring rubric and was assessed through a review of personnel records.

Staff Capacity: 5

Staff capacity refers to the ACT program operating at full capacity. According to personnel records, the ACT program has operated at or above full staffing capacity 97% of the time, which exceeds the 95% benchmark set forth in the scoring rubric.

Psychiatrist on Team: 2

Fidelity to the ACT model requires 1.0 FTE psychiatrist per 100 consumers. For 55 consumers, the ACT team would require a .55 FTE psychiatrist. Currently, the ACT team provides psychiatrist one day per week for 8 hours, as reported by staff. This results in a rating of 2.

Nurse on Team: 5

The ACT model requires 1.0 FTE per 100 consumers. Currently, the ACT team employs a full-time nurse, as observed by personnel records and staff interview. This results in a rating of 5.

Substance Abuse Specialist on Team: 1

The ACT model includes a substance abuse specialist position on the ACT team. Currently, TPCP's ACT program has five (5) personal service coordinators that provide a more generalized approach to case management rather than specialty areas of practice, as observed by personnel records and staff interview. This results in a rating of 1.

Vocational Specialist on Team: 1

The ACT model includes a vocational specialist position on the ACT team. Currently, TPCP's ACT program has five (5) personal service coordinators that provide a more generalized approach to case management

rather than specialty areas of practice, as observed by personnel records and staff interview. This results in a rating of 1.

Program Size: 5

Program size refers to the size of the staffing to provide necessary staffing diversity and coverage. TPCP's program exceeds the staffing ratio, as observed by personnel records and staff interview. This results in a rating of 5.

Organizational Boundaries

Explicit Admission Criteria: 5

The ACT team, in partnership with HHSA, has explicit admission criteria for enrollment into ACT. The responsibility for actively identifying and engaging potential ACT consumers is shared between HHSA and TPCP, and the ACT team takes a "whatever it takes" approach to engage consumers once they have been identified as ACT eligible. This was observed through staff interviews and results in a rating of 5.

Intake Rate: 5

Intake rate refers to the rate at which consumers are accepted into the program to maintain a stable service environment. In the past six (6) months, there have been no more than six (6) consumers admitted in any given month resulting in a rating of 5. This was observed through a review of consumer records.

Full Responsibility for Services: 3

Fidelity to the ACT model requires that ACT programs not only provide case management services but also provide psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, and employment and rehabilitative services. Currently, the ACT team provides psychiatric and housing support services and refers to other programs for psychotherapy, substance abuse, and employment services. This was observed through program meeting observation and staff interview as well as a review of personnel records and results in a rating of 3.

Responsibility for Crisis Services: 5

The ACT model includes a 24-hour responsibility for covering psychiatric crises. TPCP's ACT team provides 24-hour coverage through a rotating on-call system that is shared by all program staff, with the exception of the program assistant. The Team Leader and Clinical Director provide back-up coverage and support. This was observed through program meeting observation and staff interview as well as a review of personnel records and results in a rating of 5. However, the Team Leader and Clinical Director discussed with assessors that while the program provides 24-hour coverage, it is dependent on ACT consumers accessing the crisis support and that others (e.g. hospitals, police) infrequently access crisis supports when they encounter ACT consumers in crisis.

Responsibility for Hospital Admissions: 1

The ACT model includes the ACT program participating in decision-making for psychiatric hospitalization. Currently, the ACT team is willing and available through the on-call system, mentioned above, to participate in all decisions to hospitalize ACT consumers. However, this requires that hospitals and emergency departments are 1) aware that a consumer is enrolled in ACT and 2) willing to involve the ACT team in the decision-making process. ACT team members discussed that they rarely become aware that a consumer may be hospitalized until after the person has already been admitted to the hospital and are infrequently involved in the decision-making process. This removes a key function of the ACT program to intervene with consumers and reduce associated hospitalizations and results in a rating of 1.

Responsibility for Hospital Discharge Planning: 4

The ACT model includes the ACT program participating in hospital discharge planning. Currently, the ACT team participates in all hospital discharge plans that they are aware of. While the ACT team is willing and available to participate in all discharge planning, this requires that hospitals are 1) aware that a consumer is enrolled in ACT and 2) willing to involve the ACT team in the decision-making process. ACT team members discussed that they think that they become aware of the majority of hospitalizations and respond accordingly to support discharge planning but that this is especially problematic with the out-of-county hospitals, specifically when consumers may present to out-of-county Emergency Departments in neighboring counties (e.g. Sacramento) and not communicate to the hospital that they are enrolled in the ACT program. This results in a rating of 4 as they are participating in many but not all discharge planning.

Time-Unlimited Services: 4

The ACT model is designed to be time-unlimited with the expectation that less than 5% of consumers graduate annually. TPCP's ACT program graduated 9% of consumers during 2015, according to a review f consumer records and staff interview. While this suggest that consumers are achieving a level of recovery that allows for transition to a less intensive service delivery model, it results in a rating of 4 for this ACT program.

Nature of Services

Community-based Services: 5

ACT services are designed to be provided in the community, rather than in an office environment. According to staff, consumer, and family reports, approximately 90% of services are provided in the community. The only service that is primarily office-based is psychiatry. This exceeds the 80% benchmark in the scoring rubric and results in a rating of 5.

No Dropout Policy: 4

This criterion refers to the retention rate of consumers in the ACT program. According to consumer records and staff report, 3 consumers dropped out of the ACT team in the past twelve (12) months. This 5% dropout rate meets the standard for retaining at least 95% of consumers.

Assertive Engagement Mechanisms: 5

As part of ensuring engagement, the ACT model includes using street outreach and legal mechanisms as indicated and available to the ACT team. The ACT team includes a subsection of consumers who are enrolled in Assisted Outpatient Treatment, a legal mechanism for supporting engagement, as well as a variety of outreach mechanisms to engage consumers. During the program meeting observation and staff interviews, team members discussed places where they regularly frequent to locate and interact with consumers. Specific examples include deploying staff to local businesses, homeless encampments, and other service locations, as identified in the program meeting team discussion, to locate ACT consumers that day. This results in a rating of 5.

Intensity of Services: 3

Fidelity to the ACT model requires that consumers receive an average of two (2) hours per week of face-to-face contact. A review of consumer records and staff interview suggest that ACT consumers are receiving an average of one (1) hour per week of face-to-face contact, supplemented by phone calls. Given that the ACT team did not provide group interactions, the majority of the face-to-face contacts were individualized. This results in a rating of 3.

Frequency of Contact: 2

Fidelity to the ACT model requires that AT consumers have an average of at least four (4) face-to-face contacts per week. A review of consumer records and staff interview suggest that ACT consumers are receiving an average of one (1) face-to-face contact, supplemented by additional phone calls. This results in a rating of 2, according to the scoring rubric.

Work with Informal Support System: 4

The ACT model includes support and skills for the consumer's support network, including family, networks, and employers. A review of consumer records and staff interview suggest that the ACT team is providing support to informal support systems during most of their face-to-face interactions with consumers (once per week). Full fidelity requires four (4) or more contacts per month with consumer support networks. Providing support during most of the weekly face-to face consumer contacts suggests a rating of 4, which is 2-3 times per month.

Individualized Substance Abuse Treatment: 1

The ACT model is based on an interdisciplinary team that provides all of the services a consumer may need to support their recovery and address their psychosocial needs, including individualized substance abuse treatment. Because this ACT team does not employ a substance abuse treatment specialist, consumers do not have access to individualized substance abuse treatment from the ACT team. TPCP's ACT program refers to another program, also operated by TPCP and co-located with the ACT office, to address consumer substance abuse needs. This was observed through a review of personnel and consumer records, staff interview, and consumer focus groups and results in a rating of 1.

Co-occurring Disorder Treatment Groups: 1

The ACT model is based on an interdisciplinary team that provides all of the services a consumer may need to support their recovery and address their psychosocial needs, including co-occurring disorder treatment groups. Because this ACT team does not employ a substance abuse treatment specialist and does not currently provide group treatment, consumers do not have access to co-occurring disorder treatment groups from the ACT team. TPCP's ACT program refers to another program, also operated by TPCP and co-located with the ACT office, to address consumer substance abuse needs. This was observed through a review of personnel and consumer records, staff interview, and consumer focus groups and results in a rating of 1.

Dual Disorders Model: 3

The ACT model is based on a non-confrontational, stage-wise treatment model that considers the interactions between mental illness and substance use and has gradual expectations of abstinence. The assessors were impressed with the implementation of motivational interviewing and stages of change principles throughout the program meeting and staff interviews found that the ACT program clearly meets and exceeds the treatment philosophy set forth in the ACT model. However, the ACT program does not provide any co-occurring disorders treatment to consumers directly and refers to another program, also operated by TPCP and co-located with the ACT office. This results in a rating of 3.

Role of Consumers on Team: 1

The ACT model includes the integration of consumers as full-fledged ACT team members, usually in the provision of peer support and/or peer counseling. TPCP's ACT program does not include consumer membership as a part of the ACT team staffing. This was observed through a review of personnel and consumer records, staff interview, and consumer focus groups and results in a rating of 1.

Other Feedback

ACT consumers and family members were generally appreciative of the ACT program and believed that participating in ACT had been beneficial. Program strengths included:

- **24-hour availability:** Participants commented on the supportive nature of the program and the availability of staff outside of business hours. One consumer stated, "If I'm crying and need to call them late at night, they're support outside of your family."
- **Team approach:** Participants acknowledged having relationships with many of the ACT team members. Consumers shared. "there's more than one person who cares," and "Here you have a team…everyone knows what's going on with everyone so you can call and talk to anyone."
- **Inclusive approach to services:** Participants highlighted that the ACT team is responsive to a variety of support needs, including:
  - Attending doctor and psychiatry appointments
  - Support with medications, specifically injections
  - Navigating the DMV and obtaining ID and Driver's license

- Obtaining and filling prescriptions
- Understanding documentation from other agencies (e.g. social security)
- Supporting housing identification, placement, and retention

Discussion participants also provided suggestions for improving the program, including:

- **Frequency and Intensity of Services:** Participants shared that they would like to have more frequent contact with the ACT team as well as participate in more groups, especially socialization and activity groups.
- **Crisis Response:** Family members discussed that the crisis line can be helpful but that the ACT team could improve their approach to crisis prevention before situations escalate. Participants suggested that it would be useful to modify the level of intervention based on current presentation (i.e. increase contact during times of crisis and reduce contact during times of relative stability.)
- **Organization and Follow-up:** "Sometimes you have to call and stay on top of it to get a response," and "I don't want to have to worry about having to remind them." There was also mention that the phone system may be inconsistent and/or difficult to navigate.
- **Consumer Expectations:** Both consumer and family member participants discussed that the ACT team may have unrealistic expectations for consumers. "They expect more than we can do sometimes." Both consumers and family members agreed that they appreciate the ACT team's commitment to support self-sufficiency and independence but that it would be useful to provide more support as someone is developing life skills or is experiencing challenges.
- **Strengthen Family Component:** Family members discussed how difficult it is to support their loved ones and that it would be useful to have a family support group for ACT family members as a part of the program. Family members also suggested regularly scheduled treatment team meetings that included the family members, as permitted, rather than crisis driven interactions.

Additional Analysis

Frequency of ACT Services

In 2015, Turning Point ACT service teams provided services and supports 55 clients enrolled in its ACT Program. To understand the frequency of ACT services, RDA looked at the number service encounters provided by Turning Point ACT teams to ACT consumer during 2015. We excluded services provided by ADMH, inpatient facilities, and other providers.

From the period of January to December 2015, Turning Point service had 5,477 encounters with ACT clients. On average, Turning Point had 456 contacts per month with ACT consumers. When looking at contacts during the week, Turn Point had an average of 105 contact per week. However, since the total number of clients who received services varies each month; these averages do not accurately reflect the frequency of service utilization by ACT consumers at the individual level.

Table 1. The frequency of ACT Encounter per ACT Consumer By Month, Week, and Year

	Weighted Average # of ACT Encounters	Median # of ACT Encounters	Min. # of ACT Encounters	Max. of ACT Encounters
Per Week	2.13	2.06	0.38	4.43
Per Month	9.24	8.92	1.67	19.17
12-Month Total	101.43	95.50	5.00	230.00

At the individual level, ACT consumers on average had slightly more than two (2) contacts per week with an ACT team member. As Table 1 illustrates, using a weighted average, an individual ACT consumer experienced slightly more two (2) encounters on average per week from Turning Point service teams. As depicted, the monthly and annual average totals also correspond with the average weekly frequency. The median number of encounters also corresponds to the weighted mean suggesting that the mean accurately reflects the number of contacts that ACT consumers usually receives. The utilization data also suggests a wide range in the number of encounters at weekly, monthly, and yearly periods. This may reflect varying level of engagement of across ACT consumers as well as clients having long periods of incarceration or hospitalization.

This review of the utilization data suggests a higher number of contacts per week than suggested by staff members (1 per week); however, two (2) contacts per week still results in a rating of 2 according the fidelity scoring rubric.

Intensity of ACT Services

The intensity of ACT services is measured by the number of hours of face-to-face contact that consumers receive from the Turning Point service teams. Based on utilization data, the number of the units of services ACT consumers received from Turning Point staff members in 2015 is on average about 2 hours and 20 minutes per week. This level of intensity of services is consistent at average totals for monthly and annual time periods. As depicted in Table 2, the median level of intensity is consistent with the mean suggesting that the average intensity accurately reflects utilization. Similar to frequency in the previous section, the range of intensity is spread across wide ranges, suggesting the service utilization varies across ACT consumers likely due to periods of incarceration or hospitalization.

Table 2. The Intensity of ACT Services per Client measured in Hours

	Mean ACT Hours	Median ACT Hours	Min. ACT Hours of Service	Max. ACT Hours of Service
Per Week	2.3	2.2	0.3	4.4
Per Month	10.1	9.4	1.3	18.9
12-Month Total	110.5	104.4	4.0	226.8

Based on interviews from staff and a review of case records, ACT consumers receive one (1) hour of face-to-face contact per week on average supplemented by phone calls. As utilization data indicates, on average, Turning Point staff log 2 hours and 20 minutes of contact with clients. However, qualitative data collected from staff interviews and a review of client records, suggest that Turning Point staff generally spend one (1) hour with ACT consumers per week in person with the remaining contacts occurring over the phone.

The intensity of all Turning Point ACT services on average exceeds the fidelity requirement of two (2) hours per week of face-to-face contact per client; however, providing an average of only one (1) hour of face-to-face contact does not meet the requirement for fidelity to the model.

Hospitalizations

In 2015, 14 of the 55 consumers enrolled in ACT experienced hospitalizations. The 14 clients represent approximately 25 percent (25%) of all ACT consumers in 2015. All together, ACT consumers were hospitalized 62 times averaging 3.2 admissions per client (*n = 14*). The 62 hospital admissions resulted in a cumulative total of 492 days spent in the hospital at an average of 35 hospital days per consumer (*n = 14*). Table 3 provides an overview of the number of hospitalized ACT clients and the days spent.

Table 3. Hospitalizations of ACT Consumers in 2015

Number of ACT Consumer hospitalizations	14
Total Number of Hospital Days	492
Total number of Hospital Admissions	62
Mean # of Admissions per client	3.2

Among the 14 consumer who were hospitalized in 2015, seven (7) of those ACT consumers accounted for 85 percent of the total days spent in the hospital. Table 4 provides quartile rankings of consumers based on the number of days spent hospitalized in 2015. Collectively, ACT consumers in the third (*n = 3)* and fourth *(n = 3)* quartiles spent 417 of the 492 days in the hospital; whereas, the first and second quartile combined (*n = 7)* only amounted to 75 hospital days or 15 percent of the total. This small cohort of high utilizers of hospital and inpatient services represents only seven (7), or 12 percent, of all ACT Consumers (*n = 55)*.

Table 4. The Ranking of Hospitalized ACT Consumers by the Number of Days Spent in the hospital

	Min Hospital Days	Max Hospital Days	Median Hospital Days	Mean Hospital Days	Total Hospital Days	Percent of Total Hospital Days
First Quartile	1	11	7	6.25	25	5%

(n =4)						
Second Quartile *(n = 3)*	12	19	19	16.6	50	10%
Third Quartile *(n = 4)*	28	54	40	40.5	162	33%
Fourth Quartile *(n = 3)*	63	102	90	85	255	52%
Total (n = 14)	***1***	***102***	***23***	***35***	***492***	***100%***

The high utilization of hospital and inpatient services also brings large and avoidable financial burdens to the public system of care. In 2015, the total cost of hospitalizing ACT Consumers was $278,153 with the seven consumers in the third and fourth quartiles accounting for $212,315 of all inpatient costs. Interestingly, the cost to the system to serve all 55 consumers through Turning Point, including those that were hospitalized, was $834,240 in 2015.

Such elevated numbers of hospital days among ACT-engaged consumers is an area for concern in terms of fidelity as large numbers of hospitalizations is inconsistent with ACT outcomes when implemented with fidelity with the model. The high amount of hospital days and avoidable costs to the system by a small group of consumers already engaged in ACT suggests a need for Turning Point to re-evaluate service delivery and engagement strategies used with these clients. It is also recommended that Turning Point pay particular focus towards reducing this group's utilization of inpatient services by identifying triggers that have led to hospitalization in the past, developing treatment plans aimed at early intervention, and partnering with Emergency Departments where this group is likely to present.

Discussion

Strengths

The assessors were impressed with a variety of elements of TPCP's ACT team and observed that many of the program elements were present and met or exceeded fidelity measures. The program was robustly staffed with more team members than required with staff who are clearly committed to the success of the program and consumers. Staff demonstrated their expertise with ACT, motivational interviewing, and the recovery model in conversations with assessors as well as through the program meeting discussion. The program is structured to provide adequate staffing that can do "whatever it takes" to support consumers and meet them "wherever they're at," literally and figuratively. Team members appeared to work together throughout the day to ensure that all consumers receive individualized support to achieve their goals. Both consumers and family members expressed gratitude to the ACT program and staffing for the accomplishments that ACT consumers have achieved during program participation. Throughout the focus groups, assessors heard consumer and family member accounts of increasing stability and finding hope, as well as a number of tangible successes, including:

- Maintaining an apartment for the first time
- Obtaining a drivers' license and subsequent employment
- Reducing the frequency of hospitalization
- Improving and repairing family relationships
- Believing that recovery is possible

Opportunities

The fidelity assessment also revealed areas where the ACT program is not in alignment with the ACT model, including: 1) the composition of ACT staffing and subsequent service availability, 2) individual delivery and resulting service intensity, and 3) participation in hospital admissions and discharges. Each of these areas are discussed below.

ACT Team Composition and Service Availability

TPCP's ACT team exceeds the staffing ratios, but five (5) of the positions are for personal service coordination. While many high-fidelity ACT teams would include this type of case management position, the ACT model includes a substance abuse specialist, vocational specialist, and consumer position. The impact of this staffing decision is that ACT consumers may not have access to all of the services expected within an ACT team, including substance abuse, vocational, and peer support services. For example, the ACT program provides robust housing supports and the majority of ACT consumers are stably housed. The ACT program does not include the required vocational specialist and only two (2) of the ACT consumers are engaged in employment.

This also means that the ACT team is not able to assume total responsibility for services for ACT consumers and relies on other programs and providers to meet the needs of ACT consumers. This is especially notable for the substance abuse specialist as 60% of ACT consumers have a co-occurring disorder.

The ACT program may wish to consider transitioning three (3) of the five (5) personal service coordinator positions to specialized designations, which would increase the fidelity scores in the Human Resources and Nature of Services domains as well as support consumers to gain access to the full range of ACT services and likely improve consumer outcomes related to substance abuse, employment, and recovery.

Individual Service Delivery and Service Intensity

While the ACT team exceeds consumer-to-provider ratios and staff appear to have high levels of productivity, consumers are receiving a lower intensity of services than expected in an ACT model. Assessors suspect that this may be related to the reliance on individual service encounters and the absence of group treatment opportunities. If the ACT team were to develop more group opportunities, also requested by consumers in their focus group discussion, the ACT program may be able to provide a greater number of face-to-face contacts and bring the program in alignment with ACT fidelity expectations without increasing staffing, which already exceeds ACT standards.

Groups that the ACT program may consider for implementation include:

- Substance abuse treatment (ACT program element)
- Co-occurring disorder groups (ACT program element)
- "Job club" (Assessor suggestion for vocational services)
- General support groups (Consumer suggestion)
- Socialization and activity groups (Consumer suggestion)
- Nutrition and exercise groups (Consumer suggestion)

Participation in Hospital Admissions and Discharges

A hallmark of the ACT model is the ability to reduce psychiatric hospitalizations through the provision of 24-hour coverage and participation in all hospital admission and discharge decisions. While the ACT team is willing and able to serve in this capacity, there appear to be certain barriers that prevent the ACT team from partnering with emergency departments and hospitals to prevent and reduce hospitalizations for ACT consumers. As mentioned in the Results section, the two (2) barriers discovered through this assessment are hospitals and emergency departments being 1) aware that a consumer is enrolled in ACT and 2) willing to involve the ACT team in the decision-making process.

However, 35% of ACT consumers were hospitalized in 2015, which suggests that the ACT program is not able to intervene in crises to prevent and reduce inpatient hospitalization despite their willingness and availability to do so. Addressing the identified barriers and increasing the ACT program's participation in hospital admissions and discharges will bring the ACT program in closer alignment to the ACT model as well as likely reduce the number of consumers being hospitalized and the length of hospitalization.

In order to accomplish this, TPCP may wish to consider providing ACT consumers with some sort of identification or ACT team membership card that includes the 24-hour crisis number that consumers can keep with them (e.g. in their wallet or purse) to share with emergency or medical personnel in crisis situations. Additionally, HHSA may wish to explore how to strengthen the communication between the ACT team and hospitals and emergency departments frequently accessed by ACT consumers in Yolo and neighboring counties.