



Implementing Community Treatment Teams

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Objectives

- Explain how best practice research and local data have supported the implementation of Community Treatment Teams (CTTs).
- Review ongoing collaboration, monitoring and interventions to insure best practice adherence.
- Describe perspectives from team leader.
- Discuss the evolution of monitoring efforts over time and implications for the future.

Service Delivery System Prior to CTT

- Catchment areas
- Largely office-based
- Case Management not sufficiently engagement oriented
- Crisis service system ER based, leading to hospitalizations
- Little crisis diversion
- Consumers receiving services from all over system- inpatient and outpatient, nothing sticking
- Record high community and state hospital admissions, readmissions, and LOS

CTTs As An Essential Ingredient In System Transformation

- Recovery Movement
- County Leadership Efforts
- Historically, high inpatient utilization locally
- Expand BH system focus to include housing opportunities, vocational and social opportunities.

Team Leader's Thoughts on CTTs As An Essential Ingredient In System Transformation

- Recovery Movement

How CTTs have begun to change how systems think

- Expand BH system

Housing

Vocational

Social

Why CTT?

- **Origins:** 1970s Mendota State Hospital, Madison WI, Stein and Test developed the PACT model: Moving intensive treatment and support from the hospital to the community
- **Outcomes:** extensive research has demonstrated reduction in psychiatric hospitalizations, increased housing stability, improved quality of life
- Model has been identified as an evidence-based practice (EBP) by SAMHSA

Principles of ACT Model

- Specific population (i.e. SPMI)
- Treatment, support, rehab provided by multi-disciplinary team (psychiatrist, nurses, MH therapist, D&A specialist, vocational specialist, forensics, peer specialists, etc.)
- Team members SHARE responsibility
- Staff ratio is small (1:10)
- Treatment & services are comprehensive & flexible (24/7)
- Interventions are in the community
- Individualized (tailored) care
- Assertive engagement mechanisms

Principles of ACT Model: Team Leader's Perspective

- Examples of:
 - SHARED responsibility
 - Individualized (tailored care)
 - Harm reduction
 - Assertive engagement mechanisms

Early Development of CTT

- Importance of multi-level partnering (MLP)
- County Office of Behavioral Health and Community Care Behavioral Health considered CTT a jointly funded project
- AHCI provided technical assistance and developed a web-based monitoring application
- RFP's issued by Community Care in collaboration with the County
- Stakeholder Review Team

Unique Characteristics of MLP

- Provider-funder oversight
- Oversight provided outside traditional structure (County, MCO, AHCI)
- Data used for quality improvement vs. punitive
- Consumer advisory committee is an integral component of MLP with authority

MLP Infrastructure to Support CTT Development

- Leadership Team
- CTT Network Workgroup
 - Team Leaders and Leadership Team
- CTT Core Team
 - Broad Stakeholder Representation
- CTT Consumer Advisory Committee
 - Team Leader will discuss the impact of the Advisory Committee on consumer recovery
- Promotes stakeholder feedback, review and input based upon review of data

Allegheny County CTTs

- 4 Teams (3 adult, 1 transition age), started 2001
- Consumers' treatment is funded by MA or County dollars (depending on eligibility)
- Teams are paid a fee-for-service rate, regardless of funding stream
- Managed care organization manages referrals, authorizations
- Teams bill either County or Community Care

CTT Performance Standards

- Performance standards define admission/discharge criteria and dictate structure/activities of CTTs
- Developed through collaboration between funders, monitoring entity, and providers
- Core requirement: structure of CTTs will follow the ACT model
- Additional specifications included to suit local needs

Monitoring, Evaluation, Performance Improvement for CTT

- Model adherence
- Consumer satisfaction
- Clinical scales
- Outcomes application
- UM monitoring, cost analyses across funding streams
- Team perspective on each initiative

Measuring Adherence to an EBP

- ACT is one of SAMHSA's EBP Implementation Resource Kits
- Each toolkit contains objective tools to measure fidelity to the EBP (DACTS is the fidelity assessment tool included in the ACT toolkit)
- Items scored using specific criteria on a 1-5 scale
- Customized to include additional elements of local performance standards

Model Adherence: Collaborative Measurement Process

- Representatives from AHCI, County, and Community Care performed assessments at each of the 4 sites
- Each rep. responsible for interviews, chart reviews, consumer interviews
- Process took approximately 8 months (i.e. meetings, assessments, results, feedback)

Model Adherence: Results

- Met with teams individually to discuss results
- Teams received improvement plan on items with a score of 3 or lower
- Improvement plans developed (e.g. increasing DD treatment, psychiatrist time)
- Consultant provides technical assistance and oversight

Using the DACTS: Pros and Cons

Pros

- Information can be used to improve specific program aspects which should impact effectiveness, clinical practice and outcomes

Cons

- Primarily measures structure, not team processes
- Some elements are more important than others
- Time-consuming

Ultimate goal: self-monitoring by teams

Model Adherence: Results

Strengths

- On-Call Services
- Hospital discharges (involvement)

Opportunities for Improvement (Scores 3 or lower)

- MISA Services
- Vocational Services
- Psychiatrist Services
- Team Leader To Discuss How Assessment Process Has Assisted With Change

How Does Allegheny County Compare to Other ACT Programs?

	HR	OB	NS	Overall Mean
NY ACT (N=27)	3.7	4.3	3.8	3.9
Illinois ACT (N=10)	3.3	4.6	4.1	4.0
East Cost ACT (N=14)	4	4.3	3.8	4.0
Allegheny ACT (N=4)	3.72	4.7	3.91	4.1

HR = Human Resources; OB = Organizational Boundaries; NS = Nature of Services

Consumer Satisfaction (C/FST)

- Consumer Action Response Team (CART), group of consumers who go to provider sites, gather satisfaction data via CSQ-8 instrument
- CSQ-8 instrument, self report, measures satisfaction with services received at specific provider site
- Provider sites receive quarterly feedback
- Teams incorporate feedback into daily practice

Clinical Scales

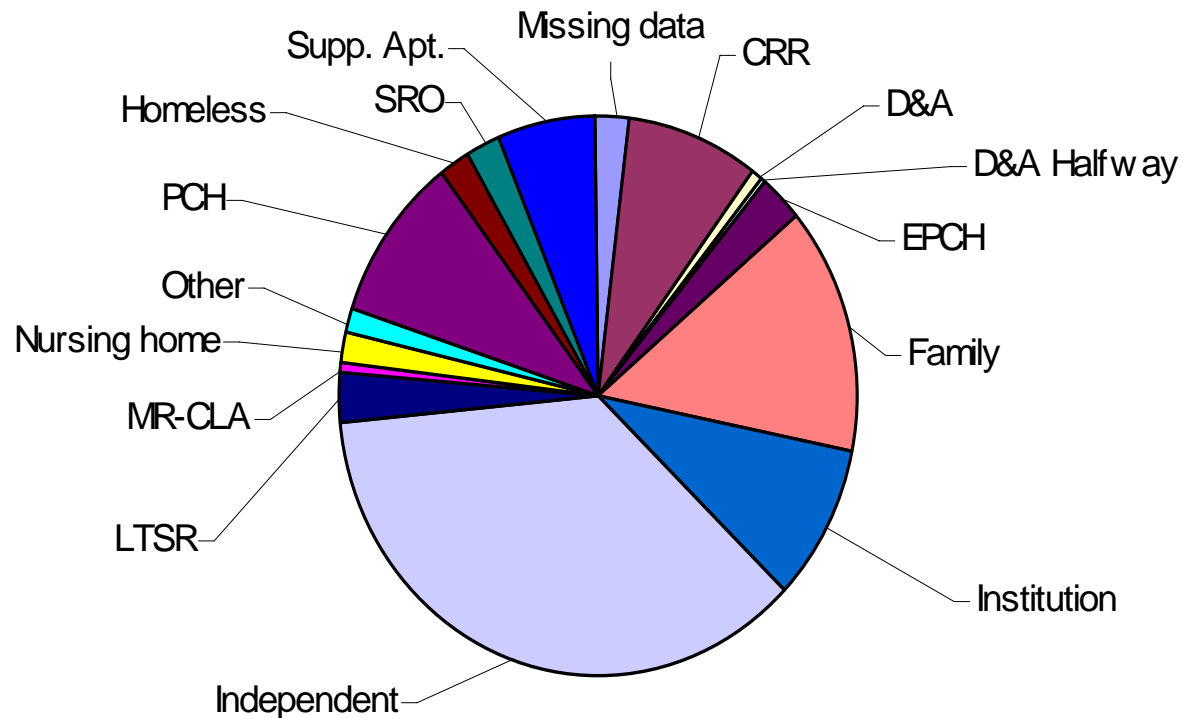
- Initial plan: multiple instruments collected every 6 months at *each* site for *every client* (incorporated with treatment plan)
- Problem: very low submission rate
- Revised plan: one simplified instrument discussed and piloted with consumers and teams
- The instrument includes elements from the Multnomah, Quality of Life Scale, SF-12

Outcomes Application

- Outcomes application developed to track change over time at the individual level
- Simple interface with drop-down menus
- Domains include:
 - Housing, employment, education, justice system involvement, crisis interventions, non-behavioral supports, GAF scores
- Each time a consumer's status in a domain changes, team records it
- Teams created internal processes to keep track of changes and enter in application
- Quarterly reporting and pre-post analyses

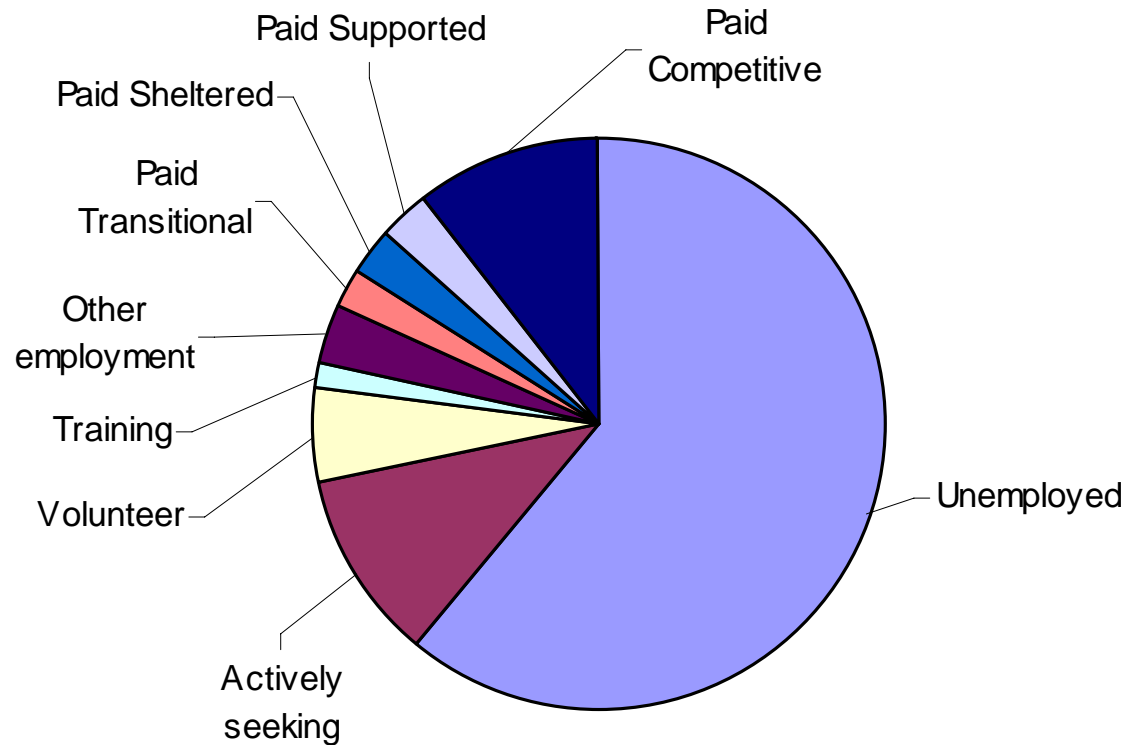
Example: Housing Status Report

Housing Status of CTT Consumers, Q1 2005



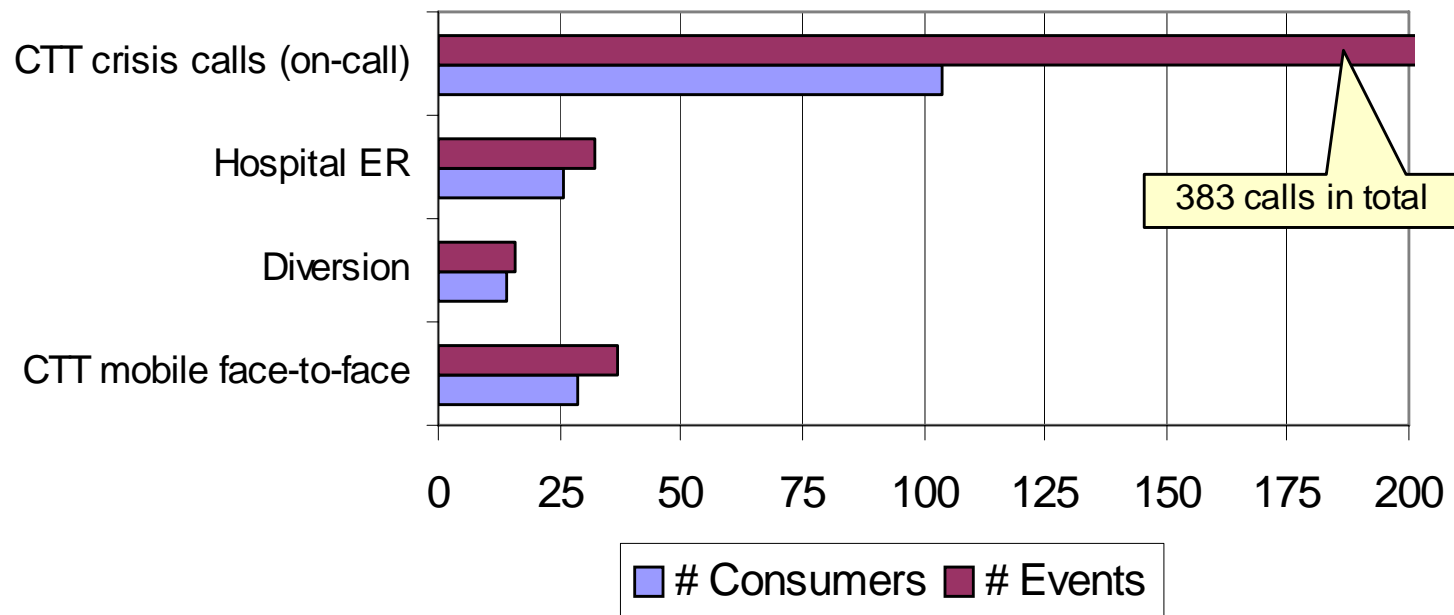
Example: Employment Report

Employment Status of CTT Consumers, Q1 2005



Example: Crisis Services Report

Crisis Services Provided by Teams, 1/1/05 - 3/31/05



Utilization Monitoring

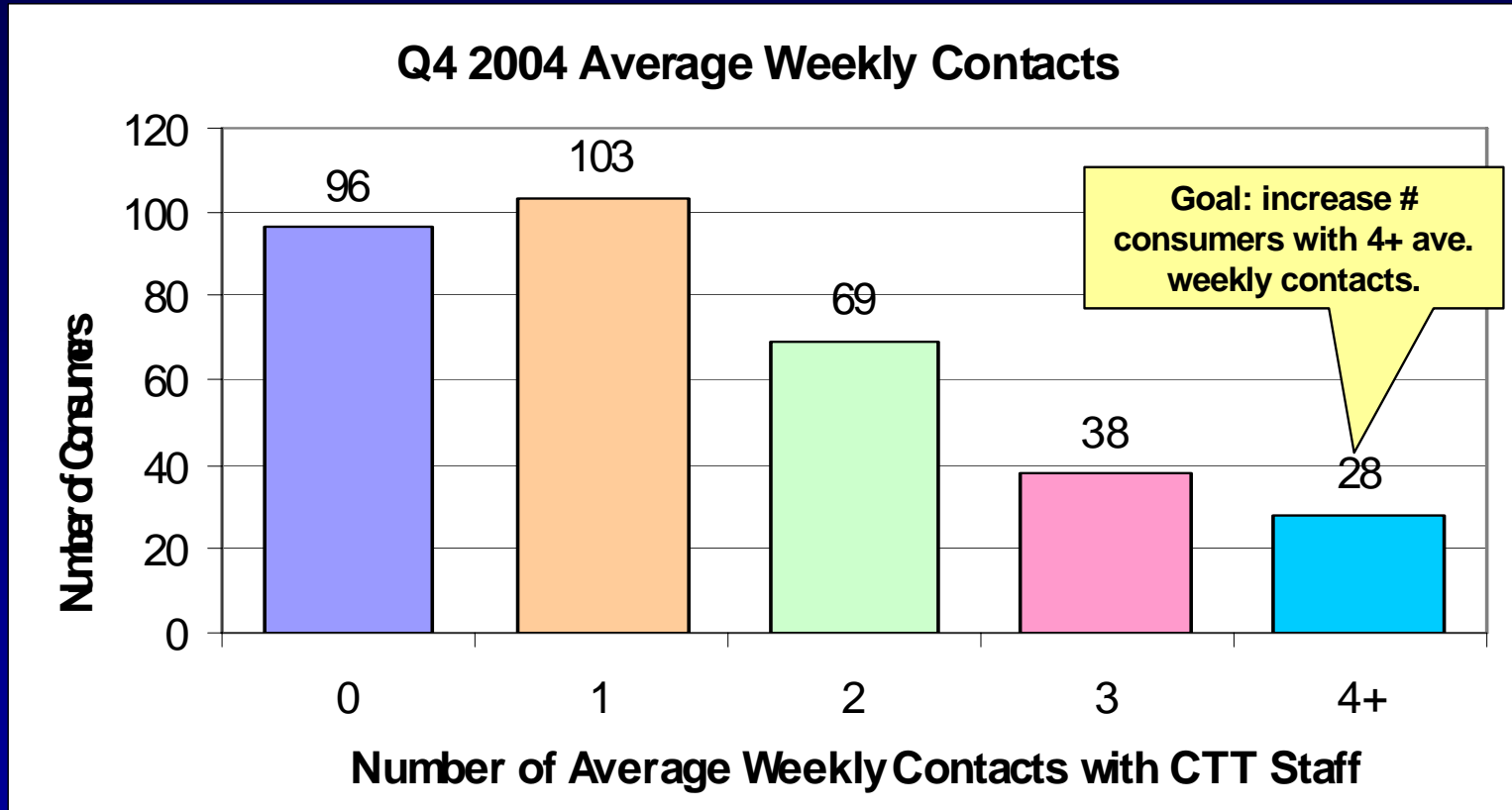
- Reports include claims data and hospital admissions data (both community psych and state hospitals)
- Report utilization data along with outcomes monitoring data on a quarterly basis
- Reports combine both MA and County-funded services
- ‘Lag time’ in claims data is longer, when compared to outcomes monitoring

Utilization Monitoring

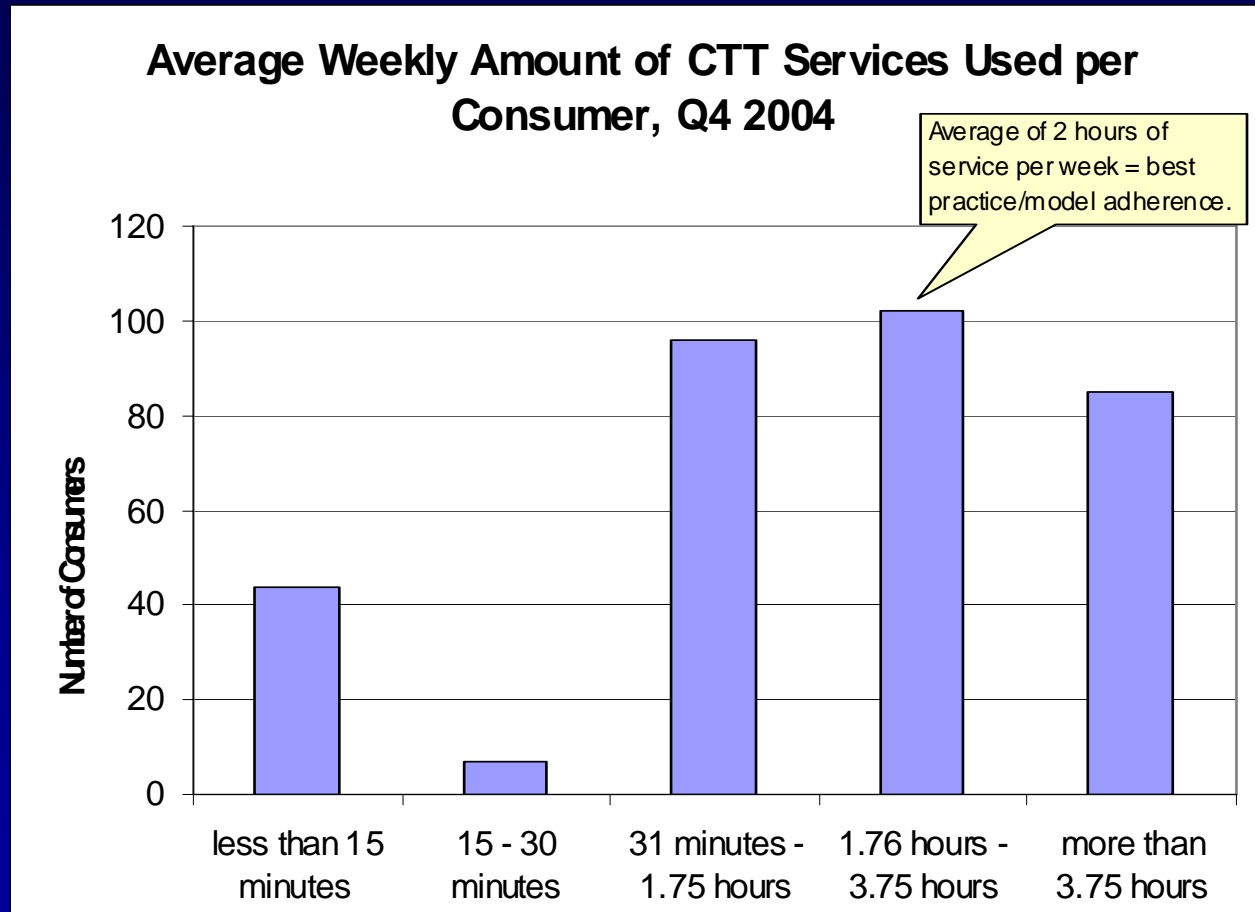
Claims Reports: measure frequency and intensity of services, in line with ACT model

- Average weekly CTT contacts
- Average weekly CTT service amounts
- Group, community, office-based service units

Average Weekly Contacts



Average Weekly Use of CTT Services



Location of Services Provided

Q4	# Cons.	% of Total Time (hours)	Paid Claims
Office-based services	249	15%	\$158,052
Community-based services	258	64%	\$684,032
Group services	144	21%	\$60,346
Total	332		\$902,430

ACT model: 75% of services should be provided in the community.

Utilization Monitoring (cont.)

Hospitalization Reports: monitor frequency and length of hospitalizations for CTT consumers

- State hospital stays
- Community hospital admissions, number of members, ALOS

State Hospitalizations Reports

	Q1	Q2	Q3	Q4
# Consumers	37	34	29	26
% of Cons. in SMH	12%	10%	9%	8%

This report includes consumers who were enrolled on a team while they were still in the state hospital, and consumers who were admitted to the state hospital after receiving services from a team in the community.

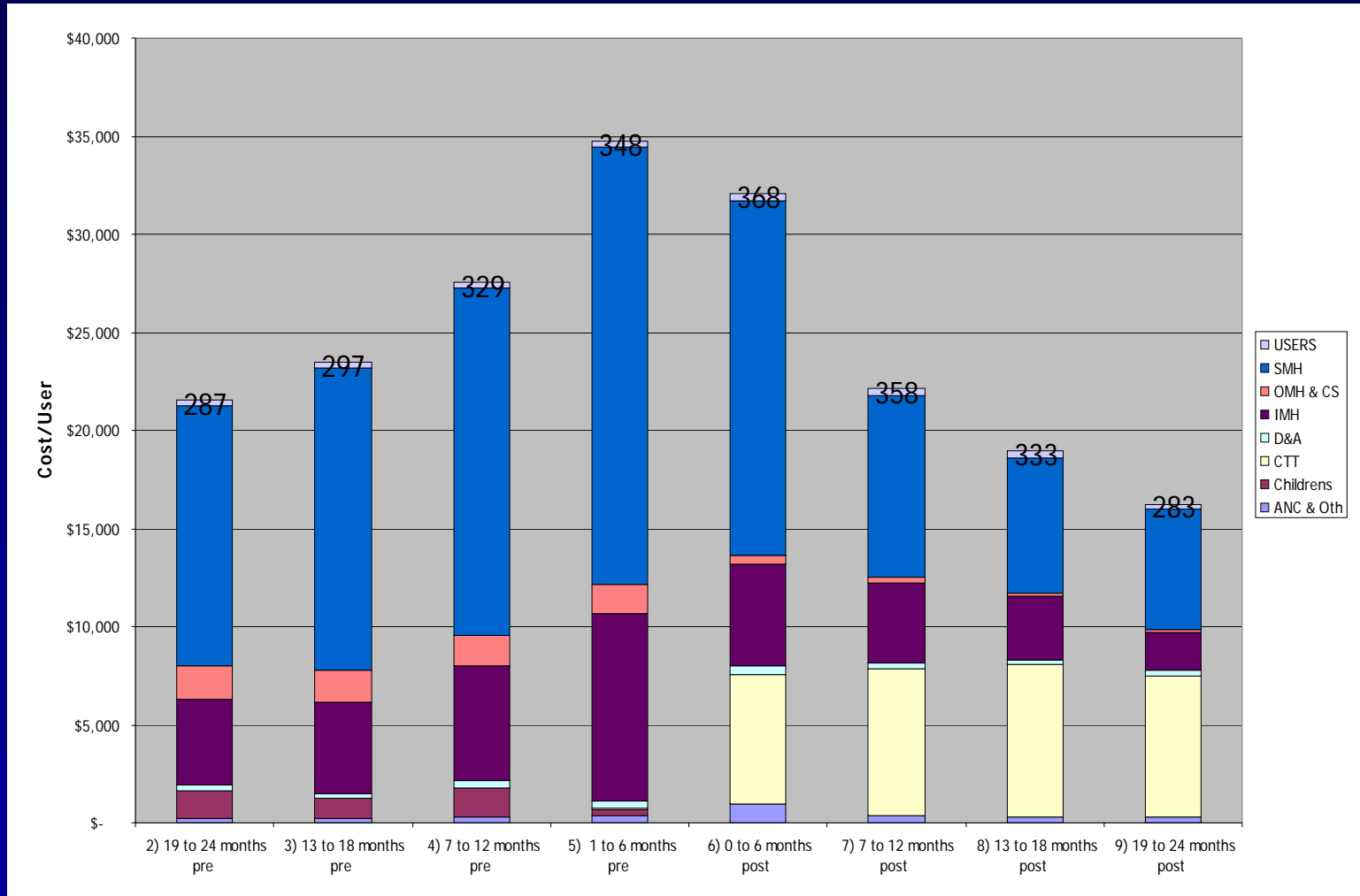
Community Hospitalizations Reports

Report Period	# Cons.	% of Cons. on teams	# Admits	ALOS
Q1	55	18%	73	14.5
Q2	50	15%	77	14.1
Q3	57	17%	79	15.3
Q4	62	19%	91	14.4

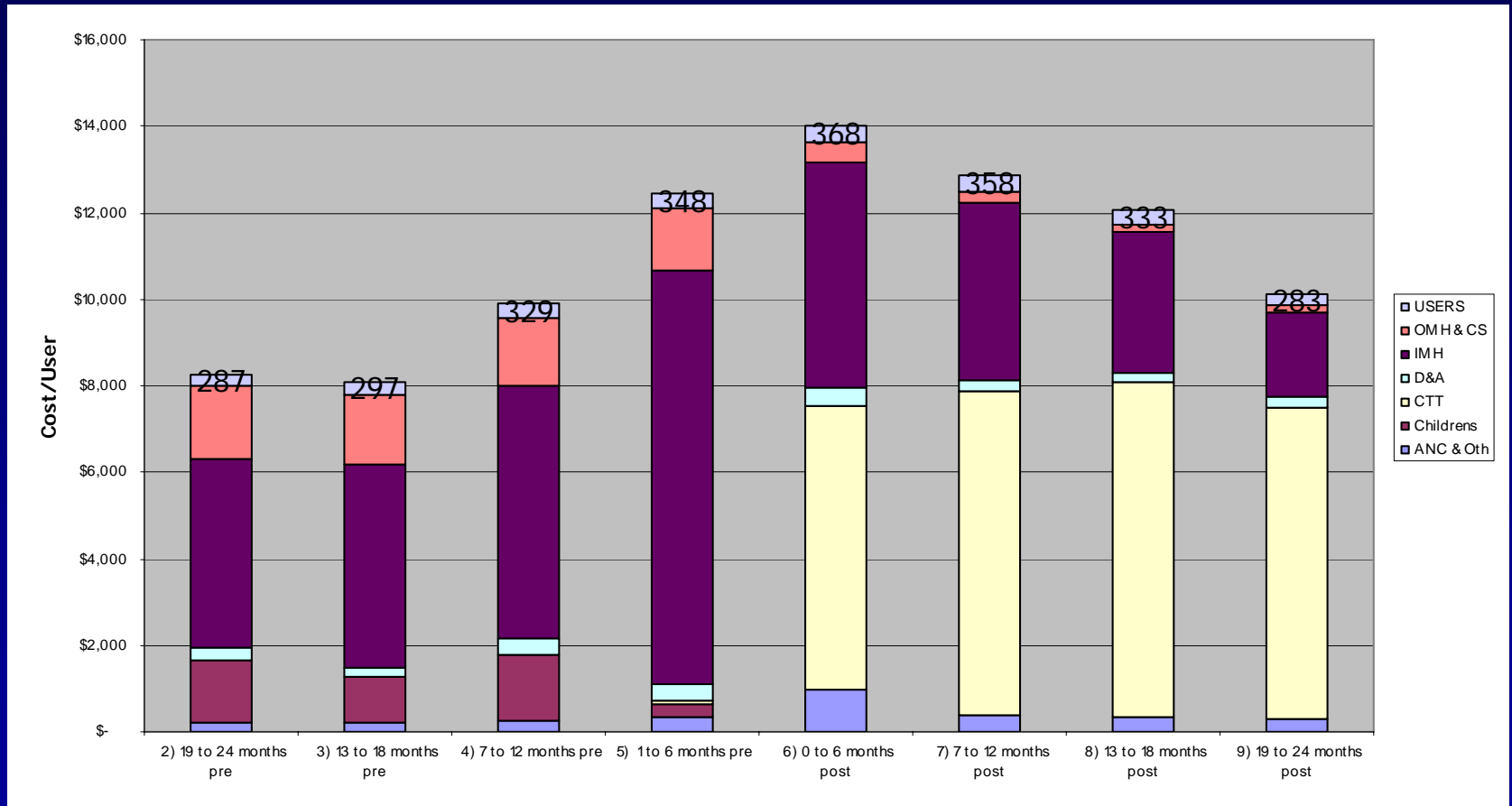
Service Cost Analyses

- Assessing service utilization and costs prior to CTT involvement and post CTT involvement
- Are there cost savings to the system as a result of implementation of the teams?
- Plan to continue to assess over time

Members Enrolled in CTT > 6 Months



Excluding State Hospital Costs



Lessons Learned

- 1. Keep measurement simple and have a reliable process.**
 - Significant learning curve for DACTS
 - Some indicators (hospitalization, number of treatment hours) duplicated other data sources
 - Some teams had difficulty tracking some indicators (crisis, non-behavioral supports)
 - Outcomes scales: length, process for completion

Lessons Learned

2. Develop meaningful reports that are useful and are provided to teams and consumers.

- Reports need to be timely, easy to understand
- Data should be used to monitor program operations, intervene when necessary
- Results should be provided back to teams, consumers

Lessons Learned

- 3. Making the connection between reports and improving day-to-day clinical services is a challenge.**
 - Team leaders, staff and administrators can use these reports to see overall patterns
 - How can teams better use data at the individual level? (i.e. treatment planning)

Next steps

- Re-administer the DACTS; consider assessment of embedded EBPs (Integrated Dual Treatment, Illness Management)
- Follow-up on Performance Improvement Plans
- Focus on Core Clinical/Skill Based Processes
 - Importance of supervision, modeling by Team Leaders
 - Importance of maintaining a focus on desired outcomes: work, housing
- Assertively address inpatient utilization; consider aligning incentives to address use of inpatient care by the Teams
- Consider further specialization of teams