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ACT Transition Model

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Presenter Disclosures

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Background

Assertive Community Treatment

- ACT is the most intensive and costly outpatient service for adults with severe mental illness
  - Low case-load ratio
  - Community, in-vivo services
  - Multidisciplinary team approach
  - 24/7 coverage
- ACT in New York State
  - 78 licensed ACT teams serving 4,759 clients

Need for enhancing transition services on ACT

- "Time-unlimited services" interpreted as life long services
- Most clients are discharged from ACT for adverse or neutral reasons
- Graduation not well-specified in ACT model
- Accumulating evidence of successful transition from ACT
- Better understanding of recovery
- Serving clients most in need

Model Development & Implementation

Transition Model Development

- Interviews with ACT experts (n=41)
- New York State focus groups (6 groups, n= 49 ACT staff)
- Review of the literature on existing models
  - Critical Time Intervention (CTI)
  - Bridger programs
- Developed by workgroup
  - State & New York City Operations
  - Consumers
  - ACT Service Providers
  - ACT Institute
  - CTI Experts

ACT Transition Model

- Engage clients in transition discussions
- Conduct assessment & develop a transition plan
- Introduce clients to Transition Group and wellness planning

- Build-on and Test Client's Skills
- Prepare, strengthen, and test existing supports
- Develop and test linkages with new supports

- Finalize transfer of care
- Monitor client's progress following transition

Learning Collaborative

- Three Learning Collaborative Groups
  - New York City I (n=8 teams), go-live January 2010
  - New York City (n=11 teams) , go-live September 2010
  - ROS (n=6 teams) , go-live July2010
- Initial Onsite Training(n= 199 staff)
- Monthly calls & quarterly in-person meetings
- Site Visits and Technical Assistance
  - Baseline, 6, 12, and 21 month visits
  - TA calls and meetings as needed
- Access to PSYCKES & Training

Evaluation

Methods

- Setting and Population
  - 25 ACT Teams participating
  - 172 ACT clients targeted for transition
- Data Sources
  - Client Phase Tracking Form completed by teams monthly and confirmed by technical assistance team during site visits (preliminary data)
  - CAIRS: web-based outcome reporting system for ACT teams
    - ACT teams required to submit clinician reports of sociodemographics and clinical outcome data at admission and every 6 months thereafter
  - Medicaid: health data warehouse

Measures

- Client Characteristics (CAIRS)
  - Demographics: (age, race/ethnicity, gender)
  - LOS: (% gtr 5 years / % gtr 3 years /average months on the team)
  - Primary MH diagnosis
  - Historical acuity and acuity at project start (status of substance use , psychiatric hospitalization , arrest, incarceration, homeless, harmful behaviors, employment)
- Planned discharge (CAIRS)
- Transition services received by clients (CPTF)
- Received outpatient MH services prior to discharge (Medicaid)
- Behavioral health hospitalizations after discharge (Medicaid)

Analyses

- Characteristics of clients selected for transition
  - Summary statistics
- Discharge Outcomes
  - Summary statistics and trends over time
- Examine the relationship between transition model activities and planned discharge from ACT
  - $\chi 2$: Received Transition Services (yes/no), Planned Discharge (yes/no)
- Compare proportion of clients with a planned discharge receiving services prior to discharge
- Compare proportion of clients with a planned discharge who had a BH hospitalization within 180 days following discharge

Client Characteristics: Targeted clients (n=172) and the rest of census in participating teams (n=1597)

- Targeted clients were more likely to:
  - Have a length of stay > 5 years (62.8% compared to 36.3%)
  - Older (50.3 compared to 46.3 years of age)
- Targeted clients were less acute at admission to ACT
  - Less psychiatric hospitalizations 6 and 12 month prior to intake
  - Less Substance Use in prior 6 months
  - Less harmful behaviors in prior 6 months
- At the time they were targeted for transition, targeted clients were less acute by some measures, however, in NYC:
  - About 25% had a psychiatric hospitalization in the last 6 months
  - About 20% had a harmful behavior in the last 6 months
  - About 25% use substances in the last 6 months

Discharge Outcomes at 25 Months

Discharge Status	NYC I		NYC II		ROS		Total	
	n	%	n	%	n	%	n	%
Targeted for Transition	49		81		42		172	
Planned d/c	32	65	40	49	29	69	101	59
Other d/c	4	8	12	15	4	10	20	12
No d/c	13	27	29	36	9	21	51	30

Phase I Model Elements Associated with Planned Discharges: Transition Planning

	Received Activity	Targeted clients	% Planned Discharge	χ2	pValue
Activity 1: Discuss transition process	Yes	168	57.74	1.7082	0.1912
	No	4	25.00		
Activity 2: Discuss accomplishments	Yes	157	59.87	6.1588	0.0131
	No	15	26.67		
Activity 3: Discuss hopes and expectations	Yes	145	60.69	5.1947	0.0227
	No	27	37.04		
Activity 4: Discuss feelings about moving beyond ACT	Yes	158	60.76	11.3311	0.0008
	No	14	14.29		
Activity 5: Discuss concerns about connecting with other providers	Yes	145	60.69	5.1947	0.0227
	No	27	37.04		

(Cont.) Phase I Model Elements Associated with Planned Discharges: Transition Planning

	Received Activity	Targeted clients	% Planned Discharge	χ2	pValue
Activity 6: Comprehensive Assessment	Yes	137	60.58	3.5737	0.0587
	No	35	42.86		
Activity 7: Transition Needs Form	Yes	153	60.13	5.6206	0.0178
	No	19	31.58		
Activity 8: Identify Potential Referrals	Yes	143	63.64	15.3449	<.0001
	No	29	24.14		
Activity 9: Update Treatment Plan	Yes	153	58.82	1.9271	0.1651
	No	19	42.11		
Activity 10: Engage in Wellness Group	Yes	138	59.42	1.7005	0.1922
	No	34	47.06		
TOTAL: Clients that received ALL Phase I activities	Yes	93	70.97	16.1689	<.0001
	No	79	40.51		

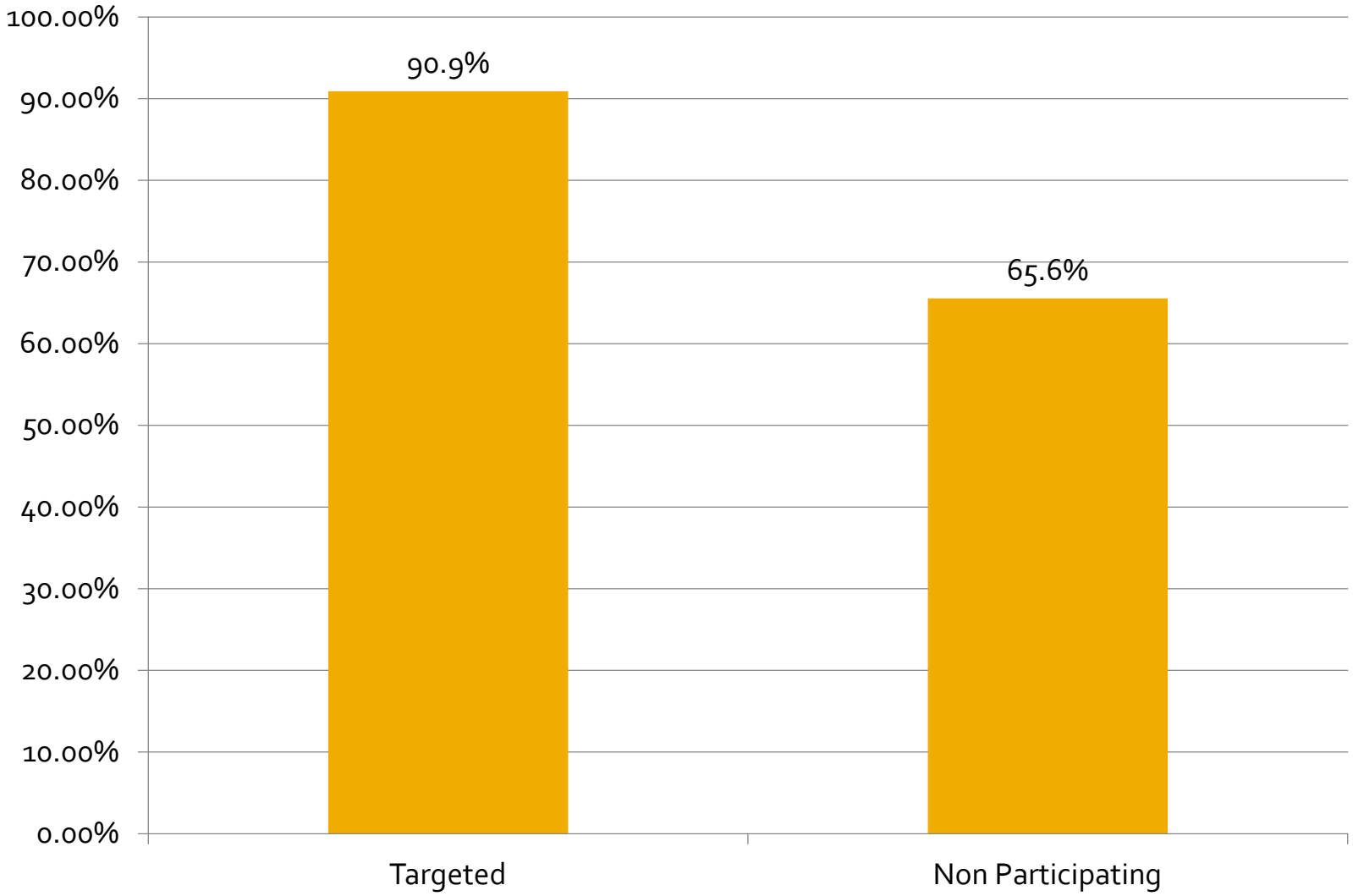
Phase II Model Elements Associated with Planned Discharges: Linkage & Try-Out

	Received Activity	Targeted clients	% Planned Discharge	$\chi 2$	pValue
Activity 11: Provide skills coaching and support in relevant recovery areas	Yes	136	60.29	2.9171	0.0876
	No	36	44.44		
Activity 12: Practice keeping appointments in the community	Yes	116	62.93	5.153	0.0232
	No	56	44.64		
Activity 13: Field visits to new providers and community/rehab resources	Yes	79	62.03	1.5192	0.2177
	No	93	52.69		
Activity 14: Continue WSM Group	Yes	117	60.68	2.0512	0.1521
	No	55	49.09		

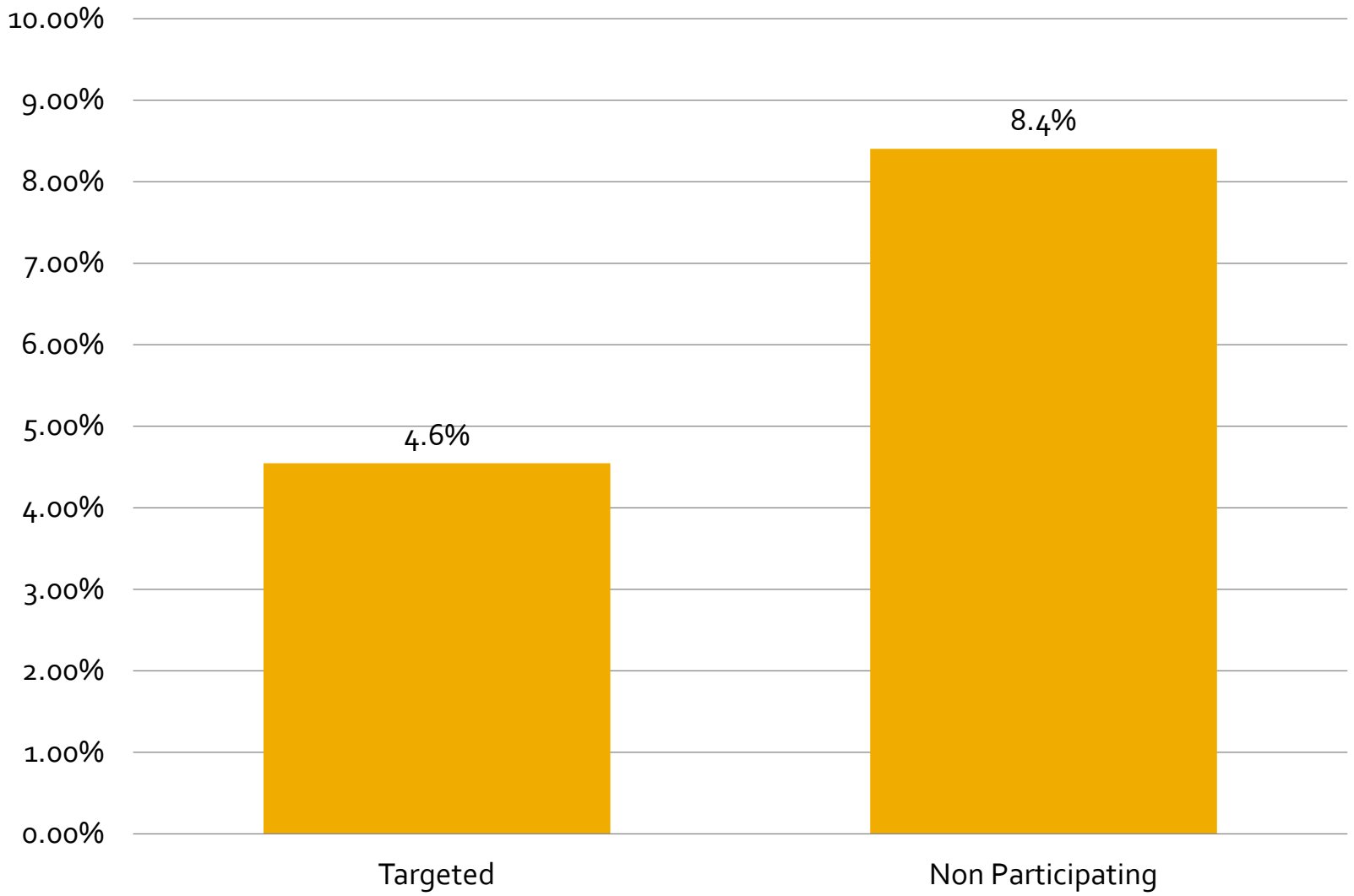
(Cont.) Phase II Model Elements Associated with Planned Discharges: Linkage & Try-Out

	Received Activity	Targeted clients	% Planned Discharge	χ^2	pValue
Activity 15: Engage existing supports	Yes	100	66.00	7.9345	0.0049
	No	72	44.44		
Activity 16: Coordinate meeting with existing supports	Yes	69	68.12	5.8324	0.0157
	No	103	49.51		
Activity 17: Provide emotional support and education to existing supports	Yes	70	68.57	6.4736	0.0109
	No	102	49.02		
Activity 18: Develop linkages with new providers	Yes	124	70.97	35.4818	<.0001
	No	48	20.83		
Activity 19: Develop linkages with new natural supports	Yes	60	73.33	10.0565	0.0015
	No	112	48.21		
Activity 20: Pre-transition planning visits with new providers	Yes	107	75.70	40.4952	<.0001
	No	65	26.15		

Proportion of Clients with a Mental Health Outpatient Service Prior to Discharge (Group I only)



Proportion of Clients with a Behavioral Heath Hospitalization within 180 Days Following Discharge (Group I only)



Next Steps

- Outcome Analysis Across Groups
  - Continuity of Care – engagement in outpatient MH services
  - Clinical outcomes (hospitalization, return to ACT)
- Process Analysis
  - Team Level Model Fidelity
  - Feedback from participating teams on transition
    - Exit Interviews
    - Surveys
- Relationship between transition services and client outcomes
- Model Revisions
  - Transition Model
  - Wellness Self Management for Transition Curriculum
- Dissemination

Discussion