ASSERTIVE COMMUNITY TREATMENT TEAM (ACTT) TOGETHER - IMPLEMENTATION PHASE

Year 1 Progress Report (2014-2015)

Submitted to the Central East Local Health Integration Network on May 29, 2015, on behalf of the ACTT Oversight Committee

Ontario Shores Centre for Mental Health Sciences

Canadian Mental Health Association Toronto

Northumberland Hills Hospital

The Scarborough Hospital

Canadian Mental Health Association Durham

Rouge Valley Health System

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1.0 Acknowledgements

This project could not have been completed without the dedication and expertise of the Oversight Committee and all of the CE LHIN ACTTs. We would also like to acknowledge former members of the Oversight Committee (included below) who provided assistance during portions of the implementation phase.

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2.0 Executive Summary

In April 2014, the Assertive Community Treatment Teams (ACTT) across the Central East LHIN began the implementation of recommendations that resulted from the 2012/2013 ACTT Together Quality Improvement Initiative (QII). The goals of the three-year implementation phase were to increase overall capacity of the eight ACTTs by implementing a Stepped Care Model into each Team, allowing for the admission of new clients into ACTT, and to promote and improve communication and collaboration between ACTTs and other Health Service Providers. Over the course of the first year of implementation (April 1, 2014 to March 31, 2015), all eight CE LHIN ACTTs implemented the majority of recommended standards and best practices from the QII, which included process improvements to intake and referral, treatment, hospital relationships, and discharge. Each team implemented a Stepped Care Model into their practice, which saw the addition of one Stepped Care Nurse to each team, who would oversee the transition and support of clients from "regular", high-intensity ACTT services, to lower intensity services within ACTT. These clients, while identified as successful in "regular" ACTT, are not yet ready for Case Management or less intensive services outside of ACTT.

During year one of implementation, the eight CE LHIN ACTTs transitioned a combined 90 clients into Stepped Care, while admitting an additional 104 clients to their "regular" ACTT rosters. These newly admitted ACTT clients had a combined total of over 17,700 psychiatric hospital bed days over two years prior to ACTT, and represent among the highest acuity of users of the System. It was anticipated that the capacity of CE LHIN ACTTS would increase by 200 clients by 2017, and the client numbers to date represent approximately 50% of this number in the first year of implementation alone. Over 95% of clients that transitioned into Stepped Care remained in Stepped Care over the course of the year (i.e., did not decompensate back to "regular" ACTT services). Feedback from Stepped Care clients, gathered through questionnaires and focus groups, highlighted extremely high satisfaction ratings with the Stepped Care experience and transition to the new Model.

The next phase of this project (years two and three) will see the evaluation, improvement, and sustainability/growth of the work completed to date. This next phase will include ongoing client data collection and progress reports, measure of success surveys and peer reviews, continued client satisfaction questionnaires/focus groups, and ongoing communication with various stakeholders such as local area hospitals/agencies and the Ontario ACTT Association, to continue collaboration and knowledge sharing.

3.0 Background

3.1 ACTT Quality Improvement Initiative Project Summary

In 2012 the Central East Local Health Integration Network (CE LHIN) funded the Assertive Community Treatment Team (ACTT) Quality Improvement Initiative (QII) to explore capacity and flow amongst the ACTTs in the CE LHIN. The recommendations from the QII outlined four areas of best practice to ensure consistency and promote fidelity to the ACTT model across all eight ACTTs. Each of the following areas was reviewed using Lean Kaizen methodology to explore opportunities for process improvements and generation of efficiencies:

1. Referral and intake policies and procedure
2. Treatment planning
3. Hospital and ACTT relationship and coordination
4. Discharge policies and procedures

Participants of the QII consisted of front line staff from the hospital and community sector, team leaders, inpatient psychiatrists, community psychiatrists, mental health and addictions lead from the CE LHIN, administrators and community and hospital partners. The QII identified ways to improve the process of these four key objective areas within ACTT and recommended a Stepped Care Model (SCM) as a transitional, integrated approach to Case Management (CM) and psychiatric care provision.

The purpose of the implementation phase of the project was to support the ACTTs under the CE LHIN to meet the standards and recommendations outlined in the QII. This next phase expected to see all eight ACTTs follow the same standards and procedures, as developed during the QII phase, introduce a Stepped Care Model (SCM) into their ACTT programs, and report on specific client data to ensure the overall CE LHIN goals, as well as the QII project goals, were being met. The overall project goals were to:

- Enhance the capacity of ACTTs to accept increased numbers of clients with SMI
- Safely and efficiently transition ACTT clients to ACTT Stepped Care, and eventually to step-down Case Management (CM) with standardized processes for transfer of accountability
- Promote clear communication between the Health Service Providers (HSPs)

Key objectives to support the project goals were to:

- Promote increased patient flow out of hospital and onto ACTTs throughout the CE LHIN
- Reduce the number of hospital inpatient days for individuals with severe mental illness (SMI) by up to 10,000 by April 1, 2017
- Enhance the capacity of the ACTTs to accept increased numbers of clients with SMIs
- Promote recovery and community-based living for clients living with SMI

- Ensure continuity of care throughout transitions to lower intensity interventions (e.g., Stepped Care)
- Gather ACTT program data and measure against CE LHIN and project goals
- Continue the work of ACTT QII Oversight Committee for knowledge creation and exchange, as well as further opportunities for improvement
- Study of key objective successes (i.e., working group measures of success)

3.2 ACTT Stepped Care Model

To implement the Stepped Care Model (SCM) across ACTTs in the CE LHIN, one additional Registered Nurse (RN) was to be added to each team as a Stepped Care Nurse. The role of the Stepped Care Nurse would be to work with clients who are ready for transition, but who may not yet be manageable by existing, 'step-down' Case Management teams, and/or who may be waiting for space on those teams to become available. The integration of the RN into the existing ACTT would allow the client the opportunity to gradually disengage and to build confidence in their ability to manage with decreasing levels of support, while still being supported by the ACT Team's psychiatrist. If the client were to experience a decline in function or mental stability during the transition process, the client could then be moved back onto the higher level case management program provided by their ACTT (i.e., "regular" ACTT).

3.3 Funding

Funding for the three-year implementation phase of this project was provided by the CE LHIN and covered costs associated with the eight new FTE RNs (one in each ACTT), a 0.5 FTE Project Manager, additional hours of psychiatric support for new patients, and additional capital costs. Ontario Shores Centre for Mental Health Sciences took on the role of executive lead for the project. As a result of funding delays, not all ACTTs could hire Stepped Care Nurses in the time allotted, and thus implementation of Stepped Care in two of the ACTTs was delayed, impacting Stepped Care performance measures.

This progress report will provide a review of and progress on the objectives and associated activities as part of the scope for the first year of implementation of the QII recommendations. The report will also relay, at a high level, some of the constraints around completion of some activities. Lastly, the report will provide recommendations that resulted from the items above, to be implemented with the support of the CE LHIN over the remaining two years of the project.

4.0 Project Activities and Timelines

4.1 Overview of Activities

Approach to Implementation Phase

April 1, 2014 was designated as the start date for the design and implementation of the Stepped Care Model and QII recommended best practices and standards. Guided by the recommendations described during the QII, a project charter and scope document were developed to define, approve, and hold the Oversight Committee and ACTTs accountable to the objectives, scope, and key activities of the implementation phase for year one. Implementation strategies were also developed for each ACTT, whereby progress on implementation of each of the recommended best practices and standards was logged and the status updated on a monthly basis. Upon completion of year one, a new scope will be defined to identify new activities, redefine outstanding recommendations as appropriate, and identify areas for improvement to the implemented standards and best practices

The key objectives and recommendations from the original QII can be found below, as per the scope for year one. The progress of the objectives will be discussed throughout the report.

Key Objective	Standardized Item	Recommended Best Practice	Measure of Success/Outcomes
Referral and Intake	1. Referral source ACTT screening tool 2. Referral source ACTT referral form 3. Letters: • Receipt of comprehensive referral • Request for additional referral information • Acceptance letter (for referral source and applicant) • Decline letter (for referral source and applicant) • Client has declined service letter (for referral source) • Family welcome letter • GP notification of patient acceptance letter 4. Intake prioritization processes 5. Timeframes: 30 day notification of acceptance/declined/in process ACTT services	1. Contents of Client Welcome Package (mandatory orientation, includes best practice topics provided in the checklist) 2. ACTT intake personnel. One individual covers intake, but always a back-up	1. Reduced inappropriate referrals 2. Reduced referrals without complete information 3. Reduced referring source/applicant wait times for notification of acceptance/declined services (at 30 days with appropriate referral information)
Treatment in ACTT	1. Expectations Agreement 2. OCAN used as Treatment Plan 3. ATR used as a tool to identify potential for stepped care or discharge (all clients every 6 months, baseline within the first 6 months of intake)	1. Waiver for Group Programs, including a client safety waiver 2. Collaborative Crisis Plan	1. Fidelity to new process assessed through annual peer review 2. Participation in ATR data collection program with Gary Cuddeback 3. Reduced staff time spent on redundant paperwork 4. Current ACTT clientele identified as ready for reduced service levels (i.e. Stepped Care Model) or discharge

Key Objective	Standardized Item	Recommended Best Practice	Measure of Success/Outcomes
Hospital and ACTT Relationships	1. Psychiatrist communications 2. Documentation between ACTT and Hospitals including medication list, history, etc. (e.g., Common Assessment Tool, ED CAT, as necessary) 3. Inclusion of ACTT in rounds, case conferences and discharge meetings 4. Timings: • Crisis assessment faxed to ACTT within 24 hours of hospital assessment • ACTT to connect with client two days following admittance • Two-day advanced notification to ACTT of client discharge	1. ACTT provides local schedule 1 hospitals with updated client lists provided given client consent on a monthly basis	1. Hospital and ACTT Psychiatrist communication increases 2. Continuity of care for client is enhanced
Planning for Discharge and Stepped Care	1. ACTT readiness for Stepped Care review 2. Timelines: • Service overlap between ACTT and new provider for up to 30 days • Complete OCAN Discharge Summary within 30 days of client discharge 3. Letters: • Transfer of Care Letter • Client Discharge Letter • Circle of Care Discharge Letter 4. Forms: • Transfer of Care/Discharge Summary • Voluntary Discharge Form	1. Client Disengagement Practices and corresponding communications 2. Defined Stepped Care Model of service (operational guidelines) 3. Team staffing allocations through the discharge process	1. Implementation of a Stepped Care Model of service 2. Increased number of identified clients requiring and referred to reduced services
Overall			1. Increased capacity of 200 clients across the CELHIN causing a potential savings of 10,000 hospital inpatient days by 2017

4.2 Overview of Timelines

The timelines and status of year one activities of the implementation phase can be found in the table below.

Project Activity	Target Completion Date	Status
Stepped Care Model Implementation Start Date	April 2014	Complete
Stepped Care Nurses Hired	August 2014	Complete
Stepped Care Programs Initiated	August 2014	Complete
Project Manager ACTT Site Visits	August 2014	Complete
Stepped Care Operational Guidelines Finalized	September 2014	Complete
Project Charter Approved and Signed	October 2014	Complete
Data Collection Framework/Worksheet Designed	October 2014	Complete
First Client Data Pull by ACT Teams	October 2014	Complete
Standards Reviewed, Gaps/Barriers Identified, Implementation Strategies Developed	October 2014	Complete
Hospital/Agency Roadshows Booked	November 2014	In Progress
Hospital/Agency Guiding Principles Signed	January 2015	In Progress
Implementation of Recommendations and Standards Complete	January 2015	In Progress
Client Focus Group(s)	February 2015	Complete
Finalize Working Group Measures of Success and Surveys	February 2015	Outstanding
Year 1 Progress Report	May 2015	Complete

5.0 Progress of Objectives and Performance Measures

Three mechanisms for the evaluation of year one work were identified during the QII:

- Client data collection and review
- Measure of success surveys
- Peer review of fidelity to new processes

A client data collection framework was developed and client data is being collected on a bi-annual basis to compare against the defined performance indicators. As a result of delays in implementation of some of the recommendations, such as signing of Guiding Principles by all local hospitals and the hiring of Stepped Care Nurses, a decision by the Committee was made to delay further evaluation of project success, through the measure of success surveys and peer reviews, until all teams had implemented all standards and best practices, and a period of time had passed to allow for a more thorough and complete evaluation. As such, a full project evaluation has been rescheduled for 2015-2016.

5.1 Objectives

This section provides an overview of the status of the four key objectives/best practice areas developed during the QII (intake and referral, treatment, hospital and ACTT relationships, and discharge and Stepped Care).

Intake and Referral

Standardized Items

Standardized screening and referral tools have been implemented across all CE LHIN ACTTs. For teams where new client intake is a centralized process through partner/parent agencies (e.g., Access Point, Ontario Shores, etc.), the agencies have agreed to accept the standardized documents (as applicable), and/or have modified their own intake practices to follow the same minimum requirements as outlined in the standardized tools.

Standardized letters and forms as part of the intake process are available for use by all CE LHIN ACTTs. For ACTTs that are required to go through other agencies for intake, the letters/forms and the transmission of information have been adapted to meet the intake polices for the partner/parent agencies, while still maintaining the spirit of the QII standardized process. For example, whereby a request for additional information may not be required by a specific agency in the form of a formal letter, the ACTT will use the appropriate route of communication

(e.g., email, update to central database, etc.) while ensuring that all of the necessary information from the standardized letters is included in the communication.

All teams are following the intake prioritization standard, and have implemented the 30-day time-frame for notification of acceptance/decline of new ACTT clients. While the majority of teams were able to meet the time-frame above for new clients, a small percentage could not, primarily as a result of resourcing difficulties (i.e., short-term leave of intake coordinator/clinician) which left teams under-staffed, and/or the inability to engage with potential clients during this time-frame.

Recommended Best Practices

The process and contents for the Client Welcome Package (i.e., mandatory orientation, best practice topics, etc.) have been implemented by all CE LHIN ACTTs. If hard-copies of all items part of the Welcome Package checklist are not available to the client (e.g., hours of operation, information on OCAN, team diversity, etc.), these items will be discussed with the client during their orientation.

Having a dedicated intake worker within each team was a recommended best practice as part of the referral and intake process. While there is clear benefit in having one dedicated staff member with the necessary skill set to perform intake for all new clients, a number of ACTTs indicated that this responsibility is being shared across the team, and depends on the training and skills of individual team members, which would be better suited for intake of a specific client. After further consideration, the Oversight Committee approved the changes to this recommended best practice so that, in addition to having one dedicated intake person, other ACTT staff are to be trained as back-up and assigned to potential clients as per their skill set as necessary. This will help to ensure that intake of new clients is not delayed where staff resources are available to continue with the referral process.

Treatment in ACTT

Standardized Items

The standardized Expectation Agreement was implemented by all CE LHIN ACTTs.

Gary Cuddeback's Assertive Community Treatment Transition Readiness Scale© (ATR) was implemented as the standard tool across the CE LHIN ACTTs used to identify potential clients for Stepped Care or discharge from ACTT. The ATR defines four groups and associated scores to identify the level of support a client requires, and, along with clinical judgement, whether that client is ready to be transitioned to less intensive services. The four groups and associated scores are as follows:

- Group A (needs high support): <43
- Group B (moving towards recovery): 43-50
- Group C (transition potential): 51-58
- Group D (transition to less intensive services?): >58

Within the CE LHIN ACTTS, ATRs were performed on the majority of clients ("regular" ACTT and Stepped Care) at least once over the course of the first year of implementation.

The Ontario Common Assessment of Needs (OCAN) tool was also identified as a standardized tool to be implemented across the CE LHIN ACTTs. While six of the eight ACTTs have implemented OCAN, the tool is new to two of the ACTT parent agencies and is currently in the process of being implemented. As such, OCAN data could not be gathered and compared across the eight teams during year one.

Recommended Best Practices

Collaborative Crisis Plans have been developed by all CE LHIN ACTTs for their clients. These plans are being shared with hospitals and other agencies as appropriate (i.e., when a client is admitted to hospital).

The implementation of a standardized safety waiver for clients participating in group programs was identified as best practice. As all of the parent agencies that administer the eight ACTTs include client safety waivers as part of the admission process into any of their programs (including ACTT), the standardized client safety waiver was revised to an "information for clients participating in group activities" document, which is to be included as part of the Client Welcome Package, and outlines the responsibilities of the client when participating in group activities.

Hospital and ACTT Relationships and Coordination

Standardized Items

To meet the project goal of promoting clear communication between Health Service Providers (HSPs), an MOU was developed between local area hospitals/agencies and ACTTs across the CE LHIN. The MOU outlined the roles and responsibilities of each provider to improve communication and collaboration and agree to set standards of practice. Such standards included hospital and ACTT psychiatrist communications, case conferencing and discharge planning, and standardized documentation between ACTTs and their local hospitals. The local hospitals/agencies include:

- Lakeridge Health
- Northumberland Hills Hospital

- Ontario Shores Centre for Mental Health Services
- Peterborough Regional Health Centre
- Ross Memorial Hospital
- Rouge Valley Health System
- The Scarborough Hospital
- Campbellford Memorial Hospital
- Haliburton Highlands Health Services
- Canadian Mental Health Association Durham
- Canadian Mental Health Association Toronto
- Durham Mental Health Services

In October 2014, the CE LHIN Strategic Coordinating Council recommended that the Oversight Committee move away from a binding MOU with local hospitals/agencies, due to anticipated difficulty with signing of a binding agreement. As such, the Oversight Committee, with backing from the CE LHIN, revised the MOU into a Guiding Principles document, which, while not binding, did meet the same purpose as the original MOU. The result of this decision was a delay in issuing the Guiding Principles to local hospitals and agencies, and in the scheduling of "Road Shows" between ACTTs and hospitals/agencies to discuss the contents and outcomes of the Guiding Principles. The revised document was approved in January 2015 by the Oversight Committee. Road Shows and signing of the Guiding Principles are currently in progress. At the time of this report, 9 of 12 documents have been signed.

Recommended Best Practices

The Oversight Committee adapted the recommended best practice of providing local schedule 1 hospitals with monthly client lists. This was the result of varying protocols specific to client confidentiality, within each of the ACTTs' parent agencies. As such, the Committee agreed that, while sharing of client lists is an important best practice, they are not required to provide an updated client list to local hospitals on a regular basis should this counter parent agency policies.

Planning for Discharge and Stepped Care

Standardized Items and Recommended Best Practices

As part of the QII, new discharge and disengagement standards were developed. Recommendations and standards associated with discharge and disengagement included criteria for client discharge, and the procedures associated with contacting a client who has disengaged from a CE LHIN ACTT for a specific period of time. As part of implementation, and under the direction of the Oversight Committee, the discharge and disengagement standards were reviewed by a legal team to ensure there was no liability surrounding implementation of

the new recommendations and associated timeframes. These processes and documentation were accepted by the Oversight Committee in December 2014. The standardized tools that were developed are available for use by each ACTT as necessary.

The designated date to have all Stepped Care programs initiated across all CE LHIN ACTTs was August 2014, meaning that by this date, all Stepped Care and back-fill Nurses were to be hired, clients identified for Stepped Care were to begin transition into the Model, and the Stepped Care Operating Guidelines were finalized and approved by the Oversight Committee. The Guideline document included information on client eligibility criteria and services, Stepped Care Nurse and ACTT responsibilities, and processes around client capacity, transition, decompensation, and discharge. The Guidelines set standards/best practices for the Stepped Care Model across the CE LHIN and, will be reviewed again during year two to identify any areas for improvement.

Challenges did arise during the implementation of Stepped Care over year one. Specifically, the hire of Stepped Care and back-fill Nurses at four of the ACTTs was problematic. In one instance, a Stepped Care Nurse could not be hired until January 2015, delaying implementation of Stepped Care within that Team. Another team experienced difficulty with the hire and retention of a Stepped Care Nurse, and at the time of this report, the position remains unfilled. As mentioned earlier, funding delays also contributed to delays in implementation of Stepped Care in two of the ACTTs.

In 2014 a Stepped Care Nurses Network was established for members to collaborate on opportunities and barriers. Each CE LHIN ACTT Stepped Care Nurse is a member, and the group meets on a quarterly basis. A member of the Oversight Committee is invited to attend the Network meetings, and a member of the Network is invited to Committee meetings.

Additional Recommended Best Practices

Oversight Committee

Members of the Oversight Committee have committed to overseeing the project through to its completion (2017), and membership on the Committee includes, at minimum:

- One representative from each of the eight ACTTs (team lead/manager/director/etc.)
- One representative each from the CE LHIN, a CE LHIN ACTT Psychiatrist, and a member of Durham Mental Health Services (as the administrator of the RVHS Stepped Care Nurse)
- One representative from the Stepped Care Nurses Network (as requested)

Terms of Reference were developed to define the Committee's role and responsibilities. The mandate of the Committee will be to provide direction to the ACTTs on the implementation, measurement, and sustainability of the quality processes, maintain relationships with other key stakeholders, report to the CE LHIN on results and recommendations, and advocate on behalf of the ACTTs.

Part of the recommendation to continue the work of the Committee was to also include one client and one family member as part of the Oversight Committee. While important to engage clients and their families, Oversight Committee membership is not the best method for client/family input. Instead, focus groups with clients and families are to be held twice yearly, to review client/family satisfaction with the programs, and allow stakeholders to share their experiences. The first of these client engagement strategies was held in February 2015 with Stepped Care clients, to determine how the SCM was working for them and to identify areas for improvement. The results of these measures can be found in section 6.0.

5.2 Performance Measures

As noted in section 4.0, a client data collection framework and standardized data collection worksheet was developed to track performance measures. In addition to the specific performance measures identified through the QII, additional indicators were selected by the Oversight Committee to provide a detailed picture of progress, identify barriers to the collection of data or to meet performance measures, and to identify areas for improvement. The overall performance measures being tracked through bi-annual data pulls include:

- Increase capacity (25-30% over three years) of ACTTs through:
  - Transition of ACTT clients to Stepped Care at a rate of 1-2/month
  - Intake of new clients into ACTT at a rate of 1-2/month
- Increase ATR scores of all ACTT clients (including Stepped Care clients) over the course of transition
- Reduce the number of inpatient hospital days for individuals with SMIs through admission into ACTT
- Identify primary mental health diagnosis and complex needs of clients
- Improvement in housing stability of ACTT clients
- Frequency of clients transitioning to other services (e.g., decompensated back to more intensive ACTT services, discharged out of ACTT, etc.)
- Whether admission decisions were made within 30 days of completed referral

Data from the first year of implementation (April 1, 2014-March 31, 2015) can be found below.

Client Numbers

Indicator	As of Apr. 1, 2014 (Baseline)	As of Oct. 1, 2014 (6 months)	As of Apr. 1, 2015 (1 year)
Total # of ACTT clients (includes "regular" ACTT and Stepped Care)	Approx. 620	651	675
# of new ACTT clients (since baseline)	N/A	50	104
# of active Stepped Care clients	N/A	55	90
Approximate # of ACTT clients discharged from ACTT	N/A	N/A	64
# of inpatient hospital days for new ACTT clients (over past 2 years)	N/A	10,562*	17,724*
# of clients ready to transition to Stepped Care (as of date)	N/A	61	57
# of inpatient hospital days for clients ready to transition to Stepped Care (over past 2 years)	N/A	57	89
% of transition-ready clients in each ATR group (please note that not all clients had their ATRs completed	N/A	Group A = 0 Group B = 9.8% Group C = 21.3%	Group A = 1.7% Group B = 0% Group C = 31.6%

over the previous year)		Group D = 68.9%	Group D = 66.7%
% of active Stepped Care clients in each ATR Score group (please note that not all clients had their ATRs completed over the previous year)	N/A	Group A = 0 Group B = 5.4% Group C = 57.1% Group D = 37.5%	Group A = 0 Group B = 2.2% Group C = 45.5% Group D = 52.3%

* Please note that the hospital bed days above are an approximate number in some cases. This data is based on input from both referral sources and clients.

Between April 1, 2014 and March 31, 2015, over 100 new clients were admitted into CE LHIN ACTTs. Together, these individuals had approximately 17,700 hospital bed days over the past two years prior to admission to ACTT, and over 50% of these clients were referred directly from psychiatric hospitals/units. In comparison, the hospital days over the past two years for clients who have remained in ACTT for a number of years and are ready for transition into Stepped Care dropped significantly.

While the number of new clients admitted to ACTT is on track with the proposed 1-2/month, transition of clients into Stepped Care is below this rate, due primarily to resourcing issues. Since the implementation start date, four CE LHIN ACTTs had either difficulty recruiting or retaining Stepped Care Nurses and/or their back-fill positions, and as a result, the implementation of Stepped Care within their programs was delayed until all positions were filled and trained accordingly.

The number of clients ready to transition to Stepped Care decreased between October 1, 2014 and April 1, 2015 as clients are continuously being identified and transitioned into Stepped Care, which will see an ongoing fluctuation until Stepped Care in each ACTT reaches capacity (25 clients).

ATR scores revealed that the majority of pre-Stepped (ready for transition to Stepped Care) and active Stepped Care clients resided primarily in Groups C (51-58) and D (>58). It is premature to ascertain whether ATR scores for clients do increase over their time in ACTT, as not enough time has elapsed to track and compare scores. One objective for the next two years of the project will be to confirm whether the increase of ATR scores as readiness to transition both to Stepped Care and to transition to lower intensive services outside of ACTT. Further engagement with Gary Cuddeback for data sharing and knowledge exchange is also planned for the next phase.

Additional Client Data

(as of April 1, 2015)

Indicator	Stepped Care Clients	ACTT Clients
% of clients with primary mental health diagnosis	78.7% - Schizophrenia 11.2% - Schizoaffective Disorder 7.9% - Bipolar Disorder 2.2% - Other	78.2% - Schizophrenia and/or other Psychotic Disorder 11.3% - Schizoaffective Disorder 8.9% - Bipolar Disorder 1.5% - Other
% of clients with complex needs (information unavailable for all clients)	28.6% - Concurrent Disorder 0% - Dual Diagnosis 20.8% - Physical Health Problems 9.1% - Other	27.3% - Concurrent Disorder 4.8% - Dual Diagnosis 25.1% - Physical Health Problems 11.9% - Other
% clients with stable housing	98.9%	N/A
# of Stepped Care clients decompensated back to ACTT	2	N/A
Acceptance/decline decision within 30 days of completed referral (new ACTT clients only)	N/A	67.4% - Yes 32.6% - No/Not Available

Primary Mental Health Diagnosis

The majority of ACTT clients (including those in Stepped Care) had a primary mental health diagnosis of Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder, as per ACTT eligibility criteria. Some clients had other primary mental health diagnoses, such as personality disorder or other psychotic disorders (NOS/NYD). Possible reasons for primary mental health diagnoses that differ from the ACTT eligibility criteria may include change of diagnosis from team psychiatrist based on more intensive work with clients, or lack of resources in smaller communities for individuals with other diagnoses, resulting in admission into ACTT.

Complex Needs

The majority of ACTT clients, whether new, existing, or Stepped Care, had additional complex needs beyond their primary mental health diagnoses. These needs included concurrent disorders, physical health problems, dual diagnosis, etc. These complex needs speak to the additional support the ACTTs must provide over and above the support required for mental health issues.

Clients with Stable Housing

An important element when looking at potential discharge from ACTT was to look at whether a client had stable housing. Housing is a criterion for transition to Stepped Care, and is a measure on the ATR tool. The data revealed that almost all pre-Stepped and Stepped Care clients had stable housing in the past year.

Stepped Care Clients Transitioned Back to Regular ACTT Services

Between April 1, 2014 and March 31, 2015, two Stepped Care clients had to transition back to "regular" ACTT services as a result of decompensation. These numbers will continue to be tracked in the future to identify any issues that may arise with respect to capacity, client flow-through, and resourcing.

Decision Within 30 Days of Referral

Between April 1, 2014 and March 31, 2015, approximately 30% of the accept/decline decisions for new clients into ACTT were not completed within 30 days of the original referral. To reiterate from section 4.1, some teams were unable to meet this time-frame due to lack of engagement by the potential client, and/or resourcing issues which left teams under-staffed. As a result, these ACTTs were unable to make a decision within the designated period. As part of the next phase, the factors impacting admission decisions will be further evaluated.

5.3 Measure of Success/Outcomes

As implementation of the QII best practices and standards is ongoing (i.e., signing of Guiding Principles, implementation of OCAN, etc.), evaluation of outcomes through measure of success surveys and peer reviews could not be completed during year one. This has been rescheduled for year two of implementation, along with the objectives of identifying areas of improvement and ongoing sustainability and growth. Additional details on these objectives can be found in section 7.0.

6.0 Client Focus Groups and Questionnaires

As part of the recommendations around client engagement, focus groups and questionnaires were developed and implemented in February 2015. During year one of the project, only Stepped Care clients and families were engaged, to learn about their experience with the transition and time in Stepped Care, and identify areas for improvement.

6.1 Questionnaires

On February 2, 2015, an e-copy of the Stepped Care client questionnaire was sent to each CE LHIN ACTT Stepped Care Nurse. The Nurses were asked to distribute the questionnaires to their clients for completion. The deadline for completion was February 27, 2015. Forty-two completed questionnaires were returned from the follow regions: 36% from ACTTs in Scarborough, 36% from ACTTs in Durham, and 28% from ACTTs in the North East. Client responses are found below, and a copy of the questionnaire is found in Appendix A.

Question	Response
1. Age (in years)	
16-17	0%
18-24	0%
25-34	19.0%
35-44	33.3%
45-54	28.6%
55-64	7.1%
65-74	9.5%
75+	0%
No Response	2.4%
2. Gender	
Male	57.1%
Female	42.9%
Other	0%
No Response	0%
3. Approximate Length of Time in Stepped Care	
Less than 1 month	7.1%
1-2 months	11.9%
3-4 months	40.5%
5-6 months	16.7%
More than 6 months	23.8%

Question	Response
4. a) The Stepped Care Program was clearly explained by ACTT staff	
Strongly Disagree	0%
Disagree	2.4%
Neutral	7.1%
Agree	57.1%
Strongly Agree	31.0%
No Response	2.4%
4. b) There was enough time to be able to adjust to the idea of transitioning into Stepped Care	
Strongly Disagree	0%
Disagree	4.8%
Neutral	7.1%
Agree	54.8%
Strongly Agree	31.0%
No Response	2.4%
5. Personal experience in Stepped Care has been positive so far	
Strongly Disagree	2.4%
Disagree	2.4%
Neutral	2.4%
Agree	47.6%
Strongly Agree	42.8%
No Response	2.4%
6. Client still feels that they are part of ACTT and can ask for additional support when needed	
Strongly Disagree	0%
Disagree	2.4%
Neutral	0%
Agree	38.1%
Strongly Agree	57.1%
No Response	2.4%

7. The things clients liked most about Stepped Care:

- The familiarity of seeing the same person each week (i.e., a dedicated worker) and that the visits are scheduled on a consistent day and time
- More freedom and independence (i.e., less scheduled visits, the delivery of medications to their homes or can pick up themselves, etc.)
- That they feel respected, supported, and are given advice when they need it. They feel like “family”
- One-on-one time with the Stepped Care Nurse
- That not much has changed; so far so good
- ACTT is still available and client can still speak to someone if they need help

8. The things clients liked least about Stepped Care:
    - Overwhelming response that there were no issues, that this question was not applicable, or don't know/makes no difference
    - Some clients indicated that Stepped Care wasn't explained very well or that transition to Stepped Care was too fast
    - Don't like certain components of the program, such as OCAN, reduced transportation provided by ACTT, visits are too short or not frequent enough, etc.
    - Not being able to connect with the rest of the ACTT staff as before, and that there aren't as many people around to help
    - A couple of clients indicated that they did not like being in the program to begin with, as it implied that they will soon be expected to transition out of ACTT altogether

6.2 Stepped Care Client Focus Groups

Two focus groups were held with Stepped Care clients between the dates of February 17 and 18 2015, in Durham and Cobourg respectively. Stepped Care Nurses were asked to recruit 2-3 clients from each team to attend one hour-long focus group. Three teams were unable to recruit clients to participate, and a total of 10 clients attended the meetings across the two days. As a thank you, clients that participated were provided with a $10 Tim Horton's gift card. OTN was set up for client's/teams that could not attend the focus groups in-person. Participant responses to the focus groups questions are found below and a copy of the questions is found in Appendix A.

1. Whether participants felt comfortable with the process of moving from "regular" ACTT services to Stepped Care:

- Almost all participants agreed that their transition experience was positive, and were provided with enough time to digest the information. Some individuals were concerned at first that they would be "cut adrift" but after further discussion with the Team and their psychiatrist, they felt more comfortable. One participant indicated that the transition seemed abrupt to them.

2. What Stepped Care services participants considered important to help them in their treatment and recovery and why:

- Additional independence was extremely important to all participants (e.g., less appointments, such as psychiatrist appointments). They were pleased they were provided with reminders of other medical appointments. The additional independence allowed them to spend more time with family and friends. To continue being included in group activities was extremely important because it provided a social network and a "good balance".

3. Whether participants felt they were receiving the right amount of services to keep them healthy and help them become more independent during their time in Stepped Care:

- Participants felt they were receiving the right amount of services, and were satisfied with their care. They understood that they could pick up the phone and call ACTT if needed. Some participants indicated that they would like one more visit a week (e.g., just before and after the weekend) so they could have someone to talk to (i.e., weekends can be stressful/isolating). Participants agreed that having the psychiatrist tell them that they are doing well was extremely validating.

4. and 5. Whether participants felt comfortable that they could go back to "regular" ACTT services if they become ill again and if they still felt like members of the ACT Team:

- All participants felt comfortable that they could go back to "regular" ACTT at any time and that they still felt like members of "regular" ACTT. "Still feel connected even though the pathway isn't used as often".

6. What participants indicated they would like to see changed as part of Stepped Care to make it better for them:

- Having the Stepped Care Nurse take them to new appointments
- Stepped Care Nurse to cover more than one day a week with them
- Further clarity during transition and what the Stepped Care Program actually means
- Clients miss the one-on-one outings (e.g., grocery shopping, coffee, etc.) and would appreciate having these outings returned to once per month (at minimum)
- Participants understood that these changes were coming from "the top" and overall the independence was great

As evident from the questionnaire and focus group responses, a lot of positives have resulted from the Stepped Care program. Overwhelmingly, clients appreciated their independence and freedom, and for most, there wasn't much of a change in service from their time just prior to Stepped Care. Acknowledgment from the psychiatrist that this was a positive transition was extremely meaningful to clients, and should be considered for inclusion as part of future transition protocol(s).

Clients raised a concern that a decrease in services and transition to Stepped Care would mean an inevitable "graduation" from ACTT. While the ultimate goal is to transition clients out of ACTT to less intensive services using Stepped Care is an interim program, these concerns must be acknowledged by the teams and clients reassured that they will not be discharged from ACTT until they, their ACTT and ACTT psychiatrist, and family (as applicable) feel it is appropriate to do so.

7.0 Recommendations

A decision by the Oversight Committee was made to maintain the momentum of the work in progress. Not only is additional work required to meet the outstanding activities from the first year of implementation, but there are areas, as indicated throughout this report, that should be further evaluated and modified as necessary. As such, the Oversight Committee has recommended the following items to continue the work:

- Evaluation: to evaluate the effects of the implementation of the standards and best practices, as recommended during the QII, on ACTT and Stepped Care outcomes and performance measures
- Improvement: to identify, plan and roll-out areas where improvements can be made based on the evaluation and outcomes
- Sustainability and Growth: to maintain the progress of ACTT Together by engaging existing and new stakeholders for knowledge exchange (e.g., oversight of implementation of Guiding Principles within hospitals/agencies, revisions to and dissemination of ACTT QII and Stepped Care reports/models/presentations, execution of future models of Stepped Care in accordance with growth of regional needs, etc.)

To do so, the Oversight Committee is requesting the ongoing assistance of a dedicated 0.5 FTE Project Manager to support the work needed to implement the recommendations above for the next phase. A formal Business Case will be submitted shortly with further details of the request. It is the aim of the Committee to continue the work of the QII so as not to lose momentum, to identify areas of improvement to the implemented practices, and to ensure the work is sustainable and communicated to key stakeholders.

8.0 Conclusion

Year one of implementation of the QII recommended standards and best practices, including Stepped Care, saw a preliminary positive impact on overall ACTT capacity, ACT Team work-flow, and client satisfaction. While only at year one, it is expected that capacity of the CE LHIN ACTTs will increase at the same rate over the next year, and conversely, hospital bed utilization of ACTT clients will decrease further. Through ongoing evaluation and improvement, the outcomes are anticipated to further improve over the next two years. The next phase of the project (years two to three) will see more thorough evaluation of outcomes and identify areas of improvement.

Through feedback from stakeholders such as the Ontario ACTT Association (OAA) and ACTTs across other LHINs in Ontario, the CE LHIN Stepped Care Model has garnered great interest across Canada. For one, the OAA has endorsed Stepped Care through propagation of Stepped Care materials on its website to other ACTTs. A variety of speaking engagements have been requested by other agencies to members of the ACTT Oversight Committee, as well as requests for sharing of the QII report. The CE LHIN ACTT Oversight Committee is committed to continue the work through to year three, to see the work sustained within the LHIN and communication and collaboration of the Stepped Care Model across the province. Based on the progress of phase one of Stepped Care and the evidence-based literature on the reduction of hospital days attributed to ACTT services, it is feasible that the ACTT QII/ Stepped Care Initiative could on its own complete the CE LHIN's goal to "*Strengthen the system of supports for people with Mental Health and Addictions issues so they spend 15,000 more days at home in their communities by 2016.*"

9.0 Appendix A – Survey and Focus Group Questions

9.1 Stepped Care Client Questionnaire

Thank you for taking the time to complete the ACTT Stepped Care questionnaire. The goal of the questionnaire is to find out what you think about the Stepped Care Program that you are part of and to help make the services better for you.
The survey is made up of a total of 8 questions and will take about 5 minutes to complete. For each question, please choose the answer that best describes how you feel. This survey is voluntary and the answers you provide will be kept confidential.

1. My age, in years is (please check one):

- ☐ 16-17
- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ 75-85
- ☐ 85+

2. The gender I identify most with is:

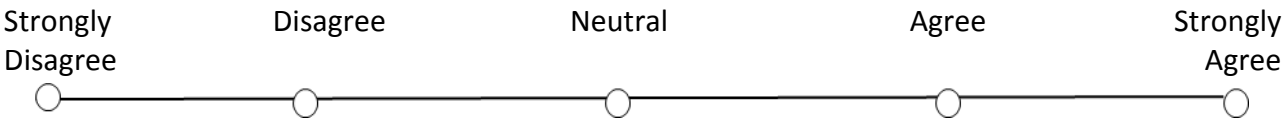
- ☐ Male
- ☐ Female
- ☐ Other

3. I have been in the Stepped Care Program for approximately:

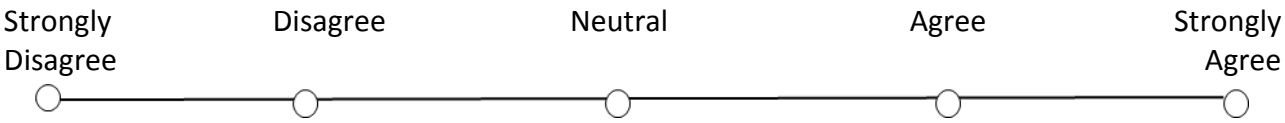
- ☐ Less than 1 month
- ☐ 1-2 months
- ☐ 3-4 months
- ☐ 5-6 months
- ☐ More than 6 months

4. Thinking about my transition into Stepped Care, I found that:

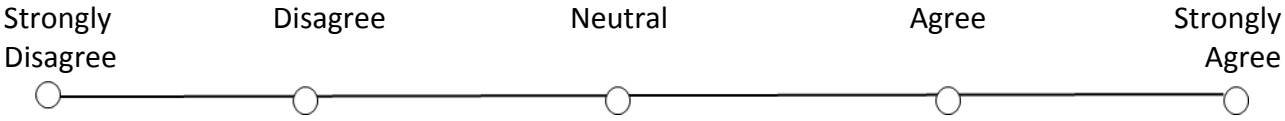
a) The ACTT staff clearly explained to me what the Stepped Care Program was about and what would change in my care:



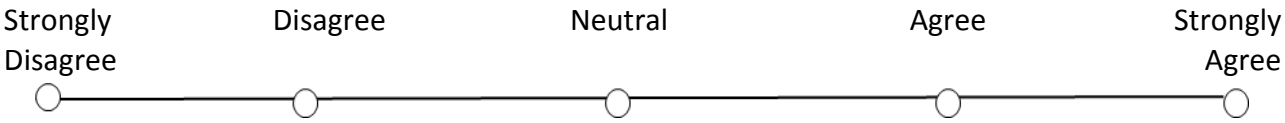
b) I had enough time to be able to adjust to the idea of transitioning into Stepped Care:



5. My personal experience in the Stepped Care Program so far has been positive:



6. In Stepped Care, I still feel that I am part of ACTT and that I can ask for additional support (help or services) when I need it:



7. The things I like **most** about the Stepped Care Program are (please provide an answer in the box below):

8. The things I like **least** about the Stepped Care Program are (please provide an answer in the box below):

9.2 Stepped Care Client Focus Group Questions

1. Thinking about your experience transitioning into Stepped Care Program, were you comfortable with the process of moving from regular ACTT services to Stepped Care?
2. Which services as part of Stepped Care would you consider important to help you in your treatment and recovery and why?

3. Throughout your time in Stepped Care, do you feel you are receiving the right amount of service to keep you healthy and help you to become more independent?

4. Do you feel comfortable that you can go back to regular ACTT services if you become ill again?

5. Do you still feel like a member of the ACT Team?

6. What would you like to see changed as part of the Stepped Care Program to make it better for you?