

What Your ACT Daily Team Meeting May Reveal About Overall Practice

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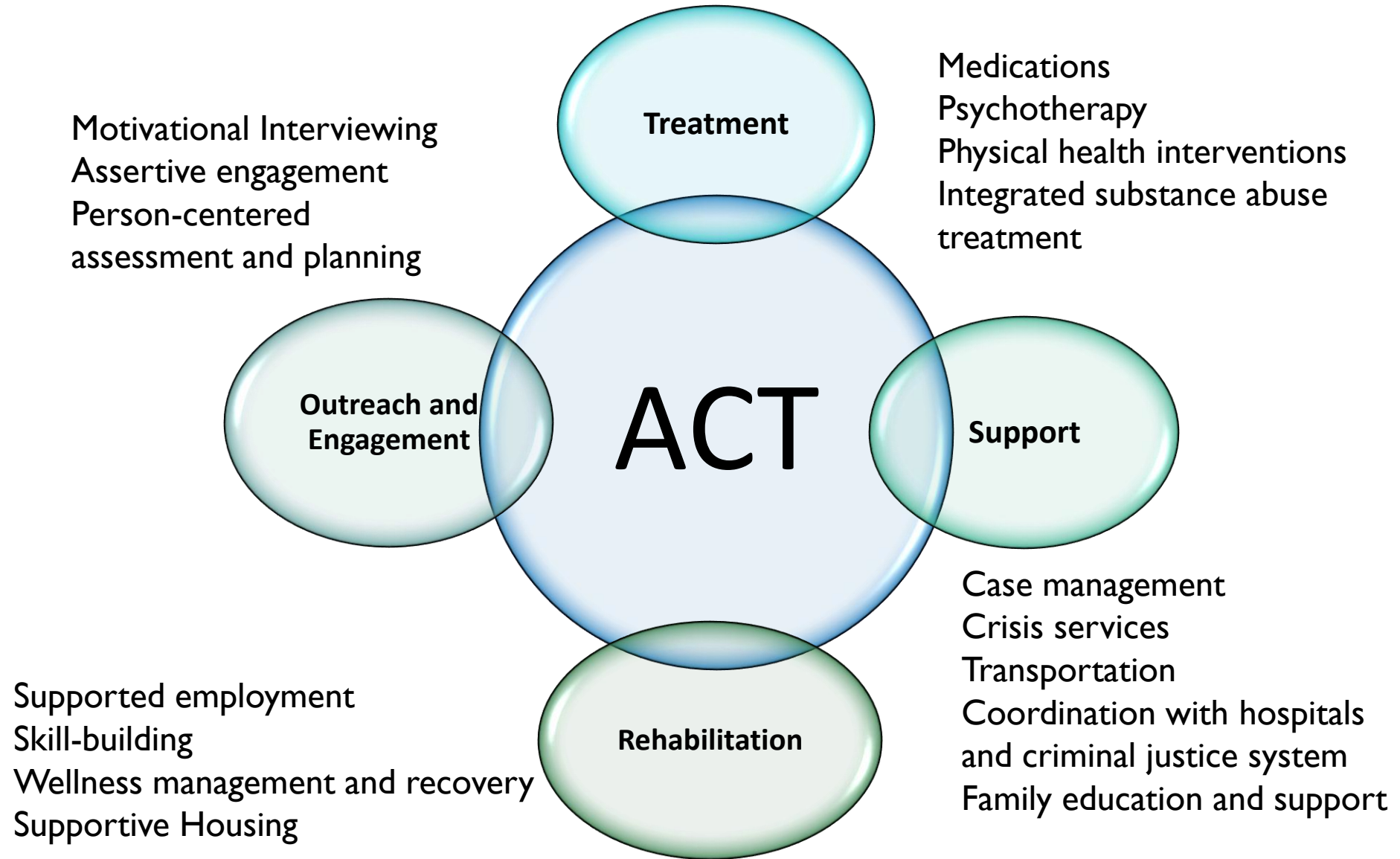
Director, Institute for Best Practices

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Getting on the Same Page

Quick Overview of ACT
and ACT Daily Team
Meeting (DTM)

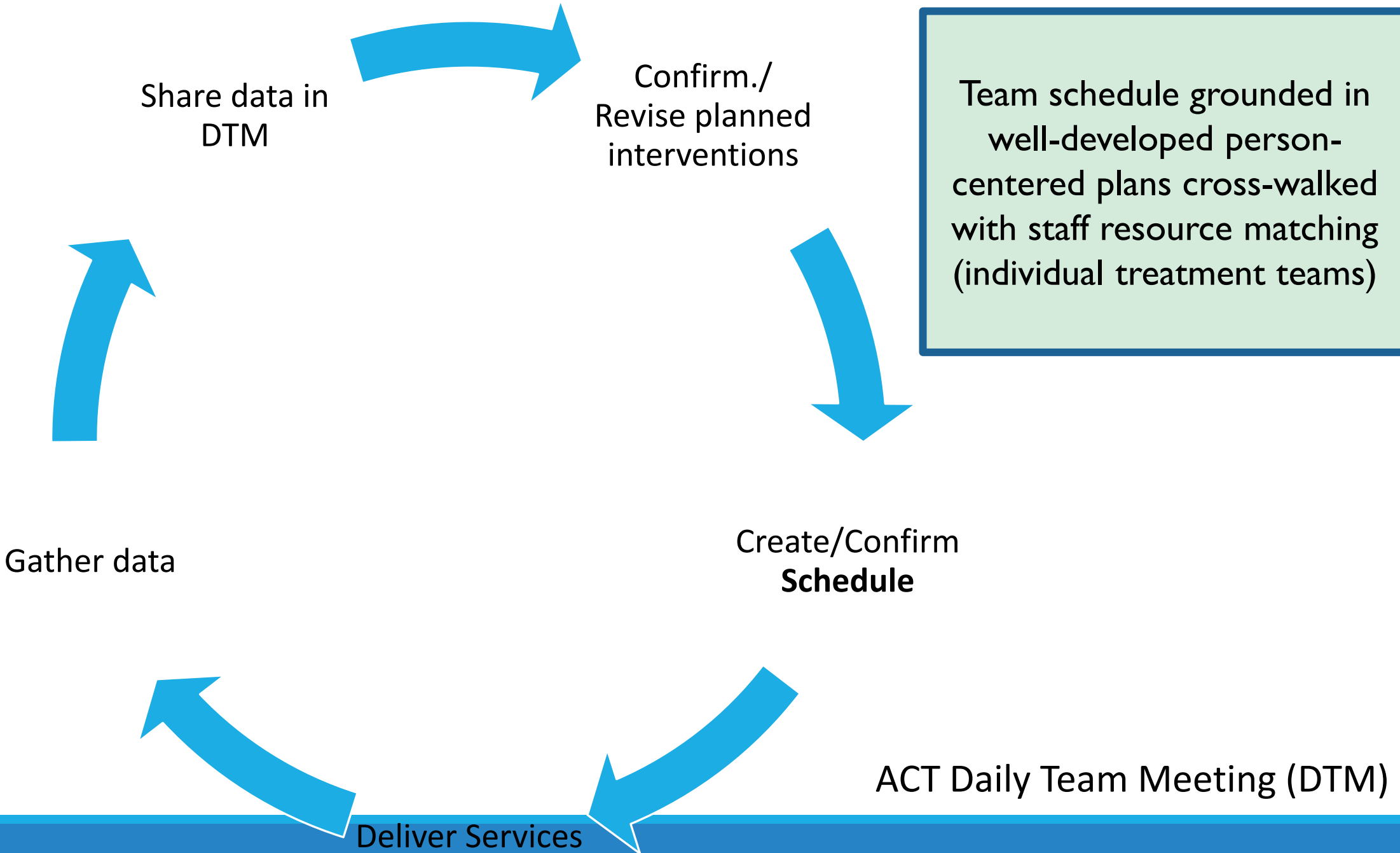
ACT is a way of organizing best practices



Daily team meeting is the essence of care coordination

Care coordination involves deliberately organizing individual **care** activities and sharing information among all of the participants concerned with an individual's **care** to achieve safer and more effective **care**

The main goal of care coordination is to meet individuals' needs and preferences in the delivery of high-quality, high-value health care.



Share data in DTM

Confirm./
Revise planned interventions

Team schedule grounded in well-developed person-centered plans cross-walked with staff resource matching (individual treatment teams)

Gather data

Create/Confirm
Schedule

ACT Daily Team Meeting (DTM)

Deliver Services

Relaying Info with Intention

Critical Events

Updates

Roll Call

Observing Stage of
Change Readiness

Summary
Presentations (e.g.,
following intakes;
assessments)

Parked
Conversations for
Deeper Dive

Roll Call: What to Share

clinical status/presentation, esp. if deviations from what seems more typical for that person

interventions delivered (checked against schedule)

Specify a Plan,
where Needed

noteworthy responses from service recipient; highlight successes

any lingering issues or to-dos that may need to be problem-solved and/or scheduled



Client Log - Record status of all individuals

Individual status (mental status/relevant behaviors & staff interaction with individual) is recorded in some form of a log for each day of the week.

Also record who saw individual and whether attempt was made

Log is organized by individual-month

One line per day

Log is available to team members.

Destination: Daily Team Schedule

Predictable portions can be pre-populated ahead of time and then updated during meeting

Staff Schedules

Planned Interventions

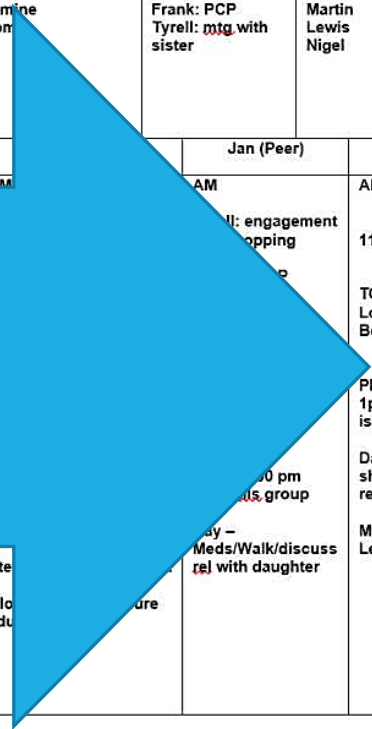
Client Monthly Schedules

Emerging and Proactive Contact Needs

Indirect Time (Daily Team Meeting; Supervision; Progress Notes)

Staff Coverage

DATE: Wednesday		CRISIS PHONE: LYNN		CARS:	
HOSPITAL James	Pending Admissions: Alycia Transitions & Discharges: Bradley	Watch List: Manuel	New Clients: Jasmine Thom	TX Planning & ITT's: Frank: PCP Tyrell: mtg. with sister	Daily Meds: Kay Martin Lewis Nigel
					Lab: IM's Lucy Charles
	Jeff (LCAS)	Anne (Voc Spec)		Jan (Peer)	Lynn (QP)
	AM	AM	AM	AM	AM
10am SUPERVISION w Jeff	10 am SUPER stacy			11 a.m. Frank' PCP	Read Alycia referral
Read Alycia referral	11 am: mtg			TOPPSx2 Lorraine Bob	Dr. Harris/PCP consult for Steve
	Manuel relapse			PM 1pm: Lydia - Housing issues	Office appts; 10:30 Emily
	PM			Daily PP's/ create shopping list and review budgets:	11: a.m. Frank's PCP
1:00 - 2 group	3:00pm MI/SA & HUD application			Martin Lewis	Harry/psych assessment in field
					PM
					1pm: Tonya: ask about DSS
					Ethyl Check labs from last week & discuss
					Jasmine: engagement



Specificity of Person-Centered Plan Interventions

What is being provided by team
(it should be stage-appropriate)

Who is providing

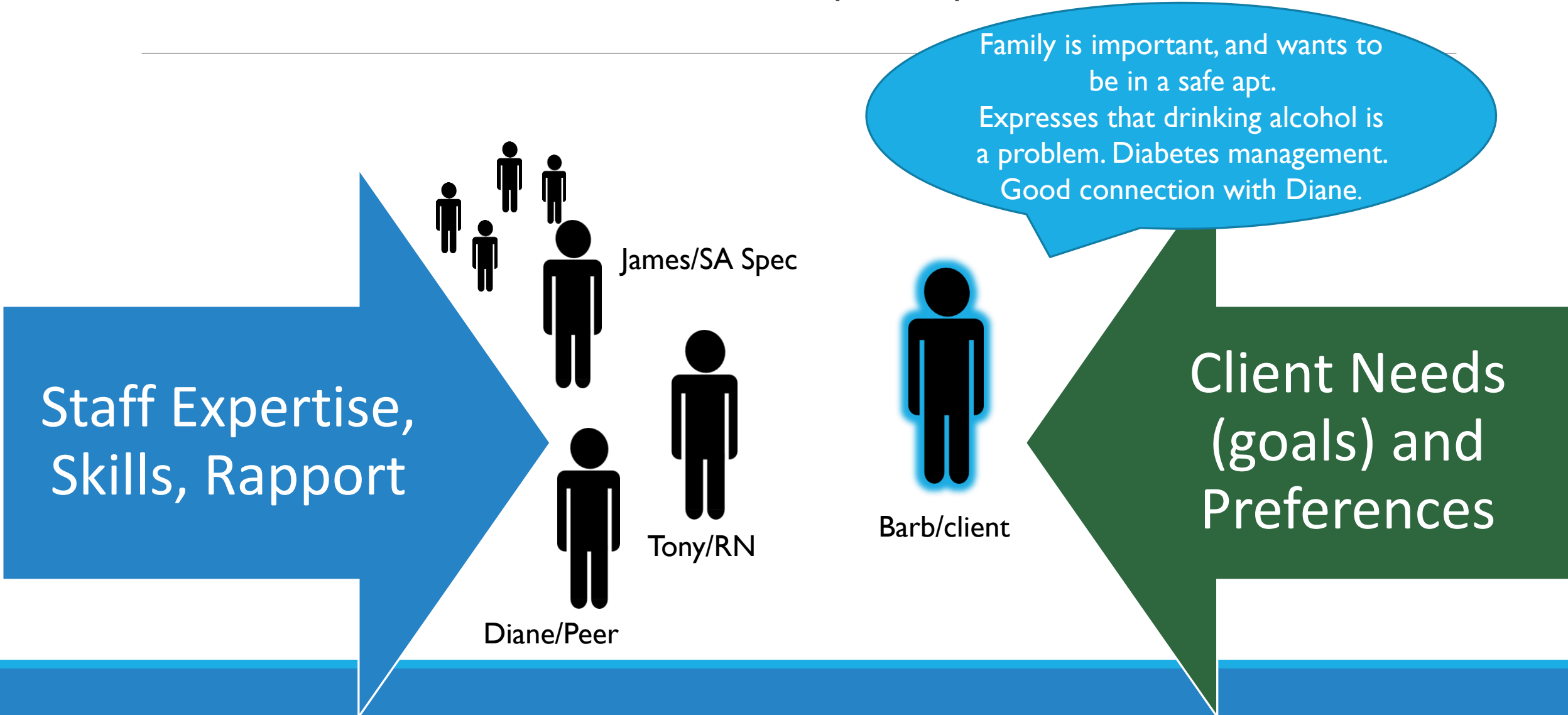
How often is it being provided

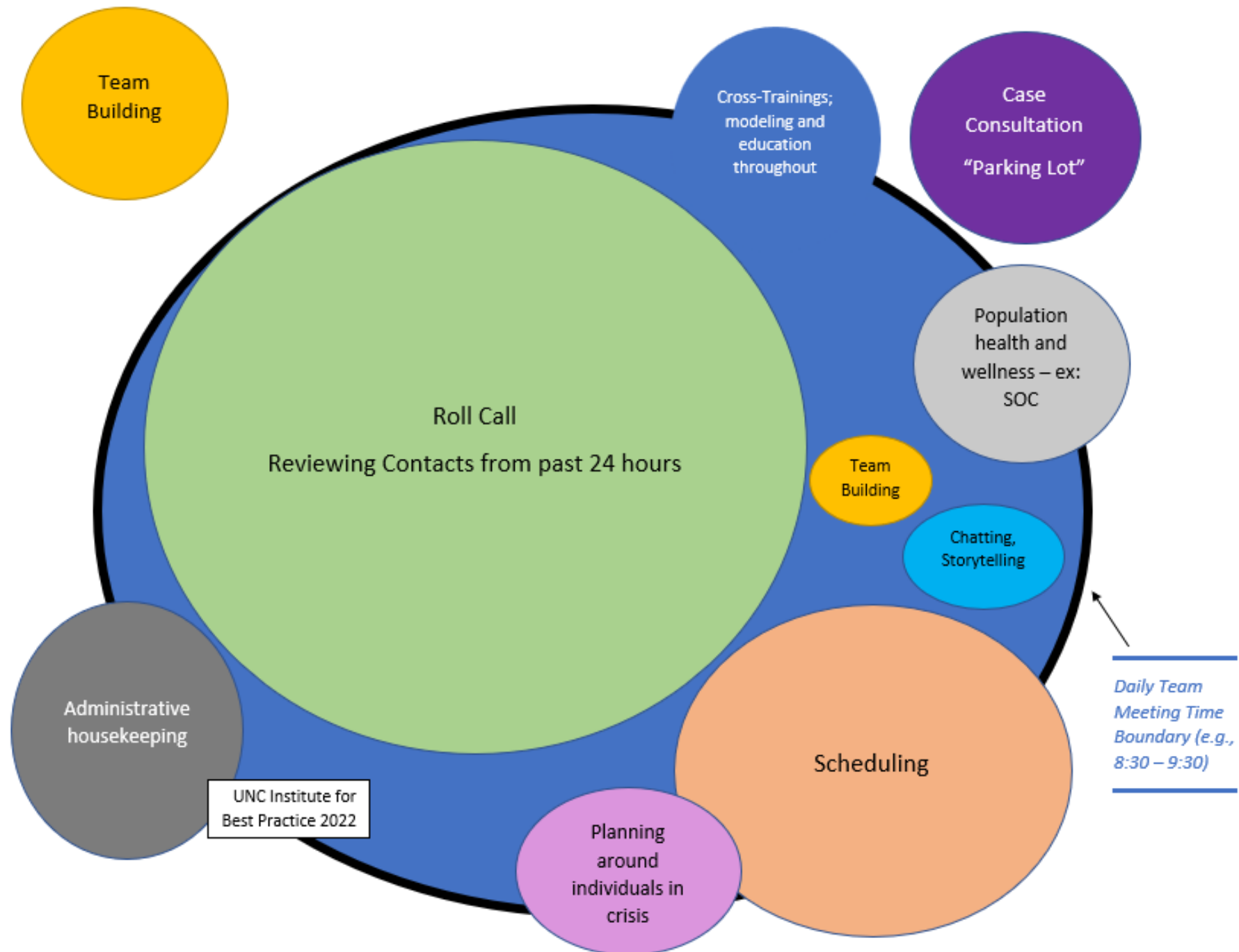
Also important to be clear on **why** it's being delivered – how does it connect upstream to objectives and goals?

Preferences for **when**

For **how long?**

Arriving at a “Team Approach” by using Individual Treatment Teams (ITTs)

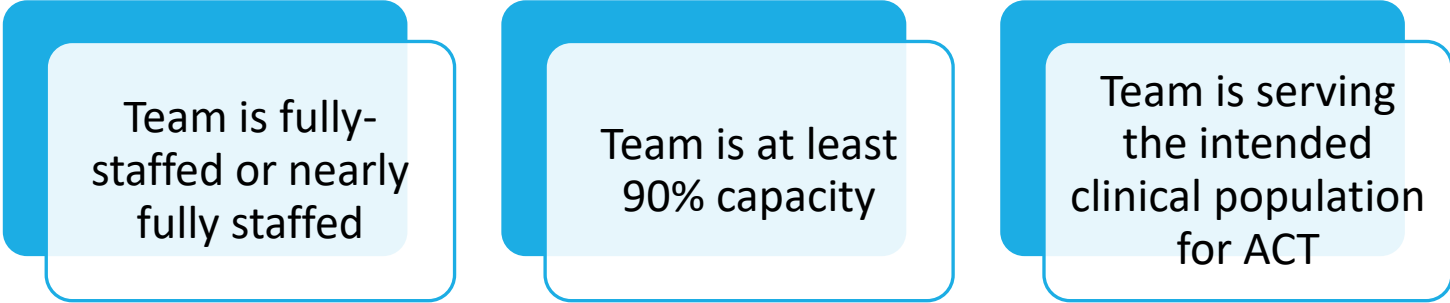






DTM Practice Examples

(AND WHAT THEY MAY REVEAL ABOUT
OVERALL PRACTICE)



Team is fully-staffed or nearly fully staffed

Team is at least 90% capacity

Team is serving the intended clinical population for ACT

Practice Example Assumptions

Minimal Info Reported Out

Very basics of case/care management services are being offered (i.e., there is nothing more to report)

Lack of planned interventions (esp. from a person-centered plan)

Staff not trained on what to report out

Too many contacts assigned each day (i.e., no time to do much more than check-in and med support)

“Dropped off meds,
doing ok”

“Baseline”

Gossiping and Story-Telling

Lack of leadership within meeting and team

Recovery-culture may be lacking

Inadequate service dose (i.e., there is not clear attention to need to get moving to see individuals that day)

Staff enmeshment and/or cliques formed

“and then her mom came by with this new man... you recall the last two guys she was with?”

A Lot of “Attempts”

Lack of planful interventions addressing what people want from the team

Staff schedule rotation (i.e., “everyone sees everyone”) is degrading continuity of care

Not attending to individual preferences, including when and where to be seen

Poor attention to stages of change readiness and related stagewise interventions

Camille: Not home

Ricardo: seemed less depressed,
provided weekly med pack

Peter: Attempt

Foster: Attempt

Reporting Activities from Two Weeks Ago

Daily team meeting not routinely happening

Staff attendance is highly inconsistent

Psychiatric care provider is not attending routinely (catching them up often)

“I saw her a couple of weeks ago for her injection. She was preparing apartment for an inspection the next day”

Psychiatrist Pops In for Updates

Not integrated within the team; not a co-clinical leader

Very little time assigned with the team

Information shared in DTM not serving to be useful

“Anything to know about
the three people on my
schedule for today?”

A Concerning Situation is Shared

(and that's about it)

Lack of clinical sophistication

Clinical leadership is absent

Lack of understanding and implementation of risk-need-responsivity model for ACT (i.e., Inadequate sense of responsibility in anticipating and addressing emerging needs)

Felicia: "She was very anxious and hyperverbal this morning. She shared that she believes someone broke into her apartment over the weekend. I saw that the lock on her door appeared messed with ..."

Bill: "Baseline"

A Lot of Multi-Tasking Among Staff

Minimal use of a Team Approach (i.e., don't really have to attend to individuals not immediately on my "caseload")

Staff are overextended with no protected time for service notes

What is shared is of little value to the team

"Maria, didn't you see
Troy yesterday?"
Maria: (looking up from
service notes) "Oh yeah
– he's fine"

No Discussion or Review of Schedule

Minimal use of Team Approach (staff make their own schedules)

Inadequate oversight of emerging needs and flexing the schedule

Little tailoring of schedule per individual served

[Roll-call wraps up]
“Ok, everyone have
a great day!”

Everyone is Scheduled to be Seen Once a Week

Lack of person-centered planning

Limited scope of practice being offered to individuals

Reliance on other service providers patching-in (service brokering – e.g., home nurses, residential staff)

Service catchment area too expansive (staff have too much indirect time with travel)

No Successes Are Shared

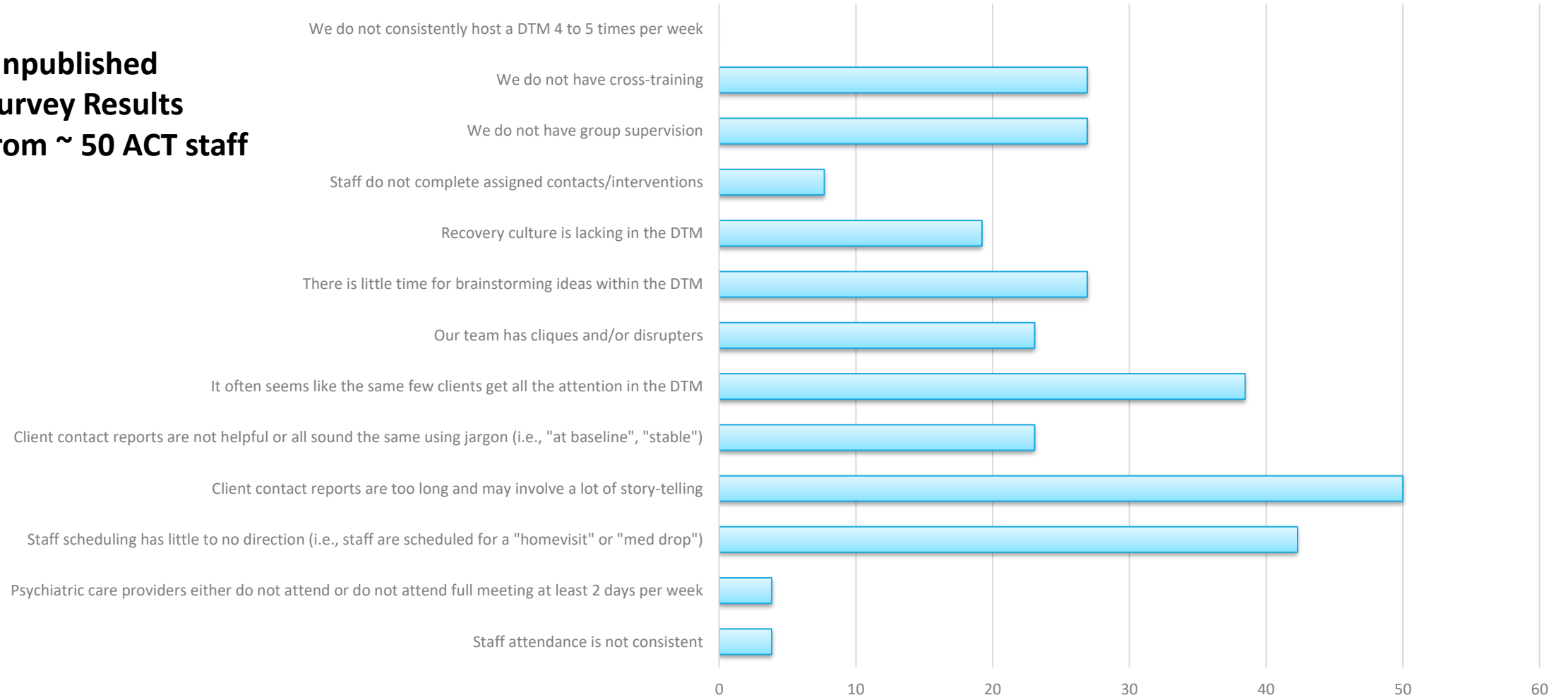
Lack of recovery culture

Limited scope of services provided

Poor team cohesion

**Unpublished
Survey Results
from ~ 50 ACT staff**

Which of these are challenges to having an effective DTM (check all that apply)?





Q&A

THANK YOU!

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