**ACT TEAM SURVEY**

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| Team Name: | | |
| Team Leader: | Year of Team Start-Up: | Today’s Date: |

**Please answer each question about your ACT team as best as you can.**

1. Please complete Table 1 below regarding your **ACT team staffing in the past 3 months**. **[OS1, OS5, CT1, CT3, CT6, ST1, ST4, ST7]**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 1. ACT Team Staffing** | | | | | | | | |
| Staff Name | Position | Date of hire on to the Team1 | Start date in current position1  Place a \* here if staff are no longer on the team1 | Number of hours the staff member works with the ACT team per week2 | Highest Level of Education | Specialized training, clinical experience, and Board Certification3 | Number of years of experience with adults with SMI including their work with the ACT team | Daily Team Meetings per week. Note typical days of attendance (MTWRF) |
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1We want to differentiate dates of hire with the team from when a staff member may have started in their current position. We also want to clearly capture staff listed in table who worked with the team in the past three months but are no longer employed with the team at the time of the review. 2Include the number of hours each team member works, not just whether they are available (and may be holding another role in the Agency at that time). 3 Specialized training (e.g., licensure, training in co-occurring disorders) and # of years of clinical experience. Please note if Psychiatric Care Provider is Board Certified in Psychiatry, and/or if any physician extenders have specialized certification and training in psychiatry.

1(a) Are any of the staff above interns or Residents?  **YES**  **NO**

(b) If yes, please specify length of time for the rotation of each staff person who is an intern or Resident:

Name: Length of time in rotation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In the past 2 years, how many staff members have left the team? If your team has been in existence for a shorter period, please indicate the time frame that corresponds to the length of time your team has been operating (e.g., in the past 1 year)

**# staff members**      **Time frame (if not in the past 2 years)**

1. In the past year, how many vacant positions did you have on the team each month? Please specify which positions were vacant.Start with the current month and work backwards**.**

| **Table 2. ACT Staff Vacancies** | | |
| --- | --- | --- |
| Month | # of Vacancies | Positions Vacant |
| **January** |  |  |
| **February** |  |  |
| **March** |  |  |
| **April** |  |  |
| **May** |  |  |
| **June** |  |  |
| **July** |  |  |
| **August** |  |  |
| **September** |  |  |
| **October** |  |  |
| **November** |  |  |
| **December** |  |  |

1. In the past year, how many staff members have been on leave for more than one month? (Include any extended absences, e.g., sick leave or leave after the birth of a child.)

**# staff on extended leave for more than one month in the past year**

1. In the past month, about how many hours on average did the team leader spend providing direct services to clients and natural supports each week? Direct services include face-to-face services and assessments, phone contacts, and treatment planning meetings that include clients and/or natural supports. **[CT2]**

**# hours per week providing direct services to clients/families**

1. In the past month, how often did the team leader meet with each of the two staff to whom he/she consistently provides the most clinical supervision? Clinical supervision is defined as the provision of guidance, feedback, and training to team members to assure that quality services are provided to clients (e.g., following evidence-based practices, negotiating ethical quandaries) and maintaining and facilitating the supervisee’s competence and capability to best serve clients in an effective manner. Examples include mentoring in the field, review of clinical cases, and providing feedback on tools such as assessments and treatment plans. Only count meetings that were scheduled (vs. impromptu), regardless of whether the meeting took place within a group setting (i.e., weekly clinical meeting) or individually, or in the office or in the field. [**CT2]**

**Please indicate the number of times over the past month the team leader provided clinical supervision to each of the two staff most consistently supervised:**

**# times you provided scheduled supervision to team member #1 over past month.**

**Team member name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**# times you provided scheduled supervision to team member #2 over past month**

**Team member name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Client caseload size: **[OS1, OS5, OS10]**

(a) How many clients are currently enrolled on your team?      

(b) How many clients is your team equipped to serve at capacity (i.e., caseload cap)?      

(c) How many clients were enrolled one year ago?

1. Do you currently serve any clients who you think do NOT meet ACT admission criteria and/or are inappropriate for ACT? Please mark one. **[OS6]**  **YES**  **NO**
2. If you answered yes, how many clients do you estimate do NOT meet ACT admission criteria? **[OS6]**      **# clients who do NOT meet ACT admission criteria**
3. Approximately how many of your current clients were “stepped-up” to ACT from a less intensive program or service within your agency (i.e., client was enrolled with another program and eventually referred to ACT to receive more intensive services than s/he was receiving)? Do not count clients who went from a less intensive program to the hospital, and then were referred to ACT from the hospital. **[OS7]**      **# clients “stepped up” to ACT from a less intensive program or service** [Note to evaluator: calculate the inverse, representing # of clients who were not stepped up to ACT from a less intensive program or service for rating OS7].
4. In the past 6 months, what is the highest number of clients admitted to the ACT team per month? **[OS8]**       **Highest number of clients admitted per month, in past 6 months**
5. In the past year, how many clients were discharged for the following reasons? **[OS9, OS10]**

**# unable to locate client**

**# incarcerated**

**# discharged as a result of not receiving authorization from managed care organization**

**# transferred to a more restrictive service setting (e.g., hospital, nursing home, residential treatment center)**

**# refused services and/or requested discharge**

**# moved out of service area without assistance from team**

**# moved out of service area with assistance**

**# transitioned to less intensive services/graduated (i.e., was discharged because of significant improvement)**

**# deceased**

**# other: (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Please list all groups provided by your team.

|  |  |  |  |
| --- | --- | --- | --- |
| **Group Name/Type** | **Group Facilitator(s)** | **Frequency/Duration** | **Average # of Participants** |
|  |  |  |  |
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1. Please list the last 7 client psychiatric hospitalizations, noting both the admission and discharge months. A single client may be listed more than once. Include a brief description of the team’s involvement in the decision-making process, clearly indicating whether team was involved in the admission/discharge process (note that “involvement” in an admission is not limited to directly facilitating a voluntary or involuntary admission). Additional questions will be asked about the team’s role in the admission and discharge during the interview. **[OS11]**.

|  |  |  |  |
| --- | --- | --- | --- |
| **Last 7 Client Psychiatric Hospitalizations (note that there may be repeated clients).** | | | |
| **Unique Client Identifier** | **Month of Admission** | **Month of.**  **Discharge** | **Was team involved in the decision-making process around this admission and/or discharge?**  **(indicate yes/no for each and provide brief summary)** |
| **1.** |  |  |  |
| **2.** |  |  |  |
| **3.** |  |  |  |
| **4.** |  |  |  |
| **5.** |  |  |  |
| **6.** |  |  |  |
| **7.** |  |  |  |

1. Client demographics. To understand who is receiving services, we are asking that you share basic, aggregate demographic data with us.

**\_\_**# of clients who are age 25 years old or younger.

\_\_# of clients who are age 67 years old or older.

\_\_# of clients who are Black, Indigenous, or other people of color (BIPOC).

Of those identified as BIPOC, please indicate the two largest groups represented by noting a “1” and “2” of the

following:

|  |  |  |  |
| --- | --- | --- | --- |
| American Indian/ Alaskan Native \_\_\_\_ | Asian \_\_\_\_ | Black \_\_\_\_ | Hispanic \_\_\_\_ |
| Middle Eastern/ North African \_\_\_\_ | Native Hawaiians and Pacific Islanders \_\_\_\_ | Other (please specify) \_\_\_\_ | |