ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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AHCCCS Fidelity Reviewers

Method

On July 25-26, 2017, TJ Eggsware and Karen Voyer-Caravona completed a review of the Southwest Network Osborn Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

Southwest Network (SWN) operates five ACT teams, one of which is located at the Osborn clinic located in Phoenix. At the time of the review, the ACT team consisted of 11 staff serving 97 individuals, 65 of whom are also identified as having a co-occurring disorder.

The individuals served through the agency are referred to as "clients" and "members", but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

During the site visit, reviewers participated in the following activities:

- Observation of a daily ACT team meeting on July 25, 2017;
- Individual interview with the Director of ACT Services in lieu of the Team Leader/Clinical Coordinator (CC), who was out of the office;
- Interview with one of the team's two Substance Abuse Specialists (SAS);
- Individual interviews with the Rehabilitation Specialist (RS) and Peer Support Specialist (PSS);
- Group interview with five members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- Review of the following documents and resources: Mercy Maricopa Integrated Care ACT Admission Screening Tool; the SWN *Groups 2 Go Substance Abuse Group* manual; the SWN ACT Graduation Process form; SWN *Lack of Contact Checklist*, SWN staff roster tracking report for the two years prior to review, and resumes for the team SASs and RS.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The ACT team meets as a full team four days a week to discuss all ACT members, and one day a week for more in-depth discussion of targeted members.
- The ACT team is of sufficient size to provide necessary staffing diversity and coverage.
- The team maintained a consistent member census year-to-year, with low graduation and drop-out rates, and a steady flow of intakes for the six months prior to review.
- Members interviewed were aware of staff specialty roles on the team and contact numbers for staff. The team no longer has a clinic stationed staff to respond to crisis; instead, staff receives and responds to member crisis or other concerns while in the community.
- The team seems to be aware of, responds to, and assists with the coordination of the medical health care needs of the members. During the morning meeting observation, staff noted medical appointments, cited references of providing assistance to members attending appointments, and discussed medical treatment provided to the members. The team Nurse reported her plans to make contact with members to discuss specific health issues, and offered guidance to the team.

The following are some areas that will benefit from focused quality improvement:

- The team experienced staff turnover during the 24 months prior to review, including the CC and both SASs. Some positions, such as the CC and Employment Specialist (ES), remained vacant for three months or more. The agency has tracking mechanisms in place to monitor staff turnover. Using the staff turnover data, the agency may be able to evaluate teams with higher turnover rates and link them to teams with lower turnover rates; this could essentially provide direct, on-the-job mentoring on methods to stabilize staffing.
- The ACT team should increase the frequency and intensity of face-to-face member engagement, with a focus on community-based contact. In face-to-face environments, staff can best help members build skills, gain insight, and develop resources/natural supports that help sustain community living and recovery.
- When teaching skills, evaluate the benefit of clinic-based groups versus individualized supports provided to members in their communities. Individualized support should be the primary focus on an ACT team. Review whether member participation rates support continuing ACT staff facilitated, clinic-based groups. Other than substance use treatment groups, which are likely to occur in the clinic setting, services should primarily be delivered in the community. It was not clear if clinic-based groups followed a structured approach to treatment.
- Consider updating the agency website to outline ACT services, to direct community members or stakeholders on whom to contact regarding referrals, to identify where ACT services are offered at SWN, etc.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The member to staff ratio for the Osborn ACT team, excluding the team Psychiatrist, is approximately 10:1. The Employment Specialist position was vacant at the time of the review.	• See recommendation for H10, Vocational Specialist on Team.
H2	Team Approach	1 – 5 4	Members interviewed reported that they met with one of the team Nurses, the Psychiatrist, and/or other ACT staff during the month prior to review, but few reported contact with ACT staff in the week prior to review. A review of ten randomly sampled member records found that 80% of members were seen by more than one staff in a two week period. Staff reported the agency provides cell phones and transcription technology for staff to document interactions with members.	• To ensure that ACT staff are familiar and work with all members, 90% or more of members should have face-to-face contact with more than one staff in any two week period. To the extent possible, plan for targeted interventions by specialists based on member goals, needs, etc.
H3	Program Meeting	1 – 5 5	The ACT team meets four days a week - Monday, Tuesday, Thursday and Friday- to discuss each member of the team. On Wednesday a meeting is held for more in depth discussion of targeted members. The team Psychiatrist attends team meetings on Monday, Tuesday, Thursday and the clinical staff meeting on Wednesday. During the meeting observed, discussion varied based on member need and status. There was evidence of specialists taking the primary role in implementing services related to their service areas, including: supporting members in their homes, assisting members with housing, assisting members with socialization and vocational activities, substance use treatment interventions, and working with members to establish rapport.	
H4	Practicing ACT Leader	1 – 5	The CC joined the team June 2017, after the position remained vacant since late December	• The CC should continue his efforts to meet members, build rapport, and begin to

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		2	2016. In ten member records reviewed, all documented contacts with members by the CC occurred in the office, and were generally characterized as a first contact with members to build rapport, or to serve as backup to staff while they were in the field. Based on a productivity report, CC direct services to members accounted for about 11% of hours worked over a month timeframe reviewed (excluding one vacation day). Due to the recent hire of the CC, 28 hours of his time was spent in training, and this appeared to have an impact on his ability to provide direct services to members.	engage in direct service provision in the community, allowing for opportunities to train and mentor other staff in appropriate clinical interventions that follow the ACT model.
H5	Continuity of Staffing	1 – 5 3	The agency has a tracking report that was provided which reflects the staff turnover. The Osborn ACT team experienced staff turnover at a rate of slightly less than 46% over the last two years, with 11 staff who left the team in the two years prior to the fidelity review, including the departure of two CCs during that timeframe.	• ACT teams should experience turnover no greater than 20% over a two year period in order to support the therapeutic relationship with members. Using the staff turnover tracking report utilized at the agency, consider analyzing what factors are present on teams with lower turnover rates that can be adopted by teams with higher turnover rates.
H6	Staff Capacity	1 – 5 3	In the 12 months preceding the fidelity review there were 37 vacancies on the ACT team, resulting in a staff capacity rate of just over 74%. Some positions remained vacant for three months or more, including: PSS, ES, SAS, and CC. As a result of vacancies, support was sought from ACT staff at other clinics to provide services to ACT Osborn members. In ten member records reviewed there were also instances of a Medical Assistant providing services to ACT members in lieu of the ACT team Nurses.	• Fill vacant positions as soon as possible to ensure continuity of care for members. Doing so should prevent the need to seek outside support from staff who are not on the ACT team to provide services to ACT members.
H7	Psychiatrist on Team	1 – 5	The team Psychiatrist dedicates 40 hours to the ACT team during her four, ten-hour/day work	

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		5	schedule. In addition, the Psychiatrist works a separate shift of ten hours at the clinic. During that ten hour shift she reportedly assists other teams, and completes administrative tasks related to her role as the lead doctor at the clinic. The Psychiatrist's lead role duties also require attendance of a meeting off-site for two hours per month. The Psychiatrist provides services in the community every Wednesday, and can accommodate other community-based services if needed. Some members reported the Psychiatrist had met with them in their homes.	
H8	Nurse on Team	1 – 5 5	At the time of review, the ACT team was staffed with two full-time Nurses, one of who is the lead Nurse at the clinic. However, other than a monthly two-hour meeting, it was reported duties associated with that role do not take away time from her role as an ACT Nurse. Members interviewed reported they generally meet with the ACT Nurse at the clinic, but some confirmed Nurses have visited with them at their residences.	
H9	Substance Abuse Specialist on Team	1 – 5 5	There was turnover in the SAS position in the year prior to review, but at the time of review two SASs were assigned to the team, with the most recent joining early July 2017. Though neither SAS is licensed, one SAS has more than one year prior experience in the role of SAS on an ACT team. The second SAS has a history of providing substance use treatment services in the past ten years, but not as a primary role since October 2010. However, the SAS reported she participated in SWN training over the course of two months after hire in February 2017, with topics of focus including: treatment modalities used, motivational interviewing, integrated dual diagnosis treatment, and trauma.	• Continue to provide training and guidance to both SASs, and to empower them as they cross-train other ACT staff. • The agency should consider providing the SASs with regular supervision by an experienced substance abuse clinician who is knowledgeable about the co-occurring model and its relationship to the evidence-based practice of ACT.

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H10	Vocational Specialist on Team	1 – 5 3	The team RS fills one of the two Vocational Specialist roles on the team. The ES position remains vacant since April 2016. The RS has a degree in a behavioral health related field, and he reported receiving vocational services training through the Regional Behavioral Health Authority (RBHA) staff when he joined the team. He also reported he was frequently provided with resources, training and guidance by RBHA staff. Based on the morning meeting observation and documentation, there was evidence the RS assists members to access socialization activities and to explore vocational interests. Members interviewed were aware the team could assist them to explore vocational goals. Administrative staff reported it can be difficult to identify candidates for vacant ES roles due to lack of relevant work experience in vocational support services, a lack of awareness of the benefits of competitive employment, and/or lack of experience in supporting members with a diagnosis to pursue employment.	• The agency should recruit and hire a second Vocational Specialist with training and experience in vocational services related to assisting people identified with an SMI and/or co-occurring disorder prepare for and attain competitive employment. The ES should have the knowledge and skills necessary to collaborate with the RS to engage and assist members to pursue employment goals, and cross train other members of the team on how to assist members to obtain competitive employment.
H11	Program Size	1 – 5 5	With 11 staff serving 97 members, the ACT team is currently of sufficient size to provide staffing diversity and coverage.	• See recommendation for H10, Vocational Specialist on Team.
O1	Explicit Admission Criteria	1 – 5 5	The team uses written admission criteria outlined by the RBHA, but this follows assessment by the team. If deemed appropriate for ACT, the member makes the final decision to join the team (i.e., voluntarily). When there are openings, the team informs other staff within SWN first, and confirms that other referrals are managed by RBHA staff. Referrals may also be sent directly by other clinics outside of SWN. Staff reported there was no administrative pressure to accept admissions, but occasionally some stakeholders (e.g., guardians, advocates) request members be referred to ACT	

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			when other treatment may be more appropriate. In those cases, it is necessary to discuss with them the benefits of ACT in comparison with other service options.	
O2	Intake Rate	1 – 5 5	Since January 2017, the peak admission rate was four members in June 2017. No members were admitted in April 2017, one member was admitted each month for January and May 2017, and three members were admitted to the team each month during February and March 2017.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In ten member records there were examples of nursing services (e.g., measuring member vital signs) and case management activities (e.g., home visits) occasionally provided by staff not on the Osborn ACT team. However, it appeared the majority of case management and nursing services were delivered by ACT staff. Members interviewed were aware that different ACT staff fulfill specific roles on the team, and confirmed they were provided with a list of staff contact cell phone numbers. In addition to case management, the ACT team provides psychiatric services, substance use treatment, employment and rehabilitation services, and most housing services. Based on report of staff, less than 8% of members reside in staffed residences. Based on observation of the morning meeting, the team Housing Specialist (HS) assists members to explore housing options, and Independent Living Skills Specialist (ILS) assists members with developing skills to live independently. The ACT team does not provide counseling services; members are referred to external agencies or served by staff at the clinic who are not on the ACT team.	• The team should be capable of directly providing individual supportive counseling psychotherapy (with the necessary clinical supervision and oversight) for members, and avoid reliance on outside providers or staff who are not on the ACT team. • Work to eliminate the need for ACT services to be delivered by staff at the clinic or other SWN clinics who are not part of the Osborn ACT team.
O4	Responsibility for	1 – 5	Staff reported the team provides 24-hour crisis	

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	Crisis Services	5	services, with the on-call number rotated weekly among ACT staff. The clinic based "blue dot" approach was eliminated. Staff reported that ACT member calls are routed to ACT staff cell phones directly rather than through the clinic so staff can respond and remain mobile in the community. Staff confirmed they communicate using company provided cell phones, with the capability to receive and respond to emails and text messages on those devices. Members confirmed they were aware of staff contact cell numbers, and in member records reviewed, some contacts were documented during evening hours when the clinic was closed, usually related to medication prompting activities.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Per report, the team was involved in most (80%) of the last ten member psychiatric hospital admissions. However, it was reported some members self-admit without reaching out to the team prior to admission for support, or without team involvement, or are brought to urgent care by police.	• The team should continue to work with members to discuss the pros and cons of informing the team of issues that may lead to hospitalization; attempt to resolves barriers to the team not being involved, including those related to contact between staff and informal supports. • Increasing member engagement through more frequent and intense provision of community-based services may provide ACT staff with more opportunities to assess and provide intervention to reduce psychiatric hospitalizations.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff said they were involved in all of the last ten psychiatric hospital discharges, and they are always involved in hospital discharge planning. Per report, the ACT team role in hospital discharges includes: staff visits every 72 hours during the inpatient stay; Psychiatrist and inpatient provider consultation; ACT staff usually pick up members at discharge; most members meet with the Nurse	• Continue efforts to educate hospital staff of the role and availability of ACT staff to facilitate hospital discharges.

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			and/or Psychiatrist on the same day, or the day after discharge to ensure they have medication to transition back into the community; and face-to-face contact with members for five days post discharge. Staff cited a recent example of a member discharging from an inpatient setting without being picked up by staff. However, it was reported that staff coordinated with hospital staff prior to discharge, scheduled a time for pick up, and attempted to pick up the member, who was discharged before staff arrived.	
O7	Time-unlimited Services	1 – 5 5	When determining if members are ready for graduation the team relies on an informal ACT graduation process (i.e., not a formal policy at this time) to assesses whether members have met their goals, and are ready for graduation. Per staff report, when members are identified as ready for graduation the team begins to decrease services, for example, reducing the frequency of contact over the course of 30 to 60 days. The team has a celebration with the member to commemorate the event. In the year prior to review, five members graduated off the team. The ACT team expects to graduate about 5% of the 97 current members in the next 12 months.	
S1	Community-based Services	1 – 5 2	Staff estimated they spend 75-90% of their time delivering community-based services directly to members. However, the review of ten randomly selected member records found that 38% of services were delivered in the community. Various staff on the team facilitate clinic based groups (e.g., craft group), and it was difficult to ascertain in the scope of this fidelity review if those activities diverted staff from delivering community-based services. Members interviewed had individual schedules of activities for the	• ACT staff should increase community-based services to 80%. • The team should evaluate the benefit of current clinic based groups, and whether the services can be more appropriately delivered in the community where staff can directly assess needs, monitor progress, model desired learning, assist in identifying and using resources and natural support, etc. in a natural setting. For members who

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			month, some of which were clinic based. Also, not all members felt they selected the activities, but rather some were selected by staff.	prefer group activities, determine if those can be fully transitioned to occur in the community with team support or in a setting that best meets the member's preference.
S2	No Drop-out Policy	1 – 5 5	For the year period under review, two members declined ACT services and left the team, and one member moved from the geographic area. However, the member who left the geographic area was offered resources in their new area, but reportedly wanted to remain open with the ACT team even though the member lived out of state. One of the members who declined ACT services elected to transition to a provider where they could receive integrated behavioral and medical care, and the second member preferred less frequent contact.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Members interviewed confirmed ACT services were voluntary, and that they could elect to participate or terminate services at their discretion. Staff reported that if members are reluctant to participate, the team attempts to match the frequency and intensity of service to member preference in an effort to build rapport. The team uses a lack of contact checklist and addendum with telephone numbers for local hospitals, jails, health plans, shelters, etc. as a supplement to individualized outreach. The outreach checklist prompts for a minimum of six weeks, but can accommodate the tracking of up to 12 weeks of outreach. Staff confirmed they coordinate with formal supports (e.g., payee, probation or parole officers) but not in a coercive manner such as having checks sent by payees to the clinic so members are forced to visit the team to obtain those funds. The team does not withhold member	

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			funds in order to have contact.	
S4	Intensity of Services	1 – 5 2	The review of ten randomly selected member records showed an average service time per week of less than 36 minutes per member. Weekly service time averages ranged from a low of seven minutes per week to a high of just under 129 minutes; five members received less than 36 minutes of service time, on average, per week. Some services were delivered by staff who were not part of the ACT team (e.g., Medical Assistant, home visits by an ACT staff from a team at another clinic), and were not included in the intensity of service calculation.	• Increase average direct service time to members to at least two hours per week, on average. Direct service contacts by ACT staff should be face-to-face and occur primarily in the community. • The team is fully staffed and should be capable of providing services without the assistance of other clinic staff. The CC or agency management may want to explore reasons for this and focus on keeping services within the ACT team.
S5	Frequency of Contact	1 – 5 2	The review of ten member records found the median face-to-face staff contacts with members to be 2 contacts per week. Some agency staff face-to-face contacts with members could not be counted for this item because they were not delivered by the staff on the Osborn ACT team.	• ACT staff must increase the frequency of contact with members so that the average contact across all members is four or more per week. Certain members may receive more or less contact week-to-week than the average, based on individual needs, status goals, etc.
S6	Work with Support System	1 – 5 2	One staff estimated about half of the members on the team had informal supports, and another staff estimated a higher percent of members (70-80%) have informal supports, but both reported the team averaged about weekly contact with informal supports. One staff reported in the prior week they had contact with two or three informal supports. In ten member records reviewed there were few instances of contacts with informal supports (less than one per month on average). When contact was documented it did not appear the team sought contact, but that contact occurred due to the informal support being present when at the clinic or home with the member. There were multiple contacts with an	• The team should encourage members to identify natural and informal supports and discuss with them the benefits of involvement in their treatment. • Proactively engage informal supports on average four times monthly as partners in support of recovery goals. A new family psychoeducation group may aide the team as they work to engage informal supports. • Work with staff and monitor the documentation of contacts with informal supports.

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			informal support for one member, but zero informal support contacts over the course of a month for eight of ten members.	
S7	Individualized Substance Abuse Treatment	1 – 5 3	Staff reported the team attempts to provide weekly individual substance use treatment with each of the 65 members on the team identified with a co-occurring disorder. One staff reported about 40 of the 65 members with an identified co-occurring disorder were actively receiving individual treatment, and estimated that each session lasts about 30 minutes. One staff reported that about 25 individual substance use treatment sessions occurred in the week prior to review. During the meeting observation SAS staff discussed engaging members to address substance use, but there was limited evidence to support that formal individualized treatment is provided. SAS staff referenced recent contact or plans to engage about ten members, with most of those references related to SA group involvement rather than individual treatment. Of ten member records examined, the reviewers did not find any instances of formal individual substance use treatment. Five of the ten members selected for record reviews were listed on a stage of change tracking sheet provided by the team and a sixth member not listed on the tracking sheet carried a substance use diagnosis of "in remission" per the record.	• Ensure that the SASs receive the necessary training, mentoring, and ongoing supervision to provide structured, individual substance use counseling to members identified with a co-occurring disorder. • Resolve any barriers to timely documentation of individual substance use treatment. • Monitor member participation in individualized substance use treatment through the SASs. Review documentation of individualized treatment during supervision with SASs to ensure services align with the members' stages of change and stage of treatment.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The team had only one SAS from May 24, 2017 through July 3, 2017. One weekly substance use treatment group was offered up to the date of review. It was reported the team seeks to target groups based on members' stage of change, and draws from the agency *Groups 2 Go* curriculum. One staff confirmed nine of the 65 members with	• The ACT team should expand substance use treatment group options for members, along with outreach efforts to increase attendance to at least 50% of members with an identified co-occurring disorder. • Build on the *Groups 2 Go* curriculum to

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			a co-occurring disorder, or about 14%, attended the weekly treatment group in the month prior to review, but another staff estimated ten to 15 members attended.	move closer to a co-occurring model.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Per interviews, the team follows the Integrated Dual Disorders Treatment model. However, reviewers did not locate evidence of those principles in treatment plans, some of which were more than 12 months old. Staff on the team did not appear to be familiar with a stage-wise approach but some motivational interviewing interventions were cited during the morning meeting observation (e.g., expressing empathy, instilling self-efficacy and hope, developing discrepancy) Staff also provided recent examples of harm reduction efforts. The team does track members with a co-occurring disorder by stage of change, and staff reported member statuses are reviewed at least monthly. Staff report they do not refer to alcoholics anonymous (AA). One staff reported detoxification support is not sought unless medically necessary (for example, if a member was cycling off a high dose of opiates, or presented with alcohol withdrawal symptoms and could not be safely managed in their home). A second staff interviewed did not distinguish symptoms or substances that may indicate medical detoxification was appropriate.	• Continue to provide support and clinical guidance to the SASs so they can build on existing resources (e.g., *Groups 2 Go*, stages of change therapy manual) and provide cross training to other staff in a co-occurring disorders model of treatment. Ensure all staff are trained in and familiar with a stage-wise approach to treatment in relation to stages of change.
S10	Role of Consumers on Treatment Team	1 – 5 5	The PSS joined the team in June 2017. Based on staff and member interviews, the PSS shares her lived experience with others. Members interviewed reported having met with the PSS, and staff reported the PSS functions as an equal team member.	
Total Score:		**3.89**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	4

6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.89**	
Highest Possible Score	**5**	