ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: September 25, 2018

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AHCCCS Fidelity Reviewers

Method

On September 4-5, 2018, TJ Eggsware and Annette Robertson 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 the Central Region of Arizona.

Southwest Network offers behavioral health services to infants, children, adolescents and adults. Adults are served through four service sites, one of which is the Osborn location. The Osborn ACT team is one of three ACT teams operated by the agency.

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 September 4, 2018;
- Interview with the Clinical Coordinator (i.e., Team Leader);
- Interview with one of the team's two Substance Abuse Specialists (SAS);
- Individual interviews with the ACT Specialist and Peer Support Specialist (PSS);
- Group interview with ten members receiving ACT services;
- Charts were reviewed for ten randomly selected members using the agency's electronic medical records system; and,
- Review of the following items: Mercy Care *ACT Admission Screening Tool*; the team contact and specialist role description document; team welcome document for new members; *Lack of Contact* checklist; substance use treatment group sign-in sheets; and, training records and resumes for the team SASs, Rehabilitation Specialist (RS), and Employment Specialist (ES).

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 services for all ACT members.
- The ACT team is of sufficient size to provide necessary staffing diversity and coverage.
- The team maintained a consistent member census. The team had a low monthly number of new member admissions to the team and few other members moved off the team because they declined ACT or due to lack of contact. The number of members who transitioned because of improvement during the year prior to review, is the same number projected to graduate over the course of the next year.
- Members interviewed were aware of staff specialty roles on the team and contact numbers for staff. Members receive a list of staff names, numbers, and directions on how to get in touch with staff at the clinic or after hours. The same document includes a brief and straightforward description of each position on the team, including how each staff can help the member.
- Based on the team meeting, and documentation, it appears staff work to coordinate treatment with physical healthcare providers.

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

- Evaluate the team approach to maintaining contact with members. Optimally, members have contact with multiple staff that provide targeted specialty support services. Over a two-week timeframe, only 50% of members were seen by more than one staff member. Consider comparing staff contacts with members who participate in groups offered by the team and those members who infrequently participate in group activities. Ensure the team offers individualized contacts with members. Some members may prefer group contacts, but other members may prefer individual support services.
- The ACT team should increase the frequency and intensity of face-to-face member engagement. The majority of services documented in ten member records occurred in the community, but members received less than 40 minutes of service time and less than two face-to-face contacts with staff on average per week. As the team increases service time and the frequency of face-to-face contact with members, they should continue to provide the majority of services in the community.
- Educate all staff on stage-wise approach to substance use treatment including persuasion, engagement, active treatment, relapse prevention, associated treatment interventions, and staff activities. Additionally, the ACT team should expand substance use treatment group options for members, along with outreach efforts to increase attendance
- 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 the agency, 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 9:1.	
H2	Team Approach	1 – 5 3	Staff reported the team goal is for all members to receive services from multiple staff. Members interviewed reported staff had specialty roles on the team, and most reported that they met with two to three staff in the week prior to the review. Some reported they participate in groups with ACT staff. A review of ten randomly sampled records found that 50% of members were seen by more than one staff in a two week period. There was documentation in records that members received services at the clinic from a Nurse and Medical Assistant, not identified as part of the ACT team, therefore services from those staff was not factored.	• To the extent possible, plan for targeted individualized interventions by specialists based on member goals and needs. 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. If not in place, a calendar to plan and track member services may aid the team to ensure members receive support from multiple staff.
H3	Program Meeting	1 – 5 5	The ACT team meets four days weekly to discuss each member of the team. Staff reported that the team Psychiatrist attends team meetings four days a week. During the meeting observed, 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 searches or applications, assisting members with vocational activities, and substance use treatment interventions.	
H4	Practicing ACT Leader	1 – 5 4	The CC reported that he provides direct services, usually accounting for 35-40% of his time. Based on a productivity report over a month timeframe, the CC's direct services to members accounted for about 33% of his time. Examples of office and	• The ACT team leader should provide direct member services at least 50% of the time. • Work with the ACT CC to identify and shift administrative duties (outside of necessary supervisory or other program leader

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			community-based services delivered to members by the CC were found in ten member records reviewed.	functions) to allow for direct service provision.
H5	Continuity of Staffing	1 – 5 4	Based on information provided, seven staff left the team over the last two years, including turnover at the SAS and Nurse positions. Staff reported no temporary staff provided coverage. However, in records multiple examples of a Nurse providing services to ACT members was documented. The Nurse was not identified on the current staff roster or staff who left. It appears the team experienced approximately 33% turnover.	• If any staff leave the team, vet future candidates to ensure potential hires are prepared for the demands of an ACT level of service.
H6	Staff Capacity	1 – 5 4	In the 12 months preceding the fidelity review, the team operated at approximately 92% staff capacity with 11 vacancies on the ACT team. One position remained open for more than half of the year, a SAS position. The team was without any assigned Nurses for two full months.	• Fill vacant positions as soon as possible to ensure continuity of care for members.
H7	Psychiatrist on Team	1 – 5 5	Staff reported the full-time Psychiatrist assigned to the team usually attends the team meeting four days a week. Staff did not identify any instances of the Psychiatrist providing services to members not on the ACT team, nor does she have other administrative duties. Staff confirmed that the Psychiatrist is accessible to them and responds to texts promptly, including over the weekend when necessary. During the meeting observed, the Psychiatrist provided guidance and instruction to staff regarding members' treatment and services. A weekday is allotted in the Psychiatrist's schedule for services in the community, including visits to members who are inpatient.	
H8	Nurse on Team	1 – 5 5	The ACT team is staffed with two full-time Nurses; both joined the team in August 2018. Members interviewed stated they generally meet with the	

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			ACT Nurse at the clinic, but some reported former ACT Nurses visited with them at their residences. The Nurses work four ten-hour days and each attends team meetings at least two days a week.	
H9	Substance Abuse Specialist on Team	1 – 5 5	At the time of review, there were two SASs assigned to the team. One SAS joined the team July 2017. In addition to her time on the Osborn ACT team, the SAS had more than one year prior experience in the role of SAS on another ACT team. The second SAS joined the team in July 2018 after the position was vacant since December 2017. The second SAS has more than one year prior experience working in substance use treatment and assessment screening. Staff reported the SASs receive training approximately every three months in addition to conversations with supervisors and online training.	• Consider providing the SASs with regular supervision (e.g., weekly) by an experienced substance abuse clinician who is knowledgeable about the co-occurring model and its relationship to the evidence-based practice of ACT. Empower them as they cross-train other ACT staff.
H10	Vocational Specialist on Team	1 – 5 4	During the morning meeting observed, staff recounted recent contacts with members to support employment goals and the plans to provide support services. Members interviewed were aware the team could assist them with exploring vocational goals. The team Vocational Specialist roles are filled by the RS and ES. The RS joined the team November 2017 and the ES in December 2017. In addition to her time with the Osborn ACT team, the RS worked in the same capacity on another ACT team for more than three years. It does not appear the ES has more than one year of training/experience providing employment support services.	• Provide training and guidance to Vocational Specialists so they can continue to enhance their skills to engage and support members to pursue employment in integrated settings. Provide cross-training to other specialists to ensure a fully integrated team.
H11	Program Size	1 – 5 5	With 12 staff serving 100 members, the ACT team is of sufficient size to provide staffing diversity and coverage.	
O1	Explicit Admission	1 – 5	The ACT team follows defined ACT admission	

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	Criteria	5	criteria outlined by the Regional Behavioral Health Authority (RBHA). The CC completes screenings for potential members using the RBHA *ACT Admission Screening Tool*. Staff educates the member on what ACT services entail. Information about the member is presented to the team to discuss if admission to ACT is appropriate. The member can accept or decline ACT. Staff reported the team has full control over admissions to the team with no administrative mandates to accept referrals.	
O2	Intake Rate	1 – 5 5	The ACT team reports seven admissions in the last six months. The team's highest intake month was March 2018 with three admissions. There were two admissions in May 2018, one monthly for June and August 2018, and zero admissions during April and July 2018. The team serves 100 members, so recruitment efforts have not been needed to maintain the census.	
O3	Full Responsibility for Treatment Services	1 – 5 4	Members interviewed were aware that different ACT staff fulfills specific roles on the team, and confirmed that they were provided with a list of staff contact phone numbers. The ACT team assumes primary responsibility for psychiatric medication/monitoring, substance use treatment, the majority of housing, and employment support services, but not counseling. The SAS provides group and individual substance use treatment to members. Staff reported the ES and RS support the 17 members on the team who are employed, the eight members pursuing employment, and the ten members involved in education programs. Two members receive employment support services from an external agency, so it appears less than 10% receive	• The agency should explore options to support ACT staff to provide counseling services through the team, either with new or existing ACT staff. If there are certain specialized areas commonly referred to other providers, review options to train or support staff to develop the skills to provide those services. On some teams, SASs with licensure and training provide counseling.

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			brokered vocational support services. The team Housing Specialist and other staff assist members to secure and maintain housing, but about 9% of members reside in staffed residences. The team does not provide counseling services; any member who might benefit from counseling is referred elsewhere.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour crisis service to ACT members. Staff provides to members a list of staff names, contact numbers, a description of each position and how they can help the member, and specific directions on how to get in touch with staff at the clinic or after hours. Coverage of the on-call number is rotated weekly among ACT specialists. If necessary, staff may contact the team Psychiatrist or Nurses for consultation. Staff reported most support is provided to members over the phone, but staff also responds in the community. Additionally, one staff is scheduled to work on Saturday, and another on Sunday shifts.	• The contact and position description document utilized by the team may be useful as an example for system partners and stakeholders to share with other teams on how they can inform members of ACT staff and how to seek support.
O5	Responsibility for Hospital Admissions	1 – 5 4	Some staff reported the team is involved in all member psychiatric hospital admissions. Team involvement for voluntary admissions includes arranging for members to meet with the team Psychiatrist during regular business hours, and bringing members to hospitals to coordinate admissions, which can also occur after-hours or the weekend. Based on review of psychiatric hospital admissions, the team was involved in seven of the most recent ten, with three members who self-admitted without team involvement. When they are aware of or informed of an admission, staff reportedly visit members within 24 hours, make contact with the inpatient staff,	• Work with each member and their support network to discuss how the team can support members in the event of a psychiatric hospital admission. Proactively develop plans with members on how the team can aid them during the admission, especially if they have a history of hospitalization without seeking team support prior to going to the hospital. • Increasing member engagement through more frequent and intense provision of services may provide ACT staff with more opportunities to assess and provide intervention to reduce psychiatric

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			facilitate doctor-to-doctor contact between the inpatient and ACT Psychiatrist, and visit members every Monday, Wednesday and Friday.	hospitalizations.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff said they are always involved in hospital discharge planning, including for the ten most recent members following inpatient psychiatric treatment. ACT staff go to hospitals to transport members, ensure they have medication, and support their transition back into the community. Members meet with the Psychiatrist within 72 hours, with the Nurse within five days, and staff conducts face-to-face contact for the five days following discharge.	
O7	Time-unlimited Services	1 – 5 5	Based on staff report, it appears less than 5% of members are expected to transition from ACT services in the next year. Staff reported the team encourages members to move forward in their recovery, including eventually transitioning from ACT to less intensive services, and to build on member successes. In the year prior to review, two members graduated off the team and transitioned to Supportive services. Staff reported that graduation rate was standard and there was no pressure to transition members. If staff discusses potential graduation with members, but the member elects to remain with ACT, staff work with the member to determine what additional support the team can offer. Members confirmed it was their choice to remain or transition off the ACT team.	
S1	Community-based Services	1 – 5 4	Staff estimated they spend 80% of their time delivering community-based services directly to members, with time in the office to facilitate groups. Though some groups occur in the community, certain members interviewed	• Staff should continue providing a high frequency of community-based services, with the goal that 80% of ACT services occur in the community.

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			reported visiting the clinic multiple times per week to attend groups. The review of ten randomly selected member records found that about 78% of services delivered by ACT staff occurred in the community.	
S2	No Drop-out Policy	1 – 5 5	Staff reported that if members are not in contact with the team, and after outreach efforts occur, members are stepped-down to the Supportive service level. The team does not directly step-members down to Navigator status, but the Supportive team may do so if they are not able to make contact or re-engage the member in services. For the year period under review, two members dropped-out of ACT.	
S3	Assertive Engagement Mechanisms	1 – 5 5	When members are not in contact with the team, staff reported they conduct outreach for 12 weeks, including community-based activities at last known addresses, or areas where members are known to visit. Staff reported that if members are reluctant to participate in ACT, the team attempts to utilize motivational interviewing to engage them. Staff follow the agency *Lack of Contact* checklist to track their outreach and reach out to friends and family of the member as well. Members interviewed confirmed services were voluntary, and that they could elect to accept or decline ACT at their discretion. Staff confirmed they coordinate with formal supports (e.g., payee, probation).	
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 39 minutes per member. Weekly service time averages ranged from about 19 to 78 minutes per week. Some services were delivered by staff who were not part of the ACT team (e.g., Nurse not listed on staff roster, Medical Assistant),	• Increase average direct service time to members to at least two hours per week. Consider evaluating what barriers exist to staff increasing the intensity of service provided to members.

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			and were not included in the intensity of services calculation.	
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 1.5 contacts per week. Some agency staff face-to-face contacts with members, all of which occurred in the clinic, could not be counted for this item because they were not delivered by the staff on the Osborn ACT team.	• ACT staff should 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 3	Staff estimated that about 50% of members on the team have natural or informal supports. Staff reported that contact with those supports may range from weekly to once a month, but ideally, staff have contact with supports at least four times a month. During the morning meeting observed, staff referenced recent or planned contacts with informal supports (for about 20% of members). In ten member records reviewed, documented contacts with informal supports resulted in 1.4 contacts on average per member over the course of a month. Although, there were multiple contacts with an informal support for one member, it is not clear if staff document all contacts with informal supports.	• The team should encourage members to grow and identify natural and informal supports and discuss with them the benefits of involvement in their treatment. • Continue efforts to engage natural supports. Optimally, ACT staff have contact with informal supports on an average of four times monthly as partners in supporting members' recovery goals. Seek training and guidance, whether at the agency or through system partners, to enhance strategies for engaging informal supports. • Consider tracking or monitoring staff documentation of contacts with informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Individualized treatment is provided but averages less than 24 minutes weekly for members with an identified substance use diagnosis. The team functioned with one SAS for most of the 12 months prior to review. The second SAS joined the team in July 2018. Responsibility to provide individual treatment fell to the primary SAS who was with the team since July 2017. Staff reported the SAS schedules about 30 individual member contacts per week, and usually meets with roughly	• Continue efforts to engage members in individual treatment. With the addition of the second SAS, the team may be better positioned to increase the frequency and intensity of individual treatment • Ensure that the SASs receive the necessary training, mentoring, and ongoing supervision to provide individual substance use treatment to members identified with a co-occurring diagnosis.

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			20 members weekly. Staff reported 10 to 15 of those members meet for individual sessions weekly, others every other week, and some every three weeks. Examples of individual treatment were found in member records reviewed. Notes included member's stages of change and summaries of conversations. During the meeting observed, the SAS discussed contact with members and referenced individual treatment.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The SAS facilitates two weekly substance use treatment groups; one at the clinic and the second in the community. Every other week the community-based group occurs at a congregate living property in the community where members of the ACT team reside and on alternate weeks in a local park. Staff estimated that over the course of a month; about 13-20% of ACT members with a co-occurring diagnosis attend group treatment with the SAS. Based on review of sign-in sheets over the course of four weeks, about 15-17% of members with a co-occurring diagnosis attended at least one substance use treatment group. Some members attended multiple meetings. One group during the month timeframe listed housing and substance use as the topic. Some ACT members without a co-occurring diagnosis attended the group and were not included when determining participation of members in substance use recovery groups.	• 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 diagnosis. • Consider structuring groups to support members in different stages of treatment. Members in earlier stages of treatment (e.g., persuasion or engagement) may benefit from a different approach than those in later stages (e.g., active treatment, relapse prevention, recovery). Offering different groups to members based on stage of treatment may allow for more targeted intervention.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Per interviews, the team follows an Integrated Dual Disorders Treatment (IDDT) model. Resources provided draw from SAMHSA anger management and stages of change materials rather than a uniform IDDT approach. Staff on the team did not appear to be familiar with a stage-wise approach,	• Educate all staff on stage-wise approach to treatment including persuasion, engagement, active treatment, and relapse prevention, and how it relates to IDDT. Using a stage-wise approach may help staff to interact with members in a consistent

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			but were familiar with the stages of change model. Staff provided recent examples of harm reduction efforts and in records documented interventions that appeared appropriate to members' stages of treatment. Examples included expressing concern, assisting members to build coping skills, and maintaining support to members who experience a recurrence of use. Staff report they do not refer to alcoholics anonymous (AA). One staff reported withdrawal management (i.e., detoxification) support is not sought unless medically necessary (e.g., alcohol or opiate use). Another staff interviewed was unable to distinguish symptoms or substances that may indicate when medical withdrawal management was appropriate. However, the team Psychiatrist is trained to provide medication-assisted treatment options.	fashion, with specific recommended activities to utilize, and those to avoid. Empower SASs to assist in cross-training team staff. • Ensure treatment plans reflect goals of members (and optimally needs/objectives), in their words, incorporating interventions and activities for service staff that align with member stages of treatment. • Review with staff the substances that withdrawal management may be most effective or recommended.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team is staffed with a PSS who shares her lived experience with others. Members interviewed reported they receive services from the PSS in group and individually. Staff reported the PSS functions as an equal team member. Additionally, another staff person revealed being in recovery, and divulges to members when appropriate to support them in their recovery.	
Total Score:		**4.21**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	4
5. Continuity of Staffing	1-5	4
6. Staff Capacity	1-5	4
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	4
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

	Rating Range	Score (1-5)
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	4
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	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.21**	
Highest Possible Score	**5**	