ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 20, 2015

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ADHS Fidelity Reviewers

Method

On October 21-22, 2015 Georgia Harris and Karen Voyer-Caravona completed a review of the Partners in Recovery- Metro Center Omega Assertive Community Treatment (ACT) team. For the remainder of this report, this team will be identified as PIR-Omega. 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.

The Partners In Recovery Network serves individuals with Serious Mental Illness (SMI) through five locations in Maricopa County: Metro, West Valley, Hassayampa (Wickenburg), East Valley, and Arrowhead. Each of these locations provides services such as Psychiatric, Case Management, Transportation, Interpreter Services, and Health & Wellness Groups. The PIR Metro Campus serves approximately 1,200 members and has two ACT teams. This report will focus on the PIR-Omega ACT team.

The individuals served through the agency are referred to as "members", and for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used. The agency recently changed the positions of Employment Specialist (ES) and Rehabilitation Specialist (RS) to two Vocational Specialists (VS). The term Vocational Specialist will be used throughout the report.

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

- Observation of a daily ACT team meeting.
- Individual interview with ACT Clinical Coordinator (Team Leader).
- Group interview with one Nurse and the team Psychiatrist.

- Group interview which included nine members and two guardians.
- Individual interviews with one Substance Abuse Specialist (SAS), and one Vocational Specialist (VS).
- Charts were reviewed for ten members using the agency's electronic medical records system, with assistance from the CC.
- Review of team documents such as, *Members of the ACT Clinical Team*, *ACT Presentation for the Doctor*, *MMIC ACT Team Eligibility Criteria*, and the *ACT Morning Meeting Log*.

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 team Psychiatrist is regarded by the team and members as a fully-integrated team member, involved in all aspects of members' psychiatric, medical, and service coordination. She also provides supervision to ACT staff as needed. The Psychiatrist is accessible by phone, email, and text/group chat 24 hours a day.
- The team benefits from being assigned two, full-time Nurses. The Nurses are given separate assignments, with one being assigned primarily psychiatric, in-office care, and the other serving members in the community and members in need of intensive medical coordination.
- The Housing Specialist (HS) has specific experience working in non-profit, low-income housing. The HS uses his expertise to assist members with not only RBHA-contracted providers, but also community resources geared towards long-term housing solutions.
- The team provides above 80% of their services in the community. The chart review, staff and member statements all demonstrated the team's commitment to providing services in the natural environment where they occur.

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

- The scoring domains Frequency of Contact, Intensity of Services, Practicing Team Leader (CC), and Team Approach were all challenged by the lack of resources needed to meet documentation requirements. Though not a scoring factor in this review, the ACT staff indicated that having a strong program assistant has helped to relieve the ACT CC of many administrative

responsibilities. However, the agency should still work on ways to develop more consistent, accurate documentation of services.

- Although over 80% of services are performed in the community, the limited number of encounters documented makes it the true value or quality of those services unclear. In addition to improving documentation, consider implementing a scheduling system/planning technique that can aid the team in allocating their time and arranging their schedules in ways that will allow members to be supported by multiple staff members (i.e. zone coverage, specialty assignments, etc.).
- Member attendance and progress in co-occurring treatment groups should be tracked and documented in the clinical record. As the team works towards improving group attendance, consider implementing a structured, evidence-based curriculum, to ensure that a stage-wise treatment approach is being imparted to members. Structured groups may also provide planned opportunities to evaluate members' treatment progress.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team maintains a suitable caseload size. The member to staff ratio is 9:1. The team roster consists of: (2) RN's, (1) Housing Specialist, (1) Clinical Coordinator, (1) ACT Specialist, (2) Substance Abuse Specialists, (1) Rehabilitation Specialist, (1) Vocational Specialist, (1) Peer Support Specialist and (1) Independent Living Skills Specialist. This count excludes the Psychiatrist and any Administrative support.	
H2	Team Approach	1 – 5 3	The member chart review indicates that members are seen by multiple ACT staff approximately 50% of the time, over a two-week period. Data for this calculation was extracted from ten randomly selected member charts. Staff estimates were much higher than the record review results, with most staff estimating between 80% to 90% contact with members. The ACT CC described her process for tracking member contact, stating she reviews the team's contact report on a weekly basis and uses its information to discuss contact frequency with ACT staff. Members varied in the responses, ranging from seeing one ACT staff per week to almost daily contact. ACT staff indicated that they often have difficulty balancing their time spent helping members with the time needed to complete documentation in a timely fashion.	• Consider implementing a scheduling system/planning technique that can aid the team in allocating their time and arranging their schedules in ways that will allow members to be supported by multiple staff members (i.e. zone coverage, etc.) • It is recommended that agency leadership discuss with staff their challenges and needs to devise a solution for inconsistent record keeping in member charts.

Item #	Item	Rating	Rating Rationale	Recommendations
H3	Program Meeting	1 – 5 5	The ACT team meets often to review members and their services. The team meets four days a week from 9:30am to 11:00am. Fridays are often reserved for staff to update their assigned clinical files.	
H4	Practicing ACT Leader	1 – 5 3	The ACT CC provides direct care services to members. The ACT CC is also responsible for evaluating potential members for care, administrative and supervisory team functions. The ACT CC estimates spending 60% of her time in direct care with members. The ACT CC demonstrated knowledge of all members served, their whereabouts, and who she engaged with in the previous 24-hours during the morning meeting. Members interviewed often praised the CC, often identifying her as the member with whom they have the most regular contact. Though interviews and observations supported the ACT CC's assessment, the member chart review captured the CC's time as less than 25% of total time worked. The ACT CC stated that she previously experienced barriers to documentation that no longer exist, and intends to have a more accurate reflection of her time in the future.	• The team supervisor should provide services at least 50% of the time. • Consistently document face-to-face encounters with members in the agency's documentation system.
H5	Continuity of Staffing	1 – 5 4	The team experienced a 29.1% turnover in staff positions in the most recent two-year period. Staff identified the Vocational Specialist (VS) position as the most difficult position to fill partly because the team did not	• Continue working with administration to thoroughly vet position candidates to ensure they are the best fit for the position and the demands of an ACT level of

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			find a candidate that was "equipped" to work in the ACT level of care. One staff said, "you have to love this [ACT], or you won't do it very long". The second VS position was filled in October 2015 by the previous Transportation Specialist (TS).	service.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the ACT team maintained consistent, multidisciplinary services by operating at more than 92% of full staffing capacity. The team hired their additional team Nurse in June 2015, and has operated at full capacity since that time. The team went without an Independent Living Specialist for three months and without a Vocational Specialist (VS for eight months. The team's Transportation Specialist (TS) replaced the most recent ES in October 2015. Staff did not discuss the reasons for the changing of multiple VSs in the past year, but felt the previous TS would be the best fit for the position.	• See recommendations in H5.
H7	Psychiatrist on Team	1 – 5 4	The team has an assigned full-time Psychiatrist. The ACT Psychiatrist is the Chief Psychiatrist at the clinic, who also preforms some supervision responsibilities for interns. The Psychiatrist stated that she sometimes takes up to 105 members on the team. The staff and Psychiatrist report that she is able to attend two to three of the daily morning meetings weekly. On the days she does not attend, the CC will recap the results of the	• The ACT model supports the assignment of one full-time Psychiatrist per 100-member team. Consider reviewing the necessity (and potential reassignment) of the team Psychiatrist's responsibilities, to align more closely with the ACT model.

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			meeting at a later time that day. Staff and members interviewed stated that the Psychiatrist makes home visits on a weekly basis and is available by phone, email and text/chat to staff, 24-hours a day. Though the ACT staff did not feel the Psychiatrist's additional responsibilities conflict with her accessibility, the true impact of her availability on team outcomes is unclear.	
H8	Nurse on Team	1 – 5 5	The team benefits from having two Nurses on staff. The Nurses are given separate responsibilities; one Nurse assumes primary responsibility for providing in-clinic care for members, while the other is assigned the members who require more intense medical/Primary Care Physician (PCP) coordination. Staff reported the team has grown reliant upon the community services provided by the additional Nurse.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The team has two Substance Abuse Specialists (SASs) on staff. The first SAS has worked for three and a half years on multiple ACT teams in this capacity. The second SAS was previously an ACT Specialist, but has been working as an SAS for over a year. The CC reports that the second SAS has participated in trainings offered by the RBHA and internally through PIR. Both SASs attend NA/AA meetings in the community whenever possible, mostly to refine the intervention techniques used with members. Staff prefers not to refer members	

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			to outside providers for treatment, but rather have the SASs work with members in individualized settings, using various treatment models.	
H10	Vocational Specialist on Team	1 – 5 4	The ACT team currently has two Vocational Specialists (VSs). One of the VSs has had over one year of training, participating in regular trainings offered by the RBHA and the Arizona Rehabilitation Services Administration (RSA/VR). The newest VS transitioned from the team Transportation Specialist (TS) to the second VS in the month of the review. Staff said that even when the VS was the team's TS, he was very skilled helping members to find work and other meaningful daily activities. Though the new VS did not have any targeted specialty training at the time of review, staff report that the VSs are used as the primary provider for work exploration, job search, and other job related activities for ACT members. The VSs stated that members are only referred to work adjustment trainings (WAT) when they have minimal or large gaps in work experience, and are in need of a current employment reference for job applications.	• Ensure that all staff members receive adequate training in their field of specialty. • When interviewing candidates for team positions, verify their training and experience in the specialty area.
H11	Program Size	1 – 5 5	The ACT team consists of 12 full-time staff. The program is sufficient size to provide necessary staffing coverage.	
O1	Explicit Admission Criteria	1 – 5 5	The team has clearly defined ACT admission criteria, as outlined by the RBHA. The ACT team also uses an assessment tool called *The*	

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			ACT Presentation to the Doctor to gather pertinent information from the potential member for team evaluation. The ACT Team Leader stated that the team focuses on members who have had frequent hospitalizations, homelessness, those who need help with medication adherence, and those who are in need of more frequent engagement. Though members have the final word on if they want services from the ACT team, the ACT staff confirm the team Psychiatrist as the final determination for ACT services on the clinical end.	
O2	Intake Rate	1 – 5 5	The ACT team reports eight admissions in the last six months. The ACT CC reported the team's highest intake month was July 2015 with four admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team maintains full responsibility for the areas of substance abuse treatment, psychiatric care/medication monitoring, housing, and employment. There are currently no members who currently see another doctor for psychiatric care. The team provides all medication monitoring services for members in need. ACT team staff explained their process for helping members to obtain housing. The current Housing Specialist (HS) previously worked in the non-profit housing sector and	• Consider options that will minimize the need for the team to refer to outside agencies for services that are to be provided by the ACT team (e.g., vocational services).

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			uses his knowledge and resources to educate and help members to obtain suitable housing. The HS also helps members to apply for RBHA-contracted housing programs. The ACT VSs are responsible for helping members with work exploration, DB 101, and job search (i.e. job fairs, applications, etc.). The team reports 7% of members are going to WEDCO for short-term, work adjustment training. The team does not provide general counseling services; however, the team provides substance abuse counseling upon request. Staff refers members to detox or other co-occurring treatment options when the doctor feels it is medically necessary.	
O4	Responsibility for Crisis Services	1 – 5 5	ACT staff reported that the ACT CC and the Psychiatrist are available 24 hours a day, seven days a week for crisis support. When asked the reason for the extended support hours, the CC said, “Our members live 24/7. Our support should be the same”. The team maintains a daily group text/chat; staff updates each other with changes in member conditions in real time. Every member is given the phone number to the team’s on-call phone. The on-call phone is passed around to other ACT staff every two days. Members occasionally call the County’s crisis line, but ACT staff still	

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			encourages them to call the team first.	
O5	Responsibility for Hospital Admissions	1 – 5 3	One of the ten most recent hospitalizations was a medical admission. The ACT team was involved in five of the most nine most recent psychiatric hospitalizations. Many staff referred to the start of the admissions process as the point when someone has requested admission from the team, or has already self-admitted. Staff also stated that many of the members who recently performed a self-admission are those who are high utilizers of crisis emergency services, who also prefer not to involve the team in their admissions.	• The ACT team should continue to educate members on the benefits of ACT team involvement in the decision to hospitalize, particularly regarding the additional supports that may help avoid the need for hospitalization.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Reviewers discussed the last ten hospital discharges with the team CC. One of the most recent discharges was related to a medical admission. The ACT team was involved in the coordination of all of the last nine psychiatric hospital discharges. The ACT CC said the team's responsibility is to coordinate with the hospital Social Worker on discharge arrangements. Once discharged, ACT staff transport members to pick up medications and food before returning them home. Members are then seen by the doctor as a part of the five-day follow up strategy.	
O7	Time-unlimited Services	1 – 5 4	The team has graduated four members in the past 12 months; however, they intend to graduate six members within the next year, due to significant improvement. Though the current transfer rate is within optimal limits,	• The ACT model does not require members to close services at any time. Services have arbitrary time limits and should be ongoing, until the member feels they are no

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			reviewers observed during the morning meeting that some staff expressed interest in transitioning certain members to supportive teams that did not express any desire to transfer themselves. Staff also reported that some members missed transfer appointments because of their desire to stay with their Psychiatrist and team.	longer in need of them. The CC should help model and educate staff to ensure all are adhering to this key ACT principle.
S1	Community-based Services	1 – 5 5	The ACT team aims to provide services and monitor member statuses in the community whenever possible. The results of the chart review show staff making contact with members in community settings over 80% of the time. Observation of the team meeting and the reactions of members and staff in interviews indicated that staff prioritizes providing services where they are needed rather than in the clinic office. Though the chart review affirms the team's commitment to community-based services, it is unclear the impact of inconsistent chart noting practices on the score for this item.	• See discussion on documentation in the report summary *and Key Recommendations* on Page 2.
S2	No Drop-out Policy	1 – 5 5	The team has retained more than 98% of their caseload over the most recent 12-month period. The members who did terminate services moved to another state, then called the team upon arrival. Once contacted, the team worked with the member to locate and coordinate services close to the new home. Staff report that their members are devoted to the Psychiatrist, and often do not want to	

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			transfer for fear of losing her and her services.	
S3	Assertive Engagement Mechanisms	1 – 5 5	According to the ACT CC, the team's strategy for engaging members who are disconnected starts at 4pm each day. "By 4pm I know who has missed appointments with the doctor. We immediately assign someone to stop by their home on that day to follow up with them". The Psychiatrist also conducts home visits on Thursdays. If the member is not located, they begin to follow their contact strategy, which includes contacting morgues, hospitals, representative payees, etc. If a member is not found in five days, a missing persons report is filed and the contact strategy is continued. ACT staff said they aim to never close members. "Most of them [members] are found within two weeks."	
S4	Intensity of Services	1 – 5 2	The ACT team spends approximately 42 minutes per week in total service time per member. Ten member records were reviewed to determine the amount of face-to-face service time spent with each member. The median face-to-face service minutes across the ten member records fell within a range of 15-49 minutes per week. Staff stated that they often struggle to meet intensity requirements because they serve a lot of people who live far distances from each other. The team also reports having a number of high-intensity, high-profile members who require a lot of intensive team coordination. Upon reflection,	• Consider implementing a scheduling system/planning technique that can aid the team in allocating their time and arranging their schedules in ways that will allow members to be supported by multiple staff members (i.e. zone coverage, specialty assignments, etc.)

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			staff stated that the amount of time used to manage intense and/or crisis situations instead of scheduled, maintenance care, is unbalanced.	
S5	Frequency of Contact	1 – 5 2	The team averages 1.5 contacts, per member, per week in face-to-face service contacts. Ten member charts were reviewed to determine the amount of times per week each member is receiving contact from the ACT staff. Staff and most members interviewed confirmed the members were being seen frequently by the ACT team staff; however, staff viewed their technological difficulties and administrative deadlines in direct competition with their ability to provide quality services to members. Some members felt they did not see staff frequently enough.	• Agency leadership should review barriers to staff providing sufficient frequency and amount of contacts. This is key to delivering ACT services with quality outcomes. • See recommendations in H2 and S4.
S6	Work with Support System	1 – 5 3	The ACT team reports working with members' support systems quite frequently. Reviewers met and talked with one family who was present during the member interview for safety reasons. The family expressed their gratitude to the team for their daily coordination with the two members from their home served by the ACT team. The ACT CC said, "Some families are out of state and we talk to them." Staff estimated that at least half of their members have someone involved. In addition, staff estimated talking with members' supports two to three times a	• It is recommended that agency leadership discuss with staff their challenges and needs to devise a solution for inconsistent record keeping in member charts. • Staff should devise a method for tracking contacts with member supports as well as the offering of team coordination with supports for members who do not currently have supports involved.

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			month. The morning meeting revealed that six of eighteen member supports mentioned by the team were directly contacted by the team that day. Results of the member chart review estimated less than .5 contacts per month, per member. Staff again cited their challenges with timely documentation as the reason for infrequent noting of support contacts within the chart.	
S7	Individualized Substance Abuse Treatment	1 – 5 4	The team now offers individualized substance abuse treatment to members. There are 45 members diagnosed with a co-occurring disorder. ACT staff interviewed estimate that 12 to 13 members receive individualized treatment services. Those members are receiving an average of 52.5 minutes of treatment per session, and are meeting with the SASs twice monthly. The interviewed SAS stated that these sessions are scheduled between the member and the SAS. The SAS also stated a team Nurse will often sit in on the individual member sessions to provide education and support. When asked about the focus of the treatment sessions one staff said, "We find out what stage of their recovery they are in, and provide education and resources to help them, even during our off [non-business] hours". The SAS states that the team creates a mini-treatment plan for the co-occurring members, which is used to guide the	• Create a system for integrating interventions related to co-occurring disorder treatment into the clinical notes more explicitly. Keeping track of a member's stage of recovery and interventions used could help improve team coordination and member outcomes.

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			individualized treatment sessions. The Nurse will often guide members through a smoking cessation program as needed. The SAS also stated that these sessions are documented in the member chart as a face-to-face encounter rather than a separate treatment note. Reviewers noted the interactions with members in the chart as a standard, face-to-face note, rather than an identified substance abuse treatment session.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The team offers two weekly substance abuse groups. The groups are for ACT members only. The groups average 17% of the 45 members diagnosed with a co-occurring disorder. Staff state the co-occurring treatment groups are comprised of information collected from multiple sources (i.e. AA/ NA/ RBHA), and does not represent a structured, meeting-by meeting curriculum.	• Ensure that member progress in group settings is documented in the clinical record. Summarizing member progress and level of participation in the member record at least on a monthly basis will help staff tailor groups to fit members' specific needs. • The ACT team needs to implement a structured, evidence-based curriculum, to ensure that a stage-wise treatment approach is being imparted to members.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	With regards to treatment models, the ACT staff were primarily focused on the Trans-theoretical model (Stages of Change). Staff members shared with reviewers how they are using the model to identify treatment options during treatment planning. One staff said, "12-Step does not work for everyone. We work to find what works for each person individually".	• Create a system for integrating interventions related to co-occurring disorder treatment into the clinical notes more explicitly. Keeping track of a member's stage of recovery and interventions used could help improve team coordination and member

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			Though the team verbally shared examples of how they are implementing the model, there was no documented evidence exhibiting how the stage-wise approach is being applied in any formal way. Staff also confirmed they will refer some staff to detox or inpatient facilities, but only if the Psychiatrist deems it as medically necessary.	outcomes.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has a fully-integrated Peer Support Specialist (PSS). The PSS is a full-time staff and is assigned responsibilities equal to those of all the other team members. Many staff view the role of the PSS as one of engagement, focused on improving therapeutic rapport and clinical outcomes.	
Total Score:		**4.1**		

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	3
5. Continuity of Staffing	1-5	4
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	4
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	3
6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	5
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	**4.1**	
Highest Possible Score	**5**	