ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: Rosalie D. Eddingfield, CC

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ADHS Fidelity Reviewers

Method

On December 10-11, 2014 Jeni Serrano and T.J. Eggsware (Fidelity Reviewers) completed a review of the Partners In Recovery Network (PIR), Metro Omega 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.

The Partners In Recovery Network Organization (PNO) brings more than 130 years combined behavioral health experience by some of the leading providers of recovery-based psychosocial rehabilitation services in Maricopa County for individuals diagnosed with a serious mental illness. The PIR Metro clinic is located in Phoenix, AZ with clinic services including ACT, family and peer mentoring, and other wellness and recovery activities provided by PIR staff as well as co-located providers. The PIR Metro clinic has two ACT teams, and this review focuses on the Omega team, which serves 99 members.

The individuals served through the agency are referred to as "recipients," 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 December 11, 2014.
- Individual interview with team Clinical Coordinator (CC).
- Individual interviews with Substance Abuse Specialist (SAS), Act Team Specialist and Housing Specialist.
- Charts were reviewed for 10 members using the agency's electronic health records system.
- Three group interview sessions with a total of 9 members.
- Individual interview with member and his guardian (mother).

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 members interviewed stated that they like the setup of the ACT team office space. Members stated that the office is inviting and that all staff is easily accessible and helpful anytime they enter.
- The ACT team operates at near full capacity with a low member-to-staff ratio. The team has 11 full-time equivalent (FTE) staff, which includes one full-time psychiatrist, and a peer specialist with full professional status.
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- The ACT team is very involved in assisting members with their medical appointments, providing assistance with scheduling, transportation and attending appointments if requested.
- All members are served on a time-unlimited basis, with fewer than 5% expected to graduate annually.
- The ACT program demonstrates assertive engagement mechanisms, including consistently well-thought-out strategies, street outreach and legal mechanisms whenever appropriate. The ACT team has a no drop out policy, and the team engaged and retained members at a mutually satisfactory level.
- The members served by the team generally report feelings of appreciation for the services provided, stating the support from the team was vital to their recovery, employment, living situation or life.

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

- Although there is evidence that staff share responsibility for each member, it is not clear if staff consistently function as specialists rather than as primary case managers with lower caseloads.
    - The team approach ensures continuity of care for consumers and creates a supportive organizational environment for members. The current team structure relies on primary staff acting as case managers, with secondary contact expectations for other members based on rotation rather than member status or need.
    - ACT team specialists would benefit from additional training and guidance regarding expectations of their role as specialists on the team. If a member has an identified challenge, the applicable specialist should take a central role to engage the member, to drive treatment, and to coordinate services with other ACT staff. As part of those activities, the specialist should share their expertise with other staff.
    - The team should minimize referrals to outside providers for employment, rehabilitative, housing or substance abuse services and provide those services through the team. Generally in high fidelity programs, it is more effective if services are provided as an integrated component of the ACT program rather than relying on brokered services through outside agencies.

- The ACT team should directly provide formal and structured substance use treatment in both group and individualized settings.
    - Ensure staff (at all levels of the system) who are expected to provide substance use treatment activities receive training, education, support and ongoing supervision related to specific substance use treatment models.
    - At the ACT team level, implement a structured stage-wise treatment approach that includes treatment stages, interventions, and strategies such as Integrated Dual Diagnosis Treatment (IDDT).
- The ACT team should emphasize skill development and support in natural community settings rather than functioning as an office-based program. This is especially important when providing vocational services that assist members to find and keep jobs in integrated work settings.
    - At the network and clinic level, ensure all staff involved in vocational support activities receives training, education, support and ongoing supervision related to provision of those services.
    - The team should increase the amount of face-to-face contacts by ACT specialists based on member needs and status, as well as increase service time, per member.
    - Ensure documentation is entered in a timely manner, consistent with agency policy as well as any expectations of other involved entities that provide oversight.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The Metro Omega ACT team consists of ten staff members excluding the team psychiatrist and administrative support staff. At time of review this team services 99 members.	
H2	Team Approach	1 – 5 (4)	Staff are assigned a primary caseload that ranges from 10-13 members. Based on the available evidence, staff have primary caseloads but also share responsibility for each member on the team, with 80% of members seen by more than one staff over the applicable two week timeframe reviewed. During staff interviews, staff referred to having a team rotation schedule in order to assure they make contact with other members of the team that are not assigned to their primary caseload.	• Although members are in contact with at least two staff members consistently, it is not evident that staff provides services primarily as specialist. • Training of all specialist staff should occur on a recurring basis to discuss current trends, interactions, and barriers to staff acting primarily as specialist on the ACT teams.
H3	Program Meeting	1 – 5 (5)	The team meets at least four times a week (sometimes five days a week) and reviews each member. During the AM meeting observation, all members were reviewed and team staff appeared to be aware of member status as evidenced by discussion and shared decision-making.	
H4	Practicing ACT Leader	1 – 5 (2)	The CC is unable to estimate the time she spends providing direct services due to be several months behind on entering her notes into the system. The CC is responsible for a significant amount of administrative duties. The CC did not provide an encounter report. There is one direct face-to-face service by the CC in ten records reviewed. As a result, it appears the supervisor provides services exclusively on rare occasions as backup.	• The network and system should utilize a time study to identify the amount of time the average CC on ACT teams spends completing administrative functions, attending meetings, or engaging in other duties without direct contact with members. The system should carefully review if each activity is essential, if some can be eliminated or streamlined, or transitioned to other staff.
H5	Continuity of	1 – 5	In the two years prior to review, six staff	• If not in place, consider completing an

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	Staffing	(4)	transitioned off the team, one of whom subsequently rejoined the team. As a result, the team experienced 20 – 39% turnover in the applicable 2 year period.	exit interview with staff who resign in order to gather their feedback regarding their reasons for leaving, and actions management can take to maintain staff.
H6	Staff Capacity	1 – 5 (4)	There were eight staff vacancies over the twelve-month review period, including positions with staff on leave for one month or more. There are 12 positions on the team, with the independent living specialist (ILS) position vacant. The team operated at slightly under 95% of full staffing in the past twelve months.	• It is critical to maintain adequate staff size and disciplinary background to provide comprehensive, individualized service to each member.
H7	Psychiatrist on Team	1 – 5 (4)	The team has had the same psychiatrist since 2012, (who may occasionally see members from other teams, but these activities do not constitute a significant amount of time). The psychiatrist is the lead psychiatrist of the clinic and has other duties, attending monthly and weekly staff meetings off site. The psychiatrist attends team meetings at least three to four days a week depending on the week. She is off on Wednesdays and goes on home visits on Fridays. The team staff reports the psychiatrist is available 24/7 via text or cell phone even when she is off or in field.	• Establish ongoing clinic monitoring of psychiatrist coverage to minimize the additional responsibilities and the number of non-ACT members that are served by the ACT psychiatrist.
H8	Nurse on Team	1 – 5 (3)	The team currently has only one full-time nurse. The nurse assists members with their needs (e.g. Medi-sets, Injections, blood labs, etc.). The nurse co-facilitates the substance abuse group bi-weekly with the team SAS 's to offer education. The nurse's schedule is very compact and leaves little room for her to meet members in the community, or educate members outside of emergency services.	• At the clinic or network level, review options to add an additional nurse to ensure that two full-time nurses are available for a 100-member program. This would allow the nurse additional flexibility to provide services (i.e., one nurse remaining in the clinic, and one in the field).
H9	Substance Abuse	1 – 5	There is one staff with the job title of SAS on	• Concurrent substance-use disorders are

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	Specialist on Team	(1)	the team. A second staff is reportedly the second SAS, but she is titled as an ACT team specialist. The staff identified in the SAS role reported minimal experience working with individuals who may have experienced substance use challenges. Neither staff has specialized training working with clients with co-occurring substance use and mental illness. There is no evidence that both substance abuse specialists received one year of substance abuse training or supervised substance abuse treatment experience that supported the staff achieved a level of expertise in the area. The SAS Staff also reported having an assigned caseload with associated responsibilities (i.e., paperwork activities) in addition to their role as a Substance Abuse Specialists.	common in members. Appropriate assessment and intervention strategies are critical. The team should review training and supervision options to ensure staff identified in the role of Substance Abuse Specialists receive support, monitoring, and education in the role for the population served (i.e., adults diagnosed with a serious mental illness).
H10	Vocational Specialist on Team	1 – 5 (2)	Although the ES and RS positions are filled on this team, it is not clear that staff have training or experience in providing vocational rehabilitation and support due to their reliance on external providers. Occasionally the ES or RS may help members with online job searches, but they refer members for employment services at other agencies (e.g., Vocational Rehabilitation or Supported Employment provider). The ACT team does not appear to provide individual employment services focused on directly assisting members in job search and sustained employment in integrated work settings.	• Fully integrated ACT teams include vocational services that assist consumers to find and keep jobs in integrated work settings. The team should identify potential barriers to directly providing vocational services versus referring to outside providers. • Review training and supervision options to ensure staff identified in the role of Vocational Specialists receive support, monitoring, and education in the role for the population served (i.e., adults diagnosed with a serious mental illness).
H11	Program Size	1 – 5 (5)	The team consists of more than 10 full time equivalent staff.	
O1	Explicit Admission	1 – 5	The team has a clearly defined target population	• Preferably, the team makes the

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	Criteria	(4)	with whom they work. The team seeks referrals through the clinic (when not at capacity) and uses formal admission criteria, with screenings completed by the CC or other seasoned team members prior to review of the team psychiatrist. The team psychiatrist generally makes the final determination if a member is admitted to the team; however, the program occasionally bows to organizational pressure. Although the CC reports the team feels people generally benefit from ACT services, in at least one instance an administrator requested the team accept a member onto the team even though the team questioned if their services were necessary due to the member's circumstances (i.e., diagnosis, other supports involved).	ultimate determination if members are admitted to the team based on application of a set criteria and appropriate consistent screening of all referred members.
O2	Intake Rate	1 – 5 (5)	The CC reported nine member intakes to the team in the past six months. The highest monthly intake rate was no greater than three members.	
O3	Full Responsibility for Treatment Services	1 – 5 (3)	Aside from case management, this team provides psychiatric services and housing support services. The team refers out for counseling/psychotherapy, which includes individual and some group substance abuse treatment. Additionally the team refers out for employment /rehabilitative activities. Although the team refers members to live in staffed residences where there is an overlap in services, the team reports they assume the role of service provider.	• Members benefit when services are integrated into a single team, rather than when they are referred to many different service providers. Furthermore, an integrated approach allows services to be tailored to each member. • Team needs to directly provides psychiatric services and medication management, counseling/ psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services, in addition to case management services.
O4	Responsibility for	1 – 5	The team provides 24-hour coverage directly (i.e.,	

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	Crisis Services	(5)	an ACT team member is on-call at all times, typically by carrying a cell phone),	
O5	Responsibility for Hospital Admissions	1 – 5 (4)	The ACT team is involved in 80% of admissions, with some self-admissions without team involvement, whether sought by members independently or with assistance from outside supports (e.g., family members). During office hours, members meet with the psychiatrist with effort made to prevent hospitalization.	• If members self-admit or family members assist with admissions without informing the team, consider educating the member or family member on the role the ACT team plays in the decision to hospitalize ACT members.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	When the team is aware of member admissions, outreach with social worker, inpatient providers, and members begins immediately. The team is involved with 95% or more of discharges.	
O7	Time-unlimited Services	1 – 5 (4)	All members served on a time-unlimited basis, with a 6% graduation rate in the twelve months prior to review. The team estimates 7% expected discharges in the next 12 months.	
S1	Community-based Services	1 – 5 (2)	Based on staff and member interviews, and records reviewed, the team provides face-to-face service contacts in community approximately 29% of the time with a range of 20% to 39% community-based services. The majority of community-based activities include medication observations and staff members attending medical appointments and procedures. The doctor and nurse also provide services in the community, with evidence of those activities documented in the ten records reviewed.	• The team needs to work towards monitoring status and developing skills in natural community settings (where members live, work and interact with others), rather than function as an office-based program. • The team CC should monitor staff workload and time to ensure the majority of activities occur in the community.
S2	No Drop-out Policy	1 – 5 (5)	During the 12-month review period three members left the geographic area with referral, one of those three returned and reopened, two other members requested transfers, and one member died. As a result, 95% or more of the caseload is retained over a 12-month period.	

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S3	Assertive Engagement Mechanisms	1 – 5 (5)	The team demonstrates consistently well-thought-out strategies and uses stress outreach and legal mechanisms (e.g., probation/parole, outpatient commitment) or other techniques to ensure ongoing engagement. The team appears to have rapport with members; members seem to value the team, and note their ability to voice concerns, even if they don't always agree.	
S4	Intensity of Services	1 – 5 (3)	Based on records reviewed, over a four week period the median direct service minutes per week is 56 minutes per week of face-to-face contacts for each member. The duration of weekly contact minutes is just under 27 minutes to just under 127 minutes. Medication observation is a recurring service documented in three of the records reviewed.	• Team leader should periodically review member records and staff schedules to ensure appropriate face-to-face contacts are being made. • Review potential barriers that may prevent staff from higher face-to-face service time spent with members. • Consider what actions the team may take (e.g., reduction of referrals to outside providers, increase in services through the ACT team) that could result in higher service intensity per member while focusing on meeting individual member's needs.
S5	Frequency of Contact	1 – 5 (3)	Based on records reviewed, the average number of ACT staff contacts per member per week is 2.25. The average range of contacts was 1-12.5, with eight of 10 under four contacts per month.	• Review contact expectations to determine if the minimum of one face-to-face contact per member is adequate. This includes review of team and possible system barriers to maintaining frequent face-to-face contact with members.
S6	Work with Support System	1 – 5 (1)	CC reports if family members or supports are involved, team has several contacts per week depending on individual's needs. However, based	• Identify external member supports and discuss with members the benefits of involving supports in treatment (e.g.,

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			on record review and member interviews, there were less than 0.1 contact/month for each member. Additionally, contacts with external supports is not consistently referenced during the AM meeting.	may be able to provide information or supplement the member's story of recovery). If members decline to allow the team to contact supports, the team can still receive information from supports if they contact the team. If a member is estranged from family or friends, consider involving peer or family peer supports to reach out to the member's support system to provide education, resources, or guidance. • Ensure all staff contacts with member supports are documented.
S7	Individualized Substance Abuse Treatment	1 – 5 (1)	The team CC reported that there are 50 out of 99 members on the team that are identified with co-occurring disorder. The team does not offer structured individual counseling for substance use because they do not have a licensed substance abuse counselor on the team.	• Review team, provider, and system options related to securing or training staff to provide individual substance abuse treatment in a structured manner.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	The SAS co-facilitates a weekly hour long SA group with the team nurse. Of the members with a co-occurring disorder, about 6-8 attend at least one group with the team per month, and a few other members occasionally attend. It is determined 5-19% of members with substance-use disorder attend at least one substance treatment group meeting each month.	• The SAS needs training in stage-wise approach to treatment. The provider and system should ensure ongoing and structured training is provided to all specialty staff, including integrated treatment for dual-disorders. For members with substance use challenges, the SAS should be a primary voice in driving team interventions for those members. Enhanced integrated dual disorder training on a recurring basis may empower SAS staff across the system to intervene in a proven

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				and consistent manner.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (2)	When they were interviewed, ACT team staff(?) used stages of change language and discussed how they use motivational interviewing techniques to facilitate movement from pre-contemplation to contemplation stages. While staff views abstinence as a desirable goal, they consider it an ideal; harm reduction strategies can support improved independent functioning in the community. Staff also transports members to community based Alcoholic Anonymous group if requested.	• Review options to provide training and information to the ACT team to implement a stage-wise treatment approach. Standardizing basic tenants of the treatment may help to ensure consistent interventions at all levels across the system.
S10	Role of Consumers on Treatment Team	1 – 5 (5)	A Peer Specialist is employed full-time as ACT team staff (e.g., case managers) with full professional status. The team peer specialist position has been filled with the same team member since 2012.	
Total Score:		**3.5**		

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	4
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	1
10. Vocational Specialist on Team	1-5	2
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	4
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	3
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	4
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	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	1
7. Individualized Substance Abuse Treatment	1-5	1
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.5**	
Highest Possible Score	**5**	