ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: Jessica Lemon, Clinical Director
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ADHS Fidelity Reviewers

Method

On December, 14-15, 2015 Georgia Harris and Karen Voyer-Caravona completed a review of the Southwest Network's Bethany Village 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) is a Provider Network Organization (PNO) in Maricopa County, Arizona. SWN is contracted to provide behavioral health care to members diagnosed with a Serious Mental Illness (SMI). The Bethany Village Clinic is located at 4210 West Bethany Village Road, Phoenix, Arizona 85019. Located in Phoenix's Northwest Valley, the clinic is accessible by public transportation, and is in close proximity to local businesses. The Bethany Village ACT team serves 100 members. The team historically targeted and served the SMI young adult population. Though the team no longer holds the young adult designation, there are still a significant proportion of young adult members being served by the team.

The individuals served through the agency are referred to as "clients", 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 (morning meeting).
- Individual interview with Team Leader (ACT Clinical Coordinator/ACT CC).
- Individual interviews with the Substance Abuse Specialist (SAS), the Housing Specialist (HS) and the team Psychiatrist.
- Group interview with four ACT members receiving services.
- Charts were reviewed for 10 members using the agency's electronic medical records system.
- Review of agency documents such as the Mercy Maricopa Integrated Care ACT *Admission Screening Tool*, *ACT Weekly Groups* schedule, and the CC *Encounter Report*.

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:

- ACT staff share responsibility for all members by working cross-disciplinarily. Each specialist contributes to the team by providing expertise, as well continuity of care to members.
- The team benefits from employing two full-time Nurses (RNs). The RNs function as full members of the ACT team, providing onsite and in-home clinical support to members through the use of role diversification and flexible scheduling practices.
- The team provides individualized substance abuse treatment to ACT members. The team has regularly-scheduled sessions that are focused on assessing recovery progress, skill building, and action planning for relapse prevention.
- In addition to having a Peer Support Specialist (PSS), the team employs multiple specialists who correspondingly identify as people with lived experience with a mental illness and/or substance abuse. Members readily identified these staff and noted that their effectiveness in their specialty on the team is enhanced by having lived experience in similar areas of struggle as their own.

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

- The ACT team provided community-based services approximately 38% of the time for the members reviewed. The team reported recent changes to policies that are aimed at improving this measure, but these were not implemented or captured in the timeframe for the data reviewed. The team could benefit from continued evaluation of the effectiveness of their contact strategy and the relocation of other activities that are currently housed in the clinic (i.e. ACT groups).
- The team provides approximately 27 minutes of service contact per week, per member. ACT teams should provide high intensity services to maintain progress, with the goal of 2 or more hours per week, per member. Also, the team should continue implementing a scheduling system/planning technique that can aid the staff 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.).
- Of the 58 members diagnosed with a co-occurring disorder, only 7% of them attend a weekly treatment group. Though the team benefits from having both an Addiction Psychiatrist and a qualified SAS, the team reports low attendance in co-occurring treatment groups. As efforts are being made to revamp the group curriculum, the team should use feedback from past and present group attendees to guide their outreach approach to members. With over half of the ACT members being diagnosed with a co-occurring disorder, it would also be beneficial to add a second SAS to the team.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The member-to-staff ratio is 11:1. The team roster consists of: (1) Clinical Coordinator, (2) Registered Nurses , (1) Housing Specialist, (1) Substance Abuse Specialist, (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. The Clinical Coordinator (ACT CC) reports that the team is still in need of an additional Substance Abuse Specialist and ACT Specialist.	• To maintain a low member-to-staff ratio, continue efforts to recruit qualified ACT staff to fill vacant positions.
H2	Team Approach	1 – 5 5	ACT staff share responsibility for all members by working cross-disciplinarily. The member chart review indicates that members were seen by multiple ACT staff more than 90% of the time, over a two-week period. The ACT CC reports using a zone coverage strategy to ensure that members are seen by multiple ACT staff on a weekly basis. When asked about the role of ACT staff in their lives, members made statements like, “I don’t have a case manager, I have a team” and “The ACT team is like my family”.	
H3	Program Meeting	1 – 5 5	The ACT team meets often to review members and their services. The team meets four days a week to discuss all members on the team’s roster (Tuesday through Friday). The RN and Psychiatrist schedules are discussed daily. Mondays are reserved for discussions about the weekend activities and/or the recent crisis incidents.	
H4	Practicing ACT Leader	1 – 5 2	The ACT CC provides direct care to members. ACT staff and members report that the ACT CC	• The team supervisor should provide services at least 50% of the time.

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			regularly provides in-home and in-office support and is always available in crisis situations. The ACT CC estimates spending approximately 30% of his time in direct service to members, with the expectation of increasing to above 50% with a newly-implemented contact strategy; The team is moving away from a caseload-driven, semi-zoned strategy, to an entirely zone-based strategy. In the morning meeting, the ACT CC provided the team with information and supervision based on recent interactions with members. The member records examined by reviewers also showed evidence of the ACT CC's direct involvement with members. An encounter report for the CC was provided; however, the report reflected services minutes rather than the actual minutes of service. The inability to confirm actual service minutes was reflected in the score.	• Consistently document face-to-face encounters with members in the agency's documentation system.
H5	Continuity of Staffing	1 – 5 3	The team experienced a 50% turnover in staff positions in the most recent two-year period. Some staff were promoted to other positions, while others left for other opportunities. The most difficult staff transition reported by the team was being without a Psychiatrist for three months, mainly because of the gaps it created in member care. The team is optimistic that the current staff is equipped with the skills necessary to provide on-going specialty services to members.	• Continue working with clinic administration to thoroughly screen potential candidates, ensuring they are the best fit for the position and the demands of an ACT level of service.
H6	Staff Capacity	1 – 5 4	The ACT team maintained consistent, multidisciplinary services by operating at more than 88.2% of full staffing capacity in the most recent 12-month period. The team had been without a Peer Support Specialist (PSS) for seven months and without a second Substance Abuse Specialist (SAS) for eight months. Though the team is actively recruiting for an additional SAS, the staff	• Continue efforts to recruit qualified and experienced staff to fill vacant ACT specialties.

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			reports that their new team psychiatrist, who is also certified in Addiction Psychiatry, has helped to provide expertise and coverage for the substance abuse specialty.	
H7	Psychiatrist on Team	1 – 5 4	The team acquired a new Psychiatrist in August 2015. The current Psychiatrist is certified in Addiction Psychiatry; she administers detox treatments Suboxone and Naltrexone to both ACT and non-ACT members at the clinic. The Psychiatrist is also overseeing the development of new curriculum for the ACT co-occurring treatment group, facilitated by the SAS. The Psych attends most team meetings and members view her expertise as a valuable asset to the team.	• The Psychiatrist has a specialization that is being minimally shared with the other clinical teams. However, the eventual demand for this specialty could detract from availability for ACT members in the future. Evidence-based practice suggests that Psychiatrists are solely dedicated to ACT clients because they serve as the medical director for the team and are considered equal contributors to all areas of treatment planning.
H8	Nurse on Team	1 – 5 5	The team benefits from having two RNs on staff. The RNs are given separate responsibilities; one RN assumes primary responsibility for providing in-clinic care for members, while the other is assigned to home visits and dose-by-dose medication administration. Staff and members report that the RNs are both flexible and accessible to members and staff.	
H9	Substance Abuse Specialist on Team	1 – 5 3	The team currently has one SAS, a Licensed Independent Substance Abuse Counselor (LISAC) who integrates her personal experience in recovery into treatment. She has worked on the ACT team for over a year, but who has multiple degrees in addictions counseling and chemical dependency. Also, the team Psychiatrist is a certified Addiction Psychiatrist who currently administers Suboxone treatments.	• Though appropriate assessment and intervention strategies are being performed, the team will need an additional SAS in order to meet the needs of the program.
H10	Vocational Specialist on Team	1 – 5 3	The team currently has two vocational specialists: a Rehabilitation Specialist (RS) and an Employment	• Continue ongoing specialty training and supervision opportunities for team staff

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			Specialist (ES). Though reviewers were unable to verify education or formal training for these staff, it was reported that both specialists have worked in their same capacities on a supportive care team in the past and have taken recent offerings of training on their specialties, as offered by MMIC. The inability to verify specialty-specific training for both vocational specialists was reflected in the scoring of this item.	to ensure that all staff are adequately trained in their specialty areas, and that such training and experience is noted.
H11	Program Size	1 – 5 5	The ACT team consists of 10 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 CC also reports that Southwest Network provides them with an ACT appropriateness tool as a guide for screening potential ACT members. Potential members can be screened by any ACT staff, but the team collectively discusses ACT appropriateness with the Psychiatrist prior to program admission. The team denied that any members were administratively transferred to the team over the past year.	
O2	Intake Rate	1 – 5 5	The ACT team reports seven admissions in the last six months. The ACT CC reported the team's highest intake month was September 2015 with three admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team is fully responsible for the psychiatric, housing, and substance abuse specialties. The team currently provides some supported employment services, but refers members to external supported employment agencies for paid opportunities they are unable to provide. Also, the RS has been collaborating with local peer-run agencies to assist	• The agency should evaluate the gaps in resources (i.e. technology, trainings, etc.) that are needed to provide the full spectrum of specialty services to members.

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			with engaging members who experience isolation.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for members. Every Wednesday, the staff changes responsibility for the on-call phone. When experiencing crisis, members are instructed to call the team directly. Should a member call the crisis line instead of the team, the call will be transferred to the ACT team. . The ACT CC is always available to provide support for the on-call staff, if a decision to visit a member in crisis needs to be made.	
O5	Responsibility for Hospital Admissions	1 – 5 3	The team was involved in 60% of the ten most recent hospital discharges. All four of the admissions missed by the team involved two members who frequently self-admit. One of the two members has his family transport him directly to the hospital, rather than contacting the ACT team. The team reports encouraging members to contact them directly while deciding to go inpatient. The team prefers to triage members with an RN and/or the team Psychiatrist, with hopes of de-escalating the member and/or increasing necessary supports.	• 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. • Informal support networks may benefit from education on the role of the ACT team in admissions. Informal supports may serve as significant partners in reinforcing team efforts to provide relevant services to members.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	The team was involved in 90% of the most recent ten hospital discharges. In the one incidence reported where the team was not involved in hospital discharge, the member was discharged to his family. In most incidents, the team reports being involved in discharge planning from the moment a person is admitted.	• Continue efforts to coordinate with inpatient staff on discharge planning for ACT members. • Informal support networks may benefit from education on the role of the ACT team in discharges. Informal supports may serve as significant partners in reinforcing team efforts to provide relevant services to members.
O7	Time-unlimited Services	1 – 5 5	The program remains an indefinite point-of-contact to ACT members. The team has not graduated any members in the past year. The	

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			team expects to graduate two members in the next 60 days. The team estimate a total of five graduations in the coming year	
S1	Community-based Services	1 – 5 2	Of the ten member records reviewed, approximately 38% of all face-to-face encounters between staff and members were in the community. Staff expects that recent changes to team policies will increase their days in the field from two to four days a week. Staff were previously scheduled to spend 50% of their time in the office, however, the CC has recently reduced their office time to once weekly, per staff. Members also lacked consensus on the most frequent meeting location with ACT staff; some members felt that staff visited them at home "all the time" while others stated that the home visits were infrequent in comparison to their weekly visits to the clinic.	• Continue to explore and implement a contact strategy that will reduce the amount of time spent meeting members in office. There should be no time requirement for ACT staff to be in the office but just the opposite. A key principle of ACT is for staff to spend a majority of time serving members in the community. • Review current staff duties (i.e. group facilitators, blue dot, etc.), assessing for opportunities to move some activities into the community (i.e. didactic/skills groups out of the clinic into more natural settings).
S2	No Drop-out Policy	1 – 5 5	The program retains members at a mutually agreeable level. Staff report that members will ideally graduate from the team when they become "totally enmeshed in the community with good support systems, taking [and understanding] their meds, and in secure housing." Members said they feel confident that the team will help them transition to a lower level of care when they are ready. Staff also report providing ongoing support to members who have graduated in the past.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The team has retained more than 98% of their caseload over the most recent 12-month period. The member who did terminate services moved out-of-state and had a parent contact the team. He received closure paperwork, signed it, and returned it to the team.	
S4	Intensity of Services	1 – 5	Based on the records reviewed, the team provided	• Continue implementing a scheduling

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		2	27 minutes of service per week, per member. Staff discussed with reviewers their recent transition to a new zone contact strategy which embraces a visitation schedule of four days weekly instead of the previous two-days a week visitation schedule. Staff maintains that the new schedule will help them to connect with members more frequently outside of the office.	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.)
S5	Frequency of Contact	1 – 5 3	Ten member charts were reviewed to determine the amount of times per week each member is receiving contact from the ACT staff. The team averages 2.25 face-to-face contacts, per member, per week. Most members interviewed confirmed they were being seen frequently by the ACT team staff; however, some members felt they were not being seen frequently enough. The staff report that their previous contact strategy limited their ability to meet face-to-face with members, but the new strategy will improve their opportunities to contact members by about 50%.	• The CC should monitor staff contacts closely to ensure time and intensity of service increases. • See also recommendation in S4.
S6	Work with Support System	1 – 5 4	This ACT team has a significant number of members who reside with family members who are also involved with their treatment. Members reported that ACT staff regularly coordinated with their families to meet treatment needs. The team estimates that 60% of all members have natural supports, however, a lesser amount of those supports have disclosure authorizations on file. Staff were also observed discussing contacts with natural supports in the morning meeting. The chart review indicated that natural supports received an average of 2.2 contacts per month from the team.	• Continue to engage members and encourage them to a sign disclosure authorizations for natural supports that may be beneficial for treatment coordination.
S7	Individualized Substance Abuse	1 – 5 4	The ACT team provides individualized substance abuse treatment to members. The ACT SAS	• Continue to encourage individualized treatment to members who are not

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	Treatment		reports that 58 of its 100 members are diagnosed with a co-occurring disorder. Of the 58 members, 13 members regularly attend individual substance abuse treatment; five members attend every week and eight members attend every other week. The sessions are still based in the Stages of Change, but they are focused on topics such as behavior change analysis and action planning. Member sessions are 30 minutes or more in length. The total caseload of members who are dually-diagnosed averages less than 24 minutes of service per week.	currently receiving treatment. Consider involving natural supports or other members who are benefitting from this type of treatment.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Of the 58 members diagnosed with a co-occurring disorder, approximately 7% of them regularly attend a co-occurring disorder treatment group. There is currently one group offered on Mondays from 2-3pm. The SAS stated that the team invites members by way of phone calls, text messages, face-to-face interactions and emails; still, the response rate is low. When asked what measures are being taken to improve group attendance, the SAS reported multiple interventions. The SAS and team Psychiatrist are co-developing curriculum that targets the needs of their members, and the SAS is planning on adding a weekly relapse prevention group to the calendar.	• Continue to evaluate the root causes for low attendance rates for co-occurring groups. Group evaluations/surveys for current and past members are examples of ways to gather their input. Use this information in the program design and the scheduling of group sessions. • Hiring an additional SAS staff could improve effectiveness of outreach efforts and accelerate group/program expansion.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The team focuses on a Dual Diagnosis treatment model, but concedes to more traditional approaches at the members' requests or in instances they deem as medically necessary for detox. The Psychiatrist and SAS take lead roles in educating the team on the dual disorders model Though some of the staff are new to the co-occurring treatment model, the ACT CC reports that the team is receptive, and newer staff seeks to understand the Transtheoretical Model of	• Educate all staff on a proven DD model and stress this consistent approach to co-occurring treatment.

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			Behavior Change (Stages of Change). Though the co-occurring model is not fully evident in all aspects of care, all staff discussed the importance of harm reduction and SMART (Specific/Meaningful/Attainable/Realistic/Timely) goals instead of abstinence in the lives of ACT members.	
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. Staff report that the PSS is focused on therapeutic rapport with members, but is cross-trained in all other clinical areas. Members identified three staff that identify as peers and function in that capacity.	
Total Score:		**110/28 =3.92**		

ACT FIDELITY SCALE SCORE SHEET

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

6. Responsibility for Hospital Discharge Planning	1-5	4
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	3
6. Work with Support System	1-5	4
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	**3.92**	
Highest Possible Score	**5**	