ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 4, 2016

To: Jill Teslow Rowland, Director of Medical Management
From: TJ Eggsware, BSW, MA, LAC
Karen Voyer-Caravona, MA, LMSW
AHCCCS Fidelity Reviewers

Method

On October 11-12, 2016, TJ Eggsware and Karen Voyer-Caravona completed a review of the Partners in Recovery (PIR) Metro Center 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.

PIR offers behavioral health services and coordinated medical health services to individuals diagnosed with a Serious Mental Illness (SMI) through multiple clinic locations in Maricopa County. The PIR Metro Center houses two ACT teams, the Varsity and Omega teams. This report will focus on the PIR-Omega ACT team.

The individuals served through the agency are referred to as *clients*, *recipients* or *members*. 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 October 11, 2016;
- Individual interviews with the ACT Clinical Coordinator (i.e., Team Leader), Lead Substance Abuse Specialist (SAS), Employment Specialist (i.e., Vocational Specialist), and Psychiatrist;
- Three group interviews with a total of seven members and one guardian;
- Charts were reviewed for ten members using the agency's electronic medical records system;
- Review of team documents, including: *ACT Eligibility Screening Tool* and *ACT Exit Criteria Screening Tool d*eveloped by the Regional Behavioral Health Authority (RBHA)*; PIR Policy Number: PRG .05 Inpatient and Admission Discharge Planning;* the ACT brochure*,* the *Omega Team Meeting* log*;* and PIR co-occurring treatment materials and resources.

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 is of sufficient size to provide necessary staffing diversity and coverage, maintaining a member-to-staff ratio of 10:1. The team shares service provision responsibilities, with most members having contact with multiple staff. During the team meeting observed, multiple staff contributed to discussions, were involved in planning services, and outlined their efforts to support members.
- The team is staffed with a full-time Psychiatrist, and staff reported she collaborates with the team to determine treatment actions. Members interviewed spoke favorably of the Psychiatrist, noting that the she takes time to listen to them, discusses their treatment options, and will adjust the course of treatment (e.g., modifications to medications) based on their feedback. The Psychiatrist is accessible by staff via phone, email, and/or text group chat 24 hours a day.
- The team is staffed with two SASs, and is equipped to provide substance use treatment. One SAS is a Licensed Independent Substance Abuse Counselor (LISAC). Per report, all PIR SASs meet weekly for training co-facilitated by agency administrative staff (i.e., a Licensed Professional Counselor and a LISAC).
- The team maintains low admission, graduation and drop-out rates, ensuring consistency and continuity of care for members. Members are not forced to leave the team until they feel they are ready, and members are rarely closed due to lack of contact.
- The team provides behavioral health services and monitors medical services. During the team meeting observed, the team discussed medical health treatment, appointments, and member medical health statuses in addition to behavioral health information.

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

- The team should increase the frequency and intensity of services to members, with a focus on providing services in their communities. Most services are available and provided through the team rather than brokered agents, but most face-to-face contacts with members occur in the clinic. The team averaged less than two face-to-face service contacts, per member, per week, and provided limited face-to-face service time to members based on ten member records reviewed. Service delivery varied significantly among ten member records reviewed. Some well-served members receive the majority of team contacts. Seek to balance the distribution of member services, so members with fewer team contacts, or lower intensity of services, experience an increase in service through the team.
- Do not create groups or activities in the clinic setting unless proven effective and supported by research in the SAMHSA ACT evidence based practice (EBP). Instead, work with members to identify activities in their communities that align with their interests, preferences, and recovery goals. Consider meeting with members in their homes to provide individual substance use treatment.
- Work with members to connect with or identify informal supports in their communities. Review with members the potential benefits of involving informal supports and engage those informal supports as partners in aiding member recovery.
- Consider updating the agency website to outline ACT services offered, referral contact information for the ACT teams, and current clinic administrative contact information.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The team serves 99 members with ten staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of 10:1.	
H2	Team Approach	1 – 5 (5)	The team appears to primarily function with a shared caseload. The CC estimated 90% of members see more than one staff over a two-week period, which was consistent with a review of ten member records. Members interviewed confirmed there are multiple staff on the team they can contact for support. During the AM meeting, reviewers observed evidence of a team approach, as multiple staff contributed their knowledge and awareness of member statuses to the conversation.	
H3	Program Meeting	1 – 5 (5)	Per staff report, the program meeting is held four days a week, all members are discussed at each meeting, and the team Psychiatrist attends two meetings a week. The meeting observed lasted about an hour and thirty minutes.	
H4	Practicing ACT Leader	1 – 5 (3)	The CC estimates her time providing direct services to members at around 80%, seeing about 27-35 members a week, and splitting her time between the office and field. Based on review of the CC's productivity report over a month period, the supervisor provides direct services routinely or as backup, about 22% of the time. There were seven CC contacts with members over a month timeframe documented in ten member records reviewed, all which occurred in the office setting.	• CC should provide direct services 50% of the time; ensure all direct service contacts are documented.
H5	Continuity of Staffing	1 – 5 (3)	Based on data provided by the agency, ten staff left the team in the most recent two-year period, resulting in a 42% turnover rate.	• Continue efforts to hire and retain qualified staff, including working with administration to thoroughly vet candidates to ensure they are the best fit for the position and

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				the demands of an ACT level of service.
H6	Staff Capacity	1 – 5 (4)	In the past 12 months, the ACT operated at 92% of full staffing capacity. There was one vacancy at the time of review due to the departure of a Nurse who left the team late in September 2016.	• See recommendation in H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 (5)	The team has an assigned full-time Psychiatrist who is also the Chief Psychiatrist at the clinic, which requires attending meetings for about two hours weekly. Additionally, the Psychiatrist occasionally provides second opinions for members who are not on the ACT team. However, staff reports the Psychiatrist conducts these activities outside of her 40 hour work week. Staff reports the Psychiatrist is accessible outside of regular business hours via group text or directly if the need arises. Per report, the Psychiatrist provides services in the field one day a week (i.e., 25% of her time), but evidence of community-based service was not located in the ten member records reviewed.	
H8	Nurse on Team	1 – 5 (3)	At the time of review, the team had one Nurse. Staff report the Nurse provides services in the community, but evidence of community-based service was not located in the ten member records reviewed. Staff report the Nurse rarely provides services to members from other teams, or to members on the other ACT team at the clinic.	• Fill the vacant Nurse position and ensure both Nurses are fully dedicated to serving members on their assigned ACT team. If time is spent providing services to members not on the assigned ACT team, it is factored in this area.
H9	Substance Abuse Specialist on Team	1 – 5 (5)	The team has two SASs: one SAS is a LISAC, and the other has three years of experience in the role of SAS on the team. The CC reports that the second SAS is familiar with the stages of change, and has participated in trainings offered through PIR. Per report, all PIR SASs meet weekly (since July 2016) for training co-facilitated by a Licensed Professional Counselor (LPC) and LISAC. At those	

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			meetings, case presentation discussions occur in addition to training on EBPs that include Illness Management and Recovery (IMR) and Integrated Dual Disorder Treatment (IDDT).	
H10	Vocational Specialist on Team	1 – 5 (4)	The ACT team currently has two Vocational Specialists, identified as the Employment Specialist (ES) who has been in in the position for just over a year, and Rehabilitation Specialist (RS) who has been in the position since January 2013. Per CC report, the training of vocational staff includes quarterly meetings with RBHA staff, and self-directed enterprises (e.g., attending job fairs). The team provided some examples of assisting members to obtain employment in integrated settings, but also in positions set aside for persons with disabilities (i.e., non-integrated settings). It was not clear if both vocational staff had training and experience focused on assisting members to obtain employment in integrated settings.	• Ensure both vocational support staff receive supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings. Examples of training focus areas include: engagement, job development and placement supports, benefits education, and follow-along supports. Review the benefits of jobs in competitive settings versus non-integrated settings.
H11	Program Size	1 – 5 (5)	The team is of adequate size, with 11 staff, excluding administrative support staff.	
O1	Explicit Admission Criteria	1 – 5 (4)	The team has clearly defined ACT admission criteria, developed by the RBHA. The ACT team also uses an untitled supplemental assessment form that addresses member status related to employment, illness management, health and physical status, meaningful activity, substance use, and activities of daily living skills. Referrals originate through hospitals, other clinical teams, and by the CC reviewing the clinic crisis tracking for members with frequent contacts as potential referrals. The CC conducts most screenings of referrals to the team, but occasionally other experienced staff conducts the screenings. Staff brings the information back to the Psychiatrist	• The ACT team should make the final determination regarding who is admitted to the team and should not allow members on the team who do not meet the specific ACT criteria due to outside request or administrative pressure.

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			who makes the final determination for admittance, if the member agrees to ACT services. However, the CC cited an example of a situation where the team was required to accept a member.	
O2	Intake Rate	1 – 5 (5)	The ACT team reports in the past six months the peak admission rate was four members during July 2016. The other months ranged from zero to two admissions per month.	
O3	Full Responsibility for Treatment Services	1 – 5 (4)	In addition to case management, the ACT team provides substance abuse treatment, psychiatric care/medication monitoring, housing, and employment services. Per staff report, no members currently see outside Psychiatrists for medications. No members receive services from brokered employment service providers or currently participate in work adjustment training (WAT). Less than 10% of members reside in staffed residences, and no members receive substance abuse treatment outside of the team. The team has two SAS, one of whom is a LISAC, and reports he provides substance abuse treatment. Per staff report, the team directly provides employment support services to members, including assisting members to look for competitive jobs. Though some jobs may not actually be competitive, and some members report previously working in WAT programs, none currently receive that service. It does not appear the team is currently providing counseling services. Some members are referred to brokered providers for counseling.	• The agency should review training and supervision options to ensure staff designated with a specialty area receives monitoring, support, and supervision specific to their role. See recommendation for H10 regarding training of vocational staff. • If certain types of counseling are consistently referred out to brokered agencies, consider adding, training, or supervising ACT staff so they are capable of providing that service.
O4	Responsibility for Crisis Services	1 – 5 (5)	ACT staff reported that the team is available 24 hours a day, seven days a week for crisis support. The team utilizes a group text/chat phone application to aid in communication. Staff updates each other with changes in member conditions in	

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			real time, and the Psychiatrist reports she monitors the discussion in order to assist if needed. Every member is given the phone number to the team's on-call phone, and members rarely call the crisis line directly. The on-call phone is rotated on the team to ensure coverage, and staff responds to members in the field if needed.	
O5	Responsibility for Hospital Admissions	1 – 5 (3)	Two staff interviewed reported the ACT team is involved in about 50% or 80% of admissions. The ACT team was involved in six of the last ten recent psychiatric admissions based on CC report. Staff estimated about five members frequently self-admit (i.e., do not inform the team). When the team is involved in admissions, and the clinic is open, members meet with the Psychiatrist or Nurse for assessment. The CC usually coordinates the admission for members who are voluntary. Transportation to the hospital and assistance in the admission is provided by the staff with whom the member is most comfortable. After normal business hours, the member does not meet with the Psychiatrist or Nurse for assessment, but the on-call staff assists with the admission. The team also completes applications for court-ordered evaluation (COE) or amendments to court-ordered treatment (COT) if members are determined to be in need of further evaluation or treatment in an inpatient setting, but are not voluntary.	• Ensure consistent contact is maintained with all members served, which may result in the identification of issues or concerns that could lead to hospitalization. • 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. • Increasing community-based services and contacts with informal supports may aid the team in proactively identifying areas of concern to prevent hospitalization, or to assist members with admissions if needed.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	Per report, the ACT team was involved in all of the last ten psychiatric discharges. Whenever the team is informed that someone goes into the hospital, the CC obtains the inpatient doctor information and contacts the Social Worker to discuss a preliminary discharge plan (which is required by the RBHA) within 48 hours of admission. Staff meets with members who are inpatient every 72	

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			hours. Meetings between the inpatient and ACT staff to discuss discharges occur, and doctor to doctor contacts are facilitated, usually for members with extended inpatient stays. ACT staff participate in the discharge, transport members to pick up medications, facilitate members meeting with the Psychiatrist (often on the day of discharge) and assist the member to return home or to the identified discharge setting.	
O7	Time-unlimited Services	1 – 5 (5)	All members are served on a time-unlimited basis; two members graduated in the past 12 months, and about two to five percent are expected to graduate in the next 12 months. Another five members are candidates for graduation but have elected to remain with the ACT team rather than move to a less intense service level, so they are not projected to graduate in the next 12 months.	
S1	Community-based Services	1 – 5 (2)	The Psychiatrist usually provides office-based services but reports going into the community about 25% of the time. One member interviewed confirmed meeting with the Psychiatrist and Nurse in the community. However, most members interviewed indicated they often meet with staff in the office. One staff reported they spend 65% of their time providing services to members in the community. Conversely, that estimated rate of community-based services across the team was not supported by documentation in ten member records reviewed, which showed a median of 29% community-based services. For two of ten members all contacts were in the community, but one member had a total of two community contacts recorded, and the other had four community contacts recorded, over a month's time.	• Attempt to increase the amount of time spent providing community-based services directly to members; ensure all services are documented. Prioritize individualized contacts with members in their communities rather than creating additional groups at the clinic. • The agency should discuss challenges to staff providing more services in the community and strategize solutions. Also, the CC should periodically monitor staff service time and location to help identify focus areas.

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S2	No Drop-out Policy	1 – 5 (5)	Based on data provided for the year prior to review, 99% of the team caseload was retained. One member refused services and was closed. No members lost contact with the team and were closed. Other members who transitioned off the team for reasons not factored in this area include those who: moved to other ACT teams (2%), receive services through the Arizona Long Term Care System (ALTCS) (4%), or moved from the geographic area with referral (4%).	
S3	Assertive Engagement Mechanisms	1 – 5 (5)	The ACT team uses a variety of outreach and engagement mechanisms, including coordination with Probation or Parole Officers (PO), coordination with payee services, coordination with guardians, and street or shelter outreach. About 14% of members have representative payees, and 10% receive services under COT. Staff reported the team outreaches the one member who is currently living on the streets. Members interviewed confirmed staff outreach and try to locate them when they are not in contact with the team, sometimes reaching out to informal supports. Some records included documentation of staff attempts to meet with members in their homes. The Psychiatrist and Nurse reportedly provide services in the community, and make contact with members who may not go to the clinic.	
S4	Intensity of Services	1 – 5 (2)	The median intensity of face-to-face service time spent per member was just over 43 minutes a week based on review of ten member records. One member received 47% of the combined documented service time in ten records reviewed over a month timeframe. The combined average weekly service time for the other nine members ranged from a low of 26.5 to a high of 64.75	• For members on the team who receive far above the average intensity of services, determine if changes should occur to allow more time to spend providing services to other members who receive far below the average intensity of service from the team. Increase the average intensity of services to

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			minutes.	members, with a goal of two hours a week or more of face-to-face contact for each member. Work with staff to identify and resolve barriers in increasing the average intensity of services to members.
S5	Frequency of Contact	1 – 5 (2)	Ten member records were reviewed to determine the amount of times per week each member is receiving face-to-face contact. Though one highly-served member averaged 11 contacts per week, for all ten members, the team averaged fewer than two face-to-face service contacts, per member, per week. When members go to the office, they tend to have contact with multiple staff, resulting in a higher frequency of contact than with those members who go to the clinic less often. However, some clinic contacts were brief in nature, with examples of staff greeting members, or repeating topics discussed with other staff the same date. It was not clear if all clinic contacts were purposeful, and tied to member recovery, or were documented to satisfy contact requirements.	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member. • Ensure contacts are purposeful, and connected to member recovery goals, strengths, needs, or objectives.
S6	Work with Support System	1 – 5 (2)	Three staff interviewed were asked what percent of members have informal supports, and their estimates ranged from 50-97%. One staff estimated about 65% of members had informal supports, and the team averages about two contacts a month with those supports. One staff estimated weekly contact occurred with informal supports for nearly all members. However, the estimated high frequency of contact with informal supports was not evident in the ten member records reviewed, which showed an average of .8 contacts over a month period. In those instances, the informal support often initiated contact with the team. Contact with informal supports was infrequently discussed during the team meeting	• Ensure ACT staff review with members the potential benefits of engagement with informal supports, and work to engage the supports in treatment, not only when people face challenges, but to celebrate success toward recovery.

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			observed, with references of recent contact or plans to contact about 10% of members' informal supports. Some members interviewed who identified informal supports were either unsure if the team was in contact with their supports, or noted contact occurred only when the member was not in touch with the team. However, one member indicated contact occurred about monthly, and a guardian indicated maintaining regular contact with the team.	
S7	Individualized Substance Abuse Treatment	1 – 5 (4)	Individualized substance abuse treatment is provided through the team's Lead SAS, who is a LISAC. The second SAS focuses on education and wellness efforts, which appears to be grounded in IMR. The LISAC SAS met with about 19 of the 47 members with a substance use disorder, during the month prior to review. The LISAC SAS reported that he meets with six or seven members twice a week for about 30 minutes each session. He reported that he meets weekly with each of the other 12 to 13 members for 30 minute sessions. Staff documents the service under an IDDT titled note in the electronic medical record. Based on review of member records, some of the IDDT titled notes appeared to relate to standard interactions with members rather than an identified substance abuse treatment session.	• Utilize a co-occurring, stage-wise treatment approach during member contacts, and reflect that treatment language when documenting the service.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (3)	The team offers two weekly substance abuse groups facilitated by the LISAC SAS for ACT members. One group is held at the clinic, and one is held at a residence where a group of members live (i.e., ACT house). The LISAC estimated that during the month prior to review, about 32% of members with a co-occurring disorder attended at least one group.	• Engage members to participate in substance abuse treatment through the team, using a stage-wise treatment approach.

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S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (4)	The ACT staff interviewed did not appear to be familiar with a stage-wise approach to co-occurring treatment, but were able to summarize the facets of motivational interviewing interventions. The agency has an IDDT note function in the electronic health record that includes motivational interviewing language which appears to align with treating members in the persuasion stage. However, when asked if they were familiar with a stage-wise approach to treatment, staff cited their familiarity with the stages of change model. Staff did not appear trained in stage-wise treatment (i.e., the stages of engagement, persuasion, active treatment, or relapse prevention). The agency is in the process of implementing a model of substance use treatment that incorporates IDDT and IMR principles, but it appears staff are more familiar with IMR at this time. Some members and staff cited the use of homework as an element of treatment. Staff may refer members to Alcoholics Anonymous (AA), but it is not the only intervention offered. Staff may refer members to detoxification if medically necessary depending on substance used; though there was some ambiguity what specific substances require medical detoxification.	• Ensure all ACT staff are familiar with stages of treatment and corresponding stage-wise interventions and activities for staff.
S10	Role of Consumers on Treatment Team	1 – 5 (5)	At the time of review, the team had a full-time, fully-integrated Peer Support Specialist (PSS) with responsibilities equal to all the other team staff. Members interviewed were familiar with the staff and her role on the team.	
Total Score:		**4**		

ACT FIDELITY SCALE SCORE SHEET

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