**ASSERTIVE COMMUNITY TREATMENT (ACT)**
**FIDELITY REPORT**

Date: February 9, 2015

To: Vanessa-Gissele Holliman, West McDowell ACT Clinical Coordinator

From: T.J. Eggsware, BSW MA LAC
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ADHS Fidelity Reviewers

## Method

On January 22-23, 2015 T.J. Eggsware and Jeni Serrano completed a review of the Choices West McDowell 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 West McDowell clinic is one of seven clinics under the Choices network of Arizona. The Choices network serves over 7,000 community members diagnosed with serious mental illness. The mission of the network is to offer choice and promote recovery for people needing behavioral health services through a collaborative provider network organization

The individuals served through the agency are referred to as "clients" or "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:

- Observation of a daily ACT team meeting.
- Individual interview with team Clinical Coordinator (CC).
- Individual interviews with a team Substance Abuse Specialist (SAS), Peer Support Specialist, and Independent Living Specialist (ILS).
- Charts reviewed for 10 members using the agency's electronic medical records system.
- Interview with six members who receive services from the team.
- Review of program documents including team referral form, eligibility criteria, team tracking of member status, and team morning meeting checklist.

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 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 shows strengths related to human resources and organizational boundaries by tracking relevant member information through the use of data sheets by staff position, and morning meeting discussions of staff specialty activities with members. About six months ago the team started to focus more on staff functioning as specialists, with CC education and monitoring of roles and expectations.

- The program staff functions well as a team, with a unique morning meeting structure that supports the team approach.
    - During the AM meeting, rather than reviewing members by alphabetical order, members are reviewed based on status (e.g., inpatient, recent crisis) or goals of focus (e.g., those seeking employment, in school, or seeking housing support). Specialty staff updates member status, and the team works collaboratively planning interventions and activities.
    - The program assistant (PA) serves a primary function during AM meeting, tracking activities for the group. Members are discussed under various categories, and at the end of the meeting the PA prompts for discussion of remaining members.
    - The morning meeting structure and approach of this team may serve as an example to teams that struggle with organization of the AM meeting, with lengthy AM meetings, or with supporting specialty staff roles on ACT teams.

- The current CC started with the team in March 2014, and since then the team has been in a positive transition. The new CC has taken an active role in implementing the ACT approach, with the expectation that team specialists function in those roles.
    - As part of the culture change, staff don't view themselves primarily as case managers with the titles of specialists, but as functioning specialists who provide case management services.
    - Both SAS staff have substance use treatment experience and training.
    - The vocational staff on the team assist members with job searches.
    - The CC completes activities in the field with other staff, as well as supporting members with medication observation services. The ability of the CC to provide services in the field is made possible, in part, by the supportive role the PA serves on the team (e.g., during AM meeting) and tracking of other data (e.g., last doctor visit, upcoming doctor visit, all recipients with co-occurring, last group, last face-to-face contact, all hospital discharges).

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

- Further training, education and support of specialty staff needs to occur to bolster their ability to be the primary service delivery agent for members. As noted above, the program has made adjustments in practice to align activities with specialty positions, but further support from the Regional Behavioral Health Authority (RBHA) and the Arizona Department of Health Services (ADHS) is recommended.
- To effectively provide services in accordance with the ACT model, services should be delivered in vivo. The team needs to review strategies to provide services and support to members in their community.
    - The team should revise processes which require members to go to the clinic. For example, some members' checks are mailed from payees to the clinic. In at least one case, this led to some conflict for a member who felt staff had withheld checks from him. Although the approach ensures contact with the member, it is not clear if those contacts are beneficial to therapeutic rapport.

    - The agency and team should minimize or eliminate any requirements for staff to be on site certain set times each day, if applicable.
    - Staff responsibilities, mandated through the RBHA or ADHS, should be reviewed to determine if all are required for a functioning ACT team. To the extent possible, ACT staff job performance expectations should be aligned with the ACT model.

- A core component of ACT services is integrated services provided in the community. Through the use of time studies, the team, network and RBHA should review how direct service time with members can be increased. As the team continues with development of strategies to support services delivery through specialty positions, and continues to decrease reliance on outside providers, direct service time with members may increase.
- It is recommended that the CC periodically reviews member records to ensure consistent face-to-face contacts, and appropriate service delivery duration occurs for all members.
- The team should continue to explore opportunities to engage family or other supports in member treatment, and continue their goal to maintain at least monthly contact with identified supports. Also, it is not clear if the families' of members or inpatient providers are informed of ACT services and supports the team can provide. In some cases, families may assist members in seeking inpatient treatment, without the member, family or inpatient facility informing the ACT team. In addition to ongoing education efforts through the team with members, their families, and other agencies involved in member care, the RBHA should conduct trainings with system partners (e.g., inpatient facilities, medical facilities, nursing facilities, family support networks) to increase awareness of ACT team services in the community.

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| H1 | Small Caseload | 1 – 5 (5) | The team provides services to 90 members. Excluding the team psychiatrists, ten staff on the team conducts home visits and case management activities. The ratio of members served to staff is 9:1. | |
| H2 | Team Approach | 1 – 5 (5) | The group functions well as a team; staff know and work with all members. Based on available information, 100% of members meet with two or more staff over a two-week period. Members report they can go to other available staff for assistance if their primary contact is not available. | |
| H3 | Program Meeting | 1 – 5 (5) | The team meets five days a week and all members are discussed. The team utilizes an *ACT Morning Meeting Checklist* document which outlines the structure the meeting follows. The structure of the ACT team morning meeting facilitates integrated conversation about each member. Member status updates, as well as plans for follow up activities, are discussed based on the member's current status, their goals and services provided per specialist position. The PA monitors discussion and ensures all members are discussed during the meeting.<br><br>The morning meeting supports the staff specialist roles on the team, allows for discussion based on member status and need, ensures all members are discussed, allows for focused discussion, and has a central role for the PA to play in organizing and supporting the team. | • Some programs elect to discuss members in alphabetical order during the AM meeting. This team's approach differs. The morning meeting structure and approach of this team may serve as an example to teams that struggle with organization or supporting specialty staff roles on ACT teams. The morning meeting also serves as an example of how the PA can play an integral support role to the CC and other team members. |
| H4 | Practicing ACT Leader | 1 – 5 (3) | The CC provides direct services via medication observation activities, contact with members who are inpatient, and accompanying the nurse and | • The program needs to continue to explore barriers to the CC providing direct services and look for solutions to |

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| | | | doctor during community visits. There is documentation of CC direct contact with members in records. Based on documentation tracking, the CC provides 2.92 hours of direct services per week. The CC provides services, not only as backup, but as regular part of activities. However, direct services to members by the CC accounts for less than 25% of her time. | those barriers. For example, some tracking activities for the team are assigned to the PA, which allows the CC time to provide more direct services. A time study at the agency, network, and system level is recommended. Any activities deemed non-essential to a functioning ACT team should be identified to determine if they can be eliminated, transitioned to other staff, or reduced. |
| H5 | Continuity of Staffing | 1 – 5 (3) | The team experienced some instability in staffing, with ten staff that left positions. In addition, the team experienced changes in specialty staff positions, with five switching roles from December 2013 through August 2014.<br><br>Based on available information, 20 staff filled 12 positions over the two year period. In addition to five changes of specialty role, ten staff left positions over the review timeframe. The team turnover rate is 42%. | • The agency should review why staff elected to change specialty positions on the team after date of hire. If not in place, interviews should be tailored to the specialty position open on the team to attempt to match the best candidate with the position in an effort to minimize staff specialty position changes.<br><br>• If not in place, the agency needs to complete exit interviews with staff to determine and track reasons staff give for leaving the team. This information could be aggregated and may assist with addressing those reasons to attempt to minimize turnover. |
| H6 | Staff Capacity | 1 – 5 (4) | The team had ten total vacancies over the last 12 months. The team maintained 93% staffing capacity for the last 12 months. | • See recommendations for H5. |
| H7 | Psychiatrist on Team | 1 – 5 (5) | Although the team works with two psychiatrists, one is primarily assigned to the team 30 hours per week, and one works with the team ten hours one day a week. The psychiatrist is accessible to other | |

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| | | | staff, and they feel the psychiatrist makes efforts to be available, including going into the office on off days. The psychiatrist also completes community visits. | |
| H8 | Nurse on Team | 1 – 5 (3) | The ACT team has only one nurse. The nurse is accessible to other staff as well as members, and completes community visits. | • ADHS, the RBHA and the agency should review options to add a second nurse to the team. An additional nurse could allow flexibility in nursing coverage, and increased nursing services in the community versus the clinic. |
| H9 | Substance Abuse Specialist on Team | 1 – 5 (5) | There are two staff members on the ACT team with at least 1 year of training or clinical experience in substance abuse treatment, for this 90 member program. | |
| H10 | Vocational Specialist on Team | 1 – 5 (3) | There are two staff in vocational roles on the team; an employment specialist (ES) and a rehabilitation specialist (RS). Based on interviews with staff and members, as well as observation of AM meeting, the staff make efforts to support member vocational goals.<br><br>Although with the team for over a year, both the RS and ES previously held other staff positions on the team, with less than one year in their current positions. In addition to the lack of one year experience in vocational rehabilitation support, it does not appear the team was fully functioning with team specialists before the last six months. It is not clear if staff were encouraged, fully supported, or expected to function as specialists prior to that point. Staff report trainings through prior RBHA quarterly and one-on-one training with the current RBHA Employment Vocational Manager. | • Increase depth and frequency of training for vocational specialists. Consider adopting aspects of supported employment in training. The Program of Assertive Community Treatment Integrated Vocational Rehabilitation Approach (PACT IVR) is one approach that the RBHA, network and team can review to determine if aspects can be incorporated into the practices of the West McDowell, or other ACT teams in the county. |
| H11 | Program Size | 1 – 5 | The team includes 11 full time staff, with a | |

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| | | (5) | transportation specialist (TS) position vacant. | |
| O1 | Explicit Admission Criteria | 1 – 5 (5) | The program serves a defined population; all members meet criteria with the team CC and psychiatrist making the final decision to admit members to the team. The team uses a referral form and written admission criteria. The CC or other experienced staff members complete screenings with potential members and discuss the results with the psychiatrist. There are occasionally administrative lateral transfers of members already working with ACT teams and for those members the team uses a 30 day assessment period after transfer to ensure they still meet ACT criteria. | |
| O2 | Intake Rate | 1 – 5 (5) | The team maintains a low intake rate, with no more than four new members joining the team in any of the prior six months. The admission rates for October and November 2014 is four per month. For December, September, August and July the admission rate is one per month. | |
| O3 | Full Responsibility for Treatment Services | 1 – 5 (3) | The CC reports effort to educate staff on expectations regarding their specialty roles. The CC and staff report increased emphasis of empowering specialist roles on the team. This transition to specialty roles, underway for about six months, is integrated into everyday activities. For example, one member reported staff focus or assist members with certain activities, such as employment. Additionally, staff update the team on specialty role services during the AM meeting.<br><br>Although caseloads are assigned, they represent a mix of members across the team. About 50% of each caseload assignment is based on member goals and status with applicable specialist | • Further training, education and support of specialty staff needs to occur to bolster their ability to be the primary service delivery agent for members. The provider should carefully examine the reasons for each referral to outside providers to ensure it is a support the team cannot fulfill. |

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| | | | assignment based on that information (e.g., if a person wants to work, assignment to ES). Although the team is strengthening specialty staff roles on the team, there are members who receive services from outside providers.<br><br>The team provides some substance abuse treatment, primarily in the form of groups but refers to co-located and other outside agencies for most individual services. The team provides employment support to some individuals but refers some members to outside providers. Rehabilitative services are primarily provided through outside agencies<br><br>The team provides psychiatric services and medication management, as well as housing support to approximately 95% of members receiving housing support services. The team does not provide at least 90% of services for substance abuse treatment, or employment/rehabilitative services. The team does not provide counseling or psychotherapy. | |
| O4 | Responsibility for Crisis Services | 1 – 5 (5) | The team is primarily responsible for crisis services, available 24 hours a day, seven days a week. The CC meets with new members, discusses the role of the team during crisis, and provides the phone number for the on call, the back up on call, and CC phone. | |
| O5 | Responsibility for Hospital Admissions | 1 – 5 (4) | The ACT team is involved in 70% of admissions. In some cases, members self-admit to the hospital, or team is not informed of contact. In some cases, family members complete paperwork to admit members for assessment at inpatient facilities without team involvement. | • The RBHA needs to review system challenges to promptly informing ACT teams of member contacts with inpatient admission facilities. When teams are informed, they should meet with members to assess their status |

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| | | | | and discuss alternative supports (to address the presenting issue), or coordinate the admission.<br><br>• Review with each member and their support network to review how the team can support them in a hospital admission, if the need should arise. The RBHA, in conjunction with the ACT teams, should offer family and other member supports information and education regarding the role of ACT teams. |
| O6 | Responsibility for Hospital Discharge Planning | 1 – 5 (4) | The ACT team is involved in the majority of discharges, approximately 91%; however system challenges are present that impact the team to fully engage in discharge planning support activities. It is not clear if the team is consistently informed of member admissions or discharges over the weekend, or if members transition from medical and psychiatric services while inpatient. To address those challenges, the team nurse is more involved in meeting with members and coordinating with the facilities providing medical services. | • The RBHA needs to conduct trainings with system partners (e.g., inpatient facilities, medical facilities, nursing facilities, family support networks) to increase awareness of ACT team services in the community.<br><br>• The RBHA should ensure contact information for ACT on call phones for each team are distributed to all emergency care facilities, and to the extent possible, convey the expectations for those locations to contact the ACT teams to coordinate discharges. |
| O7 | Time-unlimited Services | 1 – 5 (5) | The team experienced a 2% graduation rate in the past 12 months and anticipates two discharges due to graduation in the next twelve months. | |
| S1 | Community-based Services | 1 – 5 (3) | Staff report higher levels of community over clinic based services than what is evident in records, reporting up to 80 – 90% of services in the community. The range of community-based | • The team needs to review strategies to provide services and support to members in their community. |

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| | | | services for the ten member records was 14% to73%, with a median of 40%. On the lower end of the range, some members receive multiple contacts at the clinic with various staff members when in to pick up checks, to pick up medications, or for other activities. | |
| S2 | No Drop-out Policy | 1 – 5 (5) | Some members moved from the geographic area served by this ACT team with referral, and some members were closed due to extended incarceration. One member moved from the geographic area without initial referral, but the team established contact with the member and confirmed he was receiving services in the new location.<br><br>Two members refused services. Therefore, 98% of the team caseload is retained over the 12 month period. | |
| S3 | Assertive Engagement Mechanisms | 1 – 5 (5) | The CC reports the team uses an eight week outreach process when a person is out of contact with the team. Staff confirm the use of the eight week outreach and engagement timeline. The efforts include phone calls and face-to-face outreach at least once a week, with as many as two face to face outreach efforts per week.<br><br>ACT team members make efforts to contact emergency contacts, family, and community supports. For members with housing vouchers, the team tries to connect with housing providers to confirm members are paying rent. The team has regular contact with probation or parole officers, counselors, shelters, member run agencies, jails, and uses outpatient commitment if deemed necessary. The CC reports the team schedules appointments for members under Court Ordered | |

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| | | | Treatment (COT) so even if an appointment is missed, the team has a few days to complete outreach and engagement before it is necessary to amend a COT to force treatment, in an effort to support members in the community rather than hospitalize. | |
| S4 | Intensity of Services | 1 – 5 (2) | The monthly service time documented in ten member records ranged from 104 to 283 minutes. Seven of ten members received less than one hour per week of direct services. The median weekly face to face service time is 46.25 minutes. Many direct contacts with members are brief in duration. | • The RBHA and network should conduct time studies to identify barriers to staff providing increased direct services to members. A review of non-direct activities needs to occur to determine if all are essential to the functioning ACT team.<br><br>• The team, network and RBHA need to review how direct service time with members can be increased. As the team continues to enhance services delivery through specialty positions, and continues to decrease reliance on outside providers, direct service time with members may increase. Before referring to outside agencies, the team should carefully consider what service the external agency can offer that the ACT team is not expected to provide. |
| S5 | Frequency of Contact | 1 – 5 (3) | The average team rate of face-to-face contacts with members over a month period ranges from 2 to 5.5 per week for ten members. The median face to face contacts is 2.38 per week, with seven of ten members receiving an average of less than three face to face contacts per week. | • The team, network and RBHA should review potential barriers to staff maintaining a high frequency of contact with all members.<br><br>• The CC should periodically review member records to ensure consistent face-to-face contacts are being made for all members. |

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| S6 | Work with Support System | 1 – 5 (2) | The CC estimates approximately 45 members identified natural supports. Of those 45, the team works to maintain contact at least monthly but report success every few months in some cases. Some staff report as many as ten support contacts weekly. Based on documentation in member records, staff maintains contact with supports on average of one contact per month per member. Some notes reference supports are involved with members, such as assisting with shopping or living with the member, but did not indicate if staff maintains contact with the supports.<br><br>Based on available information, across the caseload, the average support contact per month per member is approximately .5. | • If a family member or support is involved, continue efforts to coordinate with those supports. This includes check-ins with supports when members are doing well and when members experience challenges. These supports may include family, landlords, employers, or anyone else members have consistent contact. Establishing communication may allow the team to provide education regarding serious mental illness, and to advocate for members.<br><br>• If family provides central specific supports (e.g., taking a person shopping weekly, assisting with rent payments), ensure the team maintains consistent contact with members and their supports to confirm those activities occur.<br><br>• For members who do not identify supports, continue to work with members to discuss the benefits of a support network, to identify supports the team is now aware of, and to discuss the potential benefits from engagement of those supports. |
| S7 | Individualized Substance Abuse Treatment | 1 – 5 (3) | The SAS reports the team provides some individual substance abuse treatment support to approximately three members. Documentation supports the team primarily engages members to attend groups when substance use issues are identified. Approximately four members receive | • The team, network, RBHA, and ADHS need to explore if ACT staff are allowed to provide individual substance abuse treatment. This may include additional education, training, or changes to position expectations to allow for staff |

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| | | | individual services from another agency, co-located at the clinic or at an external location, to address substance abuse. | to provide individual substance abuse treatment. If licensure barriers persist, investing in staff development in this area may be necessary. This may require clarification from ADHS and the RBHA on licensure and certification requirements for staff to provide treatment independently, or under the supervision of a licensed professional, as well as guidance on how to document services in accordance with state and federal guidelines. |
| S8 | Co-occurring Disorder Treatment Groups | 1 – 5 (3) | The team serves 39 members with co-occurring disorders. The team offers two substance use treatment groups, one for Spanish speakers and one group conducted in English. Documentation supports member engagement to attend groups, and staff report efforts to increase member awareness of how substance use impacts their life. The group format is a blend of models; partially developed through the RBHA with components of the Wellness Self-Management approach. There is some focus on overall wellness, such as changing negative thinking rather than a fully integrated model.<br><br>Approximately ten to 12 members attend at least one session per month. Therefore, 28% of members with substance-use disorder attend at least one treatment group during a month. | • Enhanced training and support of specialists to provide the full array of substance use treatment services, including individual treatment, may positively impact service delivery in this area. There would be no need to refer to outside providers; allowing members to receive individual or group treatment from the ACT team. |
| S9 | Co-occurring Disorders (Dual Disorders) Model | 1 – 5 (4) | The team does refer members to AA and inpatient for detoxification as adjunct supports. The team views abstinence as the ultimate goal but focuses on harm reduction interventions. Member decrease of substance use is encouraged and acknowledged. SAS staff on the team has | • See recommendation for S8.<br><br>• Ongoing refresher trainings regarding an integrated model of substance abuse treatment should occur. In |

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| | | | knowledge of stages of change and application and have the primary responsibility on the team to provide substance use treatment to members. Other ACT team staff and the SAS staff engage members to address substance use through groups with the SAS staff. It is not clear if an integrated treatment approach is applied by all staff members, in a conscious effort to match specific interventions with individual members' stage of change. The team provides group treatment but refers members to co-located and other outside providers for individual treatment.<br><br>It does not appear the team is fully based in a dual diagnosis model with the team providing all substance use treatment. | addition to regular refresher trainings for all staff, specialists on the team should conduct day-to-day education with other ACT team staff regarding stages of change, and associated interventions recommended. |
| S10 | Role of Consumers on Treatment Team | 1 – 5 (5) | A person with a lived experience of mental illness works on the team full-time and has the same performance expectations as other staff, including participation in the morning meeting, coordination with inpatient facilities, coordination with member support systems, contact with members in the community, documentation requirements, and coordination of specialty staff service delivery with other ACT team members. | |
| **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 | 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 | 3 |
| 4. Responsibility for Crisis Services | 1-5 | 5 |
| 5. Responsibility for Hospital Admissions | 1-5 | 4 |

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| 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 | 3 |
| 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 | 2 |
| 7. Individualized Substance Abuse Treatment | 1-5 | 3 |
| 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** | |