ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: April 23, 2015

To: Gail Salentes, Clinical Coordinator

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ADHS Fidelity Reviewers

Method

On March 24-25, 2015. Jeni Serrano and T.J Eggsware completed a review of the People of Color Network Comunidad 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 People of Color Network (PCN) provides mental health services to children and adults. PCN operates three adult clinics in Maricopa County for members of the community diagnosed with a serious mental illness. This review focuses on one of the two ACT teams at the Comunidad site. The team was housed in a clinic that primarily served members who were homeless prior to the team moving to the current location at the Comunidad site.

The individuals served through the agency are referred to as "client" or "recipient", 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 March 24, 2015.
- Individual interview with Clinical Coordinator (CC).
- Individual interviews with Substance Abuse Specialist (SAS), Rehabilitation Specialist (RS) and Housing Specialist (HS).
- Individual interviews with seven members.
- Charts were reviewed for 10 members using the agency's electronic medical records system.
- Review of the team's admission criteria.
- Review of the Clinical Coordinator (CC) direct service documentation logs.
- Review of the clinic group calendar.

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 operates at full capacity with a low member-to-staff ratio. The team has 12 full-time equivalent (FTE) staff, which includes one full-time psychiatrist, and a peer specialist with full professional status.
- The team maintained consistent staffing over the twelve-month period reviewed, which enhances team cohesion; additionally, consistent staffing enhances the therapeutic relationships between members and provider.
- All members are served on a time-unlimited basis, with fewer than 2% expected to graduate annually.

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

- To effectively provide services in accordance with the ACT model, services should be delivered in the members' own communities. The team needs to review strategies to provide services and support to members in their community.
- Outside of the team psychiatrist and nurse, it does not appear that other ACT team staff are fully functioning as specialists, but rather primarily as case managers. Staff report that they all work with each member in ACT services but also report there are assigned caseloads.
- Per records reviewed and interviews, some community-based contacts are for medication observations, with some interactions in the parking lot of the clinic listed as community contact. Additionally, there are many activities held at the clinic, some that members must participate in to obtain other resources (e.g., must attend group prior to obtaining food through waste not program)
- The team approach needs to be integrative: A multidisciplinary group merges their expertise to provide an array of coordinated services necessary to achieve desired goals; however, due to the demands of the primary caseloads, the program needs to ensure the specialty staff are able to perform their role as a primary function on the team. Preferably, the team as a unit is responsible for service provision to support members, with specialists cross-training other team members.
- Although this ACT team has two SAS specialists on the team who meet the fidelity requirements of at least one year of training or clinical experience in substance abuse treatment, the SAS specialists need formal training to offer effective strategies for treating dually diagnosed members.
- Although this ACT team includes two staff with extensive experience as case managers, and some vocational rehabilitation training (i.e., quarterly through the Regional Behavioral Health Authority), there is no evidence that these vocational staff provide the necessary support to assist members with obtaining, keeping, or transitioning to another job. Rather, members are referred out to other agencies for this service and support.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The team consists of 11 staff (excluding the psychiatrist) and provides services to 91 members, resulting in a member to staff ratio of 8:1.	
H2	Team Approach	1 – 5 (5)	ACT team staff know and work with all members on the team. However, staff report that they are each assigned a primary caseload of approximately nine to 12 members each; they provide case management and assure member's paperwork is up to date. Due to the time demands of the case management responsibilities, staff report there is limited time to provide an array of coordinated services necessary to achieve desired goals. Based on available information, 100% of members meet with two or more staff over a two-week period. However, the contacts are often completed by primary case manager, with secondary contact with another staff based on a rotation list by regions. Based on notes, it does not appear staff consistently addresses skill development or goals at each contact. In four records, frequent contacts were due to medication services (e.g., observations, medi-sets); across the team, many contacts occur at the clinic.	• Although members are in contact with at least two staff consistently, it is not clear if member specific services occurred during each contact. The CC should periodically review documentation to ensure individualized services are provided to members. • Each team staff needs to be empowered to contribute expertise as appropriate. The entire team needs to share responsibility for each member to ensure continuity of care and to create a supportive organizational environment for team members. Ensure contact with members is for a specific purpose, preferably including skill development, and addressing member goals at each contact rather than the current approach which seems to be based on primary case manager (CM) assignment with secondary CM contact based on a rotation schedule.
H3	Program Meeting	1 – 5 (5)	The team meets five days a week and reviews each member. During the AM meeting observation, all members were reviewed. The team uses a list of member names to track most recent contact and encounter code type. Staff is aware of member status if assigned as their case manager, if there was recent contact based on geographic region, if the member attends a group at the clinic, or if staff	• On the day of the review, this team's morning meeting was two hours in duration. If ACT team morning meetings are typically two hours long, it will present challenges for the team to provide effective community services. • In order to focus conversation during

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			completed medication observations. Rather than a shared decision-making model, most direction comes from the psychiatrist. Conversation regarding some members was lengthy, and focused primarily on medication adherence. The meeting lasted approximately two hours. This was due in small part to one staff arriving late for the meeting, and a brief introduction by the team and the reviewers. It is not clear if the length of the meeting, or depth of some discussions is indicative of a standard meeting for this team.	the meeting, the team should utilize a morning meeting document to track member status. Some teams elect to use a tracking form, listing members alphabetically with brief information related to current status (e.g., areas of specialist focus), last home visit, last contact with the nurse, last contact with the psychiatrist, plan of action and responsible staff, etc. Some teams use a checklist to structure the meeting which facilitates integrated team conversations based on member status, plans for follow up activities based on the member's goals, and services provided per specialist position.
H4	Practicing ACT Leader	1 – 5 (3)	The CC estimates approximately 50% of her time is spent providing direct services, but based on documentation tracking, the CC provides approximately 22% of direct services per week. There is evidence of CC face-to-face contact with members, sometimes for extended durations, documented in records. In records reviewed, most of the CC face-to-face contact with members was in the clinic, or the parking lot of the clinic.	• Preferably the CC provides direct face-to-face services at least 50% of the time. The CC should review current duties to see if some could be adjusted to allow more time for direct service. The Regional Behavioral Health Authority (RBHA) should consider shadowing this CC's activities on a standard day to attempt to identify how she manages her day and reflects those activities in documentation. There may be time management strategies or techniques that other CCs could implement in their own practice.
H5	Continuity of Staffing	1 – 5 (5)	This team experienced an 8% turnover rate in two years. This team maintained consistent staff, which enhances team cohesion. At time of review all positions are filled.	

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H6	Staff Capacity	1 – 5 (5)	This team maintains consistent, multidisciplinary services by operating at 99% of full staffing in the past 12 months.	
H7	Psychiatrist on Team	1 – 5 (5)	The team has had the same psychiatrist since 2009. Although he may occasionally see members from other teams, the activity does not constitute a significant amount of time and is not planned into the schedule with recurring time dedicated to those tasks. The psychiatrist works four, ten hour days per week, attends team meetings four days a week, and is accessible.	
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 CC states that the nurse occasionally goes in the community to administer injections, is accessible and attends team meetings five days a week.	• 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). Some ACT programs assign small caseloads to the nurse as the primary direct contact for members who experience significant medical challenges or require more frequent medication management assistance. Having a second nurse on this team may free up specialty staff time that is now allotted to medication observation activities.
H9	Substance Abuse Specialist on Team	1 – 5 (5)	There are two staff on the ACT team with at least 1 year of training or clinical experience in substance abuse treatment, for this 91 member program. The SAS staff on the team engages members to address substance use issues, but due to other case management duties they primarily refer to other providers for substance use treatment.	

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H10	Vocational Specialist on Team	1 – 5 (4)	The team has two full-time staff who fill vocational roles on the team: an employment specialist (ES) and a rehabilitation specialist (RS). Both staff have extensive training and experience as case managers, but limited formal training in vocational support services (i.e., quarterly trainings through the RBHA).Based on interviews with staff and members, as well as observation of the AM meeting, the vocational staff make efforts to support members' vocational goals through initial engagement, but due to case management responsibilities, the staff refer out for most vocational services.	• Prior to referring a member to an external provider, review what the program will offer that the team is not expected to provide. For example, if a person wants to work, the team employment specialist should assist in the job search.
H11	Program Size	1 – 5 (5)	There are 12 full-time staff on the team. All positions are filled, and the team is of sufficient size to consistently provide necessary staffing diversity and coverage.	
O1	Explicit Admission Criteria	1 – 5 (5)	The program serves a defined population; all members meet criteria with the team making the final decision to admit members. The team uses a referral form and written admission criteria. The CC completes screenings with potential members, explains ACT services to potential members, ensures members want to join the team, and discusses the results with the psychiatrist. Per report the whole team meets with potential new members before they are admitted to the team, and the CC would object if the team is forced to admit members who do not meet criteria.	
O2	Intake Rate	1 – 5 (5)	The CC reports six member intakes to the team in the past six months (one per month). Per report, the CCs at the clinic meet daily to discuss members who may benefit from ACT services and the CC reviews the clinic crisis contacts to determine if members with frequent crisis or those hospitalized	

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			may benefit from ACT services.	
O3	Full Responsibility for Treatment Services	1 – 5 (2)	Aside from case management, this team provides psychiatric services. There are 11 members in residences with staff support (e.g., one-on-one staff, 24-hour residential treatment, community placement). The team refers out for counseling/psychotherapy, which includes individual and some group substance abuse treatment. Although the RS and ES may assist members with job search or with creating a resume, the ACT team primarily refers to external providers for supported employment services. As observed in documentation and the AM meeting, when follow up plans are identified, specialty staff are not consistently assigned based on member status. SAS, vocational specialists, and a housing specialist are on the team, but their duties are primarily focused on their roles as case managers; staff have not been empowered to fill their specialist roles and the team often refers to outside providers. The group generally functions more as a collection of staff with individual caseloads. Specialists do not appear to work with members on need basis but rather as case managers responsible for all activities on their assigned caseload. In addition, just recently they have been charged with the expectation that they maintain contact with a subset of the team based on geographic regions.	• A core of the ACT team philosophy is that services are integrated into a single team, rather than referring members to many different service providers. The goal is for services to be tailored to each member, and the team should directly provide full services in addition to case management, including psychiatric services and medication management, counseling/ psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services. • The RBHA and agency should collaborate to develop an action plan to support, train, and supervise direct service staff on the ACT team. The team should work toward aligning contact with members based on identified goals and needs, with services delivered through specialists.
O4	Responsibility for Crisis Services	1 – 5 (4)	The team provides 24-hour coverage directly (i.e., an ACT team member is on-call at all times, typically by carrying a cell phone), and the CC acts as back-up. Most members are eventually provided with the on-call phone number, but in some cases	• The team should provide crisis stabilization services to all members 24 hours a day. Ensure members are provided with key phone numbers. At admission, some teams provide a list of

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			members are not provided the information due to behavioral issues (i.e., calling after hours just to check on staff). Additionally, some members report they did not receive the on-call information from the team and are not sure who to contact if they experience a crisis. For the members who do have the on-call phone contacts, staff report members call the team rather than the crisis line. The team assesses the situation (e.g., whether the person is danger to self or others) and the team will go out if they cannot work with the member over the phone to de-escalate the crisis.	all team cell phone numbers for members to use during specific business hours, and an on-call number for after hour calls. Provide education to members regarding the team's role in crisis services, but do not withhold team contact information from members.
O5	Responsibility for Hospital Admissions	1 – 5 (4)	In preparation for the review, when asked for information for the ten most recent member hospital admissions, the CC reported eight members who experienced an admission. However, during the AM meeting the team referenced plans for petitions for court-ordered evaluation, amendments to court-ordered treatment, and other members who recently experienced a hospitalization, suggesting more admissions than initially reported. During office hours, members usually meet with staff and the psychiatrist in an effort to prevent hospitalization. The team is generally involved in decisions to admit members, but staff estimates their involvement with 80-90% of admissions. There are some cases when members are admitted without team involvement (e.g., police intervention, people seeking shelter).	• It is not clear if hospitalization admission and discharges are tracked regularly by the team. See recommendation for H3 regarding the morning meeting tracking document. Using a tracking sheet can help the team to monitor those members currently hospitalized, track admission and discharge planning activities, and identify possible patterns of hospitalization that can be addressed proactively.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	When the team is aware of member admissions, they begin outreach with social workers, in-patient providers, and members immediately. Based on staff report, the team is involved with 95% or more of discharges. There is evidence of team	

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			coordination with in-patient provider and member documented in one applicable record reviewed.	
O7	Time-unlimited Services	1 – 5 (5)	The team experienced a 2% graduation rate in the past 12 months and anticipates two to three discharges due to graduation in the next twelve months.	
S1	Community-based Services	1 – 5 (3)	Staff estimate that community contacts with members occurs approximately 50-65% of the time, and documentation reviewed resulted in 59% community-based contact. For the purposes of the review, contact with members in the parking lot of the clinic was considered a clinic contact, but some documentation suggests this activity is viewed as a community contact. The team appears to be office-based, with many member contacts occurring at the clinic. The ratio of community to office-based contacts is also somewhat inflated due to three of ten members receiving medication observation activities in their homes almost daily.	• 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. • The team should review all activities that require members to go to the clinic and attempt to transfer those activities to community-based interactions. This includes a close review of the purpose, attendance, and benefit of groups other than substance abuse treatment groups offered through the team.
S2	No Drop-out Policy	1 – 5 (5)	One member was closed after the team could not locate them, and one member refused services, resulting in 98% team caseload retention over the 12 month period.	
S3	Assertive Engagement Mechanisms	1 – 5 (5)	Staff report efforts are made to engage members who ask to end services, including: asking members why they want to close, what they are receiving from services, assessing if members are able to make an informed decision regarding treatment, and ask that members meet with the	

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			psychiatrist and CC prior to closure. The CC reports, and staff confirm, the team uses a variety of outreach and engagement efforts, including: visits to known addresses or places members frequent, visits to shelters, visits to community resource centers, outreach with the doctor, outreach with the nurse, alternating visits with the doctor or nurse in the member's home and clinic, building rapport with downtown ambassadors if they make contact with members, coordination with payees or family members, coordination with probation or parole officers, offering a lower level of care, reducing contact with members if they prefer, and outpatient commitment.	
S4	Intensity of Services	1 – 5 (5)	The median weekly face-to-face service time is 191 minutes per member per week, well exceeding the two hour face-to-face per member threshold identified for higher fidelity programs. However, as noted above under item S1, many contacts are office-based with three or more staff making contact with some members in the clinic on the same day. Some team contacts were in group settings where two team staff documented one hour of activity for each member. Some notes had the same content for different members, and some notes had limited information related to actual skill building service. Community contacts include daily medication observation services with the duration of 10 minutes (or more), or extended home visits with assessment of the home, but limited content regarding actual interaction with the members. In some cases, documentation identified few tangible skill building or supportive service activities when considering the duration of time documented. Per report, the agency expects staff to document six hours per workday,	• The CC should periodically review staff notes to ensure activities are documented, accurately reflect the duration of the service, and include services to address member goals and needs. • The team and agency should review the benefit of group activities to members to ensure specific skill building activities occur and are documented. • The system, RBHA, and agency should collaborate to determine if there are other ways to incent service delivery based on member outcomes.

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			compared to five as expected in other similar settings.	
S5	Frequency of Contact	1 – 5 (5)	Based on ten records, selected by the CC for review, the median average contact per person per week is 5.5. However, the notes for members receiving medication observation services (three of ten records) are frequent, but the content tends to be minimal, with duration of ten minutes or more per contact. Although in some instances staff documented additional time spent performing home visits, challenges (e.g., hygiene) are not addressed, and subsequent notes do not always reflect that the issues have been addressed by ACT team specialists. Members report weekly contact with generally one or two staff. In some cases staff have contact with members up to six times per week. Those with more frequent contact with the team generally receive daily medication observations, or go to the clinic for medication services or groups. In some cases members met with multiple staff at the clinic, and when those additional contacts are accounted, the median drops to 4.4.	• The CC should periodically review team documentation to ensure it complies with agency expectations, that the duration of the contact is consistent with the activity, and that the team is working collaboratively to deliver services across specialists.
S6	Work with Support System	1 – 5 (1)	CC reports that members assigned to this team does not have a lot of supports due to the target population of homeless individuals, although it does not appear most members currently served are classified as homeless. According to records reviewed 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.	• For members who do not identify supports, continue to discuss the benefits of a support network, to identify supports the team is not aware of, and to discuss the potential benefits from engagement of those supports. • 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

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				experience challenges. These supports may include family, landlords, employers, or anyone else with whom members have consistent contact. Establishing communication may allow the team to provide education regarding serious mental illness, and to advocate for members.
S7	Individualized Substance Abuse Treatment	1 – 5 (2)	The team does not provide formal, structured individualized substance abuse treatment; however, the SAS reports efforts are made to engage with individuals one-on-one based on member stage of change. Also, the team engages members to build rapport, and efforts occur to identify discrepancies of where the person is and what goals they want to accomplish. There is evidence of some SAS interactions with members to address substance abuse concerns, and based on report, individual contact accounts for approximately 11 minutes per member a month. However, it is not clear if the team consistently addresses SA concerns with members.	• Structured training should be provided to all specialty staff, including integrated treatment for dual-disorders. The SAS should be a primary voice in driving team interventions for members with a substance use challenge. Enhanced integrated dual-disorder training on a recurring basis may empower SAS staff across the system to intervene with members in a consistent manner, based on a proven model. • The agency should ensure supervision is provided to SAS staff by a person with experience providing integrated dual-disorder treatment. If this option is not available through the clinic, the agency and system should explore whether some agencies with multiple ACT teams could have one supervisor over all SAS staff as an adjunct to existing CC supervision activities.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (1)	The SAS staff provides one co-occurring disorder treatment group every other month for one hour. The ACT SAS do not use a curriculum but state that they search the internet for group ideas, rely on open discussion, or ask group members what they	• The SAS needs training in a stage-wise approach to treatment. The SAS should be a primary voice in driving team interventions for members with a substance use challenge. Enhanced

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			want to discuss during the next group. Per report approximately 3-7 of the team's 58 members with an identified co-occurring disorder attend one substance abuse group per month. There was no documentation in files reviewed, and the group was not listed on the monthly clinic activity calendar; however, this was attributed to the group day falling on a holiday.	integrated dual disorder training on a recurring basis may empower SAS staff across the system to intervene in a proven and consistent manner. • The program should increase the frequency of integrated dual-disorder groups through the SASs on the team and reduce the reliance on outside providers. If the program determines that the group will only be offered once a month, alternative days should be offered if the regular group day falls on a holiday.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (2)	Although some staff on the team use motivational interviewing, are aware of a stage-wise approach to treatment, and focus efforts on harm reduction, it is not clear if the whole team shares the same approach. Rather than proactively outreaching members in the community, the team appears to focus on engaging members who are at the clinic regularly and may be using substances. Additionally, it does not appear SAS input is incorporated into all service plans for members with a substance use challenge, and although motivational interviewing training was provided through the agency approximately a year ago, it is not clear if ongoing training or supervision occurs. There is report of referral to outpatient providers for substance use treatment, encouragement to attend AA, and team referral for detoxification services.	• The provider and system should ensure ongoing and structured training is provided to all specialty staff, including integrated treatment for dual-disorders. SAS staff should be proficient in specific substance use interventions (e.g., counseling, pharmacological adjuncts). • Enhanced integrated dual-disorder training on a recurring basis may empower SAS staff across the system to intervene with members in a consistent manner, based on a proven model. If the clinic does not have the capacity to provide this training or supervision, then the RBHA and agency should work collaboratively to explore alternative training and supervision options.
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	

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			participation in the morning meeting, coordination with in-patient 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:		**4.07**		

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	5
6. Staff Capacity	1-5	5
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	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	2
4. Responsibility for Crisis Services	1-5	4
5. Responsibility for Hospital Admissions	1-5	4

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	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	5
5. Frequency of Contact	1-5	5
6. Work with Support System	1-5	1
7. Individualized Substance Abuse Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	1
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.07**	
Highest Possible Score	**5**	