ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: Diane Clodi, CD

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ADHS Fidelity Reviewers

Method

On December 3-4, 2014 T.J. Eggsware and Jeni Serrano completed a review of the Southwest Network (SWN) Hampton 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 SWN Hampton clinic is located in the southeast of Maricopa County. The network has an integrated approach to services, and has a goal to create partnerships, inspire hope and change lives. The Hampton ACT team includes some staff who have been with the team for many years including their psychiatrist (since 2007), nurse (since 2004), rehabilitation specialist (formerly the team substance abuse specialist, on the team since 2009), independent living specialist (on the team since 2000) and clinical coordinator (since 2007). As a network, efforts are made to help members realize their ambitions based on preferences. One example is an art contest, and during the review staff discussed the event and those members who may be interested in participating.

The individuals served through the agency are referred to as "recipients," but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

During the site visit, reviewers participated in the following:

- Observation of a daily ACT team meeting on December 3, 2014.
- Individual interview with team clinical coordinator.
- Individual interviews with substance abuse specialist, the vocational specialist and housing specialist.
- Charts were reviewed for 10 members using the agency's electronic health records system.
- Group interview with four members.
- Three individual member interviews.

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 Hampton ACT team office space is open and shared with all staff in one room.
    - The layout allows staff to freely interact with each other, as well as members, who seemed to be allowed to freely come and go from the room with an "open door policy."
    - The team seemed open to interacting with members, and were able to observe each other during those interactions. During the AM meeting, staff on the team acknowledged another staff member who had effectively engaged with a member.
    - Members and staff appear comfortable in the shared space, which seems to contribute to fostering a respectful environment.
- The Hampton ACT team references cultural preferences in dialogue, and seems to strive to respect preferences expressed by members as well as staff.
- Members interviewed appear to value the staff, even at times when they may disagree with them, which seem to support members can be open and direct with staff without fear of reprisal.
- The team meets as a full group at least four times per week. During the AM meeting, team members collaborate to discuss member strengths, possible concerns, and briefly discuss members status updates.
- In the records reviewed, AM meeting notes are not heavily represented, but rather appear to be entered when significant changes or substantive discussions occur for applicable members.

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

- Conduct a time study to assure the clinical coordinator (CC) has 50% time for direct face-to-face ACT services with members.
- Member records reflect a variety of staff contacts (relates to item H2), in the community (relates to item S1), with frequent contact (relates to item S5). However, the high frequency of staff contact is due to many member medication observations. Those medication observations occur primarily in the community, which appears to result in an elevated ratio of community to clinic contacts.
    - In the majority of medication observations, the contact tends to be brief, with a focus only on observing the member take medications. It appears there could be missed opportunities to engage members in addressing other areas of their lives. At a minimum, if issues are identified (e.g., disorganized or untidy home, potential substance use) while conducting medication observation services, ensure those issues are discussed with the team in order to develop a plan for follow up with the applicable specialists (e.g., housing or substance abuse specialist) leading the interventions.
- Outside of the team psychiatrist and nurse, it does not appear that other ACT team staff are fully functioning as specialists. Staff report that they all work with each member in ACT services but also report there are assigned caseloads.
    - Training of all specialist staff should occur on a recurring basis to discuss current trends, interventions, and barriers to staff acting primarily as specialists on the ACT teams.

- The team refers members to treatment settings or housing settings where staff provides services that overlap with activities the ACT team should provide. Although members are transitioned off the ACT team after 30 days if a member is in 24-hour residential treatment, in some cases there is evidence of overlapping duties (e.g., ability to provide medication observation, ability to assist with skill training in the home) between ACT teams and housing support or residential treatment providers. The system should review options to allow for increased ACT member choice of residences where the ACT team can provide supportive housing services rather than relying on outside agencies.
- Although the team seems to support client preferences, and works to treat members with respect, documentation does not totally align with the approach. In some home visit notes, the phrasing to describe member residences included the words “filthy and nauseating”. Staff training should occur to ensure all documentation is objective, non-derogatory and phrased appropriately.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The Hampton ACT team consists of ten staff members excluding the team psychiatrist and administrative support staff.	
H2	Team Approach	1 – 5 (5)	Although staff report having assigned caseloads, they add they have some capacity to fulfill specialty position duties. The team appears to function with some primary responsibilities as a case manager, and members report they have contact with two to four staff depending on the member. Documentation in the ten member records supports two or more staff face-to-face contacts with members over a two week timeframe.	• Although members are in contact with at least two staff members consistently, it is not clear if all staff provide services primarily as specialists. Training of all specialist staff should occur on a recurring basis to discuss current trends, interventions, and barriers to staff acting primarily as specialists on the ACT teams.
H3	Program Meeting	1 – 5 (5)	The team meets at least four days a week (sometimes five days a week). During the AM meeting, all members are reviewed, and team staff appeared to be aware of member status as evidenced by discussion and shared decision making. In the records reviewed, AM meeting notes are not heavily represented, but rather appear to be entered when significant changes or substantive discussions occur for applicable members. Although the team meets in their shared workspace, they appear to be mindful of confidentiality. For example, during the AM meeting a member met with the doctor, and the team members adjusted their interactions to maintain the confidentiality of individuals discussed until the member meeting with the doctor was in his office with the door closed.	

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H4	Practicing ACT Leader	1 – 5 (2)	The CC estimates the time she spends providing direct services at approximately 50-60%, depending on the week, with a goal of 75%. The CC is responsible for a significant amount of administrative duties. The CC's encounter report for a month period shows about 1% of time average per week spent providing direct services. There are no direct face-to-face services by the CC in ten records reviewed. As a result, it appears the supervisor provides services on rare occasions as backup.	• It is recommended that a time study is utilized to identify the amount of time the average CC on ACT teams spends completing administrative functions, attending meetings, or engaging in other duties without direct contact with members. If each activity is essential, it should be reviewed to determine if some can be eliminated or streamlined, or transitioned to other system, clinic or agency staff.
H5	Continuity of Staffing	1 – 5 (4)	In the two years prior to review, six staff transitioned off the team, one of whom subsequently rejoined the team. As a result, the team experienced 20 – 39% turnover in the applicable 2 year period.	• If not in place, consider completing an exit interview with staff who resign in order to gather their feedback regarding their reasons for leaving, and actions management can take to maintain staff.
H6	Staff Capacity	1 – 5 (4)	There were 23 total vacancies over the 12-month review timeframe, with a peak of three vacancies for March and April 2014. The vacancy rate for the 12 months prior to review was 84%.	• If certain positions are difficult to fill (e.g., substance abuse specialist or peer support specialist) consider outreach to local colleges or programs (e.g., member run agencies or peer training programs) where individuals with applicable qualifications may be accessible.
H7	Psychiatrist on Team	1 – 5 (5)	The team has the same psychiatrist since 2007, who may occasionally see members from other teams, but 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 attends team meetings at least four days a week and is accessible.	
H8	Nurse on Team	1 – 5	Although there is only one nurse (same one since	• The program may benefit from

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		(3)	2004) assigned to the 100 member program, the nurse completes home visits, community visits, and medication services in the home. Additionally, the nurse co-facilitates the substance abuse group with the team SAS. In addition, the nurse is the lead nurse at the clinic and does occasionally dedicate time to those duties; however, the team reports the nurse is accessible and attends team meetings.	exploring options to incorporate a second nurse on the team, including shifting current staff positions not specified in the ACT model, if appropriate. • A second nurse on the team could potentially assist with field or clinic activities. For example, if the nurses complete medication observations in the field rather than other specialty staff, those specialty staff could have more time to engage members based on goals and identified needs rather than primarily medication observations.
H9	Substance Abuse Specialist on Team	1 – 5 (3)	Although new to the role of SAS on the team (team SAS and RS switched positions October, 2014), the one SAS has at least two years of experience and knowledge of a stage-wise approach to treatment. The second SAS position was vacant for the past twelve months, and the agency is seeking a licensed SAS.	• See recommendation for H6, which relates to recruiting. • The system should review opportunities to cultivate trained SAS staff (e.g., through an internship program).
H10	Vocational Specialist on Team	1 – 5 (3)	The team has one employment specialist (ES). One staff is listed as rehabilitation specialist (RS) but recently transitioned to the role from SAS. It is not clear if either staff fully provide direct vocational employment services due to the team propensity to refer members to external vocational programs. It does appear the ES engages members who express a vocational goal. However, the members are referred to providers for vocational services, and the team ES monitors the status of job searches for members in vocational programs, such as job development or workshops, outside of	• 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.

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			the ACT team. The RS engages people in other community activities, but neither appears to directly provide vocational services on a consistent basis.	
H11	Program Size	1 – 5 (5)	The team consists of 11 full-time staff. The second SAS position is vacant.	
O1	Explicit Admission Criteria	1 – 5 (4)	The team has a clearly defined target population they work with, seeks referrals through the clinic (when not at capacity), uses formal admission criteria, with screenings completed by the CC or other seasoned team members prior to review of the team psychiatrist. The team psychiatrist generally makes the final determination if a member is admitted to the team; however, the program occasionally bows to organizational pressure. Although the CC reports the team feels people generally benefit from ACT services, in at least one instance an administrator requested the team accept a member onto the team even though the team questioned if their services were necessary due to the member's circumstances (i.e., diagnosis, other supports involved).	• Preferably, the team makes the ultimate determination of members admitted to the team based on application of a set criteria and consistent screening of all referred members.
O2	Intake Rate	1 – 5 (5)	The CC reports four member intakes to the team in the past six months.	
O3	Full Responsibility for Treatment Services	1 – 5 (4)	The ACT team provides group counseling for substance use, and report no members currently receive individual substance abuse counseling due to the team not having a counselor. The CC reports the agency wants to hire a licensed SAS. Two members receive services in 24 hour co-occurring residential treatment settings and another substance abuse treatment provider agency attempts to engage a small number of members in services.	• Four members transitioned from the team due to placement in residential treatment. Per report, a 30 day period of transition is in place when members enter residential treatment in order to ensure a smooth transition to the setting. Prior to referral to residential treatment, the clinical team should carefully review what services will be provided in residential setting that a fully functioning ACT team can't

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			The team provides engagement for employment activities, and once a member identifies a vocational goal, the team generally refers to outside providers for job development, and workshops, with some members involved with vocational rehabilitation. There is evidence of engagement for some rehabilitative activities (e.g., exercise) or monitoring of member status if in school, but the team also refers members to external providers. The employment specialist monitors member status in external employment service agencies, but it is estimated less than 10% of the members are in external vocational programs. The team provides housing services but also refers members to staffed residences where there is some overlap with ACT activities (e.g., activities of daily living skill development, budgeting), but the team apparently assumes provision of the service when members are in those settings. Nine of ten records indicate medication observation activities occurred over a month period. Documentation tended to focus only on medication observations, with brief, but frequent notes that lacked depth of content or did not consistently indicate plans to follow up with applicable specialists if concerns were identified. The team directly provides case management services, psychiatric services and medication management. The team provides 90% or more of the following: housing support (less than 10% of the members in a residence with external staff), substance abuse treatment (i.e., groups), but refers employment/rehabilitative services	provide, with consideration for the rapport the team has with the member, and plans for transition of members off the team when in residential treatment. Due to the relatively small percentage of team members transitioned to those settings out of a 100 member team, it is possible those discussions occur with the team.

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			externally, for some members. The ACT team does not directly provide counseling/psychotherapy, and refers out to other providers for general counseling.	
O4	Responsibility for Crisis Services	1 – 5 (5)	The team provides 24-hour coverage; with a primary on call and backup on call. The ACT team has a sheet noting all team staff, phone numbers, and on call with back up on call. When a member first goes to the team or during treatment, if the need arises, members are given the sheet, so they have information to contact the on call directly. The team reports they can often resolve member concerns over the phone but may go out to provide services directly to members, or, if there is a safety situation, may call emergency services to support staff in the field. If a member goes to the emergency room and is medically cleared outside of normal business hours, the team will pick the member up and help them transition back home.	
O5	Responsibility for Hospital Admissions	1 – 5 (4)	The ACT team is involved in 90% of hospital admissions, with some self-admissions without team involvement, whether sought by members independently or with assistance from outside supports (e.g., family members). During office hours, members meet with the psychiatrist with effort made to prevent hospitalization. If inpatient service occurs, the team assists, whether through self-admission or court ordered treatment process.	• If families admit members to inpatient settings without informing the team, consider engaging family peer services to make contact with the families of members to discuss the potential benefits of involving ACT team staff in admissions. Examples are improved coordination of care (i.e., team staff aware of member histories and medications can provide information to inpatient providers) improved timely care, and possibly reduced lengths of stay, with a goal of more effective discharge planning.
O6	Responsibility for Hospital Discharge	1 – 5 (5)	When the team is aware of member admissions, outreach with social worker, inpatient providers,	

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	Planning		and members begins immediately. The team is involved with 95% or more of discharges.	
O7	Time-unlimited Services	1 – 5 (5)	All members are served on a time-unlimited basis, with fewer than 5% expected to graduate annually. One member closed but reopened per CC report. Additionally, the team's, graduation rate in the 12 months prior to review is zero.	
S1	Community-based Services	1 – 5 (5)	Based on ten records, the team provides face-to-face service contacts in community approximately 84% of the time with a range of 31% to 100% community-based services. Some community-based activities include shopping assistance (e.g., budgeting, encouraging purchase of food or drink over non-necessities). The doctor and nurse also provide services in the community, with evidence of those activities documented in the ten records reviewed. Nine of ten records reflect medication observation services, ranging from three days per week to daily contact. It is possible the ratio of community to clinic based services was higher due to number of member records selected for review with medication observation services in the community.	• Monitor selection process for future reviews to ensure records reflect a cross section of members served.
S2	No Drop-out Policy	1 – 5 (5)	During the 12-month review period one member declined services, one member could not be located, and one member left the geographic area without referral, but subsequently returned. In addition, three other members transferred at their request, and four members were transitioned off the team due to referral to residential services. Considering the members who declined, transferred or could not be located, 95% or more of the caseload is retained over a 12-month period.	• See recommendation for O3.

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S3	Assertive Engagement Mechanisms	1 – 5 (5)	The program uses street outreach; for example, in one case a member was residing in relatively remote and indistinct location, but the team was able to locate the member in an effort to reengage. The team uses legal mechanisms (e.g., probation/parole, outpatient commitment) or other techniques to ensure ongoing engagement. The team appears to have rapport with members; members seem to value the team and note their ability to voice concerns, even if they don't always agree.	
S4	Intensity of Services	1 – 5 (3)	Of ten member records, over a four week period the median direct service minutes per week is just under 52 minutes per week with a range of 17.23 minutes to 128.25 minutes per week. However, the minutes per week average appears to have been skewed higher by minutes spent providing only medication observation services. Medication observation is a recurring service documented in nine of the ten records reviewed, and in the tenth record, the nurse provided medi-sets every three to five days. As a result, a sizeable portion of records reviewed reflected primarily medication related activities. For example, the percent of time spent providing only medication observations for one member was 42%, and for another member it was 51%. In these two examples, other issues were identified, referenced in notes (e.g., cleanliness of residence), but not addressed.	• In the majority of medication observations, the contact tends to be brief, with a focus only on observing the member take medications. It appears there could be missed opportunities to engage members in addressing other areas of their lives. If the ten records reviewed are representative of the 100 members served, it is not clear if team members are actively addressing assessed areas of concern consistently. If home visits occur and concerns are identified, a follow up plan should be developed that outlines how applicable specialty positions will follow up to address the area with the member. For example, if a member's home is assessed to be untidy, the housing specialist or independent living specialist should follow-up with the member. • Training of all specialist staff should occur on a recurring basis to discuss

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				current trends, interventions, and barriers to staff acting primarily as specialists on the ACT teams. The team should review the current approach to member contact, which seems to be based on medication observation or caseload assignment primarily. Member contacts should be based primarily on member needs, addressed by specialty team staff.
S5	Frequency of Contact	1 – 5 (4)	Based on ten records, the average contact per person per week is 3.6 with a range of 2 to 8.5. However, the range is skewed by the high frequency of contacts for medication observation. The notes for members receiving medication observation services are frequent, but the content tends to be minimal, with a brief duration. Although in some instances staff documented additional time spent performing home visits, assessed challenges (e.g., hygiene) are not addressed, and subsequent notes do not always support the issues are addressed by ACT team specialists.	• See comments for S4 regarding specialty staff follow-up on identified areas of concern.
S6	Work with Support System	1 – 5 (1)	If family members or supports are involved, the team reports contact occurs about weekly, or multiple times a week. One member record of ten includes a note referencing contact with an external support. Additionally, contacts with external supports is not consistently referenced during the AM meeting. As a result, it is determined the team has less than .5 contact/ month for each member across all members served.	• Identify external member supports and discuss with members the benefits of involving supports in treatment (e.g., may be able to provide information or supplement the member's story of recovery). If members decline to allow the team to contact supports, the team can still receive information from supports if they contact the team. If a member is estranged from family or friends, consider involving peer or family peer supports to reach out to

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				the member's support system to provide education, resources, or guidance. • Ensure all staff contacts with member supports are documented.
S7	Individualized Substance Abuse Treatment	1 – 5 (3)	The team does not provide formal, individualized substance abuse treatment with an experienced specialist. However, the staff identified as SAS is familiar with a stage-wise approach to treatment, and there is evidence members are assessed for stage of change, with team integration of some substance abuse interventions into regular member contact (e.g., motivational interviewing). The SAS reports efforts are made to intervene based on member stage of change, 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. For example, the SAS intervened with one person using alcohol, attempted to work with the member to build awareness of the problem, identify supports, or those unhealthy supports, and engaged the person to attend the substance abuse group at the clinic. This is the only example of engagement by the SAS for members of ten records reviewed. In another record, documentation referenced beer cans, but it was not clear if the SAS was informed so follow-up could occur. The team approach focuses on harm reduction versus abstinence and the team works to help members build support networks in the community.	• The SAS reports prior training in a stage-wise approach to treatment, but no refresher trainings since joining the team in March. The provider and system should ensure ongoing and structured training is provided to all specialty staff, including integrated treatment for dual-disorders. For members with substance use challenges, the SAS should be a primary voice in driving team interventions for those members. Enhanced integrated dual-disorder training on a recurring basis may empower SAS staff across the system to intervene with members in a consistent manner, based on a proven model.

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S8	Co-occurring Disorder Treatment Groups	3– 5 (3)	The SAS co-facilitates a weekly hour long substance abuse group with the team nurse. Of the members with a co-occurring disorder, about 10-15 attend at least one group with the team per month, and a few other members occasionally attend. It is determined 20 – 34% of members with substance-use disorder attend at least one substance treatment group meeting each month.	• See recommendation for S7.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (4)	The SAS reports team interventions based on member stage of change, with most members in contemplation, pre-contemplation stage of change. The team refers to AA, at member request, and the team may accompany members to AA. The team uses detoxification treatment rarely, and only in cases where members are using substances that require the intervention. The team does refer some members to 24 hour co-occurring residential treatment. The team uses a dual disorder model primarily, offering treatment groups and engagement. The team rarely hospitalizes for rehabilitation or detoxification (except for medical necessity) and refers out some substance abuse treatment. Neither the SAS nor the team described abstinence as the goal, but rather focus on harm reduction.	• See recommendation for S7.
S10	Role of Consumers on Treatment Team	1 – 5 (5)	Members are employed full-time as ACT team staff (e.g., case managers) with full professional status. The team peer specialist position, vacant for a portion of the 12 month review period, was filled by September, 2014. Observation, interviews and documentation supports the peer specialist is a full-time staff member with the same expectations as other staff.	

Item #	Item	Rating	Rating Rationale	Recommendations
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	2
5. Continuity of Staffing	1-5	4
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	3
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	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	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	5
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	4
6. Work with Support System	1-5	1
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	**4.07**	
Highest Possible Score	**5**	