ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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ADHS Fidelity Reviewers

Method

On August, 5-6, 2015 Georgia Harris and Karen Voyer-Caravona completed a review of the Partners in Recovery - West Valley 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.

Partners In Recovery serves individuals with Serious Mental Illness (SMI) through five locations in Maricopa County: Metro, West Valley, Hassayampa (Wickenburg), East Valley, and Arrowhead. Each of these locations provides services such as Psychiatric, Case Management, Transportation, Interpreter Services, and Health & Wellness Groups. The PIR West Valley campus serves approximately 1,200 members and has one ACT team. Since last year's review, the ACT team has welcomed a new Clinical Director, Clinical Coordinator, additional Substance Abuse Specialist and an additional Nurse.

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 activities:

- Observation of a daily ACT team meeting (morning meeting).
- Individual interview with The Clinical Coordinator (Team Leader).
- Group interview with four members served by the ACT team.

- Individual interview with one of the identified Substance Abuse Specialists.
- Group interview with one Nurse and one Housing Specialist.
- Charts were reviewed for ten members using the agency's electronic medical records system, with assistance from the Team Leader.
- Review of ACT Admission Screening, ACT Presentation for the Doctor, and the ACT Morning Meeting log as provided by the Team Leader.

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 ACT team benefits from having two Nurses on staff. The ACT Nurse position is considered a critical ingredient in successful ACT teams. Having two Nurses expands the team's capacity for delivering vital services such as medication administration, health and wellness education, Primary Care Physician (PCP) coordination, and involvement in treatment planning.
- Beyond the *ACT Admission Screening* tool provided by the Regional Behavioral Health Authority (RBHA), the *ACT Assessment Presentation to the Doctor* is a thorough review of the key elements of the member's case. The ACT *Presentation* is also used as a rapport-building opportunity between the ACT staff and a prospective member, with the potential for a detailed cost-benefit analysis of the value of ACT services for the member. Every ACT staff is trained to conduct the admission screening and to present the results to the team.
- The ACT team takes full responsibility for crisis services. The approach used by the team is centered on providing after-hours care with the same intensity as during normal business hours.

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

- Maintaining a consistent staff roster is vital to the provision of reliable services, as well as establishing a therapeutic rapport with members. With approximately 50% of all staff members leaving the team within two years, some of whom were employed for one month, it is advantageous to explore candidate selection and exit interview procedures in depth. Tracking the satisfaction of current employees may also support agency strategies for improving employee retention.
- Overall, the staff views ACT services as rather time limited. ACT services are designed to be available for as long as the member wants them. Creating arbitrary time limits or transitioning without the member being fully confident in their ability to remain successful can cause regression. The team should prioritize retention until the member expresses full confidence in their ability to succeed in a lower level of care.
- In regards to inpatient hospitalizations, many team members expressed concern for the lack of communication between members, local hospitals and ACT team staff. The lapse in communication among entities has resulted in a few incidents where members have been transferred to out-of-county hospitals without the team's knowledge; in one of these episodes, the members died, and the team was never notified. ACT staff must continue to educate members on the benefits of ACT involvement in the decision to hospitalize. Moreover, the agency and RBHA should explore all opportunities to encourage improved sharing of pertinent member information across hospital and behavioral health systems.
- The team does not currently provide regular, direct, substance abuse treatment to members with co-occurring disorders. With the recent acquisition of a second Substance Abuse Specialist (SAS), the team should have an increased capacity to provide individualized treatment to members.
    - As the SASs become increasingly confident in their roles as service providers, they can begin to take leadership as advocates for treatment interventions that support an integrated, dual disorders treatment (IDDT) model. True IDDT supports the use of all ACT specialties such as employment and stable housing, while increasing assistance from family/support systems.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team's member to staff ratio is approximately 8:1. The team serves 85 members and has 11 ACT staff. The staff roster consists of the following: a Team Leader, an ACT Specialist, an Employment Specialist, a Housing Specialist, a Peer Support Specialist, two Nurses, a Rehabilitation Specialist, two Substance Abuse specialists, and a Transportation Specialist. The team is actively recruiting for an Independent Living Specialist. This count excludes the Psychiatrist and administrative support staff.	
H2	Team Approach	1 – 5 5	The team shares responsibility for the entire caseload. One-hundred percent of the ten randomly selected member records indicated that members had face-to-face contact with multiple staff members, in a two-week period. When asked about the team's strategy for ensuring that all members are seen, ACT staff stated that they have members who are primarily assigned to them, as well as weekly, rotating responsibilities with the remaining caseload.	
H3	Program Meeting	1 – 5 5	The ACT team meets four days a week for their morning meeting. On Monday, Tuesday, Wednesday and Thursday the ACT team meets from 9:30am-11am. All members are discussed at the morning meeting. The Team Leader stated that in-depth case staffings with the Psychiatrist are scheduled on an as-needed basis. When needed, staffings are scheduled on Thursdays or Fridays.	

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H4	Practicing ACT Leader	1 – 5 3	The data provided suggests that the ACT Team Leader provides routine backup coverage for the team. The Team Leader estimated approximately 15% of her time was allotted to direct service provision to members. The records selected for the chart review did not display any face-to-face services performed by the ACT Team Leader. However, like the other ACT staff, the Team Leader is assigned a weekly coverage route. ACT staff stated that the Team Leader's administrative duties will sometimes conflict with her ability to meet with the assigned members. In these instances, other staff will complete her coverage route.	• A practicing ACT Team Leader is highly correlated to improved member outcomes. Consider all options for administrative supports that will improve the ACT Team Leader's ability to provide direct service to members and mentoring to other ACT staff.
H5	Continuity of Staffing	1 – 5 3	Over the past two years, 12 ACT staff left the team. ACT staff stated that staff left for a variety of reasons. Some were terminated from the company, while others, who were employed for very short timeframes, quickly realized they were not the best fit for their positions. When asked about the candidate selection process, ACT staff stated that a "good employee" is one who is good at building rapport with other staff and is willing to help others in need.	• Implement and/or review exit interviews of previous staff members, with the intention of identifying imperative trends in employee retention. • Create strategies for screening potential candidates for key qualities in successful ACT staff (e.g., group and/or panel interviews with leadership and selected ACT staff to score candidates). • Tracking the satisfaction of current employees may also support agency strategies for improving employee retention.
H6	Staff Capacity	1 – 5 4	The team had 11 vacancies in the past 12 months, resulting in a 93% staff capacity. The team is actively recruiting for an Independent Living Specialist.	• Overall, the ACT team has maintained consistent, multidisciplinary services. However, improving the continuity of staffing (H5) could potentially improve

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				this item.
H7	Psychiatrist on Team	1 – 5 4	The ACT team is assigned one, full-time Psychiatrist. The team Psychiatrist is also the clinic's medical director. Staff report that the Psychiatrist is in full command of her caseload and her staff. The Psychiatrist was observed as informed and actively engaged in the treatment discussions for all members during the team meeting. ACT staff reported that the Psychiatrist is invested in the ACT caseload: however, her additional supervision responsibilities and leadership role in the organization prohibit her from being as accessible as they would like.	• Full fidelity in this item is tied to the complete dedication of the ACT Psychiatrist to the services of ACT members only.
H8	Nurse on Team	1 – 5 5	The ACT team currently has two full time nurses. The ACT staff report that both nurses are accessible and willing to provide physical and behavioral health support and education to all members. In addition to injectable medications and health monitoring, the ACT nurses provide PCP coordination for members who have authorized the team to assist them with monitoring their treatment with external providers.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team has two full time Substance Abuse Specialists (SASs). The first SAS has worked in her capacity on the ACT team since 2009, and the second SAS was hired a month preceding the review. When asked about prior training and professional experience, the Team Leader reported both SAS staff as having at least one year of training and/or experience in substance abuse treatment.	

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H10	Vocational Specialist on Team	1 – 5 5	The ACT team has two full-time Vocational Specialists. Both the Rehabilitation Specialist (RS) and Employment Specialist (ES) have been with the team in their capacities since 2009. The Team Leader stated that both staff participated in specialty-related, State and RBHA trainings over the years.	
H11	Program Size	1 – 5 5	The ACT team consists of 12 full-time staff for 85 members. The team is able to provide adequate coverage and diversity of staffing to the members served.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team uses the *ACT Admission Screening tool* (as outlined by the RBHA) as the initial screening for eligibility criteria. The team also provided the reviewers with a copy of their *ACT Assessment Presentation for the Doctor* – a tool used to gather member information pertinent to the team Psychiatrist. After assessing a member with the tool, the assessor (ACT staff) will present the member's case to the Psychiatrist and team, who in turn will decide if the member is admitted to the team.	
O2	Intake Rate	1 – 5 5	To support consistency in member services, the team maintains a low growth rate. The Team Leader reports that the team admits one member per week to ACT services, for a total of 4-5 members per month.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the ACT team provides two additional services, and refers externally to others. The ACT team provides psychiatric services and housing support. ACT staff report referring to network providers for	• Consider opportunities to assist ACT specialists to receive training and resources aligned with assigned specialties, so that a majority of services are provided to members by

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			supported employment programs, general counseling and individualized substance abuse treatment.	the ACT team.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team assumes full responsibility for crisis services for members. The ACT team is available to serve member 24 hours a day, seven days a week. ACT staff rotates responsibility for the ACT on-call phone on a weekly basis. The Team Leader serves as the backup responder to all crisis calls and is available for consultation to on-call staff at any time. When asked about the types of services provided to members using on-call services, the Team Leader stated, "We do our best to provide the same types of services that we would offer during normal business hours."	
O5	Responsibility for Hospital Admissions	1 – 5 3	Based on the data provided, the ACT team was involved in 60% of the ten most recent hospitalizations. ACT staff stated that they encourage members to call them if considering inpatient admission; however, there are members who choose to self-admit. Moreover, staff expressed their concern for a recent trend, in which local hospitals have not only denied the release of member information to clinical teams, but have transferred members to out-of-county hospitals without notifying the team. Staff discussed two recent episodes of this type, one of which the team was never notified of circumstances for hospitalization and ultimately, the death of the member. Staff stated they have been working diligently to educate members on	• The team should continue to build rapport and educate members on the benefits of ACT involvement in the decision to hospitalize. • The agency and RBHA should explore opportunities to improve communication with local hospitals on the inpatient status and condition of members.

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			the benefits of partnering with the team prior to hospital admission.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	The ACT team exhibits responsibility for hospital discharge planning. Information provided by the Team Leader indicated that ACT staff were involved in the ten most recent hospital discharges. Staff said that the ACT team begins discharge planning and working with hospital social workers from the day a member is admitted to the hospital. ACT staff transport members home from the hospital, assist with obtaining medications from the pharmacy, and schedule follow-up appointments with the team Psychiatrist.	
O7	Time-unlimited Services	1 – 5 3	Overall, the team views ACT services as rather time limited. The team articulated the need to transition members at their own pace. However, it was also stated that the team Psychiatrist provides the most direction in the matter. During the morning meeting, reviewers observed occasions where members where being identified for graduation from services when the primary ACT staff identified them as reluctant to graduate. The team expects to graduate ten to 15 members within the next 12 months.	• ACT services are designed to be available for as long as the member wants them. Creating arbitrary time limits or transitioning without the member being fully confident in their ability to remain successful can contribute to regression. The team should prioritize retention until the member expresses full confidence in their ability to succeed in a lower level of care.
S1	Community-based Services	1 – 5 4	Based on the records reviewed, the team performed 75% of all face-to-face contacts in the community. ACT staff stated they attempt to meet members wherever it is most convenient for them; however, there are occasions where staff will attempt to meet with members who are at the	• Continue to work towards making 80% of all face-to-face contacts with members in the community.

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			clinic for an appointment or a group.	
S2	No Drop-out Policy	1 – 5 5	The team has retained more than 95% of their members in the past 12 months. The Team Leader stated that most members who left the team were transferred to ACT teams at other clinics. Of the three members who terminated services, two dis-enrolled from PIR and one moved out of town without a referral to subsequent services.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The ACT team uses a variety of techniques to find members who have lost contact with the team. Staff reported the use of a weekly contact strategy, which includes a checklist of sources that should be contacted while in search of the member (e.g., the morgue, representative payee) Staff report using non-traditional means to locate members as well (e.g., Google, reverse phone number search). Staff also confirmed occasions when have chauffeured members home from out-of-state locations.	
S4	Intensity of Services	1 – 5 4	The available data indicates that members receive an average of 90.25 minutes of face-to-face contact per week. Staff encounter notes in the records revealed various types of interactions with members, including independent living skills training, medication monitoring, wellness visits, and crisis stabilization.	• Continued improvement in the quality of member encounters may positively impact this item.
S5	Frequency of Contact	1 – 5 4	The ten member records reviewed indicate that members received an average of 3.63 face-to-face contacts per week. Staff explained their contact strategy, which includes the use of both primary staff assignments and a zone-style coverage system (i.e. “fidelity box”). Staff are required to	• Continue the implementation of the current version of the member contract strategy as outlined by the ACT team leadership.

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			see both their primary members and their assigned fidelity box for one week. The fidelity box rotates among staff on a weekly basis.	
S6	Work with Support System	1 – 5 3	The data provided implies the ACT team provides occasional interaction with the members' support systems. Staff estimated that over 90% of staff had informal supports involved in treatment; however, it appears that approximately 30% to 35% of them actually had contact with the team regularly. It was also observed during the morning meeting that ACT staff made contact with the supports of approximately 30% of the members discussed. The record review indicated that the team averaged 1.5 contacts per month with the members' support systems. In addition, staff contacts with members' support systems were inconsistently documented throughout the electronic medical record. In addition, each ACT staff did not document support system contacts with a consistent encounter/documentation code.	• Focus on documenting team contacts with member support system(s) in a consistent fashion, to ensure this measure is being accurately captured. • Continue to educate members on the benefits of and encourage the involvement of informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 2	The team does not currently provide regular, direct, substance abuse treatment to members with co-occurring disorders. The staff indicated that members can discuss concerns with the SAS; however, these interactions are informal and unscheduled. The tenured SAS stated that most members in need of relapse prevention will meet with her for help. Most members who need individualized treatment are referred to external treatment programs in the provider community (e.g., Friendship, Terros).	• With the recent acquisition of a second Substance Abuse Specialist (SAS), the team should have an increased capacity to provide individualized treatment to members. The agency should provide the support and any additional training to ensure that the SAS provides this service within the ACT team.
S8	Co-occurring	1 – 5	The ACT team provides a Substance Abuse group	• Explore potential outreach and

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	Disorder Treatment Groups	3	one time weekly, exclusively for ACT members diagnosed with a co-occurring disorder. The ACT staff stated that 7-8 of 38 members diagnosed with a co-occurring disorder attend the weekly group. This group uses a curriculum supplied by the RBHA. In addition, the SAS use the principles from 12-step programs to supplement the RBHA program.	engagement strategies to increase member attendance to weekly co-occurring groups (e.g., open house, Motivational Interviewing, increased group offerings • If not already established, the RBHA should ensure appropriate training and education is provided to ensure the ACT teams are specifically following an established, stage-wise curriculum, such as Integrated Dual Disorders Treatment.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 2	The team acknowledges elements of harm reduction; conversely, it operates primarily from a traditional model for co-occurring treatment. The SAS indicated that the team uses detox, inpatient care and the 12-step model as recovery methods for members experiencing co-occurring symptoms. Staff encourage members to secure an Alcoholics Anonymous/Narcotics Anonymous sponsor once they complete treatment. Though the ACT staff interviewed expressed working knowledge of harm reduction principles, they framed them as a type of concession for those members who were not ready to be drug-free.	• As stated in S8, the RBHA should ensure appropriate training and education is provided to ensure the ACT teams are specifically following an established, stage-wise curriculum, such as IDDT. • Substance Abuse Specialists should serve as advocates among their clinical teams for clinical interventions that support the principles of IDDT treatment models. True IDDT supports the use of all ACT specialties such as employment and stable housing, while increasing assistance from family/support systems.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team currently has a full-time, fully integrated, Peer Support Specialist (PSS). The PSS provides member engagement and support services. The role of the PSS is seen as the vital connection between members and the clinical team, often	

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			serving as an advocate for members' needs to the team while clarifying clinical interventions to the members.	
Total Score:		**4.11**		

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	4
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	5
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	3
6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	3
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	4
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.11**	
Highest Possible Score	**5**	