ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: Jennifer Starks

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ADHS Fidelity Reviewers

Method

On July 13-14, 2015 Jeni Serrano and T.J Eggsware completed a review of the Osborn 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 *Southwest Network* Provider Network Organization (PNO) serves over 7,600 adults who are identified as having a Serious Mental Illness (SMI) in Maricopa County, Arizona. Located in the metropolitan Phoenix area, the Osborn Adult Clinic is easily accessible to its members by public transportation. Using various classroom and office spaces, the Osborn Adult Clinic offers an array of clinical services and other activities to its members via the clinical/professional staff and auxiliary co-located service providers (e.g. Terros, DKA Employment Services). At the time of this review, the Osborn ACT team was comprised of nine staff members who served a caseload of 95 individuals. The tenure of the ACT team staff ranges from six years to two months.

Throughout this report, the term "member" will be used when identifying individuals who receive services through the ACT team.

During the site visit, reviewers participated in the following activities:

- Observation of a daily ACT team morning meeting.
- Individual interview with Clinical Coordinator (CC).
- Group interview with 4 members receiving services through the ACT team.
- Individual interviews with Substance Abuse Specialist (SAS), Peer Support Specialist (PSS) and Rehabilitation Specialist (RS).
- Charts were reviewed for 10 members using the agency's electronic medical records system.

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 currently has two full-time nurses that function as full members of the team, including conducting home visits, community medication observation rotation with other team staff, participation in treatment planning, administering medications, attending daily morning meeting, and offering education to the members and the staff.
- The CC is currently on the rotation for medication observations, and provides outreach and engagement for members of the team.
- The team aims to provide consistent, individualized, and comprehensive services to members, by taking new members at a low rate to maintain a stable service environment.
- The team does not immediately amend or discharge members from services due to failure to keep appointments, or for lack of engagement. The staff is persistent and use street outreach as well as having the nurses come to them to administer medications in an attempt to engage and educate members in treatment.

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

- The agency needs to evaluate administrative duties and activities of the CC in order to increase community direct service percentage. It is recommended that she increase to spend at least 50% of the time providing direct services.
- Administrative responsibilities of the psychiatrist outside of the team should also be monitored to maximize psychiatrist availability to the team.
- The agency needs to fill the ACT staff open positions as soon as possible, for it appears many of the reduced scores over last year are due to the shortage. This will help to decrease caseload size, to support a team approach, and to increase the intensity, frequency, and diversity of services provided through the team.
- The team needs to increase their efforts to involve members' identified support system. It is recommended that the team support and encourage members to identify their informal supports (i.e., people not paid to support members, such as family, landlord, neighbor, friend) and then assist them in acquiring the knowledge, resources and skills needed to support members.
- Services should be delivered primarily in the community and not the office setting; the team should identify what services are currently delivered in the clinic setting that can be provided to members in the community.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (4)	The member to staff ratio for this team is above 10:1. This count excludes the Psychiatrist and the administrative support staff. At time of review this team was short three staff, Employment Specialist, ACT Specialist, and second Substance Abuse Specialist, bringing caseloads to 12:1.	• The agency needs to fill the open positions and focus on staff retention in order to ensure that caseloads are at the 10:1 range for adequate intensity and individualization of services.
H2	Team Approach	1 – 5 (3)	The team reported that the entire team shares responsibility for each member on the team, however, through review of the records, data showed that only 60% of members have been seen by more than one team member in a two-week period. Staff estimated that approximately 50% of members see more than one staff person over a typical two week period.	• The agency leadership needs to ensure that the members are being seen by each staff member on the team rather than only their assigned primary case manager. • Team needs to plan encounters focused on needs of members and allow each staff person to contribute based on their area of expertise, as appropriate.
H3	Program Meeting	1 – 5 (5)	The team meets four days a week for the daily morning meeting and the expectation is that all staff on the team is to attend. The psychiatrist attends morning meetings three out of the four days due to her flex schedules. All members on this team are discussed, even if only briefly.	
H4	Practicing ACT Leader	1 – 5 (3)	The CC reported that she increased her member contacts since last year's review. CC reported that she continues to conduct occasional hospital visits, occasional face-to-face contacts, is now assisting with medication observations, and outreach. Evidence of CC outreach was documented in some records but is not considered direct service unless contact is made with the member. The CC has administrative duties through the clinic that pose some limitation to providing direct services to members. Based on records reviewed and productivity	• CC needs to increase direct services to 50% in order to remain in touch with the members served by the team and model appropriate clinical interventions. • The agency needs to review CC's administrative duties and clinic activities and consider if there are any other supports at the clinic who could assist in completing some or all of those tasks which may allow for the CC to increase direct service to members.

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			reports, the CC provides services as part of her regular schedule, but direct face-to-face services by the CC occur less than approximately 10% of the time.	
H5	Continuity of Staffing	1 – 5 (3)	The team experienced 50% turnover in 2 years with 12 staff leaving positions.	• If not in place, the agency should consider using staff satisfaction surveys to determine what is working to retain staff as well as staff exit interviews/surveys to determine what contributes to staff turnover.
H6	Staff Capacity	1 – 5 (4)	There were 23 total vacancies over the 12-month review timeframe. The vacancy rate for the 12 months prior to review was 84%. There was transition on the team over the past year; one position was eliminated (Transportation Specialist), a new position was added (second nurse), and the team is seeking a second SAS.	• See comment for H5 above.
H7	Psychiatrist on Team	1 – 5 (4)	The Psychiatrist assigned to the team remains the same as last year's review. The Psychiatrist's work schedule remains full time, working a four-day, ten - hour flex schedule Monday through Thursday. She is the lead doctor for both the Southwest Network Highland and Osborn clinics and continues to provide monthly supervision to the doctors at both clinics. Per interviews it was reported that the Psychiatrist is available to the team, but that she also has demands outside of her role as Psychiatrist on the team. One staff estimated, conservatively, at least 20% of the Psychiatrist's time is spent with duties outside the ACT team. These include: covering other psychiatrists, conducting mortality reviews, medical meetings, court ordered meetings at the other assigned clinic, all doctor meetings,	• The agency needs to review the Psychiatrist's administrative duties and other clinic coverage responsibilities in order to minimize any activities outside of the ACT team.

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			supervision of other psychiatrists and interns. One example of these activities arose during the morning meeting observation when there was discussion between the psychiatrist and CC regarding a scheduled activity that did not appear to pertain to serving members on the team. The staff reported the Psychiatrist is accessible, but they are aware she has other duties outside of the team. It is not clear if these other duties result in reduced Psychiatrist availability beyond the conservative 20% estimate referenced above.	
H8	Nurse on Team	1 – 5 (4)	As of April 13, 2015, the team has two full-time nurses assigned to the team. The CC reported that both nurses function as full members of the team, which includes conducting home visits, participation in treatment planning, and attending the daily morning meetings. Both nurses help administer medications and offer education and coordination as needed. The CC stated during the interview that she has seen the advantages of having two nurses on the team; she has seen the benefits from having the nurses go out into the community and meet people who may have barriers to attending clinic appointments. Additionally, having the nurses conduct more home visits has decreased the fears of medications, with increased rapport and engagement. Although the team is assigned two nurses, it is estimated by staff that up to 30% of their schedules may be utilized for members outside of the ACT team. One of the two nurses is the lead nurse at the clinic with approximately 5% of time addressing	• The agency needs to refrain from assigning the nurses additional duties or pulling them to cover other teams and have them remain full-time and readily accessible for the ACT team only. • The agency should train and educate other staff at the clinic regarding the purpose of having two nurses assigned to the ACT team, which could help minimize requests for nursing activities outside of the ACT team.

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			responsibilities of that role.	
H9	Substance Abuse Specialist on Team	1 – 5 (3)	The team has one full time SAS on the team with at least one-year training and experience. Per staff, the agency is seeking a licensed SAS to fill the vacant position. Licensure or state certification is desirable, but not required to meet the requirement in this area.	• The team should have at least two staff members on the team with at least one year of training or clinical experience in substance abuse treatment, per 100 members. • Continue efforts to recruit experienced staff for the SAS position.
H10	Vocational Specialist on Team	1 – 5 (1)	The team currently has one full-time RS on the team with minimal training and experience in vocational rehabilitation and support. Since the last year review, the team has experienced staff turnover. There have been vacancies in both the rehabilitation specialist position and employment specialist position throughout the year. The employment specialist position remains vacant at the time of this review. I It was noted during interviews and chart reviews that the team relies on referring members to outside providers for vocational services.	• The team should have at least two staff members with at least one year of training/experience in vocational rehabilitation and support. • Ensure that vocational staff are receiving regular trainings and have the support to provide direct services. • Ensure vocational supports on the team assist members with rapid access to employment rather than relying on outside referrals to vocational support service providers.
H11	Program Size	1 – 5 (4)	The team currently has nine staff including the psychiatrist (excluding administrative support staff). The team has three open positions making it less than adequate staff size.	• The agency needs to fill open positions to ensure team provides necessary staffing diversity and coverage.
O1	Explicit Admission Criteria	1 – 5 (5)	The team has written admission criteria. The CC reports that she continues to utilize an *ACT Admission Screening* form provided by the Regional Behavioral Health Authority (RBHA); an *Osborn ACT Team Pre-Referral Form* which further evaluates the appropriateness of the referral for this location; and an *ACT Criteria Checklist for New Referrals*. All of these documents were provided for this review. ACT CC reported that during this past year she was not required to accept any referrals that were	

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			determined inappropriate for ACT services; the team has the final determination whether to accept or deny referrals.	
O2	Intake Rate	1 – 5 (5)	The team continues to take in members at a low rate. The team reported one intake per month for January – May, 2015. The highest intake month recorded in the past six months was two for the month of June 2015.	
O3	Full Responsibility for Treatment Services	1 – 5 (3)	In addition to case management, the team directly provides psychiatric services and housing supports. However, the team continues to refer externally for counseling/psychotherapy, substance abuse treatment and employment/rehabilitation services. Those members currently on the team who receive housing support services generally receive the support through the team; however, the team does rely on referrals to residential services and transitions members who are in those settings off of the team.	• Ensure vocational supports on the team assist members with rapid access to employment rather than relying on outside referrals to providers for vocational services. • The team should directly provide substance abuse treatment, including individual treatment, without relying on outside providers. • The team should request training for any of the areas above they do not feel they are equipped to provide. If other barriers exist to providing the full range of services those issues should be discussed with the agency and the RBHA to find resolutions.
O4	Responsibility for Crisis Services	1 – 5 (5)	The team continues to offer 24-hour, seven days a week crisis coverage directly. The team continues to rotate an on-call phone; the CC provides emergency service backup all the time. Per morning meeting observation, some members did contact the on-call for services.	• During member interviews, some members stated that they did not know who to call on the team after hours. The team should ensure members are aware of the 24-hour service through the team, including who to call, and back up contacts through the team.
O5	Responsibility for Hospital Admissions	1 – 5 (4)	Staff reported their goal is try to work with members to divert hospitalizations by providing support to assist members to stay safe and healthy in the community. Based on data provided, overall the team remains involved in most hospital	• The team should continue to work with members to discuss the pros and cons of informing the team of issues that may lead to hospitalization; attempt to address barriers to the team not being involved in

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			admissions. Staff report some members elect to self-admit. One staff estimates the team is involved in about 85% of admissions. The team was involved in eight of the prior 11 (82%) admissions based on data provided.	all admissions.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	Staff reported that they were involved in all 10 of the most recent hospital discharges, and are generally involved in all discharges. The staff stated that they continue to visit members in the hospital every 72 hours, as well as maintain regular contact with hospital social workers for discharge planning.	
O7	Time-unlimited Services	1 – 5 (5)	In the 12-month period prior to this review, three members graduated (i.e., need for services was reduced), and the CC projected a 2% graduation rate for the upcoming 12 months. The CC reported that the team does not have arbitrary time limits for members admitted to the team and remains the point of contact for those who transfer for higher level of care until they are transitioned and stable.	
S1	Community-based Services	1 – 5 (2)	Though staff estimate contacts with the member in the community occur 40-60% of the time, it is not clear if most services occur in the community, based on member report and documentation. Per 10 member records randomly selected for review, the ratio of services delivered in the community verses those delivered in the office decreased slightly from last review. These records showed a median of 20% face-to-face contacts in the community.	• The agency and CC need to review staff duties and activities to assure that staff are supported to spend at least 80% of total service time in the community. • The team Psychiatrist should consider increasing community-based services.
S2	No Drop-out Policy	1 – 5 (4)	The team reports that they continue to engage and retain members at a 92% rate. During the 12 months reviewed, seven members refused services and one member moved without referral. Another factor for consideration in this area, based	• The team and agency should review the reasons members leave the team or refuse services; the team may benefit from additional training or support (e.g., motivational interviewing or other structured intervention techniques).

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			on data provided, is the fact that five members transitioned off the team due to placement in residential treatment settings.	• The team, agency and RBHA should evaluate why the ACT team is referring members to 24 hour-residential treatment. Consider whether services through a fully functioning ACT team (e.g., substance abuse treatment, housing support services) may more appropriately meet member needs over residential treatment services.
S3	Assertive Engagement Mechanisms	1 – 5 (5)	The team reported that they continue to be persistent in outreach and engagement. During the morning meeting, outreach was discussed, ranging from status updates to further planning needed. During CC interview, she further explained the lengths the team goes to in order to find a member as well as techniques staff uses to engage members who do not want to engage. CC confirmed that there is a process and protocol, using an outreach checklist, to follow when members need outreach. Team outreach efforts are discussed in the morning meeting.	
S4	Intensity of Services	1 – 5 (2)	Ten member charts were reviewed to determine the amount of face-to-face service time spent with each member. The sum of the face-to-face service times was determined for each member. The median service time per member is 35.9 minutes/week.	• The team needs to increase service intensity per member and decrease services through outside agencies.
S5	Frequency of Contact	1 – 5 (2)	Ten member charts were reviewed to determine the amount of times per week each member is receiving contact from the ACT staff. The calculated team median face-to-face contacts per member was 1.6 per week. This is significantly lower than last year's review that noted 4 or more contacts per week for each member. Staff reported that being assigned other duties to cover missing staff takes away from direct service time.	• The agency should work on filling staff vacancies as soon as possible, and new staff should be trained on the important benefits of the high frequency of member contacts, with a goal of at least 4 face-to-face contacts per week, per member.

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S6	Work with Support System	1 – 5 (2)	The CC reported if a family member or supports are involved, team has several contacts per week depending on individual's needs. However, based on record review, there is less than one contact per month for each member. Staff report some members do not have informal supports.	• The team needs to encourage members to identify external supports and discuss with them the benefits of involving supports in treatments. • Once a member identifies a support, the team should maintain contact consistently to support members who are doing well as well as to proactively identify and address potential issues if necessary.
S7	Individualized Substance Abuse Treatment	1 – 5 (1)	The CC reported that 64 out of 95 members on the team are identified with co-occurring disorder. The team reported that they do no direct, individualized substance abuse treatment because they are not permitted to offer treatment due to not having licensed substance abuse counselor on the team. Licensure or state certification is desirable, but not required to meet the requirement in this area per the SAMHSA model. Based on staff report and morning meeting observation, it appears the SAS provides initial engagement, but the team utilizes outside providers or a co-located provider for individualized substance abuse treatment.	• The team should directly provide substance abuse treatment, including individual treatment, without relying on referrals to outside providers that are not integrated into the team. • The team, agency, and RBHA should collaborate to clarify state licensure requirements to provide individual treatment, or if the service can be provided by a non-licensed staff under supervision of a licensed staff.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	The SAS specialist reported that she facilitates one group per week for one hour. The team uses a curriculum developed by the RBHA, but staff are not clear if the information follows a specific model of treatment. Of the 64 identified co-occurring members on the team, staff estimated that seven to 10 members attend this group weekly. As a result, it is estimated that 11-16% of members with substance-use disorders attend at least 1 substance abuse treatment group meeting a month.	• Agency needs to provide training to SAS in integrated dual diagnosis stage-wise approach to treatment. • Engage members with dual diagnosis to attend substance abuse treatment groups through the team.

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S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (2)	Staff reported abstinence is viewed as the ultimate goal using a harm reduction model, and increased use of motivational interviewing techniques. It is not clear if all staff are familiar with a stage-wise approach to treatment, and staff confirm the team refers to AA and inpatient detox. Although staff use a standard curriculum in group treatment, they are not clear what model the curriculum follows. During morning meeting and in documentation reviewed, it did not appear that staff used a formal dual treatment model.	• Agency needs to provide training to staff in integrated dual diagnosis stage-wise approach to treatment such as IDDT and use this as the standard approach when working with members who have co-occurring disorders.
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 reported during interview that she has been on the team for five years and she works full time with same expectations as other staff.	
Total Score:		**3.46**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	3
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	4
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	1
11. Program Size	1-5	4
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

6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	1
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.46**	
Highest Possible Score	**5**	