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

Date: January 10, 2015

To: Laurie Senyk, Site Administrator

From: Georgia Harris, MAEd
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ADHS Fidelity Reviewers

## Method

On December 8-9, 2014, Georgia Harris and Karen Voyer-Caravona (Fidelity Reviewers) completed a review of the Partners in Recovery (PIR) Metro Center Campus' Varsity Assertive Community Treatment (ACT) team. For the remainder of this report, this team will be identified as PIR-Varsity. 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 Partners In Recovery Network Organization (PNO) 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 Metro Campus serves approximately 1,200 members and has two ACT teams. This report will focus on the PIR-Varsity ACT team.

The individuals served through the agency are referred to as members.

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

- Observation of a daily ACT team meeting.
- Individual interview with the ACT Team Leader.
- Individual interviews with the identified Substance Abuse Specialist, the Peer Support Specialist and one identified Vocational Specialist.
- Group interview with seven members receiving ACT team services.
- Charts were reviewed for ten clients/consumers using the agency's electronic medical records system, with assistance from 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 areas:

- The Varsity ACT team provides timely, regular, community-based services.
  - Their zone coverage plan is designed to ensure visits by multiple staff; members have face-to-face contact with multiple staff members more than 90% of the time.
  - The team prioritizes providing services in natural settings; more than 80% of total face-to-face contacts are in the community.
- The team benefits from experienced, committed leadership, and staff who take pride in the services they provide.
  - The team and the Psychiatrist work synergistically to conduct home, hospital and clinical visits, and readily share responsibilities for member monitoring.
  - The Team Leader understands the complexities of the behavioral health system and readily helps the staff and members to identify available resources for needs, and effective procedures for member monitoring. Both the Team Leader and Psychiatrist facilitate staff educational/supervision opportunities as needed.
  - The Peer Support Specialist (PSS) is fully-integrated and provides the team with additional perspectives, solutions, and support with member challenges.
- The team is committed to member wellness in both physical and behavioral healthcare. The staff and Psychiatrist coordinate physical health appointments with members' primary care physicians (PCPs) as well as the Integrated Health Home (IHH) clinic doctor on-site.

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

- Monitoring a core set of outcomes will improve the team's ability to assess its effectiveness in responding to members' needs. These outcomes include: psychiatric or substance abuse hospitalization, incarceration, housing stability, independent living, competitive employment, educational involvement, stage of substance abuse treatment, and involvement of member

supports. Though the team does monitor most of these items in some fashion, allowing the specialists for each domain to assume primary responsibility for tracking and treating members for these areas is a critical feature of the ACT model. In addition to tangible data, this will allow specialists to function in their primary role.

- When specialists function in their primary assignments, case management functions will become tailored to member needs; not team coverage schedules, reporting criteria, billable minutes, etc. Currently, the team averages less than 50 minutes of face-to-face weekly contact per member.  Decreasing the use of brokered services though outside agencies, sharing and/or reassigning staff responsibilities should increase the amount and intensity of services by the ACT staff.
- Substance abuse specialists should provide individualized substance abuse treatment and groups according to an Integrated Dual Diagnosis Treatment model. Using a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions between mental illness and substance abuse, and has gradual expectations of abstinence.

## ACT FIDELITY SCALE

| Item # | Item | Rating | Rating Rationale | Recommendations |
|---|---|---|---|---|
| H1 | Small Caseload | 1 – 5<br>5 | The team benefits from a small caseload. Per the team roster, the team roster consists of: (1) Team Leader, (1) Substance Abuse Specialist, (1) Rehabilitation Specialist, (1) Employment Specialist, (1) Independent Living Skills Specialist, (1) Housing Specialist, (1) Nurse, (1) Transportation Specialist, (1) Peer Support Specialist and (1) Mental Health Worker. The team serves 98 people. The ratio of members to staff is 9.8:1. This count excludes the Psychiatrist and any administrative support. | • The agency and the ACT Team Leader should continue to monitor and manage the team's caseload at a ratio below 10:1. |
| H2 | Team Approach | 1 – 5<br>5 | The ACT team provides services as a team; members have face-to-face contact with multiple staff members more than 90% of the time. Each staff member is assigned primary members, as well as a "zone" coverage route each week. If any of their primary members are assigned to their zone route for the week, the staff is required to "trade" coverage for those members with members on another route. This ensures that each member will be seen not only by their primary staff, but also by other members of the team. The chart review indicated that 100% of members were seen by multiple staff member in a 2 week period. | |
| H3 | Program Meeting | 1 – 5<br>5 | The ACT team meets as a group four days a week, and reviews every member at each meeting. The PIR-Varsity meeting schedule is Tuesday through Friday, from 9:00am – 10:30am. The expectation | |

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| | | | is that every staff member is in attendance (including the Psychiatrist and the Nurse). It was observed that each staff came prepared to discuss the caseload and provided feedback for each person discussed. The Psychiatrist provided insight on members and their conditions to the staff in an active and engaging way. | |
| H4 | Practicing ACT Leader | 1 – 5<br>3 | The ACT Team Leader provides direct services to members less than 25% of the time. Per staff interviews, the Team Leader performed the administrative duties for the team, provided back up assistance with zone coverage, and conducted hospital visits as needed. Upon review of productivity reports, the Team Leader met with members face-to-face 22% of the time. | • Review Team Leader administrative requirements to confirm if all duties are required through the PNO/RBHA.<br>• If all administrative activities are deemed essential, determine if there are other clinical supports that could acquire these tasks, releasing the Team Leader to provide increased direct service to members. |
| H5 | Continuity of Staffing | 1 – 5<br>3 | The ACT team has had 10 staff members leave over the past 2 years. Five team members left in 2013, and five left in 2014. This resulted in a 41.7% turnover rate. Staff did not cite the exact reasons for team member turnover, however, it was stated numerous times that the role and functions of the ACT team are often misunderstood and undervalued by other groups (i.e. hospitals, law enforcement, other RBHA/PNO entities, etc.) | • Examine employees' motives for leaving the team. Employee exit interviews can help to determine trends in employee turnover. This may be an area of further ongoing network, clinic and system review.<br>• Consider implementing experiential hiring practices such as job shadowing for potential new ACT team staff, particularly for those job candidates new to the ACT model. |
| H6 | Staff Capacity | 1 – 5<br>5 | The team has maintained consistent, multidisciplinary services by operating at more than 95% of full staffing capacity, in the past 12 months. The team recently lost one Substance Abuse Specialist and is in the process of filling that vacancy. | |
| H7 | Psychiatrist on Team | 1 – 5<br>5 | The team has a full-time Psychiatrist whose assignment is dedicated to ACT members. Team | |

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| | | | members report that the Psychiatrist is open to input from the staff and prefers when they can be a part of the member's appointments with him. The Psychiatrist conducts home visits with staff members on Thursdays and provides supervision to the team as needed. According to ACT staff, the Psychiatrist will only provide coverage for other teams on rare occasions (i.e. another doctor is out of the office for the day). | |
| H8 | Nurse on Team | 1 – 5<br>3 | The team has only one nurse for a team caseload of 98 members. The team recently acquired a nurse in December 2014. The nurse is assigned only to ACT members. Though she is new to the team, the staff values her flexibility, accessibility, and willingness to go out into the community. | • Determine options for obtaining an additional nurse. Nurses function as full members of the team and serve as educators to both members and staff. Two nurses will ensure flexibility and availability of medical services such as injections and labs in the community and at the clinic. |
| H9 | Substance Abuse Specialist on Team | 1 – 5<br>1 | The team currently has one assigned substance abuse specialist (SAS). Though there is an assigned SAS, the review team was unable to verify that the SAS has at least one year of verifiable training or clinical experience in substance abuse treatment at this time. Staff interviews verified that the SAS is new to this role and is currently undergoing training for this function. | • Review training options for current and new hires to ensure staff designated with a substance abuse specialty receives monitoring, support and education in their role, for the population served. Ideally, the SAS would be hired with the required specialty training and certification. Assure that the designated Substance Abuse Specialists are providing co-occurring disorders specific individual and group counseling sessions (See items S7 & S8). |
| H10 | Vocational Specialist on Team | 1 – 5<br>5 | The team has identified two vocational specialists: (1) Rehabilitation Specialist (RS) and (1) Employment Specialist (ES). Per staff interview, both team members work together to | • Continue to ensure vocational supports on the ACT team assist members with rapid access to employment rather than relying on referrals to outside providers. |

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| | | | provide services and referrals for members. The RS assesses member needs and provides referrals to community services agencies that are in line with the member preferences (i.e. peer run organizations for social goals, etc.). The ES assesses the member's readiness for employment. Once determined, the ES will either help the member directly with a job search or refer members to a Supported Employment provider for services. | Though supportive level clinical teams may benefit from the use of Supportive Employment providers, high fidelity ACT views the team specialist(s) as the primary clinician/practitioner in their area. Providing additional educational opportunities/access to resources will strengthen staff's ability to provide services in this manner. |
| H11 | Program Size | 1 – 5<br>5 | The ACT team consists of 11 full time staff. The program is sufficient size to provide necessary staffing coverage. | |
| O1 | Explicit Admission Criteria | 1 – 5<br>5 | The team has a clearly defined population and uses defined criteria to screen out inappropriate referrals. The ACT Team Leader stated that the team focuses on members who have had frequent hospitalizations, homelessness, those who need help with medication adherence, and those who are in need of more frequent engagement. The Team Leader (and multiple team members) confirmed that the team is in full control of the admission process and they provide direction to referring teams on supports they can implement for members who are not ACT appropriate. | |
| O2 | Intake Rate | 1 – 5<br>5 | The program maintains a low growth rate to maintain stability of service delivery. The team has had eight admissions in the past six months. The ACT Team Leader stated that the team limits admissions to two new members a month. | |
| O3 | Full Responsibility for Treatment Services | 1 – 5<br>4 | The team provides four of the core ACT services, including housing services, independent living skills, employment services, and rehabilitation services. The team does not provide | • Consider options that will minimize the need for the team to refer to outside agencies for services that are to be provided by the ACT team (e.g., |

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| | | | counseling/psychotherapy.<br>The team does not have licensed staff to provide individual counseling/psychotherapy or individualized counseling for substance abuse. The team refers to external sources for this function. | vocational services).<br>• At the network and RBHA level, explore training and educational opportunities for staff that lead to certification or licensure to facilitate the provision of individualized counseling and substance abuse treatment. |
| O4 | Responsibility for Crisis Services | 1 – 5<br>5 | The ACT team provides 24-hour coverage for members. Per Team Leader, the staff rotate coverage on the on-call phone. Members may call the team directly or call the crisis line. The crisis line will contact the team when they receive a call. Staff will contact the Team Leader if a decision needs to be made regarding visits to members in crisis. | |
| O5 | Responsibility for Hospital Admissions | 1 – 5<br>3 | The team was closely involved in 40% of the last 10 hospitalizations. Staff stated that there are members and family supports that will call the team to notify them of their intent to hospitalize a member. In the case of voluntary hospitalizations, the team's protocol requires a face-to-face meeting between the member and the team Psychiatrist for assessment. If the Psychiatrist recommends inpatient hospitalization, the team will work with the member as to choice of hospitals. Others were admitted to the hospital for medical reasons and subsequently transferred to or self-admitted to behavioral health units. | • It is recommended that the PNO/ACT team continue efforts to collaborate with hospitals, clinics, and area human service programs that could share information about potential crisis leading to a hospital admission.<br>• The ACT team should continue to educate members on the benefits of ACT team involvement in the decision to hospitalize, particularly the opportunity to provide additional supports that may avoid the need to hospitalization. |
| O6 | Responsibility for Hospital Discharge Planning | 1 – 5<br>5 | The ACT team is involved in more than 90% of all hospital discharges. Each ACT staff, excluding psychiatrist, RN and Team Leader, has the responsibility of visiting members (from their assigned zone) that are hospitalized three times | |

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| | | | weekly. The Psychiatrist and Team Leader are involved in discharge planning with hospital doctors and staff; moreover, both of them conduct hospital visits. | |
| O7 | Time-unlimited Services | 1 – 5<br>4 | The team has graduated 3 members in the past 12 months; however, they intend to graduate 10 members within the next year, due to significant improvement The ACT team works closely with the Psychiatrist to identify members who have reduced their dependence on the ACT services and have not had a major crisis or hospitalization for a year. If the member agrees, they will graduate to a supportive or connective team. They will remain open with the team for approximately 45 days before closure. | • In high fidelity programs, ACT teams remain a point of contact for all members indefinitely. Members often regress when stable, therapeutic relationships are disrupted; even for positive reasons (i.e. graduation). PNO/ACT teams should allow members who are showing improvement to modify services rather than discharging them from the team, unless a transfer to supportive/connective teams is requested. |
| S1 | Community-based Services | 1 – 5<br>5 | The team prioritizes providing services in natural settings; more than 80% of total face-to-face contacts are in the community. Staff and member interviews and the observation of the team meeting suggest that the team has also internalized the importance of meeting with members in their natural setting rather than in the clinic. | |
| S2 | No Drop-out Policy | 1 – 5<br>5 | The team has retained more than 95% of their caseload over the most recent 12-month period. Of the members who did terminate services, one was in need of intensive medical services; another member was fully independent and felt the ACT services were “too intrusive”. The Team Leader stated that the third member was not interested in taking psychiatric medications and did not want psychiatric services in any form. The Team Leader also stated that no members are officially discharged from the team unless they | |

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| | | | provide a plan to the team, explaining how their behavioral health needs will be met once they are closed. Most times, the Psychiatrist will scheduled a *doctor-to-doctor* phone call with the member's new psychiatrist or their PCP. | |
| S3 | Assertive Engagement Mechanisms | 1 – 5<br>5 | When members miss an appointment, the team will attempt to contact them by phone or email. If there is no response, the team will send a certified letter to their home. The team will then begin to conduct home visits every day until the member is found. Part of the team's strategy for retention includes working with members to develop a care plan for themselves, should they decide to discontinue ACT services. | • Continue to expand on assertive engagement mechanisms that reach membership in their community. Aside from home visits, conduct regular searches at other entities (i.e. hospitals, morgues, jails, etc.) |
| S4 | Intensity of Services | 1 – 5<br>2 | The team spends under 50 minutes per week in total service time per member.<br>Ten member records were reviewed to determine the amount of face-to-face service time spent with each member. The median face-to-face service minutes across the ten member records fell within a range of 15-49 minutes per week.<br>The record review showed that staff were meeting with members regularly, but for small increments of time. Many of the encounters were medication observations or wellness checks. These encounters ranged from 2 -10 minutes per session. Staff stated that many of the new requirements they have makes it difficult to spend "quality time" helping members for extended periods of time. One staff stated the intense interactions are what made their job most meaningful and is hoping for changes that | • The ACT model is designed to deliver intense, frequent face-to-face services to members in their own communities. This is not reflected in the records that were reviewed. The ACT model takes into account the occurrences where members have "stepped down" in their services; however, this must also be reflected in the member record.<br>• Explore what actions the team might take that could result in higher service intensity per member (e.g. increase in services through ACT staff, decrease in brokered services though outside agencies, sharing and/or reassignment of staff responsibilities, etc.). Management should also review what the "new requirements" are that staff feel is interfering with quality time with members, and if these are all necessary. |

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| | | | will revive that element of ACT services. | |
| S5 | Frequency of Contact | 1 – 5<br>4 | The team delivers a high number of services contacts, averaging 3-4 contacts, per member, per week. Ten member charts were reviewed to determine the amount of times per week each member is receiving contact from the ACT staff. Staff and member interviews confirmed the members were being seen frequently by the ACT team staff. | • Continue to outreach members and conduct weekly services activities with members as needed. |
| S6 | Work with Support System | 1 – 5<br>3 | The team provides support to the members' informal support network as needed. The record review captured very few informal support contacts. However, when asked, team members were able to easily identify the support network of most members on the team. Approximately 69 of the 98 members had informal support contacts, with an estimated eight contacts per month. The results from the record review and the staff reporting were combined, resulting in an average of approximately 2 contacts per month. | • Focus on documenting team contacts with member support system(s) to ensure this measure is being accurately captured. |
| S7 | Individualized Substance Abuse Treatment | 1 – 5<br>1 | No direct, individualized substance abuse treatment is being provided to members from the ACT team. The team serves 53 members who are identified with a co-occurring disorder. The SAS did state that individual counseling is needed; however it is provided by an outside source. Staff report that they are prohibited from providing this service because they are not licensed substance abuse specialists. Currently, members are referred to external treatment programs for this service. | • Review team, provider, and system options related to securing or training staff to provide individual substance abuse treatment in a structured, measurable manner. |
| S8 | Co-occurring Disorder Treatment Groups | 1 – 5<br>2 | The ACT team provides one treatment group per week. The ACT Substance Abuse Specialist (SAS) uses a curriculum guide named *ACT Team* | • Review the substance use treatment groups curriculum to ensure a co-occurring disorders treatment model is |

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| | | | *Substance Abuse Group Curriculum.* This guide was created by the RBHA. Multiple staff stated that the workbook provides general directions for conducting groups but does not represent a formally- structured, meeting-by-meeting curriculum for an identified stage-wise approach. Approximately 6-8 of the team's 53 members with an identified co-occurring disorder attend the weekly group. | utilized. Several good manuals contain curriculum and strategies to engage clients in co-occurring stage-wise treatment groups.<br>• Ensure that staff facilitating co-occurring disorder treatment groups document and/or summarize member progress and level of participation in the member record at least on a monthly basis. Tracking member progress (or lack thereof) will help staff target their groups to members' specific needs. |
| S9 | Co-occurring Disorders (Dual Disorders) Model | 1 – 5<br>3 | The team uses a mixed model in approaching co-occurring disorder treatment. Staff members confirmed that confrontation is a technique used when members attend group under the influence of substances. Team members report attempting to use stage-wise approaches. However, there is no documented evidence that the stage-wise approaches are being applied in any formal way. Staff use hospitalization and detox routinely, but also embrace harm reduction techniques whenever possible. The SAS stated that she will often utilize the Peer Support Specialist in instances when harm reduction techniques are needed. | • At the team, PNO and RBHA level, continue efforts to provide education and training on Integrated Treatment for Co-Occurring Disorder as a stage-wise treatment approach. Standardizing basic tenant of treatment may help ensure consistent interventions across the system. |
| S10 | Role of Consumers on Treatment Team | 1 – 5<br>5 | The team has a fully-integrated Peer Support Specialist (PSS) who provides direct services to members. The PSS has a full caseload and was observed being active in all aspects of the team's daily meeting. Staff members stated that the PSS provides insight on how to engage members and provides an empathetic perspective in challenging situations. One staff said, "He is the | |

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| | | | best in the county". | |
| Total Score: | | 3.96 | | |

## 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 | 5 |
| 7. Psychiatrist on Team | 1-5 | 5 |
| 8. Nurse on Team | 1-5 | 3 |
| 9. Substance Abuse Specialist on Team | 1-5 | 1 |
| 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 | 4 |
| 4. Responsibility for Crisis Services | 1-5 | 5 |
| 5. Responsibility for Hospital Admissions | 1-5 | 3 |

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| 6. Responsibility for Hospital Discharge Planning | 1-5 | 5 |
| 7. Time-unlimited Services | 1-5 | 4 |
| 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 | 2 |
| 5. Frequency of Contact | 1-5 | 4 |
| 6. Work with Support System | 1-5 | 3 |
| 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 | 3 |
| 10. Role of Consumers on Treatment Team | 1-5 | 5 |
| **Total Score** | **3.96** | |
| **Highest Possible Score** | **5** | |