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

Date: May 29, 2015

To: Jessica Lemmon, Site Administrator

From: T.J. Eggsware, BSW, MA, LAC
Jeni Serrano, BS
ADHS Fidelity Reviewers

**Method**

On May 6-7, 2015 T.J. Eggsware and Jeni Serrano completed a review of the People of Color Network (PCN) Capitol Center Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

The People of Color Network (PCN) provides mental health services to children and adults. PCN operates three adult clinics in Maricopa County for members of the community diagnosed with a serious mental illness (SMI). This review focuses on the ACT team at the Capitol site. Although the team does not carry any additional special designation, it is located in a clinic that is known to serve members with challenges maintaining safe and stable housing. As a result, staff reported new members referred tend to be homeless or have a history of homelessness.

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

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

- Observation of a daily ACT team meeting on May 6, 2015
- Individual interview with the Site Administrator (team has no current Team Leader/Clinical Coordinator)
- Individual interviews with Substance Abuse Specialist (SAS), Transportation Specialist (TS) and Employment Specialist (ES)
- Group interview with five members and two individual member interviews
- Charts were reviewed for ten members using the agency's electronic medical records system
- Review of the following documents: ACT team morning meeting tracking log, ACT team member admission criteria, agency ACT team referral and graduation policy, and agency case closure and re-engagement policy
- Review of other ACT team data, including: member roster, member admissions in the six months prior to review, members with a co-occurring disorder, members who discharged from the team in the 12 month period prior to review, staff vacancies for the 12 month period prior to review, recent member admissions to an inpatient setting, recent member discharges from an inpatient setting, and staff roster for the two year period prior to review

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 uses a morning meeting tracking sheet to track data. The data can aid new staff members to acclimate to member statuses.
- Some staff have been with the team for five years or more including: Psychiatrist, ES, and TS.
- The Psychiatrist and Nurse provide some services to members in the community.

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

- The team is below preferred staffing thresholds for a functioning ACT team with 91 members served. As a result, staff are expected to serve multiple specialist roles. For example one staff serves as the primary housing specialist, and both vocational roles (rehabilitation specialist, and employment specialist) on the team rather than three different staff filling the roles.
- The team is not providing services with sufficient intensity to members, just over 30 minutes per member per week on average. The team should increase the frequency and duration of member contacts with multiple staff. The team should strive to provide at least four contacts totaling at least two hours per week per member.
- Most member contacts occur in the clinic versus the community; the ACT team should increase community-based contact with members.
- The ACT team is not providing the full complement of expected services: employment support services, substance abuse treatment, counseling, and the majority of housing support services. Staff should be trained, empowered, and expected to fill the roles within their area of specialization and cross-train each other so that staff can respond to member needs immediately rather than referring them to outside brokers.

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| H1 | Small Caseload | 1 – 5 (4) | Excluding the Psychiatrist and Program Assistant, there is six staff on the team, including: Nurse, ES, TS, two SAS, and Independent Living Skills Specialist (ILS). Vacant positions include: Clinical Coordinator (CC), Rehabilitation Specialist (RS), Peer Support Specialist (PSS), Housing Specialist (HS), an ACT Team Specialist, and the team has no second Nurse position. The team serves 91 members. The ratio of members to staff is 15:1. Member to staff ratio should be at ten members per staff or lower. | • The agency should recruit and hire qualified candidates as soon as is possible to fill vacant positions. |
| H2 | Team Approach | 1 – 5 (4) | Staff is aware members on the ACT team should have contact with multiple staff to share responsibility for services. Staff on the team interviewed estimate they have numerous contacts with members over a given week period, ranging from 25 members to 70 members, but not all members report they have contact with multiple staff.<br><br>Some members report contact with one staff unless they go to the clinic, where they usually have brief contact with more than one staff. Based on the clinical records reviewed, 70% of members had face-to-face contact with two or more staff during a two-week period. Contacts with members tend to be by a primary assigned staff, unless a person receives medication observation, experiences a crisis, or goes to the clinic for groups or other services. | • Additional staff is needed so the team can ensure continuity of care for the members.<br>• Consider implementing a rotation schedule for specialist staff contact with members based on member goals and needs.<br>• Ensure all contacts with members are documented in a timely manner. The agency should support staff by allotting time for them to document services provided. |
| H3 | Program Meeting | 1 – 5 (5) | The team reports they meet daily Monday through Friday, with the doctor and nurse attending four of five days a week. All members are discussed at each meeting. The team utilizes a morning | |

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| | | | meeting log to track member data. | |
| H4 | Practicing ACT Leader | 1 – 5 (1) | There is no CC on the team; the position has been vacant since March 26, 2015. The SA and CD share supervision of the ACT team along with office management duties for the clinic due the elimination of the Office Management position at the agency. | • The agency should recruit and hire a qualified CC for the ACT team as soon as possible. The CC should provide supervision to ACT staff, and direct services to members. |
| H5 | Continuity of Staffing | 1 – 5 (3) | When fully staffed, the team has 12 positions. In the two-year period prior to the review, 13 staff left the team, which is a 54% turnover rate. Recent staff turnover during March and April, 2015 are attributed to the agency's staff reduction; with some staff terminated for not meeting the agency's documentation expectations. | • The agency should review the impact of staff reduction activities on the ACT team composition and ability of the team to provide effective services to members.<br>• PCN should conduct satisfaction surveys with staff to determine what is working to retain current staff, as well as exit surveys to determine reasons staff leave positions.<br>• The agency should review staff performance expectations to ensure they align with a functioning ACT team and make every effort to support staff retention in order to provide consistent services to members. |
| H6 | Staff Capacity | 1 – 5 (4) | The program had 16 total position vacancies in the 12 months review period, with four positions vacant in March, 2015 and five positions vacant in April, 2015. The program operates at approximately 89% staffing. | • The agency should offer trainings and support in order to maintain staff.<br>• See also recommendation for H5. |
| H7 | Psychiatrist on Team | 1 – 5 (3) | There is one full-time Psychiatrist on the team who works four ten-hour days a week on the team. Per report, the ACT Psychiatrist is available to the team, reportedly attends morning meeting four days a week, and does perform community visits.<br><br>The ACT Psychiatrist works a fifth day at the clinic when he is not serving ACT members. Another Psychiatrist is at the clinic ten hours a week, and | • It is clear the ACT Psychiatrist cannot effectively provide services to the ACT team members as well as coverage for many other members served through the clinic.<br>• Additional psychiatric support at the clinic is needed in order to ensure the ACT Psychiatrist can primarily serve the ACT members. The agency should take |

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| | | | other Psychiatrists may cover sporadically, but the ACT Psychiatrist is the primary coverage for the clinic the remaining hours of the week. The clinic serves approximately 700 members.<br><br>Due to lack of other psychiatrists at the clinic, staff estimates the Psychiatrist spends approximately 40-50%% of his time with other duties when assigned to cover the ACT team; as a result, Psychiatrist time dedicated to the ACT team and community visits with members have decreased. | whatever steps are necessary to assure the ACT team has a full-time psychiatrist as soon as possible. |
| H8 | Nurse on Team | 1 – 5 (3) | There is one full-time Nurse on the team. Per staff report, the Nurse is available to the team and attends meetings approximately three days a week, but his schedule is often fully booked by ACT members and other members at the clinic who are not on the ACT team. As with the Psychiatrist, the Nurse provides coverage to other members at the clinic that are not on the ACT team approximately 20% of the time. | • The agency should hire a second nurse for the team. |
| H9 | Substance Abuse Specialist on Team | 1 – 5 (2) | Two SAS staff members are assigned to the team. One of the staff has experience and training in substance abuse treatment in a behavioral health setting, including experience conducting substance abuse treatment groups. However, the second SAS has limited training and experience with substance use treatment. | • The provider and RHBA should train and support the SAS staff in dual diagnoses treatment.<br>• The agency should ensure the SAS staff receives supervision and training by someone qualified in substance use treatment. |
| H10 | Vocational Specialist on Team | 1 – 5 (3) | One vocational staff is assigned to the team (classified as an ES). The vocational staff has served in the position since 2008 with experience in vocational rehabilitation. The second position, classified as RS, has been vacant since April 21, 2015. The current vocational staff assumed the responsibilities of both vocational roles (ES and RS) on the team. | • The agency should seek a second experienced vocational staff person, and should ensure both vocational staff members are empowered to provide employment services as vocational specialists (i.e., assisting members directly with job searches, and ongoing vocational support rather than relying on outside |

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| | | | | providers).<br>• The agency, in conjunction with the RBHA, should provide the vocational staff with ongoing training, education and monitoring in supported employment and other vocational services. |
| H11 | Program Size | 1 – 5 (3) | Excluding the administrative assistant, the program consists of seven staff. Due to the small number of staff, they are expected to serve multiple roles on the team, for example serving both vocational roles on the team (ES and RS) and HS limiting the diversity of services and supports available to members. | • Because there is too few staff to adequately provide services to the 91 ACT team members, the agency should proactively seek qualified candidates, with experience and training to stabilize the team and buttress against further staff attrition. |
| O1 | Explicit Admission Criteria | 1 – 5 (3) | If the position was filled, the team CC would primarily screen referrals. The CC position is vacant, so screening of new members shifted to experienced staff on the team, the SA or CD. The team does have written criteria for admission, but there is some discrepancy on the team regarding the process for new member admissions. One staff reports the team has the final say of who is admitted to the team and other staffs report the team is forced to accept admissions, often if members are inpatient at time of enrollment, with some admissions due to administrative transfers. | • The team should have final determination of admissions to the team. The provider and RBHA should ensure the team is trained and empowered to make determinations whether members should be admitted to the team.<br>• The agency should ensure the team is uniformly applying the written criteria, and support the team in the determination to admit or not admit members.<br>• The addition of a CC should aid to ensure explicit admission criteria are uniformly applied. |
| O2 | Intake Rate | 1 – 5 (5) | The team had no more than five admissions to the team in the six month review period; with no admissions for the months of October-December, 2014 or February, 2015; one admission March, 2015, and five admissions January, 2015. | |
| O3 | Full Responsibility for Treatment Services | 1 – 5 (2) | The team directly provides case management and psychiatric services, with a focus on medication and crisis management. | • The provider should make all effort to add additional qualified staff to the team.<br>• With the addition of qualified new staff added to the team, the provider and RBHA |

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| | | | Due to the limited number of staff positions filled on the team, the program is not of adequate size to perform all services expected of a high functioning ACT team. For example, the program has two SAS, but based on record review, meeting observation, and staff report, the majority of their time seems to be spent in general case management activities. Specialists on the team tend to focus their efforts on initial engagement, and rely on referrals to outside providers for many services (e.g., vocational support, substance use treatment, housing support services).<br><br>Across the team, documented contact with members tends to include limited information, with some assessment of status but no in depth review of member strengths, challenges, or goals. The team refers out for counseling, substance abuse treatment, employment services, and has approximately 14% of members in staffed residences where services overlap with ACT supports. | should ensure the team screens all referrals to outside agencies to ensure they occur only when a functioning ACT team would not be expected to provide the service.<br>• The team should closely evaluate all referrals to residential treatment, community living programs, substance abuse treatment providers, and employment support services to avoid unnecessary duplication of services that should be provided by the team. |
| O4 | Responsibility for Crisis Services | 1 – 5 (4) | The staff reports they are the primary responders for members who contact them with crisis. The team has an on-call phone; back-up on call phone, and due to no CC, the CD is the team backup. The team provides phone or in the field crisis support services. Although team on-call phone information was reportedly provided to all members approximately a year ago, not all members confirm they have the information. The team reported that they are also contacted by crisis services directly rather than from members themselves. | • Due to changes in staff, the team should provide the on-call information to all members. The information should be provided on a recurring basis to ensure members have access to the most up-to-date team staff names, and after hours contact information. |
| O5 | Responsibility for Hospital Admissions | 1 – 5 (3) | The team reports they are involved in most hospital admissions, and generally members are | • With a fully staffed ACT team there will be |

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| | | | engaged to meet with the Psychiatrist during normal business hours if issues arise. After hours, the team may not always be informed or aware of admissions; some members self-admit.<br>Based on review of members with recent admissions, the team is involved in approximately 63% of admissions. | more opportunities to have contact with members and supports to identify potential issues earlier that could lead to hospitalization. |
| O6 | Responsibility for Hospital Discharge Planning | 1 – 5 (4) | There is some discrepancy in how often the team is involved in hospital discharges; one staff reports the team is involved in all discharges, while other staffs report some members are discharged by hospitals without coordinating with the ACT team. When the team is informed members are hospitalized, staffs report the team makes efforts to coordinate with inpatient providers. These efforts are sometimes compromised; some inpatient staff contact the team to inform them that a member is inpatient, request a staffing and inform the team of the plan to discharge on the same date, but not all inpatient providers contact the team for discharges. In situations where the outpatient ACT team and inpatient staff disagree on a discharge, some members are reportedly discharged without team involvement. In these cases, rather than the ACT team assisting with discharge, hospital staff enlists family members to pick up members at discharge. | • The team should seek support from the provider administration to report discharges they feel are inappropriate. The provider and RBHA should provide the team with information on who the team can contact to serve as a liaison between the team and inpatient staff if there is disagreement. |
| O7 | Time-unlimited Services | 1 – 5 (4) | The program reports no graduations in the 12 month review period. However, this is reportedly due to breakdowns in successfully coordinating with other teams and clinics to transition members, which has resulted in a backup of members who could have graduated over time. As a result, the team estimates approximately ten members are awaiting graduation from the team in the next twelve months. Some members who | • The provider should seek Psychiatrist coverage for the clinic so that ACT members who elect to step-down but want to remain at the clinic are afforded the option.<br>• The team should inform the administrative support at the agency, and the RBHA when they experience challenges transitioning |

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| | | | are ready for step-down from ACT, and want to remain at the clinic, are held on the team due to lack of Psychiatrist coverage. The team reports that transitioning members to other providers can take a prolonged amount of time. | members to other providers in a timely manner. The RBHA should provide the team with information on who the team can contact to serve as liaison between the team and other providers when they experience challenges transitioning members who want to graduate from the team. |
| S1 | Community-based Services | 1 – 5 (3) | Staff members on the team estimate 50 – 60% of their contacts with members occur in the community. Based on records, the team spends on average of 44% providing community-based services. | • The program should seek opportunities to increase in-vivo services. Consider eliminating practices that require members come to the clinic (e.g., bus pass every seven days versus a monthly pass) and attempt to transition those services to the community. Supportive housing services, assisting with employment goals, peer support services, and other skill development activities should occur in the community rather than the clinic whenever possible. |
| S2 | No Drop-out Policy | 1 – 5 (4) | In the 12 month review period, two members transitioned off the team due to referrals to residential services, one member transitioned off the team due to placement in the Arizona State Hospital (ASH), three members left the geographic area without referral, one member refused services and two members cannot be located. | • It is not clear if the limited staff size of the team impacted the program's ability to effectively engage members to prevent drop-outs. The provider should monitor the members who withdraw from the program, and add additional qualified staff to the team. |
| S3 | Assertive Engagement Mechanisms | 1 – 5 (4) | The agency has a case-closure and re-engagement policy. The team reports assertive engagement mechanisms including: community outreach, coordination with payees, coordination with probation or parole, contact with family or friends (if known and if the program has a release of information), contact with guardians or advocates, co-case management with lower level of service, | • It is recommended the provider add additional staff to the team to ensure adequate coverage to perform all team functions, including outreaching members who are not in contact with the team. The provider should track the members who are closed from the program, and monitor if the agency policy regarding closure is |

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| | | | and offers to step-down members to lower level of service (e.g., one member elected to transfer clinics to step down to Supportive services). Due to lack of Psychiatrist coverage at the clinic, member step-down to a Supportive level of service may be delayed if a member wants to remain at the clinic. Some staff report that due to the small size of the team, the team is not able to outreach members over the preferred 90 day timeline, and in the past three months some members were closed after 30 days of outreach.<br><br>It appears the limited staff size of the team impacted the program's ability to effectively outreach and engage members prior to closure. The change to the shorter outreach timeline corresponds with recent reduction in staffing over the three months prior to review. | followed. |
| S4 | Intensity of Services | 1 – 5 (2) | Based on records, the team provides on average 31.25 minutes of services to members per week. When contact occurs, the documented duration varies dramatically by staff, but the content of notes tends to be limited. For example, some staff document 45 minutes to an hour or more of service with note content of two or three sentences. Other staff document similar notes of ten minutes or less with the same note content. In extreme examples, notes of 180 minutes are entered, but the content of the notes indicates limited service provided. It appears the team attempts to focus on making contact with members, but the contacts are often brief or lack in depth review of member status and staff support of members. The agency requires staff to document 1800 minutes of services per week, or six of every eight hours during a standard | • The team should attempt to increase the duration of contact with members.<br>• The covering supervisors at the clinic should review staff documentation to ensure staff document similar contacts in the same fashion, including depth of notes, and duration of service based on the services provided. Some staff do not use complete sentences or punctuation in clinical documentation, which potentially compromises an accurate reflection of the service provided.<br>• The provider should review whether current encounter expectations for staff have been helpful or detrimental to member care. For example, consider how many staff met the previous member |

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| | | | workday. | encounter expectation but struggle to meet the current expectation. |
| S5 | Frequency of Contact | 1 – 5 (2) | Well functioning ACT teams provide an average of 4 face-to-face contacts for each member each week. Based on records reviewed, the team averages 1.63 contacts per member per week. Some members report contact with case management staff, nurse and doctor once a month per staff unless they receive medication observation services or go to the clinic for other purposes. When at the clinic, members often see two or more staff. Members are generally aware there are other staffs on the team with specialty roles, but the knowledge of the specialists and their specific roles varies across members. | • The team should attempt to increase contacts with members, preferably increasing community-based services.<br>• The team should provide staff position summaries and contact information to members. As new staffs are added, the information should be updated so members are aware of their current clinical team supports. |
| S6 | Work with Support System | 1 – 5 (1) | There is limited evidence the team maintains consistent contact with members' support systems. During the morning meeting observation, there were limited references of the team's outreach to informal support systems. In records, there are few references to the team's contact with informal supports, with contact initiated by the informal supports and not the team in the few examples located in the ten records reviewed. It is estimated the team maintains contact with informal supports less than .5 contacts per member per month. | • The team should regularly discuss with members the pros and cons of involving their informal supports. Also educate members about seeking support from those other than family, such as former landlords, neighbors, employers, probation officers, etc. It is likely some members may have a limited support network, but it is not clear if the majority of members have no supports outside of the clinical team or paid service providers. |
| S7 | Individualized Substance Abuse Treatment | 1 – 5 (1) | The team does not provide individual substance abuse treatment to any of the 62 members identified with a co-occurring disorder. The team SAS staff engages members, but relies on referrals to outside providers as well as staff from another agency that are co-located at the clinic. These external providers are not integrated in the team. | • The team should provide individual substance abuse treatment rather than relying on co-located or other providers who are not integrated into the team.<br>• The program should add additional staff so the SAS staff has the opportunity to provide individual substance abuse treatment. Preferably, SAS staff would be credentialed, |

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| | | | | but at a minimum should be supervised by someone qualified to monitor the substance use treatment they provide. |
| S8 | Co-occurring Disorder Treatment Groups | 1 – 5 (1) | The team does not provide group substance abuse treatment to any of the 62 members identified with a co-occurring disorder. The team SAS staff engages members, and relies on referrals to outside providers that are not integrated with the team; external providers as well as another agency with staff co-located at the clinic. | • The team should provide group substance abuse treatment rather than relying on co-located or other providers who are not integrated into the team.<br>• The program should add additional staff so the SAS staff has the opportunity to provide group substance abuse treatment. |
| S9 | Co-occurring Disorders (Dual Disorders) Model | 1 – 5 (2) | Overall the team reports they favor a harm reduction approach to treatment, but does not follow a specific treatment model. Although some staff may be aware of the existence of stage-wise approaches to treatment, it does not appear the team consistently applies a stage-wise approach.<br><br>The team refers members to Alcoholics Anonymous, and in some cases does not actively outreach and engage members to address substance use challenges, but they may default to forcing inpatient treatment. During the morning meeting there were references to members who were recently assessed to be under the influence of a substance, reportedly experiencing an increase in mental health symptoms, and the ultimate decision was to amend a member's court order for treatment rather than engage the member in substance use treatment through the ACT team. | • The provider and RBHA should ensure SAS staff receives ongoing training and education in dual diagnosis treatment models, including a stage-wise approach to treatment.<br>• The provider should seek additional qualified staff to ensure appropriate coverage for the team, enabling specialists to establish themselves on the team and drive treatment. |
| S10 | Role of Consumers on Treatment Team | 1 – 5 (1) | There is no one with a self-reported lived experience of mental illness who works on the team; the Peer Support Specialist position has been since March 30, 2015. | • The provider should actively seek qualified staff to fill the vacant role of Peer Support Specialist. |
| **Total Score:** | | **2.89** | | |

**ACT FIDELITY SCALE SCORE SHEET**

| Human Resources | Rating Range | Score (1-5) |
|---|---|---|
| 1. Small Caseload | 1-5 | 4 |
| 2. Team Approach | 1-5 | 4 |
| 3. Program Meeting | 1-5 | 5 |
| 4. Practicing ACT Leader | 1-5 | 1 |
| 5. Continuity of Staffing | 1-5 | 3 |
| 6. Staff Capacity | 1-5 | 4 |
| 7. Psychiatrist on Team | 1-5 | 3 |
| 8. Nurse on Team | 1-5 | 3 |
| 9. Substance Abuse Specialist on Team | 1-5 | 2 |
| 10. Vocational Specialist on Team | 1-5 | 3 |
| 11. Program Size | 1-5 | 3 |
| Organizational Boundaries | Rating Range | Score (1-5) |
| 1. Explicit Admission Criteria | 1-5 | 3 |
| 2. Intake Rate | 1-5 | 5 |
| 3. Full Responsibility for Treatment Services | 1-5 | 2 |
| 4. Responsibility for Crisis Services | 1-5 | 4 |
| 5. Responsibility for Hospital Admissions | 1-5 | 3 |

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| 6. Responsibility for Hospital Discharge Planning | 1-5 | 4 |
| 7. Time-unlimited Services | 1-5 | 4 |
| Nature of Services | Rating Range | Score (1-5) |
| 1. Community-Based Services | 1-5 | 3 |
| 2. No Drop-out Policy | 1-5 | 4 |
| 3. Assertive Engagement Mechanisms | 1-5 | 4 |
| 4. Intensity of Service | 1-5 | 2 |
| 5. Frequency of Contact | 1-5 | 2 |
| 6. Work with Support System | 1-5 | 1 |
| 7. Individualized Substance Abuse Treatment | 1-5 | 1 |
| 8. Co-occurring Disorders Treatment Groups | 1-5 | 1 |
| 9. Co-occurring Disorders (Dual Disorders) Model | 1-5 | 2 |
| 10. Role of Consumers on Treatment Team | 1-5 | 1 |
| **Total Score** | **2.89** | |
| **Highest Possible Score** | **5** | |