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

Date: August 29, 2017

To: Maria Cholley, Clinical Coordinator
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AHCCCS Fidelity Reviewers

## Method

On August 7-8, 2017, TJ Eggsware and Georgia Harris completed a review of the Maricopa Integrated Health System (MIHS) Mesa Riverview 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.

In addition to various inpatient and other healthcare services, MIHS operates one ACT team, Mesa Riverview, which began providing services in August 2016. At the time of the review, the ACT team consisted of 12 staff serving 82 individuals, 45 of whom are also identified as having a co-occurring disorder.

The individuals served through the agency are referred to as "clients" and "members", 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 August 7, 2017;
- Individual interview with the Clinical Coordinator (CC);
- Interview with one of the team's two Substance Abuse Specialists (SAS);
- Individual interviews with the Employment Specialist (ES) and Housing Specialist (HS);
- Group interview with three members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of the following documents and resources: Mercy Maricopa Integrated Care ACT Eligibility Screening Tool and ACT Exit Criteria Screening Tool; the MIHS ACT Graduation Process form; MIHS *Lack of Contact Checklist*, resumes for the team SASs and RS, and training records for the RS, ES, and one of the SASs.

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 meets as a full team four days a week to discuss all ACT members, and one day a week for more in-depth discussion of members.
- The ACT team is of sufficient size to provide necessary staffing diversity and coverage.
- Members interviewed expressed their appreciation of the support offered by ACT staff, were aware of staff specialty roles on the team, and confirmed they received contact numbers for staff, including the after-hours on-call resource.
- The team seems to be responsive to the medical health care of members through coordination with healthcare providers and by taking members to appointments. During the morning meeting observed by reviewers, staff noted medical appointments, referenced providing assistance to members attending appointments, and discussed medical treatment provided to the members.
- The agency website has a section that provides an overview of ACT services and referral contact/location information for the Mesa Riverview team, with links to the Regional Behavioral Health Authority (RBHA), the SAMHSA toolkit, and AHCCCS fidelity review webpage.

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

- If not in place, consider utilizing staff exit surveys or other mechanisms to ascertain what factors led to staff turnover. The team experienced staff turnover during the 12 months prior to review. Some positions, such as the RN and Rehabilitation Specialist (RS), remained vacant for three months or more.
- The ACT team should increase the frequency and intensity of face-to-face member engagement, with a focus on community-based contact. Ensure all documentation is entered in a timely fashion to reflect this. Review with staff, or outline agency expectations, regarding timely documentation of direct services.
- When teaching skills, evaluate the benefit of clinic-based groups versus individualized supports provided to members in their communities. Individualized support should be the primary focus on an ACT team. Review whether member participation rates support continuing ACT staff facilitated, clinic-based groups. Other than substance use treatment groups, which are likely to occur in the clinic setting, services should primarily be delivered in the community. It was not clear if all clinic-based groups followed a structured approach to treatment.

**ACT FIDELITY SCALE**

| Item # | Item | Rating | Rating Rationale | Recommendations |
|---|---|---|---|---|
| H1 | Small Caseload | 1 – 5<br><br>5 | The member to staff ratio for the Mesa Riverview ACT team, excluding the team Psychiatrist, is approximately 8:1. | |
| H2 | Team Approach | 1 – 5<br><br>5 | Members interviewed reported that they usually meet with one of the team Nurses and Psychiatrist at least monthly. Additionally, members reported they had contact with other ACT specialists in the week prior to review. A review of ten randomly sampled records found that 90% of members were seen by more than one staff in a two week period. Staff reported the agency provides cell phones and access to transcription technology for staff to document interactions. | |
| H3 | Program Meeting | 1 – 5<br><br>5 | The ACT team meets four days a week - Monday, Tuesday, Thursday and Friday- to discuss each member of the team. The team Psychiatrist attends team meetings, including Wednesdays when a meeting is held for more in depth discussion of members. During the meeting observed, there was evidence of staff taking the primary role in implementing services related to their specialty positions, including: providing in-home supports to enhance independent living skills, assisting members to obtain and sustain housing, assisting members with vocational activities, substance use treatment interventions, working with member support systems, and efforts to establish rapport. | |
| H4 | Practicing ACT Leader | 1 – 5<br><br>3 | In ten member records reviewed, most documented contacts with members by the CC occurred in the office, but included attending a staffing for a member who was inpatient. Per report, the CC provides individual counseling to | • The CC should focus on increasing direct service provision with a goal of 50% of her overall time. Increased community-based services may allow for opportunities to train and mentor other staff in appropriate |

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| | | | about 15 members, and facilitates an anger management group that about five members attend. In ten member records reviewed, there were no instances of individual or group services located, but based on a productivity report there was evidence the CC provides direct services to members, accounting for about 23% of her time worked over a sample month timeframe. | clinical interventions. |
| H5 | Continuity of Staffing | 1 – 5<br><br>3 | Based on data provided, the team experienced staff turnover at a rate of nearly 42% during the one year the program has been in operation, with five staff who left the team. | • Optimally, ACT teams should experience staff turnover of no greater than 20% over a two year period in order to support the therapeutic relationship with members.<br>• When recruiting for ACT staff, the agency should screen potential employees to ensure their appropriateness for the ACT team and its level of service. |
| H6 | Staff Capacity | 1 – 5<br><br>3 | In the 12 months preceding the fidelity review there were 30 vacancies on the ACT team, resulting in a staff capacity rate of about 79%. Some positions such as RN and RS remained vacant for three months or more. | • Fill vacant positions as soon as possible to ensure continuity of care for members.<br>• When recruiting for ACT staff, the agency should screen potential employees to ensure their appropriateness for the ACT team and its level of service. |
| H7 | Psychiatrist on Team | 1 – 5<br><br>5 | The team Psychiatrist's time is fully dedicated to the ACT team, but includes attendance of a meeting off-site for two hours per month. Twice weekly, the Psychiatrist sets aside a portion of her day to provide services in the community, per staff report. Evidence of community-based service was documented in one record reviewed, including attending a staffing for a member who was inpatient. Members reported the Psychiatrist had not met with them in the community, but were aware it was an option if requested. | |
| H8 | Nurse on Team | 1 – 5 | At the time of review, the ACT team was staffed with one full-time equivalent (FTE) Nurse, and a | • Add a second full-time Nurse or increase the existing second Nurse's time on the |

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| | | 4 | second Nurse who works on the team part-time (.4 FTE). Staff reported that neither of the Nurses are leads, have supervisory duties, or regularly meet with clients who are not on the ACT team. Members interviewed reported they generally meet with the ACT Nurse monthly at the clinic, but were aware that Nurses could meet with them in the community. Though, in ten member records reviewed there were no documented instances of Nursing services in the community. | team as the member roster grows to allow for flexibility in coverage and location where nursing services may occur (both in the clinic and in the community). |
| H9 | Substance Abuse Specialist on Team | 1 – 5<br><br>5 | The team is staffed with two SASs: one is a Licensed Master Social Worker (LMSW) who has more than one year experience in substance use treatment in addition to her time on the ACT team since beginning October 2016. The second SAS joined the team in August 2016, and has an employment history that includes working with individuals with substance use issues. Based on a transcript provided, the second SAS received applicable trainings since 2012, with topics of focus including: integrated treatment for co-occurring disorders, treatment modalities used, motivational interviewing, integrated dual diagnosis treatment, ASAM, and trauma. | |
| H10 | Vocational Specialist on Team | 1 – 5<br><br>3 | The team has two staff in Vocational Specialist roles – the RS and ES. Based on work history and report, the ES has more than one year experience in employment support services. Prior to joining the ACT team in January 2017, the ES worked as an RS at another agency with job duties that included assisting members to find and maintain employment. The ES participated in trainings that include: Employment Specialist training, member benefits, Disability Benefits 101 (DB101), rehabilitation and employment, motivational interviewing, and vocational rehab services and | • Ensure ongoing training occurs so that both the ES and RS are equipped to engage and assist members to pursue employment goals, and to cross train other members of the team on how to assist members to obtain competitive employment. |

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| | | | employment. It does not appear the RS has at least one year training and experience in vocational services. The RS joined the team late July 2017, and her training history includes: DB101, rehabilitation and employment, and motivational interviewing. Her prior work experience was on an ACT team in a general specialist role, and it does not appear that a primary function of the position was to assist members to obtain and maintain competitive employment. | |
| H11 | Program Size | 1 – 5<br><br>5 | The team is staffed with 11 FTE staff, and one .4 FTE Nurse. The ACT team is currently of sufficient size to provide staffing diversity and coverage. | |
| O1 | Explicit Admission Criteria | 1 – 5<br><br>5 | If a member is referred to the team, ACT staff screen the member and bring the information back to the team for discussion. In some circumstances a doctor-to-doctor consultation may occur to gather additional information. Staff reported there was no administrative pressure from stakeholders (e.g., administrators at the RBHA or MIHS) to accept admissions; the team Psychiatrist and CC make the final determination on who joins the team. The team uses written admission criteria outlined by the RBHA. Recruitment strategies include the CC visiting prisons, staff on the team collaborating with hospital Social Workers, and RBHA coordination. | |
| O2 | Intake Rate | 1 – 5<br><br>4 | During the six months prior to review, the peak admission rate was eight members in March 2017. Seven members were admitted in each of the months of February, May and July 2017, with five members admitted to the team during April 2017, and six during June 2017. | • Monitor member admissions to maintain a stable service atmosphere. Optimally, the peak admission rate should be no more than six members during any one month. |
| O3 | Full Responsibility for Treatment | 1 – 5 | In ten member records there were examples of specialty staff delivering services related to their | • Work with members who reside in staffed residence to determine if other options are |

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| | Services | 4 | roles. Members interviewed were aware that each ACT staff fulfilled specific roles on the team, and confirmed they were provided with a list of staff contact cell phone numbers. In addition to case management, the ACT team provides psychiatric services, counseling, substance use treatment (individual and group), and employment and rehabilitation services. Based on observation of the morning meeting, staff report, and documentation, the team Housing Specialist (HS) assists members to explore housing options, and Independent Living Skills Specialist (ILS) assists members with developing skills to live independently. However, based on report of staff, more than 10% of members reside in a variety of staffed residences. In those settings some social service supports may overlap with ACT staff roles. | available where members can be supported fully by ACT staff. |
| O4 | Responsibility for Crisis Services | 1 – 5<br><br>5 | Staff reported the team provides 24-hour crisis services. Staff work staggered shifts to cover 7 a.m. through 7 p.m. Monday through Sunday. In addition, the team has an on-call staff and backup on-call staff that members can contact for support during those hours and after hours. Members confirmed they were aware of staff contact cell numbers, and in member records reviewed, some contacts were documented during evening hours. | |
| O5 | Responsibility for Hospital Admissions | 1 – 5<br><br>4 | Per report, the team was involved in most (80%) of the last ten member psychiatric admissions. However, it was reported some members self-admit without reaching out to the team prior to admission for support, or without team involvement. Team supports are immediately provided once they are informed members are inpatient. | • The team should discuss with members the pros and cons of informing the team of issues that may lead to hospitalization; attempt to resolve barriers to the team not being involved, including those related to contact between staff and informal supports.<br>• Increasing member engagement through more frequent and intense provision of |

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| | | | | community-based services may provide ACT staff with more opportunities to assess and provide interventions to reduce psychiatric hospitalizations. |
| O6 | Responsibility for Hospital Discharge Planning | 1 – 5<br><br>4 | Staff said they were involved in all but one of the last ten psychiatric hospital discharges. Per report, the staff at a particular inpatient setting does not consistently coordinate discharges with the team. The ACT team follows the RBHA ACT operational manual, and the team strives to pick up all members upon discharge from an inpatient setting. In documentation, there was evidence the CC and team Psychiatrist attended a staffing for a member who was inpatient. Following discharge, staff conducts five days of follow-up with members. | • Educate hospital staff on the role and availability of ACT staff to facilitate hospital discharges. |
| O7 | Time-unlimited Services | 1 – 5<br><br>5 | When determining if members are ready for graduation, the team relies on the RBHA ACT Exit Criteria Screening Tool to assess whether members have met criteria for graduation. Per staff report, when a member is identified as ready for graduation, the team reviews the member's status, meets with the member and begins to decrease services, reducing the frequency of contact (for example, from four contacts a week to one or two times per week). No members graduated off the team in the 12 months prior to review, and per report, slightly fewer than 5% of members are expected to graduate in the upcoming year. One member interviewed reported they were scheduled to transition off the team after a planned surgery. | |
| S1 | Community-based Services | 1 – 5<br><br>4 | One staff estimated they spend 75-80% of their time delivering community-based services directly to members. Another staff was aware of the 80% | • ACT staff should increase community-based services to 80%.<br>• The team should evaluate the benefit of |

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| | | | goal, but estimated 55-60% of their time was spent in the community, citing that some group activities bring members to the clinic and staff meets with members who visit the office for those groups. The review of ten randomly selected member records found that 63% of services were delivered in the community. This data includes one member who received no community-based contacts. Various staff on the team facilitate clinic based groups (e.g., craft group), and it was difficult to ascertain in the scope of this fidelity review if those activities diverted staff from delivering community-based services. Staff reported efforts to move team facilitated groups to community-based settings (e.g., the library), but it was not clear if those settings allow for individualized services to be provided in the community where staff can directly assess needs, monitor progress, model desired learning, assist in identifying and using resources and natural support, etc. in a natural setting. Some members interviewed cited the value of socialization that groups offer. | current clinic based groups, and whether the services can be more appropriately delivered in the natural settings where members live. Ensure team facilitated groups are structured, have a specific purpose, and, ideally, are based on evidence-based interventions.<br>• For members who prefer group activities, determine if those can be fully transitioned to occur in the community with team support or in a setting that best meets the member's preference, which may help to increase their informal social supports. |
| S2 | No Drop-out Policy | 1 – 5<br><br>5 | For the year period under review, four members left the team, three of whom joined the team and subsequently requested to step-down to a lower level of care, and a third member who transitioned services to ALTCS. Per report, no members declined services, moved out of the geographic area without referral, were closed due to the team losing contact, or were closed due to the team determining they could not be served. | |
| S3 | Assertive Engagement Mechanisms | 1 – 5<br><br>5 | There is no formal protocol related to outreach and engagement, but staff confirmed that the team coordinates with formal supports (e.g., payees, Probation and Parole Officers) and conducts outreach for about two members who have | • Consider developing a formally written protocol or process to outline standard expectations regarding outreach efforts. Some teams utilize a checklist to track at |

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| | | | periods of living on the streets. Also, most members on the team have an active court order for treatment due to frequent member referrals from inpatient settings. The team conducts at least eight weeks of outreach for members who are not in contact with the team, and staff interviewed could not recall any instances of the team closing a member due to lack of contact. Staff cited an example of a member who left and was incarcerated in another state; staff facilitated the transition from the jail in the other state and then went to escort the member back to Arizona. The three members interviewed confirmed their involvement in ACT services was voluntary, and that they could terminate services at their discretion. There were instances of outreach documented in some of the ten member records reviewed; however, some outreach notes referenced an earlier date of outreach in the body of the note that differed from the date the note was actually entered. | least eight to 12 weeks of outreach.<br>• Review expectations for documenting outreach and engagement efforts to ensure notes are accurate. |
| S4 | Intensity of Services | 1 – 5<br><br>2 | The review of ten randomly selected member records showed an average service time per week of slightly more than 48 minutes per member. Only one of the ten members received 120 minutes or more of service time. However, for that member, the majority of that time was spent attending an informal social activity (BINGO), a structured group (WRAP), or contacts with ACT staff while attending groups at the clinic. | • Increase direct service time to members to at least two hours per week, on average. Direct service contacts by ACT staff should occur primarily in the community and be focused on individual needs. |
| S5 | Frequency of Contact | 1 – 5<br><br>2 | The review of ten member records found the median face-to-face staff contacts with members to be 2 contacts per week, with only one member who received four or more documented contacts, per week, over the course of one month. Staff reported that some members live in residences | • ACT staff must increase the frequency of contact with members so that the average contact across all members is four or more per week. Certain members may receive more or less contact week-to-week than |

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| | | | located many miles from the office, and members served reside throughout the valley. Due to a large catchment area staff report time spent driving across the city can take up a significant amount of time. | the average, based on individual needs, status goals, etc.<br>• Ensure all documentation is entered in a timely fashion. Review with staff, or outline agency expectations regarding timely documentation of direct services. |
| S6 | Work with Support System | 1 – 5<br><br>3 | One staff estimated about 30-40% of the members on the team had informal supports, and another staff estimated a higher percent of members (80%) have informal supports. Both reported the team averaged about weekly contact with informal supports. One staff reported in the prior week they had contact with three or four informal supports, but tended to have fewer informal support contacts compared with other specialists due to their role on the team. During the morning meeting observed, staff frequently (for about 39% of members) referenced contact or plans to contact informal supports, often referencing those supports by first name. However, in ten member records reviewed, documented contacts with informal supports resulted in 1.3 contacts on average, per member, over the course of a month. It is not clear if staff documented all contacts with informal supports. | • The team should encourage members to identify natural and informal supports and discuss with them the benefits of involving them in their treatment.<br>• Proactively engage informal supports on average four times monthly as partners in achieving recovery goals. A new family psychoeducation group may aide the team as they work to engage informal supports.<br>• Work with staff and monitor the documentation of contacts with informal supports. |
| S7 | Individualized Substance Abuse Treatment | 1 – 5<br><br>4 | During the meeting observation SAS staff discussed contact with members, and referenced individual treatment as well as the duration of the service. Staff reported the team provides weekly individual substance use treatment with 37 of the 45 members on the team identified with a co-occurring disorder. Staff reported that staff aims to provide 30 minutes of service weekly. One staff reported individual sessions last at least 23 minutes, and a second staff reported 25 minutes | • Resolve any barriers to timely documentation of individual substance use treatment.<br>• Monitor member participation in individualized substance use treatment through the SASs. Ensure that the SASs receive the necessary training, mentoring, and ongoing guidance to provide structured, individual substance use counseling to members identified with a |

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| | | | was the minimum service time. The frequency and intensity of individual treatment was not confirmed in ten member records reviewed; documentation was vague in this area. The majority of those members (seven of ten) were identified with a co-occurring disorder. In one record reviewed there were three weekly sessions documented over the course of one month. In two records there were documented outreach efforts to meet with the member for individual treatment. In another record one individual session was documented, as well as contact with the member in the lobby, but it was not clear if other individual sessions occurred. In one record a member with a co-occurring disorder participated in group activities at the clinic, but evidence of weekly individual substance use treatment was not located in documentation. | co-occurring disorder. |
| S8 | Co-occurring Disorder Treatment Groups | 1 – 5<br><br>3 | One weekly hour-long substance use treatment group is offered. The group follows an eight-week, open-ended curriculum that allows members to attend when they are able and willing. Initially it was reported that 19 members attended at least once in the prior month, but upon further review it appears two months of member participation was incorporated in that report. Upon inspection of group sign in sheets, it appears that over the course of a month where four weekly groups occurred, 12 members attended, or about 27% of members with a co-occurring disorder. | • The ACT team should expand substance use treatment group options for members, along with outreach efforts to increase attendance to at least 50% of members with an identified co-occurring disorder.<br>• Build on the curriculum to move closer to a co-occurring model. |
| S9 | Co-occurring Disorders (Dual Disorders) Model | 1 – 5<br><br>4 | Per interviews, the team follows a co-occurring treatment model, drawing from SAMHSA's Integrated Treatment for Co-Occurring Disorders toolkit, and the RBHA's substance abuse group workbook, which is supplemented by resources gathered by the SASs. Harm reduction is | • Continue to provide support and guidance to both SASs as they work to synthesize integrated treatment resources (e.g., RBHA and SAMHSA materials) and cross-train other ACT staff in stages of change, a stage- |

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| | | | reportedly the focus over abstinence, and staff interviewed cited examples of harm reduction efforts, such as one member eliminating the use of one illegal substance. Per report, the SASs provide cross-training to other staff. For example, during the Wednesday team meeting the SASs may direct other staff regarding issues to watch for or areas that may need follow up at the next contact. Based on records provided, the SASs and other staff on the team received substance use treatment related trainings. Staff interviewed appeared to be informed of the stages of change model, and the SASs created a spreadsheet to track members' stage of change. In treatment plans reviewed there were references to individual and/or group substance use treatment, and examples of treatment aligned to the members stated goals (e.g., to stay sober one day at a time, to learn how to deal with triggers and thoughts of drinking). However, it was not clear if all staff on the team were familiar with a stage-wise approach. For example, one staff documented they informed a member they should focus on getting sober and becoming financially independent. When asked about a stage-wise approach, one staff discussed the stages of change approach. Staff report they do not refer to alcoholics anonymous (AA) or similar programs, and one staff reported detoxification support is not sought unless medically necessary, (e.g., related to opiate or alcohol use). | wise model of treatment aligning clinical interventions with the member's stage of treatment, and a harm reduction approach. |
| S10 | Role of Consumers on Treatment Team | 1 – 5<br><br>5 | The team employs a PSS who joined the team shortly after inception in August 2016. Based on staff and member interviews, the PSS shares her lived experience with others. Members interviewed reported having met with the PSS, and | |

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| | | | staff reported the PSS functions as an equal team member. | |
| **Total Score:** | | **4.07** | | |

**ACT FIDELITY SCALE SCORE SHEET**

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

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| 6. Responsibility for Hospital Discharge Planning | 1-5 | 4 |
| 7. Time-unlimited Services | 1-5 | 5 |
| 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 | 2 |
| 5. Frequency of Contact | 1-5 | 2 |
| 6. Work with Support System | 1-5 | 3 |
| 7. Individualized Substance Abuse Treatment | 1-5 | 4 |
| 8. Co-occurring Disorders Treatment Groups | 1-5 | 3 |
| 9. Co-occurring Disorders (Dual Disorders) Model | 1-5 | 4 |
| 10. Role of Consumers on Treatment Team | 1-5 | 5 |
| **Total Score** | **4.07** | |
| **Highest Possible Score** | **5** | |