ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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AHCCCS Fidelity Reviewers

Method

On October 1-2, 2018, T.J. Eggsware and Annette Robertson completed a review of the Partners in Recovery Metro Center Varsity 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 the Central Region of Arizona.

Partners in Recovery (PIR) serve individuals with Serious Mental Illness (SMI) through multiple campus locations: Metro Center, West Valley, Hassayampa, East Valley, Arrowhead Health Home, Gateway Health and Wellness, and West Indian School. There are two ACT teams located at the Metro Center campus, Omega and Varsity; the latter was the focus of this review.

The individuals served through the agency are referred to as *members* and *clients*, 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 an ACT team meeting on October 1, 2018;
- Interviews with four members receiving ACT services: group interview with three members, and an individual interview;
- Interview with the Clinical Coordinator (i.e., Team Lead);
- Individual interviews with the Substance Abuse Specialist (SAS), Independent Living Specialist (ILS) and Employment Specialist (ES);
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of documents: ACT team roster, Varsity ACT Morning Meeting log, CC productivity report, resumes for Vocational and SAS positions, group supervision information, program brochure, outreach checklist, *Assessing ACT Appropriateness Tool*, *ACT Assessment Presentation for the Doctor*, and *ACT Eligibility Screening Tool*, and *ACT Exit Criteria Screening Tool* developed by the Regional Behavioral Health Authority (RBHA).

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 four days a week to discuss each member of the team. During the meeting observed, some staff appeared to take the primary role in implementing services related to their specialty positions in addition to shared team duties.
- The team has an assigned Psychiatrist who attends the team meeting four days a week and is accessible to staff and members, including coordinating with other ACT Varsity staff outside of regular business hours by monitoring, and communicating through, group text.
- The team provides crisis coverage to members 24 hours a day, seven days a week.
- Staff reported few members closed due to refusing or terminating services or moving from the geographic area without referral.

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

- The team struggled to retain staff over the last two years, with about 58% turnover. Attempt to screen and orient potential ACT staff so they are prepared to deliver ACT services. Examine employees' motives for resignation, and consider using tools (e.g., employee exit interviews) to identify trends in employee turnover.
- The ACT team should increase the intensity of face-to-face member engagement, with a focus on community-based individualized services. Based on ten records reviewed, members received frequent contact from staff, but in some instances this occurred when they visited the clinic for an appointment. Several of those contacts were brief, five minute interactions, with an unclear purpose. Members received about 52 minutes of service time on average per week over a month period.
- Engage ACT members who experience co-occurring challenges to participate in substance use treatment through the team. Ensure all staff is knowledgeable of the stage-wise approach to substance use treatment including persuasion, engagement, active treatment, relapse prevention, associated treatment interventions, and staff activities. Additionally, increase engagement of members in individualized substance use treatment.
- Engage informal/natural supports in member treatment. Staff reported the team strives for at least four contacts a month with informal supports, and one stated this was an area that the team is working to improve.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of review there were eight full-time staff working on the ACT team. A float staff (titled Senior ACT Specialist) provides coverage to the team two days a week. Excluding the Psychiatrist, the member-to-staff ratio is more than 11:1 for the 93 member program.	• Recruit and hire qualified staff who are oriented and prepared to provide ACT services.
H2	Team Approach	1 – 5 4	Staff reported they carry caseloads of 12 members who they are expected to meet with face-to-face weekly. In addition staff have a *fidelity* caseload whom they are also expected to meet with face-to-face weekly. The fidelity caseloads rotate weekly among specialists so members meet with different staff regularly. One staff estimated more than 50% of members have face-to-face contact with more than one staff over a two week period. A review of ten member records showed that 80% had face-to-face contact with more than one staff member over a two week period.	• Optimally 90% or more of members should have face-to-face contact with more than one staff in any two week period.
H3	Program Meeting	1 – 5 5	The ACT team meets four days a week – Tuesday through Friday – to discuss each member of the team. The team Psychiatrist and Nurse attend each meeting, as does other staff on the days they are scheduled to work. During the meeting observed, there was evidence of specialists taking the primary role in implementing services related to their positions, including: assisting members with vocational activities, assisting members to enhance independent living skills, and group substance use treatment. During the team meeting observed, staff discussed psychiatric services delivered by the team and coordination of physical health services.	
H4	Practicing ACT	1 – 5	The CC estimated that about 40-50% of her time is	• The CC should provide direct service to

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	Leader	2	spent providing direct services. In ten member records there were examples of the CC providing direct services to members at the office. Services seemed to be in a backup role, including updating forms with members. A report of direct services by the CC over a month timeframe showed about 8% of her time was spent providing direct services. The report indicated all contacts with members occurred in the office.	members with a goal of 50% of her time spent providing direct services, including community-based activities. • Explore with the CC what barriers exist in provision of direct services. Work with the ACT CC to identify and shift administrative duties (outside of necessary supervisory or other program leader functions) to allow for increased direct service provision.
H5	Continuity of Staffing	1 – 5 3	The team experienced about 58% turnover, with 14 staff that left, or provided temporary coverage to the team, in the past two years. Included was a staff that left the team the week prior to review, as well as a CC who provided coverage for a period of several months when the team was transitioning CCs. Multiple staff filled certain positions during the two year timeframe, including: Nurse, CC, HS, PSS, and SAS.	• Continue to screen and orient potential ACT staff to assess their preparedness to deliver ACT services. Examine employees' motives for resignation, and consider using tools (such as employee exit interviews) to identify causes for employee turnover. Optimally, ACT teams experience no greater than 20% turnover over a two year period.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the ACT team operated at approximately 81% of full staffing capacity. Some positions remained vacant for five to nine months, including: SAS, PSS and Nurse.	• Fill vacant positions as soon as possible to ensure continuity of care for members. Filling positions may also help to prevent burnout of current ACT staff who share responsibility for caseloads above optimal levels.
H7	Psychiatrist on Team	1 – 5 5	The team has one assigned Psychiatrist who works four, ten-hour days and attends the team meeting four days a week. In addition to her 40 hours with the Varsity ACT team, the Psychiatrist works an additional shift at the campus. During that time, the Psychiatrist mainly serves members of other teams at the campus, but ACT staff reported that she is available to them if needed. It was reported the Psychiatrist provides community-based services. Staff reported that the Psychiatrist is available to staff via a group text application that	

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			the team uses to coordinate member care, including outside of regular business hours.	
H8	Nurse on Team	1 – 5 3	The team currently has one full-time Nurse who staff reported provides community and office-based services. Staff reported that the Nurse assists members with psychiatric and physical health services, occasionally accompanying members to outside specialist appointments. The Nurse attends clinical team meetings four days a week and is accessible, per staff report. On rare occasions, the Nurse may provide services to members of other teams at the campus. ACT staff reported the majority of her is spent providing services to ACT Varsity members.	• Add a second full-time Nurse.
H9	Substance Abuse Specialist on Team	1 – 5 3	The team has one SAS that joined the team in July 2017. Based on his resume, the SAS has over ten years experience providing substance use treatment. Additionally, the SAS meets with other ACT team SASs weekly where they receive supervision in Integrated Dual Disorders Treatment (IDDT) and substance use treatment related interventions. It was reported that the SAS occasionally provides group substance use treatment to other members who are not part of the Varsity ACT team. This occurs at a congregate living setting where PIR ACT members from multiple teams reside. Staff from other ACT teams may also provide group substance use treatment to Varsity ACT members at that location.	• Hire a second SAS and continue to provide training in substance use treatment and interventions so that SAS staff can effectively cross-train other staff. • Evaluate the benefit of having the SAS from Varsity providing substance use treatment to members from other teams. The time the ACT SAS spends providing services to members on other teams affects the assessment of whether he is fully assigned to the Varsity team. The evaluation of item O3, Full Responsibility for Treatment Services, may be impacted if services are provided by staff that are not part of the Varsity ACT team.
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has one Vocational Specialist (VS), classified as an ES. The ES has held the position since January 2018. In addition, based on the ES's resume and her report, she previously held a position at another agency for about ten months where she assisted individuals in exploring and	• The agency should recruit and hire a second VS with training and experience in vocational services related to assisting people identified with a SMI prepare for and attain competitive employment.

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			obtaining employment.	
H11	Program Size	1 – 5 4	At the time of review there were eight full-time staff working on the ACT team: Psychiatrist, Nurse, CC, ES, SAS, ILS, HS, and an ACT Specialist. A float staff (titled Senior ACT Specialist) provides coverage to the team two days a week. One note attributable to him was located in ten member records reviewed.	• Recruit and hire qualified staff who are oriented and prepared to provide ACT services.
O1	Explicit Admission Criteria	1 – 5 5	Staff confirmed that the team controls admissions with no organizational pressures to admit. Staff reported most referrals to the Varsity ACT team originate from other less intensive service teams at the Metro Center campus. Staff from referring teams reportedly utilize the *ACT Eligibility Screening Tool* to determine if members meet ACT criteria. Most screenings are then conducted by the team CC. ACT staff complete a form titled *ACT Assessment Presentation for the Doctor* to present information to the team Psychiatrist who makes the final admission determination.	
O2	Intake Rate	1 – 5 5	The peak admission rate in the last six months was three in August 2018, a low of zero during September 2018, and intakes for the months of April through July 2018 ranged from one to two per month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team is providing psychiatric services, substance abuse treatment, and employment and rehabilitative services. Counseling/psychotherapy is not available from the team. Some staff reported that counseling is referred out to other providers when members require the service. Additionally, more than 10% of members are in housing where there is staff that	• The agency should explore options to support ACT staff to provide counseling services through the team, either with new or existing ACT staff. If there are certain specialized areas commonly referred to other providers, review options to train or support staff to develop the skills to provide those services. On some teams, staff with licensure and training provide counseling. • Work with members who reside in staffed

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			may supplement ACT. These settings primarily include a variety of congregate housing settings. Staff at these residences may provide meal preparation, prompt members to engage in self-care or address hygiene concerns, and/or notify the ACT team when a member presents with a concerning behavior. During the meeting observed, and in some notes, certain locations where members reside were referred to as *placements*. In cases when members were in need of housing, staff stated plans to assist them with placements rather than housing.	residences to determine if other options are available where members can be supported fully by ACT staff. Optimally, ACT members reside in integrated housing rather than placement, unless a congregate living setting is the member's preference.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for members. Staff provide members with a list of staff names and contact numbers, including how to reach the assigned on-call staff person. Staff schedules include Saturday and Sunday shifts. Members interviewed reported the team is available and they can call staff if members experience a crisis. The staff rotates coverage duties with the team's on-call phone weekly, and the CC serves as backup. During the team meeting observed, one ACT staff reported recent crisis calls received, presenting issue, services rendered, and follow-up activities.	
O5	Responsibility for Hospital Admissions	1 – 5 2	Staff reported that during business hours, staff attempt to triage members with the Nurse or Psychiatrist to support the member on an outpatient basis prior to recommending hospitalization. Based on review of the last ten members who recently experienced a psychiatric hospitalization, staff on the team reported involvement in three of those admissions. Some of members were assisted by family or did not seek team support prior to the admission. Staff reported that once they are aware that a member	• Work with each member and their support network to discuss how the team can support members in the event of a psychiatric hospital admission. Proactively develop plans with members on how the team can aid them during the admission, especially if they have a history of hospitalization without seeking team support prior to going to the hospital. • Increasing member engagement through a

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			is at the hospital, outreach is immediate. When members are inpatient, staff visit them on Monday, Wednesday, and Friday. Staff attend staffings, are in contact with inpatient staff, and the team Psychiatrist attempts to conduct doctor-to-doctor consultations. During the meeting observed, staff referenced plans to visit members who were inpatient and collaborative doctor-to-doctor efforts.	higher frequency of community-based interactions may provide ACT staff with more opportunities to assess and provide intervention to reduce psychiatric hospitalizations, or to assist in admissions when indicated. This may also offer more opportunities for staff to engage and build rapport with natural/informal supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported they pick up members who are discharged from psychiatric inpatient settings. Within 72 hours of discharge, the member meets with the team Psychiatrist. Staff maintain five days of face-to-face contact with members after discharge. In one case, a member travelled out of the service area and experienced an inpatient admission. ACT staff coordinated with the inpatient staff, and travelled more than 100 miles to pick-up and transport the member at discharge.	
O7	Time-unlimited Services	1 – 5 5	Over the prior year, three members graduated from the team, and in the upcoming year the team expects about that same number to graduate. The team utilizes the *ACT Exit Criteria Screening Tool* developed by the RBHA, when evaluating if member graduation may be indicated.	
S1	Community-based Services	1 – 5 2	Staff estimated a higher percent of time spent in the community than what was documented over a month timeframe in ten member records reviewed. Staff estimates ranged from 70-80% of their time is spent in the community. Based on review of ten members over a month timeframe, a median of 30% of services occurred in the community. Some staff facilitate groups in certain congregate living settings where sub-groups of ACT members reside and other staff facilitate	• ACT teams should perform 80% or more of their contacts in the members' communities where staff can directly assess needs, monitor progress, model behaviors and assist members to use resources in a natural, non-clinical setting. Ensure all staff are engaging members in the community at a similar level as what was reported by staff interviewed. • Evaluate if office-based groups inhibit staff

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			groups at the clinic. Staff provide a document with staff contact numbers that also notes groups occurring daily at the Metro Center Campus. The document also includes a schedule of community-based groups.	ability to conduct services in members' natural community settings. Consider options to work with members to explore socialization or events in their communities based on their individual interests.
S2	No Drop-out Policy	1 – 5 5	Based on staff report, few members dropped-out of ACT services in the year prior to review. One member declined to continue with services and closed. Another member left the geographic area without a referral and declined assistance to make contact with services in the new area when the team determined the person's location. Other members transitioned off the team for varying reasons not factored in the drop-out area, including: moving to other ACT teams or providers (6); referred to a residential treatment setting (3); transitioned to another system of care such as Arizona Long Term Care System (2); or had an extended incarceration (1). Staff reported that members transition off the team to Navigators if the team is unsuccessful at making contact after a period of disengagement, but no members transitioned in the prior 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff reported they follow an eight week checklist to track outreach to members who are not in contact with the team. The document prompts for various tasks each week including at least one home visit or community-based outreach. However, in one record reviewed, there was a lapse of about two weeks without any community-based outreach.	• Track outreach attempts to ensure community-based efforts occur and are documented. Identify specific staff and follow up activities so staff can coordinate outreach.
S4	Intensity of Services	1 – 5 3	The median intensity of service found in ten member records reviewed was 52 minutes a week. However, only two of the ten members received an average of more than 120 minutes of service	• 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

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			time per week over a month period and those members were being supported for medication adherence.	focused on individual needs. • Review with staff to ensure they are accurately and consistently documenting services rendered.
S5	Frequency of Contact	1 – 5 4	The median weekly face-to-face contact for ten members was just under 3.4 based on review of ten member records. The team averaged four or more contacts with four members. However, some members received multiple contacts with staff over the course of a day when they visited the clinic. Certain notes were documented in five minute duration, for brief check-in with members, or included areas addressed by other staff who made contact with the member on the same date.	• Increase the frequency of contact with members by ACT staff to average four or more per week.
S6	Work with Support System	1 – 5 2	All staff interviewed said 47 members have informal supports. Staff reported the team has contact with informal supports weekly or every other week. Based on other sources, the ACT team has less frequent contact with informal/natural supports. During the morning meeting observed, contacts with informal supports were infrequently referenced, for about 15% of members. The team does not meet Monday's, so the meeting observed reflected services from at least the previous Friday as well as Monday. An average of 0.5 interactions with informal supports was found in ten randomly selected member records for a month reviewed.	• The team should encourage members to grow and identify their support systems. Discuss with members the benefits of involving those supports in their treatment. • Seek training and guidance, to enhance strategies for engaging informal supports. Optimally, ACT staff have contact with informal supports on an average of four times monthly as partners in supporting members' recovery goals. • Consider tracking or monitoring staff documentation of contacts with informal supports to ensure timely completion.
S7	Individualized Substance Abuse Treatment	1 – 5 3	It was reported that the one SAS on the team met individually with eight of 43 members with a co-occurring diagnosis weekly, for 24 to 60 minutes each, during the month of August 2018. However, no examples of individualized substance use treatment were found in ten member records reviewed. There were multiple references to staff offering group treatment. It was not clear if	• Ensure individualized substance use treatment is available to all members identified with a substance use diagnosis, and that staff document when they offer individual and/or group treatment. • Monitor member participation in individualized substance use treatment through the SAS. Interventions should align

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			members who experienced substance use challenges were regularly offered individualized substance use treatment with the SAS. During the meeting observed, staff referenced members who participated in group substance use treatment, but it appeared individual contact was planned for only two members. Group treatment appears to be the focus of engagement.	with a stage-wise approach, and staff should be able to identify interventions that are most effective with identified stages.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The SAS offers three weekly treatment groups, two of which are held at the clinic and one that is held at a congregate living setting where a subset of ACT Varsity members reside. Staff reported the groups focus more toward earlier stages of treatment, using Illness Management and Recovery (IMR). Based on sign-in sheets, it appears about 30% of the members identified with a co-occurring diagnosis participated in a IMR group treatment during a month timeframe. However, the IMR groups appear to be open to all members to attend, with none of the three group options structured primarily for members with a substance use diagnosis. Some of the groups over a month period were attended mostly by members without an identified co-occurring diagnosis.	• Consider offering an IMR group for members with co-occurring diagnosis and another IMR group for members without a substance use diagnosis. This may aid in targeted interventions based on members' diagnoses. • Consider revising the approach of how groups are implemented, with one group for members in earlier stages, and at least one group for members in later stages of recovery. • The ACT team should engage members diagnosed with a co-occurring disorder to participate in treatment groups with the goal that 50% or more of dually-diagnosed members attend at least one treatment group monthly.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Agency administrators provide Dartmouth Psychiatric Research Center (PRC) Hazelden resources for staff to use to guide treatment. Those resources include: Integrated Dual Disorders Treatment (IDDT), IDDT Recovery Life Skills Program, and Illness Management and Recovery (IMR). Documents provided showed that the SAS receives training and supervision on substance use treatment. Staff reported they do not focus on abstinence unless that is the member's goal. Staff	• Train all staff in a stage-wise approach to treatment. Staff appeared to be familiar with stages of change, but not all appeared familiar with stage-wise treatment and interventions. • The team may benefit from further training on how write treatment plans in the words of the members, and documenting stage-wise treatment interventions in treatment

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			cited recent examples of harm reduction interventions. Staff reported they do not refer members to Alcoholics Anonymous (AA) or similar groups unless members express interest. The team rely on the Psychiatrist to determine if detoxification is warranted, which may occur if someone was abusing alcohol. Based on data provided, all members with a substance use diagnosis were assessed to fall into the pre-contemplation or contemplation stage of change. As a result, Illness Management and Recovery (IMR) treatment is provided but staff have not drawn from other resources (i.e., the IDDT manual). Substance use, alcohol use, and relapse prevention are elements of IMR, but staff reported they haven't shifted treatment to draw from IDDT resources. Groups are anchored in IMR, open to all members and not geared toward those with co-occurring diagnoses. It does not appear individual treatment is regularly offered to members. Staff interviewed appeared to be informed of the stages of change model and treatment but it wasn't clear if corresponding stage-wise treatment was commonly understood across the team. There was limited evidence that stage-wise treatment interventions were incorporated to support member goals in treatment plans reviewed.	plans and notes.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team is staffed with a PSS. Staff and members confirmed that the PSS divulges information about shared experiences to members to support them in their recovery. Staff reported the PSS has the same performance expectations as other staff.	
Total Score:		**3.75**		

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	2
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	3
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	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	2

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	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	4
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.75**	
Highest Possible Score	**5**	