ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: December 16, 2016

To: Monecia Hill, ACT Clinical Coordinator

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AHCCCS Fidelity Reviewers

Method

On November 15-16, 2016, T.J. Eggsware and Georgia Harris completed a review of the Southwest Network (SWN) Saguaro clinic 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.

Southwest Network provides behavioral health services to youth and adult populations. Southwest Network staff provides services to adults through seven outpatient clinics, five of which have ACT teams. Per the agency website, services at the clinics include: psychiatric evaluations, substance abuse evaluations, crisis intervention, help with thoughts of suicide, medication, nursing, case management, rehabilitation and support, personal care and life skills development, employment rehabilitation and training, peer and family support, housing support, transportation assistance, and language services.

The individuals served through the agency are referred to as "members" so that term will be used in this report.

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

- Observation of a daily ACT team meeting on November 15, 2016;
- Individual interviews with Clinical Coordinator (i.e., Team Leader), Substance Abuse Specialist (SAS), Employment Specialist (ES), and ACT Specialist;
- Group interview with eight members;
- Charts were reviewed for ten members using the agency's electronic health records system; and,
- Review of the agency documents and resources, including: *ACT Admission Screening Tool* developed by the Regional Behavioral Health Authority (RBHA), SWN *Lack of Contact Checklist*, outreach letters, intent to close letter, ACT team group flyers, and training transcripts for the SAS and staff identified in the Vocational Specialist positions.

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 is adequately staffed to ensure a small member to staff caseload ratio, and is of sufficient size to consistently provide necessary staffing diversity and coverage to the 97 members served at the time of review.
- The team is staffed with two Nurses, which in addition to providing adequate coverage to the team, allows for services to be provided in the community or office.
- The team maintains low admission and drop-out rates, ensuring consistency and continuity of care for members. Members are rarely closed due to lack of contact.

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

- Work with each member and their support network to educate them on how the team can assist in a hospital admission, if the need should arise. Seek to build rapport and trust with members who elect to self-admit without informing the team. To aid in that effort, consider providing members and their support networks with a list of all team staff, their position titles, primary functions of their roles, contact information, and brief biographies. Educate members, informal supports, and inpatient staff on the role of the ACT team to support members who discharge from inpatient settings.
- Hire a second SAS, and train staff in stage-wise treatment approaches, interventions, and activities for co-occurring treatment. A second SAS should enable the team to increase the number of co-occurring treatment groups offered, as well as to provide formal and structured individual treatment for substance use. Provide ongoing clinical supervision and training to SASs in co-occurring treatment, facilitated by staff with experience providing that service.
- Increase the intensity and frequency of services to members so average frequency of face-to-face contacts is four or more per week, and average intensity of service is two hours or more per week, per member. Work with members to identify activities in their communities that align with their interests, preferences, and recovery goals. Ensure groups developed and facilitated by ACT staff are supported by research as outlined in the SAMHSA evidence based practice (EBP) of ACT.
- Consider seeking input from members, informal supports, frontline staff, and other ACT teams regarding how services in lower fidelity areas can be improved at the team and system level.
- Consider updating the agency website in order to utilize multimedia to explain ACT services offered, contact information for referrals, etc.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 (5)	The team serves 97 members with ten staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of approximately 10:1.	
H2	Team Approach	1 – 5 (4)	The team appears to primarily function with a shared caseload. The CC developed a contact grid to plan out staff interactions with members weekly, and reported that all members meet with more than one staff over a two week period. During interviews, staff spoke of primary caseload assignments to complete annual paperwork requirements, but indicated staff serves all members on the team. However, staff seemed more familiar with members for whom they were assigned as a primary contact (e.g., members on their primary caseloads or those who receive medication observation services) rather than displaying awareness of all members equally. Based on ten records reviewed, 80% of members met with more than one staff over a two-week period.	• The team should continue their efforts to ensure all members are served by the full team, resulting in 90% or more of members having face-to-face contact with more than one ACT staff consistently over two week periods. Monitor the effectiveness of the grid system for staff and member interactions, and ensure all contacts are documented in member records.
H3	Program Meeting	1 – 5 (4)	Per staff report, the program meeting is held four days a week, and all members are discussed at each meeting. The team Psychiatrist and Nurses attend all meetings. During the meeting observed, all members of the team were presented for discussion. However for about 20% or more of members there was no reference to status, recent contact, or plan for contact by the team; only mentioning the member's name. For members who were discussed, conversation varied depending on their status, and topics included: recent appointments, inpatient status, doctor-to-doctor contacts with inpatient staff, recent	• Ensure all members are discussed in the meeting, even if only briefly. Morning meetings allow ACT team staff to discuss members, solve problems, and plan treatment and rehabilitation efforts. For example, the team uses a grid system to track staff and member contacts, so consider incorporating the grid tracking into the morning meeting by confirming upcoming planned member visits, and topic/focus of those contacts.

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			hospital discharges, medical health and treatment, after hour contacts, outreach efforts, and activities such as volunteer work, or plans to tour a member run program.	
H4	Practicing ACT Leader	1 – 5 (2)	Based on available information, it appears the Clinical Coordinator (CC) provides services routinely as backup, primarily making contact with members at the clinic. The CC estimates her time providing direct services to members at around 25%. The CC had been with the team for approximately one and a half months at the time of review. Based on review of the CC's productivity report over a month period, the supervisor provides direct services about 8% of the time. In ten member records reviewed, there was one CC contact with a member (in the office) over a month timeframe.	• The CC should provide direct services 50% of the time. Continue efforts to monitor and track CC actual direct service time to members. Monitor the grid system for staff and member interactions, and consider including the CC in that grid planning. This may allow the CC more opportunities to provide direct member services, to model interventions, and support the team specialists.
H5	Continuity of Staffing	1 – 5 (4)	Based on data provided by the agency, seven staff left the team in the most recent two-year period, including two CCs, resulting in a 29% turnover rate.	• Continue efforts to hire and retain qualified staff. Work with administration to thoroughly vet candidates to ensure they are the best fit for the position and the demands of an ACT level of service.
H6	Staff Capacity	1 – 5 (4)	The team operated at approximately 84% of staff capacity over the year timeframe, with 23 total vacancies over a 12 month period. It appears the agency had difficulty filling the second SAS position.	• Continue efforts to hire and retain qualified staff to fill the vacant SAS (or other positions) in the future.
H7	Psychiatrist on Team	1 – 5 (5)	There is one full-time Psychiatrist assigned directly to the 97 member program. Staff report the Psychiatrist attends team meetings, provides community-based services about five hours a week, and is accessible. The Psychiatrist is not the lead Psychiatrist at the clinic, and rarely meets with members from the clinic who are not on the ACT team. The Psychiatrist works four, ten-hour	

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			days with the Saguaro ACT team, and one day a week spent at the SWN Bethany Village clinic. ACT staff confirmed that the Psychiatrist is accessible to Saguaro ACT staff during the 40 hours he works with the team, as well as the one day a week when he is at the Bethany Village clinic.	
H8	Nurse on Team	1 – 5 (5)	There are two full-time Nurses assigned to the team. The CC reports that usually one Nurse remains in the clinic while the other goes into the field. Nursing duties include: medication services (e.g., injections, medication observations), providing training to the team on how to conduct medication observations, coordinating with medical health providers, taking members to Primary Care Physician (PCP) or specialist appointments and conducting home visits. Staff report the 97 member roster is split between the two Nurses, but both Nurses still serve all members. Staff report the Nurses are accessible, and attend all of the morning meetings. Per report, neither is the lead Nurse at the clinic, and they rarely meet with members from other teams.	
H9	Substance Abuse Specialist on Team	1 – 5 (3)	The team has one SAS, who has been in the position since September 2014. The SAS has experience with substance use treatment, primarily related to Alcoholics Anonymous (AA), the stages of change model, Motivational Interviewing (MI), American Society of Addiction Medicine (ASAM) criteria, and residential substance use treatment settings. Per report, the SAS meets with the team Psychiatrist for supervision.	• Fill the vacant SAS position. • Provide ongoing clinical supervision to SASs on a stage-wise approach to co-occurring treatment, including: engagement, persuasion, active treatment, and relapse prevention. Provide guidance and training to align staff activities and interventions to each member's stage of treatment.
H10	Vocational Specialist on Team	1 – 5 (5)	The ACT team currently has two Vocational Specialists, identified as the ES and Rehabilitation Specialist (RS). Both have been in their positions	• Ensure Vocational Specialist staff receives ongoing supervision and training related to vocational services that enable members to

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			for more than a year. Agency staff provided training transcripts for the vocational staff; both participated in trainings related to employment services such as benefits planning and supported employment.	find and keep jobs in integrated work settings, including: job development, individualized job searches, and follow-along supports.
H11	Program Size	1 – 5 (5)	The team is of sufficient size to provide coverage, with 11 direct service staff.	
O1	Explicit Admission Criteria	1 – 5 (5)	Members join the ACT program through referrals from other teams at the clinic or other clinics, and, in some cases, family member or hospital Social Worker referrals through the RBHA. Members are not forced to join the team. Staff meets with members to discuss ACT services prior to admission. Screenings for ACT are conducted by the CC, using the *ACT Admission Screening Tool*, and that information is reviewed with the Psychiatrist who makes the final determination whether the member will join the team. The CC reports no administrative pressure to accept members who are determined to be inappropriate for ACT.	
O2	Intake Rate	1 – 5 (5)	The peak intake rate in the six months prior to review was six members in September 2016, with the other months of May through October 2016, ranging from one to four admissions per month.	
O3	Full Responsibility for Treatment Services	1 – 5 (4)	In addition to case management, the team directly provides psychiatric services, and it appears that most members who receive employment, rehabilitative, or housing services, receive support through the team. Less than 10% of members reside in residential or other staffed settings. Staff and one member reported vocational service staff work with members to develop resumes, with more than 20% of members working with the team for an employment or rehabilitative goal.	• Ensure staff receives monitoring, support, and supervision specific to their role. See recommendations for H9, Substance Abuse Specialist on Team, and H10, Vocational Specialist on Team. Training focus areas for vocational staff include: job development in the community, aligning the job search with member goals, disclosure, and follow-along supports. Ensure ACT SASs are trained and receive ongoing supervision

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			There was evidence in some member records of the vocational service staff engaging members on their employment goals. However, most members report that they have not been offered assistance to locate jobs in the community; rather, staff informs them of available job opportunities. Additionally, some records reflected that members were encouraged to consider peer support specialist training, even if their employment goal did not specifically align with that goal. It does not appear that the team is providing the full spectrum of substance use treatment. A small number of members attend group with the SAS, but the structure of the group seems informal. It is not clear if individual treatment is provided. Additionally, some members are referred to AA, sober living treatment settings, and it appears at least one member was involved in an outside substance use treatment program. Counseling/psychotherapy is not provided by the team; it was estimated that approximately ten members are referred to brokered providers for the service.	(based in a co-occurring approach) so they are able to provide individual and group substance use treatment. • If certain types of counseling are consistently referred out to other agencies, consider adding, training, or supervising ACT staff so the team is equipped to provide that service.
O4	Responsibility for Crisis Services	1 – 5 (4)	ACT staff reported that the team is available through the team's on-call phone. Staff cited a recent example of staff outreaching, and coordinating care for a member over a holiday. However, it was noted in multiple records that members were instructed to contact 911, go to the nearest ER or contact crisis line if symptoms become worse or suicidal/homicidal.	• Clarify the team's role in 24-hour coverage for psychiatric crises and increased symptoms versus emergency situations where other care is indicated (e.g., medical emergency requiring 911 contact). Consider reviewing with the team the conditions when a staff can provide support to members who experience medical crisis. For example, possibly meeting first responders in the field or at the emergency room if they are contacted by or on behalf of members.

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O5	Responsibility for Hospital Admissions	1 – 5 (1)	The team was unable to display congruence between their hospital admissions protocol and actual performance in this area. Per the protocol, when the team is involved in admissions, and the clinic is closed, the member can be brought directly to an inpatient setting with assistance from on-call staff. If the clinic is open, the member usually meets with the Psychiatrist, or other staff (e.g., Nurse) relay information about the member's status to the Psychiatrist. The team coordinates the admission for members who are voluntary. The team also completes applications for court-ordered evaluation (COE) or amendments to court-ordered treatment (COT) if members are determined to be in need of further evaluation or treatment in an inpatient setting, but are not voluntary. Some of the staff interviewed reported the ACT team is involved in about 80-90% of admissions. In contrast, the review with the CC revealed the team was not involved in the ten recent admissions. Members elected to self-admit without informing the team, or were brought to an inpatient setting by the police.	• If certain members have a history of self-admitting without informing the team, focus efforts on outreach and relationship building. For example, work with each member and their support network to discuss how the team can support members in the community to avert, or to assist in a hospital admission, if the need should arise. • Ensure all staff are trained in the team protocol for hospital admissions and follow this practice.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (4)	The team was involved in eight of the ten most recent member psychiatric hospital discharges based on review with the CC. The CC reports staff meets with members within 24 hours of being informed of the admission, and then visits with the member three days per week (Monday, Wednesday, and Friday). Staff maintains contact with the inpatient Social Workers (SW), and the team Psychiatrist conducts doctor-to-doctor consultations with the inpatient doctor during the member's stay to formulate a discharge plan. After	• Optimally, the team should be involved in all discharges. If members are discharged, but elect to transport themselves home or have other means of transport (e.g., through informal supports), consider having ACT staff meet with members at the inpatient setting at the time of discharge to ensure a smooth transition, to discuss follow up appointments, and discuss other plans for contact after discharge.

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			discharge, the team facilitates an appointment with the team Psychiatrist within 72 hours, with the team Nurse within ten days, and meets with members daily for the first five days. However, evidence of five day follow up contact post discharge was not documented in a member record reviewed.	• Educate inpatient providers about the ACT team's role in discharge planning, including discussing the team's role on the day of discharge.
O7	Time-unlimited Services	1 – 5 (4)	Per CC report, members left the team for various reasons over the 12 months prior to review for reasons including: transition to residential treatment, moved out of geographic area, lost contact with the team, or deceased. However, none graduated due to significant improvement. When a member is stepping down to a lower level of care (e.g., Supportive case management) the teams hold a staffing to discuss the member's status, and talk with members about the positive aspects of the change in service level. It was projected that three members were likely to graduate during December 2016, with five total members likely to graduate in the next twelve months.	• Optimally, fewer than 5% of ACT members are expected to graduate over a 12 month period.
S1	Community-based Services	1 – 5 (3)	One staff reported spending about 80-85% of their time providing services to members in the community, and another staff estimated the rate of community-based services at around 95%. The rate of community-based services documented in ten member records reviewed showed a median of 49%. Most members interviewed indicated they primarily meet with staff in the office, but some reported a staff member visits with them at their home weekly. Some members reported they prefer to go to the clinic frequently to attend groups facilitated by ACT staff. It is not clear if	• The ACT team should increase community-based services to members, with the goal of 80% of contacts being made in the community versus the office setting. Prioritize individualized contacts with members in their communities, where staff can support them to connect with their natural supports, or identify resources. Co-occurring treatment groups are part of the SAMHSA ACT EBP, but other groups facilitated by the ACT staff are not part of the model.

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			groups facilitated by ACT staff limit their ability to provide a higher level of individualized community-based services to members.	
S2	No Drop-out Policy	1 – 5 (5)	Based on data provided for the year prior to review, no members closed due to the team determining they could not be served, no members refused services, two members closed after they could not be located, and one member closed due to moving out of the geographic area without referral. Per report, other members who transitioned off the team for reasons not factored in this area include: graduated (2%), moved to other ACT teams (1%), referral to residential treatment (7%), sentenced to prison (3%), deceased (4%), or moved from the geographic area with referral (3%).	
S3	Assertive Engagement Mechanisms	1 – 5 (5)	The ACT team uses a variety of outreach and engagement mechanisms, including: searching the streets and shelters, contacting payees, coordinating with Probation Officers, attempting to meet members at last known addresses, locating members through emergency contacts or last known phone numbers, and by sending outreach letters. The team follows the agency *Lack of Contact Checklist* which prompts for 12 weeks of outreach activities.	
S4	Intensity of Services	1 – 5 (2)	The median intensity of service per member was about 33 minutes a week based on review of ten member records. One member received over 195 minutes of average service time per week over a month period, and another received 179 minutes of average service time per week over the same period. However, six members received an average of about 30 minutes service time per week, or less, over the same timeframe.	• Increase the intensity of services to members, optimally averaging two hours a week or more of face-to-face contact for each member. Work with staff to identify and resolve barriers in increasing the average intensity of services to members.

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S5	Frequency of Contact	1 – 5 (2)	Ten member records were reviewed to determine the amount of times per week each member is receiving face-to-face contact. The median face-to-face contact was 1.5 per week over a month timeframe. The average contacts per member per week ranged from one to ten, with seven of ten members who received less than two contacts per week.	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member, with an emphasis on community-based services to support member goals. Work with staff to identify and resolve barriers to increasing the frequency of contact with members.
S6	Work with Support System	1 – 5 (3)	Staff reported the majority of members have informal supports. One staff reported that for most of the team there was at least one contact with informal supports in the month prior to review, and other staff interviewed reported about weekly or more contact with informal supports based on their primary caseload assignments. Contact with informal supports or plans to outreach informal supports were infrequently discussed in the team meeting observed, for about 10% of members. However, in ten member records reviewed the team averaged 2 contacts per month with informal supports. The team ranged from one to eight contacts with informal supports for seven of ten members; three had zero informal support contacts.	• Ensure ACT staff review with members the potential benefits of engaging with informal supports, and include supports in treatment, not only when people face challenges, but also to celebrate success toward recovery. Educate informal supports about ways to support member recovery.
S7	Individualized Substance Abuse Treatment	1 – 5 (2)	The SAS reported he believes he and other members of the team meet with all of the 64 members who have a substance-use disorder for some form of substance use discussion, in an effort to reach a 30 minute a week threshold per member. The SAS reported the contacts focus on harm reduction and cutting back on use. The contacts seem to focus on engagement; however, it does not appear structured individual counseling for substance use is provided. Additionally, records reflected that members	• Train SASs and make available ongoing supervision to support their efforts to provide individual substance use treatment. Hiring a second SAS should allow the SAS more time to provide individualized substance use treatment in addition to group treatment. • The agency should explore mechanisms to monitor and track individual substance use treatment activities without creating additional paperwork for direct care staff.

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			experiencing substance use challenges were offered group, but not individual treatment. As an example, one member received medication observation nearly daily by various ACT staff, including the SAS, but substance use was infrequently discussed. It was not clear if the member was actively engaged in individual treatment.	See also recommendations for S9, Co-occurring Disorders (Dual Disorders) Model.
S8	Co-occurring Disorder Treatment Groups	1 – 5 (2)	Per report, the SAS on the team facilitates one weekly, hour long treatment group which draws from an integrated dual diagnosis treatment model, thought it appears the SAS may draw on other resources as well (e.g., SWN group format, motivational interviewing, SAMHSA). Per report, of the 64 members who face co-occurring challenges, about two to three members attended group weekly, and another five to ten attended at least once in the month prior to review.	• Increase the frequency, and/or number, of co-occurring treatment groups offered through the team. Consider aligning the focus of each co-occurring treatment group to accommodate members in different stages (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention). Increase outreach efforts to encourage more member participation in co-occurring treatment. • Ensure co-occurring treatment groups are based on an evidence-based approach. • See recommendations for S9, Co-occurring Disorders (Dual Disorders) Model.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (2)	Staff seems to be familiar with the stages of change, with language included on plans, and one staff identified examples of members in different stages. During the morning meeting staff occasionally noted what stage of change a member was in related to substance use. For one individual, the SAS and Psychiatrist had a brief discussion to clarify the member's stage of change. It did not appear that staff are familiar with a stage-wise treatment approach, which aligns interventions with the member's stage of, or readiness for, change. The CC and SAS identified	• Train staff in a stage-wise approach to treatment; interventions should align with a member's stage of treatment. Train staff on the activities that align with member's stage of treatment and how to reflect that treatment language when documenting the service. This may better equip other ACT staff to engage members in individual and group treatment through the team. • Offer individualized treatment in addition to co-occurring disorder treatment groups. • During clinical supervision, review with staff whether research supports AA,

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			some harm reduction strategies, but it was not clear how widely the approach has been adopted by the team. Documentation in ten member records did not seem to consistently reflect a harm reduction approach when members reported or were known to use substances. In some member records, and per interviews, sobriety-focused treatment programs were offered, sometimes as the primary option. Group treatment was offered, but individual treatment was not consistently reflected in ten member records reviewed. Detoxification may be used, and one staff reported members are referred to AA, identifying it as a proven intervention that is evidence-based and has been around the longest.	whether it is an EBP, and how staff can support members who elect to seek that form of support.
S10	Role of Consumers on Treatment Team	1 – 5 (5)	The ACT team has a full-time PSS, with full professional status. Some members interviewed were familiar with a staff person who shared their lived experience, and they reported they knew of staff by name and not title. In a record reviewed, the PSS documented she used disclosure when working with a member.	• In an effort to familiarize members with the full team, consider providing members with a list of all team staff, their position titles, responsibilities, contact information, and brief biographies.
	Total Score:	**3.71**		

ACT FIDELITY SCALE SCORE SHEET

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

	Rating Range	Score (1-5)
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	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	2
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.71**	
Highest Possible Score	**5**	