ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: November 9, 2016

To: Pete Tomasello, Clinical Coordinator

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AHCCCS Fidelity Reviewers

Method

On October 11-12, Jeni Serrano and Georgia Harris completed a review of the Southwest Network Mesa Heritage Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

The Southwest Network Mesa Heritage clinic (previously known as Hampton clinic) recently relocated to 460 North Mesa Dr., Ste. 201, Mesa, AZ 85201. The ACT team serves 98 members and has a team of ten staff. The team includes a new full time Psychiatrist (June 1, 2016), a Clinical Coordinator(CC), two Nurses(RN), one Substance Abuse Specialist(SAS), two Vocational Specialists, a Rehabilitation Specialist(RS), an Employment Specialist (ES), an Independent Living Skills Specialist (ILS), a Housing Specialist (HS), and an ACT Specialist (AS). The team has two vacancies: the Peer Support Specialist (PSS) and second Substance Abuse Specialist (SAS).

The individuals served through the agency are referred to as "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 a daily ACT team meeting.
- Individual interview with Clinical Coordinator (i.e. Team Leader).
- Individual interviews with Vocational Specialist, Housing Specialist, and Substance Abuse Specialist.
- Group interview with ten members who receive ACT services.
- Charts were reviewed for ten members using the agency's electronic medical records system.
- Review of agency *Closure for Lack of Engagement Desktop Procedure, Act Exit Criteria Screening Tool and Admissions Forms.*

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 benefits from having two Nurses on staff. The ACT Nurse position is considered a critical ingredient to successful ACT teams. Having two Nurses expands the team's capacity for delivering vital services such as medication administration, health and wellness education, Primary Care Physician (PCP) coordination, and involvement in treatment planning.
- The ACT team takes full responsibility for crisis services. The approach used by the team focuses on providing after-hours care with the same intensity as during normal business hours.
- The ACT team has a full-time Psychiatrist who is described as being consistently available to staff and member needs, and is not distracted by outside responsibilities.

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

- While the ACT Team Leader (i.e., CC) is committed to supporting the staff and providing services to members, the ACT CC does not spend 50% of his time providing direct services to ACT members.
- Members are not participating in formal substance abuse treatment. Filling the vacant SAS position with a qualified candidate, and training the existing SAS so the team has two staff that can provide integrated dual diagnosis treatment should be a priority for the agency and the ACT team.
- Clarify for ACT staff the connection between frequency and intensity of services, and member outcomes. Most staff were unaware that the indicators for these items were based on an average of two hours direct service contacts with members and not fixed numbers (i.e., exactly two hours direct service per member); There should not be a priority placed on one indicator over the other, but rather a commitment to providing both quality interactions with members several times a week, on average, for all ACT staff.
- The team needs to increase their efforts to involve members' identified support systems. It is recommended that the team support and encourage members to identify their informal supports (i.e., people not paid to support members, such as family, neighbor, friend) and then assist them in acquiring the knowledge, resources and skills needed to support members.
- The team should increase the intensity and duration of services to members, including community-based activities. Services should be delivered primarily in the community and not the office setting; the team should identify what services are currently delivered in the clinic setting that can be provided to members in the community.
- Hire a Peer Support Specialist to ensure a recovery focus through the continuous recognition and attention to the member perspective and voice, and to help facilitate engagement of informal support systems.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The ACT team serves 98 members with ten staff who provide direct services (excluding the Psychiatrist) resulting in an 11:1 ratio.	• Recruit qualified staff to fill vacant positions, including Substance Abuse Specialist (SAS) and the Peer Support Specialist (PSS) positions.
H2	Team Approach	1 – 5 4	ACT members receive direct, face-to-face contact with multiple staff 80% of the time, based on records reviewed. Members interviewed reported they are assigned a primary case manager; however, their contact with other staff is usually limited to medication observations and/or visits in the clinic. Staff interviewed reported that they are assigned a primary caseload; however, members on the team are seen depending on their identified needs, as listed on their monthly member calendars.	• Increase the percentage of members seeing more than one staff member in a two week period to 90% or more. Maintaining full staffing may result in improvement in this area.
H3	Program Meeting	1 – 5 5	The ACT team meets four days per week, Tuesday through Friday, from 11:00am to 12:00pm to review all members of the team. The team uses member calendars to track face-to-face contacts, appointments, and medication observations. The Psychiatrist and Nurses attend morning meetings. During the daily meeting, reviewers observed all staff offering updates and input on the members discussed; member monthly calendars were utilized for tracking and were updated during meeting.	
H4	Practicing ACT Leader	1 – 5 3	Based on the data provided, records reviewed and the *Monthly Service Delivery* report, the ACT Clinical Coordinator (CC) provides direct care to members less than 25 % of the time. During the daily meeting, the CC offered updates on services he provided directly to members. The CC gave reviewers his estimation of his service encounters;	• The ACT CC should spend 50% of his time providing face-to-face member services. • The agency should have mechanisms to track actual service time spent by the CC providing direct service time to members. • The CC and the agency should identify any administrative functions not essential to

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			he acknowledged that administrative responsibilities can compete with opportunities for direct service provision.	the CC's time that could be performed by the program assistant or other administrative staff to free up time for direct member services, such as shadowing and mentoring staff in delivery of community-based services.
H5	Continuity of Staffing	1 – 5 4	The team has experienced a 33% staff turnover, with eight staff who have left the team in the past two years. At time of review the team had two vacancies, Peer Support Specialist (PSS) and the second Substance Abuse Specialist (SAS). Per data provided and interviews, the Peer Support Specialist (PSS) position has been vacant for over 12 months.	• The ACT team should maintain consistent staff over time for a turnover rate that does not exceed 20% in two years. Continuity of staffing is essential for promoting trust, therapeutic relationships, staff cohesion, and for maximizing the benefits of specialty training and other professional development efforts.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the ACT team maintained consistent, multidisciplinary services by operating at approximately 86% of full staffing capacity. For 12 of the months, the team was without a Peer Support Specialist (PSS), for three months the team was without a Psychiatrist and since August 31, 2016, the team has only had one Substance Abuse Specialist (SAS).	• The agency should fill all positions on the team with qualified personnel to adequately provide the specialized services offered by the ACT team. • The agency should consider reviewing and revisiting the current recruiting strategy for talent acquisition, especially for specialty roles with extended vacancies (i.e. Peer Support Specialist).
H7	Psychiatrist on Team	1 – 5 5	As of June 1, 2016 the ACT team has one assigned, full-time Psychiatrist. She works Tuesdays through Fridays, four days per week, in ten hour shifts. She is 100% assigned to the ACT team with no other duties. She attends all morning meetings, and staff interviewed reported that she is accessible and goes out in the community for home visits on Tuesday afternoons and Thursday mornings.	
H8	Nurse on Team	1 – 5 4	The ACT team has two full-time Nurses. Both Nurses help with medication administration and monitoring, primary care provider (PCP) coordination, education about physical health	• To ensure the Nurses are able to fulfill the needs of the ACT members, the agency and team should evaluate the amount of time spent on the Lead

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			conditions, as well as conducting home visits and risk assessments. Lead Nurse facilitates weekly one hour SA group Both Nurses work a four, ten-hour day schedule and attend morning team meetings on days assigned to work. Per records reviewed, there were notes entered from other Nurses not assigned to the ACT team. One assigned team Nurse is a lead Nurse for the clinic; she has other responsibilities such as providing supervision of other Nurses.	Nurse's responsibilities of coverage and supervision, as well as the time spent facilitating the weekly SAS group.
H9	Substance Abuse Specialist on Team	1 – 5 2	There is one SAS on the team. The SAS joined the team on May 16, 2016. She reported her past work experience as a general mental health counselor, with limited experience in providing any direct substance abuse treatment or services to individuals with serious mental illness (SMI). The team reported 56 members diagnosed with a co-occurring disorder (COD). The limited experience of the current SAS, and absence of a second SAS staff with specific training and education in substance abuse treatment (for a team of 100 members), is reflected in the score.	• The team should have at least two staff members on the team with at least one year of training or clinical experience each in substance abuse treatment, per 100 members. • Continue efforts to recruit experienced staff for the SAS position. • Explore opportunities for clinical oversight/supervision/training for SAS staff.
H10	Vocational Specialist on Team	1 – 5 5	The team identifies two staff as vocational specialists: an Employment Specialist (ES) and Rehabilitation Specialist (RS). The ES has been on the team since December 2015, and reports a ten year history working with individuals on their employment goals and providing related supports. She reports that she has experience in assisting individuals with legal or substance abuse histories with building a resume, job searching online and in the community, as well as offering job retention support. The ES reported that she does not refer out for employment services, including no referrals for work adjustment trainings, and feels	

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			she provides supportive employment to all members on the team with an employment goal. The CC reported during interview that the RS has been on the team since May 2010 and attends RHBA and agency Rehabilitation trainings when scheduled. The CC was unsure of the dates of the last training attended by the RS. It was reported that the RS engages ACT members in daily activities, referring to peer run programs and exploring employment goals.	
H11	Program Size	1 – 5 5	The ACT team consists of 10 staff. This count includes the Psychiatrist. At time of review the team had two vacancies, PSS and second SAS. The team is of sufficient size to consistently provide adequate diverse staffing coverage.	
O1	Explicit Admission Criteria	1 – 5 5	The team has clearly defined ACT admission criteria, as outlined by the Regional Behavioral Health Authority (RBHA). The CC provided a copy of the MMIC *ACT Eligibility Screening Tool* used to screen potential/new members. Staff report that the team carefully screens referrals, and does not have to bow to organizational pressure to accept administrative transfers from other organizations and/or ACT teams.	
O2	Intake Rate	1 – 5 5	The ACT team reports four admissions in the last six months. The ACT CC reported the team has not accepted more than one admission a month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	Along with case management services, the ACT team is fully responsible for providing three other services: psychiatric, housing, and employment and rehabilitative services. Members only receive psychiatric services from the ACT Psychiatrist. Members whose housing needs require a staffed level of care are transferred to supportive teams. Members with employment goals are being	• The CC, agency, and RBHA should ensure specialists receive education, training and mentoring to support cross-training for all staff so that all services can be effectively provided by the ACT team.

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			supported with their employment search and ongoing retention services, as well as engagement in daily activities of socialization programs or ACT groups. No members receive employment services from external providers. The team offers substance use engagement, but there was no evidence of formal treatment through the team.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for members. The staff rotates coverage with the on-call phone. The ACT CC reports that members have access to the on-call number, and the CC is the back up. When crises arise, staff will contact the CC if a decision needs to be made regarding visits to members in crisis. Staff were able to give reviewers examples and members reported they are aware of crisis service procedures.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff interviews indicate that the team was involved in five of the last nine hospital admissions of ACT team members. The tenth member was not counted due to being inpatient when transferred to the ACT team. Two members self admitted, one member was admitted by ER responders, one member was petitioned by neighbors and another member was admitted by guardian.	• The team should build rapport and educate members on the benefits of ACT involvement in the decision to hospitalize. • The agency and RBHA should explore opportunities to improve communication with local hospitals on the inpatient status and condition of ACT members.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	The record review and staff interviews indicate that the team was involved in all of the last ten hospital discharges. The CC stated that the team starts discharge planning as soon as a member is admitted. Once discharged, the ACT staff will transport members from the hospital to their homes and ensure the member has access to basic necessities (e.g. food and prescriptions).	
O7	Time-unlimited Services	1 – 5 5	The CC reported that in the last year three members graduated with significant improvement to a supportive team. He expects that four more	

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			members will graduate in the next 12 months.	
S1	Community-based Services	1 – 5 2	Per ten member records randomly selected for review, the ratio of services delivered in the community verses those delivered in the office averaged 29% face to face contacts in the community. Staff reported that barriers to meeting recommended community-based service goals was appointment cancellations and travel distances for members located throughout the county.	• Staff should utilize the tools provided by the agency to work remotely, with the goal of providing 80% of all face-to-face contacts with members in the community. • Establish a coverage schedule that strategically organizes staff in a rotation that maximizes member contacts, working towards the goal of averaging at least four contacts per week, per member • The CC should periodically monitor time and location of individual staff contacts and incorporate into performance goals.
S2	No Drop-out Policy	1 – 5 5	The team has retained 97% of their members in the past 12 months. Staff report they make efforts to engage and see what services the member will accept if he or she refuses ACT services prior to transferring to a lower level of care or closing. The CC reported that one member left the team and could not be located; one member left the team and moved out of state with resources provided by the team.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Member engagement strategies include medication observations, ACT home inspections, advocacy and support in mental health and criminal court, and hospital visitations. ACT staff also use legal mechanisms to keep members active in the program (e.g., court ordered treatment, parole officer, surveillance officer, representative payee). The CC provided reviewers with a written engagement policy.	
S4	Intensity of Services	1 – 5 3	Ten member records were reviewed to determine the amount of face-to-face service time spent with each member. The team spends an average of approximately 57 minutes per week in total	• ACT teams should average two hours or more of face-to-face services per week per member. • Member contacts should be based on need

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			service time per member.	rather than strict time guidelines for services to every member. Seek to increase the amount of service for members who receive less than two hours of service through the team.
S5	Frequency of Contact	1 – 5 3	The ten member records reviewed indicate that members received an average of 2.75 face-to-face contacts per week. Staff explained their face to face contacts are tracked on the monthly member calendar throughout the month and the member monthly calendars are reviewed during morning team meeting daily when discussing the member	• Establish a coverage schedule that strategically organizes staff in a rotation that maximizes member contacts, while allowing for staff specialist contact based on member needs, working toward the goal of averaging at least four contacts per week, per member.
S6	Work with Support System	1 – 5 2	During interviews, staff had difficulty estimating the average monthly contact with informal supports, noting that informal support involvement varies from member to member, and that some members do not have any informal supports. The CC reported about 50% of members have informal supports, and he estimates five contacts weekly. Based on record review, there is less than one contact per month for each member. During morning meeting observation, there was evidence of recent team contact with informal supports for about fifteen of the 98 members. It is estimated the team maintains .5 to one contacts per month per member.	• The team needs to encourage members to identify external supports and discuss with them the benefits of involving supports in treatment. These supports may include family, landlords, employers, or anyone else with whom members have consistent contact. Establishing communication may allow the team to provide education regarding serious mental illness, and to advocate for members. • Once a member identifies a support, the team should maintain contact consistently to support members who are doing well, as well as to proactively identify and address potential issues if necessary.
S7	Individualized Substance Abuse Treatment	1 – 5 3	According to the CC, 56 of the 98 ACT members have been identified as having a co-occurring disorder. The SAS reported that of those 56 members, 20 are in maintenance, 16 are in action, and 20 are in engagement with the SAS. She reported that she meets with the 20 who are engaged members weekly for approximately thirty minutes. Per records reviewed, data did not show	• Schedule members for structured individualized substance abuse treatment sessions, preferably separate from other home visits. Use this time to develop goals and a recovery plan, and track progress towards individual recovery goals.

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			formal individualized substance abuse treatment. There were some notes entered from the SAS titled "SA interventions". However, contact appeared to be ancillary to home visits or other activities.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	One team Nurse co-facilitates the Substance Abuse group alongside the team's Rehabilitation Specialist (RS). It is not clear why the team SAS was not the lead facilitator of the group. The CC reported that the SA group is scheduled weekly on Wednesdays for an hour. The same eight to ten members attend and the group is focused on experiences, use and relapse prevention, but no formal curriculum is used. Staff estimated that approximately 10% of members attended at least one group session in the month prior to review. During interview, staff used a blend of stages of change and stage-wise language, but it was not clear if staff activities aligned with the member's stage of treatment.	• If not already established, the agency should provide appropriate training and education to ensure the ACT staff are following an established, stage-wise curriculum, such as Integrated Dual Disorders Treatment (IDDT). Ensure clinical supervision and guidance is provided to staff with limited training or experience in co-occurring treatment. • Consider involving the SAS in group facilitation. • Continue to engage members to attend the co-occurring treatment groups.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The CC reported that although the ultimate goal is abstinence, the team uses harm reduction tactics that celebrate steps toward reducing use as progress. The team continues to offer engagement and education. The team refers to detox only if medically necessary and uses Alcoholics Anonymous (AA) as a community resource if members are interested, but they are not referred or encouraged to attend. It was not clear if staff were trained in a stage-wise approach to co-occurring treatment or if the team utilized a standard approach to substance use treatment.	• The agency and RBHA should provide education and training to all ACT staff on a dual disorder treatment model, such as Integrated Treatment for Co-Occurring Disorder, the stage-wise treatment approach, and motivational interviewing. Training should be ongoing to accommodate for new and less experienced staff. Standardizing a basic tenant of treatment may help ensure consistent interventions across the team.
S10	Role of Consumers on Treatment Team	1 – 5 1	The ACT team currently has no identified peer support specialist. This position has been vacant	• ACT teams should have a full-time PSS, with full professional status to provide direct

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			since August 2015.	service to members and ensure a member perspective in service design and delivery.
Total Score:		**3.79**		

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	3
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	4
9. Substance Abuse Specialist on Team	1-5	2
10. Vocational Specialist on Team	1-5	5
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	3

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	5
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	1
Total Score	**3.79**	
Highest Possible Score	**5**	