ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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AHCCCS Fidelity Reviewers

Method

On August 15-16th, 2017 Georgia Harris and T.J. Eggsware completed a review of the Partners in Recovery- West Valley 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 Partners in Recovery Network (PIR) serves individuals with Serious Mental Illness (SMI) and provides services such as Psychiatric, Case Management, Transportation, Interpreter Services, and Health & Wellness Groups. Though the West Valley clinic is well established in the neighboring community, their integrated health program has extended to a local medical provider who has access to urgent care facilities. At the time of review, there were 97 members being served by the West Valley ACT team.

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 on August 15, 2017;
- Individual interview with the ACT team leader/ Clinical Coordinator (CC);
- Individual interviews with one Substance Abuse Specialist (SAS), the Employment Specialist (ES) and Rehabilitation Specialist (RS);
- Group interview with three members receiving ACT services;
- Charts were reviewed for 10 members using the agency's electronic medical records system; and,
- Review of administrative documentation provided such as the Substance Abuse group sign in sheets, the *ACT Presentation to the Doctor*, the *Integrated Dual Disorders Treatment* manual; the Illness *Management and Recovery: Session Guidelines* manual; the *Recovery Life Skills* group manual; an outreach tracking sheet, as well as multiple ACT agency and ACT Team Eligibility Criteria (developed by the 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:

- Assertive engagement mechanisms: The team was able to comprehensively demonstrate their outreach strategy used for members who are not in contact with the team. Not only were procedures discussed, they were also thoroughly documented in member clinical records.
- Explicit admission criteria: The team extends beyond the standard RBHA ACT criteria by developing and using an internal assessment tool. The *ACT Presentation for the Doctor* supplements the standard criteria by providing the team with a more detailed understanding of the member and their needs, while providing staff with an opportunity to build rapport with the potential member.
- Co-occurring Disorder treatment groups: Approximately 58% of all members diagnosed with a co-occurring disorder attend at least one treatment group per month. The team provides three co-occurring treatment groups per week; one conducted in the clinic and two conducted in the community at locations where some ACT members reside.

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

- Practicing ACT team Leader: Based on the data provided, the ACT CC provides direct services to members as backup on rare occasions. The ACT protocol identifies this factor as one of the five most strongly related to better member outcomes. The agency should work with the ACT CC to identify any administrative duties that may prohibit her ability to provide direct clinical contact to members.
- Continuity of staffing: The ACT team experienced 83% turnover in the past two years, with the majority of the attrition taking place in 2016. The agency should study employee satisfaction and seek to improve employee morale through feedback forums and/or other opportunities, which could help explore solutions to perceived workplace hindrances.
- Community based services: The team currently performs just 29% of their face-to-face contacts in the community. Revisit the purpose and location of groups and other services performed by the ACT team. The team must work to improve their ability to monitor member statuses and develop living skills in the community, which is a key principle of the ACT model.
- Work with support system: Staff report frequent contact with members' support systems; however, clinical documentation indicates that support systems receive less than one contact per month. The team should develop a strategy for engaging and documenting contact with member support systems regularly.
- Throughout the course of the review, the ACT team consistently demonstrated and stated their challenges in balancing their real and/or perceived SAMHSA fidelity review expectations, ancillary duties, and documentation requirements. The agency and/or RBHA should work with the team to identify and solve any barriers to documentation of comprehensive service provision.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team serves 97 members with ten full-time staff and one float staff. At the time of review PIR had recently developed a new float ACT staff position. The float ACT staff is available to provide coverage to any PIR ACT team as vacancies arise. The member to staff ratio is approximately 10:1. This count excludes the Psychiatrist.	
H2	Team Approach	1 – 5 4	The ACT team mostly practices a team approach to service delivery. Of the ten records reviewed, it was determined that 80% of the members had face-to-face contact with multiple team members, in a two week period. Of the members that were not contacted, it was clear from the clinical record that one of them had significant outreach attempts performed by the team, while the other member had no documented contact with the team for two of the weeks included in the review period. The CC reports that she populates a weekly encounter report; this report is used to create a visitation calendar. Reviewers observed staff discussing the calendar in the team meeting. The calendar is used to track member visits on a daily basis. The team schedules their contacts based on emergencies, crisis follow up, and regular face-to-face visits.	• The team should work toward the goal of 90% or more members having face-to-face contacts with more than one staff member, in a two week period. • Assess current documentation practices of ACT staff. Identify any barriers that may prevent them from entering clinical documentation in a timely fashion.
H3	Program Meeting	1 – 5 5	Staff report that the team meeting is held four days a week: Monday, Tuesday, Thursday and Friday. Both the team Psychiatrist and the team Nurses work a flex schedule. They attend all meetings on their scheduled work days. Staff report that all members are discussed during the daily meeting. Reviewers also observed the team's discussion of all their affiliated members.	

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H4	Practicing ACT Leader	1 – 5 2	ACT staff and members report that the ACT CC provides in-home and office support and is always available in crisis situations. The ACT CC estimates spending approximately 20% of her time in direct service to members. However, based on the data provided, the CC appears to provide backup services to members on rare occasions. It was unclear from the CC encounter report what the actual service time was for the identified review time period; the CC was absent for a number of dates throughout the date range. For the months of May through July, the CC's documented direct services ranged between 0% and 11% of her time. Also, the record review did not reveal any service contacts attributable to the ACT CC.	• As a key principle of the ACT model, the ACT team leader should provide direct member services at least 50% of the time. • The agency should work with the ACT CC to identify any administrative duties that may prohibit her ability to provide direct clinical contact to members. • Ensure that the ACT CC's face-to-face encounters with members are consistently recorded in the agency's documentation system.
H5	Continuity of Staffing	1 – 5 1	The ACT team experienced more than 83% turnover in the past two years, with approximately 20 ACT staff leaving the team; 13 of the staff left in 2016. When asked about the factors affecting staff attrition, ACT staff were unable to deduce any specific reason(s) for employee turnover. When asked about their own challenges on the job, most staff expressed difficulty balancing real and/or perceived agency expectations with their ACT performance requirements.	• The team lost a significant portion of their staff in the most recent 12 month period and should work diligently to prevent any further attrition. The agency should explore and continue any efforts to receive feedback on employee satisfaction. This may be an area of further ongoing provider agency, clinic and system review. • As new candidates are being reviewed, consider implementing experiential hiring practices such as job shadowing for potential new ACT team staff, particularly for those job candidates new to the ACT model.
H6	Staff Capacity	1 – 5 4	The team has operated at approximately 92% of staffing capacity in the past 12 months. Though the team experienced much turnover, the team was able to mitigate the problem by filling vacant positions quickly. The team was using a PIR float	• See recommendations H5 regarding the thorough vetting of candidates. Ensure that potential recruits are the best fit for the position and the demands of an ACT level of service.

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			staff to fill a vacant position at the time of the review.	
H7	Psychiatrist on Team	1 – 5 5	The team benefits from a full-time, fully-integrated Psychiatrist. Though she is the Chief Psychiatrist for the agency, staff and members report that she is fully dedicated to the ACT team during her scheduled hours. Staff reported that she is still accessible during her days off, usually by phone and the company's text messaging system. The Psychiatrist was observed providing guidance and instruction to staff regarding members' treatment and services.	
H8	Nurse on Team	1 – 5 5	The team currently has two nurses (RNs). ACT staff reported that the team's RNs are accessible and flexible with their schedules. The RNs are responsible for medications, monitoring of vitals, coordination with Primary Care Physicians (PCPs) and other specialty medical services. Staff also report that RNs will travel into the community to deliver injections to members who have missed their appointment. Though the team has two RNs, there were two instances noted in the clinical records where RNs outside of the team provided services to ACT members.	• Though the team meets requirements for this area, the agency may want to explore the circumstances that create a need for members to be served by outside RNs.
H9	Substance Abuse Specialist on Team	1 – 5 5	The team currently has two Substance Abuse Specialists (SASs). The first SAS has been on the team since June 2016. She is an LMSW and has previous work experience as a clinician for a dual-diagnosis treatment program. The second SAS joined the team in September 2016. She has a Master's degree in Addiction Counseling. She has previously worked as a Recovery Specialist for a residential drug treatment facility. Additionally, per report the SASs receive weekly supervision, as well as occasional presentations on related topics	

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			(e.g., harm reduction, needle exchange).	
H10	Vocational Specialist on Team	1 – 5 3	The team currently has a Rehabilitation Specialist (RS) and an Employment Specialist (ES). The RS has been with the team in this capacity since July 2016, but she has worked with the company as an RS since 2002. The ES joined the team in December 2016. She had previously worked as a Case Manager, but did not have any rehabilitation-specific work history or training. Since obtaining this position, the ES stated that she has been receiving training from her agency and the RBHA on the Evidence Based Practice (EBP) of *Supported Employment*.	• Though the team is equipped with two vocational staff, the ES has not been with the team for over a year, nor has she received a year's worth of relevant training and/or job specific experience. Continue with all efforts to train and mentor the vocational staff on vocational best practices for SMI individuals.
H11	Program Size	1 – 5 5	The ACT team has 11 full-time staff and one float staff. The program is of sufficient size to consistently provide necessary ACT services.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team has clearly defined ACT admission criteria, as outlined by the RBHA. Though multiple ACT staff are capable of performing the admission screening, the vast majority are performed by the ACT CC. In addition to the RBHA criteria, the team completes a document named the *ACT Presentation for the Doctor*; this form is used to gather in-depth information that is not captured in the initial screening, but is helpful for the team to make an informed decision regarding admitting the potential member. The team reports having full control over the admissions process. The CC described an instance when a member was recommended to the ACT team directly from the Children's System of Care. Even on this occasion, the CC felt that the referral was appropriate and the ACT team was in full control of the ultimate decision for admission.	
O2	Intake Rate	1 – 5	The ACT team reports 16 admissions in the last six	

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		5	months. The ACT CC reported the team's highest intake month was March 2017 with three admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 3	The ACT team has assumed full responsibility for two of the ACT-identified services, psychiatric medication/monitoring and Substance Abuse (SA) treatment. For SA treatment, the team offers three weekly treatment groups and some individual support to members. The team provides housing and independent living skills training to members; however, about 16% of the members currently reside in places where members receive some monitoring and/or case management services. The team has two vocational specialists, an ES and an RS, but the team consistently considers referral to external SE agencies. In the team meeting, reviewers observed the team discussing referrals to local Work Adjustment Training (WAT) programs and other employment agencies. In one clinical record, it was noted that a member declined WAT because he "did not want to work for free". The team proceeded to encourage him (and his family) to enroll in the program, though he was not interested. Additionally, the team is not equipped to provide in-house counseling for members. The team refers to external providers for all general and specialized counseling services.	• ACT services should be fully integrated into a single team, with referrals to external providers only for specialty cases. • The team should assist members to find housing in the least restricted environments, which can reduce the possibility for overlapping services with other housing providers. • The team should fully assume responsibility for assisting members with the process of finding and maintaining employment in integrated community settings according to the member's preferences. • The agency should explore their options for providing counseling services on the team, either with new or currently existing ACT staff.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for its members. Staff considers themselves to be first responders in times of crisis. Staff rotates coverage of their on-call phone weekly. The ACT CC is the secondary backup and is contacted if a decision needs to be made regarding visits to members in crisis. New members are given a packet outlining the ACT services and the list of staff numbers to	

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			call for assistance in crisis situations.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The ACT team was directly involved in 70% of the ten most recent hospital admissions. Two of the remaining three were self-admissions, while the third was a court petition prompted by the local police department. Once admitted, the hospitals often notify the ACT team. Thereafter, the ACT team participates in ongoing treatment coordination with the hospital team. In some cases, the ACT team has used the RBHA Care Coordinators to identify inpatient locations where the member recently received services. Once identified, the team contacts the inpatient facility, beginning the team's discharge planning process.	• The team should continue to educate member on the team's role in crisis and/or hospital admission. As the therapeutic relationship is strengthened, members may increase their communication with the team in times of crisis. • The team should revisit relationships with local law enforcement and educate them on their role in ACT members' care.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	The ACT team was directly involved in 90% of the most recent hospital discharges. The one member that was not discharged to the team was discharged to the community prior to the ACT staff's arrival. ACT Staff were unclear of the reason for the early discharge, as they reported full coordination with the inpatient team throughout the discharge planning process.	• The team should continue to build relationships with the hospitals/inpatient facilities frequented by members, so coordination of care can be fully achieved.
O7	Time-unlimited Services	1 – 5 4	The ACT team graduated six members in the past 12 months. The ACT team projects between six and eight graduations in the next year. Members that are identified as eligible for graduation are staffed at the team meeting; these members have reduced their reliance upon inpatient services and have shown increased resilience and self-sufficiency. There was no particular step-down system identified; however, the team introduces members to their new team prior to their transition.	• The team may want to revisit their philosophy regarding transitioning/graduating members from the team. ACT services are designed to encourage and maintain ongoing, therapeutic relationships indefinitely. Graduation should only occur when members feel they have attained the maximum benefit from the ACT program.
S1	Community-based Services	1 – 5	Based on the data provided, it was determined that the ACT team provides primarily office based	• The team must work to improve their ability to monitor member statuses and

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		2	services. Staff reported that approximately 50% of their face-to-face contacts with members occur in the community. However, the results of the chart review show staff making contact with members in community settings 29% of the time. The ACT team maintains a calendar of group activities, and many of the ACT staff lead groups based in the clinic. Members reported coming into the clinic frequently for groups, as well as psychiatric, medication, and nursing appointments.	develop living skills in the community. ACT teams should perform 80% or more of their contacts in the community. • The agency should evaluate if clinic-based groups are inhibiting staff time to conduct more services in members' natural community settings.
S2	No Drop-out Policy	1 – 5 5	The team has retained 95% of their members in the past 12 months. The ACT CC reports that two of the members terminated services and two declined services because they did not desire the ACT-level of intensity. The fifth person opened with the team, but could not be located afterward. None of the members who left the team moved without receiving relocation assistance from the team. Though the team has a high rate of retention, it was noted that approximately nine members were transferred off the team into residential services in the past year.	• See recommendations in O3 regarding full responsibility for treatment services.
S3	Assertive Engagement Mechanisms	1 – 5 5	The team demonstrates a well-thought-out strategy and uses street outreach and legal mechanisms when appropriate. The CC (and other ACT staff) shared with reviewers their 6-week outreach strategy; this strategy includes weekly outreach to hospitals, morgues, family, probation officers, and other involved parties. Staff also gave examples of times when they have gone to the last known addresses and/or places where members frequent. In one of the clinical records, the team's use of the outreach strategy was thoroughly documented. An outreach checklist is used that prompts for up to 12 weeks of outreach.	

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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 54 minutes per week in total service time per member. The majority showed below average contacts, with only one record reflecting slightly above 2 hours of services. Some staff indicated that sometimes their access to reliable technology limits their ability to note encounters effectively, while other ACT staff expressed some difficulty in balancing current agency billing and/or documentation requirements with their desire to provide more intense services.	• ACT teams are required to provide an average of two hours of services, per member, each week. Agency leadership should meet with the ACT team to discuss any barriers that may prevent them from increasing their service intensity. • As stated in H2, assess current documentation practices of ACT staff. Identify any issues that may prevent them from entering clinical documentation in a timely fashion.
S5	Frequency of Contact	1 – 5 3	The record review indicated that the team provides an average of 2.75 face-to-face contacts per week, per member. As stated earlier by the ACT CC, the team schedules their appointments based upon emergencies, crisis follow up, and regular face-to-face visits. When reviewers asked staff to identify their barriers to meeting contact requirements, staff expressed that they were unsure of how to balance their perceived SAMHSA fidelity expectations with their ancillary agency tasks.	• ACT teams are required engage frequently with members, with the goal of averaging four or more contacts per week, per member. • Evaluate the impact any ancillary requirements (aside from those outlined in the ACT protocol) may have on the ACT team's ability to provide an adequate level of ACT services to members. • See recommendation in H2 and S4 regarding documentation practices.
S6	Work with Support System	1 – 5 2	Staff reported that most members have informal supports, and ideally they have contact with supports four times a month, usually occurring when staff conducts home visits. During the morning meeting observed, staff occasionally referenced contact with informal supports (for about 12% of members), but at times noted only with whom members resided. In ten member records reviewed documented contacts with informal supports resulted in less than one contact	• The team should encourage members to identify natural and informal supports and discuss with them the benefits of involving them in their treatment. • Proactively engage informal supports on average four times monthly as partners in support of recovery goals. A new family psychoeducation group may aide the team as they work to engage

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			on average per member over the course of a month. It is not clear if staff documented all contacts with informal supports.	informal supports. • Work with staff and monitor the documentation of contacts with informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 3	The SAS interviewed was on leave for the month of July 2017, and it was not clear if individualized substance use treatment occurred consistently during that timeframe. It was unclear from available documentation if the second SAS was providing individualized treatment in the absence of the other SAS. Though group treatment was noted in some of the ten member records reviewed, as well as one SAS inviting members to attend substance use treatment groups, evidence of individualized substance use treatment was not located in documentation reviewed. During the meeting observation, SAS staff discussed contact with members and referenced individual treatment, as well as the duration of the service. Also, it appears some individualized treatment has resumed since the SAS recently returned from leave.	• Review options to ensure continuity of treatment and provision of individual substance use treatment if SASs are on leave for one month or more. The agency has two qualified SAS staff to provide support. • Monitor member participation in individualized substance use treatment through the SASs. Ensure that both SASs receive the necessary training, mentoring, and ongoing guidance to provide structured, individual substance use counseling to members identified with a co-occurring disorder.
S8	Co-occurring Disorder Treatment Groups	1 – 5 5	Three weekly hour-long substance use treatment groups occur: one at the clinic, one at the team affiliated ACT housing property where a subgroup of members reside, and one at another property in the community not affiliated with the provider where members of the West Valley and other PIR ACT members reside. Based on review of sign-in sheets over the course of four weeks, 58% of members of the West Valley ACT team with a co-occurring disorder attended at least one substance use treatment group over the course of a sample month; some members attended multiple meetings.	

Item #	Item	Rating	Rating Rationale	Recommendations
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	Per interviews, the team follows a co-occurring treatment model, drawing from Dartmouth Psychiatric Research Center (PRC) Hazelden resources including: Integrated Dual Disorders Treatment (IDDT), IDDT Recovery Life Skills Program, Illness Management and Recovery (IMR), and IMR session guidelines. Harm reduction is reportedly the focus over abstinence, and staff interviewed cited examples of harm reduction efforts, such as a recent interaction with a member who appeared to have used alcohol, but reported he had not used other substances. Rather than focusing on the member's ongoing alcohol use, the staff elected to validate the member's decision to discontinue his use of other substances. 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 corresponding stage-wise treatment. However, in treatment plans reviewed there were references to substance use treatment on some plans, but not on other plans. In one record it was noted the member needed to remain sober. Members who were in early stages of recovery, and previously declined group treatment, were also frequently invited to attend group, with little documented evidence of other efforts to build rapport, a trusting relationship, etc. In one record for a member who was not engaged with the team, a staff outreached to invite the member to group, but other rapport building efforts were not referenced; the member remained out of contact with the team.	• 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-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	The team employs a PSS who joined the team in October 2016. Based on staff and member	

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		5	interviews, the PSS shares her lived experience with others if applicable to the member's situation. Members interviewed reported having met with the PSS, and staff reported the PSS functions as an equal staff member.	
Total Score:		**3.96**		

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	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	1
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	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	5
3. Full Responsibility for Treatment Services	1-5	3
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	4

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	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	5
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.96**	
Highest Possible Score	**5**	