ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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ADHS Fidelity Reviewers

Method

On January 20-21, 2015, Georgia Harris and Karen Voyer-Caravona (Fidelity Reviewers) completed a review of the Southwest Network, San Tan 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 is a Provider Network Organization (PNO) contracted to provide behavioral health care services to those diagnosed with a Serious Mental Illness (SMI) in Maricopa County, Arizona. The San Tan Clinic is located at 1465 West Chandler Boulevard, Chandler, Arizona, 85224. The clinic is accessible by public transportation, and is in close proximity to local businesses. This clinic is also an Integrated Health Home (IHH) - providing both medical and psychiatric services. The San Tan ACT team serves 94 members. Many members utilize the clinic's psychiatric, medical, and other co-located services (i.e. Recovery Empowerment Network, TERROS, and Marc Community Resources). At the time of review the team was without a practicing team leader. The Clinical Director fulfilled the administrative duties, while the staff members performed the remaining activities (i.e. conducting daily ACT team meetings, etc.).

For the purpose of this report, and for consistency across fidelity reports, the term "member" will be used to describe individuals served through the ACT team.

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

- Observation of a daily ACT team meeting.
- Interview with the agency's Clinical Director, who is currently assigned as the acting Team Leader for this ACT team until this

position is filled.

- Interviews with four members receiving ACT services.
- Interviews with a Substance Abuse Specialist, Peer Support Specialist and a Vocational Specialist.
- Charts were reviewed for 10 members using the agency's electronic medical records system, with assistance from the acting Team Leader.
- Review of various documentation and data for the ACT team. Note the required review data was not provided to the review team in advance; rather, the requested information was received and reviewed onsite during the two-day review period.

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 exhibits functioning in ACT specialties:
    - One of the team's Substance abuse Specialists (SAS) has over 16 years of experience in the co-occurring disorders field.
    - Rehabilitation and Employment Specialists work with each other to coordinate and provide direct services to members relevant to their personal goals.
- The team is committed to member wellness in both physical and behavioral healthcare. The staff and Psychiatrist coordinate physical health appointments with members' primary care physicians (PCPs) as well as the Integrated Health Home (IHH) clinic doctor on-site. Members reported their successes with the IHH program.
- The team benefits from having a strong Peer Support Specialist (PSS), who has been with the team since its inception. The PSS is fully integrated and supports other specialties in engagement and recovery practices for members.
- The team has positioned itself as the 'first responder' for member crises; not the 24 hour crisis line. When the ACT team provides crisis intervention, continuity of care is maintained for members.

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

- Staff turnover was consistently identified by staff as a barrier to service improvement. Of the vacant positions, the team has lost two Team Leaders in the past year, for a total of three months without a direct supervisor in the past year. The team currently has 9 of the 12 necessary ACT positions filled. Filling vacant positions will be critical to increasing service intensity to members, as well as avoiding staff 'burnout' and improving retention of current staff on the team.

- The ACT team would greatly benefit from an experienced Team Leader. The team has been without a Team Leader since November 2014 and is being covered by the Clinical Director at the site. Though the review shows that the team has met requirements, the absence of a practicing Team Leader has created a stretch of responsibilities for team staff. For example, the review team observed the Transportation Specialist mediating the morning meeting. A dedicated Team Leader directly impacts team organization, dynamics, and cohesion, in no small part by mentoring and monitoring.

- The ACT team would benefit from focused training and development in the principles of the Integrated Dual Diagnosis Treatment (IDDT) model. While the team does have experienced Substance Abuse Specialists, it appears that the team has not yet found a way to utilize their experiences and skills to train other team members in the skills of working with members with co-occurring mental illness and substance use. Though the team speaks of the *Stages of Change*, it is important for the principles of the model to be implemented into practice and decision making for client treatment options. The ACT team has the opportunity to provide individualized treatment, as well as tracking of member progress to the maintenance stage. The team should focus more intently on harm reduction principles and strategies, rather than traditional offerings such as inpatient hospitalization or detox.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The team roster consists of: (2) Substance Abuse Specialists, (1) Rehabilitation Specialist, (1) Employment Specialist, (1) Housing Specialist, (1) Nurse, (1) Transportation Specialist, (1) Peer Support Specialist. The team serves 94 people. The ratio of members to staff is 12:1. This count excludes the Psychiatrist and any administrative support. The team lost their Team Leader in November 2014 and is looking for a suitable candidate to fill the position. In the interim, the Clinical Director (CD) has acquired the majority of the CC's responsibilities.	• It is recommended that the team explore all options for hiring additional staff for vacant positions. The ACT model is most effective when staff maintain the member-to-staff ratio of 10:1.
H2	Team Approach	1 – 5 5	The ACT team provides services as a team. The chart review indicated that 90% of members were seen by multiple staff members in a two week period. The team reviews a visitation schedule on a daily basis. Staff will volunteer to see members based on their scheduled appointments, the area of town they are traveling to, and the type of activities they have scheduled. Staff report that particular staff volunteer more frequently than others to provide coverage. While the team fulfills this item mathematically, and the work is getting	• Though the current team approach is fulfilling the needs of the members, the team should consider a coverage strategy that will evenly distribute responsibilities across all staff. • See H4 (Practicing Team Leader) for additional recommendations. Team cohesion is affected by the lack of leadership. Multiple staff members report challenges in these areas.

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			done, it did not appear that the team has a cohesive collaborative (integrated) approach to work. Even so, all members are seen weekly.	
H3	Program Meeting	1 – 5 5	The team meets daily Monday through Thursday, from 10:00am to 11:30am. The team has an additional afternoon meeting on Thursdays for clinical supervision. All staff (including the Psychiatrist and Nurse) are expected to attend scheduled meetings. All members are reviewed in the daily morning meeting. The team meeting observed by the review team was conducted by a staff member, and not the acting Team Leader.	
H4	Practicing ACT Leader	1 – 5 1	The ACT team has been without a Team Leader since November 2014. Reviewers spoke with the Clinical Director (CD) who oversees the team. The CD serves as the acting Team Leader for the ACT team and oversees an additional supportive team administratively, but she is unable to provide direct, billable services to members. As a result, there were no data sources available for tracking the team leader activities for the designated review period. The CD did express that the organization is actively searching for a qualified leader to fill this gap in services. The CD will be referenced as "Acting Team Leader" for the remainder of this report.	• It is highly recommended that the agency continue to place priority on hiring a qualified ACT Team Leader. A strong practicing ACT Team Leader is correlated with better outcomes for members.
H5	Continuity of Staffing	1 – 5 4	The ACT team has had seven staff members leave over the past two years. One staff member left in 2013, and six left in 2014. This	• Examine employees' motives for leaving the team through an exit interview process. If trends arise,

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			resulted in a 29% turnover rate. It was stated numerous times that previous ACT members left the team for promotions within the RBHA system and other, more lucrative opportunities.	consider options for accommodations and/or workplace benefits that may incentivize staff retention. • The RBHA and Agency should consider developing transitional plans for new hires coming from the PNO system for continuity of care. This may be an area of further ongoing network, clinic and system review.
H6	Staff Capacity	1 – 5 3	The Team has operated at a staff capacity of 77.8%. The team has had 23 vacancies in the past 12 months. The team is currently without a Team Leader, Housing Specialist, and a Mental Health Worker.	• While the team has managed to fulfill criteria for staff capacity, the lack of critical positions (i.e. Team Leader) continues to affect quality of services and potential member outcomes. See H5 for recommendations
H7	Psychiatrist on Team	1 – 5 5	The team has a full-time Psychiatrist who provides services only to ACT members. The Psychiatrist joined the team in December, 2014. The staff and members indicated that the Psychiatrist is very knowledgeable and has an open-door policy. The Psychiatrist was observed providing supervision to the team on potential side effects of medication changes for the members discussed. Staff report the Psychiatrist will only provide coverage for other teams in rare instances (i.e. another doctor is out of the office for the day).	
H8	Nurse on Team	1 – 5 3	The team currently has one full-time, ACT-dedicated nurse. Staff stated that their team	• Determine options for obtaining an additional nurse. Nurses function as

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			would greatly benefit from an additional nurse; a team with two nurses could manage the responsibilities of medication observation and administration for members. Staff stated that the current nurse is sometimes uncomfortable (for safety reasons) with going into the community to administer medications alone.	full members of the team and serve as educators to both members and staff. Two nurses will ensure flexibility and availability of medical services such as injections and labs in the community and at the clinic.
H9	Substance Abuse Specialist on Team	1 – 5 3	The ACT team includes two Substance Abuse Specialists (SAS). One SAS is reported to have over 16 years of experience in substance abuse treatment. This SAS is currently licensed as a substance abuse counselor in another state; however, she is currently unable to receive reciprocity, and will need to complete additional requirements for an Arizona license. The reviewers were notified that the second SAS had been in the position since 2012; however, the reviewers were unable to verify the training or clinical experience of the additional SAS through the data presented during the review.	• Assure that the designated Substance Abuse Specialists are providing co-occurring disorders specific individual and group counseling sessions (See items S7 & S8). • Provide training and support to SAS's on the IDDT model. Promote consistent messaging of IDDT principles in direct practice and cross-specialization.
H10	Vocational Specialist on Team	1 – 5 5	The ACT team includes an Employment Specialist (ES) and a Rehabilitation Specialist (RS). Per staff interviews, both team members work together to provide services and referrals for members. The RS has worked on the team as an RS since 2008. He assesses member needs and provides referrals to community services agencies that are in line with the member preferences (i.e. peer run organizations for social goals, etc.). The RS will	

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			refer members with employment goals to the ES, who will then work with the member on employment activities such as resume writing and online job search. The ES reports that the use of referrals to external agencies is limited to cases that need particular funding to fulfill a need (i.e. Vocational Rehabilitation).	
H11	Program Size	1 – 5 4	The ACT team consists of nine full-time staff, including the Psychiatrist. The program size is slightly less than sufficient for provision of optimal staffing coverage.	• See H5 for recommendations
O1	Explicit Admission Criteria	1 – 5 5	The team has a clearly defined population and uses defined criteria to screen out inappropriate referrals. The team focuses on members who fit the criteria, as outlined in agency documentation provided to the review team. This procedure determines ACT appropriateness by discussing members' service intensity, functional impairment, and agreement to be served. The acting Team Leader (and multiple team members) confirmed that the team is in full control of the admission process.	
O2	Intake Rate	1 – 5 5	The program maintains a low growth rate to maintain stability of service delivery. According to the data provided, the team completed 6 ACT team admissions in the last 6 months.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The team provides four of the core ACT services. The team fully provides case management and Psychiatric/medication management. Other services provided (in full	• Consider options that will minimize the need for the team to refer to outside agencies for services that are to be provided by the ACT team

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			or in part) are housing services, Substance Abuse treatment, employment and rehabilitation services. The acting Team Leader stated that the team does not have licensed staff to provide individual counseling/psychotherapy, or individualized substance abuse counseling. The team refers to external sources for these functions; including the co-located Marc Community Resources. In the future, it will be critical to provide over 90% of services to receive full credit in this measure.	(e.g., vocational services). • At the network and RBHA level, explore training and educational opportunities for staff that lead to certification or licensure to facilitate the provision of and substance abuse treatment (see S7) and individualized counseling.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for members. the staff will rotate coverage on the on-call phone. Though members may call the crisis line, the ACT team is viewed as the "first responder" to a crisis; the team prefers to be contacted first in a crisis situation. Staff will contact the Team Leader if a decision needs to be made regarding visits to members in crisis.	
O5	Responsibility for Hospital Admissions	1 – 5 5	The team was closely involved in 100% of the last 10 hospitalizations. The staff stated that the team actively amended the Court Ordered Treatment in five of those admissions. The remaining admissions were for increases in symptoms. The team receives call from member supports to assist with the decision to hospitalize. Members will often call the team directly if they feel they are in need of inpatient care.	
O6	Responsibility for	1 – 5	The team was closely involved in 100% of the	

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	Hospital Discharge Planning	5	last 10 hospital discharges. Once admitted, the ACT team schedules to visit members in the hospital once every 72 hours. The team provides discharged members with transportation from the hospital to the pharmacy to fill medications, and then to their homes. Family members will sometimes provide transportation to members. The team provides five days of follow-up care to members post-discharge.	
O7	Time-unlimited Services	1 – 5 5	The team has not graduated any members in the last 12 months. According to the Acting Team Leader, there is no expectation to graduate more than 3% of all members in the next year. "Our doctor is very new to our team. So, we are still assessing our members. Still, we don't see many in the future".	
S1	Community-based Services	1 – 5 3	Based on the record review, the team provides community based services 56.35% of the time. Staff estimations were 70-75%. Staff indicated that much of the variation may be due to their need for additional staff members; staffs are unable to provide in-depth services due to high caseloads.	• Community-based services are an effective way to evaluate the skills and functioning of members in their natural settings. In addition, staff are able to assess member functioning with greater accuracy than in member self-reporting. Explore all options for filling vacant staff positions.
S2	No Drop-out Policy	1 – 5 5	The team retained 97% of their caseload in the last 12 months. Of the members who terminated services only one member moved without coordination assistance from the team. One member stated that he did not desire ACT services, and another transferred	

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			to a private psychiatrist. According to staff, members must provide an official letter or statement prior to being released from the team, clearly stating their reasons for discontinuing services. Coordination/relocation services are provided once a member decides to transfer.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The team uses a 7-week, lack of contact checklist to track engagement activities for members who cannot be located. In this contact checklist, staff are prompted to record their efforts and identify any legal mechanisms used to locate missing members; this may include outreach to morgues, representative payee services, and mailed notices to member residences.	
S4	Intensity of Services	1 – 5 2	The review of ten member records indicated that members receive 50 minutes of service per week. The range of service minutes fell between 18 -76 minutes per member. Staff stated that being understaffed is the most pressing issue for them. “There is a lot of turnover right now… It creates inconsistency for members. When our [staff] numbers are low, we are stretched so thin.” Staff went on to state that each team member has primary responsibility for approximately 15 -16 members.	• The ACT model is designed to deliver intense, frequent face-to-face services to members in their own communities. This is not reflected in the records that were reviewed. Review recommendations in H1 and S1 with regards to the benefits of having a fully-staffed team. • This is another critical role for the Team Leader who coordinates staff activities, the execution of contact strategies and holding team members accountable for ACT requirements (including Intensity of Services S4 and Frequency of

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				contact S5).
S5	Frequency of Contact	1 – 5 3	The member record review indicated that members receive an average of 3.0 face-to-face contacts per member, per week. Members' contacts with the team ranged from 1.5 – 8.75 contacts per week. Staff volunteer to visit members as they feel their schedule allows. When questioned about how member contact is managed, staff stated that "some [staff] volunteer [to conduct visits] more than others, but it all gets done". The Acting Team Leader provided the fidelity review team with a weekly contact schedule for staff; however, it is not clear that this is used regularly or consistently~~.~~	• See S4 for recommendations.
S6	Work with Support System	1 – 5 2	The staff reporting of contacts with member support systems varies greatly with the documented record. Staff accounting of the percentage of members with active support systems ranged from 45- 90%, with each support receiving between one and three contacts per month. The record review captured very few informal support contacts (approximately 0.4 contacts per month). The results from the record review and the staff reporting were combined, resulting in an average of approximately 1.26 contacts per month.	• Focus on documenting team contacts with member support system(s) to ensure this measure is being accurately captured.
S7	Individualized Substance Abuse Treatment	1 – 5 3	The team integrates some substance abuse treatment into regular member contact, but no formal, individualized treatment program is provided. Per staff report, members with a co-	• Formalize the individualized counseling provided to members by the team's SAS by creating structured plans for members based

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			occurring disorder meet with the SAS for an ASAM (American Society of Addiction Medicine) Evaluation or a Motivational Interviewing (MI) session. If the SAS evaluates the member as being in the maintenance stage, the SAS will be become the primary counselor for treatment. All others will be engaged by the SAS, but can be referred to a provider for individualized counseling. Though ASAM or MI is reported to being performed, no evidence of a structured, individualized counseling program (as provided by the ACT team) was found in the record at the time of review.	on their progress though the stages of their recovery. • Ensure that staff facilitating individualized co-occurring disorder treatment summarizes and documents member progress in the record on a monthly basis at minimum. Tracking member progress (or lack thereof) will help staff target the nature of the individual sessions with the SAS.
S8	Co-occurring Disorder Treatment Groups	1 – 5 4	The team reports having 34 members diagnosed with a co-occurring disorder. Of those 34 members, 12 are reported attending the weekly substance abuse treatment group, at least once monthly (35%). The group is co-facilitated by both SAS staff and uses the *Groups-to-Go* curriculum, as provided by the RBHA. Staff report that the curriculum provides structure to the groups but has too many sessions focused on the drugs themselves, rather than coping skills. One staff said, "Sometimes, talking about it [the drugs] too much can trigger people. I like to focus on how to get past them".	• Review the substance use treatment groups curriculum to ensure a co-occurring disorders treatment model is utilized. Consider using manuals that focus their curriculum and client engagement strategies around a co-occurring stage-wise treatment approach. Document/summarize member progress toward treatment goals on a monthly basis at minimum.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 2	The team uses primarily a traditional model approach to Dual Disorders. Multiple team members were able to discuss the Stages of Change and harm reduction with reviewers with some level of understanding; however,	• At the team, PNO and RBHA level, continue efforts to provide education and training on Integrated Treatment for Co-

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			the team uses inpatient care, detox programs, and NA/AA groups regularly. At the time of review, over 20 of the 34 members were reported as participating in groups, with the vast majority in traditional model groups. Staff members indicated that the team provides "maintenance" work, but "if there is more work, we recommend inpatient and compliance with meds."	Occurring Disorder as a stage-wise treatment approach. Standardizing basic tenants of treatment may help ensure consistent interventions across the system.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team's Peer Support Specialist (PSS) is a full-time staff with full professional status. The PSS has been working on ACT teams for over 13 years, and has been with this particular ACT team since its inception. The staff stated the PSS as being helpful, professional, and able to provide strategies on engagement techniques for members who are experiencing challenges. The PSS has a full case load and was observed as an active participant in the team meetings.	• Though staff reports regarding of team cohesion with the PSS were positive, reviewers question the level of cohesion amongst all team members at this time. See *Team Approach* for further discussion.
Total Score:		**110/28 =3.93**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	1
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	3
9. Substance Abuse Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	5
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	5
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	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	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	4
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.93**	
Highest Possible Score	**5**	