ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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AHCCCS Fidelity Reviewers

Method

On January 14-15, 2019, T.J. Eggsware and Annette Robertson completed a review of the Southwest Network (SWN) Saguaro Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

Southwest Network (SWN) serves children, adolescents and adults. SWN operates four outpatient treatment centers serving persons diagnosed with a Serious Mental Illness (SMI). ACT services are available at three of those locations. The individuals served through the agency are referred to as *members*.

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

- Observation of a daily ACT team meeting on January 14, 2019;
- Individual interviews with the Clinical Coordinator (i.e., Team Leader), Substance Abuse Specialist (SAS), Employment Specialist (ES) and ACT Specialist (AS);
- Individual interviews with three members served by the Saguaro ACT team;
- Charts were reviewed for ten randomly selected members using the agency's electronic medical records system; and,
- Review of documents: ACT team roster, CC productivity log, resumes and training records for Vocational and SAS positions, program flyer, outreach checklist, substance use treatment handbook and group sign-in sheets, the SAS's individual substance use treatment schedule, the *ACT Admission Screening Tool* and *ACT Exit Criteria Screening Tool* developed by the Regional Behavioral Health Authority (RBHA).

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of

Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The ACT team meets four days a week to discuss each member of the team. One day a week the team meeting is extended to allow for in-depth discussions for specific members, to collaborate to complete annual paperwork or specialist cross-training. During the meeting observed, staff appeared to take a primary role in implementing services related to their specialty positions in addition to shared duties.
- The team has two Nurses who provide services to members in the office and in the community. The Nurses coordinate with medical health care providers. They provide guidance to other team specialists related to medications and health conditions.
- Staff reported few members closed due to refusing, terminating services or moving from the geographic area without referral.
- The team is staffed with an ES and Rehabilitation Specialist (RS) who support member employment goals.
- Staff provides to members a document outlining ACT services, staff contact information and descriptions of their roles on the team.

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

- The ACT team should increase the frequency of face-to-face member contacts. The team should also increase the amount of time spent in face-to-face member engagement, with a focus on community-based individualized services. Based on ten records reviewed, members received infrequent contact from staff. With few exceptions, the amount of time spent with members was low.
- Engage ACT members who experience co-occurring challenges to participate in individual and/or group substance use treatment through the team, as appropriate, based on each member's stage of treatment. Consider expanding substance use groups to allow at least one group to accommodate members in earlier stages of recovery and another to focus on those in later stages of recovery. Based on information provided, there is low member participation in group treatment.
- Ensure all staff is knowledgeable of the stage-wise approach to substance use treatment including persuasion, engagement, active treatment, relapse prevention, associated treatment interventions and staff activities. The team could benefit from training on how stages of change align with stage-wise treatment interventions. Using a stage-wise model may empower staff to provide specific interventions based on the member's stage of treatment.
- Engage informal/natural supports in member treatment. Staff reported the team has four contacts a month with informal supports. However, based on observation of the team daily meeting, staff referenced few recent contacts with natural supports. Few recent contacts with informal supports were documented in ten member records reviewed.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of review there were 11 full-time staff working on the ACT team. Excluding the Psychiatrist, the member-to-staff ratio is under 10:1 for the 96 member program.	
H2	Team Approach	1 – 5 2	One staff estimated about 90% of member's meet with more than one staff over a two-week period. One member interviewed reported they met with one staff in the week prior to their interview. Another member, who receives medication observation support, reported they see three to four staff weekly. A review of ten member records showed that 30% of members met with more than one staff member over a two week period.	• Ensure that ACT staff are familiar and work with all members; 90% or more of members should have face-to-face contact with more than one staff in any two week period. Contacts should be purposeful, directed at aiding members in achieving recovery goals, and preferably occurring in the community.
H3	Program Meeting	1 – 5 5	Staff said that the ACT team meets four days a week. The Psychiatrist attends all scheduled team meetings and other staff attends on weekdays they are scheduled to work. One day a week the team meeting is extended to allow for in-depth discussions for specific members, to collaborate to complete annual paperwork and for staff cross-training. During the meeting observed, all members were discussed. Staff appeared to take a primary role in implementing services of their specialty positions in addition to shared duties.	
H4	Practicing ACT Leader	1 – 5 3	At the time of review there was a full-time CC employed with the team. The CC estimated that about 60% of her time is spent providing direct services. The CC reported that she provides housing support, therapy and substance use treatment. In ten member records there were few examples of the CC providing direct services to members. A report of direct services by the CC over a month timeframe showed about 17% of her	• Explore with the CC what barriers exist in provision of direct services. Work with the CC to identify and shift administrative duties (outside of necessary supervisory or other program leader functions) to allow for increased direct service provision.

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			time was spent providing direct services.	
H5	Continuity of Staffing	1 – 5 4	The team experienced 25% turnover, with six staff that left the team in the past two years. The team had difficulty retaining a second SAS. Staff reported that all specialists, the Nurses, and the Psychiatrist work four ten-hour days with the team. The flexibility of scheduling was cited as a contributing factor in staff retention.	• Continue to screen and orient potential ACT staff to assess their preparedness to deliver ACT services. Examine employees' motives for resignation. Optimally, ACT teams experience no greater than 20% turnover during a two year period.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the ACT team operated at approximately 94% of full staffing capacity. Though sporadically filled, the second SAS position on the team was vacant for six of the past 12 months.	• Fill vacant positions as soon as possible to ensure diverse coverage and continuity of care for members.
H7	Psychiatrist on Team	1 – 5 5	The team has an assigned Psychiatrist who works four, ten-hour days. He attends the team meeting on those weekdays. The Psychiatrist was present and contributed to discussion during the team meeting observed. It was reported the Psychiatrist provides community-based services and cited attempting to visit an incarcerated member in the meeting observed. Staff reported that the Psychiatrist is available to staff and members. Members reported they usually meet with the Psychiatrist monthly. However, in ten member records reviewed, not all met with the Psychiatrist at least one time over a month period. In one record it was documented that the Psychiatrist was scheduled to leave the team January 8, 2019. This was also reported by an interviewee. However, an agency administrator informed the reviewers that the Psychiatrist's last day occurs after the fidelity review.	• Fill vacant positions as soon as possible to ensure continuity of care for members and minimize gaps in coverage.
H8	Nurse on Team	1 – 5 5	The team has two full-time Nurses. Staff reported the Nurses provide community and office-based services. Two members interviewed confirmed	

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			Nurses meet with them in their homes. Staff said the Nurses are accessible in person and by phone. Staff stated that the Nurses assist members with psychiatric and physical health services, medication observation, and coordinate with medical health specialists. The Nurses attend clinical team meetings on the days they are scheduled to work when meetings occur, for one Nurse, three days a week and the other, four days a week. Over a month timeframe, Nursing services were documented in most of the records reviewed.	
H9	Substance Abuse Specialist on Team	1 – 5 3	The ACT team is staffed with one full-time SAS. The SAS has many years of experience providing substance use treatment. Training records showed the SAS participated in five trainings pertinent to his position in the last year. Some of those trainings were facilitated by a Licensed Associate Substance Abuse Counselor (LASAC). The second SAS position is vacant. The CC and Psychiatrist reportedly share in the provision of substance use treatment. The CC previously held the position of SAS on another ACT team. However, it appears their primary duties as a Psychiatrist and CC limited their capacity to supplement substance use treatment services offered by the one SAS.	• Hire a second SAS. Ensure SAS staff receives ongoing training and supervision in current best practices in substance use treatment interventions by staff with the requisite experience to provide such oversight.
H10	Vocational Specialist on Team	1 – 5 5	The ACT team has two Vocational Specialist (VS) staff, classified as an ES and RS. Both have many years' experience working with members diagnosed with a SMI. Additionally, the RS has been in her position for more than four years and the ES in his current or comparable position for more than five years. Training records were provided and showed both participated in Disability Benefits 101 (DB101) but no other	• Ensure VS staff receives regular training to stay up to date about resources and strategies to engage members to pursue and obtain employment. Participating in meetings with other VS staff may aid them to share job leads or strategies based on their job development activities.

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			supportive employment related trainings in the 12 months prior to the review.	
H11	Program Size	1 – 5 5	At the time of review, 11 full-time staff worked on the team, including: Psychiatrist, CC, two Nurses, ES, SAS, Independent Living Skills Specialist (ILS), Housing Specialist (HS), RS, Peer Support Specialist (PSS), and an ACT Specialist.	
O1	Explicit Admission Criteria	1 – 5 5	Staff reported referrals to the team originate from other less intensive service teams at the Saguaro site, from other providers, or are streamed through the RBHA. Staff said that the team controls admissions with no organizational pressures to admit. Based on interviews with staff, the ACT team follows the *ACT Admission Screening Tool* criteria established by the RBHA. The CC usually conducts screenings, but other staff will occasionally assist with screenings of potential ACT members. Staff collaborates to review the screening information with the Psychiatrist, who then makes the final determination whether members join the ACT team. Members can accept or decline ACT. Due to the high member census and regular rate of referrals, there was little active recruitment reported.	
O2	Intake Rate	1 – 5 5	The admission rate to the team was four or less members, per month, in the six months prior to review. There were four admissions, per month, during July and September 2018, two admissions each month for August, October and November 2018, and no admissions December 2018.	
O3	Full Responsibility for Treatment Services	1 – 5 5	The ACT team provides case management, psychiatry services and medication management, employment services, and substance abuse treatment, the majority of housing support, and counseling is available. Per staff report, no	

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			members receive medication management, substance use treatment or supportive employment services from another provider. The ES and RS support member employment goals, but other specialists assist as well. During the team meeting staff referenced members' employment status and plans. Based on staff report, less than 10% of ACT members reside in a staffed residence or receive residential treatment. During the morning meeting, staff discussed providing independent living skill supports to members' in their homes. The ACT team also assists members with housing searches and coordinating with housing voucher providers. The CC provides counseling to two members. Some members are served from providers who are not part of the team. One member elected to work with an outside counseling provider. Two members were referred to specialists after staff determined their needs were in an area outside of the scope of the CC's experience.	
O4	Responsibility for Crisis Services	1 – 5 5	Members reported staff is available after hours and over the weekend. One staff is scheduled to work Saturday and another Sunday. A team flyer is given to members. The flyer describes ACT services and staff roles. It includes specialist contact numbers and hours available. The flyer directs members to contact the on-call number for the team if they experience a mental health crisis. Specialists are available 24 hours a day, seven days a week via rotation of on call duties. During the team meeting, some interviews and in a record reviewed, there were examples of members contacting the local crisis line who then relayed	

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			calls to the team. However, based on interviews, the team is the primary responder to mental health crisis. Staff confirmed the Nurses and Psychiatrist are available to on-call staff.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff reported they are usually involved in member hospital admissions. One staff said the team was involved in about 83% of recent admissions. Based on review of recent hospital admissions, the team was directly involved in seven of the last ten. One staff said that they believed the team was involved more often than what was represented in the most recent ten admissions, and estimated team involvement at 90-95%. Staff reported if a member needs assessment and the clinic is open, they are brought to the office to meet with the Psychiatrist. Occasionally, the Psychiatrist may visit them in the community. If hospitalization is necessary, staff assists members by transporting them and assisting with the admission. One staff reported some members seek hospitalization without informing the team. The staff noted some members prefer certain hospitals over those staff offer.	• Work with each member and their support network to discuss how the team can support members in the event of a psychiatric hospital admission. Proactively develop plans with members on how the team can aid them during the admission, especially if members have a history of seeking hospitalization without team support. • Increasing member engagement through a higher frequency of contact and intensity of service may provide ACT staff with more opportunities to assess and provide intervention to reduce psychiatric hospitalizations, or to assist in admissions when indicated. This may also offer more opportunities for staff to engage and build rapport with natural/informal supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff reported they see a member within 24 hours of hospital admission and meet with them Monday, Wednesday and Friday. Staff said they coordinate with inpatient staff and that the Psychiatrist completes doctor to doctor coordination. Upon discharge, staff transport members to their residence after ensuring current medications are obtained. Staff reported they meet with members face-to-face for five days beginning the day after discharge. Staff stated members meet with the Psychiatrist within 72	• Monitor team involvement in hospital discharges. Ensure member treatment requests are addressed and resolved. Monitor team adherence to hospital discharge processes.

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			hours of discharge. Based on staff summary, the team was involved in nine of the ten most recent member discharges from a psychiatric inpatient setting. However, it was not clear in one record reviewed, if ACT staff coordinated with inpatient staff or acted on the member's service request. Additionally, the staff did assist the member with discharge and to access supports in the community, but it was not clear if there was follow up or monitoring of the member's barrier to obtaining a medication. Contact with the Psychiatrist within the 72 hour timeframe was not located. Face-to-face contact was documented the day after discharge but was not located for the remaining four days; staff documented one phone attempt. The member subsequently was re-admitted to a psychiatric hospital.	
O7	Time-unlimited Services	1-5 4	Over the prior year, five members graduated from the team, and in the upcoming year the team expects about six to graduate. During the team meeting observed, staff discussed four potential graduates. The team utilizes the *ACT Exit Criteria Screening Tool* developed by the RBHA, when assessing the potential for member graduation. Factors the team considers includes: whether members have no hospital admissions over the course of a year; no crisis or on call services; whether members are stable on medications; and for some members, achieve recovery such that they feel the intensity of ACT is no longer necessary.	• Optimally ACT members are served on a time-unlimited basis with less than 5% expected to graduate annually.
S1	Community-based Services	1 – 5	Staff estimated they spend most of their time in the community (80-95%). Two members	• ACT teams should perform 80% or more of contacts in the members' communities

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		3	interviewed reported that staff usually meets with them at their homes. Based on review of ten member records over a month timeframe, a median of 58% of services occurred in the community. Some members were not in contact with the team and there was evidence of outreach documented. However, for other members, there were gaps in documented outreach or contact.	where staff can directly assess needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting. Ensure all staff engages members in the community at a similar level as what was reported by staff interviewed.
S2	No Drop-out Policy	1 – 5 5	Based on staff report, few members dropped-out of ACT services in the year prior to review. One member closed due to lack of contact and one did not respond to staff outreach. Another member left the geographic area, moving to another country the same date they informed the team of their plan. Staff said the team attempted outreach to confirm the member left the country. After eight weeks, the member was closed.	
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff said the team completes eight weeks of outreach engagement when members are not in contact with the team. They reported the team completes four outreach efforts weekly, two of which are community-based. Staff reported they follow a checklist to track outreach. The checklist provided includes space to track up to 12 weeks of outreach; with weeks nine through 12 for high-risk members. The document prompts for various tasks to be completed as part of outreach, including: attempting a home visit, calls to emergency contacts, family, shelters, hospitals, payees and probation officers. However, there were lapses in documented outreach, or contact with members, in multiple records reviewed. Over a month timeframe, contact or outreach was not documented for a week or more, for six members.	• If members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. • Evaluate how last contacts with members are tracked. Staff should coordinate contact and/or outreach plans; this collaboration usually occurs in the team meeting. Identify specific staff and activities staff will complete. • Track outreach attempts to ensure they occur and are documented.
S4	Intensity of Services	1 – 5	The median intensity of service found in ten	• Increase direct service time to members to

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		2	member records reviewed was 21 minutes a week. Only one of the ten members received an average of more than 120 minutes of service time per week over a month period. The member received medication observations, which accounted for much of the time documented for those contacts.	at least two hours per week, on average. Direct service contacts by ACT staff should occur primarily in the community and be purposeful, focusing on individual needs. • Review with staff to ensure they accurately document services rendered.
S5	Frequency of Contact	1 – 5 2	The median weekly face-to-face contact for ten members was one contact per week based on review of ten member records. The team averaged four or more contacts with one member who received medication observation. One member interviewed reported they usually meet with one or two staff during a week and another reported they usually see three to four staff.	• Increase the frequency of contact with members by ACT staff to average four or more per week. • Review with staff to ensure they accurately document services rendered. Regular reviewing of documented contacts may improve the team's application of this item.
S6	Work with Support System	1 – 5 2	Staff reported the team has frequent contact with informal/natural supports. However, documentation in ten member records over a month timeframe showed few staff contacts with informal supports. For those ten members, there was an average of less than one contact a month with informal supports. During the meeting observed, staff cited contacts with natural supports for roughly 16-21% of all members discussed, some of which occurred the prior week. Some members reported they were comfortable with staff contacting their natural supports but said they didn't believe staff had regular contact with their supports.	• The team should encourage members to develop and identify their support systems. Discuss with members the benefits of involving those supports in their treatment. • Seek training and guidance, to enhance strategies for engaging informal supports. Optimally, ACT staff has contact with informal supports an average of four times or more monthly as partners in supporting members' recovery goals. • Evaluate methods of tracking or monitoring staff documentation of contacts with informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Individual substance use treatment is available through the team. It was reported that the SAS or CC meet regularly with about 90% of the 54 members with a substance use diagnosis. Based on records reviewed, it did not appear individual substance use treatment was offered or provided to members with a substance use diagnosis at the	• Engage members with a substance use diagnosis to participate in regularly occurring individual substance use treatment with ACT staff. Across all members with a co-occurring diagnosis, an average of 24 minutes or more of formal structured individual substance use

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			frequency reported by staff. Records were reviewed for five members with a substance use diagnosis. Over a month timeframe, three members had zero individual sessions and for one of those members, there was one attempted outreach to make contact. Of members that received an individual session; one member received one individual session and two outreach efforts, and the fifth member received two sessions and two attempts.	treatment should be provided weekly. • Review documentation processes to ensure that all efforts are being recorded. The team reported more frequent services than were found in documentation. • Review activities assigned to the SAS that constricts their availability to provide individual substance use treatment.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Staff reported the SAS facilitates one substance use treatment group and a group for members who speak Spanish. The group for members that speak Spanish was reported to be open to all Spanish speaking members, not focused on members with a substance use diagnosis. Therefore, member attendance in that group was not factored into this item. Based on sign-in sheets for the substance use treatment group, over a month timeframe, about 13% of the members identified with a co-occurring diagnosis participated. Sign-in sheets were provided for multiple months that showed a small number of members regularly participated. The records reviewed showed little evidence of substance use treatment group attendance, or regular engagement for members to participate in group treatment in the thirty day period.	• All ACT team staff should engage members with a co-occurring diagnosis to participate in treatment groups based on their stage of treatment. Optimally, 50% or more of dually-diagnosed members attend at least one substance use treatment group monthly. • Consider offering groups so that at least one is structured for members in earlier stages, and at least one is available for members in later stages of recovery. Interventions should align with a stage-wise approach. • Review activities assigned to the SAS that takes time away from their availability to provide group substance use treatment.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The team is familiar with the stages of change model. Members' stages of change were discussed in the morning observed. On this ACT team, the stages of change are applied to members with a substance use diagnosis as well as other goal areas (e.g., employment, smoking cessation). Staff	• Provide training and guidance to all staff on an integrated approach to substance use treatment, including stage-wise treatment. Train staff on how to incorporate substance use treatment interventions in treatment plans.

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			interviewed identified interventions that align with members' stages of change. During the morning meeting staff cited their use of harm reduction tactics and motivational interviewing. Staff described some specific examples of harm reduction interventions. In records reviewed, examples of harm reduction efforts were documented. For example, discussing with and encouraging a member to reduce their use of a substance. Staff confirmed medication-assisted treatment is available. Staff identified a member who receives this support. It wasn't clear if all staff is familiar with a stage-wise approach to treatment. Most treatment plans for applicable members reviewed did not address substance use or, if noted as an area to be addressed, did not outline team interventions that align with a stage-wise approach to treatment. It wasn't clear if staff understood specific circumstances when withdrawal management (i.e., detoxification) may be medically indicated. Staff reported the team uses Integrated Dual Diagnosis Treatment (IDDT) but the treatment manual used for group treatment is labeled a stages of change therapy manual.	• Review with staff the conditions when withdrawal management may be medically indicated versus circumstances when other interventions can be provided in lieu of detoxification based on the substance used. • As noted earlier in the report, regularly engage members to participate in individual substance use treatment, offer multiple co-occurring treatment groups to serve members in various stages of treatment, and hire a second SAS staff.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team is staffed with a PSS. Staff said that the PSS divulges information about shared experiences to members to support them in their recovery. Not all members interviewed were familiar with the PSS staff. Staff reported the PSS has the same performance expectations as other staff. Another staff reported they also have a lived experience.	• Ensure all members are informed of a PSS, or other staff on the team with lived psychiatric experience, and how they can be a resource to members.
Total Score:		**3.93**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	2
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	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	5
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	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.93**	
Highest Possible Score	**5**	