ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: May 30, 2018

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AHCCCS Fidelity Reviewers

Method

On May 15-16th, 2018, Georgia Harris and Karen Voyer-Caravona completed a review of the Terros 23rd Avenue Recovery Center's Assertive Community Treatment (ACT) Team 2. 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.

Terros provides a wide variety of services including: primary care, outpatient and residential drug/alcohol treatment, general counseling, crisis response, recovery, and mental health treatment. Terros operates multiple adult outpatient clinics throughout Maricopa County. There are two ACT teams that reside in the 23rd Avenue Recovery Center clinic. This report will be focused on the 23rd Ave -ACT Team 2, and for the duration of the report, will be referred to as the ACT team. The ACT team has experienced much attrition in past year; however, at the time of review, the team was fully staffed and was serving 98 members.

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 the ACT Team Leader/ACT Clinical Coordinator (ACT CC);
- Individual interviews with a Substance Abuse Specialist (SAS), the Rehabilitation Specialist (RS) and the Employment Specialist (ES);
- Group interview with three members receiving ACT services;
- Charts were reviewed for 10 randomly selected clients using the agency's electronic medical records system, and other administrative documents provided by the agency.

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 maintains the low member-to-staff ratio of 9:1. Equipped with 12 staff, the team is of adequate size to consistently provide staffing diversity and coverage.
- The team benefits from a full-time, fully-integrated Psychiatrist. In addition to psychiatric medication and monitoring, he has taken an active role in the organization and coordination of the case management functions of the team.
- The ACT team considers themselves to be first responders in times of crisis. The team provides 24-hour coverage and goes into the field to assess members and intervene when appropriate.
- In addition to being a fully-integrated ACT staff, the Peer Support Specialist (PSS) is viewed as an authority in connecting members with opportunities in the community that support their individual recovery goals.

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

- The team has operated at a staff capacity of 63% as fifteen staff left the team in the past two years. Consistent staffing is a key ingredient in successful ACT teams. The agency should research/implement human resources best practices that are focused on employee satisfaction and retention.
- The ACT team provided minimal documentation to support their partnership with the informal support systems of members. Assist the team in developing a comprehensive system for outreach, engagement, and tracking of their interactions with members' supports.
- The team uses primarily a traditional model for Substance Abuse treatment. Cross-train all staff in Co-Occurring Disorder principles. Members benefit from consistent use of best practice approaches. As staff are trained, they will have a shared understanding of effective treatment interventions and will be capable of properly aligning and implementing them into all aspects of member treatment.
- Though staff report spending most of their day fulfilling the functions of their specialties, the absence of notes in the member records has impacted their ability to demonstrate proficiency in community based services, intensity of services, and frequency of contact with members. Train all ACT staff on the various documentation requirements and provide them with strategies, schedules and other aids to meet these objectives.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team maintains a member-to-staff ratio of approximately 9:1. The team serves 98 members. The team consists of 11 full-time staff: an ACT Team Leader/Clinical Coordinator (CC), two nurses (RNs), an ACT Counselor (SAS1), a Substance Abuse Specialist (SAS2), an Independent Living Specialist (ILS), a Peer Support Specialist (PSS), a Housing Specialist (HS), an Employment Specialist (ES), a Rehabilitation Specialist (RS) and one ACT Specialist (AS). This staff count excludes the Psychiatrist.	
H2	Team Approach	1 – 5 3	The ACT team generally has a strategy for connecting with members. Staff reported serving all members through the use of a rotating permanent schedule; this is a rotating calendar which provides each specialist with a rotation of geo-mapped, pre-scheduled visits for each workday. In spite of this, results of the ten-member record review suggest that only 50% of members were seen by more than one ACT staff, in a two-week period. Members interviewed reported that they had contact with multiple staff in the prior week, but many reported their contact resulted from frequent visits to the clinic for groups.	• As a first step, review the current contact strategy with the team to ensure it is implemented as intended. By design, any contact strategy used should result in a team approach to services and meeting members' needs primarily in the community. • Secondly, ensure staff is following the team approach and documenting all contacts and/or attempts.
H3	Program Meeting	1 – 5 5	The ACT team conducts a team meeting five days a week. During the meeting, staff is expected to report on the progress of every single member. Reviewers noted that the status of each affiliated member was discussed during the observed meeting. Time for in-depth discussions on member needs is carved into the daily meeting, as the need arises.	
H4	Practicing ACT	1 – 5	The ACT CC provides occasional, backup services	• A practicing ACT Team Leader is noted

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	Leader	2	to ACT members. The ACT CC estimates that 25% of her time is spent providing direct services to members. The reporting provided by the agency suggests the ACT CC spent nearly 5% of her time providing direct, face-to-face services. Moreover, the CC did not have any documented interaction with members in the records examined by reviewers. The CC joined the team six months prior to the review and reports that there has been a lot of focus placed on providing the team with structure and parameters to work from. Many staff reported that the administrative pressure to attend to matters within the clinic restricts the ACT CC's ability to provide necessary support to members and staff in the field.	as one of the five factors most strongly related to better member outcomes. As the ACT CC establishes her role on the team, increasing her time spent in direct services will offer opportunities to model appropriate clinical interventions for the other ACT staff. • The ACT CC should continue to work toward providing direct care services to members 50% of the time. • Identify and address barriers to the ACT CC providing at least 50% of the time in direct services.
H5	Continuity of Staffing	1 – 5 2	The team has operated at a staff capacity of 63%, as fifteen staff left the team in the past two years. ACT staff reported various incidents that led to the high attrition rate; however, many referenced an agency-wide demand for increased productivity among Serious Mental Illness (SMI) clinical teams as the main factor affecting the morale of staff clinic-wide. Even so, ACT staff report that the current ACT CC played a large role in implementing processes that increased productivity and improved the morale of the ACT team.	• Consistent staffing is a key ingredient in successful ACT teams. To reduce the potential for increased employee attrition, the clinic and/or agency leadership should solicit feedback from staff on matters affecting employee satisfaction. • Examine employees' motives for leaving the team. Employee exit interviews can help to determine trends in turnover. 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 ACT team staff, particularly for those job candidates new to the ACT model.
H6	Staff Capacity	1 – 5	The team has operated at approximately 94% of	• Continue efforts to recruit and screen

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		4	staffing capacity in the past 12 months. The team was without a Nurse for two months, an ES for three months, a PSS for two months or a HS for two months. The team's new HS joined the team on the week of the review.	potential employees to ensure they qualify for the ACT team. Maintaining a fully-staffed team is critical to the service consistency for members. When there are position vacancies, members are unable to receive the full breadth of essential services, as presented by the ACT team.
H7	Psychiatrist on Team	1 – 5 5	The Psychiatrist has been with the team since 2016. In addition to providing psychiatric medication and monitoring, he is involved in the overall organization and management of the ACT team. The Psychiatrist also provides community treatment to members on a weekly basis. During the morning meeting, the Psychiatrist was observed providing feedback to ACT staff on appointments and outreach visits with members.	
H8	Nurse on Team	1 – 5 5	The team currently has two full time Nurses. Both nurses provide medical integration, behavioral health consultation, injections and medication administration, emergency triage, home/hospital visits and attend medical specialty appointments. The ACT staff reported that the team Nurses are accessible and flexible with their schedules and one Nurse is always available on the weekends.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The team has two Substance Abuse Specialists (SASs). SAS1 has a Master of Science degree as a Professional Addiction Counselor and over ten years of experience in various positions related to the SMI and/or substance abuse treatment fields. SAS2 is both a Substance Abuse Specialist and the designated Counselor on the team. SAS2 is a Licensed Master Social Worker (LMSW) with over eight years of direct work experience with SMI members in Substance Abuse treatment. Both SASs	• Though the team has met the criteria for this item, the agency should investigate the concerns/requests made by staff, to ensure they feel equipped to provide the breadth of required ACT services as required.

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			have attended specialty related trainings provided by the Regional Behavioral Health Authority (RBHA) over the past year (i.e., Integrated Dual Diagnosis treatment IDDT); however, staff desire more clinical oversight to adequately develop the Co-Occurring Disorders (COD) program into the level of service required.	
H10	Vocational Specialist on Team	1 – 5 4	The team currently has an Employment Specialist (ES) and a Rehabilitation Specialist (RS). The ES joined the team in January 2018. The ES is new to the ACT model of care. The ES previously worked as an SMI Case Manager, and has provided employment training to recipients of government entitlement programs (not SMI specific). The RS has been with the team since 2016. The RS has over seven years of experience as an SMI Case Manager and held positions in which some of her duties included helping members connect to meaningful community activities. Both specialists have attended specialty-related trainings provided by the RBHA (i.e. Supported Employment).	• Continue to provide ongoing training for both specialists on vocational topics and industry best practices.
H11	Program Size	1 – 5 5	The ACT team currently has 12 staff. The team is of sufficient size to consistently provide diverse and adequate services.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team has clearly defined ACT admission criteria, as outlined by the RBHA. Though the ACT CC conducts the majority of pre-admission screenings, potential members have been screened by other ACT staff, as well. After screening, the potential member is discussed with the Psychiatrist and a determination for program admission is made. The ACT CC does not report any administrative pressure to receive any candidates onto the team; however, stated there were	• Though the team has met the criteria for this item, it would be beneficial to continue monitoring; ensuring that any potentially “rushed” screenings do not result in inappropriate admissions to the team.

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			instances when the window for determination of potential members was viewed as insufficient for a thorough evaluation of the member(s) appropriateness for ACT services.	
O2	Intake Rate	1 – 5 5	The ACT team reports five admissions in the last six 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 4	In addition to case management, the ACT team directly provides psychiatric services, counseling/psychotherapy, and substance abuse treatment. All ACT members receive ongoing treatment and medication support from the ACT medical staff. Members in need of counseling/ psychotherapy are assigned to the ACT Counselor (SAS2) for support. The ACT Counselor provides care to about four members; two additional members are referred to outside agencies for specialty treatment (i.e. Dialectic Behavioral Therapy). The team provides individual and group substance abuse treatment to those diagnosed with a COD. The team does have a limited number of members who are referred to 30-day drug treatment facilities, but the referral rate is well below 10% of all members in COD treatment. Though the team does provide housing and independent living skills support, more than 10% of members are in residences with some level of staff support. The team reports that vocational services are provided, but it is not clear if vocational service staff are fully-rooted in the vocational/rehabilitative services model for ACT, as the team actively proposes referrals to external employment agencies for services.	• The team should continue to 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.
O4	Responsibility for	1 – 5	The ACT team provides 24-hour coverage to	

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	Crisis Services	5	members. Staff considers themselves to be first responders in times of crisis, going into the field to assess members when appropriate. Each Wednesday, staff rotates coverage of their on-call phone. There is always two ACT staff assigned to the on-call crisis duties. The ACT CC is the secondary backup and is contacted if a decision needs to be made regarding the team making afterhours or weekend community visits to members in crisis.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The ACT team was directly involved in 80% of the ten most recent hospital admissions. The remaining two were self-admissions by the members and once admitted, the hospitals notified the ACT team; allowing the team to actively participate in ongoing treatment coordination. The staff reported that these two members prefer to access emergency care on their own, without the assistance of the ACT team.	• Continue to monitor and track member hospitalizations closely, as ACT team involvement in the decision to hospitalize helps to ensure that members' admissions are appropriate. • See S6 for recommendations on the role of natural support systems.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	The ACT team was directly involved in 80% of the ten most recent hospital discharges. Staff reports that the discharge process begins upon hospital admission. The team coordinates with the inpatient treatment team to establish a discharge plan. Once discharged, the team provides transportation to their residence, and begins a five-day follow up sequence. Staff reported that one member left the hospital before the ACT staff could arrive. The other member was discharged on a bus from an out-of-state hospital, but he had gotten off at an earlier bus stop than was coordinated by the team.	• Work to improve all discharge planning efforts.
O7	Time-unlimited Services	1 – 5 5	The ACT team did not report any graduations from the team over the past year. The team is monitoring the progress of one member for a potential transfer to a lower level of service and	

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			does not expect to graduate over five percent of the total team load within the next 12 months. The team views members who have increased their independence on ACT services as candidates for graduation, which is often indicated by sustained employment and lessened dependence on medication monitoring, crisis and inpatient services.	
S1	Community-based Services	1 – 5 2	The ACT staff provides some services to members in the community. Staff estimated that between 80%-90% of their contacts with members were in the community. According to the review of ten randomly selected records, the team provided 38% of their face-to-face contacts in the community. The majority of members interviewed affirmed the results of the record review, with many stating they come into the office between three and five days a week for in-clinic programs and medical services. Members said the staff will increase visits to their home when they are experiencing an increase in symptoms.	• ACT teams should perform 80% or more of their contacts in the community. • Ensure that all encounters with members are accurately documented within the clinical record. Discuss with ACT staff the reasons why their reported high community-based services was not supported in records reviewed. • For members who are coming into the clinic multiple times a week, the team should explore how to deliver those services in the natural settings where members live and/or where challenges are the most likely to occur.
S2	No Drop-out Policy	1 – 5 5	The team reports retaining about 97% of their members over the past 12 months. The ACT CC reports that two members who left the team were sent to Navigator teams for lack of contact. Eventually, it was discovered that both members moved out of the geographical area and did not involve the team in the coordination of their services with their receiving mental health providers.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The ACT team has a demonstrated strategy for connecting with disengaged members. The team uses an 8-week strategy that includes street	

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			outreach and legal mechanisms to locate and engage with members. The outreach strategy was mentioned in the team meeting and was visible in some of the members' charts. The team reports that most members are located prior to the completion of the eight week outreach, but should a member not be located in that timeframe, they are transferred to a Navigator team at the clinic for further outreach.	
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 50 minutes per week in total service time per member. Though most of the records reviewed showed below average contacts, there was still much variation in the duration of services provided; duration of services ranged from zero minutes to nearly five-hundred minutes per week per person. Little evidence was found in the records to support the team's involvement with the member(s) beyond standard home visit responsibilities.	• ACT teams should provide an average of two hours or more of face-to-face service time per peek, per member. • Continue to monitor face-to-face contacts with all members weekly and ensure they are accurately documented, including any specialty services provided by staff. • Review recommendations in H2, *Team Approach* regarding implementation of contact strategy. • The ACT team and agency administration should explore the systemic, technological, and human resource needs of the ACT team, subsequently assisting to find solutions to the needs that create gaps in services for members.
S5	Frequency of Contact	1 – 5 2	The team currently provides a low frequency of contact to members. Of the ten records reviewed, ACT staff averaged 1.75 contacts per week, per member. Members report that face-to-face contacts with staff are varied; some receiving minimal contact due to scheduling conflicts (e.g., work during the day), while others see them most frequently when they come into the clinic for	• ACT staff must consistently document all encounters with members in the clinical record for improved team coordination and continuity of care. See S4, Intensity of Services, for recommendations on the agency's role in service improvement.

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			activities and/or when they are receiving medication management services. Though staff reported seeing members frequently, some staff discussed the technological difficulties experienced by the team, which is believed to be a key factor in the team's infrequent reporting of their encounters with members.	
S6	Work with Support System	1 – 5 1	The ACT team provides minimal support to the informal support systems of members. Staff reported that nearly 65% of all members have an active informal support in their lives. Of the active supports, the staff suspects that they were in contact with at least 75% of them on a monthly basis. Though the staff could identify the informal supports they most frequently connect with, the documentation to support this was minimal. Of the ten member records reviewed, one record displayed evidence of staff contact with informal supports. Also, the team did not discuss their process for encouraging members to include natural supports in their treatment.	• Focus on documenting team contacts with member support system(s) in a consistent fashion, to ensure this measure is being accurately captured. • Educate members on the benefits of, and encourage the involvement of, informal supports. • If a member has an identified support, but declines to sign a release of information (ROI) for team engagement, this should be documented in the member record for future reference. Revisit this option with members on a recurring basis.
S7	Individualized Substance Abuse Treatment	1 – 5 4	The SASs provides individualized substance abuse treatment to COD members. Each SAS is assigned roughly half of the sixty-six COD members for treatment. Though scheduled for weekly face-to-face visits, SAS staff estimated that nearly half of their assigned members receive individualized treatment sessions during their weekly appointments. Each SASs has their own method for tracking scheduled treatment sessions. SAS staff provided evidence to reviewers of how they tracked their hand-written session notes prior to inputting them into the members' clinical records; however, few of these sessions were reflected in	• Continue all efforts to increase the time spent with member in individual sessions to 24 minutes or more, per member, and documenting it in the clinical record. • Monitor member participation in individualized substance use treatment through the SASs and increase engagement of members who are in need of COD treatment. • Ensure that both SASs receive the necessary training, mentoring, and ongoing guidance to provide

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			the clinical records of COD members included in the record review.	structured, individual substance use counseling to members identified with a co-occurring disorder.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The ACT SASs offer three COD treatment groups to members. SAS1 provides a one-hour treatment group on Wednesdays and SAS2 conducts a one-hour group on Mondays and Fridays. Of the 66 members diagnosed with a COD, approximately 16 unique members (24%) attend one group on a monthly basis. Staff report that each group was focused on particular stages of change (i.e., pre-contemplative vs. action), but this has recently been abandoned due to the increase in acting-out behaviors by the psychiatrically acute members who attend. Staff also report that they are in need of additional clinical supervision to help them assess for the most effective interventions when attendees are disruptive.	• The ACT team should have 50% or more of their dually-diagnosed members engaged in COD groups. Continue to solicit member enrollment in COD treatment groups. • Ensure that both SASs receive the necessary training, mentoring, and ongoing guidance to provide structured group treatment to COD members. • Consider returning to co-occurring groups accommodating and focusing on members in different stages of treatment (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention).
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 2	The team uses primarily a traditional model for COD treatment. Some of the ACT staff interviewed reported to receiving some training in Integrated Dual Diagnosis Treatment (IDDT); however, many more were unable to describe any of the tenants. Still, some ACT staff were able to articulate and provide examples of harm reduction tactics they have used with members. Discussions during the treatment team meeting and further review of the clinical records revealed that some staff embrace the use of detox programs and other confrontational approaches (such as urinary drug screens) as treatment paradigms. It was reported that some staff are strong proponents of community 12-step groups. Moreover, Individualized Treatment Plans (ISPs) for members with a COD often listed interventions that were	• Train all staff in a stage-wise approach to treatment. This may include using the SASs to provide ongoing cross-training to other staff members. • Train staff on the activities that align with a member's stage of treatment and how to reflect that treatment language when documenting the service, as well as writing members' ISPs.

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			incongruent with the stage of treatment identified (e.g., offering groups to members who are in the engagement stage of treatment).	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team employs a full-time, fully-integrated PSS. Staff and members interviewed view the PSS as an authority in community engagement and integration. In the team meeting, reviewers observed the PSS as he provided relevant updates on member conditions and offered strategies for improving staff/member relations.	
Total Score:		**3.89**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	2
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	4
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	4

6. Responsibility for Hospital Discharge Planning	1-5	4
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	2
6. Work with Support System	1-5	1
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.89**	
Highest Possible Score	**5**	