ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: October 31, 2016

To: Jill Teslow Rowland, Director of Medical Management

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AHCCCS Fidelity Reviewers

Method

On September 27-28, 2016, Georgia Harris and T.J. Eggsware completed a review of the PIR - Metro Varsity 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.

Partners in Recovery (PIR) serves individuals with Serious Mental Illness (SMI) through seven locations in Maricopa County: Metro, West Valley, Hassayampa, East Valley, Arrowhead, Gateway, and West Indian School. Since last year's review, the PIR Metro Varsity ACT team has been focused on reducing staff turnover, namely in the leadership position of Clinical Coordinator (CC). The most recent CC filled the role for five months; however, she was promoted to the Clinical Director role in August 2016. The CD is providing supervision to the team until the CC role is filled. Additionally, the Metro Varsity team has been working on the restructuring of their internal processes (e.g. member visitation schedule) and positioning themselves for specialty staff functioning (e.g. Substance Abuse Specialists).

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 morning meeting on September 27, 2016.
- Group interview with three members receiving ACT services.
- Individual interview with the Clinical Director (CD), who previously filled the role of Clinical Coordinator (i.e., Team Leader).
- Individual interviews with lead Substance Abuse Specialist (SAS), Peer Support Specialist (PSS) and Employment Specialist (ES).
- Charts were reviewed for 10 members using the agency's electronic medical records system.
- Review of agency/team documents such as: *ACT team roster, Varsity ACT Morning Meeting log, MMIC ACT Eligibility Screening Tool, sample ACT member visitation schedule,* and the *Community Activities with Rehab Specialist*.

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:

- Psychiatrist on Team: The team benefits from a fully-dedicated ACT Psychiatrist. While providing a full spectrum of psychiatric services to members, the Psychiatrist also provides support, education, and mentoring to the ACT staff.
- Responsibility for Crisis Services: The team provides crisis coverage to members 24 hours a day, seven days a week. The ACT staff view themselves as first responders in crisis situations, and they provide their members with multiple ways to make contact with the team.
- Peer Support Specialist: The Peer Support Specialist is fully-integrated into the ACT team and has equal responsibility for ACT services rendered to members. The Peer Support Specialist provides ongoing mentoring by modeling recovery principles and helping members to implement the same principles in their own lives.

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

- Practicing ACT Leader: The team does not currently have an ACT Leader (i.e., Clinical Coordinator); moreover, the position has been vacant for four months in the past year. The ACT model stresses the importance of having a practicing ACT Leader, identifying this as one of the five factors most closely related to positive member outcomes. Teams with greater involvement from ACT Team Leaders benefit from having a leader who is not only familiar with the members and their needs, but also a model for appropriate clinical practices for other ACT staff.
- Intensity of Services/Frequency of Contact: The results of the record review indicated that members were seen relatively infrequently; a number of member records noted less than eight total contacts in a four week period. Though some of the individual sessions were between 15 and 55 mins each (intensity), the sheer lack of frequency of episodes may have lessened the impact of those encounters. Moreover, it appears that the contact schedule, as described by staff to reviewers, did not provide any concrete plan for ensuring that members were seen sufficiently.
- Co-occurring Treatment Groups: Engage ACT members with co-occurring issues to attend substance use treatment through the team. The team currently provides one, weekly substance abuse treatment group. Approximately 17% of all members identified with a co-occurring disorder attend the group. Some ACT members participate in an offsite treatment group, facilitated by an SAS at another network clinic. In addition to improving group attendance numbers, the groups should be led by ACT staff who have regular, direct contact with the ACT members.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team maintains a low member-to-staff ratio. The team has a ratio of nearly 10 members per staff. The team serves 99 members. The team roster is as follows: A Psychiatrist, two Nurses (RNs), a Rehab Specialist (RS), an Employment Specialist (ES), two Substance Abuse Specialists (SASs), an Independent Living Specialist (ILS), a Housing Specialist (HS), a Peer Support Specialist (PSS) and an ACT Specialist. The team does not currently have a Clinical Coordinator (CC). The Clinical Director (CD) is covering the administrative portion of the CC role temporarily.	
H2	Team Approach	1 – 5 3	Though the team strives to share responsibility for each member, the team's organizational structure often emphasizes individualized case management. In the morning meeting, staff were observed discussing the status and sharing feedback on each member; at times the team would engage in healthy debate on the most appropriate interventions for challenging situations. Staff often discussed their contribution to the member's treatment, as it applied to their assigned specialty. The member record review revealed that around 50% of members had face-to-face contact with more than one staff member, in a two week period. Members interviewed also stated that they were mostly seen by their primarily-assigned specialist on a weekly basis. The staff interviewed were of the opinion that their newly-implemented member visitation schedule may improve	• Though the team exhibits cohesion, there is clearly a discrepancy between their intended and their actual member contact. Full fidelity in this item requires that 90% or more of the members served receive face-to-face contact with more than one staff member, in a two-week period. • Revisit all contact strategies used by the team. Identify the opportunities to improve team coordination with members by implementing a visitation schedule that is specialty-driven, rather than caseload dependent.

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			performance in this area.	
H3	Program Meeting	1 – 5 5	The ACT team meets regularly to plan and review members' services. The team holds a morning meeting Tuesday-Friday, from 9:00am-10:15am. All team members are expected to attend the meeting. Staff are updated on the status of each member at the morning meeting.	
H4	Practicing ACT Leader	1 – 5 1	The team does not currently have a dedicated Clinical Coordinator (CC). The most recent CC was promoted to the Clinical Director (CD) position in August 2016. The agency has been recruiting for a CC since that time. The CD mainly provides support for the team by coordinating the morning meeting and other supervisory-level assistance. The CD estimates that less than 10% of her time is spent in direct service with members. Encounter reports show that less than 1% of her time in the month timeframe reviewed could be attributed to direct care.	• It is imperative that the ACT team recruit and retain an experienced ACT Team Leader. A practicing ACT Team Leader is noted as one of the five factors most strongly related to better member outcomes. When providing direct services, the ACT Team Leader serves as a model of appropriate clinical interventions for the other ACT staff.
H5	Continuity of Staffing	1 – 5 3	The team experienced 50% turnover, with 12 staff who left the team in the past two years. Of the 12 staff that resigned in the past two years, seven staff left in 2016 alone. When asked about the causes for staff turnover, several staff stated that the instability of the CC role directly contributed to subsequent periods of staff attrition; as the team experienced voids in the CC role, staff would respond to the pressure of the leadership vacuum by resigning.	• The ACT team should work to retain above 80% of its staffing over time. It is recommended that the agency examine employees' motives for resignation. Consider using tools (such as employee exit interviews) to identify common factors in employee turnover. This may be an area of further ongoing provider agency, clinic and system review.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the ACT team operated at approximately 91% of full staffing capacity. Conversely, the team was without one RN for five of the last 12 months. They also did not have a full-time assigned CC for two of the last 12 months, and did not have one at the time of	• See recommendations in both H4, Practicing ACT Leader, and H5, Continuity of Staffing.

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			review.	
H7	Psychiatrist on Team	1 – 5 5	The ACT team has a one assigned, full-time Psychiatrist. The Psychiatrist attends the morning meetings four days a week. She currently works four, ten-hour days with the ACT team. It was also reported that she provides backup support to other teams on rare occasions. She also works with another team on her flex day. The staff and members report that the Psychiatrist is accessible and available whenever she is needed. Reviewers observed the Psychiatrist as she provided clinical direction and practice guidance to ACT staff.	
H8	Nurse on Team	1 – 5 4	The team currently has two full time Nurses (RNs). Each RN is assigned to different duties; one RN provides medical case management and community coordination. The second RN primarily provides in-office services to members. ACT staff reported that the team Nurses are accessible and flexible with their schedules; however, they are often used by other ACT teams in a scheduling rotation. Both RNs participate in the morning meetings. In the clinical record review, it was revealed that ACT members were occasionally being seen by other ACT RNs in the clinic.	• ACT RNs should be fully dedicated to their assigned ACT members. With ACT RNs being fully-integrated team members, having consistency with RNs is critical for coordination of care.
H9	Substance Abuse Specialist on Team	1 – 5 3	The team has two SAS positions: an SAS and a Lead SAS. The Lead SAS is a Licensed Associate Counselor (LAC). She has been working on the team for approximately four months and has previously worked in a methadone clinic for approximately 11 months. The Lead SAS explained that her experience was not anchored in co-occurring treatment. The second SAS has been on the team for over a year, with limited substance abuse training identified (i.e. Motivational Interviewing). It was reported that the agency has	• The agency should continue to provide both SASs with ongoing training and supervision opportunities, focused on appropriate substance abuse treatment for SMI individuals.

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			provided some recent training on Integrated Dual Diagnosis Treatment. Still, reviewers could not confirm a year's worth of training and/or clinical supervision in the provision of co-occurring substance abuse treatment for SMI members, for both SAS staff.	
H10	Vocational Specialist on Team	1 – 5 3	The ACT team has two Vocational Specialists: one Employment Specialist (ES) and one Rehabilitation Specialist (RS). The RS has been on the team for approximately four months, and was previously a Case Manager on a supportive clinical team. The ES has been in this position on the team for four years. Though the ES has been on the team for four years, most of the supervision and/or training she received was acquired in recent months. It was reported that both vocational specialists have attended recent trainings offered through the RBHA. However, it was also stated that the trainings attended have been an orientation to local providers, as well as updates to the referral process. Reviewers could not confirm that either specialist had a year's worth of training and/or supervised experience in vocational services that enable members to find and keep jobs in integrated work settings.	• Vocational Specialists should receive ongoing training and supervision, focused on vocational rehabilitation principles and supports that enable members to find and keep jobs in integrated work settings.
H11	Program Size	1 – 5 5	The ACT team consists of 11 staff. The team is of sufficient size to consistently provide diverse and adequate coverage.	
O1	Explicit Admission Criteria	1 – 5 5	The team has clearly defined ACT admission criteria, as outlined by the RBHA. The CD provided a copy of the MMIC *ACT Eligibility Screening Tool* used to screen potential/new members. Staff report that the team carefully screens referrals and does not bow to organizational pressure to accept administrative transfers from other	

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			organizations and/or ACT teams.	
O2	Intake Rate	1 – 5 5	The ACT team reports 17 admissions in the last six months. The team's highest admission months were March and April 2016, with five admissions each.	
O3	Full Responsibility for Treatment Services	1 – 5 3	Aside from case management, the ACT team is fully responsible for two additional ACT services. The team provides psychiatric services to all enrolled members. The team also offers counseling services, but the number of members engaged in counseling was not clearly identified. One member who is seeing a private psychiatrist is closing services with the ACT team. The Lead SAS is an LAC; she provides general counseling and some substance abuse counseling to members. One member receives counseling services from an outside provider When reviewers sought to distinguish between substance abuse treatment goals and general counseling goals, the ACT staff asserted that substance abuse treatment was not exclusively provided; it is often addressed alongside their other counseling concerns. It was reported that about 17% of all ACT members reside in settings that provide several of the services currently rendered by ACT teams. These settings range from residential treatment facilities to community housing settings that provide medication monitoring services to their residents. The team has both an RS and an ES providing rehabilitation services to the members. Both staff facilitate on-site rehabilitation groups for ACT members. Staff reported that they provide members with some pre-employment assistance	• The ACT team must work towards greater integration of services offered to members. As service integration improves, staff will be able to provide more customized treatment to members. This may require the team specialists to restructure their current model for service provision. The team should move away from traditional treatment approaches, such as in-house groups and walk-in hours, to more proactive engagement strategies. See S1, Community Based Services, for further discussion on this matter. • The ACT team would greatly benefit from ongoing supervision and training that provides clear guidance on the scope of work for each position. • Work towards reducing the volume of members receiving brokered services outside of the team. The aim of ACT teams should be to become the primary provider of all services; external referrals should be infrequent.

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			(e.g. resume writing) if they desire employment immediately. Reviewers observed ACT staff requesting referrals to external employment providers for members they have concluded to be less prepared for an active job search.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for members. The staff rotates coverage duties with the team's on-call phone every seven days. With the absence of a CC, the CD currently serves as the backup for the on-call phone. The ACT staff view themselves as "primary responders", and stated that the members are comfortable with calling them directly when experiencing crisis.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The ACT team reported involvement in seven of the last ten hospital admissions. Staff reported that the members who self-admitted to the hospital were voluntary, and due to increased symptoms. Staff reported that they attempt to triage members prior to recommending hospitalization; however, members and their families occasionally decide to notify the team after they settle upon hospital admission.	• Continue to build relationships with members and their natural supports, educating them on the ACT team's role in the hospitalization and discharge planning process.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	The ACT team reported involvement in nine of the last ten hospital discharges. In the one instance where a member was not discharged to the ACT team, the member was released to a family member. The ACT staff explained their discharge process to reviewers, detailing their efforts to coordinate with the hospital staff, social workers and natural supports. Staff believe that their level of involvement has been effective for most members.	• See recommendations in O5, Responsibility for Hospital Admissions.
O7	Time-unlimited Services	1 – 5 4	The team expects to close between six and eight percent of the members in the next year. Staff does not report having a distinct process for	• The team should continue to work toward maintaining an annual graduation rate of fewer than five

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			transferring members to supportive teams. Rather, the team has ongoing conversations about their progress, and then arrangements for transfer are made.	percent of the total caseload.
S1	Community-based Services	1 – 5 3	The ACT team is currently serving members in both the clinic and in the community. Based on the ten records reviewed, the team performed 54% of all face-to-face contacts in the community. The staff estimate that 70-75% of their time is spent in the community; however, some staff maintain "office hours" for walk-in, specialty service appointments with members (e.g. Employment and Substance Abuse treatment.)	• Revisit the practice of staff "office hours," with the goal of making 80% of all face-to-face contacts with members in the community. • Ensure that all encounters with members are accurately documented within the clinical record. • Work towards moving skills training, specialty services, and/or treatment sessions into community settings. Member outcomes improve when new skills are taught in the settings where they naturally occur.
S2	No Drop-out Policy	1 – 5 5	The team has retained 98% of their members in the past 12 months. All but one of the members who refused services and/or terminated services without referral eventually reinstated their ACT services.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The ACT team has a demonstrated strategy for connecting with disengaged members. Staff explained their engagement strategy to reviewers, describing weekly phone calls, visits, and other frequently-used outreach tactics. For example, reviewers heard examples of contacts being made to supports as an outreach technique. The CD provided reviewers with a detailed copy of their *Case Closure and Re-Engagement Activities Prior to Disenrollment*.	
S4	Intensity of Services	1 – 5 2	The record review indicated that the team provides an average of 36.25 minutes of face-to-face services per week per member. Members	• Staff must focus on increasing their face-to-face service time to two or more hours per week, per member.

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			reported that they mainly see staff in the clinic for a brief medical visit, or for a scheduled group activity.	• As stated in the S1, Community-based Services recommendations, staff should facilitate any skills training, groups, or therapy session in more natural settings, not in the clinic. • See S5, Frequency of Contact, for additional discussion on the potential impact the frequency of contact may have had on the intensity of services.
S5	Frequency of Contact	1 – 5 2	The record review indicated that the team provides 1.75 face-to-face contacts per week. Several of the records had less than six contacts documented in the past month. Staff reported that they are using a "newer" scheduling strategy; it allows staff to independently design their contact frequency for their assigned members, then visit other members who are in need of case management or specialty ACT services. It was also noted that many of the specialty staff (e.g. SAS, ES, and RS) conduct weekly in-office groups and maintain weekly, walk-in office hours for members who are able to attend.	• The ACT team should average four or more contacts per week, per member. • The team should revisit their current contact strategy. ACT is designed to be team-driven and community based; providing members with intense, frequent contact with multiple ACT staff. Change any element of the current strategy that does not promote these efforts (i.e., weekly walk-in hours for ACT specialty services).
S6	Work with Support System	1 – 5 2	The ACT team has minimal engagement with members' support networks. One staff estimated that half of all members have informal supports, with the team contact averaging about two times a month. A second staff estimated that just under half of their primary caseload have informal supports, and they were in contact about weekly. Another staff interviewed estimated more than half of their primary caseload have supports they speak with once or twice a month. The ten record review indicated that supports were contacted approximately 0.9 times in a four-week period. From the records, it was also noted that most	• The ACT team should have four or more contacts per month with informal supports, for each member with a support system. • Educate members on the benefits of, and encourage the involvement, of informal supports, which can include friends, mentors, faith leaders, and not just family. • If a member has an identified support, but declines to sign a release of information (ROI) for team engagement, this should be

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			family contacts were made during times of crisis. During the morning meeting observed, contacts with informal supports were referenced infrequently.	documented in the member record for future reference. Revisit this option with members on a recurring basis.
S7	Individualized Substance Abuse Treatment	1 – 5 3	The team provides individualized Substance Abuse treatment to a limited subset of members diagnosed with a co-occurring disorder. Staff estimates that 10 to 15 of the 44 members diagnosed with a co-occurring disorder are engaged in individualized Substance Abuse treatment. These sessions are estimated to last about 55 mins each. When distributed across the entire dual diagnosis caseload, it was determined that each member received about 3.9 mins of treatment in a month. Reviewers did find evidence of a few instances of individualized treatment; however, these sessions were only performed by the Lead SAS, who is a Licensed Associate Counselor.	• Continue efforts to engage members with a co-occurring disorder in individualized substance abuse treatment. • Do not limit substance abuse treatment to the Licensed Counselor on the team. The fidelity protocol only requires that treatment be performed by a staff with at least one year training, and experience in substance abuse treatment. • Provide both SASs with ongoing training and mentoring in the principles of the co-occurring model/stage-wise approach.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The team currently offers a weekly, one-hour, co-occurring disorder treatment group. This group is facilitated by the Lead SAS, and is held at the clinic. Approximately 17% of all ACT members diagnosed with a co-occurring disorder attended in the month prior to review. Additionally, some members have been attending a weekly, offsite treatment group that is facilitated by the SAS of another ACT team. The SAS uses a curriculum for her group that was provided by the agency. Upon review of the curriculum, it was noted by reviewers that the curriculum was based heavily in IMR (illness Management and Recovery), rather than Integrated Dual Diagnosis Treatment (IDDT).	• The ACT team should continually recruit members diagnosed with a co-occurring disorder to participate in treatment groups. At least 50% or more of dually-diagnosed members should attend at least one treatment group per month. • Though IMR is recognized as an ancillary rehabilitation service for members experiencing recovery, in this model, it does not replace curriculum for co-occurring treatment groups.

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			Reviewers were also notified that IDDT is used, but primarily for members who are in the "Action" stage of change.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The team currently uses a mixed model approach to treating co-occurring disorders. Though staff interviewed were able to articulate their use of harm reduction techniques, they varied greatly in their understanding of how harm reduction is linked to stage-wise treatment activities. It was reported that some members participate in Alcoholics Anonymous (AA) support groups outside of the clinic; some members have been referred to detox centers when the team becomes concerned about "their stability". Some staff on the team have received some IDDT and IMR training; however, some feel they could benefit from ongoing supervision/training in these models. One SAS's activities seem to focus on interventions drawn primarily from IMR. Staff did not appear to be familiar with a stage-wise approach to treatment.	• Cross-train all staff in co-occurring treatment principles using a stage-wise approach. Members benefit from consistent use of best practice approaches. As staff receive training, they will have a shared understanding of effective treatment interventions for DD members.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team employs a full-time, fully-integrated Peer Support Specialist (PSS). The PSS has been with the team for nearly a year-and-a-half. Staff and members interviewed view the PSS as a specialist in community engagement and family outreach. The PSS shares his personal recovery experiences with members and helps them to navigate the behavioral health system.	
Total Score:		**3.68**		

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	1
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	4
9. Substance Abuse Specialist on Team	1-5	3
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	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	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.68**	
Highest Possible Score	**5**	