ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: May 19, 2017

To: Rachelle Simmons, LaFrontera-EMPACT ACT Manager

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AHCCCS Fidelity Reviewers

Method

On April 17, 2017, Jeni Serrano and Karen Voyer-Caravona completed a review of the LaFrontera-EMPACT Capitol Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

The Capitol Center ACT team is located at the Comunidad clinic managed through LaFrontera-EMPACT. La Frontera-EMPACT provides behavioral health services to children, adults, and families. Outpatient and inpatient services include: counseling, psychiatric services, substance abuse treatment, trauma healing, crisis intervention, supportive services, and services for adults with a serious mental illness. The Capitol ACT team serves 99 members and is fully staffed at time of review.

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.
- Interview with Team Leader/Clinical Coordinator (CC) and ACT Manager.
- Individual interviews with Substance Abuse Specialist (SAS), Peer Support Specialist (PSS) and Rehabilitation Specialist (RS).
- Charts were reviewed for 10 members using the agency's electronic medical records system.
- Review of agency documents provided or referenced by ACT staff, including: ACT morning meeting tracking, the *ACT Admission Screening* criteria, *ACT Eligibility Screening Tool*, and resumes of SAS and Vocational staff.

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 is fully staffed and consists of an ACT Psychiatrist, two Nurses (RN), a Team Leader/Clinical Coordinator (CC), a Rehabilitation Specialist (RS), an Employment Specialist (ES), a Housing Specialist (HS), two Substance Abuse Specialists (SAS), an ACT Specialist (AS), an Independent Living Specialist (ILS), and a Peer Support Specialist (PSS). The member to staff caseload ratio is 9:1.
- The ACT team has a Peer Support Specialist (PSS) whose role and responsibilities are equal to those of the rest of the staff members. The PSS is valued for his ability to build rapport with difficult to engage members.
- 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.
- 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.

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

- Increase the CC time providing direct, face-to-face services to members to 50%. This service time can be spent providing training, shadowing, and mentoring to specialists during the course of providing direct services to members. Prioritize contacts provided in the community where challenges are most likely to occur.
- Increase the intensity and frequency of services to members so average frequency of face-to-face contacts is four or more per week, and average intensity of service is two hours or more per week, per member. Work with members to identify activities in their communities that align with their interests, preferences, and recovery goals. Avoid developing office-based groups facilitated by ACT staff in order to meet fidelity contact requirements.
- Train all staff in stage-wise treatment approaches, interventions, and activities for co-occurring treatment. Increase the frequency and diversify the focus of co-occurring treatment groups to accommodate members in different stages of treatment (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention). Rely on staff trained in co-occurring treatment to spearhead those efforts. Engage members with a co-occurring diagnosis to participate in individualized treatment through the SASs on the team, as appropriate to their level of treatment.
- The team uses a mixed model for substance abuse treatment. While often rooted in the Dual Disorders model, treatment provided by the team occasionally relies on traditional options. The network and Regional Behavioral Health Authority (RBHA) should work together on opportunities to educate ACT staff on how to employ a dual diagnosis (DD) model into their treatment practices and team culture (e.g. default treatment interventions, language, etc.).

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The member to staff caseload ratio is 9:1. At time of review, the ACT team serves 99 members and is fully staffed with a full time Psychiatrist, two Nurses (RNs), two Vocational staff (ES) and (RS), two Substance Abuse Specialists (SASs), an Independent Living Specialist (ILS), a Housing Specialist (HS), a Peer Support Specialist (PSS), an ACT Specialist (AS), and a Clinical Coordinator (CC).	
H2	Team Approach	1 – 5 4	Per a review of ten randomly selected member records, 80% of members see more than one ACT staff in two weeks. The reviewers also saw numerous notes entered into records by the Crisis Specialist, who was not identified as a dedicated staff member of the ACT team. These contacts were not counted toward this item.	• 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.
H3	Program Meeting	1 – 5 5	The ACT team meets five days a week, briefly reviewing every member on the team. In addition to the regular meeting, on Wednesdays, the team discusses members in length.	
H4	Practicing ACT Leader	1 – 5 4	The CC estimates that between 55-60% of her time is spent providing direct service to members. Reviewers examined the spreadsheet used to track staff encounters, which reflected that the CC averaged approximately 40% of her time in direct encounters with members. The record review revealed that the majority of the CC's documented encounters with members occur in the clinic/office setting.	• The CC should spend 50% of her time providing direct care to members. Optimally, most of this time should be delivered in the community, and should include mentoring and shadowing specialists. • Investigate barriers to the CC providing 50% direct member service. Identify what, if any, administrative tasks could be performed by another clinic staff.
H5	Continuity of Staffing	1 – 5 3	Per data provided, 13 staff left the team during the year timeframe, including the CC, both SASs, both RNs and the HS position. The team experienced over 54% staff turnover during the 12-month	• Continue efforts to recruit and screen potential employees to ensure their appropriateness for the ACT team.

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			period.	
H6	Staff Capacity	1 – 5 4	In the past 12 months, the ACT team maintained consistent, multidisciplinary services by operating at approximately 94% of full staffing capacity. At time of review the team was fully staffed.	• Maintain staffing; see recommendation for item H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	There is one full-time Psychiatrist assigned directly to the 99 member program. Staff report the Psychiatrist attends four team meetings weekly, provides community-based services, and is accessible via phone, text, emails, during the day, the evening, and weekends. The Psychiatrist has no other administrative responsibilities, and does not meet with members who are not on the ACT team.	
H8	Nurse on Team	1 – 5 5	The team currently has two full time Nurses. Both Nurses are assigned equal duties; both Nurses work four days a week, provide medical and behavioral health consultation, emergency triage, home/hospital visits and medical case management. Many ACT staff reported that the team Nurses are accessible and flexible with their schedules, as they rotate office and community responsibilities.	
H9	Substance Abuse Specialist on Team	1 – 5 3	The SAS1 has a Master of Arts in Professional Counseling, and is a Licensed Professional Counselor (LPC), as well as a Licensed Independent Substance Abuse Counselor (LISAC). She has previous work experience with another local agency providing individual and group substance abuse treatment to SMI determined adults with a dual diagnosis. The SAS2 was hired March 20, 2017, one week prior to review. While the SAS2 has adult SMI case management experience, no substance abuse treatment experience was reported or listed on	• Provide ongoing clinical supervision to SASs on a stage-wise approach to co-occurring treatment, including: engagement, persuasion, active treatment, and relapse prevention. Provide guidance, and training to align staff activities and interventions to each member's stage of treatment.

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			his/her resume.	
H10	Vocational Specialist on Team	1 – 5 5	The ACT team has two vocational staff. The ES has been with the team since July 2016. Prior to joining the team, the ES worked for three years as an Employment Specialist at a local employment provider. The RS has been on the team since 2015 and provides one on one job training (i.e., at the snack bar in the clinic) to build job skills as well as assessing members vocational goals. The ES facilitates a weekly ready to work group and provides services such as resume building, filling out job applications and applying for jobs in the community, as well as skills training in the community at locations such as St. Vincent DePaul's. The RS and ES are currently assisting 15 members with their employment goals and report 6 members have gained employment this year. RS reported that both vocational specialists are crossed trained and both work with members on their employment goals.	• The agency and the RBHA should provide the new ES and RS with ongoing education, training, and mentoring required to help members find and sustain competitive employment, including resume writing, job coaching, and follow along support, and to provide other ACT staff with cross training in vocational services.
H11	Program Size	1 – 5 5	The ACT team consists of 12 full-time staff, including the Psychiatrist, and is of sufficient size and staffing diversity to provide for the needs of its 99 members.	
O1	Explicit Admission Criteria	1 – 5 4	The ACT team uses the written ACT admission criteria provided by the RHBA. The CC and other staff interviewed described the admission criteria as based on an SMI diagnosis, with significant functional impairment, homeless status or high risk for homelessness, frequent use of crisis services/emergency room/psychiatric hospitalizations, a co-occurring substance abuse disorder, and poor response to traditional case management services. The CC reported there have been one or two occasions where the team has	• Continue to work collaboratively with other referral sources, providing recommendations for diagnostically appropriate treatment options when individuals referred do not meet the ACT admission criteria.

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			been pressured to accept referrals outside the admission criteria.	
O2	Intake Rate	1 – 5 5	The ACT team reports 10 admissions in the last six months. The ACT CC reported the team's highest intake month was October 2016 with four admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team directly provides psychiatric services. Substance abuse groups and individual treatment is also provided through the team. The team provides employment or other rehabilitative services, partnering with Vocational Rehabilitation (VR), and report that ACT staff support members with seeking employment in the community and that no members receive vocational support services from external providers. Members can receive counseling/ psychotherapy through the team. The SAS facilitates a DBT group, offers one-on-one sessions, and reports no referrals for external providers. However, it is not clear if the team fully provides housing services. The team reports that ACT staff provides in-home services and assists members to explore housing options if the need arises, but it appears more than 17% of members are in staff settings where other social service staff may provide support. These settings include community living residences and recovery homes/ half-way houses. During record review, there was evidence of outside providers delivering in-home services to ACT members, including documentation indicating that ACT staff referred a member back to an outside provider to assist with the housing search.	• Work with members to locate safe, affordable, and integrated housing in the community with ACT staff as the primary service provider; establish a goal of reducing the number of members who receive in-home support from brokered providers (i.e., providers who are not part of the ACT team).
O4	Responsibility for Crisis Services	1 – 5 5	The CC reported that the ACT team provides 24-hour crisis services. Seven out of twelve staff	

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			rotate coverage duties with the team's on-call phone every day. The CC 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. Members interviewed confirmed that services are 24 hour; they have the staff phone numbers and provided examples of when they have called, stating someone always answers the phone or calls back within minutes.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff interviewed reported that members who express symptoms of concern or who are requesting a psychiatric admission are seen in clinic by the Psychiatrist. When members go to the hospital voluntarily, a specialist is supposed to transport them to the hospital and remain with them until admitted. Per review of the last ten psychiatric hospitalizations conducted with the CC, the reviewers found that the ACT team was directly involved with 70% of admissions. The CC attributed this to some members not seeking hospitalizations through the team but instead admitting themselves or being admitted through jail. The CC reported that when this occurs the team usually is notified about the hospitalization within 24 hours. ACT staff start discharge planning right away with the hospital Social Worker and visits members every 72 hours while inpatient.	• The ACT team should be involved in all member hospitalizations. Provide ongoing education and reminders to members and their informal supports on the importance of involving the team in decisions to seek psychiatric hospitalization. • The CC should ensure all staff are aware of the team's role and process to assist with hospitalizations.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Per CC report, of the last ten psychiatric hospitalizations, the ACT team was involved in 100% of discharges. Staff report that the team is involved in discharge planning from the point of admission. Upon discharge, the team will transport	

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			members from the facility to their home and schedule follow up appointments with the Psychiatrist. Evidence of this was found in member records.	
O7	Time-unlimited Services	1 – 5 5	The ACT team reported one graduation over the past year. The team anticipates that two members will graduate within the next 12 months.	
S1	Community-based Services	1 – 5 3	Staff interviewed estimated that they spend 75% - 80% of their time in the community. Review of ten randomly selected member records found that the ACT team delivered 55% of services in the community for the period reviewed. In addition to a co-occurring disorder treatment group, other ACT staff facilitate office-based groups such as; Ready to work, benefits, walk it off, peer-to-peer, home sweet home, and real talk. It is not clear if groups lead by ACT staff limit their ability to provide a higher level of individualized community-based services.	• Focus on timely documentation to accurately reflect member engagements and where they occur. • Rather than encouraging members to come to the clinic, staff should focus on providing services in the community, where staff can more effectively assess, monitor, and assist members with problem solving and skill building, with a goal of providing 80% of contacts in the community.
S2	No Drop-out Policy	1 – 5 5	According to interviews and the provided data, the ACT team retained 97% of its membership over the last 12 months. No members closed due to moving from the geographic area without referral, or refused services. Staff interviewed reported that the three members with whom they lost contact were not closed from services, but rather placed on a navigator's case load. This caseload is reported to be for members who drop out, and if reengaged by the system or system partner such as law enforcement, they can resume services immediately because they are still considered open; however it is not clear if the member returns to the ACT team or is assigned a different team.	• Review the benefits of transitioning members to navigators, rather than the ACT team assuming full responsibility for outreach and engagement efforts. Review if the ACT team is better equipped to perform assertive engagement for ACT members versus a separate staff who may not be familiar with the member, their support system, where they may be located in the community, etc.
S3	Assertive	1 – 5	Per report, the ACT team uses outreach and	• Following a formal, written

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	Engagement Mechanisms	5	engagement mechanisms, including: searching the streets and shelters, contacting hospitals to determine if members are inpatient, coordinating with Probation Officers or other legal system representatives, contacting informal supports if known, and attempting to meet members at last known addresses. During the morning meeting observed, staff discussed outreach for members who were not in contact with the team. Staff reported previous method or location of outreach which staff performed outreach, and planned for a subsequent outreach. Reviewers did find evidence of outreach in records reviewed.	engagement strategy may aid the team as they track outreach efforts.
S4	Intensity of Services	1 – 5 2	The record review indicated that the team provides an average of 38.38 minutes of face-to face services per week, per member. Members reported that they mainly see staff in the clinic for a brief medical visit, or for a scheduled group activity.	• Members should receive an average of two hours of face-to-face service with ACT staff per week; the majority of those contacts should occur in the community where challenges and new learning and behavioral changes are most likely to occur. Providing services in the community is a key principal of the ACT model.
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 1.5 contacts per week, per member. Members report that face-to-face contacts with staff are sporadic, often only increasing when they are receiving medication management services or attend clinic group activities.	• ACT teams should average four or more contacts per week with each member, while also providing quality services based on members' individual needs. Ensure that clinic-based groups are not being developed in lieu of this primarily to achieve fidelity requirements. • ACT staff must consistently document all encounters with members in the clinical record for improved team coordination and continuity of care. • See Recommendation for S4, Intensity of Services.
S6	Work with Support	1 – 5	Staff interviewed reported that out of 99 members	• Increase contacts with informal supports to

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	System	3	approximately 30-70 members have an informal support that the team has been in contact with at least once in any given month. Per record review, staff averaged 1.9 contacts per month for each member with a support system in the community. The staff reported that the team offers a family support group once a week for natural supports; however, there was no evidence of this found in the records reviewed.	an average of four per month for each member with a support system. As much as possible, contacts with informal supports should occur during the natural course of services provided to members. • Staff should regularly check in with informal supports where appropriate to encourage their role as allies in recovery; to provide useful psychoeducation about symptoms and behaviors; and to obtain their feedback on members' functioning/needs/progress.
S7	Individualized Substance Abuse Treatment	1 – 5 3	The SAS reported that of the 99 members on the team, 76 members are diagnosed with co-occurring disorder (COD). The SAS reported that she sees approximately 12 members weekly for individual substance abuse counseling for approximately 45 minutes each. This averages to approximately 7 minutes per week of substance abuse treatment for all members diagnosed with a COD. The SAS provided contact logs, which track type of contact/service, location, time spent and date. The reviewers found limited evidence of individual substance abuse treatment in the record review. The SAS2 was hired a week prior to review but his resume did not provide evidence of training or qualifications to provide individual substance abuse counseling.	• SAS should provide an average of at least 24 minutes of individual substance abuse treatment across all members diagnosed with a COD. Sessions should be scheduled and formally structured using a stage-wise treatment approach. SASs should have the necessary clinical oversight to allow for this service to be provided by the team.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The team offers two weekly substance abuse groups. The SAS reported that the co-occurring group held weekly on Tuesday's focuses on mental health, stressors and symptoms. This group averages 5-6 members weekly. The Thursday substance group primarily focuses on relapse,	• Ensure appropriate training and education is provided to ensure the ACT teams are specifically following an established, stage-wise curriculum, such as Integrated Dual Diagnosis Treatment (IDDT). • Continue to recruit members to attend the

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			triggers, stages of change, support systems, and introduction of the 12-step support group model. This group averages 6-8 members weekly. The groups are for ACT members only. Per data and report, the groups average 16% of the 76 members diagnosed with a co-occurring disorder. Staff state the co-occurring treatment groups are comprised of curriculum provided by the RBHA; however, staff also stated that the groups are often guided by materials gathered off the internet.	co-occurring treatment groups.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Interviews with staff and records reviewed showed evidence that the ACT team uses a mix of co-occurring principles as well as more traditional approaches. While staff seemed familiar with the *stage-wise treatment approach*~~,~~ and were able to discuss general knowledge of harm reduction, few specifics were offered in interviews. Staff did not demonstrate in-depth knowledge; most did not appear comfortable with its application and often confused it with *stages of change*. It was not clear that co-occurring groups followed a structure organized around the COD model. The team does not refer members to 12 step support groups but will assist members in locating a group in the community if they express an interest in this type of support. Detox is utilized if members state a need or if they demonstrate physical symptoms of withdrawal such as shakiness or perspiration.	• Provide education and training to prepare the two SASs to cross-train the other specialists in the co-occurring model. • The agency and RBHA should provide education and training to all ACT staff~~,~~ on a dual disorder model, such as Integrated Treatment for Co-Occurring Disorders, the stage-wise treatment approach, and motivational interviewing. Training should be ongoing to accommodate for new and less experienced staff. Standardizing a basic tenant of treatment may help ensure consistent interventions across the system. • The CC, the ACT Psychiatrist, and the SASs should collaborate to ensure that program meetings support the COD treatment model.
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has a Peer Support Specialist who is a full member of the team with responsibilities equal to those of other specialists.	
Total Score:		**4.04**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	4
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	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	4
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	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	2
6. Work with Support System	1-5	3
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	**4.04**	
Highest Possible Score	**5**	