ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 1, 2017

To: Peggy Chase, President and CEO
Jennifer Nye, Senior Director of Recovery Clinic Services
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AHCCCS Fidelity Reviewers

Method

On January 9-10, 2017, Jeni Serrano and TJ Eggsware completed a review of the TERROS Townley 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 Terros Townley Clinic is located at 8836 North 23rd Avenue in Northwest Phoenix. Terros provides a wide variety of services, including: primary care, outpatient and residential drug and alcohol treatment, general counseling, crisis, recovery, and mental health services. The agency operates multiple adult outpatient clinics, and four ACT teams two of which are located at the Townley location. This review will focus on the Townley ACT Team One.

The individuals served through the agency are referred to as clients/patients, 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 Clinical Coordinator (i.e., Team Leader);
- Group interview with 5 members who receive ACT services;
- Individual interviews with the Substance Abuse Specialist (SAS), Employment Specialist (ES) and Housing Specialist (HS);
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of the following agency documents: Eight-week outreach checklist, Mercy Maricopa Integrated Care (MMIC) ACT Eligibility Screening Tool, ACT Morning Meeting Roster, ACT staff training histories, ACT staff facilitated group list, and ACT Team Staff Emergency Contact List.

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 is adequately staffed to ensure a small member to staff caseload ratio, and is of sufficient size to consistently provide necessary staffing diversity and coverage to the 98 members served at the time of review.
- The ACT Peer Support Specialist is a full member of the team with equal duties and responsibilities of the other specialists. Other specialists recognize the PSS lived experience as a necessary resource and support for members' recovery, and the PSS uses disclosure to inspire and motivate members to create and work toward their own recovery vision.
- The ACT team has two SASs. One has many years' experience working in substance abuse treatment. The other SAS uses her own lived experience to engage and connect with members working through the stages of recovery.
- The ACT team ES has training and previous experience assisting individuals in pursuing and achieving employment goals.

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

- Seek to increase community-based services to members versus services delivered in the TERROS clinic. ACT emphasizes individualized, purposeful interventions that are integrated in community settings, where member challenges are most likely to occur. Progress notes in the clinical record should reflect the intervention provided, the member's status, and should be consistent with goals and objectives in the member's Individual Service Plan (ISP).
- Seek to increase engagement of informal support networks of members; build and expand current engagement efforts such as the natural supports group.
- 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). 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.
- Consider reviewing with staff expectations for documentation. Some staff document descriptions of case management or other services, but the content of the notes often reflected limited detail about the specific member.
- Consider updating the agency website in order to utilize multimedia to explain ACT services offered, contact information for referrals, etc.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 98 members with ten staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of approximately 10:1.	
H2	Team Approach	1 – 5 4	A review of ten electronic member records found that for the period under review, 80% of members saw more than one staff person in two weeks. The staff interviewed reported that the team functions with a shared caseload but are assigned a primary caseload to complete annual paperwork requirements. Staff serves all members on the team by utilizing a contact calendar made by the team Program Liaison in order to assure all members meet with more than one staff over a two-week period to meet the ACT fidelity. Members interviewed reported that they meet with two to three different staff a week and are aware that there are several staff on the team to provide support.	• The team should continue their efforts to ensure all members are served by the full team, resulting in 90% or more of members having face-to-face contact with more than one ACT staff consistently over two week periods. Ensure all contacts are documented in member records.
H3	Program Meeting	1 – 5 5	Per staff report, the program meeting is held four days a week, and all members are discussed at each meeting. The team Psychiatrist and Nurse attend meetings on days they are scheduled to work. During the meeting observed, all members of the team were presented for discussion. The team uses a member tracking spreadsheet, which includes: primary case manager assigned, status listing natural supports, Title 19 eligibility, substance use status, housing program, payee, guardian, living in ACT housing, upcoming Psychiatrist and Nurse appointments, medication monitoring, injections, and list of specialist	

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			engagement.	
H4	Practicing ACT Leader	1 – 5 3	The CC reported that he joined the team in May 2016. He estimated that he provides direct services about 50% of the time, and that he meets face-to-face with members about 50% of his time in the clinic and 50% in the community. He stated that he accompanies the Psychiatrist one day weekly on home visits and provides Spanish translation when needed. Based on review of the CC's productivity report over a month period, the supervisor provides direct services about 15% of the time. In ten member records reviewed, there were four CC contacts with members over a month timeframe.	• The CC should provide direct services 50% of the time. Enhance efforts to monitor and track CC actual direct service time to members, with a goal of increasing the opportunities to provide direct member services, to model interventions, and support the team specialists. Where possible, streamline or eliminate CC administrative tasks not explicitly connected with his role as an ACT leader. • Ensure all direct member contacts are documented, in addition to outreach efforts.
H5	Continuity of Staffing	1 – 5 3	Based on data provided and reviewed with the CC, 13 staff left the team in the most recent two-year period, a turnover rate of 54%. This incudes: turnover in the CC and Psychiatrist positions, a Nurse who left the team the week prior to review, temporary staff, and a temporary staff who reportedly moved to the second ACT team at the clinic the week of the review.	• Continue efforts to hire and retain qualified staff to fill the vacant Nurse position (or other positions) in the future. • If not already in place, the agency should consider using a staff satisfaction survey to determine factors that contribute to staff turnover. Exit interviews should also be conducted to gather information on reasons why staff leave, and review current policies or establish new policies that support retention.
H6	Staff Capacity	1 – 5 4	The team operated at approximately 92% of staff capacity over the year timeframe, with 12 total vacancies over a 12-month period. The agency mitigated the impact of staff turnover by securing temporary staff coverage during the 12-month period.	• Continue efforts to hire and retain qualified staff. Work with administration to thoroughly vet candidates to ensure they are the best fit for the position and the demands of an ACT level of service.
H7	Psychiatrist on Team	1 – 5 4	There is one Psychiatrist assigned directly to the 98 member program. Staff report the Psychiatrist attends team meetings, provides community-based services one day a week, and is accessible	• Monitor time spent with lead tasks to assure 40 hours is spent serving the ACT team.

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			even on his flex-day off. The Psychiatrist is the lead Psychiatrist for the clinic, and spends an estimated 20% of time on other administrative tasks/ meetings, but he rarely meets with members from the clinic who are not on the ACT team. The Psychiatrist works four, ten-hour shifts weekly.	
H8	Nurse on Team	1 – 5 3	At time of review the team has one full time Nurse that works on the ACT team. The staff reported that the Nurse meets with members in the office and does home visits to deliver medications or missed injections, provides coordination of care with PCPs, conducts hospital visits, provides medication and health education and assist members with medical appointments.	• Hire a second Nurse to serve the 98 members.
H9	Substance Abuse Specialist on Team	1 – 5 5	The ACT team is served by two experienced Substance Abuse Specialists (SAS). The senior SAS has many years of experience working in substance abuse treatment, and the second SAS has both lived experience and past work history working with individuals diagnosed with substance use disorders.	• 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.
H10	Vocational Specialist on Team	1 – 5 4	The ACT team currently has two Vocational Specialists, identified as the ES and the Rehabilitation Specialist (RS). The ES has been on the team since June 13, 2016, and per his report he has over 15 years of experience supporting individuals with disabilities gain competitive employment. There was evidence in notes of the ES assisting members to obtain employment, such as visiting career centers with members, and working with a member to submit applications online. It does not appear that the RS has experience assisting members to obtain employment in integrated settings based on her resume. Also, according to the team's training	• Ensure both Vocational Specialist staff receive ongoing supervision and training related to helping members to find and keep jobs in integrated work settings. The ES on the team appears equipped to offer guidance and resources to other staff.

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			history, the RS has not participated in any training in vocational services. Based on observation of the morning meeting, it appears the RS focuses on socialization activities and referring members to consumer operated services, while the ES focuses on assisting members to obtain employment.	
H11	Program Size	1 – 5 5	With 11 staff serving 98 members, the Townley ACT team is of sufficient size to provide necessary diverse coverage.	
O1	Explicit Admission Criteria	1 – 5 5	The team has a clearly defined ACT admission criteria, as outlined by the Regional Behavioral Health Authority (RBHA). The CC reported that the team uses the MMIC *ACT Eligibility Screening Tool* to screen potential/new members. Staff report that the team carefully screens referrals, does not have to bow to organizational pressure to accept admissions, and the team makes the final determination.	
O2	Intake Rate	1 – 5 4	The CC reported that the ACT team has accepted nine members in the last six months: one member in July, seven in August, and one in September 2016.	• The team needs to take members in at a low rate (preferably no more than six per month) to maintain a stable service environment for both members and staff.
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team directly provides psychiatric services and substance use treatment services, primarily through group and individual engagement activities. Also, members reportedly receive vocational services through the team. Based on staff report, no members currently receive vocational services from a brokered provider for Work Adjustment Training (WAT), Group Supported Employment (GSE) or Supported Employment (SE). Based on staff report, less than 10% of members reside in staffed settings (e.g., flex-care, group homes, and half-way-houses). However, the team refers out for counseling.	• Ensure staff receives monitoring, support, and supervision specific to their role. Training focus areas for vocational staff include: job development in the community, aligning the job search with member goals, disclosure, and follow-along supports. See recommendations for H10, Vocational Specialist on Team. • Evaluate options to offer counseling/psychotherapy through the team.

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O4	Responsibility for Crisis Services	1 – 5 4	The ACT team reports that they have full responsibility for crisis services. All ACT members are given a printed list of numbers to call in an emergency or crisis, including the ACT team on-call number, the Warm Line and the Crisis Line. In addition, the list includes the cell numbers of all ACT team staff. It was reported that members often contact the crisis line first, and then calls are redirected to the on-call number, with the most recent example occurring the weekend prior to review.	• Continue to educate members and their supports on the role of the ACT team in crisis services. Consider revising the Townley ACT Team call sheet to highlight the role of team as first responder to psychiatric crises.
O5	Responsibility for Hospital Admissions	1 – 5 3	Per data provided and the staff interviewed, the team was involved in four out of the last ten hospitalizations; six members self-admitted without the team's knowledge until admitted.	• Optimally, the ACT team is involved in all decisions to hospitalize ACT members. Work with each member and their support network to discuss how the team can support members in the community to avert, or to assist in a hospital admission, if the need should arise. Develop plans with members in advance, especially if they have a history of admitting without informing the team, etc.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Per data provided and the staff interviewed the team is involved in all hospital discharges, including visiting with members every other day during the inpatient stay, coordinating with inpatient Social Workers, facilitating inpatient doctor contact with the team Psychiatrist, picking up members at discharge, ensuring members have medications, meeting with the team Psychiatrist within 72 hours of discharge, and five-day contact post-discharge.	
O7	Time-unlimited Services	1 – 5 5	Per staff report, no members graduated due to significant improvement over the 12 months prior to review. The CC projects that three members (3%) were likely to graduate in the next twelve	

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			months.	
S1	Community-based Services	1 – 5 3	Staff reported they are rarely in the office (e.g., only for morning meeting), spending about 80% or more of their time in the community. The rate of community-based services documented in ten member records reviewed showed that a median of 42% of services occurred in the community. Two members received zero community-based contacts, and another five received 50% or less contact in the community. Some members were encouraged to attend clinic-based groups facilitated by ACT staff.	• The ACT team should increase community-based services to members, with the goal of 80% of contacts being made in the community versus the office setting. Prioritize individualized contacts with members in their communities, where staff can support them to connect with their natural supports, or identify resources. Other than co-occurring treatment groups, which are likely to occur in the office, activities should occur primarily in the community.
S2	No Drop-out Policy	1 – 5 5	Per data provided for the year prior to review, no members closed due to the team determining they could not be served, no members refused services, one member closed due to moving out of state, one member closed due to incarceration and one member had an administrative transfer.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The ACT team uses a variety of outreach and engagement mechanisms, including: searching the streets and shelters, contacting payees, coordinating with Probation Officers, attempting to meet members at last known addresses, locating members through emergency contacts or last known phone numbers, and by sending outreach letters. The CC reported that the team conducts at least four outreach efforts per week, and tracks outreach activities for eight weeks.	
S4	Intensity of Services	1 – 5 2	The intensity of services provided to two members exceeded two hours per week, but the median intensity of service per member was about 44 minutes a week based on review of ten member records.	• Increase the intensity of services to members, optimally averaging two hours a week or more of face-to-face contact for each member. Work with staff to identify and resolve barriers in increasing the average intensity of services to members.

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S5	Frequency of Contact	1 – 5 3	Ten member records were reviewed to determine the amount of times per week each member is receiving face-to-face contact. The median face-to-face contact was 2.13 per week over a month. Members who attend groups or receive medication observation services reported a higher frequency of contacts with multiple staff.	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member, with an emphasis on community-based services to support member goals. Work with staff to identify and resolve barriers to increasing the frequency of contact with members.
S6	Work with Support System	1 – 5 2	Staff estimates of members with informal supports ranged from 30% to more than 90%, and that the team works to maintain weekly contact with known informal supports. Staff had approximately .60 contacts with informal supports over a month timeframe based on review of ten member records. Less than half of the members interviewed reported that staff are regularly in contact with their informal supports, and recent contacts with informal supports were infrequently discussed during the team meeting observed.	• Ensure ACT staff review with members the potential benefits of engaging with informal supports, and include supports in treatment, not only when people face challenges, but also to celebrate success toward recovery. Educate informal supports about ways to support member recovery. Explore options to engage informal supports. For example, develop family psychoeducational support groups where informal supports can connect and share resources, learn from each other how to support member recover, etc.
S7	Individualized Substance Abuse Treatment	1 – 5 3	Per staff report, the SASs have some type of engagement with each of the 44 members who have a substance use diagnosis at least monthly. Per report, one SAS provides individualized substance abuse treatment to an estimate of six to ten members, every two to three weeks for about 30 minutes, and there was evidence of one SAS providing individual treatment in one of the ten member records reviewed. In other records reviewed there was evidence of contact with members and invitations to attend groups, rather than individual treatment. Contacts tended to be less than 30 minutes in duration. At time of review, staff report no members are receiving SA	• The two SASs appear to be qualified to provide individual substance abuse treatment. Ensure that ongoing supervision and training is available to support their efforts in providing this through the team. • The agency should explore mechanisms to monitor and track individual substance use treatment activities without creating additional paperwork for direct care staff. Engagement efforts should be tied to a proven, co-occurring treatment approach, with staff activities documented that aligns to each member's stage of treatment. Also

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			treatment through any other providers.	see recommendations for S9, Co-occurring Disorders (Dual Disorders) Model.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The SASs on the team each facilitate one group weekly at the clinic, and co-facilitate a weekly *recovery-to-go* outing group. Per report, of the 44 members who face co-occurring challenges, about 13-14 members attend group weekly, including some members who attend both groups offered. The members who attended the weekly *recovery-to-go* outing group in the month prior to review reportedly did not have a substance use diagnosis, but it appears this group is open to both members in sustained remission and those with active use.	• Increase the frequency, and/or number, of co-occurring treatment groups offered through the team. Consider aligning the focus of each co-occurring treatment group to accommodate members in different stages (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention). Increase outreach efforts to encourage more member participation in co-occurring treatment, specifically those who have a co-occurring disorder diagnosis. • Ensure co-occurring treatment groups are based on an evidence-based approach. • See recommendations for S9, Co-occurring Disorders (Dual Disorders) Model.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	Staff interviewed provided examples of harm reduction strategies, and in some notes there was evidence of SASs working with members to engage members in addressing substance use, exploring coping skills, discussing strategies to expand their support network, and utilizing homework connected with topics covered in the substance use group. Per staff report the team approach draws from multiple sources, including: Alcoholics Anonymous (AA), twelve steps, motivational interviewing techniques, stages of change, *The Road Map to Peace of Mind*, and group facilitation materials provided by the RBHA. The team may refer members to detoxification; one staff interviewed was aware that withdrawal from some substances (e.g., heroin and alcohol) can be more dangerous than withdrawal from other substances, though it was not clear if other staff	• Train staff in a stage-wise approach to treatment; interventions and activities should align with a member's stage of treatment. Staff should be trained on how to reflect that treatment language when documenting the service. This may better equip other ACT staff to engage members in individual and group treatment through the team. • During clinical supervision, review with staff whether research supports AA, and how staff can support members who elect that form of support.

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			discerned when medical detoxification is indicated. Although the team refers members to AA and other similar self-help groups, these are not the only interventions, and staff will attend with members per the SAS report. Staff seems familiar with stages of change, but did not appear to be familiar with a stage-wise treatment approach, which aligns interventions with the member's stage of, or readiness for, change.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has a Peer Support Specialists on the team who is recognized by staff and members not only as a person with lived experience, but also as a full member of the team with responsibilities equal to those of other specialists.	
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	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	3
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	4
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	4
5. Responsibility for Hospital Admissions	1-5	3
6. Responsibility for Hospital Discharge Planning	1-5	5

7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.89**	
Highest Possible Score	**5**	