ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 9, 2018

To: Stevie Willis, Clinical Coordinator
Amadu Konteh, MD
Laura Larson-Huffaker, Executive Director

From: T.J. Eggsware, BSW, MA, LAC
Annette Robertson, LMSW
AHCCCS Fidelity Reviewers

Method

On January 23-24, 2018, T.J. Eggsware and Annette Robertson completed a review of the La Frontera-EMPACT Comunidad 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.

La Frontera-EMPACT provides crisis and behavioral health services to children, adults, and families. ACT services are available at two locations, one being the Comunidad office, located in downtown Phoenix, where there are two ACT teams: Comunidad and Capitol. The Comunidad team is the focus of this review.

In member records, the individuals served through the agency are referred to as *behavioral health recipient (BHR)*, *client*, and *patient*, 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:

- Observation of a daily ACT team meeting on January 23, 2018;
- Interview with the team Clinical Coordinator (i.e., Team Leader);
- Group interview with a total of four members receiving ACT services;
- Individual interviews with a Substance Abuse Specialist (SAS), Rehabilitation Specialist (RS), and Peer Support Specialist (PSS);
- Charts were reviewed for ten members using the agency's electronic medical records system;
- Review of team documents, including: *ACT Team Morning Meeting Notes*; *ACT Criteria Checklist*; group sign-in sheets and schedule; resumes and training histories for the SASs, RS, and Employment Specialist (ES); co-occurring treatment resources; team business card; Friends and Family flyer; hospital discharge tracking documents; and,
- Review of documents utilized by the team, developed by the Regional Behavioral Health Authority (RBHA), including: *ACT Eligibility Screening Tool, ACT Admission Screening Tool*; and, *Assertive Community Treatment (ACT) Operational Manual.*

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The ACT team meets four days a week to discuss each member of the team. During the team meeting observed, multiple staff contributed, reported on recent contacts with members, and discussed services to be delivered. The Clinical Coordinator (CC) led discussion of members. The Psychiatrist prompted staff and was involved in discussions on member care.
- Two experienced SASs provide individual substance use treatment.
- The team is of sufficient size to provide coverage and diversity.
- The team provides crisis coverage to members 24 hours a day, seven days a week, and members interviewed confirmed staff availability.
- The team maintains a low admission rate; based on staff reports, no members were closed due to refusal or terminating services, moving from the geographic area without referral, or due to the team determining the member could not be served.

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

- The ACT team should be directly involved with member psychiatric hospital admissions. The ACT team should educate members and their supports (natural and formal) on the benefits of directly involving staff in the decision to seek a psychiatric hospital admission.
- Develop strategies to increase face-to-face contacts with the goal that at least 80% of ACT services occur in the community where staff can directly assess, monitor progress, model behaviors and assist members to use resources in natural, non-clinical settings.
- Proactively engage natural supports, on an average of four times monthly, as partners in achieving members' recovery goals. Seek training and guidance, whether at the agency or through system partners, to enhance strategies for engaging informal supports.
- Provide training to staff on an integrated approach to substance use treatment, including: review of stage-wise treatment interventions, and how to develop treatment plans based on the member's perspective and incorporating co-occurring treatment language. The SASs provide individual treatment, but the team should also engage members with co-occurring disorders to participate in group treatment, with the goal that 50% or more of those members attending at least one co-occurring treatment group per month.
- Consider updating the agency website to outline ACT services offered, referral contact information for the ACT team, etc.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	Excluding the ACT Psychiatrist, the member to staff caseload ratio was about 9:1 for the 97 member program.	
H2	Team Approach	1 – 5 4	Based on review of ten randomly selected records, 80% of members saw more than one ACT staff in a two week period, which was consistent with one staff's estimate. Some members interviewed reported that they had contact with multiple staff in the prior week, but one reported no contact prior to visiting the clinic for the interview. In the records reviewed, certain staff repeatedly had more documented contacts with members than other staff.	• Ensure that ACT staff is familiar and work with all members. Ideally, 90% or more of members should have face-to-face contact with more than one staff in any two week period. • Ensure all staff document contacts with members in a timely manner in accordance to agency policy.
H3	Program Meeting	1 – 5 5	Per staff report, all members are discussed during the program meeting held four days a week (Monday, Tuesday, Wednesday, and Friday). An informal meeting is held Thursday to discuss those members who require staff contact. During the meeting observed, all members were discussed and multiple staff contributed. The meeting concluded with reporting of the Psychiatrist's schedule for the day and the Nurses identifying members and targeted treatment statuses including: overdue injections, integrated physical health, and urine drug screens (UDS).	
H4	Practicing ACT Leader	1 – 5 4	The CC reported that he provides direct services to members and examples of CC documentation were found in member records reviewed, including: contact with members at the office, and at their homes, and facilitation of group activities in the office and community. Based on review of the CC's productivity report over a recent month timeframe, direct member services accounted for	• Optimally, CC's delivery of direct services to members should account for at least 50% of his overall time and should be documented in the members' records.

Item #	Item	Rating	Rating Rationale	Recommendations
			approximately 31% of his time.	
H5	Continuity of Staffing	1 – 5 4	Based on data provided by the agency, five staff left the team in the most recent two-year period. In addition, one staff was on leave since late July 2017 and a new permanent staff joined the team early January 2018 to fill that role. Including the staff who was on leave for more than three months, the combined staff turnover was 25% during the two-year timeframe.	• When necessary, examine employees' motives for resignation, and attempt to identify causes for employee turnover. Optimally, turnover should be no greater than 20% over a two year period.
H6	Staff Capacity	1 – 5 5	The team operated at approximately 97% capacity over the last 12 months with no vacancies at the time of review. One staff was on leave late July 2017 through December 2017 and the position was filled by a new staff early January 2018.	
H7	Psychiatrist on Team	1 – 5 5	The Psychiatrist works four, ten-hour days, rarely sees members from other teams at the clinic, and has no other reported duties outside of the ACT team. Members reported they meet with the Psychiatrist monthly. Staff reported the Psychiatrist is available for consultation, including after hours if needed, and that he provides community-based services. Community-based services were documented in some records reviewed and one member interviewed reported the Psychiatrist attempted to meet with him at his home. During the morning meeting observed, the Psychiatrist prompted staff and was involved in discussions on member care, and he made plans with staff to meet with a member at his home.	
H8	Nurse on Team	1 – 5 5	The team is staffed with two Nurses; one is bi-lingual. Staff reported the Nurses are accessible and that they provide community-based services. Though no examples of Nursing staff provision of community-based services were found in ten member records reviewed, there were references	

Item #	Item	Rating	Rating Rationale	Recommendations
			to community-based activities during the morning meeting observed. It was reported the ACT Nurses rarely provide services to members from other teams.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The team is staffed with two experienced SASs, one of whom is a Licensed Associate Substance Abuse Counselor (LASAC), and the second, who completed a graduate program in Addictions Counseling in 2017, is in the licensing process. Recent sign-in sheets were provided for co-occurring treatment groups and it appears one group was open to members from another team; there were two sign-in sheets, one titled as *SA ACT* and one *SA Supportive*. There was only one such example in the documents provided, so it was not clear if this was a single occurrence or recurring service being provided by the SASs.	• As with Psychiatrists and Nurses, ACT specialists should provide services to ACT members exclusively. If time is spent providing services to non-ACT members, then this time is factored in when assessing whether the team specialists are fully available to ACT members.
H10	Vocational Specialist on Team	1 – 5 5	The ACT team has an ES and RS. Based on data provided by the team, the RS served in that capacity since March 2007 and the ES filled that role since July 2012. Staff reported members are encouraged to consider employment and activities that may lead to employment (e.g., volunteer). Staff talk with members about the benefits of employment, review how working can impact benefits, and support through Vocational Rehabilitation (VR). However, training records provided from 2007 to the present showed limited training was provided in vocational services related to assisting SMI members to obtain employment in competitive settings; about nine hours of pertinent training for one staff and about ten for the other staff.	• Ensure both vocational staff receives ongoing training, guidance, and supervision related to vocational supports and best practices that aid members to obtain competitive positions.
H11	Program Size	1 – 5	At the time of the review the ACT team consisted of 12 staff in a variety of direct service roles:	

Item #	Item	Rating	Rating Rationale	Recommendations
		5	Psychiatrist, two Nurses, CC, ACT Specialist, Employment Specialist (ES), Independent Living Skills (ILS) Specialist, Housing Specialist (HS), PSS, RS, and two SASs.	
O1	Explicit Admission Criteria	1 – 5 5	Potential admissions to the team are assessed by staff, using three forms that outline criteria: The team *ACT Criteria Checklist*, the RBHA *ACT Eligibility Screening Tool*, and the RBHA *ACT Admission Screening Tool*. Staff confirmed they control admissions to the team, with no organizational pressures in the last year to admit members whom ACT staff did not feel met ACT admission criteria. Referrals originate from less intensive teams at the clinic (i.e., Supportive), other providers, or are streamed through the RBHA (e.g., members who are inpatient or incarcerated).	
O2	Intake Rate	1 – 5 5	The ACT team admission was less than six members per month during the six months prior to review. The peak admission rate was three members in November 2017, one during the months of July and December 2017, and zero during the months of August - October 2017.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides substance use treatment and psychiatric care/medication monitoring; counseling is also available. Based on interviews, observation, and records, it appears the team provides most employment services directly, but more than 10% of members do receive support from other sources. Staff reported two members receive external employment support services, including one member in a work adjustment training program,	• Work with members who reside in staffed residences to determine if other options are available where they can be supported fully by ACT staff. As the designated housing service provider, staff should assume full responsibility for supportive housing services, including helping members find housing in integrated community settings and support to retain housing. • Minimize the number of members served by external employment service providers to ensure ACT staff is responsible for

Item #	Item	Rating	Rating Rationale	Recommendations
			and in a record reviewed, it was documented that a member receives assistance with employment from an outside provider. Staff reported that the team provides support to about ten members who are in various phases of seeking employment, as well as an additional eight employed members. It does not appear that the team fully provides housing services, with approximately 12% of members in staffed residences. Some members are reportedly mandated to reside in specific treatment settings as conditions of the state of Arizona Psychiatric Security Review Board (PSRB).	supportive employment services. Staff, on fully integrated ACT teams, are adept at assisting members in finding and retaining employment in integrated employment settings. • Ensure both vocational staff receives ongoing training, guidance, and supervision related to vocational supports and best practices that aid members to obtain competitive positions.
O4	Responsibility for Crisis Services	1 – 5 5	Based on staff interviews, the ACT team provides 24-hour crisis support; rotating on-call coverage and specialists are assigned the same day of each week. Members are provided a team business card that includes the team on-call number and phone numbers for all specialists (excluding the Psychiatrist and the two Nurses). Staff reported they respond to members in the community after hours and some work standard weekend hours. Members confirmed the team is available after hours.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff reported the team follows the RBHA's *Assertive Community Treatment (ACT) Operational Manual* with regard to hospitalization protocol. Members are encouraged to reach out to team specialists during business hours or contact the team on-call designee after hours for assistance. If hospitalization is needed, staff will transport and stay with members until admitted. Staff reported they maintain contact with inpatient staff (e.g., Social Workers and Psychiatrists), meet with members within 24 hours of notification, and then every 72 hours during the hospitalization. The team was involved in six of the last ten psychiatric	• Discuss with members and identified supports (natural, formal, etc.) the pros and cons of involving the team in issues that may lead to hospitalization. • Work to resolve barriers to team involvement in hospitalization, and ensure all staff is informed about and follows the protocol.

Item #	Item	Rating	Rating Rationale	Recommendations
			hospital admissions, based on review with the CC; some members self-admitted, and in one case, the team learned of a member's inpatient status through the RBHA's *coordination of care* form that is reportedly distributed to providers after a hospitalization.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff reported the team follows the RBHA's *Assertive Community Treatment (ACT) Operational Manual* with regard to hospital discharge planning. Some staff reported the team is involved in all psychiatric hospital discharges, though based on a review of the ten most recent discharges; there were situations where the team was not involved. One member signed out of the hospital against medical advice; staff at another hospital discharged a member without informing the team and the team learned of the discharge days after; and one member declined team involvement in picking the person up at discharge, opting for family to assist. Staff report they coordinate discharge plans with the hospital, usually pick up members upon discharge, and members meet with the team Psychiatrist within 72 hours. Five day post-discharge contact with members is tracked.	• Coordinate with inpatient staff, members, and their supports (both informal/natural and formal) to reinforce the benefits of including the team in hospital discharges.
O7	Time-unlimited Services	1 – 5 4	Staff reported that the graduation process includes educating members about Supportive services (i.e., lower service intensity), the use of crisis line services instead of staff availability, and updating the service plan to reflect the transition of the member to a lower level of care. Over the prior year, one member graduated from the team, and staff projected the team will graduate about five members (more than 5%) in the next year. Additionally, staff reported RBHA staff identify members based on claim data (e.g., members with	• The team should work toward maintaining an annual graduation rate of fewer than five percent of the total caseload. • Ensure there is no administrative pressure to transfer members off ACT services. As with admissions to the team, ensure ACT teams are empowered to work with members who may no longer benefit from ACT services based on their progress and status. Consider educating to staff on how

Item #	Item	Rating	Rating Rationale	Recommendations
			no hospitalization or recent crisis contacts) and ask ACT staff to evaluate why the members continue to need ACT services.	to engage members in those discussions.
S1	Community-based Services	1 – 5 3	Staff estimates of 80% or more of their time being spent in the community was higher than the results of ten records reviewed that found a median of 55% of face-to-face contacts with members occurred in the community. Two members interviewed reported that they had more frequent contact with staff at the clinic, and two other members reported similar frequency of contact with staff at the clinic and office.	• Optimally, the majority of ACT services (at least 80%) should occur in the community where challenges are more likely to occur, where staff can directly assess, monitor progress, model behaviors and assist members to use resources in a natural, non-clinical setting. Avoid over-reliance on clinic contacts with members as a replacement for community-based contacts.
S2	No Drop-out Policy	1 – 5 5	Based on staff report, no members closed due to refusing services, could not be located, team determined they could not be served, or left the geographic area without a referral. Two members transferred to other ACT teams. Two members transitioned off the team to a *Navigator* status; therefore, the drop-out rate was approximately 2%.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff reported they coordinate with formal supports (e.g., probation officers, payees), outreach to natural supports and search for disengaged members at shelters, and locations where members have been known to visit in the past. Staff reported they follow the RBHA *Assertive Community Treatment (ACT) Operational Manual* to guide outreach if members are not in contact with the team. However, based on records reviewed it was not clear if the manual guidelines are always followed. In one record there was no documented outreach for more than a week, and another lapse of six days with no outreach; however, there was subsequent contact with the member during the month timeframe reviewed.	• Ensure staff are familiar with the eight outreach expectations outlined in the RBHA *ACT Manual*, where it prompts staff to conduct at least four weekly outreach attempts, of which at least two must be in the community. In the team meeting, prompt for specific plans of contact for each member.

Item #	Item	Rating	Rating Rationale	Recommendations
			During the meeting observed staff mentioned recent outreach efforts, identified staff responsible and plans for subsequent outreach for some members, but for other members specific outreach plans lacked detail.	
S4	Intensity of Services	1 – 5 4	The median intensity of face-to-face service time spent per member was just under 107 minutes weekly, based on review of ten member records. Some members received individual contact by ACT staff, but others participated in multiple hours of group activity documented by ACT staff. For example, for one member, 240 minutes of group time was documented (none of which were substance use treatment groups), or just under 47% of documented service time during a month.	• The ACT team should provide members an average of two hours of face-to-face contact weekly. Intensity may vary based on where the member is in recovery, but an average of two hours across the team should be the goal. Avoid too much reliance on groups to achieve service contacts.
S5	Frequency of Contact	1 – 5 3	Some members interviewed reported contact with up to four or five ACT staff in the week prior to interview, but one reported no contact until visiting the clinic that day. The median weekly face-to-face contact for ten members was 2.5 based on review of records. Over a month timeframe, one of ten members received an average of more than four contacts per week, and seven members received an average of less than three contacts per week. One staff reported that during their time on the team, they received inconsistent direction regarding how frequently the team should have contact with ACT members. Apparently, at one time the team focused on ensuring each member received four contacts per week, but the team was subsequently informed members were to be seen *up to* four times a week. Staff reported that if they had access to small amounts of funds for incentives, it may help to engage members. Some examples include funds to purchase a non-alcoholic drink, snacks, or	• Increase the frequency of contact with members by ACT staff to *average* four or more per week. Ensure all contacts are purposeful and accurately documented.

Item #	Item	Rating	Rating Rationale	Recommendations
			lunch when working with members to complete tasks or incentivize reaching goals; staff report, at times, use of their personal funds.	
S6	Work with Support System	1 – 5 2	Staff estimates of how many members on the team have natural (i.e., informal) supports varied from a low of 30% to a high of 80%. The frequency of contact with those supports was reported to occur as often as weekly or one to two times a month. Based on ten member records reviewed, the ACT team has infrequent contact with informal supports, about once on average, per month. Staff infrequently referenced recent contact with informal supports during the morning meeting observed. Over the last year, the team facilitated a Friends and Family activity monthly, and of roughly 20 attendees during the December 2017 gathering, two members had informal supports present.	• Encourage members to identify natural and formal supports and discuss with them the benefits of involvement in their treatment. The ACT team should have four or more contacts per month with informal supports, for each member with a support system. • The team may benefit from further training and guidance, through the agency and/or system partners, on strategies to engage natural supports. • Ensure staff accurately document informal/natural supports in the member record.
S7	Individualized Substance Abuse Treatment	1 – 5 5	Based on staff report and records reviewed, it appears that members diagnosed with co-occurring disorders receive more than 24 minutes of substance use treatment weekly on average. Staff reported that the SASs meet weekly with about 80% of the 72 members diagnosed with a co-occurring disorder and that sessions range from 30 to 90 minutes. During the team meeting observed, the SASs referenced providing individual treatment. Individual substance use treatment was documented in eight of the nine applicable member records reviewed, ranging from one to four sessions per member over the month period reviewed, for an average of 32 minutes per week. Elements of treatment included; discussion of strengths, coping skills, triggers, stressors and member responses, and building rapport by focusing on member identified	

Item #	Item	Rating	Rating Rationale	Recommendations
			goals if they did not view their substance use as an issue.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The team currently offers one weekly two hour co-occurring disorder treatment group. The team also offers a smoking cessation group (i.e., titled *Smoke Less* on the group calendar) and a wellness group. Staff estimated that about seven or eight members attended the co-occurring disorder treatment group over the course of a recent month. Based on review of co-occurring treatment group sign-in sheets over a recent four week timeframe, it appears slightly under 17% of ACT members diagnosed with a co-occurring disorder attended at least once. Also, according to the sign-in sheets provided, at least one of the groups was open to members from Supportive teams at the clinic, but this was not reported during staff interviews.	• Engage members diagnosed with a co-occurring disorder to participate in treatment groups based on their stage of treatment. Optimally, at least 50% of dually-diagnosed members should attend at least one treatment group monthly. • Consider expanding the number of co-occurring groups offered to accommodate members in different stages of treatment (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention). This may be accommodated by shortening the duration of the current group, from two hours, to one. • See also, recommendation for H9, Substance Abuse Specialist on Team.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The team appears to rely primarily on the SASs to address substance use issues with members. During the meeting observed, the SASs referenced individual and group substance use treatment, and occasionally noted members' stage of change. The SASs draw from multiple resources, including: the RBHA's *Assertive Community Treatment (ACT) Team Substance Abuse Group Workbook*; *Living In Balance with Co-occurring Disorders; Living with Co-occurring Addiction and Mental Health Disorders*; *Anger Management for Substance Abuse and Mental Health Clients*; and *Stop the Chaos*. Staff reported the focus of treatment was on harm reduction, and cited recent examples, including a member who sought methadone treatment and subsequently reduced overall substance use. It appears the team does not	• Provide training to all staff on an integrated approach to substance use treatment. Having a common treatment approach, anchored in recovery language, should benefit the members served. It appears the SASs draw from various resources to provide individual and group treatment, but the resources utilized by the SAS may not be readily available and known to all staff. The SASs appear to be well positioned to cross-train other staff. • The team would benefit from further review of harm reduction tactics and documentation, such as how to incorporate interventions in treatment plans and notes. • Ensure treatment plans are written based from the member's language.

Item #	Item	Rating	Rating Rationale	Recommendations
			actively engage members to attend Alcoholics Anonymous (AA) or similar self-help groups but assist members in locating appropriate options if they elect, or if mandated through the state of Arizona PSRB. One staff does accompany members to AA meetings. Per report, those involved attend primarily as a form of socialization or have a history of attending similar self-help groups. The SAS interviewed confirmed the team may refer members for detoxification when medically necessary based on the member's substance use, and noted in other cases, supervision is beneficial (e.g., members with methamphetamines as drug of choice). Based on records reviewed, there was no evidence of stage-wise treatment interventions incorporated in service plans to support member goals and it did not appear all goals were listed in members' words. During the meeting observed staff made reference to a member being *clean and sober* or having a *clean UA*, and *clean UDS* was documented in some files reviewed.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has a full-time PSS with responsibilities equal to other staff on the team. Members interviewed reported peer support was available. Staff reported the PSS accompanies members to community-based self-help groups.	
Total Score:		**4.29**		

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	4
6. Staff Capacity	1-5	5
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	5
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	3

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	4
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	5
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.29**	
Highest Possible Score	**5**	