

## **ASSERTIVE COMMUNITY TREATMENT (ACT) FIDELITY REPORT**

Date: March 29, 2017

To: Jill Teslow Rowland, Director of Medical Management  
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AHCCCS Fidelity Reviewers

### **Method**

On February 21-22, 2017, Jeni Serrano and Georgia Harris completed a review of the Partners in Recovery- Medical Assertive Community Treatment (M-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 Partners in Recovery Network (PIR) serves individuals with Serious Mental Illness (SMI) and provides services such as Psychiatric, Case Management, Transportation, Interpreter Services, and Health & Wellness Groups. The Partners in Recovery- Medical Assertive Community Treatment (M-ACT) team recently moved into their own office space, located at 9150 W Indian School, Phoenix, AZ 85037. The M-ACT team is focused on serving members who are both ACT-eligible and deemed "medically compromised" through a qualifying medical diagnosis. The team is assigned both a Psychiatrist and a Primary Care Physician (PCP). The staff and members report that the stand-alone office space has helped to assure services are focused on the M-ACT team members only.

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 M-ACT team meeting on February 21, 2017;
- Individual interview with M-ACT Clinical Coordinator (ACT CC);
- Group interview with both Substance Abuse Specialists (SAS);
- Individual interviews with Vocational Specialist (RS) and Individual Living Skills Specialist (ILS);
- Group interview with five (5) members receiving M-ACT services;
- Charts were reviewed for 10 members using the agency's electronic medical records system; and,
- Reviewed agency documents provided by M-ACT staff, including: Case Closure and Re-engagement Activities Prior to Disenrollment, weekly client tracking calendars, daily calendar morning meeting tracking, M-ACT Group Monthly Calendar, and SAS individual NextGen

weekly schedule.

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 M-ACT team has established a team approach to service provision. The team demonstrates a strong commitment to sharing responsibility for members and providing ongoing coordination for their identified needs and/or services.
- The M-ACT team has two Registered Nurses (RNs) who have expanded functions beyond medication administration and monitoring. In addition to behavioral health and PCP coordination, the RNs conduct home visits, attend medical specialty appointments with members and conduct wellness classes for M-ACT members (i.e. Smoking Cessation, DASH diet, etc.)
- The Substance Abuse Specialists provide individualized counseling to members in settings most comfortable for the member. Approximately 78% of the dually-diagnosed members receive counseling on a weekly basis.

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

- Though there is evidence that the M-ACT CC provides direct care services to members, the data suggests that the occurrence rate is less than fifty percent (50%) of the time. Continue to evaluate and implement methods for improvement in this area.
- The M-ACT team provides about fifty-two percent (52%) of their services in community based settings. Information gathered from interviews and other data sets attribute this percentage to multiple member visits to the clinic for medication administration and scheduled group offerings. Though ACT teams are free to create and tailor programming to suit the unique needs of their members, it is imperative that ACT services are administered in community settings, preferably teaching skills in settings where they are naturally expended.
- It was reported that the team has dedicated an entire day each week to contacting member supports; however, the results of this effort are not reflected in the clinical charts. In fact, the record review results estimate the frequency of contacts with informal supports at just nearly one contact per month. Ensure that all member contacts are entered into the clinical record.

**ACT FIDELITY SCALE**

<b>Item #</b>	<b>Item</b>	<b>Rating</b>	<b>Rating Rationale</b>	<b>Recommendations</b>
H1	Small Caseload	1 – 5 (5)	The team serves 89 members with 11 staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of approximately 8:1.	
H2	Team Approach	1 – 5 (5)	Per records reviewed, 90% of members had face-to-face contact with multiple staff, over a two week period. The CC provided reviewers with a sample member calendar that shows how the staff tracks member contacts. Staff were observed coordinating visits with each other in their morning meeting. Members also reported regularly seeing multiple staff members throughout the week.	
H3	Program Meeting	1 – 5 (5)	Staff report that the program meeting is held four days a week; all members are discussed at each meeting. The team Nurses work a flex schedule and attend all meetings on their scheduled work days. The team Psychiatrist attends all four meetings. During the meeting observed, all members of the team were briefly discussed, and conversation varied depending on individual status, and topics included: recent appointments, individual counseling services through the team, inpatient status, medical health and treatment, outreach coordination, occasional references to informal support contact, coordination with external agencies, and coordination with jail or other legal system representatives.	
H4	Practicing ACT Leader	1 – 5 (3)	The team has a full-time Clinical Coordinator (CC). The CC estimates that approximately 60% of her time is spent providing direct care to members. It was also noted in the clinical record review that	<ul style="list-style-type: none"> <li>• The team supervisor should provide direct member services at least 50% of the time.</li> <li>• Consistently document face-to-face encounters with members in the agency's</li> </ul>

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			she performed regular in-office visits, weekend home visits and medication observation for members. The results of the data review suggest that the CC spent about 21% of her time in direct practice.	documentation system. <ul style="list-style-type: none"> <li>Identify any administrative task currently performed by the CC that could be provided by other staff, such as the Program Assistant. This could free her time to provide more direct service.</li> </ul>
H5	Continuity of Staffing	1 – 5 (4)	Based on the data provided by the agency, nine staff left the team in the most recent two-year period, resulting in a 37.5 % turnover rate. Over the past year, the team had five Psychiatrists; a series of three Psychiatrists alternated responsibilities for the team until the hiring of the most recent Psychiatrist in October 2016.	<ul style="list-style-type: none"> <li>Continue efforts to hire and retain qualified staff, including working 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.</li> </ul>
H6	Staff Capacity	1 – 5 (4)	M-ACT team operated at 90.97% staff capacity during the review timeframe. The team does not rely on temporary workers to fill vacant positions. At time of review, the team was fully staffed.	<ul style="list-style-type: none"> <li>Continue to maintain a fully-staffed ACT team.</li> <li>See recommendations in H5.</li> </ul>
H7	Psychiatrist on Team	1 – 5 (5)	There is one full time Psychiatrist assigned directly to the 89 member program. Staff reports the Psychiatrist works a four day/ten hours per day work schedule and attends all four team meetings. He provides community-based services one day per week, and is accessible via email, phone or text when out in the field or on her flex day. The Psychiatrist has no other administrative responsibilities, and only serves members of the M-ACT team.	
H8	Nurse on Team	1 – 5 (5)	The M- ACT team has two full-time Nurses that dedicate 100% of their time to serving ACT members. Neither nurse has responsibilities outside the team. Both nurses oversee medication, conduct home visits for outreach and medication administration and observations, provide medication education, and coordinate with primary care providers and Integrated Health	

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			Homes (IHH). The staff reported that the Nurses were accessible by phone, email, and text message, and they conduct home visits to provide injections and follow up with members who miss appointments. Both work four, ten-hour days. Both attend all the program meetings, except for their day off.	
H9	Substance Abuse Specialist on Team	1 – 5 (5)	The team currently has two, full-time Substance Abuse Specialists (SAS). Though neither of the SASs had been with the team for a year, both joined the team with more than a year of Dual Diagnosis (DD) experience. One SAS is a Licensed Independent Substance Abuse Counselor (LISAC) and has worked in hospital DD programs. The second SAS has a Masters of Arts in Substance Abuse and has professional experience in the DD field.	
H10	Vocational Specialist on Team	1 – 5 (4)	The team has two Vocational Specialists on the team, a Rehabilitation Specialist (RS) and an Employment Specialist (ES). The RS has worked on multiple ACT teams since 2008, and has been the RS on this team since January 2016. She has seven years of past experience working in a shelter assisting people with job readiness skills, resume skills, and dress for success. The Employment Specialist (ES) has been with the company over thirteen years, and has been with the M-ACT team for nearly a year. Both specialists assist members with their employment goal, job readiness skills, resume writing, and job searching. For the members on the team who are working, both Specialist provide on going supports to maintain employment. CC reported that both Vocational Specialist completed agency in-person and online trainings, and both attend quarterly RBHA specialty trainings.	<ul style="list-style-type: none"> <li>• The agency should maintain up-to date training records for all staff. Training records may assist supervisors to assess the needs and information gaps experienced on the team.</li> <li>• Create regular training opportunities for vocational specialists to receive education on vocational best practices for SMI members.</li> </ul>

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H11	Program Size	1 – 5 (5)	The M-ACT team has 12 staff. The program is of sufficient size to consistently provide necessary ACT services.	
O1	Explicit Admission Criteria	1 – 5 (5)	The team has explicit admission criteria for the M-ACT team. The team uses the RBHA Medical-ACT admission criteria as the primary source for admission screening. The M-ACT team limits admission to members who are eligible for traditional ACT services, but also have a chronic illness that is not well managed. The team reports having full control over the admissions process. Staff were unable to recall any incidence when they were required to admit a person per an administrative mandate.	
O2	Intake Rate	1 – 5 (5)	New M-ACT members are admitted at a low intake rate. The M-ACT team reports 12 admissions in the last six months. The team's highest intake month was September 2016 with five admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 (4)	In addition to case management, the team is equipped to provide psychiatric services, counseling, substance abuse, employment and rehabilitation services. At the time of review, the SASs are equipped to provide both general and substance abuse counseling. The team provides and tracks individual and group substance abuse treatment. The team does not have members enrolled in counseling services with outside providers, with the exception of the two single case agreements for specialized counseling (i.e. eating disorders and EMDR). The RS and ES provide employment and rehabilitative services to members. The team reports that 69 members are actively working on	<ul style="list-style-type: none"> <li>Continue to help members to find housing in places that do not require additional case management services.</li> </ul>

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			<p>obtaining employment with support of the team. Vocational staff report that they help members to apply for and prepare for job interviews, as well as provide ongoing supports for individuals working. The team actively helps members to find housing and retain housing. They work with members to develop independent living skills on a weekly basis. Though members are receive housing supports, approximately fourteen percent (14%) of the members live in treatment settings where members receive services from on-site staff.</p>	
O4	Responsibility for Crisis Services	1 – 5 (5)	<p>The M-ACT team provides 24-hour response for crisis intervention services. New members are given a pamphlet with the M-ACT services and the list of M-ACT team numbers to call in crisis situations. The on-call phone is rotated between M-ACT staff on a weekly basis. The team always maintains a primary and a secondary on-call responder. The M-ACT CC serves as the backup responder to all crisis calls and is available for consultation to on-call staff at any time.</p>	
O5	Responsibility for Hospital Admissions	1 – 5 (5)	<p>The ACT team reported involvement in all of the last ten hospital admissions. The team reports that they are involved in the assessment, coordination and transportation for members who require inpatient care. Staff also reports that because the team specializes in daily improvement of medical conditions, most members are willing to share any type of decline in their mental/physical health with the team.</p>	
O6	Responsibility for Hospital Discharge Planning	1 – 5 (5)	<p>The ACT team reported involvement in all of the last ten hospital admissions. The team reports consistent involvement in discharge coordination with the hospital social worker; scheduled transportation home from the hospital; filing</p>	

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			medications, and scheduling subsequent PCP and Psychiatrist appointments post-discharge.	
O7	Time-unlimited Services	1 – 5 (5)	The team has graduated four members in the past 12 months and intends to graduate less than five percent of members in the upcoming year. When members are ready to transition, the team uses a step-down process to help them adjust to a lower frequency of clinical team contact.	
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 52% of all face-to-face contacts in the community. The staff estimate that nearly 80% of their time is spent in the community; however, some members report they come into the office multiple times per week for medication refills and clinic-based groups.	<ul style="list-style-type: none"> <li>Though ACT teams are free to create and tailor programming to suit the unique needs of their members, it is imperative that ACT services are administered in community settings, preferably teaching skills in settings where they are naturally expended.</li> </ul>
S2	No Drop-out Policy	1 – 5 (5)	The team has retained 100% of their members in the past 12 months. The M-ACT CC reports that none of the members who left the team were discharged, dropped or moved without referral. Members who left the team moved out of state with family and coordinated transfers with the team.	
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 a six week engagement strategy that included weekly phone calls, visits, and other frequently-used outreach tactics such as; connecting with medical professionals, guardians, payees, and other social services providers . The team provided reviewers with the agency’s written outreach protocol for review. The team reported no closures for members	



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			within the past year due to disengagement.	
S4	Intensity of Services	1 – 5 (5)	The record review indicated that the team provides an average of 170.88 minutes of face-to-face services per week per member. Members reported that they see staff at home or in the clinic for psychiatric and/or medical visits, or for a scheduled group activity.	
S5	Frequency of Contact	1 – 5 (5)	The team performs a high number of service contacts per week. The record review indicated that the team provides an average of 4.75 face-to-face contacts per week, per member. M-ACT staff reported sharing responsibility for the entire team; rather than scheduling daily visits with their assigned members, staff schedule appointments in the area they will be visiting.	
S6	Work with Support System	1 – 5 (3)	The team has moderate engagement with members' support systems. Staff reported that 75% of informal supports are being contacted 2-3 times a week. Every Friday is family or advocate contact day. Staff stated they note all their contacts with supports in the chart and that the CC utilizes a new tracking tool that is used to track member support system engagement. The ten records reviewed indicated approximately .7 contacts with informal supports, on average, per month. It appears staff has less than two contacts per month, for all members on the team.	<ul style="list-style-type: none"> <li>• The ACT team should have four or more contacts per month with informal supports, for each member with a support system.</li> <li>• Then team should note all contacts with member supports in the clinical record.</li> </ul>
S7	Individualized Substance Abuse Treatment	1 – 5 (5)	The team SASs provide one- on-one weekly substance abuse treatment in home and in the office. Each of the SASs are assigned to meet with 19-20 members weekly for SA treatment sessions that range from 30 minutes to an hour depending on topic and individual. The SASs interviewed reported they use the Integrated Dual Diagnosis Treatment (IDDT) model. Staff said they pair the	

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			members' stage of change with the appropriate treatment, as defined by the IDDT model. The CC provided reviewers with a weekly calendar of sessions scheduled for each SAS. SAS appointments were also evident in the chart review.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 (4)	The team provides two co-occurring treatment groups weekly. Both groups are facilitated by the SASs, and the curriculum used is divided by the stage of recovery identified. The Monday group focuses on weekly reflections and orientation aspects of IDDT, and illness management and recovery (IMR). Members engage for an hour, and attendance ranges from 6-7 members weekly. On Tuesday, the group focuses more on action and maintenance. The SAS uses the IDDT model curriculum, and topics include: recovery life skills, motivation and goal setting, self care, triggers, coping skills, etc. Attendance ranges from 5-10 members weekly on average. Overall, 35% of COD members attend at least 1 substance abuse treatment group a month.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 (4)	The M-ACT team appears to follow the co-occurring model. The SASs described using the IDDT and stage-wise treatment approach and were able to easily provide multiple examples of applying interventions that align with members at each stage of readiness for change. The SASs stated that they use motivational interviewing, as well as cognitive behavioral techniques such as rational emotive behavioral therapy, processing ambivalence, and harm reduction techniques. Staff interviewed appeared trained to use non-confrontational approaches. The SASs state that there are occasions when detox is necessary for medical necessity. They believe Alcoholics	<ul style="list-style-type: none"> <li>During clinical supervision, review with staff the therapeutic and community interventions that are reflected in the IDDT model such as relapse prevention plans and Cognitive behavioral skills training.</li> </ul>

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			Anonymous (AA) is a natural support for members, and if a member chooses to attend AA then they are encouraged to get a sponsor, work the 12 steps, and attend meetings on a weekly basis.	
S10	Role of Consumers on Treatment Team	1 – 5 (5)	The team has a full-time, fully integrated, Peer Support Specialist. The PSS provides direct services to members and her case management duties are equivalent to those of the other team specialists. The PSS shares her personal recovery experiences with members, and additionally provides Peer Support Training to all ACT members who wish to attend.	
<b>Total Score:</b>		<b>4.57</b>		

**ACT FIDELITY SCALE SCORE SHEET**

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	4
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	4
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	5

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	5
5. Frequency of Contact	1-5	5
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	5
8. Co-occurring Disorders Treatment Groups	1-5	4
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
<b>Total Score</b>		<b>4.57</b>
<b>Highest Possible Score</b>		<b>5</b>