ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: January 3, 2018

To: Jocelyn Crowell, ACT Clinical Coordinator
David Adame, President & CEO

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AHCCCS Fidelity Reviewers

Method

On December 5-6, 2017, T.J. Eggsware and Annette Robertson completed a review of the Chicanos Por La Causa (CPLC) Centro Esperanza 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.

CPLC offers a variety of health and human services to families and individuals of all ages, and other community development activities. Behavioral health services, including substance abuse treatment, are offered to children, families, individuals, and older adults. This review focuses on the ACT team at the CPLC Centro Esperanza location.

The individuals served through the agency are referred to as *Behavioral Health Recipient (BHR*), *patients*, *clients* or *members*. 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:

- Interview with the team Clinical Coordinator (i.e., Team Leader);
- Observation of a daily ACT team meeting on December 5, 2017;
- Group interview with a total of four members receiving ACT services;
- Individual interviews with a Substance Abuse Specialist (SAS), Rehabilitation Specialist (RS), and Housing Specialist (HS);
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of team documents, including: *ACT Outpatient Team Morning Meeting Notes*; *ACT Admission Screening Tool* developed by the Regional Behavioral Health Authority (RBHA)*;* resumes and training histories for the SAS and Vocational staff; ACT brochure*; Change in Level of Care (LOC)/Navigator Panel* (i.e., outreach tracking form); and co-occurring treatment resources.

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 to discussions, reported on recent contacts with members, and discussed plans to contact members.
- The team is of sufficient size to provide coverage.
- The team provides crisis coverage to members 24 hours a day, seven days a week, and members interviewed reported staff availability.
- The team maintains a low admission rate and based on staff report, 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:

- Recruit qualified permanent staff and seek to identify and address the reasons for staff turnover. The team experienced turnover at several key positions, including Psychiatrist and Nurse, with temporary staff providing coverage to mitigate position vacancies. Neither the current Psychiatrist nor Nurse on the team are permanent. Other positions on the team have also recently been filled with temporary staff.
- Develop strategies to increase face-to-face contacts in the community with time being spent directly supporting members. Optimally, 80% or more of ACT services should occur in the community where challenges are more likely to occur and staff can directly assess, monitor progress, model behaviors and assist members to use resources in a natural, non-clinical settings.
- Proactively engage natural supports on average four times monthly as partners in support of recovery goals. Seek training and guidance, whether at the agency or through system partners, to enhance strategies for engaging informal supports.
- Provide training to all staff on an integrated approach to substance use treatment, including review of: stage-wise treatment and interventions; harm reduction tactics and documentation of those interventions; working with members to develop treatment plans written based off the member's words that incorporate co-occurring treatment language; and, the benefits of structuring multiple co-occurring treatment groups to serve members in various stages of treatment.
- Consider updating the agency website to outline ACT services offered, referral contact information for the ACT team, team brochure, etc.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	Excluding the Psychiatrist, the member-to-staff ratio is 11:1 for the 99 member program. The team includes ten full-time staff: Psychiatrist, one Nurse, Clinical Coordinator (CC), ACT Specialist, Employment Specialist (ES), Peer Support Specialist (PSS), Independent Living Skills (ILS) Specialist, HS, RS, and one SAS.	
H2	Team Approach	1 – 5 4	The member record review revealed that 80% of members had face-to-face contact with more than one staff member, in a two-week period, which was higher than one staff member's estimate (50% or more). Members interviewed reported that they had contact with multiple staff in the prior week, though they are often at the clinic.	• Ensure that ACT staff are familiar and work with all members; 90% or more of members should have face-to-face contact with more than one staff in any two week period. Avoid over-reliance on clinic contacts with members as a replacement for community-based contacts.
H3	Program Meeting	1 – 5 5	Per staff report, the program meeting when all members are discussed is held four days a week. The fifth day is set aside for staffing specific members, for example, to obtain team recommendations to update assessments and services plans. Staff schedules cover weekend hours and some work four, ten-hour days; staff attend the team meeting on the weekdays they are scheduled to work. During the meeting observed, staff schedules were discussed; staff referenced recent contacts with members, and planned future contacts.	
H4	Practicing ACT Leader	1 – 5 3	The CC reported that her goal is to see at least 5 members a day and that she tries to go into the field at least once a week, though she had not had the opportunity to do so the week prior to the review. Office-based paperwork can sometimes limit her time spent providing direct services. In the ten member records reviewed, only four face-	• The CC should provide direct service to members with a goal of 50% of her overall time. Sharing in the provision of community-based services will allow for opportunities to observe, train, and mentor other staff. • The CC and the agency should identify any

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			to-face contacts by the CC with members were documented over a month timeframe; three in the office and one in the community. Based on information provided, the CC provided direct services about 11% of the time over a recent month timeframe.	administrative functions not essential to the CC's time that could be performed by the Program Assistant or other administrative staff to free up time for direct member services.
H5	Continuity of Staffing	1 – 5 1	The combined staff turnover exceeded 80% during the two-year timeframe. Based on data provided by the agency, twelve staff left the team in the most recent two-year period. However, other temporary staff provided coverage. Temporary staff included two staff who joined and left the team in the month prior to review, and excluding the current Nurse, fifteen different Nurse staff provided coverage on the team over a two-year span.	• Recruit and seek to retain qualified staff who are aware of ACT staff expectations. Continuity in staffing allows the building of therapeutic relationships between members and staff. • 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 4	There were two vacancies at the time of review – the second SAS and one unfilled Nurse position. In the past twelve months, the ACT team operated at approximately 83% of full staffing capacity.	• See recommendation for H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	The ACT team Psychiatrist joined the team November 2017 as temporary coverage. 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. Staff reported the Psychiatrist is available for consultation and there are plans for her to provide some community-based services.	
H8	Nurse on Team	1 – 5 3	Multiple Nurses worked with the team since August 2016. Some of the covering Nurses were with the team for about two to three months, others less than a week, and it appears clinic Supportive team Nurses also provided coverage. The current Nurse joined the team in September 2017 in a temporary status. Staff reported the	• Fill both Nurse positions with permanent staff to provide consistency and coverage for both clinic and community-based services. Optimally both Nurses provide services only to ACT members.

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			Nurse is accessible. Some members confirmed that Nurses have provided community-based services in the past, but also commented on the multiple Nursing changes on the team. Some staff reported the Nurse does not see members from other teams, but other staff reported that occasionally the Nurse sees members from other teams as walk-ins.	
H9	Substance Abuse Specialist on Team	1 – 5 3	The single team SAS joined the team in October 2016 and is a Licensed Independent Substance Abuse Counselor (LISAC). The SAS has more than ten years' experience providing substance use treatment in a variety of positions working with a range of populations.	• Fill the vacant SAS position. • Ensure both SASs receive training and guidance in an evidence-based integrated substance use treatment approach.
H10	Vocational Specialist on Team	1 – 5 2	The ACT team has two Vocational Specialists, an Employment Specialist (ES) and RS. Both have been in their positions for a short time. The RS transitioned from the role of HS during the month prior to the review, and the ES joined the team in October 2017. Based on training records and resumes, both have limited experience in vocational services related to assisting SMI members to obtain employment in competitive settings. The RS participated in an hour-long training regarding benefits. The ES attended a three hour employment and vocational training in 2012, and received an Offender Employment Specialist certificate in 2013.	• Ensure both vocational staff receives ongoing training, guidance, and supervision related to vocational supports and best practices that aid members to obtain competitive positions. Fully integrated ACT teams include vocational services that enable members to find and keep jobs in integrated work settings
H11	Program Size	1 – 5 5	The size of the team is sufficient to provide coverage, consisting of ten staff who provide services. Two positions are unfilled, the second SAS and second Nurse. However, the current Psychiatrist, Nurse, and one other staff positions are filled by temporary staff.	
O1	Explicit Admission	1 – 5	The team utilizes the *ACT Admission Screening*	

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	Criteria	5	*Tool* developed by the RBHA to assess potential admissions to the team. Staff confirmed they control admissions with no organizational pressures to admit members who the team feels do not meet ACT criteria. Referrals originate from other less intensive teams at the clinic, other providers, or are streamed through the RBHA.	
O2	Intake Rate	1 – 5 5	The ACT team admission rate remained low, with less than six members per month. The peak admission rate was two members per month in three of the past six months, one during one month, and zero the other two months.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team provides substance abuse treatment, psychiatric care/medication monitoring, most housing, and counseling. The SAS meets with some members for general counseling, and the team only refers out for specialty support that the SAS is not trained to provide. About 9% of members reside in staffed residences; most of those in some type of RBHA affiliated treatment setting. The team, however, does not fully provide employment support services. Some members, identified as employed, receive employment supports through a brokered agency, and it was not clear that the team encouraged them to pursue competitive employment with ACT staff support.	• Provide on-going training and mentoring to the ES and RS on assisting members in finding and retaining employment in integrated settings. • Ensure all staff on the team are trained on the benefits of competitive employment in comparison to sheltered work experiences. • Work with members who reside in staffed residences to determine if other options are available where members can be supported fully by ACT staff.
O4	Responsibility for Crisis Services	1 – 5 5	Based on staff interviews, the ACT team provides 24-hour crisis support, rotating an on-call phone weekly. Staff reported they respond to members in the community after hours, and members confirmed the team is responsive. Based on the team meeting observation, staff reported providing services over the weekend and evening hours, and evening services were documented in	• Ensure all staff are aware of crisis services through the ACT team so they can appropriately relay the information to members in a manner consistent with what was reported by staff interviewed and as noted in the ACT Brochure.

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			some member records reviewed. However, one staff documented in multiple records that members were aware of crisis services with UPC (Urgent Psychiatric Care) and warm line.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Information was requested for the ten most recent hospitalizations, and data provided by the team included one admission from January 2017, and two from June 2017, which seems to indicate the members served on the team may have infrequent psychiatric hospitalizations. During business hours, members can reach out to team specialists. Members can contact the team on-call after hours for assistance. If hospitalization is needed, staff will stay with members until admitted. Staff reported they maintain contact with inpatient staff (e.g., Social Workers and Psychiatrists) and meet with members every 72 hours while hospitalized. The team was involved in six of the last ten reported psychiatric hospital admissions based on review with the CC; some members self-admitted or were brought in by police.	• System stakeholders should consider obtaining information from the team on what strategies they implement to divert psychiatric hospital admissions and to support members in the community. • Discuss with members and identified supports (natural, etc.) the pros and cons of involving the team in issues that may lead to hospitalization; work to resolve barriers to team involvement.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff reported the team is involved in all psychiatric hospital discharges. Staff report they coordinate discharge plans, pick up members at discharge, and members meet with the team Psychiatrist within 72 hours. Staff reported the team maintains face-to-face or phone contact up to four times a week following discharge, though some members who receive medication observation may be seen twice per day. The ACT CC confirmed involvement in nine of the last ten hospital discharges. In the one instance, a member was discharged without the ACT team being present or involved; staff reported the	• Coordinate with inpatient staff, members, and their supports (both informal/natural and formal) to reinforce the benefits of including the team in hospital discharges.

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			member declined team involvement.	
O7	Time-unlimited Services	1 – 5 4	Staff reported that the graduation process includes updating the service plan to reflect the transition of the member to a lower level of care, but it does not appear a specific step-down process occurs other than listing "Supportive" services on the plan around the transition date. Over the prior year, one member graduated from the team, and staff projected the team will graduate about five members in the upcoming weeks. Ten total members have been identified for step-down to other teams at the clinic. This includes members identified by the team, and by the RBHA based on claim data (members with no hospitalization or incarcerations over the course of the recent year). RBHA staff reportedly discussed the potential graduates with the ACT team. In one record, it was documented that the agency Chief Medical Officer emailed an administrator at the clinic to inform him that a member met full criteria to exit the team based on review of the member's medical record.	• The team should work toward maintaining an annual graduation rate of fewer than five percent of the total caseload. • It may be beneficial to review with staff how to document the transition strategy on service plans when preparing for members to move to a less intense service level. Some ACT teams report they follow a timeline (e.g., 90 days) with incremental reduction in ACT contact as the transition date nears. • As with admissions to the team, ensure ACT teams are empowered to work with members to determine whether they are appropriate for ACT services and ready for graduation.
S1	Community-based Services	1 – 5 3	Staff estimates of 70-75% of their time being spent in the community was higher than the results of ten records reviewed that found a median of 55% face-to-face contacts with members occurred in the community. One staff reported it is sometimes easier to work from the clinic to fax documents or access member files. Most members interviewed reported they have contact with staff more frequently at the clinic than their communities. One member reported that they were not allowed to arrange appointments with the Psychiatrist and Nurse on the same day.	• Optimally, the majority of ACT services (at least 80%) 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. • Minimize requirements on members to frequently visit the clinic and transition paperwork tasks to office-based staff (e.g., Program Assistant) when possible so specialists can increase community-based services.

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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 referral. Two members did leave the geographic area and staff confirmed they had established services in their new areas.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff reports the team has a process in place to monitor outreach to disengaged members. Staff reported they use a four-week checklist to track outreach to members who are not in contact with the team, following the *Change in Level of Care (LOC)/Navigator Panel*. However, in one record reviewed, there was limited outreach or engagement for a member who was not in contact with the team. Over the course of a month, only two direct contacts (at the clinic on the same date) were documented, and no other outreach occurred. Additionally, when asked how the program could improve services, a member interviewed stated the team could do a better job checking-in on members who do not frequently visit the clinic.	• Monitor outreach and engagement for members who are not in contact with the team or do not frequently visit the clinic. Ensure specific plans for outreach with staff responsible are identified (e.g., during the team meeting). • Ensure staff are aware of the agency expectations and document outreach. • Consider revisiting the four-week outreach strategy and whether the four-week timeline should be extended and more specific to monitor outreach efforts by ACT teams.
S4	Intensity of Services	1 – 5 3	The median intensity of face-to-face service time spent per member was just over 55 minutes based on review of ten member records. Some members received medication observation services, but the documented duration of the support varied for similar contacts. For example, some staff documented less than ten minutes in two notes (i.e., one outlining a home visit and one for the medication observation) and others documented 25 minutes or more.	• 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.
S5	Frequency of Contact	1 – 5 2	The median weekly face-to-face contact for ten members was just under 1.9 based on review of member records. Some members received few	• Increase the frequency of contact with members by ACT staff to average four or more per week, and ensure all contacts are

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			contacts, and only three of ten member records reviewed had a weekly average of four or more direct contacts documented. However, one staff reported recent tracked contacts indicated the team had nearly four contacts a week per member. The reason for the discrepancy in records reviewed and staff report was unclear.	accurately documented.
S6	Work with Support System	1 – 5 2	Staff reported the majority of members have informal/natural supports and the team goal is to have weekly contact. Based on ten member records reviewed, the ACT team has infrequent contact with informal (i.e., natural) supports, less than once on average, per month. Staff infrequently referenced contact with informal supports during the morning meeting observed.	• Encourage members to identify natural and supports and discuss with them the benefits of involvement in their treatment. • Ensure staff accurately document informal/natural supports in the member record.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff reported individualized substance abuse treatment occurs about weekly, lasting for approximately 55 minutes, with 12 of the 47 members diagnosed with a co-occurring disorder. It was calculated that about 14 minutes of individual substance use treatment is provided, on average, by the SAS. During the team meeting observed, the SAS referenced providing individual treatment, and substance use treatment was documented in some of the applicable ten member records reviewed.	• Continue to engage members to participate in regularly occurring individual substance use treatment. The addition of a second SAS should result in more frequent opportunities to engage members and to provide individual substance use treatment services.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The team currently offers three weekly co-occurring disorder treatment groups facilitated by the SAS. Staff reported the groups are open to members in all stages of change. The SAS reported he discusses with the members their stage of change. Staff reports of how many members attended co-occurring disorder treatment groups over the course of a recent month varied from about 15% to 47%. However, based on review of	• 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 modifying the groups offered so that at least one is structured for members in earlier stages, at least one is available for

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			sign-in sheets provided for a recent month timeframe, about 11% of members with a co-occurring diagnosis attended group at least once. Some members attended multiple groups over the month and were factored into the participation rate one time, and other members who attended were not listed as having a co-occurring disorder.	members in later stages of recovery, and review whether the third, possibly open to all members, can be adapted and transitioned to occur in the community where staff can directly assess, monitor progress, model behaviors and assist members to use resources in a natural, non-clinical setting.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The team appears to rely primarily on the SAS to address substance use issue with members. During the meeting observed, the SAS referenced members' stages of change, as well as individual and group substance use treatment recently attended. The SAS draws from multiple resources he has gathered over the course of his career, including: the RBHA's *Assertive Community Treatment (ACT) Team Substance Abuse Group Workbook*; *100 Interactive Activities for Mental Health and Substance Abuse Recovery*; The American Society of Addiction Medicine (ASAM) materials, SAMHSA; *Recovery Life Skills Program* handbook; and Cognitive Behavior Therapy. It was reported some members met with the team Psychiatrist for medications to address cravings to assist them in reducing use. The team refers members to Alcoholics Anonymous (AA), but one staff explained that some open groups may be more accepting to SMI members, and the SAS does go with them if asked. The team will refer to detoxification facilities, if members ask for it, primarily if medically necessary based on substances used such as abruptly stopping the use of alcohol, for members using heroin, but also those using methamphetamines. It is not clear if the team practices from a dual	• Ensure all staff work from a harm reduction approach. 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 off the member's words. • Provide training to all staff on an integrated approach to substance use treatment. Referring members to meet with the SAS is not itself an intervention. Additionally, the resources utilized by the SAS may not be readily available and known to all staff. Having a common treatment approach should benefit the members served. The SAS appears to be well positioned to cross-train other staff after he receives integrated treatment training through the agency or system stakeholders. • As noted earlier in the report, offer multiple co-occurring treatment groups to serve members in various stages of treatment and hire a second SAS staff

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			diagnosis integrated treatment approach. There was no evidence of stage-wise treatment interventions incorporated to support member goals in applicable treatment plans reviewed. In some cases, it did not appear the members' goals were listed in the members' words, but rather clinic team goals (or rephrased goals on behalf of members), often related to maintaining stability in regards to mental health, housing and/or in the community. Staff reported the focus of treatment was on helping members abstain, but one staff noted that harm reduction steps were sometimes necessary due to withdrawal concerns of certain substances (e.g., alcohol). One staff documented in multiple records reviewed that members focus on maintaining "sobriety and AA 12 step." Staff were familiar with stages of change, but not a stage-wise approach to treatment interventions. When asked about interventions, one staff reported the team engages members to meet with the SAS, and focused on coping skills.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has a full-time Peer Support Specialist (PSS) with responsibilities equal to all the other team staff. Members interviewed were not familiar with the PSS's role on the team. One member identified a Peer Support staff, but it was not clear if the person worked with the ACT team or in another capacity at the agency.	• Ensure members are informed of all staff on the team and their roles.
Total Score:		**3.64**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
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	1
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	2
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	4
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.64**	
Highest Possible Score	**5**	