ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: May 17, 2018

To: Laura Larson-Huffaker, Executive Director
Tina Gabrielson-Brooks, ACT Clinical Coordinator
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AHCCCS Fidelity Reviewers

Method

On April 17-18, 2018, Georgia Harris and T.J. Eggsware completed a review of the LaFrontera-EMPACT Capitol Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

La Frontera-EMPACT provides both outpatient and inpatient behavioral health services to children, families and adults diagnosed with a Serious Mental Illness (SMI). Services available to members include: counseling, psychiatric services, substance abuse treatment, trauma healing, crisis intervention and other supportive services. La Frontera-EMPACT currently has two ACT teams at the Comunidad location: The Comunidad and Capitol teams. This review will be focused on the Capitol ACT team.

The individuals served through the agency are referred to as *clients*, but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

During the site visit, reviewers participated in the following activities:

- Observation of a daily ACT team meeting on April 17, 2018;
- Interview with the team Clinical Coordinator (i.e., Team Leader);
- Group interview with 13 members receiving ACT services;
- Individual interviews with a Substance Abuse Specialist (SAS), Rehabilitation Specialist (RS) and Peer Support Specialist;
- Charts were reviewed for ten members using the agency's electronic medical records system; and,
- Review of team documents and resources, including: *ACT Referral Approval Process*, Mercy Maricopa Integrated Care (MMIC) *ACT Eligibility Screening Tool, ACT Admission Screening,* and *Assertive Community Treatment (ACT) Operational Manual,* team meeting member roster tracking, resumes and training transcripts for the SASs, RS, and Employment Specialist (ES), group sign-in sheets, and staff 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 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 currently has 12 staff. The team is of sufficient size to consistently provide diverse and adequate services.
- The team maintains consistent, multidisciplinary services by sustaining minimal position vacancies. The team has operated at nearly 98% of staffing capacity over the past year.
- In addition to psychiatric medication and monitoring, the Psychiatrist is heavily involved in the case management functions of the ACT team.

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

- Staff estimated that between 75%-80% of their contacts with members were in the community; however, according to the data provided, the team provided less than 59% of their face-to-face contacts in the community. The team should review the services provided to members who come most frequently into the clinic, and explore how to deliver those services in the natural settings where members live.
- Staff report frequent contact with members' support systems; however, clinical documentation indicates that support systems receive less than one contact per month. The team should develop a strategy for engaging and documenting contact with member support systems regularly.
- The results of the member record review suggest that members receive less than two face-to-face contacts per week from the ACT team. Staff should evaluate the current contact strategy and the impact any additional activities (aside from those outlined in the ACT protocol) may have on the ACT team's ability to provide an adequate level of ACT services to members.

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 is approximately 9:1 for the 97 member program. At the time of the review, the team consisted of one Clinical Coordinator (CC), two Registered Nurses (RNs), two Substance Abuse Specialists (SASs), one Rehabilitation Specialist (RS), one Employment Specialist (ES), one Housing Specialist (HS), one ACT Specialist (AS), one Peer Support Specialist (PSS) and an Independent Living Specialist (ILS).	
H2	Team Approach	1 – 5 4	The ACT team generally functions as a unit and has a strategy for connecting with members. Staff reported serving all members through the use of a "quadrant" blocks system; this is a rotating calendar which is focused on grouping visits based on common factors among members (i.e., proximity to each other). However, the results of the ten-member record review suggest that 70% of members were seen by more than one ACT staff, in a two-week period. Members interviewed reported that they had contact with multiple staff in the prior week, but some reported their contact resulted from frequent visits to the clinic for groups.	• As a first step, review the quadrant contact strategy with the team to ensure it is implemented as intended. By design, any contact strategy used should result in a team approach to services and meeting members' needs primarily in the community. • Secondly, ensure staff is following the team approach and documenting all contacts and/or attempts.
H3	Program Meeting	1 – 5 5	The ACT team conducts a team meeting five days a week. During the meeting, staff is expected to report on the progress of every single member. Reviewers noted that the status of each affiliated member was discussed during the observed meeting. Prior to the regular program meeting on Wednesdays, the full team participates in group supervision.	
H4	Practicing ACT	1 – 5	The ACT CC provides routine services to ACT	• The CC should spend 50% of her time

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	Leader	3	members. The CC estimates that approximately 30% of her time is spent providing direct service to members; the data provided by the agency suggests that her time was about 16% over a recent month timeframe. The record review also suggests a lower contact percentage than reported. In addition, the majority of the CC's documented encounters with members occur as unscheduled meetings in the clinic/office setting, or in the form of backup support and phone calls.	providing direct care to members. • Investigate barriers to the CC providing and documenting direct services in the member charts. Identify what, if any, administrative tasks can be reassigned or could be performed by another clinic staff.
H5	Continuity of Staffing	1 – 5 4	The team has operated at a staff capacity of 29%; seven staff left the team in the past two years. The ACT staff report that their attrition rates have improved in the past year, as the team has not lost any staff since August 2017. In the same month, the team was fully staffed and has remained so since that time.	• The team and/or agency should continue with any of the current practices that are supporting the recruitment and retention of qualified ACT staff for specialty positions.
H6	Staff Capacity	1 – 5 5	The team has operated at approximately 98% of staffing capacity in the past 12 months. The team was without an ILS for three months; however, the team has been fully staffed since August 2017.	
H7	Psychiatrist on Team	1 – 5 5	The team has one, full time Psychiatrist. He has been with the team since 2005. In addition to providing psychiatric medication and monitoring, staff report that the Psychiatrist is heavily involved in the case management functions of the ACT team. Both staff and members report that the Psychiatrist provides community treatment to members on a weekly basis and participates in the team's street outreach strategy for the members who have lost contact with the team. During the morning meeting, the Psychiatrist was observed providing feedback to ACT staff on his appointments and outreach visits with members.	
H8	Nurse on Team	1 – 5	The team currently has two full time Nurses. Both	

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		5	Nurses are assigned equal duties; both nurses provide medical (Integrated Health Home; IHH) integration, behavioral health consultation, injections and medication administration, emergency triage, home/hospital visits and medical specialty appointments. Many ACT staff reported that the team Nurses are accessible and flexible with their schedules, as they rotate their in-office and community responsibilities frequently. Evidence of their presence in the community was established in the clinical records examined.	
H9	Substance Abuse Specialist on Team	1 – 5 3	The team currently has two Substance Abuse Specialists (SASs). SAS1 is a Licensed Professional Counselor (LPC) and a Licensed Independent Substance Abuse Counselor (LISAC). She has been with the team since July 2016, and has held multiple positions previously which involve the treatment of co-occurring disorders of SMI individuals. SAS2 has been with the team since March 2017. With a previous employer, in a role as a ILS CM, SAS2 facilitated 12-step and co-occurring treatment groups for SMI individuals, but these appeared to be ancillary to other primary functions in his role as an ILS CM. Based on the staff's resume, he fulfilled many other functions in that role.	• Provide clinical supervision to SASs on a stage-wise approach to co-occurring treatment, and aligning staff activities and interventions to each member's stage of treatment.
H10	Vocational Specialist on Team	1 – 5 5	The team currently has two Vocational Specialists: a Rehabilitation Specialist (RS) and an Employment Specialist (ES). The RS has been with the team since 2015. The ES has been with the team since October 2017 and previously worked as an Employment Specialist with a different employer for eleven months. Training records show that both the RS and ES have taken vocational competencies, such as Disability Benefits 101 (DB 101), provided by the Regional Behavioral Health Authority (RBHA) in the	

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			past year.	
H11	Program Size	1 – 5 5	The ACT team currently has 12 staff. The team is of sufficient size to consistently provide diverse and adequate services.	
O1	Explicit Admission Criteria	1 – 5 4	The ACT team has clearly defined ACT admission criteria, as they follow the protocol outlined by the RBHA in the ACT *Admission Screening Tool*. Recruitment is minimal because the team census is often close to capacity. Potential members may be screened by any ACT team staff; most often, they are screened by the ACT CC. After screening, the team collectively discusses the member's appropriateness for ACT services with the Psychiatrist prior to program admission. Though the team does not report any administrative pressure to admit potential members to the team, staff report that agency administrators screen internal referrals for appropriateness before sending the referral to the ACT team.	• All ACT referrals should be screened through the same process, providing equal opportunity for potential members to be assessed by the defined criteria for the population being served.
O2	Intake Rate	1 – 5 5	The ACT team reports seven admissions in the last six months. The ACT CC reported the team's highest intake month was December 2017 with four admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team fully provides psychiatric services, substance abuse treatment, and counseling. The team provides psychiatric care to all of its members through the Psychiatrist and RNs. The team has two SASs providing both group and individual treatment. It was reported that none of the members are currently attending outside drug treatment programs. One of the team's SAS's is an LPC and provides individual counseling treatment /psychotherapy. The SAS also provides a weekly Dialectic Behavioral Therapy (DBT) group to the	• ACT services should be fully integrated into a single team, with referrals to external providers only for specialty cases. • The team should assist members to find housing in the least restricted environments, which can reduce the possibility for overlapping services with other housing providers. • The team should fully assume responsibility for assisting members with the process of finding and maintaining employment in integrated community

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			members. It was reported that approximately 20% to 25% of the members are actively working on employment goals. Though the team will help with pre-employment and job search activities, 40% of the job-seekers are attending a local work-related day program. The team provides housing and independent living skills training to members; however, about 10% of the members currently reside in places where members receive some monitoring and/or case management services.	settings according to the member's preferences.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for its members. Staff considers themselves to be first responders in times of crisis, going into the field to assess members when appropriate. Each weekday, staff rotates coverage of their on-call phone. The ACT CC is the secondary backup and is contacted if a decision needs to be made regarding visits to members in crisis.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Based on the data provided, the ACT team was directly involved in nine of the ten most recent hospital admissions. Staff report that they work quickly to assess and de-escalate members who are experiencing crisis. Members are triaged by medical staff, and if deemed necessary, are transported by ACT staff to a hospital for inpatient care. The one member, who did not receive team coordination, was a self-admission.	• The team should continue to educate members on the team's role in crisis and/or hospital admission. As the therapeutic relationship between members and staff is strengthened, members may increase their communication with the team in times of crisis.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	The ACT team was directly involved in 90% of the most recent hospital discharges. Staff reports full coordination with inpatient teams throughout the discharge planning process, often attending planning meetings at the hospital and being the point of contact to transport a member home on the discharge date. The team proceeds with a five-day follow up protocol upon discharge. The one	• The team should continue to build relationships with the hospitals/inpatient facilities frequented by members, so coordination of care can be fully achieved.

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			member that was discharged without team coordination was transferred from the hospital to another inpatient facility in the community, without ACT staff coordination. The member left that facility on their own.	
O7	Time-unlimited Services	1 – 5 5	The ACT team reported a three percent (3%) graduation rate over the past year. The team is monitoring the progress of between three and five members, but does not expect to graduate over five percent of the total team load within the next 12 months. The team views members who have lessened their dependence on ACT services as candidates for graduation; however, staff report that the RBHA will inquire about the potential transition of members who have low utilization (claim) rates. Per staff report, the ultimate decision to transition comes from agreement between the team and the member.	
S1	Community-based Services	1 – 5 3	The ACT staff provides many of their services to members in the community. Staff estimated that between 75%-80% of their contacts with members were in the community. According to the review of ten randomly selected records, the team provided 59% of their face-to-face contacts in the community. The majority of members interviewed echoed the results of the record review, stating that staff will visit them at home, but some reported that they come into the office for groups throughout the week.	• ACT teams should perform 80% or more of their contacts in the community. • For members who are coming into the clinic multiple times a week, the team should explore how to deliver those services in the natural settings where members live.
S2	No Drop-out Policy	1 – 5 5	The team reports retaining about 96% of their members over the past 12 months. The ACT CC reports that four members who left the team were all sent to Navigator teams for lack of contact. One of the four was sentenced to prison and was transferred to navigation until his release. Two	

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			members moved out of the geographical area and allowed the team to help coordinate their transfers with the receiving counties.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The team demonstrates a well-thought-out strategy and uses street outreach and legal mechanisms when appropriate. The CC (and other ACT staff) shared with reviewers their 8-week outreach strategy; this strategy includes weekly outreach to hospitals, morgues, family, probation officers, other involved parties, etc. On week 8, a chart audit is conducted and the member is transferred to a Navigation team for continued outreach. Staff also gave examples of how they have used this strategy to locate members. Also, reviewers heard evidence of this strategy in the daily team meeting observed.	
S4	Intensity of Services	1 – 5 3	Ten member records were reviewed to determine the amount of face-to-face service time spent with each member. The team spends an average of approximately 77 minutes per week in total service time per member. Though most of the records reviewed showed below average contacts, there was still much variation in the duration of services provided; duration of services ranged from 5 minutes to 255 minutes per week per person. Little evidence was found in the records to support the team's involvement with the member(s) beyond standard home visit responsibilities.	• ACT teams should provide an average of two hours or more of face-to-face service time per peek, per member. • Continue to monitor face-to-face contacts with all members weekly and ensure they are accurately documented, including any specialty services provided by staff. • Review recommendations in H2 *Team Approach* regarding implementation of contact strategy. •
S5	Frequency of Contact	1 – 5 2	The record review indicated that the team provides an average of 1.63 face-to-face contacts per week, per member. As stated earlier by the ACT CC, the team schedules their appointments based upon a bi-weekly quadrant strategy. Staff reports that during each visit, members are provided the services they need and are offered the specialty	• ACT teams are required to engage frequently with members, with the goal of averaging four or more contacts per week, per member. • Review recommendations in H2 *Team Approach* regarding implementation of contact strategy.

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			service(s) relating to visiting staff (i.e. ILS services from the ACT ILS.	• Evaluate the impact that any additional activities (aside from those outlined in the ACT protocol) may have on the ACT team's ability to provide an adequate level of ACT services to members.
S6	Work with Support System	1 – 5 2	Staff interviewed reported that approximately 31-67 of the team's 97 members have an informal support that the team has been in contact with (at least once) in any given month. Per record review, staff averaged .60 contacts per month for each member with a support system in the community. The staff reported that the team offers a family support group once a week for natural supports; however, the reported attendance rate was between one and two percent of the total membership (1% -2%).	• Increase contacts with informal supports to an average of four per month for each member with a support system. As much as possible, contacts with informal supports should occur during the natural course of services provided to members. • Staff should regularly check in with informal supports where appropriate to encourage their role as allies in recovery; to provide useful psychoeducation about symptoms and behaviors; and to obtain their feedback on members' functioning/needs/progress. • Staff should document all contacts with informal supports in members' records.
S7	Individualized Substance Abuse Treatment	1 – 5 4	The ACT team serves 72 members who are diagnosed with a substance use disorder. Staff report that both SASs provide individual Co-occurring Disorder (COD) treatment to members; SAS1 is assigned approximately 26 members for individual counseling services and SAS2 regularly sees about 10 to 15 members for early engagement. Staff report the remaining members are not in contact with the SASs. Reviewers received copies of SAS1's calendar that showed completed appointments over a selected timeframe. Sessions are scheduled to last between 30 and 80 mins; actual participation consistently fell within that range. Little evidence was found in the clinical records of either SAS providing	• Monitor member participation in individualized substance use treatment through the SASs and increase engagement of members who are in need of COD treatment. • Continue all efforts to increase the time spent with members in individual sessions by both SASs to 24 minutes or more, per member, and document time in the clinical record. • Ensure that both SASs receive the necessary training, mentoring, and ongoing guidance to provide structured, individual substance use counseling to members identified with a co-occurring disorder.

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			targeted treatment sessions and discussing specific treatment goals and interventions for each participant; therefore, the duration and occurrence rate of these appointments did not mirror the level of frequency that was presented by the team.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The SASs on the team offer two treatment groups weekly at the clinic titled Relapse Prevention and Straight Talk, and they recently implemented an Integrated Dual Diagnosis Treatment (IDDT) group. Other available groups focus on skill building (e.g., budgeting, community resources) and a DBT group is available open to all members. Sign-in sheets for a recent four week period showed 19 members identified with a co-occurring diagnosis (about 26%) attended Relapse Prevention, Straight Talk or the IDDT group. Some of the members attended multiple groups offered, but two members with a co-occurring diagnosis attended the DBT group but none of the COD groups.	• Engage members diagnosed with a co-occurring disorder to participate in treatment groups based on their stage of treatment. Optimally, at least 50% of members diagnosed with a COD should attend at least one treatment group monthly. • Consider adjusting co-occurring groups offered to accommodate and focus on members in different stages of treatment (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention). • Consider modifying the DBT group with options available to those members with or without co-occurring diagnosis so the content can be modified to the specific groups' needs.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The team uses a mixed approach to co-occurring diagnosis treatment. The SAS staff interviewed was able to clearly articulate the stage-wise treatment model used by the team (Integrated Dual Diagnosis Treatment- IDDT) and the implementation of treatment strategies that are stage appropriate; however, other staff- though familiar with Motivational Interviewing- showed variability in their understanding of and the appropriate interventions for each stage of treatment. Many of the Individualized Service	• Continue to train all staff in a stage-wise approach to treatment. This may include using the SASs to provide ongoing cross-training to other staff members, so they will be able to identify stage-appropriate language and interventions. • Train staff on the activities that align with a member's stage of treatment and how to reflect that treatment language when documenting the service, as well as writing members' ISPs.

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			Plans (ISPs) for COD members had goals that were clearly focused on sobriety; in fact, many of the ISPs for members diagnosed with a COD did not include goals for substance abuse treatment.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team employs a full-time, fully-integrated Peer Support Specialist (PSS). The team also has identified at least two other staff members who are self-disclosed as persons with lived experience. Staff interviewed regards the PSS as an authority in community engagement and a role model of recovery to members. In the team meeting, reviewers observed the PSS as he provided relevant updates on member conditions and statuses.	
Total Score:		**4.11**		

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	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	3
10. Vocational Specialist on Team	1-5	5
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	4
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	4

6. Responsibility for Hospital Discharge Planning	1-5	4
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	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	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.11**	
Highest Possible Score	**5**	