ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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AHCCCS Fidelity Reviewers

Method

On July 25-26th, 2017, Georgia Harris and Hannah Koch completed a review of the Terros - Enclave Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

The Terros-Enclave Clinic is located in Tempe, Arizona. In addition to psychiatric services, the Enclave clinic provides its members with access to many activities and co-located services; this includes some social services and an on-site pharmacy where members can fill both their psychiatric and medical prescriptions. Terros assumed ownership of the Enclave clinic and several other CHOICES clinics in mid-2015. Though the clinic has experienced much attrition in the past year, the ACT team has managed to maintain a consistent leadership team. At the time of this review, the Enclave ACT team was nearly fully staffed and was serving 99 members.

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 July 26, 2017
- Individual interview with the ACT team leader/ Clinical Coordinator (ACT CC)
- Individual interviews with a Substance Abuse Specialist, ACT Counselor, and Independent Living Skills Specialist
- Charts were reviewed for 10 members using the agency's electronic medical records system
- Review of administrative documentation provided (i.e. the *Meet Your ACT Team* list, the agency-wide encounter report, *Family Psychoeducation Support Group* flier, the *Assessing ACT Appropriateness* tool, the *8-week Re-engagement Flow Chart*, Substance Abuse

Group sign in sheets, and a sample staff visit rotation calendar)

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:

- Psychiatrist on team: The team benefits from a full-time, fully-integrated Psychiatrist. In addition to psychiatric medication and monitoring, she creates opportunities for members to engage with her in activities that directly support their health and wellness goals.
- Full responsibility for treatment: The ACT team assumes full responsibility for the delivery of treatment services, and keeps referrals to external agencies for specialty services at an acceptable threshold.
- Peer Support Specialist (PSS): In addition to being a fully-integrated ACT staff, the PSS specializes in connecting members with opportunities in the community that support their individual recovery goals.

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

- Responsibility for hospital admissions: Though the team has 24-hour crisis services available, approximately 50% of the most recent hospitalization cases opted to self-admit to an inpatient facility. The team must be diligent in educating members on their role in the provision of crisis services. Additionally, the team should evaluate their current crisis workflow to determine if members who are escalated are being met with appropriate de-escalation interventions.
- Intensity of services: Though the clinical records reveal that services are being provided to members, the intensity of services still remains below requirement for most members reviewed. Many staff stated that they felt incapable of balancing their agency's requirements for billing and/or documentation alongside their ACT fidelity requirements. They agency should evaluate any ACT staff administrative obligations (aside from those outlined in the ACT protocol) that affect the ACT team's ability to provide an adequate level of ACT services to members.
- Co-Occurring Disorders Model: Though the ACT team is able to articulate the principles of the "Stages of Change" and harm reduction, they were unable to display a full comprehension of a Dual Disorders treatment model. It seems that the team would benefit from training focused on how to align treatment programming/ interventions to the stages of recovery they have identified.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team maintains a member-to-staff ratio of approximately 10:1. The team serves 99 members. The team consists of 10 full-time staff: an ACT Team Leader/Clinical Coordinator (CC), two nurses (RNs), an ACT Counselor (SAS1), a Substance Abuse Specialist (SAS2), an Independent Living Specialist (ILS), a Peer Support Specialist (PSS), a Housing Specialist (HS), an Employment Specialist (ES), and one ACT Specialist (AS). The ACT CC stated that the agency is actively recruiting for a permanent Rehabilitation Specialist (RS). This staff count excludes the Psychiatrist.	
H2	Team Approach	1 – 5 4	Staff mostly practice a team approach to service delivery. Of the ten records reviewed, it was determined that 70% of the members had face-to-face contact with multiple team members in a two week period. The CC specified that staff schedules are developed on a monthly basis. The staff schedules are comprised of members requiring their specialty, as well as those who live in their assigned catchment area. These catchment areas are rotated among staff daily. During the morning meeting, staff were observed discussing the daily schedule; the CC periodically requested staff to follow up with members who were not seen recently by the team.	• Work to improve the team approach to services by ensuring: (1) sufficient rotation of staff visits to members; (2) all face-to-face contact with members are documented in the clinical record.
H3	Program Meeting	1 – 5 5	The ACT team conducts a morning meeting five days a week. During the meeting, staff is expected to report on the progress of every single member. In addition to the regular meeting, on Wednesdays the team discusses members in length with the	

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			team Psychiatrist.	
H4	Practicing ACT Leader	1 – 5 4	The ACT CC routinely provides services to members. The ACT CC reports facilitating two of the scheduled ACT groups, as well as being on the medical observation schedule rotation. The CC presented reviewers with an agency-wide, encounter tracking report. According to this report, the CC's direct service time with members falls between 25% and 30% of her total work hours. The agency report did not provide a filtering option for recent absences/PTO time; therefore, all of her recent absences/ PTO time was factored into the encounter report and could not be removed from the encounter percentage calculation.	• The ACT CC should continue to work toward providing direct care services to members 50% of the time.
H5	Continuity of Staffing	1 – 5 4	The team has operated at a staff capacity of 33%; eight staff have left the team in the past two years. The ACT staff report that their attrition rates have slowed in the past year. Nonetheless, some staff disclosed that an agency-wide demand for increased productivity among SMI clinical teams contributes to a decrease in staff morale throughout the clinic.	• Consistent staffing is a key ingredient in successful ACT teams. To reduce the potential for increased employee attrition, the clinic and/or agency leadership should solicit feedback from staff on matters affecting employee satisfaction.
H6	Staff Capacity	1 – 5 4	The team has operated at approximately 93.6% of staffing capacity in the past 12 months. The team was without an AS for eight months and without an RS for six months. The team is still actively recruiting for an RS.	• During recruitment, screen potential employees to ensure their appropriateness for the ACT team and its level of service.
H7	Psychiatrist on Team	1 – 5 5	The team benefits from a full-time, fully-integrated Psychiatrist. In addition to psychiatric medication and monitoring, she facilitates a member fitness group, conducts home visits and coordinates care with members' PCP clinics. Though she is the Chief Psychiatrist for the agency, staff and members	

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			report that she is fully dedicated to the ACT team during her scheduled hours. In addition, staff affirmed that she is still accessible during her days off.	
H8	Nurse on Team	1 – 5 5	The team currently has two full time nurses. Both nurses are assigned equal duties; both nurses provide medical and/or behavioral health consultation, emergency triage, home/hospital visits and medical case management. Many ACT staff reported that the team nurses are accessible and flexible with their schedules, as they rotate their in-office and community responsibilities daily. Evidence of their presence in the community was established in the clinical records examined.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The team is staffed with two, full-time Substance Abuse Specialists (SASs). The first SAS (SAS1) has been working on the team since 2008, but has just been in this position since 2016. SAS1 holds the title of ACT Counselor because he has an LMSW and is positioned to provide both general and Substance Abuse counseling to the members. He has received position specific training from the RBHA and has completed additional CBT training externally. The second SAS (SAS2) has been on the team and in this position since 2009. SAS2 has a Masters in Counseling Psychology, and has provided Substance Abuse treatment in a variety of settings.	
H10	Vocational Specialist on Team	1 – 5 3	The team currently has one ES and is actively recruiting for an RS. The ES had been with the team for approximately three months at the time of review. Prior to this position, the ES worked as a Vocational Rehabilitation Counselor for SMI individuals in the state vocational rehabilitation	• Continue efforts to recruit a fully-qualified RS for the ACT team.

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			system.	
H11	Program Size	1 – 5 5	The ACT team currently has 11 staff. The team is of sufficient size to consistently provide diverse and adequate services.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team has clearly defined ACT admission criteria, as outlined by the RBHA. Potential members can be screened by any ACT staff, but the CC conducts the majority of pre-admission screening. The CC also provided reviewers with an additional set of questions used in their screening process; this tool was called the *Assessing ACT Appropriateness Tool*. After screening, the team collectively discusses the member's appropriateness for ACT services with the Psychiatrist prior to program admission.	
O2	Intake Rate	1 – 5 5	The ACT team reports 10 admissions in the last six months. The ACT CC reported the team's highest intake month was March 2017 with three admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 5	The team assumes full responsibility for the delivery of treatment services. In addition to case management, the team provides the full spectrum of ACT services: psychiatric services, counseling, housing support, substance abuse treatment, employment and rehabilitative services. The team does not refer to external providers for the above listed services, except in instances when a member is in need of specialty services counseling (i.e. DBT). In one case, the team referred externally for counseling because the member had a cultural preference for her treatment. The total number of referrals made to external providers is well below 10% in any service category.	

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O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for its members. Staff consider themselves to be first responders in times of crisis. The staff rotate coverage of their on-call phone weekly. The ACT CC is contacted if a decision needs to be made regarding visits to members in crisis. Though staff acknowledged that some members default to calling the county crisis line, they are working to foster cooperation by educating them on the ACT team's purpose and role. Staff provided reviewers with copies of the *Meet Your ACT Team* list, a document provided to the members listing the titles and direct phone numbers of the ACT staff.	•
O5	Responsibility for Hospital Admissions	1 – 5 3	The ACT team was directly involved in 50% of the ten most recent hospital admissions. The remaining five were all self-admissions by the members. Once admitted, the hospitals notified the ACT team so they could participate in ongoing treatment coordination. The staff reported that they try to educate members on the role of the ACT team in crisis; however, some members simply prefer to access emergency care on their own, even after contracting for safety earlier in the day.	• The team must continue to educate members on the team's role in crisis and/or hospital admission. • Additionally, the team should evaluate their current crisis workflow to determine if members who are escalated are being met with appropriate de-escalation interventions by ACT staff.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	The ACT team was directly involved in 90% of the most recent hospital discharges. The one member that was not discharged to the team was discharged to the community. Staff reports that the discharge process begins upon hospital admission. The team coordinates with the inpatient treatment team to establish a discharge plan. Once a member is discharged, the team provides transportation to their residence, and begins their five-day follow up sequence.	• Continue current discharge planning efforts.
O7	Time-unlimited	1 – 5	The ACT team reported two graduations over the	

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	Services	5	past year. The team expects to graduate four members over the next 12 months. The ACT team gradually reduces contact with members who have lessened their dependence on psychiatric and/or emergency services, or may be requesting transition to a lower level of care.	
S1	Community-based Services	1 – 5 5	The ACT team aims to provide services and monitor member statuses in the community whenever possible. The results of the chart review show staff making contact with members in community settings over 87% of the time.	
S2	No Drop-out Policy	1 – 5 5	The team reports retaining 95% of their members over the past 12 months. The ACT CC reports that four of the members who have left the team were transferred to a residential care. One other member left to be served by a Psychiatrist in private practice.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The ACT team has a demonstrated strategy for connecting with disengaged members. The team uses street outreach and legal mechanisms to ensure ongoing engagement. The ACT CC provided reviewers with their 8-Week Re-Engagement Flow Chart. Each staff must complete all the steps in the flow chart prior to closing any member. The team reports that most members are located prior to the end of the eight weeks. If the staff misses a step in the strategy, or a member makes contact in any way during the 8-week period, the strategy timeline is reset.	
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 78.25 minutes per week in total service time per member. Though a couple of	• ACT teams should provide an *average* of two hours or more of face-to-face services per week. This is based on all members across the team; some may need more and some less week to week

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			records met the two hour requirement, the majority showed below average contacts. Two of the records had below ten minutes of face-to-face contact during the review period. Staff indicated that they were experiencing some difficulty in balancing current agency billing and/or documentation requirements and the ability to provide members with the quality time they often need.	based on their individual needs. • Ensure that all face-to-face contacts with members are documented in the clinical record. • Evaluate the impact any administrative requirements (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.
S5	Frequency of Contact	1 – 5 4	The record review indicated that the team provides an average of 3.75 face-to-face contacts per week, per member. The ACT CC stated that the team schedules are created monthly, and their progress toward meeting those appointments is tracked daily. Visits are often scheduled based on their catchment areas, their ACT specialties and any immediate needs that arise throughout the week. Later in the week, the remaining members are scheduled based on the number of visits staff has left to fulfil.	• The ACT team should continue to engage frequently with members, with the goal of averaging four or more contacts per week, per member. • Though the ACT team is close to full fidelity in this measure, review discussion and recommendations in S4 to address the need for a balanced approach for service provision.
S6	Work with Support System	1 – 5 3	Staff varied in their estimates of the number of members who have informal supports; however, most staff believes that between 40% and 50% of all members have active support systems. The ACT CC reports that she personally makes phone calls to support systems weekly. Evidence was found in the records to support this. The team currently facilitates a family psychoeducational group at the clinic every other Tuesday evening for two hours. The informal supports in the member records reviewed showed an average of one contact per month.	• Continue every effort to build relationships with the support systems of the ACT members. • Educate support systems on the role of the ACT team in the lives of both the members and their active supports.

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S7	Individualized Substance Abuse Treatment	1 – 5 4	Both SASs schedule and provide individual Substance Abuse (SA) treatment to members. Each SAS is assigned 22 of the 44 members diagnosed with a SA disorder. Approximately 30 members are seen regularly for individual sessions. Evidence was found in clinical records of the ACT Counselor (SAS1) providing targeted treatment sessions, often discussing specific treatment goals and assigning homework to each participant. SAS2's role seemed to be more focused on outreach and engagement of inactive members. Sessions are scheduled to last 30 mins, but actual participation was said to vary greatly from member to member. Based on data provided, roughly 20 minutes of individual service is provided to SA-diagnosed members.	• Continue all efforts to increase the time spent with members in individual sessions to 24 minutes or more, per member.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The SASs offer a one-hour Co-Occurring Disorder (COD) treatment group, twice per week. Staff reported between six and eight regular participants, with 15 unique participants in the past month. This accounts for around 34% of the total members diagnosed with a COD. Staff teaches from a Stages of Change group treatment book provided by the RBHA, as well as other sources the facilitators deem relevant to the topic of discussion for that session.	• The ACT team should strive to have 50% or more of their dually-diagnosed members engaged in COD groups on a regular basis. Solicit member enrollment in COD treatment groups; consider involving current participating members with this effort.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The team uses a mixed model for COD treatment. Though the team is familiar with some of the concepts associated with an integrated treatment approach, they still rely upon some traditional treatment options. ACT staff stated that they had received some IDDT training from agency administrative staff in recent weeks. Though the	• Train all staff in a stage-wise approach to treatment. • Train staff on how to align treatment interventions to the stages of recovery they have identified.

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			SAS staff were somewhat unfamiliar with language and principles of a COD treatment approach, they were able to comfortably discuss the role of harm reduction in COD treatment. SAS (and other) staff were open to the use of medical detoxification solutions and community 12-step groups, but were able to articulate how they work closely as a team to monitor a member's "Stage of Change" while on their journey to recovery.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team employs a full-time, fully-integrated Peer Support Specialist. Staff and members interviewed view the PSS as an authority in community and family engagement. In the team meeting, reviewers observed the PSS as she provided relevant updates on member conditions and offered strategies for improving staff/member relations within the behavioral health system.	
Total Score:		**4.32**		

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	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	3
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	5
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	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	5
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	4
6. Work with Support System	1-5	3
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	**4.32**	
Highest Possible Score	**5**	