ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: September 7, 2016

To: Guillermo Velez, Vice President

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AHCCCS Fidelity Reviewers

Method

On August 9-10, 2016, Jeni Serrano and Karen Voyer-Caravona completed a review of the Chicanos Por La Causa (CLPC) Maryvale 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.

Chicanos Por La Causa is a community-based nonprofit that started 1967, when a group of young Latino men and women deliberated and collaborated on ways to improve the quality of life for Arizona's Mexican-American population. The organization has grown significantly since then. Among the social service programs it offers today are behavioral health, domestic violence shelter and prevention, emergency assistance, elder services, legal immigration counseling, HIV counseling, individual and family counseling, women's health, employment training, and drug and alcohol rehabilitation. This ACT team began operation on August 1, 2015. It should be noted that the reviewers were provided contradictory information regarding when the ACT team actually started. Some reports show the team starting in August 2015, and other reports indicate the team started in October 2015, when the majority of the staff appeared to have joined the team.

The individuals served through the agency are referred to as participants, or 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.
- Individual interview with team leader (i.e., Clinical Coordinator/CC).
- Group interview with eight members receiving ACT services.
- Individual interviews with Substance Abuse Specialist, ACT Specialist (AS) and Employment Specialist (ES).
- Charts were reviewed for ten members using the agency's electronic medical records system, with IT assistance from the Team Leader .

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 team's office location is designed for community, or shared, workspace, which encourages community-based service delivery as opposed to clinic-based interventions. Without other agency coverage duties or responsibilities such as all-agency staff meetings, the team can fully focus on ACT services.
- Staff are provided with the necessary tools and technology support (including cell phones and laptops) in order to perform community contacts effectively.
- The Psychiatrist and Nurse are fully dedicated to the ACT team and do not cover for other teams.
- ACT staff is available 24 hours a day, seven days a week to respond to members' emergency/crisis needs. The staff rotates on-call responsibilities on a weekly basis, with the CC functioning as their back up. All "blue dot" calls, or emergency calls, go directly to the on-call phone or to each specialist's work cell phone 24 hours a day, seven days a week.
- The ACT team meets five days a week to discuss all ACT members.

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

- While the ACT Team Leader (CC) is committed to supporting the staff and providing services to members, the ACT CC does not spend 50% of their time providing direct services to ACT members.
- The team has been providing services for 12 months. In that period of time, 58% of the staff positions have experienced turnover. Staff turnover might contribute to numerous challenges in providing effective services to ACT members. The team and the members would benefit from reducing this staff turnover rate.
- ACT teams such as this provide services to members with a very high rate of co-occurring substance use disorders. Filling the vacant SAS position with a qualified candidate who can provide integrated COD treatment should be a priority for the agency and the ACT team.

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 7:1. The team serves 51 members. The current ACT team consists of seven full time staff: 1. an ACT team Leader(CC), 2. one Nurse (RN), 3. one Substance Abuse Specialist (SAS), 4. an Independent Living Specialist (ILS), 5. a Housing Specialist (HS), 6. an Employment Specialist (ES), 7. and an ACT Specialist (AS). The ACT Team Leader stated that the agency is actively recruiting for a second nurse (RN), a Peer Support Specialist (PSS), a second Substance Abuse Specialist (SAS), and a Rehabilitation Specialist (RS). This count excludes the Psychiatrist.	• The agency should fill the four vacancies with well-qualified staff in specialty positions in order to offer members a full range of specialty services.
H2	Team Approach	1 – 5 (4)	10 member records were reviewed to determine the level of team responsibility for each member. 70% of members reviewed had face-to-face contact with multiple staff, over a two-week period.	• To ensure that ACT staff know 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.
H3	Program Meeting	1 – 5 (5)	The ACT team meets five days a week, Monday through Friday, beginning at 10 AM. Meetings last for one to 1.5 hours, and all members are discussed. All current ACT team staff attended the meeting observed by the reviewers; all staff were actively engaged in discussion of member status, recent contacts, identified needs, and action planning.	
H4	Practicing ACT Leader	1 – 5 (2)	The ACT CC carries a caseload of 3 members. The CC reported she assists with covering substance abuse one-on-one sessions as well as offering	• The CC should focus on spending 50% of the time in direct face-to-face member services on a consistent basis, not just in

			coverage for SA groups as needed in the absence of a second SAS. CC reported that she mainly provides direct services in the office setting, estimating 30% of direct services in the community. Reviewers could not verify this due to no encounter report submitted and no evidence of contact in records reviewed.	the absence of specific staff. This helps to model appropriate interventions for staff and fosters relationships with the members. Document all member face-to-face services in the clinical record to ensure an accurate history of assessment, intervention, and community contact.
H5	Continuity of Staffing	1 – 5 (2)	The ACT team began operation as of August 2015. The reviewers found variability between staffing data reported by the agency and that which was reported in staff interviews. Despite the discrepancy, it appears that the team started with five staff, and throughout the 12-month period experienced a staff turnover rate of 58%, as reported by the agency. Some staff only served on the team for a very brief period of time. Additionally, the ACT team has never been fully staffed with specialists prepared to provide services in all the areas offered.	• ACT staff turnover should be no more than 20% in two years. In the future, the agency should explore the candidate selection criteria to ensure the new hires are the proper "fit" for the ACT model, and use staff exit interviews to determine factors contributing to high staff turnover. Also, staff satisfaction surveys may help to gather feedback on factors that contribute to staff retention.
H6	Staff Capacity	1 – 5 (2)	The team currently has eight staff including the Psychiatrist. The team has not been fully staffed since in it began operation 12 months ago. The information provided to the reviews about when the ACT team started was contradictory. Some reports show the team starting in August 2015, and other reports indicate the team started in October 2015, when most of the staff joined the team. Based on the data provided by the agency and information provided during staff interviews, it appears the staff operated at about 63% capacity.	• The agency should fill all positions on the team with qualified personnel to adequately provide the specialized services offered by the ACT team. • As the team continues to grow, ensure that both new and current staff are not only trained in their areas of specialization, but also are cross-trained in other ACT specialties, to ensure continuity of care when vacancies arise.
H7	Psychiatrist on Team	1 – 5 (5)	The ACT team currently has one assigned, full-time Psychiatrist. He attends the daily team meetings four days per week, and conducts home visits with	• As the team reaches a full roster of 100 members, the agency should caution Psychiatrist coverage with the Centro

			members on a regular basis. The Psychiatrist is not the lead doctor at the clinic, however, on occasion offers coverage duties for other clinical teams at Centro Esperanza clinic, such as when another psychiatrist is out sick. Staff interviewed did not feel this coverage affected his ability to provide quality care to the members and reported he is very accessible.	Esperanza or other clinics to assure coverage doesn't compromise primary availability to the ACT team.
H8	Nurse on Team	1 – 5 (4)	At the time of the review the team had one full-time Nurse (RN). The Nurse helps with medication administration and monitoring, primary care provider (PCP) coordination, psychoeducation and education about physical health, goes out on weekly home visits, and conducts risk assessments. The Nurse does not have assigned duties outside the team and attends most morning meetings.	• Hire a second team Nurse as the members increase to a 100 member team.
H9	Substance Abuse Specialist on Team	1 – 5 (2)	There is one SAS on the team; she has 15 years of work experience in behavioral health servicing individuals with serious mental illness (SMI) as a case manager. The CC reports that she provides back up for substance abuse treatment and that she has completed substance abuse college classes and trainings. The team reported 36 members diagnosed with a co-occurring disorder (COD). The absence of one SAS staff with specific training and education in substance abuse treatment is reflected in the score.	• ACT teams should have two SASs to provide substance abuse treatment for 100 members. SASs also provide consultation and cross-training in co-occurring disorder treatment to staff in other specialties. • At least one SAS on the ACT team should have experience and training to provide individual substance abuse counseling rather than brokering the service to outside providers. The agency should provide clinical oversight to less experienced SASs delivering those services.
H10	Vocational Specialist on Team	1 – 5 (3)	The team has an Employment Specialist (ES) who has 15 years' work experience as a case manager working with individuals with serious mental illness. ES reported that she supports members with employment goals, assists with developing	• The ACT team should have two vocational staff with at least one-year training/experience each in vocational rehabilitation and support. The agency should continue efforts to hire an RS

			resumes, job searches and provides job coaching if needed. It was not clear whether or not the ES has had any formal training in vocational services; however, it appears she may have self-directed training, per specific ES knowledge and information demonstrated in interview, the observed team meeting, and the record review. The CC reported that the ES has participated in supported employment trainings from the RBHA but did not have documentation to verify this. CC reported the RS position has been vacant for five months, and remained vacant at time of review.	with relevant training and experience in vocational services.
H11	Program Size	1 – 5 (4)	At time of review the team had eight staff excluding the program assistant. There are four staff vacancies, PSS, SAS, RS, and second Nurse. During CC interview, CC reported that the team's SAS has resigned and her last day would be August 11, 2016. Additionally, CC will be leaving the team end of the month. Those pending changes were not factored into scoring in this item.	• The ACT team should be of sufficient size and diversity to provide for member coverage and the range of member identified recovery goals. Staff should have the experience and education to represent the range of specialty areas and provide guidance and cross-training to each other.
O1	Explicit Admission Criteria	1 – 5 (4)	Admission to ACT is based on written criteria set by the Regional Behavioral Health Authority (RBHA). Screening is done by the CC who meets with the person individually, discusses them with the team, with the final decision to accept made by the Psychiatrist. Potential members must be willing to accept the ACT level of intervention. Despite explicit admission criteria, the team faces and bows to administrative pressure to accept clients they do not feel are appropriate in order to build up their census.	• Review each ACT referral and maintain the established admission process to ensure the appropriateness of each member to the team.
O2	Intake Rate	1 – 5 (2)	The team ranged from one to 13 admissions per month, in the six-month review period, with March 2016, being the highest at 13. There were seven admissions in April 2016, six admissions in February 2016, five admissions for the months of	• The team needs to take members in at a low rate to maintain a stable service environment for both members and staff. This is very important as a new team gets up and running.

			May and June 2016, and one admission in July 2016.	
O3	Full Responsibility for Treatment Services	1 – 5 2	In addition to case management services, the ACT team provides psychiatric services and housing services. While the team offers employment/rehabilitative services and substance abuse treatment, it was not clear to the reviewers how much or the full scope of these services the team actually provides to its members. Additionally, the team lacks trained and experienced staff in areas. If members need more structured substance abuse treatment, the team refers to outside providers such as TERROS Ladders, or the Momentum program. The team also refers members out for counseling/psychotherapy, for they do not have qualified staff on team to provide this service.	• The agency should provide members with access to staff with the training and experience to provide substance abuse treatment, counseling/psychotherapy, and vocational services directly on the team.
O4	Responsibility for Crisis Services	1 – 5 4	The ACT team assumes full responsibility for crisis services for members. The ACT team is available to serve members 24 hours a day, seven days a week. ACT staff rotates responsibility for the ACT on-call phone on a weekly basis. The CC serves as the backup responder to all crisis calls and is available for consultation to on-call staff at any time. While the team reports they offer 24 hour emergency services, it is not clear based on data provided, , if they are providing it to the full extent. See also item O5, Responsibility for Hospital Admissions. Staffing issues discussed earlier in this report may also play a role in this item.	• The team should build trust and rapport with members and educate them on how ACT staff can assist them in managing crisis situations. • Trust and rapport building should extend to members' informal supports, and the team should have regular discussions with members regarding the benefits of allowing ACT staff to communicate with their informal support network.
O5	Responsibility for Hospital Admissions	1 – 5 (3)	The ACT team was in involved in six out of the last ten (60%) hospitalizations offered for review. Per CC interview, members sometimes self-admit or are taken to the hospital which causes a delay in notification to the ACT team. Sometimes hospitals do not immediately notify the ACT team.	• The team should build rapport and educate members on the benefits of ACT involvement in the decision to hospitalize. • The agency and RBHA should explore opportunities to improve

			The team seeks to only use hospitalizations as the last resort but will work with members who feel they cannot manage symptoms, as well as coordinate with guardians, family members and hospitals to gain admission. When necessary, the team uses amendments and petitions to hospitalize members who are an immediate danger to themselves. While the ACT team policy is that hospitalized members are seen every 72 hours, it was not clear from charts reviewed that this was occurring.	communication with local hospitals on the inpatient status and condition of members.
O6	Responsibility for Hospital Discharge Planning	1 – 5 (4)	The ACT team was involved in nine out of the last ten psychiatric hospital discharges. Staff reported they are involved in discharge planning, and the team assists in coordinating their transportation home, filling of prescriptions from the pharmacy, and scheduling follow up appointments with the team Psychiatrist.	• At the provider and RBHA level, continue to develop strategies for ensuring hospitals and detox programs make every effort to coordinate discharges. ACT teams should be involved in hospital discharges so that members are not released on to the street without a plan for medication management, safe and sanitary housing or other shelter, or without social supports to reduce the need for hospital readmission.
O7	Time-unlimited Services	1 – 5 (5)	Staff anticipate stepping down two members within the next 12 months. The CC reports no one has stepped down in the last 12 months.	• It is recommended that the ACT team establish a written statement of clear examples of progress milestones that support graduation and that those are explicitly documented in member records.
S1	Community-based Services	1 – 5 (4)	The ACT CC reported that the team is located in a non-clinical setting, sharing space with a resource center that serves children and adults. The team has a conference room and a couple of designated offices that are not assigned to specific staff members but rather are open for anyone to use as	• Staff should utilize the tools provided by the agency to work remotely, with the goal of providing 80% of all face-to-face contacts with members in the community. • Ensure all community contacts are

			needed. Staff are provided with work cell phones and laptops, and are equipped to meet members in the community. Staff reported that they meet daily, Monday through Friday for the morning meeting and then spend the rest of their time in the community. The record review shows that community-based contacts occur at a median rate of 62%.	accurately documented.
S2	No Drop-out Policy	1 – 5 (5)	Staff make efforts to engage and see what services the member will accept if he or she refuses ACT services. Two members left the team and could not be located. The ACT CC said that only one member has left the team and moved out of state with resources provided by the CC.	
S3	Assertive Engagement Mechanisms	1 – 5 (4)	Member engagement strategies include medication observations, ACT home inspections, advocacy and support in mental health and criminal court, and hospital visitations. ACT staff also use legal mechanisms to keep members active in the program (e.g., court ordered treatment, parole officer, surveillance officer, representative payee). Staff report they do not have a written engagement policy; no formal outreach approach was identified.	• The team should build rapport with new members and track and document outreach attempts. The agency should provide the team with a written protocol to follow.
S4	Intensity of Services	1 – 5 (3)	The available data indicates that members receive an average of 73.13 minutes of face-to-face contact per week. Staff encounter notes in the records revealed various types of interactions with members, including medication monitoring, wellness visits, and crisis stabilization.	• While the staff to member ratio is still relatively low, the ACT team staff should focus on providing an average of two hours of direct service per week to each member. • The CC should monitor weekly member contacts to identify issues that may be

				prohibiting staff from providing the required intensity of service.
S5	Frequency of Contact	1 – 5 (3)	The ten member records reviewed indicate that members received an average of 2.75 face-to-face contacts per week. Staff explained their contacts are based on need and they do not have a zone-style coverage system or strategy in place.	• Teams who achieve high fidelity in this area provide an average of four visits of direct member service per week. However, rather than focusing on a fixed number of visits, staff should strive to provide face-to-face contacts that actively engage members in achieving their stated goals and immediate needs, that promote skill building, and build upon strengths of the member. • Actual time with each member may be less than or greater than four visits per week but result in an average across the team of four visits.
S6	Work with Support System	1 – 5 (2)	The data provided implies the ACT team provides occasional interaction with the members' support systems. Staff estimated that over 60% of members had informal supports involved in treatment; however, the records reviewed indicated that the team averaged .9 contacts per month with the members' support systems. The team reported that they facilitate a family support group which meets once monthly for an hour, but no evidence of this was found during record review.	• Focus on documenting team contacts with member support system(s) in a consistent fashion, to ensure this measure is being accurately captured. • Continue to educate members on the benefits of and encourage the involvement of informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 3	According to the CC, 35 of the 51 ACT members have been identified as having a co-occurring disorder. The SAS reported that of those 35 members, nine of them participate in structured,	• Schedule members for individualized substance abuse treatment sessions, preferably separate from other home visits. Use this time to develop recovery

			individual substance abuse counseling one time per month. Sessions usually occur in members' homes and last 45 minutes to one hour. The record review found evidence of one scheduled substance abuse sessions provided by the SAS for 21 minutes. The SAS reported that through building rapport with members, she is able to assess risk, learn to develop coping skills and learn different ways to manage symptoms, via harm reduction tactics. Although the CC said she provides individual substance abuse counseling, the reviewers did not see evidence of this in the record review.	goals, develop a recovery plan, and track progress towards individual recovery goals. See also recommendation in item S9 Co-occurring Disorders Model.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The team offers one weekly substance abuse group. SA group is for ACT members only, and participation ranges from four to 12 of the 35 members diagnosed with a co-occurring disorder. Staff stated the co-occurring treatment groups are comprised of curriculum provided by the RBHA; however, staff also stated that the class is often guided by the Matrix Model curriculum obtained from the SAMHSA website, which is not indicated for individuals identified with a co-occurring disorder.	• Provide appropriate training and education to ensure the ACT teams are specifically following an established, integrated treatment model. • Actively recruit members to attend the co-occurring treatment groups.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 2	The CC reported that although the ultimate goal is abstinence, the team uses harm reduction tactics that celebrate steps toward reducing use as progress. The team uses a Matrix Model, an intensive outpatient treatment, for their groups and one-on-one sessions. As stated in the above items, this is not a co-occurring model that aligns with the ACT emphasis on stage-wise approaches and strategies such as harm reduction. The SAS reported that she uses topics from her one-on-one sessions to assign homework and use for upcoming substance abuse group. The SAS reported team refers members to Alcoholics	• The provider and RBHA should provide education and training on a dual disorder treatment model, such as Integrated Treatment for Co-Occurring Disorder, as a stage-wise treatment approach. Standardizing a basic tenant of treatment may help ensure consistent interventions across the system.

			Anonymous/Narcotics Anonymous (AA/NA) only upon request from the member and will refer to detox when the team feels medically necessary. Examples provided were for alcohol use or for someone who has smoked spice.	
S10	Role of Consumers on Treatment Team	1 – 5 (1)	The ACT team currently has no identified peer support specialist. This position has been vacant since February 2016.	• ACT teams should have a full-time PSS, with full professional status to provide direct service to members and ensure a member perspective in service design and delivery.
Total Score:		**3.25**		

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	2
5. Continuity of Staffing	1-5	2
6. Staff Capacity	1-5	2
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	4
9. Substance Abuse Specialist on Team	1-5	2
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	4
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	4
2. Intake Rate	1-5	2
3. Full Responsibility for Treatment Services	1-5	2
4. Responsibility for Crisis Services	1-5	4
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	4
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	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	1
Total Score	**3.25**	
Highest Possible Score	**5**	