ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: 5/4/2015

To: Todd Andre, Clinical Director
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ADHS Fidelity Reviewers

Method

On March, 24-25th, 2015 Georgia Harris and Karen Voyer-Caravona (Fidelity Reviewers) completed a review of the CHOICES-Townley Center Clinic's 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 CHOICES-Townley Center Clinic is located at 8836 North 23rd Avenue in Northwest Phoenix. The clinic is accessible by public transportation and is in close proximity to local businesses. The ACT team serves 99 members, 42 of which are diagnosed with a co-occurring disorder. The team is comprised of 10 staff members: one psychiatrist, one nurse, one Clinical Coordinator (ACT Team Leader), one Peer Support Specialist, one Independent Living Specialist, one Housing Specialist, one Transportation Specialist, two Substance Abuse Specialists and one Rehabilitation Specialist. Lifewell provides individual counseling services, and TERROS Ladder co-occurring treatment services are co-located at the site.

The individuals served through the agency are referred to as "members" and will be referenced as such throughout this report.

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

- Observation of a daily ACT team meeting.
- Interview with the ACT Team Leader.
- Individual interviews with one Substance Abuse Specialist and one Independent Living Specialist.
- Charts were reviewed for 10 members using the agency's electronic medical records system, with assistance from the agency staff. Team data was also provided to the reviewers by the ACT Team Leader.
- Group interviews with 6 members receiving services.

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 CHOICES Townley Center ACT Team is comprised of many experienced ACT staff, and although there has been a considerable amount staff turnover and migration to other positions in recent months, the team is currently rebuilding. With a new ACT Team Leader, the team is now filling current vacancies with qualified staff and is focusing on the re-establishing of ACT specialties (i.e. Substance Abuse Specialist, Employment Specialist, etc.), as outlined in the ACT model.

The agency demonstrated strengths in the following program areas:

- This team benefits from a strong ACT Team Leader, with verifiable experience in the ACT model and its successful implementation. The Team leader presented a strong understanding of ACT principles and provides the team with direct supervision, as well as modeling of service provision. The ACT Team Leader is seen as accessible by the team while remaining directive in her guidance of decision-making and professional behavior. She provided candid discussion on the strengths and areas of opportunity for team growth and service improvement.
- The team prioritizes providing services in natural settings; this was verified by the high percentage of community based services recorded in the data. ACT Team Leader, the Psychiatrist and the Nurse conduct weekly home visits alongside the team staff. The ACT Team Leader provides medication monitoring on a daily basis, in addition to conducting home and hospital visits.

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

- Staff consistently stated that high staff turnover compromises their ability to become fluent in their areas of specialization, due to the coverage needs that are subsequently absorbed by the remaining staff. Moreover, staff stated their difficulties in maintaining intensive levels of therapeutic rapport with members when the team is not fully staffed. Of the vacant positions, the team has lost two Team Leaders in the past year. The team also frequently experiences the shifting of ACT specialists into vacant roles on the team. The team currently has 10 of the 12 necessary ACT positions filled. However, filling staff vacancies and stabilizing current specialties will be critical to increasing service intensity to members, as well as helping to avoid staff 'burnout' and improving current staff retention on the team.
- Many of the ACT services provided by the team were not consistently reflected in the member records. Staff continually identified their barriers to completing documentation in an effective manner. It is recommended that the agency discuss the needs of the staff and include them in the exploration of solutions that will optimize their efficiency, especially in regards to chart documentation.
- Substance abuse specialists should provide individualized substance abuse treatment and groups according to an Integrated Dual Diagnosis Treatment model. Using a non-confrontational, stage-wise treatment model follows behavioral principles, considers interactions between mental illness and substance abuse, and has gradual expectations of abstinence. ACT research shows that integrated substance use services are most effective when provided by ACT staff. In high fidelity ACT teams, external substance use

programs and service providers are used as occasional supports, rather than primary sources of support. As the team Substance Abuse Specialists provide these services, the need for brokered services with external providers should diminish.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The team serves 99 members. The team roster consists of nine staff: an ACT Team Leader, an Independent Living Specialist, two Substance Abuse Specialists, a Rehabilitation Specialist, a Housing Specialist, a Nurse, a Transportation Specialist and a Peer Support Specialist. The team currently has two vacant positions that are being temporarily filled by employees [from staffing agencies] who are not credentialed to carry out all the duties of the position (i.e. both are unable to conduct home visits at this time.). These temporary staff are not counted in the ratio. The member to staff ratio for the team calculates as 11:1, though staff report managing caseloads ranging between 15-17 members during times when staff turnover is high. This count excludes the Psychiatrist and any administrative support.	• It is recommended that the team explore all options for hiring additional staff for vacant positions. Maintaining a member-to-staff ratio of 10:1 is optimal.
H2	Team Approach	1 – 5 5	Of the 10 records selected for review, 100% of the members were seen by multiple staff in a two week period. Staff are responsible for seeing their assigned members weekly. Staff will see additional members based on multiple factors (i.e. visiting all members who are hospitalized or multiple members residing in the same neighborhood). The ACT Team Leader will often volunteer to conduct medication observations and visits with members in the community. Though the data confirms the team's fulfilment of this indicator, staff state that being short-staffed has impacted their ability to maintain their team approach.	• Though the current team approach is fulfilling the needs of the members, the team should consider exploring coverage strategies that will evenly distribute responsibilities across all staff. • Having a fully-staffed ACT team (see H1) can aid in the distribution of responsibilities among staff.
H3	Program Meeting	1 – 5 5	The program meeting is conducted daily Monday – Friday, from 10-11:30am. In addition to the team meeting, on Wednesdays the team meets for	

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			clinical supervision and case staffing. All members are discussed during the program meetings. All staff are expected to attend these scheduled meetings.	
H4	Practicing ACT Leader	1 – 5 3	Staff and members confirm that the ACT Team Leader is actively involved with members in the office, in the community, and with family supports. The ACT Team Leader is scheduled to provide crisis and quotidian services (i.e. medication observation) to members. Staff interviewed said they believe that the Team Leader spends between 40-50% of her time providing direct services; conversely, there is very little time to document all encounters. The Team Leader states she is doing more than documented. The record review confirms that the ACT Team Leader provides meaningful, engaging services with members; however, this accounts for less than 25% of all the documented activities.	• Review Team Leader administrative requirements to confirm if all duties are required through the PNO/RBHA. • If all administrative activities are deemed essential, explore available options to increase the Team Leader's opportunities to document effectively (i.e. administrative. or technological supports that could improve opportunities for documentation).
H5	Continuity of Staffing	1 – 5 2	The ACT team has had 16 staff members leave over the past two years. This resulted in a 68.75% turnover rate. Moreover, the data suggests that three of the staff transferred to other positions within the ACT team during this period. In these instances, staff wanted to explore other roles for which they felt they were professionally a "better fit". Though this is not a part of the turnover rate calculation, staff report it further complicates their ability to provide quality care to members. Staff also stated that some have left the team for other positions that offered higher compensation.	• The clinic, PNO and RBHA should identify factors contributing to high staff turnover, possibly through exit interviews and employee surveys, and develop a plan to support staff retention. This may be an area of further ongoing network, clinic and system review. • Though the ACT model promotes cross-specialization of roles, specialists should be primarily committed to their specialty of employment, housing, etc. Consider implementing experiential hiring practices such as job shadowing for potential new ACT team staff, particularly for those job candidates

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				new to the ACT model.
	Staff Capacity	1 – 5 4	The team has operated at a staff capacity of 86.1%, with 20 vacancies in the past 12 months. The team is currently without a Vocational Specialist and a Mental Health Worker.	• See H5 for recommendations. While the team has managed to fulfill criteria for staff capacity, the inability to retain staff continues to affect quality of services and potential member outcomes.
H7	Psychiatrist on Team	1 – 5 4	The team has a Psychiatrist who works full-time for the agency. She also spends approximately 20% of her time providing coverage services to additional teams on Tuesdays. The Psychiatrist recently joined the team two weeks prior to review. The staff and members indicated that though the Psychiatrist is new, she is very knowledgeable and does meet with members in the community. The Psychiatrist was observed providing supervision during the daily meeting.	• Explore options for limiting the Psychiatrist's coverage of other teams. Having a dedicated, full-time psychiatrist is a critical feature of the ACT model.
H8	Nurse on Team	1 – 5 3	The team currently has one full-time, ACT-dedicated nurse. Staff stated that their team would greatly benefit from an additional nurse because their nurse actively visits members in the community. Members could benefit from more nursing services provided in their homes.	• Determine options for obtaining an additional nurse. Nurses function as full members of the team and serve as educators to both members and staff. Two nurses will ensure flexibility and availability of medical services such as injections and labs in the community and at the clinic.
H9	Substance Abuse Specialist on Team	1 – 5 4	The team includes two Substance Abuse Specialists (SAS). One SAS is a Certified Addiction Counselor in Michigan. The second SAS has been with the team since September 2014. The professional training/experience of the second SAS was not verified; however, it was stated that the SAS has "lived experience". The inability to verify the professional experience of the second SAS is reflected in the scoring of this item.	• It is recommended that the ACT team keep formal records of all SAS resumes, including documentation of professional credentials and trainings.
H10	Vocational Specialist	1 – 5	This team currently has one Rehabilitation	• Determine options for obtaining an

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	on Team	3	Specialist (RS) on staff. The RS began working for the agency on the first day of review. The Team Leader stated that the RS was hired due to her experiences with employment and rehabilitation services at another community services provider. There was no Vocational Specialist assigned to the team at the time of review.	additional Vocational Specialist, specifically an experienced Vocational Specialist who can provide the team expertise and cross-training in this area.
H11	Program Size	1 – 5 5	The ACT team consists of 10 full time staff for 99 members. The program is sufficient size to provide necessary staffing coverage.	
O1	Explicit Admission Criteria	1 – 5 5	The team has a clearly defined population and uses defined criteria to screen out inappropriate referrals. The Team uses ACT admission/screening criteria, as determined by the RBHA. Beyond the admission/screening tool, potential members must be willing to accept the ACT level of intervention, prior to being admitted to the team. The Psychiatrist and the Team Leader make the final decisions for the team.	
O2	Intake Rate	1 – 5 5	The program maintains a low growth rate to maintain stability of service delivery. In the four months since the current Team Leader has been present, the team limits admissions to one new person a month. The team has had eight admissions in the past six months.	
O3	Full Responsibility for Treatment Services	1-5 3	The team currently provides two additional services to case management: psychiatric services and housing services. One of the Substance Abuse Specialists is a Certified Addiction Counselor, but is not providing one-to-one treatment services for the ACT members. The Team Leader is a Licensed Associate Counselor (LAC) and has recently begun to provide some general counseling services to members. Members that are out of their scope of	• Consider options that will minimize the need for the team to refer to outside agencies for services that are to be provided by the ACT team (e.g., vocational services). • Explore opportunities for professional development for staff in specialty ACT positions (e.g. substance abuse treatment, public housing programs,

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			services, such as PTSD counseling, are referred to Lifewell and Terros.	etc.) • Recruit staff members with expertise in ACT specialties (noted above) who are capable of cross-training other staff in specialty areas.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for members. Per Team Leader, members may call the team directly or call the crisis line. The staff rotates coverage with the on-call phone. Staff will contact the Team Leader if a decision needs to be made regarding visits to members in crisis.	
O5	Responsibility for Hospital Admissions	1 – 5 5	The team was closely involved in 100% of the last 10 hospitalizations. The staff stated that the team actively amended the Court Ordered Treatment in three of those admissions. The remaining admissions were for increases in symptoms. The team often assists members' families in the admission and petitioning processes. Three of the most recent hospital admissions were coordinated with family members. Members will often call the team directly if they feel they are in need of an evaluation by the team Psychiatrist.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	The team was closely involved in 100% of the last 10 hospital discharges. Staff is committed to planning discharge prior to hospital admission. Once a member is admitted, the ACT team schedules to visit the member in the hospital once every 72 hours. The ACT team uses the discharge plan in the member's Individualized Service Plan (ISP) as the foundation for coordination with the in-patient clinical team. The team often provides discharged members with transportation from the hospital to the pharmacy to fill medications, and then to their homes. Family will sometimes provide transportation to members.	

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O7	Time-unlimited Services	1 – 5 5	The Team Leader estimates that 3 members will graduate in the next year. If the member agrees, they will graduate to a supportive or connective team. However, the team will attempt to triangulate data to determine a client's readiness for transition (e.g. the client's request to leave the team, their behavioral patterns, their consistency in treatment, and progress towards recovery goals).	
S1	Community-based Services	1 – 5 4	Over 65.87% of total face-to-face contacts are in the community. The Team Leader explained the team's strategy for making member contacts in the community a priority. The Team Leader also schedules and attends home visits with the Psychiatrist and Nurse.	
S2	No Drop-out Policy	1 – 5 5	The team retained 100% of their caseload in the last 12 months. The eight members who no longer receive services from the ACT team were transferred to other ACT teams (i.e. Forensic ACT Team). According to the Team Leader, coordination/relocation services are provided once a member decides to transfer.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The team has an 8-week contact strategy. This includes a contact checklist, used for tracking engagement activities for members who cannot be located. In this contact checklist, staff are prompted to record their efforts and identify any legal mechanisms used to locate missing members; this may include outreach to morgues or representative payee services, and mailed notices to member residences. Member status and team engagement with family supports were discussed and noted during the daily team meeting.	
S4	Intensity of Services	1 – 5	Ten member records were reviewed to determine	• Explore what actions the team might

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		3	the average amount of face-to-face service time spent with each member. The team spends an average of 75 minutes per week in total service time per member.	take that could result in higher service intensity per member. Suggestions include creating targeted service agendas for appointments with members, increasing services provided through ACT staff, decreasing brokered services though outside agencies, sharing and/or reassignment of staff responsibilities, etc.
S5	Frequency of Contact	1 – 5 2	Staff and member interviews were paired with data from the record review to determine the amount of times per week each member is receiving contact from the ACT staff. The team provides an average of 1.88 contacts, per member, per week. Staff report that their contact frequency is partially affected by their team being understaffed at the time of review. Staff state they do not have the ability to see members more frequently because of their increased caseload. Documentation, which usually must be recorded in the office, further detracts from the time staff can devote to frequency of contacts.	• Team Leader should review staff schedules and workflow to help determine areas for improved efficiency while recruiting to fill open positions. • See recommendations for Items H5 and S4.
S6	Work with Support System	1 – 5 3	The team reports providing regular support to members' informal support network. Staff report varied levels of contact, based on members' needs; however, the record review captured very few informal support contacts. The results from the record review and the staff reporting were combined, resulting in an average of approximately 2 contacts per month.	• Focus on documenting team contacts with member support system(s) to ensure this measure is being accurately captured. • Provide training regarding identification of supports outside of direct family members. • Provide ideas in supervision regarding key opportunities to ask members about engaging their supports in services.
S7	Individualized Substance Abuse	1 – 5 2	This team has a Certified Addiction Counselor and a Licensed Associate Counselor on staff. Though	• Continue implementation of individualized substance abuse

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	Treatment		highly-qualified staff exists on the team, there is very little individualized treatment reflected in the clinical record. The team reports that they have recently begun to provide this service; however, individualized treatment has historically been provided by brokered agencies such as Momentum, TERROS, and Lifewell for counseling.	programming for the team. • Develop tracking mechanisms for individualized substance abuse services provided to members.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Seven of the 42 members with a co-occurring disorder attend a weekly Substance Abuse group at the clinic. The group is not exclusive to ACT members and is open to all members at the clinic. The group follows a curriculum focused on identifying triggers and relapse prevention techniques. Members also receive "library cards", which enable them to check out curriculum and self-help materials compiled by the SAS to aid in their development.	• Create a group specifically for ACT team members. This will require assertive outreach to members with co-occurring disorders who are not participating in groups or treatment. The frequency of group offerings should also be increased. • Review current curriculum to ensure all materials and strategies engage clients in co-occurring stage-wise treatment.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The team currently engages in a mixed-model of treatment for those with co-occurring disorders. Staff state that members use multiple techniques and resources for treatment: 12-step models, stages of change and harm reduction techniques. Many members are referred to NA/AA open groups. The Team Leader states that she is focused on transitioning the team from a primarily traditional model, to Integrated Dual Diagnosis Treatment (IDDT). The Team Leader is currently providing formal supervision on counseling techniques and other tools such as the ASAM (American Society of Addiction Medicine) Criteria, with the goal of helping staff adjust to the changes in thought process and practice that come with a change in treatment models.	• Continue implementation of IDDT with the current ACT team staff. Regular individual and group supervision may be necessary for successful transition to the model. • At the team, PNO and RBHA level, continue efforts to provide education and training on Integrated Treatment for Co-Occurring Disorder as a stage-wise treatment approach. Standardizing basic tenant of treatment may help ensure consistent interventions across the system.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team's Peer Support Specialist (PSS) is a full-time staff with full professional status. The PSS has	

Item #	Item	Rating	Rating Rationale	Recommendations
			worked on multiple teams in the RBHA system and has also worked on connective treatment teams throughout the behavioral health system. The other staff noted that she provides a lived, peer perspective to the team regarding member challenges, as well as shares her story with members who need that type of support and direction. She also provides strategies for engaging members who are experiencing challenges. The PSS has a full case load and was observed as an active participant in the team meetings. In addition to a PSS, one of the Substance Abuse Specialists identifies as a person with the lived experience of recovery from substance abuse.	
Total Score:		**109/28 =3.89**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	2
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	4
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	3
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	5

6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
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	3
7. Individualized Substance Abuse Treatment	1-5	2
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	**109/28 = 3.89**	
Highest Possible Score	**5**	