ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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AHCCCS Fidelity Reviewers

Method

On July 12-13, 2016, Georgia Harris and Jeni Serrano 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. The clinic is a hub for many member activities and co-located services, including an on-site pharmacy where members can fill both their medical and psychiatric prescriptions. Terros assumed ownership of the Enclave clinic and several other CHOICES clinics in mid-2015. During last year's review cycle, the Enclave ACT team was in the process of recruiting and restructuring, after a season of substantial employee turnover. At the time of this review, the Enclave ACT team was fully staffed and was serving 96 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 12, 2016 at 3:00pm.
- Individual interview with ACT Team Leader/ Clinical Coordinator (CC).
- Individual interviews with one Substance Abuse Specialist (SAS), the Employment Specialist (ES) and the ACT Specialist.
- Group interview with three members who were served by the ACT team.
- Review of agency documents such as the *Monthly Service Delivery* spreadsheet; *MMIC ACT Eligibility Screening Tool*; *Substance Abuse Outcomes Report* (stages of change tracking); *Team Work Schedule*; *Terros Health ACT* brochure; *ACT Employment Group* flyer; and the *8-Week Re-Engagement Flow Chart*.
- Charts were reviewed for 10 members using the agency's electronic medical records system.

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:

- Team Approach: In the past year, the ACT team has transitioned from a traditional case management model to a team approach. The team shows shared responsibility for members by a scheduling method that affords each staff to see different members, on a weekly basis.
- Full Responsibility for Treatment Services: The team has added a dedicated, full-time Clinician (i.e. licensed therapist) to the staff roster. The Clinician was hired to eliminate the need for referrals to external providers for counseling services. The clinician only serves ACT members and has the same responsibilities as all other ACT staff.
- Community Based Services: The team demonstrates efforts to monitor and teach skills in natural settings, by maintaining above 95% of all documented contacts with members in community settings.
- Role of Consumers on Treatment Team: The team has a fully-integrated Peer Support Specialist (PSS). Both staff and members report that the PSS is professional, engaging, and supportive; she empowers members by sharing her recovery experiences and provides additional perspective to the clinical team when difficulties with members arise.

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

- Practicing ACT Team Leader: The ACT CC is acquainted with the ACT members and is visibly engaged with the ACT staff. However, the chart records, documentation, and outcomes reports indicate that less than 25% of her time is spent in direct service with members. A practicing ACT Team Leader is noted as one of the five factors most strongly related to positive member outcomes. Teams with greater involvement from ACT Team Leaders benefit from having a leader who is not only familiar with the members and their needs, but also a model for appropriate clinical practices for other ACT staff.
- Frequency of Contact/Intensity of Services: Clarify for ACT staff the connection between a high frequency of contact (S5), high intensity of services (S4), and member outcomes. Most staff were unaware that the indicators for these items were based on average contacts and not fixed numbers; often feeling the need to prioritize the amount of time spent with members, over the amount of face-to-face contacts made, especially during their busiest weeks. There should not necessarily be priority placed on one over the other, but rather a commitment to providing both quality interactions with members several times a week, on average, for all ACT staff.
- Individualized Substance Abuse Treatment: Members are not participating in formal substance abuse treatment. Currently, substance abuse treatment is incorporated into standard home visits. Though it may seem logical to provide substance abuse treatment as a natural extension of a home visit, substance abuse counseling often requires a dedicated focus on its particular complications.
- Dual Disorders (DD) Model: The team uses a mixed model for substance abuse treatment. While often rooted in the Dual Disorders

model, treatment occasionally relies on traditional options. The network and Regional Behavioral Health Authority (RBHA) should work together on opportunities to educate ACT staff on how to employ a DD model into their treatment practices and team culture (e.g. default treatment interventions, language, etc.)

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT maintains a member-to-staff ratio of 8:1. The team serves 96 members. The team consists of 12 full-time staff: An ACT Team Leader, two nurses (RN), two Substance Abuse Specialists (SAS), an Independent Living Specialist (ILS), a Clinician, a Peer Support Specialist (PSS), a Housing Specialist (HS), an Employment Specialist (ES), and an ACT Specialist. The team currently has a full-time, temporary staff in the Rehabilitation Specialist (RS) position. The ACT Team Leader stated that the agency is actively recruiting for a permanent RS. This staff count excludes the Psychiatrist.	
H2	Team Approach	1 – 5 5	To determine the level of team responsibility for each member, 10 member records were sampled for review. Ninety percent of members reviewed had face-to-face contact with multiple staff, over a two-week period. Over the past year, the team changed their contact strategy. The team created a work schedule that allows each staff the opportunity to visit with ten different members each week.	
H3	Program Meeting	1 – 5 5	The ACT team meets five days a week from 3:00pm to 4:30pm, briefly reviewing every member on the team. In addition to the regular meeting, on Wednesdays the team discusses members in length with the Doctor.	
H4	Practicing ACT Leader	1 – 5 3	Based on the data provided, the ACT Team Leader provides direct care to members less than 25% of the time. The CC estimates that between 40-50% of her time is spent providing direct service to members. Reviewers examined the *Monthly Service Delivery*	• The Team Leader should spend 50% or more of her time providing direct services to members. A practicing ACT Team Leader is noted as one of the five factors most strongly related to better member outcomes. As the ACT Team

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			spreadsheet, a document used to track staff encounters, which reflected that the CC averaged approximately 24.1% of her time in direct encounters with members. The record review reflected the same percentages, and also revealed that the majority of the CC's documented encounters with members occur in the clinic/office setting.	Leader provides services, they serve as a model of appropriate clinical interventions for the other ACT staff.
H5	Continuity of Staffing	1 – 5 3	The team has operated at a staff capacity of 46%, with 12 staff who left the team in the past two years. Proportionately, 11 of the 12 staff left in 2015; many of them were affected by the network transition from CHOICES to Terros. The CC reports that in the past year, the team has worked to reduce employee attrition by becoming more selective when choosing staff, focusing equally on their qualifications and their enthusiasm for providing the ACT level of service for members.	• Continue efforts to recruit and screen potential employees to ensure their appropriateness for the ACT team.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the ACT team maintained consistent, multidisciplinary services by operating at approximately 91% of full staffing capacity. For seven of the 12 months, the team was without an Employment Specialist. The team has been without a Rehabilitation Specialist for three months.	• See H6 for recommendations.
H7	Psychiatrist on Team	1 – 5 4	The ACT team currently has one assigned, full-time Psychiatrist. She regularly attends the daily team meeting, and conducts home visits with members on a weekly basis. The Psychiatrist is the lead doctor at the clinic which results in occasional coverage duties for other clinical teams, as well as supervisory responsibilities for other doctors. Most staff and members interviewed did not feel her additional responsibilities affected her ability to provide quality care to the members.	• Though no difficulties were reported, full fidelity in this item is tied to the complete dedication of the ACT Psychiatrist to the services of ACT members.

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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 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 in-office and community responsibilities daily.	
H9	Substance Abuse Specialist on Team	1 – 5 3	There are two, dedicated, full-time SASs on the ACT team. Though the CC reported that the first SAS has been working with the team for a number of years, reviewers were unable to verify her qualifications. The second SAS has a background in Corrections, with a focus on substance abuse with juvenile offenders. He has worked on the team as an SAS for a year, and reports that he has completed all the related trainings offered by the RBHA on co-occurring disorders.	• Explore all options for providing subject matter-specific training on substance abuse treatment for current staff. • When hiring, focus on recruiting staff that have one year of training and/or clinical experience in substance abuse treatment.
H10	Vocational Specialist on Team	1 – 5 3	The team currently has one full-time Vocational Specialist, the Employment Specialist (ES). The ES has been with the ACT team for five months; however, he has worked as a Job Developer in a Supported Employment agency for nearly three years. The Rehabilitation Specialist (RS) is a full-time, temporary staff. The CC was unable to confirm the qualifications of the temporary staff for the RS position. The team continues to recruit a qualified RS in order to fill vacancy on the team.	• Ensure that the ACT team is staffed with two vocational staff with at least one year of training/experience in vocational rehabilitation and support.
H11	Program Size	1 – 5 5	The ACT team consists of 13 staff. This count includes the ACT-dedicated clinician, whose case management duties are equal to those of the other ACT specialist positions. The team is of sufficient size to consistently provide staffing and adequate coverage.	
O1	Explicit Admission	1 – 5	The team has clearly defined ACT admission	• Ensure that all enrolled cases comply

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	Criteria	4	criteria, as outlined by the RBHA. The CC provided a copy of the MMIC *ACT Eligibility Screening Tool* used to screen potential/new members. Staff report that the team carefully screens referrals, but occasionally bows to organizational pressure to accept administrative transfers from other organizations and/or ACT teams.	with the established admission criteria for this team. The CC and/or the Psychiatrist should monitor this with final approvals.
O2	Intake Rate	1 – 5 5	The ACT team reports 18 admissions in the last six months. The ACT CC reported the team's highest intake month was February 2016 with five admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 5	The ACT team assumes full responsibility for all treatment services. In addition to psychiatry and case management, the team provides housing assistance, vocational services, and substance abuse treatment. In February 2016 the team added a full-time clinician to provide counseling/psychotherapy services to ACT members. With this new addition, the team no longer refers members to outside providers for counseling services. The staff report that they do not refer to provider agencies for services that are affiliated with ACT specialties.	
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour coverage for members. The staff rotates coverage with the on-call phone. Though the team has an on-call phone, the ACT CC reports that members have access to the list of ACT staff phone numbers and often prefer to make direct calls to the cell phones of the ACT staff. When crises arise, staff will contact the CC if a decision needs to be made regarding visits to members in crisis.	• If the team prefers that members call the on-call phone after normal business hours for crisis situations, they should educate members on the preferred process.
O5	Responsibility for Hospital Admissions	1 – 5 4	The record review and staff interviews indicate that the team was involved in eight of the last ten hospital admissions of ACT team members. In one	• Continue ACT team involvement hospital admissions. • The team should work to build

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			of those two instances, it was reported that the member was hospitalized for medical reasons and was eventually transferred to the psychiatric unit. The other member was experiencing a drug overdose and was transported by ambulance to the hospital.	relationships with local hospitals, social workers, and other entities that have influence on the decision to hospitalize members. Educate them on the ACT team's services and role in treatment decisions.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	The record review and staff interviews indicate that the team was involved in all of the last ten discharges. The CC stated that the team assumes responsibility for the coordination of member discharges alongside the hospital staff. The ACT team will transport members from the hospital to their homes and ensure the member has access to basic necessities (e.g. food and prescriptions).	
O7	Time-unlimited Services	1 – 5 5	The ACT team reported two graduations over the past year. The team anticipates that two members will graduate within the next 12 months.	
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 95% of the time.	
S2	No Drop-out Policy	1 – 5 5	The team has retained 96% of their members in the past 12 months. All of the members who terminated services without referrals reported that they felt the ACT level of care was intrusive and interfered with their personal affairs (e.g. family and college life).	
S3	Assertive Engagement Mechanisms	1 – 5 5	The team uses street outreach and legal mechanisms to ensure ongoing engagement with members. ACT staff reported the use of a highly-detailed, 8-week contact strategy prior to closing any member. The contact strategy (written as a flow chart) informs ACT staff on the strategies used to engage members who have lost contact	

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			with the team. If the 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 approximately 80 minutes per week in total service time per member. Eight of the ten records showed staff spending between 70 and 139 minutes per week with members. Service times documented for the remaining two records were significantly reduced; one member was in jail and the other member did not attend the last eight appointments with the ACT team. Staff interviewed stated they experience some pressure from the organization to see all members four times weekly. Many staff felt this requirement was excessive and impinged upon their ability to provide a greater intensity of services.	• ACT teams should average two hours or more of face-to-face services per peek. • Clarify the correlation between high services intensity and member outcomes. Staff misunderstood that the ACT model requires two hours of contact per member, rather than an *average* of two hours per week, per member. This provides some flexibility in how time is allotted for members, which bases contacts on member need rather than strict guidelines for services.
S5	Frequency of Contact	1 – 5 4	Based on the records reviewed, the team delivers an average of 3.5 contacts per member, per week. As noted earlier, staff interviewed stated they experience some pressure from the organization to see all members four times weekly. Some staff reported that in order to meet weekly requirements, they often felt the need to choose between providing excellent service intensity and meeting their frequency of contact quotas.	• ACT teams should average four or more contacts per week with each member, while also providing quality services based on members' needs. • Clarify the connection between a high frequency of contact and member outcomes. See recommendations in S4, Intensity of Services.
S6	Work with Support System	1 – 5 3	Based on the data provided, the ACT staff offers adequate support to members' informal network. The CC reports that approximately 33 members have natural supports involved in treatment. The ACT CC reports that staff are in contact with each natural support at least twice monthly. The CC	• Continue to build relationships with the support systems of the ACT members. • Clearly document contacts with support systems in the clinical record.

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			teaches a family psychoeducational group twice monthly; currently four families attend regularly. During the daily meeting, staff spoke often of their engagement with family members, talking about their roles in reporting each member's progress to the team. The clinical record review indicated that support contacts are estimated at one per month; however, members interviewed felt that the team spoke with supports on a frequent basis.	
S7	Individualized Substance Abuse Treatment	1 – 5 3	Members are not participating in formally scheduled substance abuse treatment. As indicated by the results of the record review, the team currently integrates substance abuse treatment into regular contacts; however, no formal, individualized substance abuse treatment sessions were noted in the records.	• Schedule members for individualized substance abuse treatment sessions. Use this time to develop recovery goals, develop a recovery plan, and track progress towards individual recovery goals.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The team offers two weekly substance abuse groups. The groups are for ACT members only. The groups average 20.5% of the 39 members diagnosed with a co-occurring disorder. Staff state 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 interests and/or questions posed by members.	• Ensure appropriate training and education is provided to ensure the ACT teams are specifically following an established, stage-wise curriculum, such as IDDT. • Continue to recruit members to attend the co-occurring treatment groups.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The team uses a mixed model for COD treatment, which is often rooted in the Dual Disorders model, but occasionally relies on traditional treatment options. The team has established a tracking mechanism for the *Stages of Change*; the team uses a spreadsheet to track the *stage* for each member in their recovery. However, when asked how this information was being used to inform treatment for each member, staff were unable to provide clear examples of how the information is being used. Staff report that they believe in harm	• At the team, provider and RBHA level, continue efforts to provide education and training on 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.

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			reduction; however, abstinence is the ultimate goal. The team also offers community-based, 12-step programs to members if requested. The team does not refer to detox, but if a member requests Narcotics Anonymous or Alcoholics Anonymous, the staff will give them information to connect with them in the community. The staff describes their approach as one that provides supports to members with addictive personalities, and not one that forces abstinence.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has a fully-integrated Peer Support Specialist (PSS). The PSS is a full-time staff and is assigned responsibilities equal to those of all the other team members. Many staff view the role of the PSS as one of engagement, focused on improving therapeutic rapport and clinical outcomes.	
Total Score:		**4.18**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
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	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	4

8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	3
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	4
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	4
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	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	3
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	**4.18**	
Highest Possible Score	**5**	