ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: May 21, 2018

To: Granville Monroe, F-ACT 3 Clinical Coordinator
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AHCCCS Fidelity Reviewers

Method

On May 1-2, 2018, T.J. Eggsware and Georgia Harris completed a review of the Community Bridges Inc. (CBI) Assertive Community Treatment (ACT), Forensic ACT Team Three. 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.

CBI operates five ACT teams, two ACT teams located in Avondale, AZ, and three Forensic Assertive Community Treatment (F-ACT) teams. The agency F-ACT teams temporarily operate from several CBI facilities until a permanent office space is licensed.

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

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

- Observation of a daily F-ACT team meeting on May 1, 2018 at the CBI Avondale location;
- Individual interviews with Clinical Coordinator (i.e., Team Leader), ACT Specialist (AS), a team Nurse, and the team's Substance Abuse Specialists (SAS);
- Group interview with six members;
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system; and,
- Review of documents and resources, including the agency website*; ACT Operational Manual,* developed by the Regional Behavioral Health Authority (RBHA); *F-ACT Admission Criteria* ; and resumes and training records for the SAS and Employment Specialist (ES).

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:

- Staffing is adequate to ensure an appropriate member to staff caseload ratio. Staffing is of sufficient size to provide necessary coverage to the 89 members served.
- The team meets at least four times a week to discuss and plan services delivered to all members, including one day a week when an extended meeting allows for more in-depth discussions for members with unique or challenging needs.
- The ACT team has two Nurses. Interviews and the records reviewed suggest that both Nurses provide clinic and community based services to members. Staff reported the Nurses are available to on-call staff over the weekend and after hours.
- The team maintained consistency and continuity of care for members with a low admission rate, and few members transitioned off the team over the year prior to review.
- The majority of services documented in the ten records reviewed occurred in the community or outside of CBI facilities. The team appears to prioritize individualized contacts with members in their communities, and does not rely on office-based contacts or group activities for face-to-face contact.

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

- Evaluate precipitating factors affecting team involvement in member psychiatric hospital admissions. The ACT team should be directly involved with member psychiatric hospital admissions, and this review reflected staff participation in just six of the last ten admissions. Work to develop plans with members and their support network in advance to discuss how the team can support members in the community to avert, or to assist, in a hospital admission, especially if they have a history of admitting without seeking team support.
- Engage natural supports, on an average of four times monthly, as partners in supporting members' recovery goals. Seek training and guidance, whether at the agency or through system partners, to enhance strategies for engaging informal supports.
- Provide training to staff on an integrated approach to substance use treatment, including review of stage-wise treatment and associated interventions; how to develop treatment plans based on the member's perspective and incorporating co-occurring treatment language; and, strategies to engage members in individual and/or group treatment. Offer individual and group co-occurring treatment to accommodate members in different stages of treatment (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention).
- Securing permanent office space may improve service delivery. Some staff and members interviewed reported that the lack of a permanent office-space was a hindrance.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 89 members with nine staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of about 10:1.	
H2	Team Approach	1 – 5 4	Staff reported having assigned caseloads for paperwork tasks, but that they serve all members. Based on ten records reviewed, 80% of members met with more than one staff over a two-week period. Members interviewed reported they have contact with multiple staff on the team, about two to five staff during a recent week.	• Optimally, 90% or more of members have face-to-face contact with more than one F-ACT staff regularly over two week periods.
H3	Program Meeting	1 – 5 5	One staff reported that the program meeting occurs five days a week, but another reported that some weeks it happens four days. The team discusses all members during team meetings, and a longer meeting occurs on Wednesdays to allow for deeper discussions on members with unique or challenging needs. During the morning meeting observed, multiple staff contributed to discussions that progressed at a steady pace. The CC identified certain members for more in-depth discussion during the Wednesday meeting later that week.	
H4	Practicing ACT Leader	1 – 5 3	The CC estimated he spends 25-30% of his time providing direct member services. The CC provided a graph that reflected his monthly contacts for a 15-month timeframe. Based on that document, the CC contacts ranged from seven to thirty-seven percent of his time. The reviewers found no direct services rendered by the CC in ten member records reviewed, but there were two examples of contacts with informal supports noted. The CC reported he facilitates a group with members who have a co-occurring diagnosis and during the meeting observed; the CC referenced direct	• Optimally, CC's delivery of direct services to members should account for at least 50% of his overall time and be documented in the members' records. • Consider comparing the CC's direct services during the time when the team had consistent office-space to his current level of direct services as an indicator of how the lack of dedicated office-space may be affecting the team.

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			services that he provided. Based on review of the CC's productivity report over a month, he provided direct services to members about 17% of the time.	
H5	Continuity of Staffing	1 – 5 3	The team has 12 positions when fully staffed. Per data provided, 13 staff left the team during the recent two-year timeframe. The team experienced about 54% staff turnover, including two CC's, two SAS's, and two Psychiatrists (one of who provided temporary coverage).	• Optimally, turnover should be less than 20% for any two-year period. When able, examine employees' motives for resignation, and attempt to identify other causes for employee turnover.
H6	Staff Capacity	1 – 5 4	The team operated at approximately 84% of staff capacity over the past year, with 23 total months with staff vacancies. Certain positions were vacant for multiple months. For example, one SAS position remained vacant over a 12-month timeframe, and both SAS positions were vacant for February and March 2018.	• Continue efforts to hire and retain qualified staff. Work with administration to vet candidates to ensure they are the best fit for the position and the demands of the F-ACT level of service.
H7	Psychiatrist on Team	1 – 5 5	Staff reported the full-time Psychiatrist assigned to the team has no other administrative responsibilities, rarely sees members from other teams, and attends team meetings at least three days a week. The Psychiatrist provides services entirely via telemedicine utilizing interactive video. Staff reported most of those contacts occur with members at one of the hub CBI facilities. No members interviewed cited any objections to telemedicine services rendered by the Psychiatrist. However, one staff confirmed a small number of members expressed concern, but reported staff have attempted to allay concerns expressed by those members. Staff confirmed that the Psychiatrist is an integrated member of the team, is accessible to them, and will respond to texts or phone calls promptly, delayed only when he meets with a member. During the meeting observed, the Psychiatrist participated via interactive video.	• Due to the flexibility of telemedicine, there may be opportunities for staff to facilitate Psychiatrist interactions in members' homes or other secured settings in their communities rather than requiring members to travel to a nearby CBI hub facility.

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H8	Nurse on Team	1 – 5 5	There are two full-time Nurses assigned to the team. Staff reported that the Nurses do not have other administrative responsibilities, are rarely called on to provide services to members from other agency teams, and both attend the team meeting at least three days a week. Nursing activities occur in the office and community, and include facilitating member telemedicine appointments with the Psychiatrist, treatment planning, providing guidance to other staff regarding medication education services to members, injections, and coordinating with other healthcare providers. In addition to their Nursing duties, they also assist members to address other needs, such as securing safe housing, building resumes, and in one record reviewed a Nurse assisted another staff in moving a bed into a member's residence. Some members confirmed the Nurses have visited their home to provide services. Staff reported that the Nurses are accessible, responsive, and are available during the evening and weekend.	
H9	Substance Abuse Specialist on Team	1 – 5 3	At the time of review, the team had one SAS who joined the team in late April 2018. The SAS previously had the same positon on a different agency's ACT team for ten months. Based on interview and resume review, the SASs prior experience was primarily with children and families or as a college instructor, and not specific to co-occurring treatment with adults diagnosed with a SMI. Staff reported a second SAS is scheduled to join the team May 2018.	• Provide clinical supervision to SASs on a stage-wise approach to co-occurring treatment, and aligning staff activities and interventions to each member's stage of treatment.
H10	Vocational Specialist on Team	1 – 5 1	The ACT team has one vocational staff, the ES, who joined the team in March 2018. Based on resume and training records, the ES has experience as a juvenile probation officer.	• Provide ongoing training, guidance, and supervision to vocational staff related to supports and best practices that aid

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			Assisting those youths to build resumes was one of many job duties listed on the ES's resume, but it did not appear the staff has at least one year of training/experience in vocational rehabilitation and support assisting adults diagnosed with a SMI.	members to obtain competitive positions in integrated work settings. Training areas of focus should include job development, individualized job searches, and follow-along supports.
H11	Program Size	1 – 5 5	The team is of sufficient size to provide coverage, with ten direct service staff. The Rehabilitation Specialist and second SAS position remained vacant at time of review.	
O1	Explicit Admission Criteria	1 – 5 5	Member referrals to the F-ACT team generally stream through the RBHA, and may originate from staff at the Arizona Department of Corrections, inpatient staff, or other provider clinics. The CC or another specialist meet with potential members to discuss the voluntary services, and complete screenings using the *F-ACT Admission Criteria* which is inclusive of a member's recidivism risk score obtained from legal system representatives. After specialists complete the member screening they review the information with the team. The CC reported no administrative mandates to accept admissions to the team.	
O2	Intake Rate	1 – 5 5	The team is less than 100 members, but staff reported that recruitment efforts are not occurring due to the number of members scheduled to join the team. Monthly admissions to the team over the six months prior to review peaked at four members during the month of November 2017. There were zero admissions December 2017 through February 2018.	• Continue to monitor the member census and engage in recruitment efforts when appropriate.
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team directly provides psychiatric services, and most housing support services. The team provides in-home services, and assists members to explore housing options if the need arises. Based on staff	• With the addition of two SASs, the team should be positioned to offer individual counseling and multiple groups to support members in different stages of treatment. • Continue to track the number of members

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			estimates, roughly 7% of members are in staffed residences or treatment facilities. Some members referred to treatment or other staffed settings were discussed in the team meeting observed, and those member statuses were reported in staff interviews. One staff speculated that speedier access to independent living could aid F-ACT members. The team provides employment and other rehabilitative support. Staff reportedly assist members in updating their resumes, and in their job searches. No members receive vocational support services from external providers. It does not appear that psychotherapy/counseling and substance abuse service was available through the team at the dates of program review. Gaps in services may be related to staff vacancies. Limited substance use support was available. The CC facilitates a peer-to-peer self-help group that addressed substance use issues, which a small number of members reportedly attend. Formal counseling to address substance use and/or other areas was not directly available.	in staffed residences. Optimally, no more than 10% of F-ACT members are in settings where other social service staff may provide support. • With the addition of a second vocational staff, and training in vocational supports that enable members to obtain competitive employment, the team should be able to enhance the scope of support available.
O4	Responsibility for Crisis Services	1 – 5 5	Staff reported the F-ACT team is available to provide services 24 hours a day, 7 days a week, 365 days a year, including crisis and emergency response to support members. Members interviewed confirmed that the team is available through the team's on-call phone, with coverage that rotates daily among staff. Staff provide members with a list of their phone numbers and the on-call contact information.	
O5	Responsibility for Hospital Admissions	1 – 5 3	Staff reported the team is involved with member hospital admissions as soon as they are informed, but confirmed a small number of members have been admitted without team involvement. Team	• Work with each member and their support network to discuss how the team can support members in the community to avert, or to assist, hospital admissions.

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			involvement occurred in six of the ten most recent psychiatric admissions based on data provided. Staff reported that when possible, they involve the doctor in admissions during business hours and work with members for voluntary admissions. When they are aware of or informed of an admission, the team completes a Continuation Of Care (COC) form, facilitates a doctor-to-doctor contact between the inpatient and F-ACT Psychiatrist, coordinates with hospital staff, and visits the member every 72 hours while inpatient.	Develop plans with members in advance, especially if they have a history of hospitalization without seeking team support.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported the team is involved in all hospital discharges. Based on review with the CC, the team was involved in the ten most recent member psychiatric inpatient discharges. Staff reported members meet with the F-ACT Psychiatrist within 48 hours after discharge, and that the team has face-to-face contact with medication observation for five days to support the member's stable transition back into the community.	
O7	Time-unlimited Services	1 – 5 5	Staff reported one member graduated due to significant improvement over the 12 months prior to review and projected that two members were likely to graduate in the next 12 months. The process to transition members off the team includes revising their treatment plan, and reducing the frequency of weekly contact over a 90-day period.	
S1	Community-based Services	1 – 5 5	The team moved from their office in December 2017 and utilizes other CBI office space until their permanent location is licensed. Staff reported they spend the majority of their time in the community. Staff reports were corroborated in ten member records reviewed that showed a median of about 94% of services were delivered to members at	

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			numerous locations in the community or non-CBI settings. The team does not rely on office-based groups to maintain contact with members. One staff reported that when groups occur, they focus on targeted issues that affect specific members (e.g., health and wellness, walking group).	
S2	No Drop-out Policy	1 – 5 5	Based on data provided for the year prior to review, no members closed due to the team determining they could not be served or because the member refused services. One member closed that could not be located and was transitioned to *Navigator* status. The team identified two members who suddenly left the geographic area without informing the team of their plans, and one of those members accepted the team's offer to link them to services in the new location.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff reported they follow the RBHA ACT Manual guidelines when performing outreach, which requires four outreach attempts weekly, including two community-based efforts. Staff reported they conduct outreach for at least eight weeks. If members do not want F-ACT services, then staff tries to re-engage them and problem solves for potential solutions. During the morning meeting observed, staff discussed outreach for members who were out of contact with the team.	
S4	Intensity of Services	1 – 5 3	The median intensity of face-to-face service time per member was under 55 minutes weekly, based on review of ten member records. Two of the ten members received more than 120 minutes on average of weekly service time, but seven received less than 60 minutes on average weekly. Members who received medication observations have more documented service time and some staff documented significantly more service time than	• The ACT team should provide members an average of two hours of face-to-face contact weekly. Work with staff to identify and resolve barriers to increasing the average intensity of services to members. • Explore why certain staff have more documented service time than other staff when performing medication observation.

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			others. For example, one staff documented about 19% of all service time over a month timeframe.	
S5	Frequency of Contact	1 – 5 3	A median weekly face-to-face contact of 2.25 was found in ten member records reviewed. One of those members received over 13 contacts on average weekly, but no other member had face-to-face contact with staff four or more times weekly over a month timeframe. Members who received medication observation services had a higher frequency of contact with staff.	• Increase the frequency of contact with members by ACT staff, preferably averaging four or more face-to-face contacts a week per member. Work with staff to identify and resolve barriers to increasing the frequency of contact with members.
S6	Work with Support System	1 – 5 3	Two staff interviewed reported that approximately 52%-57% of all F-ACT members have informal supports; a third staff estimated that about 60% of her caseload has informal supports. All staff reported that the goal is to have at least weekly contact with member supports. During the morning meeting observed, for fewer than 10% of members, staff discussed recent contact with informal supports, or plans to make contact. In ten member records reviewed, the average contact with informal supports was just over once per month. The team had seven contacts with informal supports for one member over a month timeframe, but only one to two contacts for other members. One staff reported that some members have no supports identified.	• Encourage members to identify their supports and discuss with them the benefits of involvement in their treatment. The ACT team should have four or more contacts documented per month with informal supports, for each member with a support system. Educate informal supports about ways to support members' recovery. • The team may benefit from further training and guidance, through the agency and/or system partners, on strategies to engage natural supports. • Monitor accuracy of documentation of contacts with informal/natural supports in the member records.
S7	Individualized Substance Abuse Treatment	1 – 5 2	There was no evidence of formal or individualized substance abuse treatment in the documentation reviewed, but one staff documented they discussed recent use and status with a member. During the meeting observed, staff discussed members' stages of change, but there was no indication of individual treatment.	• With the addition of two SASs, the team should be positioned to offer individual treatment to members with a co-occurring diagnosis. Provide ongoing training to SASs and make available ongoing supervision to support their efforts to provide individual substance use treatment.
S8	Co-occurring Disorder Treatment	1 – 5	Per report, the CC facilitates one co-occurring treatment group weekly and about five members	• With the addition of two SASs, the team should be positioned to offer multiple

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	Groups	2	attend. In applicable records reviewed, there was no evidence members with a co-occurring diagnosis were engaged to participate in group treatment with F-ACT staff.	groups to support members in different stages of treatment (i.e., engagement, persuasion, late persuasion, active treatment, relapse prevention).
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	During the meeting observed, staff identified the stage of change for members who have a co-occurring diagnosis. Staff seemed to be more familiar with stage of change and it was not clear if all were familiar with a stage-wise approach to treatment. Staff reported they do not refer members to Alcoholics Anonymous (AA) or similar groups, but attended with interested members in the past. One staff cited situations when detoxification may be medically indicated, due to certain substances used. When substance use treatment was addressed in applicable treatment plans reviewed, there were examples of focusing on sobriety. In some cases, it was not clear if the goal of sobriety aligned with the members' statuses, but one plan included a reference to a member's willingness to participate in individual treatment. Based on records and observation, it does not appear individual or group treatment is consistently offered or provided.	• Include staff activities in member plans based on members' stage of treatment. For example, for those in earlier stages of treatment, interventions may include a focus on more immediate needs and individual rather than group support. • Provide ongoing guidance to staff in a stage-wise approach to treatment, interventions that align with a member's stage of treatment, and how to reflect that treatment language when documenting the service. This may better equip other ACT staff to engage members in individual and group treatment through the team. • It may be beneficial to develop a list of available self-help groups that are more open to members with co-occurring diagnoses.
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff reported some of the specialists are certified peer supports, but some staff were uncertain if anyone on the team disclosed their direct lived experience of mental health recovery. However, one staff and some members reported staff on the team had lived experience. Some staff reported specialists on the team had a history of recovery from substance use and/or experience with the legal system and that they shared those experiences with members.	• For improved coordination of care, ensure staff is familiar with the qualifications/capabilities of their fellow ACT staff. The team may benefit from discussing with each other the level at which they feel comfortable sharing stories of lived experience and their comfort level at establishing boundaries with members as professionals based on their roles on the team.
Total Score:		**3.96**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	3
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	3
10. Vocational Specialist on Team	1-5	1
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	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	3

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	3
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	**3.96**	
Highest Possible Score	**5**	