**ASSERTIVE COMMUNITY TREATMENT (ACT)**
**FIDELITY REPORT**

Date: August 24, 2018

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AHCCCS Fidelity Reviewers

## Method

On August 7-8, 2018, T.J. Eggsware and Karen Voyer-Caravona completed a review of the Community Bridges, Inc. (CBI) 99th Ave. Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, to improve the overall quality of behavioral health services in Maricopa County.

The 99th Ave ACT team is located in Avondale, Arizona at a location that houses another ACT team, as well as a primary care provider (PCP). In addition, CBI operates a third ACT team and three Forensic ACT (F-ACT) teams at other locations. The 99th Ave. ACT team began operating in August 2015, under another agency, and transferred to CBI management in April 2017.

The individuals served through the agency are referred to as *clients* or *members*, 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 August 7, 2018;
- Group interview with five members receiving ACT services;
- Individual interview with Clinical Coordinator (i.e., Team Leader);
- Individual interviews with a Substance Abuse Specialist (SAS), the Housing Specialist (HS), and the Act Specialist (AS);
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system; and,
- Review of administrative documentation provided, including the agency website*;* the Regional Behavioral Health Authority (RBHA) *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual*; resumes and training records, the CC encounter report, individual treatment tracking, Integrated Dual Diagnosis Treatment (IDDT) resources, and substance use treatment group sign in sheets.

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 for an appropriate member to staff caseload ratio and to provide necessary coverage to the 84 members served.
- The ACT team has two Nurses. Interviewees said that both Nurses carry caseloads and share similar responsibilities as other staff, in addition to traditional nursing services. Interviewees reported that the Nurses provide clinic and community-based services to members. Staff reported the Nurses are available to on-call staff on weekends and after hours.
- The team maintained consistency and continuity of care for members with a low monthly admission rate, and few members transitioned off the team over the year prior to review.

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

- Evaluate barriers to team involvement in member psychiatric hospital admissions. The ACT team should be directly involved with member psychiatric hospital admissions. Discuss with members (and their support network) how the team can support them in the community to avert, or to assist, in a hospital admission, especially if they have a history of admitting without seeking team support. If not in place, orienting those members to stabilization supports through CBI may allow for more detailed and proactive crisis planning, giving members a voice in preference of support in the event of a crisis.
- Provide ongoing training to staff on an integrated approach to substance use treatment. Include review of stage-wise treatment, specific associated interventions, recovery language, and how to develop treatment plans based on the member's perspective and incorporating co-occurring treatment language.
- Increase community-based services. The majority of services documented in the ten records reviewed occurred in CBI offices or facilities.

**ACT FIDELITY SCALE**

| Item # | Item | Rating | Rating Rationale | Recommendations |
|---|---|---|---|---|
| H1 | Small Caseload | 1 – 5<br><br>5 | The team serves 84 members with 10 staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of about 8:1. | |
| H2 | Team Approach | 1 – 5<br><br>5 | Based on ten records reviewed, 90% of members met with more than one staff over a two-week period. Most members interviewed said they had contact with at least two to three staff the prior week, and meet with at least two staff regularly. | |
| H3 | Program Meeting | 1 – 5<br><br>4 | Staff reported that the ACT team holds a program meeting five days a week. All members are discussed four days a week. On the fifth day, more in-depth discussions occur. During the meeting observed, the Program Assistant (PA) listed the name of members for discussion and prompted staff to identify the member's stage of change related to substance use. Each member was discussed, and certain information was consistently noted by the PA (e.g., whether the member had informal supports or a Probation Officer). Staff contributed to updates on recent and/or planned contacts. One staff said the Psychiatrist attends meetings sporadically. Other staff reported the Psychiatrist does not attend or participates occasionally. The Psychiatrist did not participate in the daily meeting observed. | • The Psychiatrist should participate in at least one meeting weekly when all members are discussed. On some teams, Psychiatrists participate in all team meetings. |
| H4 | Practicing ACT Leader | 1 – 5<br><br>3 | The Clinical Coordinator (CC) estimated that she spends about 60% of her time providing direct service to ACT members. Data provided to the reviewers showed that of the CC's total documented services over a month timeframe, about 57% of documented time accounted for direct services. However, this area is not based only on documented time, but rather actual time | • Monitor and track CC direct service time with members in relation to actual time worked, with a goal of providing direct member services (preferably in the community) 50% of the time, to model interventions, and support the team specialists.<br>• Where possible, streamline or eliminate CC |

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| | | | worked. Roughly, an average of 15% of the CC's actual time worked over the course of a month was spent providing direct services to members. Record reviews confirmed the CC's service occur in the office and community. | administrative tasks not explicitly connected with her role as an ACT leader. |
| H5 | Continuity of Staffing | 1 – 5<br><br>2 | The team has 12 positions when fully staffed. CBI assumed operation of the team in April 2017 and none of the prior agency's staff remained with the team following the transition to CBI. Since April 2017, four CBI staff left the team. Staff reported the team primarily relied on coverage from one CBI Psychiatrist prior to the current Psychiatrist joining the team in April 2018. With these combined factors, roughly 17 people left the team in the two-year period resulting in about 71% staff turnover. | • Continue efforts to hire and retain qualified staff. ACT teams should experience turnover no greater than 20% over a two-year period in order to support the therapeutic relationship and mitigate disruptions in services provided to members. |
| H6 | Staff Capacity | 1 – 5<br><br>4 | The team operated at approximately 81% of staff capacity over the past year. There was a total of 28 months with vacant positions, including staff on leave for at least one month. Certain positions remained vacant for multiple months, including one Nurse, the Psychiatrist, and Employment Specialist (ES). | • See recommendation for Item H5, Continuity of Staffing. |
| H7 | Psychiatrist on Team | 1 – 5<br><br>5 | Staff reported the Psychiatrist assigned to the team works 35 or more hours a week, has no other administrative responsibilities and rarely sees members from other teams. The Psychiatrist provides services entirely via telemedicine utilizing interactive video. Though located out of state, staff confirmed that the Psychiatrist is accessible to them, and will respond to texts or phone calls promptly. Staff reported most of those contacts occur with members at the office but estimated 10-15% of members received telemedicine contact in their home. Some members interviewed cited | • 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 the CBI facility. |

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| | | | discomfort with interacting with the Psychiatrist via interactive video, but most agreed that the current Psychiatrist takes the time to listen to their concerns and discusses medications. Staff confirmed a small number of members expressed concern with telemedicine but reported staff have attempted to improve rapport in order to assuage those concerns. | |
| H8 | Nurse on Team | 1 – 5<br><br>5 | There are two full-time Nurses assigned to the team. Staff reported that the Nurses do not have other administrative responsibilities outside of the team and are rarely called on to provide services to members from other agency teams. It was reported that both Nurses work four ten-hour days, and regularly attend the team daily meeting on the days they work, unless they are facilitating member interactive video contact with the Psychiatrist. Staff confirmed that the Nurses are accessible, responsive, and available during the evening and weekend for consultation or emergencies. Staff reported that Nursing activities occur in the office and community, and include facilitating member telemedicine appointments with the Psychiatrist, treatment planning, injections, and health promotion. One member confirmed a Nurse visited them at home. | |
| H9 | Substance Abuse Specialist on Team | 1 – 5<br><br>5 | The ACT team has two SASs; both are Licensed Master Social Workers (LMSW). The training and experience of the SASs appears to be sufficient to provide services to the 84-member program. One SAS has more than one years' experience in substance abuse treatment, including work with co-occurring diagnosed adults. The second SAS has been with the team since November 2017, but previously had limited direct experience providing substance use treatment. | |

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| H10 | Vocational Specialist on Team | 1 – 5<br><br>3 | The team has one vocational staff, the RS, who joined the team in May 2017. Based on resume and training records, the RS has experience in case management with young adults/transitional age youth, but limited training related to assisting adults to obtain competitive employment. Based on training records, the staff participated in Disability Benefits 101 (DB101) and Rehabilitation Services trainings, totaling six hours, but not other trainings directly related to vocational rehabilitation and support to assist adults diagnosed with a SMI attain competitive positions. | • Fill the second vocational specialist position.<br>• Provide ongoing training, guidance, and supervision to vocational staff related to supports and best practices that aid 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<br><br>5 | At the time of the review, the members were served by 11 staff: a Clinical Coordinator (CC), one Psychiatrist, two Nurses, two Substance Abuse Specialists (SAS), a Rehabilitation Specialist (RS), an Independent Living Specialist (ILS), a Housing Specialist (HS), a Peer Support Specialist (PSS) and an ACT Specialist (AS). The Employment Specialist (ES) position was vacant at time of review. | |
| O1 | Explicit Admission Criteria | 1 – 5<br><br>5 | The ACT team follows the ACT eligibility criteria, developed by the RBHA, and outlined in the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual*. Referrals to the team generally originate through the RBHA or other provider clinics. The CC, or another specialist, meets with potential members for a screening to determine if they meet criteria. It was noted the Psychiatrist is usually updated on the status of the screening to make sure he agrees. The CC reported no administrative mandates to accept admissions to the team. | |
| O2 | Intake Rate | 1 – 5<br><br>5 | Monthly admissions to the team over the six months prior to review peaked at six members during the month of March 2018. There were four | • Continue to monitor the member census and engage in recruitment efforts when appropriate. |

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| | | | admissions monthly for February, May and July 2018, two during the month of June 2018, and one during the month of April 2018. The team is less than 100 members. Staff reported that recruitment efforts to increase the census have included networking with other clinics to inform them about ACT services. One staff confirmed there was likely outreach to inform staff at other potential referral sources (e.g., hospitals and legal system representatives) of ACT services. It was not clear if other recruitment efforts occurred. | |
| O3 | Full Responsibility for Treatment Services | 1 – 5<br><br>4 | In addition to case management, the team directly provides psychiatric services, substance use treatment, psychotherapy/counseling, and most employment/rehabilitative services. Staff reported that about 12 members receive counseling through the SASs, and none from other agencies. Examples of general counseling and co-occurring individual treatment were documented in records reviewed. Staff reported the SASs are trained in Integrated Dual Disorder Treatment (IDDT), and pursue other specialty trainings, including Eye Movement Desensitization and Reprocessing (EMDR).<br><br>The team is without an ES, but staff reported they assist members in updating their resumes, and in their job searches. Members reported the team did not have an ES and one reported they receive employment support services from another agency.<br><br>The team provides in-home services and assists members to explore housing options if the need arises, but based on staff estimates, more than 10% of members are in staffed residences. Staff | • Continue to track the number of members in staffed residences. Optimally, no more than 10% of ACT members are in settings where other social service staff provides support.<br>• When a second vocational staff joins the team, and with training in vocational supports that enable members to obtain competitive employment, the team should be able to enhance the scope of employment support service available. |

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| | | | approximation of how many members are in staffed residences ranged from about 9% to 24%. Some members have transitional stays at the CBI facility Transition Point, staffed by CBI employees who are not part of the ACT team. Staff estimated that during any month, about five ACT members receive services from Transition Point, occasionally with stays extending more than a week. Some members interviewed reported concerns related to their housing. | |
| O4 | Responsibility for Crisis Services | 1 – 5<br><br>4 | Staff reported the ACT team is available 24 hours a day, 7 days a week, 365 days a year, including crisis and emergency response in the community. On-call coverage rotates, and generally, staff are not on call two days in a row. The on-call staff coordinate with the CC if they need to go into the community. Members interviewed confirmed that the team is available through the team's on-call phone. One staff reported they utilize CBI crisis facilities and programs in lieu of inpatient treatment. One staff reported that on average roughly eight to ten ACT members a month receive overnight crisis stabilization at the CBI Access Point facility in place of what the ACT team can provide. | • Although the agency has multiple crisis intervention programs/facilities, ensure that the ACT team staff are the primary provider of crisis support to members of the team. |
| O5 | Responsibility for Hospital Admissions | 1 – 5<br><br>4 | Staff reported the team is involved with member hospital admissions as soon as they are informed, but reported they often utilize the CBI Access Point facility for stabilization of ACT members. Team involvement occurred in seven of the ten most recent psychiatric admissions based on data provided. Staff reported that within 24 hours of them learning of a psychiatric admission, the team coordinates with hospital staff, and facilitates a doctor-to-doctor contact between the inpatient and ACT Psychiatrist. Staff reported that | • 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. Develop plans with members in advance, especially if they have a history of hospitalization without seeking team support. |

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| | | | occasionally the team Psychiatrist conducts doctor-to-doctor calls on his days off. | |
| O6 | Responsibility for Hospital Discharge Planning | 1 – 5<br><br>4 | Staff stated that the team is involved in all hospital discharges. Based on review with the CC, the team was involved in nine of the ten most recent member psychiatric inpatient discharges; one member left the hospital against medical advice and the team began outreach efforts. Staff said members are picked up by ACT staff at discharge and usually know of discharges in advance but noted staff from one hospital are inconsistent in communicating discharges in advance. | • Work with each member and their support network to discuss the team's role in supporting members to discharge from an inpatient setting.<br>• Work with stakeholders to identify barriers in discharge plan coordination with inpatient staff. |
| O7 | Time-unlimited Services | 1 – 5<br><br>5 | Staff reported four members graduated due to significant improvement over the 12 months prior to review and projected that less than 4% of members were likely to graduate in the next 12 months. Staff stated that the team follows the ACT discharge criteria of the RBHA. Staff reported that an individualized transition plan is developed when members leave the team. | |
| S1 | Community-based Services | 1 – 5<br><br>2 | Staff reported they spend most of their time in the community, estimating about 80-90%. Staff reports were not corroborated in the ten member records reviewed that showed a median of about 28% of services were delivered to members in the community or non-CBI settings. One member received nearly 80% of contacts in the community, and staff averaged over five contacts per week over a month period. However, most other members received less than 50% of contacts in the community. | • Optimally, eighty percent (80%) of staff face-to-face contacts with members should occur in the community, where challenges are most likely to occur and learning new skills and behaviors is most effective.<br>• The CC should periodically review and monitor member records to ensure the appropriate level of community-based contacts. The CC should mentor and coach staff that appear to have difficulty engaging members the community. |
| S2 | No Drop-out Policy | 1 – 5<br><br>5 | Based on data provided for the year prior to review, two members closed due to their care transitioning to another system of care, one member transitioned to another ACT team, and | |

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| | | | three members closed due to extended incarceration (e.g., about 120 days or more). No members closed due to the team determining they could not be served or because the member refused services. Three members closed that could not be located and transitioned to *Navigator* status. One member abruptly left the geographic area without informing the team in advance, but four others left the geographic area with team support and referrals to services. | |
| S3 | Assertive Engagement Mechanisms | 1 – 5<br><br>4 | Staff reported the team follows the outreach guidelines developed by the RBHA, located in the *Mercy Care RBHA Assertive Community Treatment (ACT) Operational Manual*, of at least four outreach attempts each week for eight weeks, and at least half of those efforts occurring in the community. In some records, outreach efforts to contact members at their homes was documented. However, in four records reviewed, there were instances of a week or more with no documented outreach or contact with the members, but there was usually evidence of contact with formal or informal supports. In one record it was documented that staff contacted a legal system representative to inform them that a member was not adhering to treatment. It was not clear that the legal system representative had initiated the contact to request the specific information. During the morning meeting observed, staff referenced the same type of outreach for multiple members, described as *electronic outreach* to the Maricopa County Sherriff's Office (MCSO). | • Ensure outreach efforts are documented and planned with the team to include who on the team will do what type of outreach/contact during the week.<br>• Review with staff what information is appropriate to share with legal system representatives, and under what conditions staff should share the information. |
| IS4 | Intensity of Services | 1 – 5<br><br>3 | The median intensity of face-to-face service time per member was under 73 minutes weekly, based on review of the ten member records. One of the | • The ACT team should provide members an average of two hours of face-to-face |

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| | | | ten members received just over 105 minutes on average of weekly service time, but three received about an hour and two received about 30 minutes of service time weekly. | contact weekly. Work with staff to identify and resolve barriers to increasing the average intensity of services to members. |
| S5 | Frequency of Contact | 1 – 5<br><br>3 | A median weekly face-to-face contact of 2.63 was found in the ten member records reviewed. Two of the ten members received an average of at least four weekly contacts over a month timeframe. Some members interviewed reported that there seemed to be fewer staff available later in the week. | • 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<br><br>4 | Staff interviewed reported that approximately 75% of members have informal supports. Two staff reported there was at least weekly contact with informal supports, and one staff reported the team was in contact with informal supports at least monthly. In the ten member records reviewed, the average contact was just over twice per month, including seven contacts with informal supports of two members over the timeframe. During the team meeting observed staff, indicated if members had informal supports, but infrequently identified recent contacts with informal supports, or plans to make contact. | • 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.<br>• The team may benefit from further training and guidance, through the agency and/or system partners, on strategies to engage natural supports. |
| S7 | Individualized Substance Abuse Treatment | 1 – 5<br><br>4 | Per data provided by the agency, 57 of the 84 members have a co-occurring diagnosis. Staff reported the SASs primarily provide individual treatment, but other staff occasionally provide support. Tracking of individual treatment was provided and showed most individual substance use treatment was provided by the SASs. The SASs provided individual treatment to 25 members with a co-occurring diagnosis. Sessions ranged from one to three times a month for most members; 36% met with an SAS once and 52% met with an SAS | • Train staff on strategies to engage members in individualized treatment as appropriate, based on their stage of treatment. Make available ongoing supervision by the SASs or other qualified staff to support the SASs' efforts to provide individual substance use treatment. |

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| | | | two to three times. Based on data provided, it appears an average of just over ten minutes of individual substance abuse treatment was provided weekly. Evidence of co-occurring individual treatment was found in some of the seven applicable member records (i.e., individuals with a substance use related diagnosis). During the team meeting observed, staff reported if members received individual treatment with an SAS. | |
| S8 | Co-occurring Disorder Treatment Groups | 1 – 5<br><br>4 | The SASs offer two weekly substance use groups; one for members in earlier stages of treatment, and a second for those in later stages of recovery. Staff reported that over a recent month timeframe at least 36% of members with a co-occurring diagnosis attended group treatment at least once; some attended multiple groups. Based on group participation tracking, roughly 34% of members attended at least once. Evidence of member participation in group treatment was found in records. During the team meeting observed, staff reported if members attended substance use treatment groups. | • Continue to encourage member participation in co-occurring treatment, with a goal of at least 50% of members with a co-occurring diagnosis participating in group treatment. |
| S9 | Co-occurring Disorders (Dual Disorders) Model | 1 – 5<br><br>3 | During the meeting observed, staff identified the stage of change for members who have a co-occurring diagnosis. Staff seemed to be familiar with stage of change, and agency training records and interviewees indicated staff participated in IDDT training. For example, a two-part training through the online training portal was listed within staff training records. Clinical oversight is regularly provided, but the content of the oversight could not be verified in training records provided. Records listed only dates of oversight, not sub-headings with topics.<br><br>Resources used by the team outline stages of | • Ensure all staff have a shared understanding of harm reduction and align their interventions and documentation accordingly.<br>• 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.<br>• Include staff activities in member plans based on members' stage of treatment. For example, for those in earlier stages of |

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| | | | change and the corresponding stages of treatment, but it was not clear if all were familiar with a stage-wise approach to treatment. One staff documented in multiple member records that complete abstinence was advised and encouraged. Most treatment plans reviewed for members with co-occurring diagnosis included information related to sobriety. Some of those members were identified to be in the pre-contemplation stage of change. Some staff documented and used the term *clean* when discussing urine drug screens (UDS). Staff reported they do not refer members to Alcoholics Anonymous (AA) or similar groups, but have resources if members are interested. Staff said that they refer members to detox when deemed medically necessary or utilize other CBI facilities where members can stay and CBI staff at those locations can monitor for signs of withdrawal from substances. | treatment, interventions may include a focus on more immediate needs or priorities of the individual rather than sobriety or being *clean*. |
| S10 | Role of Consumers on Treatment Team | 1 – 5<br><br>5 | There is a Peer Support Specialist on the team. One staff reported many employees on the team have lived experience, including some with direct experience of mental health recovery. Some staff were uncertain whether other staff had lived experience but reported they had lived experience and share their stories with members. | • The team may benefit from discussing with each other the level at which they feel comfortable sharing stories of lived experience with each other and members. |
| **Total Score:** | | **4.07** | | |

**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 | 4 |
| 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 | 5 |
| 8. Nurse on Team | 1-5 | 5 |
| 9. Substance Abuse Specialist on Team | 1-5 | 5 |
| 10. Vocational Specialist on Team | 1-5 | 3 |
| 11. Program Size | 1-5 | 5 |
| Organizational Boundaries | Rating Range | Score (1-5) |
| 1. Explicit Admission Criteria | 1-5 | 5 |
| 2. Intake Rate | 1-5 | 5 |
| 3. Full Responsibility for Treatment Services | 1-5 | 4 |
| 4. Responsibility for Crisis Services | 1-5 | 4 |
| 5. Responsibility for Hospital Admissions | 1-5 | 4 |

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| 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 | 2 |
| 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 | 4 |
| 7. Individualized Substance Abuse Treatment | 1-5 | 4 |
| 8. Co-occurring Disorders Treatment Groups | 1-5 | 4 |
| 9. Co-occurring Disorders (Dual Disorders) Model | 1-5 | 3 |
| 10. Role of Consumers on Treatment Team | 1-5 | 5 |
| **Total Score** | **4.07** | |
| **Highest Possible Score** | **5** | |