ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: January 6, 2023

To: Nicole Nelson, SMI Administrator for ACT, Acting Clinical Coordinator
John Hogeboom, Chief Executive Officer

From: Vanessa Gonzalez, BA
Kerry Bastian, RN
AHCCCS Fidelity Reviewers

Introduction

Arizona Health Care Cost Containment System has contracted with Western Interstate Commission for Higher Education Behavioral Health Program to conduct Fidelity Reviews using an adapted version of the Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Fidelity Scale. ACT is an evidence-based practice (EBP).

Method

On November 15 – 16, 2022, Fidelity Reviewers completed a review of the Community Bridges, Inc. (CBI) 99th Avenue 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 the Central Region of Arizona.

The 99th Avenue ACT team is located in Avondale at a location that houses another ACT team, as well as a Primary Care Provider (PCP). CBI also operates a third ACT team and three Forensic ACT (F-ACT) teams at other locations. At the time of the review, the Clinical Coordinator position was vacant, thus, the newly assigned, and former ACT Clinical Coordinator, SMI Administrator for ACT, Nicole Nelson, filled the position.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing and telephone to interview staff and members.

During the fidelity review, reviewers participated in the following activities:

- Remote observation of an ACT team program meeting November 15, 2022.
- Individual video conference interview with the acting Clinical Coordinator.
- Individual video conference interviews with Housing, Peer Support, Independent Living, and Co-Occurring Specialists.

- Individual phone interviews with three members participating in ACT services with the team.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; resumes and training records for Vocational and Co-occurring Specialists staff, ACT Graduation Criteria, acting Clinical Coordinator productivity report for the month prior to the review, *(CBI) F-ACT Re-Engagement Policy, Exit Screening Tool, No Show Policy, ACT 99 Team Contact,* and *ICDT 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 review. A copy of the completed scale with comments is included as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The ACT team maintains small caseloads with a member to staff ratio of approximately 9:1.
- The ACT team has well run and organized daily meetings and will speak in depth on every member's care, engagement, and stage of change.
- The ACT team provides 24/7 crisis services to members and will meet with members in the community to conduct risk assessments and provide support as needed.
- The ACT team indicates the Peer Support is a crucial part of the team and offers insightful ideas and strategies for member care.

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

- The ACT team operated at 48% capacity over the past year with a total of 75 vacant positions. Identify factors of turnover and implement protocol that supports retention.
- Increase the intensity of services delivered to members. ACT services should be responsive to member needs, adjusting in frequency as it relates to members' individual needs and preferences resulting in an average of 2 hours of in-person services weekly.
- Increase the frequency of contact delivered to members. ACT staff should be seeing every member on average four times a week. Higher frequency of contact correlates to improved outcomes for ACT members.
- Few members with a co-occurring disorder attend the co-occurring disorder treatment groups provided by the team. Staff should continue to engage members with a co-occurring disorder to participate in treatment groups based on their stage of treatment.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 70 members with eight staff who provide direct services, excluding the Psychiatrist and Program Assistant. Given the ACT team has a low census, the member to staff ratio is appropriate at nearly 9:1. The team is comprised of 1.5 Full Time Equivalent (FTE) Co-Occurring Specialists (COS), Housing Specialist (HS), Peer Support Specialist (PSS), ACT Specialist (AS), Independent Living Specialist (ILS), Nurse, acting Clinical Coordinator (CC), and one part-time PSS (.5 Full Time Equivalent).	
H2	Team Approach	1 – 5 4	Staff interviewed said that all members are seen by more than one staff in a two-week period. Based on the ten records reviewed, 70% of members were seen by more than one staff over the last two full calendar weeks of the month reviewed. Members interviewed stated they see multiple staff weekly.	• Ensure all members are being seen by various staff as this is a crucial ingredient of the evidence-based practice. Ideally, 90% of ACT members have in-person contact with more than one staff in a two-week period.
H3	Program Meeting	1 – 5 5	Staff reported the ACT team holds a program meeting four days a week, Monday – Thursday, and all members are discussed. During the program meeting observed, the program assistant listed the members, identified natural supports, and when applicable the current stage	

			of change, and any probation or parole status. The entire team was present for the meeting including the Psychiatrist who attends four days a week. All staff members participated in providing updates on the members.	
H4	Practicing ACT Leader	1 – 5 2	The acting CC estimated providing direct member services between 10 - 15% of the time. According to productivity report provided, the month prior to the review the acting CC delivered direct member care 5% of the time. The productivity report did not indicate what direct services were being provided. One record reviewed found the acting CC hosting a meeting with several ACT staff, a member, and member's natural supports to discuss recent incidents.	• Given the importance of the CC role on the team, ensure that this position is filled by appropriately trained staff that deliver direct care services to members at least 50% of the expected productivity of other ACT staff and be documented in member records.
H5	Continuity of Staffing	1 – 5 3	Based on information provided, the team has 12 positions when fully staffed, not including the Program Assistant. Based on data provided, 13 staff left the team resulting in a turnover rate of 54% since the prior review. The most difficult positions to retain were the Nurse and Rehabilitation Specialist (RS).	• If not done so already, attempt to identify factors that contributed to staff turnover or supported retention. Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their supporters, as well as reduces potential burden on staff.

H6	Staff Capacity	1 – 5 2	The team operated at 53% capacity over the past 12 months. There was a total of 68 months of vacant positions. Certain positions remained vacant for multiple months including both RN positions which remained vacant the entire year. The AS, ES, and HS roles all remained vacant for at least seven months.	• Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually. • When applicable, fill vacant positions with qualified staff as soon as possible. To support retention, as research shows, ensure staff receive training and supervision for their specialty as staff may remain in positions longer.
H7	Psychiatrist on Team	1 – 5 5	The ACT Psychiatrist provides all services via telehealth (videoconference). The Psychiatrist works four, 10 - hour days Monday – Thursday and attends all program meetings. Staff reported all members see the ACT team Psychiatrist for medication management. Members interviewed reported seeing the team Psychiatrist once a month. Staff reported the Psychiatrist being available after business hours and only having a responsibility to the ACT team. Per review of 10 member records, the Psychiatrist provided direct services to five members in the month period reviewed.	
H8	Nurse on Team	1 – 5 4	The ACT team has one RN that joined in October 2022 and only sees members of the ACT team. The RN works four 10-hour days Monday – Thursday with the 99th Avenue team and provides coverage for the ACT Avondale team on Fridays. The RN is accessible after business hours and does not see members that are not on the ACT team. The RN tracks and administers	• Continue efforts to recruit and retain Nurses to ensure consistency of coverage for clinic-based services, as well as community-based services. Having two full time nurses is a critical ingredient of a successful ACT program. • When allocating staff partial assignment to an ACT team, ensure those staff attend a

			member injections, attends PCP appointments, conducts home visits, and provides health education to members. Although there were other nurses providing care to members of the ACT team, those nurses were not attending the program meeting at least two times a week.	minimum of two program meetings a week to allow a transfer of knowledge relating to member care.
H9	Co-Occurring Specialist on Team	1 – 5 4	The ACT team is staffed with 1.5FTE COS. One COS has over four years' experience delivering substance use treatment services and has a Master of Professional Counseling degree. According to training records provided by the ACT team, the COS lacks documentation of recent training related to substance use treatment. The second COS is an intern and has been with the team eight months, is currently completing coursework for a Master of Social Work degree. Training records provided lacked documentation of recent training related to substance use treatment. According to interviews, only one COS is currently receiving supervision by a Licensed Professional Counselor.	• Provide annual training to Co-Occurring Specialists in co-occurring treatment best practices, including appropriate interventions, i.e., stage wise approach, based on members' stage of change. COS should have the capability to cross-train other staff on the team, providing guidance on appropriate interventions based on members' stages of treatment and in the adopted co-occurring model utilized by the team. • Provide all Co-Occurring Specialist staff with regular supervision from a qualified professional.
H10	Vocational Specialist on Team	1 – 5 1	At the time of the review, there were no Vocational Staff positions filled on the team.	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met.

H11	Program Size	1 – 5 4	At the time of the review, the team was composed of nine staff including the Psychiatrist. There were four vacant positions including a permanent CC, the second RN, ES, and RS. *This item does not adjust for the size of the client/member roster.*	• Continue efforts to hire and maintain adequate staffing. A fully staffed team allows the team to consistently provide diverse coverage; allows staff to practice their specialties which can improve job satisfaction; and accommodates the delivery of comprehensive, individualized service to each member. Ideally, 10 or more staff work on an ACT team.
O1	Explicit Admission Criteria	1 – 5 5	The ACT team follows the *Mercy Care ACT Admission Criteria* to screen potential members. The team typically gets referrals from inpatient social workers. The Psychiatrist usually decides on the admission of a member onto the ACT team. The ACT team has a clearly defined target population and reports rarely feeling pressured to admit members.	
O2	Intake Rate	1 – 5 5	Per data provided, the team has an appropriate rate of admission with zero members admitted during the past six months. Due to low staffing the ACT team was not open to referrals from November 2021 – May 2022.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team is providing psychiatric and medication management services, co-occurring disorder treatment, and counseling/psychotherapy. All members on the team see the ACT Psychiatrist for psychiatric medications and none are receiving substance use treatment services off	• The team should assist members to find housing in the least restrictive environments, which can reduce the possibility for overlapping services with other housing providers. Assist members to explore low-income housing options to increase their housing choices. For

			the team. The team provides employment support to the nearly 15 members that are employed some of which are also receiving services with Vocational Rehabilitation. However, no members are working with a supported employment program. Interviews and records reviewed indicated there are several members of the ACT team receiving services from their residence including 23.0-hour behavioral health residential facility, Flexcare, and halfway homes. Some of the services provided include medication management, independent living support, health promotion, and group education.	members with histories that limit availability of housing options, consider legal measures to expunge their record.
O4	Responsibility for Crisis Services	1 – 5 5	The ACT team provides 24-hour crisis response services to members. The team utilizes an on-call phone that connects members to one of the team specialists. Staff provided the *ACT 99 Team Contact* document with the on-call/crisis line and frequently used numbers to remind members to utilize the team if needed. When the specialist receives a call, they will provide crisis intervention support and go out into the community for a higher level of care when needed. All members interviewed were aware of the on-call.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff indicated the team is directly involved in member psychiatric hospital admissions. During business hours staff will complete a risk	• Work with each member and their support network to discuss how the team can support members in the event of a

			assessment and coordinate with the CC. A decision is then made about next steps, either to the ACT clinic for an evaluation with the Psychiatrist or the hospital depending on the situation. After business hours when a member is in crisis or experiencing an increase in symptoms, the team will assess the situation, complete a risk assessment, and call the CC to decide on the next steps. When a member cannot commit to safety, the team will have them picked up by police and transported to a psychiatric facility. Once a member is admitted, the ACT team completes a visit within 24 hours and coordinates care with hospital staff. Some hospitals allow in person visits while others are closed to visitors. From there, the team communicates with the member and hospital staff every 72 hours for updates. When a member self admits to a psychiatric hospital, the team will begin coordination of care when notified. According to the data provided and confirmed with staff interviewed, the ACT team was involved in seven of the ten most recent hospital admissions which occurred over a six-month time frame.	psychiatric hospital admission. Proactively develop plans with members on how the team can aid them during the admission, especially when members have a history of seeking hospitalization without team support.

O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Based on the data provided and confirmed with ACT staff, the team was involved in nine of the ten most recent psychiatric hospital discharges. Staff interviewed indicated when a member is ready for discharge, a staffing with the hospital scheduled and the team provides a discharge appointment. Records reviewed showed staff picking up and transporting members once discharged. The team follows a five day follow up policy after discharge and the member will be seen at home by an ACT staff at least once per day for five days. The member is scheduled with the Psychiatrist within 72 hours of discharge, and the RN within 72 hours to 7 days after discharge. In one member record reviewed, there was a six-day gap between the hospital discharge and the member being seen by the team.	• Ensure the team delivers post psychiatric hospital follow up services and supports as described during interviews.
O7	Time-unlimited Services	1 – 5 4	Data provided showed the ACT team graduated six members in the last 12 months. Staff interviewed reported the team expects no members to graduate from services in the next year. The team discusses potential graduation of members during their daily meeting and uses the *ACT Graduation Criteria* to identify readiness. Over the past year the team had one client refuse services, seven that could not be located, two that could no longer be served, and two that	• The team should work toward maintaining an annual graduation rate of fewer than five percent of the total caseload

			left the area without referral. Three members were transferred to a higher level of care.	
S1	Community-based Services	1 – 5 3	Staff reported 75% or more contact with members occurs in the community. However, according to the ten randomly selected member records reviewed, a median of 45% of contacts with members occurred in the community. Members interviewed reported seeing staff in their home and in the office.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities. Avoid over-reliance on clinic contacts with members as a replacement for community-based contacts. •
S2	No Drop-out Policy	1 – 5 4	According to the data provided, the team retained 84% of the caseload in the last 12 months. The ACT team identified 15 members that were closed.	• Ideally ACT program engages and retains 95% or more of the caseload over a 12-month period.
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff reported that when the team loses contact with members, the *(CBI) F-ACT Re-Engagement Policy* is implemented. Per the policy, different team members are assigned different outreach activities to try and re-engage the member. Some examples include outreach in the areas the member hangs out, contacting jails, medical examiner's office, and the member's natural supports if they have any. The *(CBI) F-ACT Re-Engagement Policy* requires four attempted contacts a week with the member for eight consecutive weeks before transitioning the member off the ACT team to an alternative level of care. During the morning meeting observed, staff reviewed members that were on outreach and	• Ensure staff are familiar with the outreach expectations of the *(CBI) F-ACT Re-Engagement Policy*. • In addition, consider more creative outreach when there are lapses in contact with members. • Monitor documented outreach and contacts with members and evaluate the team's approach to building rapport with disengaged members. It may be useful to assign a staff to spot-check documentation in member records during the team meeting to confirm recent contacts or that outreach efforts are documented. This may enable the team to proactively assign staff

			coordinated which staff would conduct the next outreach and when. Of the ten records reviewed, records lacked assertive efforts of outreach and engagement per the teams described approach and policy. Engagement and outreach efforts were documented ranging from one to seven days. Most attempted outreaches were conducted by phone, and some were attempted home visits.	to outreach members in the event of lapses in contact.
S4	Intensity of Services	1 – 5 2	Per review of ten randomly selected member records for a month period before the fidelity review, the median amount of time the team spends in-person with members per week is 27.5 minutes. The highest member record reviewed indicated averaged a rate of intensity of 117.5 minutes a week and the lowest member record reviewed indicated averaged a rate of intensity of zero minutes a week. The team utilizes telemed when members met with the Prescriber. Records reviewed indicated phone calls were frequently used as home safety checks, although was referenced in documentation as a "home visit". *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the duration of service delivery to members. ACT teams should provide an average of 2 hours or more of in-person services per week to help members with serious symptoms maintain and improve their functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on their individual needs, recovery goals, and symptoms. • Members of ACT teams are not successful with traditional case management services and often require more frequent contact to assess current needs and to receive ongoing support. Improved outcomes are associated with frequent contact. All staff of the ACT team should be invested in delivering a high frequency of contacts to members. Those contacts should be individualized and align with treatment goals identified in member plans.

S5	Frequency of Contact	1 – 5 2	Of the ten records randomly sampled, ACT staff provided a median frequency of 1.13 in-person contacts to members per week. The highest member record reviewed indicated an average frequency of 2.75 in-person contacts a week. The lowest member record reviewed indicated no in person contacts from ACT assigned staff, yet the team did have phone contact documented four separate times. The member was housed at a motel as they were working with a voucher agency to secure affordable housing. Members interviewed had varying reports as one member reported seeing different staff at his home five different days the previous week, while another member reported seeing ACT staff only once the previous week. *The fidelity tool does not accommodate delivery of telehealth services.*	• Evaluate how the team can increase the frequency of contact with members by ACT staff, ideally averaging 4 or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals. Members may have different needs/goals and frequency of contact should be determined by those needs and immediacy, such as the member in temporary housing • Identify and resolve barriers to increasing contacts with members.
S6	Work with Support System	1 – 5 3	According to data provided and confirmed by ACT staff, 71% of members have natural supports. Staff estimated having regular contact with at least 50% of member's natural supports once a week by phone, email, or in person. During the program meeting observed, staff discussed contact with member's natural supports and documented it in member calendars.	• Continue efforts to involve natural supports in member care. Increase contacts with natural supports to an average of 4 per month for each member with a support system. As much as possible, contacts with natural supports should occur during the natural course of delivery of services provided to members, i.e., during home visits.

			Based on the ten random records reviewed, there were 14 natural support contacts documented for four members within the month reviewed for an average of 1.4 team contacts with member natural supports per month across ten records. One member interviewed reported the ACT team reaching out to their natural support one to two times a week, while other members reported no contact or not knowing when the ACT team is in contact with their natural supports.	• Ensure consistent documentation of contacts with natural supports, which include contact by phone, email, and text, as well as in person.
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 4	Per interviews and data provided, 44 members were identified with a co-occurring disorder. Staff interviewed reported 28 of these members are receiving structured individual counseling from a COS. Staff reported nearly all these members receive counseling every week, sometimes more. Sessions range from 15-60 minutes depending on member preference. Staff reported the model used is Integrated Co-Occurring Disorder Treatment (ICDT) and motivational interviewing. Data provided showed 947 minutes of individualized treatment for the month of October averaging 22 minutes of individualized counseling a month per member. Three of the ten records reviewed were identified by the team as members with a co-occurring disorder diagnosis. However, records reviewed for a month period showed no documentation of instances of individual	• Work to increase the time spent in individual sessions and increase the number of members engaged so that the average time is 24 minutes or more per week across the group of members with co-occurring diagnoses. • Consider reviewing documentation of individual treatment sessions during supervision with COS.

			substance use treatment services provided to members with a co-occurring diagnosis.	
S8	Co-Occurring Disorder Treatment Groups	1 – 5 2	Staff interviewed reported two co-occurring disorder treatment groups offered to the 99th Avenue ACT members with a co-occurring disorder each week. The groups are provided by the COS intern that does not have case management responsibilities within the team. Staff reported two to seven unique members attending the group weekly. A review of the attendance sign-in sheets for the month period prior to the review showed seven unique members attending the groups for an attendance rate of 16%. Records reviewed indicated two of the three members with a co-occurring diagnosis attending one group in the month period reviewed.	• All ACT staff should encourage members with a co-occurring disorder to participate in treatment groups. Ideally, at least 50% of members diagnosed with a co-occurring disorder attend at least one treatment group monthly. • Consider offering groups so that at least one is structured for members in earlier stages, and at least one is available for members in later stages of recovery. Interventions should align with a stage-wise approach.
S9	Co-Occurring Disorders Model	1 – 5 4	Most staff interviewed reported a harm reduction approach to working with members with a co-occurring disorder and provided examples, tactics, and interventions used. The staff utilize the Stages of Change and ICDT model and referred to it in the daily meeting indicating which stage of change members are at. Most staff were very familiar with different motivational interviewing tactics for different stages of change.	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Treatment for Co-Occurring Disorders, in the principles of stage-wise treatment, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Adhering to a co-occurring disorder treatment model within the team can promote continuity in

			ACT staff do not refer members to peer run programs in the community, but they will provide resources to members if they desire. ACT staff will refer members to detox when necessary. Records reviewed indicated all members with a co-occurring disorder had treatment plan goals written in their perspective, however; not all goals reflected the services and interventions pertaining to the co-occurring disorder.	the approaches ACT specialists utilize when supporting members.
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has at least one staff with lived psychiatric experience, the PSS. It was reported the PSS shares their story of recovery when appropriate with members. Staff interviewed indicated the PSS is a crucial part of the team and that the team appreciates the peer perspective. The PSS holds all the responsibilities as other ACT staff.	
Total Score:		**103**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	2
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	4
9. Co-occurring Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	1
11. Program Size	1-5	4
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	4
6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.68**	
Highest Possible Score	**5**	