ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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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 September 25 – 27, 2023, 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.

Community Bridges, Inc. operates several locations throughout Arizona. Services include medication management, substance use treatment, crisis stabilization, and supportive housing. The 99th Avenue ACT team is located in Avondale. The individuals served through the agency are referred to as "patient" or "client", but for the purpose of this report, and for consistency across fidelity reports, the term *member* will be used.

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 observe meetings and to interview staff and members.

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

- Remote observation of an ACT team program meeting on September 26, 2023.
- Individual video conference interview with the Clinical Coordinator (CC).
- Individual video conference interviews with Independent Living, ACT, Rehabilitation, and Peer Support Specialists.

- Individual phone interviews with two (2) 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: Resume and training records for the Rehabilitation Specialist, *Mercy Care ACT Admission Criteria*, *F-ACT Re-Engagement policy*, *F-ACT No Show policy*, member calendars, and the *99ACT Team Contact List*.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. It is a 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 with little room for improvement*).

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 team meets five (5) days a week to discuss members. During the team meeting observed, multiple staff contributed to discussions relating to treatment planning and ways to engage members' natural support. The Clinical Coordinator provided the team with strategic interventions on how to engage members based on their needs.
- The team was involved in 100% of the ten most recent psychiatric hospital discharges.
- The team has a low graduation rate and maintained 100% of their caseload over the past year.
- The team values engagement with members' natural supports which includes supportive listening and providing community resources.
- The ACT team has at least one staff member with lived psychiatric experience that shares their lived experience.

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

- Increase contact of diverse staff with members. Increasing in-person contact with members by diverse staff provides members with experiences and knowledge from a wide range of staff and helps to alleviate the potential burden on staff.
- Increase continuity and staff capacity. Several positions on the team (Co-Occurring, Employment, Housing Specialists, Nurse, and dedicated team Psychiatrist) are vacant. Filling vacant positions as soon as possible helps to reduce the burden on team staff and ensures members do not experience a disruption in service due to a lack of staff.
- Increase the intensity of services delivered to members. ACT services are responsive to member needs, adjusting in frequency as it relates to members' individual needs and preferences resulting in an average of two (2) hours of in-person services weekly.
- Increase the frequency of contact delivered to members. ACT staff provide services to every member on average four (4) times a week. Higher frequency of contact correlates to improved outcomes for ACT members.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 - 5 4	The ACT team serves 81 members with seven (7) full-time equivalent direct service staff, excluding the covering Psychiatrists and administrative staff. Staff includes the Clinical Coordinator (CC), Nurse, Co-Occurring Specialist, Rehabilitation Specialist, ACT Specialist, Independent Living Specialist, and Peer Support Specialist. The team has a member-to-staff ratio of approximately 12:1. All staff excluding the CC work four 10-hour days.	• If not done so already, agency leadership should prioritize filling vacant positions on the team to make certain a 10:1 member to staff ratio exists. Small caseload size ensures adequate intensity and individualization of services and minimizes the potential burden on staff.
H2	Team Approach	1 - 5 2	Staff reported using a geographic zone approach to ensure members are seen by more than one staff in a two-week period. Staff reported incongruent accounts on the frequency staff rotate zone assignments. Staff are assigned a caseload for administrative purposes only, e.g., updating service plans, etc. Per a review of ten randomly selected member records, for a two-week period, 30% of members received in-person contact from more than one staff. Members interviewed reported seeing staff at the clinic every two weeks.	• Ensure all members are seen by diverse 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 meeting five days a week Monday through Friday to review all members of the team. The meeting is conducted in-person and through a video conference platform. Staff attend on scheduled workdays, covering Psychiatrists attend one meeting weekly, and the Nurse attends on scheduled workdays.	

			During the program meeting observed, the program assistant identified all members on the roster and identified any natural support, advocates and/or guardians. The team discussed members' stage of change, housing, appointments, inpatient status, and engagement level. The CC provided direction to staff and suggested interventions how to engage members based on current needs.	
H4	Practicing ACT Leader	1 - 5 3	The CC estimated delivering in-person services five (5) hours a week. The CC reported participating in the team zone rotation to engage members in the community, facilitating an art group once per week at the clinic, and delivering services when members come into the clinic. In the month period reviewed records showed the CC attending a staffing at an inpatient unit and supporting one member by phone. *The fidelity tool does not accommodate delivery of telehealth services.*	• Continue efforts to provide in-person services to members. Optimally, the ACT CC delivers direct services to members accounting for at least 50% of the expected productivity of other ACT staff. • Consider identifying administrative tasks currently performed by the CC that may be transitioned to other administrative or support staff, if applicable.
H5	Continuity of Staffing	1 - 5 3	Based on the data provided and reviewed with staff, 13 staff left the team in the past two years resulting in a turnover rate of 54%. The team experienced turnover in each specialist position. Members interviewed reported an interruption in services delivered in the community due to staff turnover.	• ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff.
H6	Staff Capacity	1 - 5 2	In the past 12 months, the team operated at approximately 56% of full staffing capacity. The Co-Occurring Specialist position was vacant the longest (12 months).	• To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible with the goal of operating at 95%, or more, of full staffing annually. Timely filling of vacant

				positions also helps to reduce the potential burden on staff.
	Psychiatrist on Team	1 – 5 4	The team has two .5 FTE covering Psychiatrists that divide the team's roster to provide services to members. Both Psychiatrists attend program meetings once per week. Services are delivered to members through video conference. The Psychiatrists are unavailable to the team after hours. When the team requires guidance from a psychiatric provider after hours or weekends, staff contact the agency on-call provider, rather than the covering Psychiatrists. Per review of ten records, one of the two Psychiatrists provided direct service to five members in the month period reviewed.	• ACT teams have at least one full-time, fully integrated Psychiatrist assigned to serve as the Medical Director for the team. Continuity supports therapeutic relationships between the member and the Prescriber and helps develop team cohesion. The Psychiatrist should be available after-hours and weekends to ensure continuity of care of members.
H8	Nurse on Team	1 - 5 3	The team has one Nurse to support 81 members. Staff reported the Nurse administers injections, provides medication observation and education, and coordinates with hospitals and natural supports. The Nurse meets members in the community one day a week. The Nurse is accessible to the team by phone, email, in-person, after hours and weekends. Per record review, the Nurse documented delivering services to members at the clinic, by phone, and in the community.	• 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.
H9	Co-Occurring Disorder Specialist on Team	1 – 5 2	One Co-Occurring Specialist joined the team the week of the review. Resume and training records were requested but not received.	• ACT teams have two Co-Occurring Specialists assigned to provide services to members. When screening potential candidates for the position, consider one year or more of experience working with members with a co-occurring disorder and integrated care. • Provide annual training to Co-Occurring Specialists in co-occurring disorder treatment best practices, including

				appropriate interventions, i.e., *stage-wise approach;* the evidence-based practice of *harm reduction*; and *motivational interviewing.* Co-Occurring Specialists should have the capability to cross-train other staff on the team, providing guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorder model utilized by the team.
H10	Vocational Specialist on Team	1 – 5 2	The team has one Rehabilitation Specialist to provide vocational services to members. The Rehabilitation Specialist has been on the team since May 2023. Staff interviews and the resume provided showed the Rehabilitation Specialist has previous experience supporting individuals in finding employment. The training records provided did not show evidence of employment training relating to supporting members in an integrated work setting.	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met. • Ensure Vocational Staff receive annual training in assisting people diagnosed with a serious mental illness (SMI)/co-occurring disorder, to find and retain employment in integrated work settings.
H11	Program Size	1 – 5 4	At the time of the review, the team consisted of eight (8) staff, including two .5 covering Psychiatrists. Four direct service positions were vacant: Employment Specialist, Housing Specialist, and the second Co-Occurring Specialist, and Nurse.	• Continue efforts to hire and maintain adequate staffing. A fully staffed team, a minimum of 10 direct service staff, allows the team to consistently provide diverse coverage; helps to prevent potential staff burn-out; allows staff to practice their specialties, which can improve job satisfaction; and accommodates the delivery of comprehensive, individualized service to each member.
O1	Explicit Admission Criteria	1 – 5 5	The ACT team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. Based on interviews, the CC conducts screenings with potential members. The CC will discuss potential new members with one of the team	

			Psychiatrists who will then complete a doctor-to-doctor staffing with referring entity. The Psychiatrist makes the final determination for all new admissions. Referrals are received from the local contractor with a Regional Behavioral Health Agreement (RBHA), hospitals, outpatient clinics, and internally within CBI.	
O2	Intake Rate	1 – 5 4	Per the data provided and interviews, the month with the highest intake rate during the past six months was in February, with seven (7) new members referred by internal agency transfer. At the time of the new admissions the team was not fully staffed.	• Ideally, new intakes should not exceed six each month for a fully staffed team. Consider staffing capacity when admitting new members to the team to alleviate the potential burden on staff.
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the team provides psychiatric and medication management and employment and rehabilitative services. Members interviewed reported seeing the covering Psychiatrists once a month. In addition, members interviewed reported seeing the team Nurse for medication administration. Staff reported 5 – 10 members are employed, and the team is providing employment support for all. Support includes ensuring means for transportation, suitable clothing, speaking with employers when the member approves, and mock discussions with employers. The team is assisting 6 – 7 members with job search efforts and connecting them with Vocational Rehabilitation. Job search efforts described included building a resume, internet search for employment, obtaining interview clothing, providing bus passes, mock interviews, and transporting members to interviews. Records reviewed showed staff	• Continue to monitor the number of members in staffed residences. As the designated Permanent Supportive Housing services provider, the ACT team, to the extent possible, should seek to move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team. Optimally, members on ACT teams receive all services and support from the team. • Counseling/psychotherapy is made available to members on ACT teams and is provided by ACT staff. Ensure future staffing includes a person with qualifications to provide counseling/psychotherapy to members of the team. • Make available the delivery of co-occurring disorder treatment to members of the ACT team. ACT teams fully assume

			encouraging employment and supporting members with individual employment goals. At the time of the review the team referred members to non-act staff or brokered providers for counseling, co-occurring disorder treatment groups, and individual substance use treatment. Staff reported nine members were residing in housing that duplicated ACT services available. During the program meeting observed staff identified at least six members placements in behavioral health residentials, flex care, or inpatient substance use treatment programs.	responsibility for providing members with formal substance use treatment in an integrated setting staying within the team approach of the EBP.
O4	Responsibility for Crisis Services	1 – 5 5	Per interviews with staff, the team provides 24/7 crisis services to members of the team. Staff provided the *99ACT Team Contact List* that is provided to members and includes the on-call number, morning meeting hours, and a list of ACT staff, assigned hours, phone numbers, and positions. Staff, including the CC, rotate the on-call responsibility daily. For after-hour supervisor support, staff will contact the agency rotating on-call supervisor for direction, which may not be the CC assigned to the team. Members interviewed were aware of on-call availability on the team.	• Ideally, ACT teams are supported during crisis response by other ACT staff that are familiar with members assigned to the team rather than agency staff unaware of the history and intricacies of members' behavioral health needs.
O5	Responsibility for Hospital Admissions	1 - 5 4	Staff will meet members in the community and to assess for de-escalation and stabilization. When possible, staff transport members to the clinic to be assessed by covering Psychiatrists and Nurse to determine necessity for hospitalization. When advised, staff transport members to an inpatient facility and remain with the member until admission. Staff provides the inpatient team with current medication information and deliver	• ACT teams performing to high fidelity to the model, are directly involved in 95% or more of psychiatric admissions.

			injectable medication when needed. A staffing is held with the inpatient team within 72 hours of admission and a doctor-to-doctor staffing is completed. Staff coordinate treatment planning with natural supports and guardians. Per review of data relating to the ten most recent psychiatric hospital admissions with staff, which occurred over a two-month time frame, the team was directly involved in 90%. One additional admission was located in records that was not documented as the most recent on the data collection provided. The team was directly involved in the admission. For the admission the team was not directly involved, the member sought inpatient treatment without the team's knowledge.	
O6	Responsibility for Hospital Discharge Planning	1 - 5 5	Staff reported discharge planning beginning when a member is admitted to a psychiatric unit. Before discharge, members are scheduled with follow up appointments with the ACT Psychiatrist and Nurse within 72 hours, and a Primary Care Physician within 30 days. Staff coordinate with the hospital and members to develop plans for placement locations after discharge. Staff reported meeting members at the hospital to transport to the pharmacy to fill prescriptions and transport to desired location. When possible, members are transported to the clinic to meet the Psychiatrist the same day as discharge. Staff reported following a five-day hospitalization follow up protocol. Staff aim to see members in person for five days following discharge. Staff reported due to staff shortage, the team may contact the members by phone for the five-day follow-up.	

			Per the data collected and reviewed with staff, the team was involved in 100% of ten most recent hospital discharges that occurred over a two-month time frame. Staff met all members at the inpatient unit for discharge and transported nine (9) to their desired location. One member was transported by natural support and ACT staff met both at discharge for a warm hand off. Three additional discharges were seen in records that were not documented on the data collection provided. Records showed the team was directly involved with the discharges. Documentation of in person follow up was not documented in records.	
O7	Time-unlimited Services	1 - 5 5	Data provided and staff reported that the team has graduated three (3) members in the past 12 months. Staff stated there are potentially two members that may graduate in the next year.	
S1	Community-based Services	1 - 5 4	Staff reported 70 – 90% of in-person contact occurs in a community setting. Records showed staff delivering services in the community by completing home visits, assisting with independent living skills, engaging natural supports, and transporting members to appointments. The results of ten randomly selected member records showed a median of 63% of services in the community. Members interviewed reported seeing ACT staff in the community once a month.	• Optimally, 80% or more of services occur in members' communities where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting.
S2	No Drop-out Policy	1 - 5 5	According to data provided and reviewed with staff, the team had a 100% retention rate over the past year. No members dropped out of the program. The team experienced three deaths of members during the past 12 months.	

S3	Assertive Engagement Mechanisms	1 - 5 4	Staff reported attempting contact with members four times a week. Staff refer to treatment plans to provide services that are relevant to members' identified needs. When an appointment is missed or the team is unable to locate, staff attempt two physical and two electronic outreaches a week for eight weeks. Outreach is attempted by checking known hangouts, shelters, hospitals, jails, the morgue, payee office, last known address, and by contacting natural supports, guardians, and Probation Officers. Reviewers received a copy of the team's*s F-ACT Re-Engagement policy* and *F-ACT No Show policy.* During the program meeting observed, some members were on week 10 and 11 of outreach. Staff reported they go beyond the eight weeks at times, and this has helped some members maintain their position on the team and the ACT level of service. One member record did not show documented contacts or re-engagement attempts in the month period reviewed.	• When members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Discuss and track these efforts during the program meeting. Consider peer review of documentation to ensure efforts are accurately included in member records.
S4	Intensity of Services	1 - 5 2	Per a review of ten randomly selected records, the median amount of time spent in-person with members per week was 33.13 minutes. Nine of the ten member records showed phone contact for a median of 3.50 minutes of service duration. *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the duration of service delivery to members. ACT teams provide an average of two (2) or more hours 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 individual needs, recovery goals, and symptoms.

S5	Frequency of Contact	1 - 5 2	Per records reviewed, the median in-person contact with members was one (1) time per week. The member record with the highest average number of in-person contacts was three.	• Increase the frequency of contact with members by ACT staff, optimally averaging four (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.
S6	Work with Support System	1 - 5 3	Staff reported 50% of members have natural support. Of those, ten (10) or more natural supports are engaged frequently with team. Staff attempt contact weekly by phone, email, or in-person. Staff report providing natural supports with updates, suggestions, supportive listening, and provide resources to organizations like the National Alliance of Mental Illness (NAMI). Staff interviewed reported using varying methods for tracking natural support contacts. Tracking was reported as being documented in the member record, during program meeting, and in individual staff logs. During the program meeting observed, staff reported contact with 12 members' natural supports. Of the ten charts reviewed, there was an average of .70 contacts with natural supports documented within the period reviewed. Of the members interviewed, their natural supports do not engage with the team.	• Ensure consistent documentation of contacts with natural supports occurs, which includes contact by phone, email, and text messages, as well as in-person. ACT teams have four (4) or more contacts per month for each member with a community support system. • Assist members in developing a natural, community-based support system. Active participation with peer run programs are a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact.
S7	Individualized Co-Occurring Disorder Treatment	1 - 5 1	At the time of the review, the team was not providing structured individual substance use treatment for members identified with a co-occurring disorder. Staff reported one member	• After COS staff have been hired, work to provide an average of 24 minutes, or more, per week of formal individualized substance use treatment services for all

			was receiving individualized co-occurring disorder treatment off the team.	members with a co-occurring disorder diagnosis.
S8	Co-Occurring Disorder Treatment Groups	1 - 5 1	At the time of the review, 57 members were identified as having a co-occurring disorder. Treatment groups that are offered by the agency are not facilitated by team staff. Staff estimated four (7%) members attending groups. Records reviewed showed staff encouraging members to participate in the co-occurring disorder treatment groups.	• Provide co-occurring disorder treatment groups for members facilitated by ACT staff of this team. Groups should reflect an evidence-based approach appropriately suited for the population served. • Ideally, at least 50% of members diagnosed with co-occurring disorder attend at least one treatment group monthly. Some teams structure groups so that one is directed to members in earlier stages of treatment, and another is targeted to members in later stages of recovery.
S9	Co-Occurring Disorders Model	1 - 5 3	Staff reported helping members with reducing negative outcomes related to substance use by encouraging harm reduction strategies. Staff encourage members to participate in substance use treatment groups provided by agency staff. When members request detoxification services or when medically necessary staff will refer members. The team supports members that desire to attend peer-run substance use programs in the community and provide resources. Of the ten records reviewed, seven were identified as having co-occurring disorder diagnosis. Four records had treatment plans that identified substance use treatment goals. Records showed treatment planning language included abstinence-based approaches rather than harm reduction interventions. Not all treatment plans appeared to be written in the member's perspective. During the program meeting observed, staff provided members' stage of change, updates on progress,	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as *Integrated Co-Occurring Disorders Treatment*, in the principles of a *stage-wise approach* to interventions, the EBP of *harm reduction*, and *motivational interviewing*. With staff turnover, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Identifying a co-occurring disorder treatment model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in recovery. • Ensure treatment plans are written in the member voice, identifying goals and individual needs. Support members to identify a reduction of use goal when a desire for abstinence is expressed,

			and suggestions on interventions based on member's motivation.	supporting the evidence-based practice of harm reduction.
S10	Role of Consumers on Treatment Team	1 - 5 5	The team has more than one staff member with lived psychiatric experience. Staff share stories of recovery with members when appropriate. Staff have the same responsibilities as all others. Per record review, two staff documented conversations with members pertaining to providing services from a peer perspective based on a personal lived experience. Members interviewed were unaware of staff on the team with lived psychiatric experience. Members reported being unfamiliar with all staff due to the high rate of turnover.	
Total Score:		**95**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	2
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	2
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	3
9. Co-Occurring Specialist on Team	1-5	2
10. Vocational Specialist on Team	1-5	2
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	4
3. Full Responsibility for Treatment Services	1-5	3
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	4
2. No Drop-out Policy	1-5	5
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 Co-Occurring Disorder Treatment	1-5	1
8. Co-occurring Disorders Treatment Groups	1-5	1
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.39**	
Highest Possible Score	**5**	