ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: March 26, 2018

To: Michele Swann, F-ACT 2 Clinical Coordinator
Frank Scarpati, CEO

From: Georgia Harris, MAEd
Karen Voyer-Caravona, MA LMSW
AHCCCS Fidelity Reviewers

Method

On February 20-21st, 2018, Georgia Harris and Karen Voyer-Caravona completed a review of the Community Bridges, Inc. (CBI) Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

Community Bridges, Inc. (CBI) has a 31-year history of providing comprehensive, medically-integrated behavioral health programs which include prevention, education and treatment services. CBI currently has three Forensic ACT (F-ACT) teams and two traditional ACT teams. Until recently, the three F-ACT teams operated from the Lodestar Day Resource Center. At the time of review, all three F-ACT teams were housed in temporary clinical sites, indefinitely awaiting permanent relocation. This review of the F-ACT team 2 was conducted at the CBI Avondale location.

The individuals served through the agency are referred to as "members," and that term will be used throughout this report.
During the site visit, reviewers participated in the following activities:

- Observation of a daily F-ACT team meeting on February 20, 2018.
- Individual interview with the F-ACT Team Leader/Clinical Coordinator (F-ACT CC).
- Individual interviews with the Substance Abuse Specialist (SAS), the ACT Specialist (AS) and the Peer Support Specialist (PSS).
- Group interview with four members receiving F-ACT services.
- Charts were reviewed for 10 members using the agency's electronic medical records system.
- Review of administrative documentation provided such as: *MMIC Adult System of Care Report*, resumes for the SAS, RS and ES; and *Integrated Dual Diagnosis treatment: Stagewise Treatment and Activities* matrix.

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:

- The team benefits from two full-time Nurses. In addition to the psychiatric and medical coordination, the Nurses provide extended case management/community engagement support to the members.
- The F-ACT CC regularly provides face-to-face services to members. Interviews and clinical charts reveal that the F-ACT CC is actively involved in the intensive case management services provided by the F-ACT team.
- The team provides their full range of F-ACT services in the community to members. The result of the clinical record review suggests that virtually all services provided to members occur in community settings.
- In addition to having a fully integrated Peer Support Specialist, members interviewed reported they were aware that many staff have similar lived experiences as the members, and cited this was of value in creating and maintaining therapeutic relationships.

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

- The team does not have a full-time, fully integrated Psychiatrist. The team currently has two part-time Psychiatrists that total .5 FTE and do not regularly attend team meetings. In the ACT model, the Psychiatrist is a fully integrated team member and serves as the medical director. It is imperative that the assigned Psychiatrist(s) for the team are readily available for consultation with members and ACT staff.
- Agency leadership should meet with the ACT team to discuss any barriers that may prevent them from increasing their service intensity and frequency of contact. The team spends an average of approximately 22 minutes per week in total service time per member. Also, the team provides an average of 1.13 face-to-face contacts a week, per member. These results are considerably lower than the required service minimums for the ACT practice.

- Nearly 74% of the F-ACT 2 members are diagnosed with a co-occurring disorder (COD); however, only 15% of those members with a COD had attended a COD treatment group in the review period. Though the team has been focused on revamping the current COD treatment groups, it is imperative that the team becomes equally focused on actively soliciting members to participate in them.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The F-ACT team maintains a member-to-staff ratio of approximately 10:1. The team serves 88 members. The team consists of 9 full-time staff: A Clinical Coordinator (CC); an ACT Specialist (AS); a Housing Specialist (HS); two Nurses (RNs); one Substance Abuse Specialist (SAS); a Rehabilitation Specialist (RS); a Peer Support Specialist (PSS) and an Employment Specialist (ES). This count does not include the Psychiatrist.	
H2	Team Approach	1 – 5 3	The F-ACT team uses a calendar tracking system for each member. Each morning, staff reports the number of times they have seen each member. As the week progresses, each staff volunteers to meet with members who have not been seen or have missed their scheduled appointment(s). The F-ACT team functions as a team; however, the results of the clinical record review suggests that approximately 60% of F-ACT members receive face-to-face contact with more than one staff member in a two week period. This is an indication that there may be other factors impacting their ability to consistently employ a team approach to service delivery.	• Work to improve the team approach to services by ensuring: (1) sufficient rotation of staff visits to members; (2) all face-to-face contacts with members are documented in the clinical record. • Evaluate current strategy to ensure it is the most effective for keeping track on members' contact with staff.
H3	Program Meeting	1 – 5 4	The F-ACT specialists are scheduled to meet four days a week for their Morning Meeting, where all members are discussed. The team meets on Wednesday for a longer clinical staffing. In the clinical staffing, the team receives training on substance abuse-related topics and provides each other with feedback on members with intense treatment needs. Though the F-ACT specialists are expected to attend all meetings, the team's quarter-time Psychiatrists only occasionally attend these meetings. It was reported that one	• Though most staff regularly attends the morning meetings, the part-time staff must increase their participation. In high fidelity teams, part-time staff are expected to attend meetings at least twice weekly. This team employs two part-time Psychiatrists who reportedly share equal responsibilities on the team. Though the protocol allows for Psychiatrists to attend once weekly,

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			Psychiatrist attends by phone once weekly, while the other Psychiatrist has made a couple of virtual appearances since coming to the team in January 2018.	one of the two Psychiatrists currently does not meet this threshold. It is imperative that this measure is applied to both staff equally.
H4	Practicing ACT Leader	1 – 5 4	The F-ACT CC regularly provides intensive case management services to ACT members. In addition to running a weekly Mindfulness Group for F-ACT members, the F-ACT CC participates in case management activities such as medication observation, hospital visits, court hearings, and home visits. The F-ACT CC estimated that between 14% and 26% of her time is spent in direct services to members; however, upon review of the *MMIC Adult System of Care Report* provided to reviewers, it was determined that the F-ACT CC dedicated closer to 36% of her time to direct services.	• The ACT CC should continue to work toward providing direct care services to members 50% of the time. ACT leaders who have direct clinical contact are better able to model appropriate clinical interventions and remain in touch with the members served by the team.
H5	Continuity of Staffing	1 – 5 4	The team has had a 33% turnover rate in the past two years. Of the eight staff who left the team, three were promoted into other positions within CBI. Two of the staff who left the team were Psychiatrists.	• Consistent staffing is a key ingredient in successful ACT teams. To reduce the potential for increased employee attrition, the clinic and/or agency leadership should solicit feedback from staff on matters affecting employee satisfaction. • To mitigate the loss of staff on the team, the agency should also consider creating transition plans for the staff who are being promoted into new positions within the company.
H6	Staff Capacity	1 – 5 4	The team has operated at approximately 90% of staffing capacity in the past 12 months. The team was without an ILS for seven months and without an SAS for four months. The team is still actively recruiting for an SAS.	• See recommendations in H5 *Continuity of Staffing*. • During recruitment, screen potential employees to ensure their appropriateness for the ACT team and its level of service.

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H7	Psychiatrist on Team	1 – 5 3	The team employs two Psychiatrists who each are quarter time (.25 FTE). Both Psychiatrists were hired approximately one month prior to the review. Psychiatrist 1 works locally in the Phoenix Metro area and Psychiatrist 2 is available through tele-medicine. Psychiatrist 1 works with the F-ACT team 10 hours per week; Psychiatrist 2 works with the team for 20 hours, every other week. Per Staff, each Psychiatrist is assigned a caseload of members and are equally responsible for their full treatment. Though they are equally responsible for member treatment, the F-ACT CC reports that Psychiatrist 1 has been used as the primary point of contact for doctor-to-doctor coordination with hospitals and clinical team recommendations because he is local. F-ACT staff report that Psychiatrist 1 will attend the team meetings once weekly (by phone or in-person), while Psychiatrist 2 attends sporadically. Members report they have not had many interactions with the tele-medicine Psychiatrist, but are hoping they will have a local Psychiatrist in the near future.	• ACT teams should have at least one, full-time Psychiatrist, per 100 member team. Though this team has two part-time Psychiatrists, their time does not meet the FTE requirement for the team's census. • ACT Psychiatrists serve as medical directors for the ACT team. Correspondingly, ACT Psychiatrists should be fully integrated into the team and should be consistently available for consultation.
H8	Nurse on Team	1 – 5 5	The team consists of two RNs. Both Nurses are assigned equal duties; both Nurses provide medical and/or behavioral health consultation, emergency triage, home/hospital visits and medical case management. Many ACT staff reported that the team Nurses are accessible and perform ACT case management/community engagement activities; one member gave their personal account of how the RNs assisted with enrollment into a local fitness establishment. Evidence of their presence in the community was established in the clinical records examined.	
H9	Substance Abuse Specialist on Team	1 – 5 3	The F-ACT team is currently staffed with one Substance Abuse Specialist (SAS). The SAS is a	• The ACT team should continue to

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			Licensed Associate Counselor (LAC) and has worked as an SAS on the F-ACT team since 2016. In addition to her formal education, she recently attended a training series on Integrated Dual Diagnosis Treatment (IDDT). The SAS is currently providing clinical cross training to the other F-ACT staff on IDDT interventions for Dual Diagnosis (DD) members.	recruit an additional, qualified SAS for optimal service provision for DD members.
H10	Vocational Specialist on Team	1 – 5 2	The team is currently staffed with two Vocational Specialists: a Rehabilitation Specialist (RS) and an Employment Specialist (ES). The RS has been with the F-ACT team for seven months at the time of review. The RS has worked in various roles throughout the behavioral health system; primarily as a case manager and/or Behavioral Health Technician (BHT) in both the Adult and Children's System of Care. The ES was newly hired at the time of review. The ES joined the team with limited formal experience with behavioral healthcare, but had extensive experience with business management. Per resume provided, the ES has been a Peer Support Specialist since September 2017 and brings his personal experience with recovery to the team.	• The ACT team should include at least two vocational staff with at least one year of training/experience in vocational rehabilitation and support. • The ES should be provided the necessary training and mentoring to assist ACT members with finding and retaining employment in integrated settings.
H11	Program Size	1 – 5 4	The F-ACT team consists of 9 full time staff and a cumulative FTE of .5 Psychiatrists. This count excludes the administrative support on the team.	• The team is of adequate size to perform most duties; however, not enough to ensure necessary staffing diversity and coverage.
O1	Explicit Admission Criteria	1 – 5 5	Member referrals come to the team through various sources; this includes hospitals, institutions, or other SMI service teams. Referrals are screened by F-ACT staff using the *F-ACT Admission Screening Tool* developed by the RBHA. Referrals coming through the criminal justice	

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			system have both an Offender Screening Tool (OST) and a Field Re-assessment Offender Screening Tool (FROST) score. If the member agrees to F-ACT services, the team makes the final determination regarding admissions to the team.	
O2	Intake Rate	1 – 5 5	The F-ACT team reports seven admissions in the last six months. The F-ACT CC reported the team's highest intake month was December 2017 with two admissions.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the team fully provides psychiatric services, substance abuse treatment and psychotherapy/counseling services. All members report seeing the team Psychiatrists as their primary doctors for psychiatric services and medications. The SAS is a Licensed Associate Counselor (LAC) and provides both general and Substance Abuse counseling to members on the team. The SAS meets with nearly half the DD members on the team for individual counseling and three to four members for general psychotherapy on a weekly basis. Though the team had a couple of members referred to external programs for inpatient co-occurring treatment, there were less than 10% of all DD members utilizing these services. The staff provides independent living skills and housing services to members; however, it appears that more than 10% of all members reside in locations where case management services are partially duplicated. The team has two Vocational specialists: an RS and an ES. The ES is new to the team and has not been able to implement any vocational services at the time of review. The RS has been working with members to gain and maintain competitive employment. Staff report that multiple F-ACT staff are involved in this effort;	• In addition to case management, the ACT team is required to provide all five additional services to members. As the team is becoming fully staffed, look for opportunities to move members who are participating in external services into services offered by ACT staff.

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			approximately 10 to 12% of the members are engaged in either job search or retention with a member of the F-ACT team. Staff report that they do refer members to external providers for Work Adjustment Training (WAT) Services.	
O4	Responsibility for Crisis Services	1 – 5 5	The F- ACT team provides 24-hour coverage for its members. Staff considers themselves to be first responders in times of crisis. Each staff has an assigned day for on-call phone coverage and the team rotates responsibility for Thursday and Friday coverage. Each member is given a list of the F-ACT team phone numbers. Members are able to call the staff of their choice at any time, but the on-call team coverage is from 7pm to 7am.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The F- ACT team was directly involved in 70% of the ten most recent hospital admissions. Of the remaining three admissions, one was admitted by the police, one was admitted directly per the judge at a court hearing, and one was transferred directly to the hospital from the Department of Corrections. Once admitted, the hospitals notified the F-ACT team so they could participate in ongoing treatment coordination.	• Continue working toward full responsibility for hospital admission; to maintain continuity of care in crisis situations. • Ensure local law enforcement and justice partners are well informed of the team's role in member care and hospitalizations.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	The F-ACT team was directly involved in 100% of the most recent hospital discharges. Staff reports the discharge process begins upon hospital admission. The team coordinates with the inpatient treatment team to establish a discharge plan. Once a member is discharged, the team provides transportation to their residence, and begins their five-day follow up sequence.	
O7	Time-unlimited Services	1 – 5 5	The F-ACT team reported two graduations over the past year. The team expects to graduate four members over the next 12 months. The F-ACT team gradually reduces contact with members who	

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			have had no involvement with the Department of Corrections in the past year, lessened their dependence on psychiatric and/or emergency services, or may be requesting transition to a lower level of care.	
S1	Community-based Services	1 – 5 5	The F-ACT team aims to provide services and monitor member statuses in the community whenever possible. The results of the chart review show staff making contact with members in community settings virtually 100% of the time. Staff report that the lack of a permanent clinical location has reinforced the expectation of community based service provision.	
S2	No Drop-out Policy	1 – 5 4	The team reports retaining 93% of their members over the past 12 months. The F-ACT CC reports that four of the members who have left the team were transferred to a Navigator team. When located, two of them were residing in another city, and did not return to the team; the third decided to remain with a team that was connected to the Navigator. There was no update provided for the fourth person. Aside from those who were transferred to Navigation, two additional members left the state without warning and refused service coordination from the team.	• Continue all efforts to retain members on the ACT team at a mutually satisfactory level, as maintaining therapeutic rapport can be critical to ongoing service delivery.
S3	Assertive Engagement Mechanisms	1 – 5 5	The team demonstrates a well-thought-out engagement strategy and uses street outreach and legal mechanisms when appropriate. The F-ACT staff shared with reviewers their 8-week outreach strategy; this strategy includes weekly outreach to hospitals, morgues, family and other involved parties. Being a F-ACT team, Parole and Probation Officers are heavily involved in the coordination of outreach efforts for members who have these services. The team reports that most members are	

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			located prior to the end of the eight weeks; however, those who are not located are changed to *navigator* status and transferred to a local *navigator team* for further outreach. F-ACT staff report that approximately four (4) members have been closed in this manner. A copy of the outreach protocol was provided to reviewers. Instances reflecting the use of the outreach protocol were also noted in multiple member charts.	
S4	Intensity of Services	1 – 5 2	Ten member records were reviewed to determine the amount of face-to-face service time spent with each member. The team spends an average of approximately 22 minutes per week in total service time per member. Though a one of the records was well above the two hour requirement, the majority showed below average contact duration. Of the records reviewed, it was noted that the intensity for each member ranged from 7 minutes to 182 minutes, with half of the charts showing less than 20 minutes of contact. Staff indicated they were experiencing some difficulty in balancing current documentation requirements and the ability to provide members with the quality time they often need, especially when the team is not fully staffed.	• ACT teams are required to provide an average of two hours of direct service, per member, each week. Agency leadership should meet with the ACT team to discuss any barriers that may prevent them from increasing their service intensity. This may include an assessment of available technology, schedules, and staff workloads. • Train staff on appropriate documentation standards so their delivery of services will be accurately reflected in the members' medical records.
S5	Frequency of Contact	1 – 5 2	The record review indicated that the team provides an average of 1.13 face-to-face contacts per week, per member. The F-ACT CC stated that the team schedules are created monthly, and their progress toward meeting those appointments is tracked daily. Visits are often scheduled based on their members' scheduled appointments and any immediate needs/crises that arise throughout the week. Each Wednesday, the remaining members are scheduled based on the number of visits staff has left to fulfil. In the record review, it was apparent that members were seen relatively	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member. • Review recommendations in S4 to address the need for a balanced approach for service provision and documentation standards.

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			infrequently, unless there was a situation that required intensive case management and/or medication observation. Members also expressed a desire for more contact with the F-ACT staff, as they truly benefit from the team's involvement in their lives.	
S6	Work with Support System	1 – 5 2	Staff estimates that approximately 67% of the members have natural supports identified. The team estimates that they speak with at least 50% of them once monthly. The team maintains a tracking log of contacts on each member's calendar; each time a natural support is contacted, the encounter is logged alongside the member's appointments. Though the team does have a tracking system established, little evidence was provided of actual encounters the team has had with natural supports. Although the team estimated a lower frequency of contact with informal supports, the clinical record review suggests that team has approximately one contact with each natural support per month.	• Continue every effort to build relationships with the support systems of the ACT members. • Educate support systems on the role of the ACT team in the lives of both the members and their active supports. • Continue to encourage staff to actively pursue informal supports. Also, the team should become more assertive in their monitoring/documentation of contacts with informal supports.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Based on data provided, members receiving individual SA counseling averaged less than 10 minutes of treatment per week. The SAS estimates that approximately 49% of the 65 members diagnosed with a COD are receiving individual SA counseling. Of those receiving SA counseling, 49% had around two sessions per month, while the remaining 51% had one session each. Each session averages 30 minutes. The SAS also provided reviewers with a sample of her counseling calendar. With the information provided, reviewers calculated that each member with a COD received an average of 6.95 minutes per week of individual substance abuse counseling.	• Continue all efforts to increase the time spent with members in individual SA sessions to 24 minutes or more per week, per member. • Employ an additional, qualified SAS to assist with the SA counseling duties.

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S8	Co-occurring Disorder Treatment Groups	1 – 5 2	The SASs offers two, one-hour Co-Occurring Disorder (COD) treatment groups every other week. There is a Persuasion group for members in early stages of change and an Action group for members in later stages. The SAS reported that no groups were offered in January because the team was in the process of redeveloping the curriculum and focus of COD treatment groups. However, five unique members had participated in February. One of the RNs also has an IDDT Women's group, which is a wellness group, focused on IDDT themes. Five unique members have reportedly attended this group. The ten members attending these three groups accounts for 15% of the 65 members diagnosed with a COD.	• The ACT team should strive to have 50% or more of their dually-diagnosed members engaged in COD groups on a regular basis. Solicit member enrollment in COD treatment groups; consider involving current participating members with this effort. • The team should prioritize the establishment of the COD group curriculum, so that members can begin group treatment as soon as possible.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	The team primarily operates from a DD treatment model and generally has gradual expectations of abstinence for members. Reviewers were provided with an *Integrated Dual Diagnosis treatment: Stagewise Treatment and Activities* matrix, a tool the SAS uses to cross-train the F-ACT team on appropriate interventions with the COD members. The team exhibits understanding of the Stages of Change model and are able to articulate appropriate interventions for each stage; however, there was evidence of members being steered toward abstinence in the clinical records by certain staff. Also, occasional references to confrontation were found in the clinical records. Some staff who were interviewed believed that detox was appropriate for any substance that a member was experiencing symptoms with.	• Continue any and all efforts to educate staff on providing all services from a DD perspective; focused training on alternatives to confrontational engagement would be beneficial to staff. • Hire an additional, qualified SAS to assist with member treatment and cross training to other ACT specialists.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team employs a full-time, fully-integrated Peer Support Specialist (PSS). Staff and members interviewed view the PSS as an authority in community and interpersonal engagement. In the	

Item #	Item	Rating	Rating Rationale	Recommendations
			team meeting, reviewers observed the PSS as he provided relevant updates on member conditions and offered strategies for improving member relationships. The CBI team also consists of multiple F-ACT specialists who are Certified Peer Support Specialists. Each of these staff provides peer support to members when needed.	
Total Score:		**3.86**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	4
4. Practicing ACT Leader	1-5	4
5. Continuity of Staffing	1-5	4
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	3
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	3
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	5
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	5
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
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	**3.86**	
Highest Possible Score	**5**	