ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: John Hogeboom, Chief Executive Officer
Ywchari Manos, Clinical Coordinator

From: Vanessa Gonzalez, BA
Annette Robertson, LMSW
AHCCCS Fidelity Reviewers

Method

On April 26 – April 27, 2022, Vanessa Gonzalez and Annette Robertson completed a review of the Community Bridges, Inc. Forensic Assertive Community Treatment (F-ACT) Team 1. 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. (CBI) provides a variety of services to people that have been diagnosed with a serious mental illness including supportive housing, crisis stabilization, integrated health care, and ACT. CBI has three Forensic ACT teams and three ACT teams. The focus of this review will be F-ACT Team 1. Persons referred to the F-ACT Team 1 are at high risk of returning to the criminal justice system.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. Delivery of telehealth services, including phone only, were calculated for this review, however those totals are not included in calculating scores for those items that measure in-person contact between the ACT team and members. In the State of Arizona, delivery of telehealth services by Psychiatrists is considered as in-person because of the shortage of providers. This review was conducted remotely, using videoconferencing or telephone to interview staff and members.

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

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

- Remote observation of an ACT team program meeting on April 26, 2022.
- Individual interview with the Clinical Coordinator (CC).
- Individual interviews with Substance Abuse, ACT, Rehabilitation, and Peer Support Specialists.

- Individual phone interviews with two 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 for Vocational staff, resume and training records for one Substance Abuse Specialist, *ACT Exit Criteria Screening Tool, F-ACT Re-Engagement DTP,* and *ACT Team Contact List.*

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 attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The intake rate of members is low which allows the staff to maintain a stable service environment. The highest admission in the previous six months were three admissions in a month period.
- The team excels at providing services to members in the community, specifically in member's homes.
- The team is responsible for delivering the vast majority of services to members, with very little reliance on providers outside the F-ACT team.
- The team follows a Dual-Disorders treatment model in the delivery of services and supports to members, as well as in documentation and treatment plans.

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

- The ACT Leader should increase community contacts with members. Ideally, the practicing ACT leader spends 50% or more of their time providing direct services to members in the community.
- The team operated at 60% of staff capacity for the last 12 months. To reduce the potential for staff burnout and ensure diversity of staffing, fill the vacant positions and work with the F-ACT team on retention efforts.
- Increase involvement in member psychiatric hospital admissions. The F-ACT team should be coordinating with hospitals and when possible, member's natural supports. Ensure staff are present for transporting members to the hospital and checking members in.
- Increase the frequency and intensity of services delivered to members. Adjusting intensity and frequency as it relates to members' individual needs and preferences correlates to improved outcomes for ACT members.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, there were eight full-time equivalent (FTE) staff on the team, excluding the Psychiatrist, Program Assistant, and a student intern. There were three vacant positions on the team. It was reported that 79 members are served resulting in a 10:1 member to staff ratio.	
H2	Team Approach	1 – 5 4	Staff estimated 85 - 90% of members are seen by more than one staff in a two-week period. The team developed a zone approach to ensure diverse staff are providing members services. Staff are assigned a new zone each day and send an "End of Shift Report" to program staff to track member encounters. Of ten randomly selected member records reviewed for a month period, a median of 70% received in-person contact from more than one staff from the team in a two-week period.	• The entire caseload should be shared across ACT staff, a measure to reduce the potential for burden on staff when supporting high needs members, as well as ensuring members are provided adequate intensity, diversity of staff, and individualization of services. Consider including all direct services staff in the rotation when there are multiple staff vacancies.
H3	Program Meeting	1 – 5 5	Staff interviewed reported that the team meets five days a week to review all members on the team roster. The Psychiatrist attends the meetings virtually two days a week. Most staff are scheduled to work four 10-hour days, attending the meeting the days scheduled to work. In the meeting observed, all members were discussed.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated delivering in-person services to members 50% of the time and reported meeting with members in the office and in the community. The CC provides a supporting role to the team, indicated by documentation in the sample member records, however, there was no documented interactions with members in the	• Increase delivery of services to members in the community. Optimally, the CC should provide in-person services to members 50% or more of the time. ACT leaders that have direct clinical contact with members are better able to model appropriate clinical interventions and remain in touch with the

			community. Data provided by the CC indicated delivery of some direct member care. *The fidelity tool does not accommodate delivery of telehealth services.*	members served by the team. Shadowing and mentoring specialists delivering community-based services, such as outreach, and skill building activities designed to promote integration and recovery all qualify as direct in-person service. • The CC and agency may consider identifying administrative functions not essential to the CC's time that could be performed by the program assistant or other staff. • Ensure all services delivered to members of the F-ACT team are documented in member records.
H5	Continuity of Staffing	1 – 5 3	Based on the data provided, 13 staff left the team during the past two years, a turnover rate of 50%. The positions with the most turnover were the CC (3) and Independent Living Skills Specialist (ILS) (2).	• ACT teams should strive for a turnover rate of less than 20%. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff. • Ensure specialists are provided training and support in their specialty area. Being supported to provide services to members in the areas of staff's personal interest may bring more value to their work and to the team.
H6	Staff Capacity	1 – 5 2	Review of the data provided shows there have been 57 vacant positions over the past 12 months resulting in a 60% staffing capacity for the team. Positions that have been vacant the longest include the ILS, Substance Abuse Specialist (SAS), Peer Support Specialist (PSS), and Employment Specialist (ES) for a minimum of six months each over the last year.	• To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible with a goal of 95% full staffing annually. Timely filling of vacant positions helps to reduce potential burden on staff.
H7	Psychiatrist on Team	1 – 5	The Psychiatrist does not have a set work schedule. Staff usually get the monthly schedule at	

		5	the beginning of the month. Typically, the Psychiatrist works four days a week, Monday, Wednesday, Friday and one weekend day. Staff reported that the Psychiatrist's schedule changes weekly and is typically accessible even when not scheduled to work. The Psychiatrist is assigned only to the F-ACT team. Staff interviewed reported the Psychiatrist has telemed capabilities but normally meets with members by phone, not by videoconference. If members want to be seen by videoconference, staff will go to the member and facilitate the interaction. Members are not given a specific time to meet with the Psychiatrist, but rather are assigned a day the Psychiatrist will call them. ACT staff may support the process by meeting members in the community to facilitate the call or transport members into the office to talk to the prescriber there. Members interviewed indicated talking with the ACT Psychiatrist over the phone once a month. Some staff questioned the effectiveness of the current appointment system. Of the records reviewed, the Psychiatrist had at least a 25-minute phone call with seven of the ten members over the month period reviewed.	
H8	Nurse on Team	1 – 5 3	The ACT team has one Nurse to support the 79 members. The Nurse is only responsible for F-ACT members and has no other responsibilities outside of the team. The Nurse's role includes medication monitoring, medication delivery, injections, and behavioral assessments. Staff interviewed reported the team Nurse is accessible by email, phone, or through a messaging application used by the team. Staff also reported the Nurse attends	• Fill the vacant Nurse position. Having two full-time nurses is a critical component in a successful ACT program.

			the program meeting every day when scheduled to work and is very involved with member care. Members interviewed indicated being seen by the Nurse in their homes. Records reviewed showed all Nurse encounters were in the community with the members.	
H9	Substance Abuse Specialist on Team	1 – 5 3	At the time of the fidelity review, the team had one staff, the SAS, providing substance use treatment services to 23 members of the team with a co-occurring diagnosis. The SAS has several years of experience providing substance use treatment services on the team and is a Licensed Associate Counselor (LAC). In addition, the SAS participated in several different trainings including Cognitive Behavioral Therapy, Motivational Interviewing, and Art Therapy in the past two years. The SAS indicated receiving biweekly clinical supervision and biweekly group supervision. In addition to the SAS, the team has a Master of Social Work student intern assigned to the team two days a week co-facilitating groups with the SAS. Reviewers requested but were not provided with a resume.	• Fill the vacant second SAS position. Optimally, ACT teams are staffed with two SASs, each with a year or more of training/experience providing substance use treatment.
H10	Vocational Specialist on Team	1 – 5 3	The F-ACT team has two vocational staff, and both are new to the role on the F-ACT team. The ES started with the team the day before the fidelity review began. The RS is new to working on an ACT team (6 months) and has previous experience in a case management. Resumes were provided for both the ES and RS but did not identify previous experience in employment supports. Reviewers requested copies of recent trainings for both the RS and the ES but were not provided.	• 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, employer engagement, and follow-along supports. • If not done so already, support vocational staff to attend quarterly vocational meetings available through the Regional

				Behavioral Health Authority (RBHA) to keep up to date on resources available.
H11	Program Size	1 – 5 4	When the team is fully staffed, there are 12 staff members, currently there are 9. Three positions were vacant at the time of the review, the second Nurse and SAS, and the ILS.	• Hire and maintain adequate staffing. A fully staffed team, 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	Based on interviews with staff, the team follows admission criteria developed by the RBHA. The ACT Specialist completes the admission screenings for new referrals and reviews the results with the CC. The CC may also conduct screenings. The Psychiatrist has the final determination on admissions. Interviews indicated the members that are referred have co-occurring disorder (COD) diagnosis, criminal history backgrounds, may be on probation/parole, and are diagnosed with a serious mental illness. The team often receives referrals from mental health court and Department of Corrections, as well as other clinics/providers. Staff report the team is not actively recruiting new members to the program.	
O2	Intake Rate	1 – 5 5	Per the data provided to reviewers and an interview with F-ACT staff, six members were admitted to the team in the last six months prior to the review. This rate of admissions is appropriate. The month with the highest admissions (3) was November.	
O3	Full Responsibility for Treatment Services	1 – 5 5	In addition to case management, the ACT team provides psychiatric and medication management services, counseling/psychotherapy, employment	

			and rehabilitative services, housing supports, and substance use treatment services. All members receive their psychiatric medications through the F-ACT team. It was reported no members receive those services off the team unless they need specialized care, or court ordered cases may receive those services off the team. Reviewers assessed data provided, information provided through staff interviews, and review of member records. Per data provided and staff interviews, some members served by the team were reported to be living in residences with some level of staff support by other providers. Staff reported halfway houses may hold member medication and potentially provide prompting, rather than F-ACT 1 staff.	
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24-hour seven days a week on-call services to members. Reviewers were provided a copy of the *ACT Team Contact List* which lists the F-ACT on-call number, staff names, roles, emails, and phone numbers. Staff rotate on-call responsibilities every two days, and at the time of the review, four staff were included in the rotation. Staff are often successful at redirecting and de-escalating the situation with members, but if it is an urgent matter, staff will reach out to the CC. Members interviewed reported being aware of 24-hour services available from the team and that they found it helpful. However, members also reported sometimes calls go unanswered. Staff reported at times there are inconsistencies in response to clinical oversite when trying to	

			address immediate member needs and that there have been times when leadership is unavailable to the on-call staff.	
O5	Responsibility for Hospital Admissions	1 – 5 2	Of the ten most recent psychiatric hospitalizations, the team was directly involved in 10%. One member was admitted under a petition filed by the team. The team transported the member to an urgent psychiatric unit for care. For those members the team did not assist, it was unclear how members got to the unit, whether by law enforcement, natural supports, or self-admission. In most instances, the team was notified the day of the admission or the day after, and ACT staff moved quickly to complete coordination of care and schedule a doctor-to-doctor consultation. Normally, the team will assess members first before going inpatient. Staff will assess the seriousness, determine if there is a plan, and if so, would do an appointment with the Psychiatrist to assess by phone. Staff reported that oftentimes staff will transport the member to the hospital. When involuntary hospitalizations occur, when members present as a danger to themselves or the community, the team completes the appropriate petition and may have law enforcement meet them where the member is for transport. Sometimes upon arrival on scene the team is successful at calming the member and transitions them to a voluntary admission. Staff interviewed report if a patient believes they can transport themselves to the hospital, the team will respect that and follow behind. If there is	• The team should identify and seek solutions to barriers of direct team involvement in member inpatient admissions. Increase team responsibility for hospital admissions to at least 95%. • Frequent contact with members and their support networks may result in earlier identification of issues or concerns relating to member's symptoms. This would allow the team to offer additional supports, which may reduce the need for hospitalization. • Assist member transport whenever available to ensure the member arrives at the hospital safely, coordinate member care, and to ensure a smooth admission process.

			concern that the patient is at high risk, the team will request law enforcement also follow behind the member to the hospital.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Of the ten most recent psychiatric hospital discharges, the team was directly involved in 100%. The F-ACT team plays an active role in discharge planning. Upon hospitalization, the team connects with the member within 24 hours and has subsequent contact every 72 hours to begin discharge planning as well as weekly staffings with the inpatient team. F-ACT staff will be present to pick up the member from the hospital unless family or a natural support is transporting. When members are going into placement, staff will accompany them to the intake. Upon discharge, the member will meet with the Psychiatrist that day, will be seen by the Nurse five to seven days after discharge, and a PCP appointment will be scheduled. The team provides in-person follow-up with the member 24 hours after discharge for five consecutive days. However, one member record reviewed from the sample provided no evidence that the team was involved during the hospital discharge, yet the team had been coordinating with inpatient staff prior.	• Ensure the F-ACT team is following through with the five-day follow up protocol to support members after psychiatric hospital discharge.
O7	Time-unlimited Services	1 – 5 4	The CC predicts about 6% of members will graduate from the program in the next year. The F-ACT team provided an *ACT Exit Criteria Screening Tool* that is used to assess a member's readiness to graduate from the team. No members graduated with significant improvement in the last year. The Psychiatrist makes the final decision when a member is ready to step down to a lower level of	• Since ACT teams traditionally serve those with the most complex behavioral health issues and have been unsuccessful in traditional outpatient teams, the F-ACT team should strive to graduate fewer than 5% of membership annually.

			care and a discussion was observed during the program meeting regarding a member potentially transitioning to a lower level of care.	
S1	Community-based Services	1 – 5 5	Staff interviewed reported 75% of in-person contacts with members occur in the community. However, the results of ten randomly selected member records reviewed show staff provided services a median of 82% of the time in the community. Members interviewed reported meeting with staff in their homes most often but do meet with staff at the office for medical care.	
S2	No Drop-out Policy	1 – 5 4	Staff interviewed reported in the 12 months before the review, no members left the area without a referral for ongoing services. Six members left the team with a referral for services to a new location and the team assisted the members with locating a new provider and scheduling the initial appointment. Six members returned to the Department of Corrections, two members transitioned to a higher level of medical care, and 11 members died. There were nine members that could not be located during the past year and were closed, for a total 11% drop-out rate from ACT services.	• 95% or more of the ACT team caseload should be retained over a 12-month period. Consider other methods of outreach to ensure members are reached to lower the drop-out rate. Several factors can impact this number positively including admission policies, consistency in staffing, natural support involvement, assertive engagement practices, and taking a recovery perspective with member care.
S3	Assertive Engagement Mechanisms	1 – 5 5	During the program meeting observed, members were identified as needing outreach due to lack of contact with the team. Staff were identified as having responsibilities to outreach the member in the community. Staff report the team follows an outreach process and protocol consisting of placing the member on an eight-week outreach plan that involves multiple attempts to contact weekly via phone and in-person. This coordination was noted in the program meeting observed. Records reviewed showed attempted visits and	

			phone calls to members that were out of contact with the team.	
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 42.25 minutes. The highest rate of intensity was 260 minutes. Two records reviewed had no in-person contact by the F-ACT team, however, both members did receive telemed services as they were incarcerated at the time of the review. *The fidelity tool does not accommodate delivery of telehealth services.*	• ACT teams should provide an average of two 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. • Agency leadership may want to meet with the F-ACT team to discuss barriers that prevent them from increasing service intensity to members. This may include an assessment of staff retention practices, available technology, schedules, and staff workloads.
S5	Frequency of Contact	1 – 5 2	Of the ten member records randomly sampled, F-ACT staff provided an average frequency of 1.63 contacts to members per week. The member with the highest frequency of contact by the team had less than four contacts a week. Six members had less than two contacts a week on average. Members interviewed stated that they were seen between zero and one time over the past week. During the program meeting observed, members were discussed that needed a weekly contact, however, no-one on the team was assigned to make the contact and the team moved to the next member listed. Median phone contact by the team to members was one contact a week.	• Increase the frequency of contact with members, preferably averaging four or more in-person contacts a week. 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 F=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.

S6	Work with Support System	1 – 5 4	Staff reported that supporting natural supports of members is part of the responsibilities of the job. Multiple staff interviewed reported connecting with natural supports. One member reported the team reaches out to their natural supports twice a week. Records reviewed also indicated contacts with member's natural supports. Of the ten records randomly sampled, the average team contacts with natural supports were 2.8 times a month. The F-ACT team was active at reaching out to natural supports regarding the members who were incarcerated as well.	• Continue efforts to engage members' natural support systems as key contributors to the member's recovery team especially when supports are identified in members' service plans. Staff should aim for four or more contacts per month for each member's support system in the community.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff reported that there are 59 members on the team with a co-occurring disorder. The SAS reported having 23 of those members on their caseload and that there is another staff on the team that provides therapeutic services to a handful of members to help balance the caseload. There are currently at least 13 members that are attending scheduled individual substance use treatment sessions on a regular basis. Staff engages members to participate in substance use treatment services, but some have opted out of services. Of the records reviewed, 22% of members with a co-occurring disorder were engaged in one-to-one substance use treatment sessions by the SAS in the month period reviewed.	• Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with the co-occurring diagnosis.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The SAS facilitates two Integrated Dual Disorders Treatment (IDDT) groups for members of the ACT team weekly. Twelve (20%) unique members attended a group during a recent month reviewed. Staff reported an average of 10 members attend per session. Sign in sheets provided to reviewers showed the groups being offered every Thursday and Friday. Staff report the treatment models	• The team should continue their efforts to engage members in group substance use treatment in the safest manner possible. The SAS should continue to collaborate with other team specialists to engage members in co-occurring group participation with the goal of at least 50%

			utilized include Integrated Dual Disorders Treatment, Cognitive Behavioral Therapy and the SAS focuses on emotions and behaviors along with the *stage-wise approach* to substance use treatment.	of members with co-occurring diagnoses attending once monthly. • When fully staffed, 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.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 5	The SAS reports providing services that center on Integrated Dual Disorders Treatment (IDDT) components, focusing on a non-confrontational, stage-wise treatment model, and following behavioral principles. The SAS has no expectations of abstinence, unless identified by the members as a goal. Other staff interviewed were also familiar with the stage-wise approach, supported harm reduction over abstinence, and stated the team meets members where they are at without judgement. Reviewers observed members' stages of change being identified during the program meeting. The team does not actively refer members to 12-step programs in the community, but if members are attending, the team will support them if it is a positive experience. Review of member records echoed what staff reported, using a non-judgmental approach with members and their use, and providing opportunities to consider steps toward recovery such as attending a group offered by the team. Most treatment plans for members with a co-occurring disorder (COD) were written in the member point of view, person centered, and identified services the team would provide to support recovery.	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as IDDT, in the principles of a stage-wise approach to interventions, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate for new or less experienced staff. Identifying a co-occurring disorder model that the team adheres to can promote continuity in the approach that F-ACT specialists use when supporting members in their recovery.

S10	Role of Consumers on Treatment Team	1 – 5 5	Staff interviewed stated there are staff with lived psychiatric recovery on the team and at least one shares their story of recovery when appropriate with members. These staff are full-time F-ACT employees with full professional status. One staff shares their life experience to help the members relate to them and connect over common struggles. One member interviewed was aware of several staff with lived psychiatric recovery, the other member believed all peers had left the team.	
Total Score:		**108**		

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	3
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	3
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	5
4. Responsibility for Crisis Services	1-5	5

5. Responsibility for Hospital Admissions	1-5	2
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	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	4
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	5
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.86**	
Highest Possible Score	**5**	