ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 6, 2017

To: Frank Scarpeti, CEO
Michelle Swann, F-ACT 2 Clinical Coordinator

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

Method

On January 9-10th, 2017, Georgia Harris and Karen Voyer-Caravona completed a review of the Community Bridges, Inc. (CBI) Forensic ACT (F-ACT) team 2. 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. is a provider of integrated healthcare for individuals and their families in Arizona. CBI's range of services include: women and children's programs, crisis stabilization, prevention education, intensive outpatient programs, and Assertive Community Treatment (ACT). The team was assumed by CBI from the People of Color Network (PCN) on October 1, 2015. The CBI Forensic ACT team 2 is one of four ACT teams at CBI. The F-ACT team 2 is currently located within the Human Services campus in Central Phoenix and serves members located across Maricopa County that are dually-involved in the judicial and behavioral health system of Arizona.

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

During the site visit, reviewers participated in the following activities:

- Observation of a daily ACT team meeting on January 9, 2017;
- Individual interview with Team Leader/Clinical Coordinator (CC);
- Individual interviews with Substance Abuse Specialist (SAS), Housing Specialist (HS) and Peer Support Specialist (PSS);
- Charts were reviewed for 10 members using the agency's electronic medical records system;
- Review of agency documentation such as the *MMIC F-ACT Admission Screening* and resumes of ACT specialty staff members.

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:

- F-ACT team admission is evaluated through the combination of Regional Behavioral Health Authority (RBHA) ACT criteria and the scores from additional tools used to assess the potential for members to recidivate. The team closely adheres to these criteria and does not report any organizational pressure to admit members who do not meet the standards.
- The team maintains a low graduation rate; candidacy is often limited to members who demonstrate capability though reduced reliance upon ACT services and absence of admission to institutionalized settings (i.e. incarceration and hospitalization).
- The team has a full-time Peer Support Specialist. The team is also comprised of multiple staff that self-identify as persons with a lived experience in Behavioral Health. All self-identified staff provide experience-based support to members as they deem appropriate.

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

- The data provided reflects that the CC delivers direct services to members on rare occasions. Though staff acknowledged the low rate of CC contacts, they did not identify any potential causes. The agency should explore the role of the CC; examine the assigned duties and current priorities, with the aim of placing more focus on direct service involvement.
- The data and interviews suggest that the team is providing less than 50 minutes of face-to-face service to members per week. Though the current contact strategy seemed effective in keeping staff focused on current member issues, it lacked the structure to ensure that members were seen sufficiently to support their individual needs. Review the current plan for opportunities to meet more proactively with members.
- The team displayed little evidence to support their involvement with natural support systems. The ACT team should attempt to increase support system involvement through outreach and education to both the members and existing supports about the benefits of being part of the clinical partnerships.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team maintains a low member-to-staff ratio. The ACT team has ten (10) staff that serves eighty-eight (88) members. The team consists of one Clinical Coordinator (CC); two Substance Abuse Specialists (SAS); one Rehabilitation Specialist (RS); one Independent Living Specialist (ILS); one ACT Specialist (AS); one Employment Specialist (ES), one Registered Nurse (RN); one Peer Support Specialist (PSS); and one Housing Specialist (HS). The Psychiatrist is not included in this count.	
H2	Team Approach	1 – 5 4	The team mostly practices a team approach to service delivery. Of the ten records reviewed, it was determined that 70% of the members had face-to-face contact with multiple team members, in a two week period. Each day, the team creates their contact/outreach schedule. The team focuses first on members who have pressing needs. Second, each staff volunteers to visit a portion of the remaining members. The team's Program Assistant (PA) helps to track member contacts by giving staff daily reminders to visit members who have not had sufficient contact with the team.	• Continue working to improve the team approach to services by ensuring sufficient rotation of staff visits to members.
H3	Program Meeting	1 – 5 5	The team meets often to review services for each member. The team meets four days a week, Monday-Thursday, for one hour. The team does not have meetings on Fridays. The team was observed discussing every member on their roster. All staff are expected to attend the daily meeting.	
H4	Practicing ACT Leader	1 – 5 2	The CC provides services on rare occasions as backup. The CC reported that approximately 20-25% of her time is spent in direct care to members.	• The ACT CC should provide services to members at least 50% of the time. • Though no specific barriers were

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			Upon review of productivity data provided by the agency, approximately 4.2% of the CC's time was spent in direct practice. Of the ten records reviewed, the CC had five episodes of care. The CC notes consisted of medication observation and a mindfulness group. None of the ACT staff or members reported any challenges withholding the CC from meeting this expectation.	highlighted, the agency may benefit from a full review the administrative requirements for the CC. Confirm if all duties are required by the agency and/or the RBHA. • If all administrative activities are deemed essential, determine if there are other clinical supports that could acquire these tasks, releasing the Team Leader to provide increased direct service to members.
H5	Continuity of Staffing	1 – 5 3	The team lost 14 staff in the past 24 months. The team lost two staff in 2016 and 12 staff in 2015. This resulted in a 58.3% turnover rate. Staff did not speak to the turnover challenges of 2015; however, they stated that within the past year, the team has been stable in its consistency.	• Though the team experienced minimal turnover in the past 12 months, the team should work to prevent any further attrition. The agency should explore and continue any efforts to receive feedback on employee satisfaction.
H6	Staff Capacity	1 – 5 4	The team has operated at approximately 94% of staffing capacity in the past 12 months The team has been without a second RN for the past eight months and without a Peer Support Specialist for one month. The team plans to fill both of these positions in January 2017. The CC stated that the previous RN left for a more medically-based practice; although the prior PSS was an internal hire, that person no longer felt the ACT team was the best career fit.	• Thoroughly vet candidates to ensure they are the best fit for the position and the demands of an ACT level of service.
H7	Psychiatrist on Team	1 – 5 4	The team has a full-time Psychiatrist who resides in another state. The Psychiatrist interacts with the members through Telemedicine/videoconferencing and with the staff by phone. The Psychiatrist attends all the team meetings by phone and is not allotted additional responsibilities. The Psychiatrist's Telemedicine	• Though the Telemedicine arrangement is accepted by most participating members, there remain some people who prefer a Psychiatrist who is physically present. The agency should consider its options for obtaining a Psychiatrist who can meet with

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			portal is occasionally transported to members' homes or hospitals for appointments. The staff and members report that the Psychiatrist is accessible and schedules in-person meetings when she travels to Arizona quarterly. When emergencies arise, the staff are able to transport the Telemedicine device to the emergency site; however, no indication was made regarding the protocol for implementing this type of arrangement. In fact, the RN is viewed as the "gatekeeper" between the staff and the Psychiatrist; staff schedule all contact with the Psychiatrist through the RN. Though most members are comfortable with the Telemedicine arrangement, some members said they would prefer in-person appointments because interacting with an on-screen Psychiatrist feels "unreal" at times.	members in person or make a more regular schedule of the Psychiatrist's visits to meet with members.
H8	Nurse on Team	1 – 5 3	At the time of review, the team had one, full-time RN. The CC stated that an additional RN will join the team in the later part of January. The team's current RN provides education and medication to members, attends all team meetings, and serves as the access point between the team and Psychiatrist for member assessments and emergencies. The RN does not have additional responsibilities aside from the F-ACT team.	• The F-ACT team needs to continue with its plans to hire a second RN.
H9	Substance Abuse Specialist on Team	1 – 5 5	The team currently has two SASs. One SAS is a Licensed Associate Counselor (LAC) and has worked with the Dual Disorders population throughout her internship and her tenure on the team. She has been with the team for over one year. The second SAS is a Licensed Master Social Worker (LMSW) and has worked with the Dual Disorders population for over one year. Reviewers were also provided with clinical supervision	

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			records which reflected ongoing training from the agency for both SASs.	
H10	Vocational Specialist on Team	1 – 5 3	The team currently has two Vocational Specialists who provide group and individual treatment services. The RS is a certified PSS and has worked on the team for over one year. The ES has been with the team for over one year; however, reviewers were told that most of his training for his position is derived from personal employment experiences in his recovery journey. Reviewers were told that both the RS and ES attend the in-person and online trainings provided by the RBHA, but no specific training records were provided to verify these claims.	• The agency should maintain up-to-date training records for all staff. Training records may assist supervisors to assess the needs and information gaps experienced on the team. • Create regular training opportunities for vocational specialists to receive education on vocational best practices for SMI members.
H11	Program Size	1 – 5 5	At the time of review, the team had 11 staff. The team is of sufficient size to consistently provide services and staffing coverage when needed.	
O1	Explicit Admission Criteria	1 – 5 5	The F-ACT team operates from explicit admission criteria, as outlined in the *MMIC F-ACT Admission Screening* Tool. In addition to the general ACT standards, F-ACT members must have an increased "risk to recidivate to incarceration" based on a number of scoring measures. Staff reported that the team limits all admissions to the outlined criteria. Also, staff did not recount any instances where the team was required to receive anyone who did not fit the requirements.	
O2	Intake Rate	1 – 5 5	The team maintains a low intake rate. The reported, six-month admission rate is as follows: June- zero admissions; July- zero admissions; August- zero admissions, September- one admission; November- three admission; and October - two admissions.	
O3	Full Responsibility for Treatment	1 – 5 4	In addition to case management, the team provides psychiatric services, counseling, and	• The agency and/or F-ACT team should work to develop appropriate resources

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	Services		substance abuse treatment. The team provides psychiatric care to all of its members. Both of the SASs provide weekly substance abuse groups and counseling to members. Also, approximately six members have weekly, general counseling appointments with the SASs. Staff report that 20-30% of F-ACT members are working on employment goals. However, the team has 4.5% of members referred to a RBHA provider for employment assistance. Staff feel these referrals are "appropriate" because they have "more resources than we do" in this area. The team plans to continue referring to employment providers. The team provides housing and Independent Living Skills services to members through the assigned HS and ILS specialists. However, About 12.5% of members currently live in residences that provide some case management services (e.g. 24 hr. residential). Around 5% of all members live in homeless shelters that provide additional support services to members. Moreover, staff reported that members with criminal histories often experience challenges in obtaining suitable housing.	to fulfill members' employment services and not outsource to other providers. • The F-ACT team should continue to assist members to find homes that do not duplicate ACT services.
O4	Responsibility for Crisis Services	1 – 5 5	The team has 24-hour responsibility for crisis services to F-ACT members. The CC said that the on-call phone is rotated between F-ACT staff daily.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The team was directly involved in 80% of the ten most recent hospitalizations. Two of the admissions were petitions initiated by the local police department. The F-ACT team was informed after the members were admitted.	• The team should continue to educate members and community partners (such as police departments) on the role of the F-ACT team in hospital

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				admissions.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	The F-ACT team was involved more than 90% of all hospital discharges. Once members are admitted, F-ACT staff rotates visits to members. The staff participates in discharge planning with hospital social workers and are there to transport members home upon release. Members are scheduled to speak with the Psychiatrist within 48 hours and placed on a five day follow up plan with the F-ACT team.	
O7	Time-unlimited Services	1 – 5 5	The F-ACT team rarely closes member cases. The team reported zero graduations in the past 12 months. Staff reported that they are not expecting any graduations within the year. The ACT team maintains the standard that prospective graduates should maintain a year without incarceration/hospitalization, as well as ongoing fulfillment with their treatment plans.	
S1	Community-based Services	1 – 5 3	F-ACT staff provide their services to members in both the community and the office settings. Staff estimated around 80% of their contacts were in the community. According to the review of ten randomly selected records, the team provided 53% of their face-to-face contacts in the community. The majority of members interviewed echoed the results of the record review, stating that the staff see them at home and in the office equally. Members and staff also reported that some of the members come into the office for groups throughout the week.	• ACT teams should provide 80% of their contacts in community settings. The team may benefit from expanding their current tracking system to include location of service provision. • Ensure that all encounters with members are accurately documented within the clinical record. • Review the team's current activities to ensure that skills training, specialty services, and/or treatment sessions are taking place in community settings. Member outcomes improve when new skills are taught in the settings where they naturally occur.
S2	No Drop-out Policy	1 – 5 5	The team retained more than 95% of their caseload over the most recent 12-month period.	

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			Both of the members who were closed had moved out of state unannounced. One returned and reopened with the team. The other member remains out of town, but the team maintains contact with his support system. In both instances, the team coordinated with families to ensure each member had their medications and to confirm their safe arrival.	
S3	Assertive Engagement Mechanisms	1 – 5 4	The team often has a plan for engaging members who have lost contact with the team. The team did not acknowledge any written contact strategy; however, staff reported that the team attempts to tailor their engagement strategy to the members' known contacts and individual lifestyle. Staff will often contact family and friends or visit places the members frequent to find them. The team does not consider closing members until eight weeks of attempted contact have been completed.	• The agency and/or F-ACT team should consider creating a written document outlining the general contact strategy guidelines for assertive engagement. This can prove to be useful for onboarding new staff or ensuring that all staff have thoroughly investigated all available options when searching for a member.
S4	Intensity of Services	1 – 5 2	According to the member record review, members received an average of 49.25 minutes of face-to-face services per week. Members reported seeing staff in both the clinic and community settings, but they varied greatly in their views on the intensity of services. Most members agreed that the team will adjust both their frequency and intensity of contact as needed (or requested) by the member.	• Staff must focus on increasing their face-to-face service time to an average of two or more hours per week, per member. • As stated in the S1, Community-based Services recommendations, staff should facilitate any skills training, groups, or therapy session in more natural settings, not in the clinic.
S5	Frequency of Contact	1 – 5 3	The record review indicated that the team provides an average of 2.25 face-to-face contacts per week. F-ACT staff stated that the team creates their schedules daily, and visits are scheduled based on the immediate needs of the members. Then, the remaining members are scheduled based on their paperwork needs (e.g. Individualized Service Plan) and/or number of visits	• The ACT team should average four or more contacts per week, per member. • The team should revisit their current contact strategy. ACT is designed to be needs-driven and community based, providing members with intense, frequent contact with multiple ACT staff. Change any element of the

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			they have had already.	current strategy that does not promote these efforts.
S6	Work with Support System	1 – 5 1	The team displayed little evidence to support their involvement with natural support systems. Staff estimated that approximately 20-25% of all members have identified natural supports, and they estimate monthly contact with around 10% of member supports. Staff also report that they provide weekly phone calls to natural supports. Staff stated that they used to hold a support group for natural supports; however, it was discontinued due to low attendance numbers. Additionally, the member record review provided little support for the team's involvement with support systems; out of the ten records reviewed, the team provided approximately half a contact a month to supports.	• The ACT team should attempt to increase support system involvement. The team should regularly review with members the potential benefits of allowing the team to engage their informal supports. • If a family member or other support is involved, continue efforts to coordinate with those supports when members are doing well and when experiencing challenges. Establishing communication may allow the team to provide education regarding serious mental illness, and to enlist informal supports to advocate with members, if needed. • Focus on documenting team contacts with supports to ensure they are accurately reflected in the records.
S7	Individualized Substance Abuse Treatment	1 – 5 3	At the time of review, the team had 67 members identified with a Dual Diagnosis. Staff reported that the team's SASs schedule individualized substance abuse treatment with 18 members. Some are seen weekly and others are seen on a bi-weekly basis. Each session lasts for approximately 45 mins. Though some members meet with the SASs for treatment, the record review did not reflect the level of treatment that was described to reviewers. The content of staff notes for these sessions reflected routine home visits rather than focused, individualized sessions.	• Continue efforts to engage members with a co-occurring disorder in individualized substance abuse treatment. • Though DD treatment was integrated into regular member contact, SAS staff should ensure that members who agree to individualized treatment are aware they are participating in a substance abuse session, and have clear treatment goals for each session noted in the record.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The team provides two co-occurring treatment groups. The Thursday group is facilitated by one SAS from the F-ACT team 1 and One SAS from this	• Continue to engage members with dual diagnosis to come to group. The F-ACT team should have 50% or more of

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			F-ACT team 2. Both groups are focused on members who are in the "action stage" of their recovery. The attendees for this group are a combination of the F-ACT 1 and F-ACT 2 teams. The Friday group is for F-ACT 2 members only. This group is focused on members who are dually diagnosed, but also experience more acute behavioral health symptoms. Approximately 23% of all DD members attend at least one of the two groups on a monthly basis. The staff reported they use a combination of the Hazelden curriculum for IDDT groups and the MMIC Substance Abuse curriculum.	these members engaged in DD groups. • Consider groups for different stages of change to accommodate more members in various levels of treatment…(same as previous language)
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The team currently uses a mixed model approach to treating co-occurring disorders. Though staff interviewed were able to articulate their use of harm reduction techniques, they varied greatly in their ability to identify the elements of a stage-wise treatment approach. The SAS and the CC were able to identify the Stages of Change model, as well as give some examples of harm reduction activities. It was reported that some members participate in Alcoholics Anonymous (AA) support groups outside of the clinic and some members have been referred to detox centers when the team deems it to be a medical necessity. Some staff on the team have received some IDDT training; however, the team as a whole is grounded in the Stages of Change approach.	• Train all staff in a stage-wise approach to treatment; interventions should be aligned with a member's stage of treatment. Train staff on the activities that align with member's stage of treatment and how to reflect that treatment language when documenting the service. This may better equip other ACT staff to engage members in individual and group treatment through the team.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has one full-time Peer Support Specialist (PSS). The PSS joined the team nearly one week prior to the review. Though the PSS position was only recently filled, the ACT team is comprised of multiple staff that self-identify as persons with a lived in experience in behavioral health. Staff and members reported that these identified staff uses	

Item #	Item	Rating	Rating Rationale	Recommendations
			their personal experiences to provide ongoing, empathetic support to members.	
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	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	4
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	3
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	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	3
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	3
6. Work with Support System	1-5	1
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**108/28=3.86**	
Highest Possible Score	**5**	