ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: October 6, 2017

To: Lauren Walker, F-ACT 1 Clinical Coordinator
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AHCCCS Fidelity Reviewers

Method

On September 5-6, 2017, T.J. Eggsware and Georgia Harris completed a review of the Community Bridges, Inc. (CBI) Assertive Community Treatment (ACT), Forensic 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 Maricopa County.

Community Bridges, Inc. has a 31-year history of providing services, with locations across Arizona. CBI operates five ACT teams, three of which are identified as Forensic ACT (F-ACT) that are located in central Phoenix, AZ and two traditional ACT teams located in Avondale, AZ. This review focuses on F-ACT 1, which is one of the three F-ACT teams stationed at the Lodestar Day Resource Center, amid the multiple agencies serving the homeless communities of Phoenix. The agency website describes how ACT services are implemented at CBI; it notes there are "mutual expectations between the team and its patients that are met collaboratively" which include "face to face engagements at least 4 times per week, creating and developing support systems, maintaining home visits, all in an effort to help identify and work towards patient goals."

The individuals served through the agency are referred to as *patients* or *clients*, but 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:

- Observation of the F-ACT team meeting on September 5, 2017;
- Individual interview with Clinical Coordinator (i.e., Team Leader);
- Individual interview with the team Substance Abuse Specialist (SAS);
- Group interview with the team Housing Specialist (HS), and Peer Support Specialist (PSS);
- Group interview with seven members served by the team;
- Review of ten member records using the agency's electronic health records system; and,
- Review of agency documents and resources including: *F-ACT Admission Screening* form developed by the Regional Behavioral Health

Authority (RBHA), outcome tracking documents, training records, group descriptions, agency website, etc.

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:

- Members interviewed reported they were aware many staff have similar lived experiences as the members, and cited this was of value in creating and maintaining therapeutic relationships.
- The F-ACT team has two Nurses, who are reported by staff and members to play a vital role in services delivered by the team. The Nurses provide services in the office and in the community. The Nurses encourage members with co-occurring challenges to participate in treatment through the team, and work with those members to increase their awareness of the impact of substances on their health.
- Though multiple clinic-based groups are facilitated by F-ACT staff, documentation confirmed staff reports of a high percent of services delivered in the community.
- The team works with a variety of member supports (e.g., Probation Officers, payees, guardians, other health care facilities) as part of their assertive outreach to assist members in their recovery.

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

- The F-ACT team should increase the frequency of services to members; ensure all direct services to members and outreach efforts are documented.
- Though the team uses tracking tools, the results of some of these did not coincide with the results of the record review. The team should revisit current agency tracking tools to ensure their accuracy and validity.
- Increase engagement of member informal support networks; build and expand current engagement efforts such as the natural supports group. Seek training or guidance on techniques to help members understand the benefits of engaging informal supports, as well as techniques on how to effectively engage informal supports in treatment.
- Focus efforts on groups that are specifically identified for co-occurring treatment, with supervision and guidance to those staff who are expected to provide that service to the members. Multiple groups are facilitated by F-ACT staff, and it was reported all were based in co-occurring treatment. However, based on review of group curriculum and resources it was not clear if all groups were based in co-occurring treatment; some focused on a primary symptom or general focus area. Additionally, based on review of group sign in sheets, it was not clear if all members who participated in the groups were those members who experience co-occurring issues.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team serves 95 members with ten staff who provide direct services (excluding the Psychiatrist), resulting in a member to staff ratio of approximately 10:1.	
H2	Team Approach	1 – 5 4	Per report, staff are assigned caseloads in order to complete paperwork (e.g., demographic data, treatment plans), but otherwise the team appears to generally function with a shared caseload. Members interviewed confirmed there are multiple staff on the team they can contact directly for support. The CC estimated 80% of members see more than one staff over a two-week period, which was consistent with a review of ten member records that yielded the same result.	• Ensure the majority of members have contact with more than one staff over a two-week period, and that all services are documented.
H3	Program Meeting	1 – 5 5	A program meeting when all members are discussed is held four days a week; with a fifth day set aside for more detailed review of members experiencing acute issues. The team Psychiatrist attends one meeting a week in person on the day she works out of the team meeting location, but is available by phone if needed for consult when not in attendance. During the meeting observed by reviewers, staff reported the amount of time spent providing services to members, in some cases projecting the duration of contacts yet to occur. In addition, service time duration was tracked during the morning meeting, but the reviewers were uncertain whether this supplemental tracking limited staff discussion of more relevant member issues.	• Due to the intended focus and time-sensitive nature of the daily meeting, consider eliminating the review of administrative tasks such as tracking completed (or projected) member contact time. The purpose of the daily team meeting is to discuss concerns, treatment, support planning, recent member contacts, and plan future contacts, but not necessarily to track duration of services provided.
H4	Practicing ACT Leader	1 – 5 4	The CC provides services routinely based on report and documentation. The CC estimates her time providing direct services at around 30%; this was	• CC should provide direct services 50% of the time; ensure all direct service contacts are documented. Review what services the

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			slightly higher than a recent productivity, which showed just over 25% of the CC's time was spent in direct service provision. The CC noted administrative duties, serving as the primary point of contact for major issues, supporting staff to document services, and shadowing them in the field as barriers to her increased provision of direct services.	CC can document if she is shadowing or mentoring other staff as they engage with members directly.
H5	Continuity of Staffing	1 – 5 3	Three of the ten staff who left the team were promoted to the role of CC on other CBI ACT teams and are factored into the turnover rate of about 42% in the last two years.	• Continue efforts to hire and retain qualified staff.
H6	Staff Capacity	1 – 5 5	The F-ACT team operated at nearly 96% staff capacity during the 12 month review timeframe. The PSS position was vacant for two of the last 12 months, and the SAS position was vacant for four months, but was slated to be filled by September 11, 2017. The potential negative impact of staff turnover was moderated by quickly replacing staff, such as the Psychiatrist position remaining vacant for less than one week.	
H7	Psychiatrist on Team	1 – 5 4	The team Psychiatrist started with the team in January 2017. In part, to accommodate meeting with F-ACT 1 members who reside throughout Maricopa County, the Psychiatrist rotates days at different CBI facilities (e.g., east, west and central locations). Staff reported that the Psychiatrist was accessible, and visits with people who are in hospitals or other facilities, but that completing home visits was not an efficient use of her time. Approximately 20% of the Psychiatrist's time is spent providing coverage to another agency ACT team that has no full-time Psychiatrist. Staff reported the Psychiatrist was an asset to the team, but one staff noted that due to concern with	• Due to the member census, optimally the full-time team Psychiatrist should have no other duties other than direct services to F-ACT 1 members. Reducing the coverage the Psychiatrist provides to the other ACT team may allow her more flexibility in providing services to F-ACT 1 team members, such as the opportunity to provide a broader array of community-based service.

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			possible "burnout", they hoped the agency would add additional Psychiatrists. It was reported the Psychiatrist has no other administrative duties.	
H8	Nurse on Team	1 – 5 5	The team has two full-time Nurses, identified as Integrated Nurses, for the 95-member program. Based on observation, as well as staff and member report, the Nurses on the team provide services that are flexible to meet the needs of the members, and include traditional nursing services, coordination with other healthcare providers, as well as case management, and community-based supports. Some members interviewed confirmed the Nurses have met with them in the community.	
H9	Substance Abuse Specialist on Team	1 – 5 3	The team had two SASs from October 2016 through late May 2017 when the second SAS left the team. The one team SAS is a Licensed Associate Counselor (LAC), having earned her master's degree in rehabilitation counseling. In addition to her time on the F-ACT team, the SAS completed a three month practicum at a treatment center; there, she worked with women diagnosed with substance use issues and SMI. Although the staff member's licensure is not specific to substance abuse treatment, she has more than a year experience when factoring the practicum work in addition to her 11 months working in the role of SAS with the F-ACT team. The SAS reported she receives individual clinical supervision twice monthly, and monthly group supervision from an independently licensed professional.	• The addition of the second SAS should enhance the team's ability to provide substance abuse treatment to members with COD challenges. Optimally, due to the number of members served, the team should be staffed with at least two people who have at least 1 year of training or clinical experience in substance abuse treatment.
H10	Vocational Specialist on Team	1 – 5 5	The team has two vocational service staff: a Rehabilitation Specialist (RS) and Employment Specialist (ES) who joined the team in July 2016 and May 2016 respectively, and there is evidence	

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			the ES and RS work with members to address vocational goals. In a prior position, the RS reportedly assisted members with interviews, resumes, and resources to obtain employment as an element of his duties. The ES had limited prior experience in vocational services before joining the team, including about four months in a position where tasks included assisting with resumes, job development, and the employment search, among other duties.	
H11	Program Size	1 – 5 5	With 11 staff on the team (excluding administrative support), the team is of sufficient size to provide coverage and a range of services.	
O1	Explicit Admission Criteria	1 – 5 5	Member referrals come to the team through various sources (e.g., staff associated with the criminal justice system, institutions, or lower level of service teams) funneled to the team through the RBHA. Referrals are screened by F-ACT staff using the *F-ACT Admission Screening tool* developed by the RBHA and 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 team maintains a low intake rate. The peak intake rate in the six months prior to review was two members for the months of March, June, and August 2017, in addition to one intake for July 2017 and zero intakes for April and May 2017.	
O3	Full Responsibility for Treatment Services	1 – 5 4	Although staff are assigned primary caseloads, members confirm they are aware of specialty positions and a spectrum of services available through the team. In addition to case management, the F-ACT team directly provides psychiatric services and medication management, substance abuse treatment, and most employment or rehabilitation support. Staff reported the team	• Explore alternative independent living situations where the F-ACT team can support members for those living in staffed residences or locations where staff other than the F-ACT team provide support. • Ensure members and stakeholders are aware counseling/psychotherapy is available through the team and that

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			provides counseling, but there was no evidence counseling was available other than for substance use treatment. Based on information gathered during staff interviews, more than 10% of members are in residences with external staff support. Monthly outcomes data was provided for June 2017, but it was not clear if the data was accurate at the time of the fidelity review, as the numbers reported during interviews did not all match the living situations listed on the outcome tracking. Additionally, the employment data on the outcomes tracking report for June 2017 differed from what was reported by staff who were interviewed. There were discrepancies in the reporting of member participation rates in work adjustment training, as well as the reported rates of those who are employed and/or looking for work. When discussing the use of external WAT programs with reviewers, staff reported that some members elect to pursue WAT because they do not have to prepare for an interview, the setting is less intimidating, and requires no training to start.	ongoing supervision is provided to staff who will provide that service. • As part of career development, ensure both vocational support staff receive supervision and training related to vocational services that enable members to find and keep jobs in integrated work settings. Examples of training focus areas include: engagement, job development and placement supports, benefits education, and follow-along supports.
O4	Responsibility for Crisis Services	1 – 5 5	Per staff report, the F-ACT team provides 24-hour coverage. On-call duties are rotated between staff who are assigned one recurring day weekly, and the CC reported she serves as backup. Members rarely call the crisis line and the team does not rely on mobile crisis teams. Members are informed of the team role in crisis response at team intake.	
O5	Responsibility for Hospital Admissions	1 – 5 4	The team works with members to enhance skills on an outpatient basis in an effort to divert hospital admissions when possible. If necessary, the team will take members to hospitals to seek	• Ensure consistent contact is maintained with all members served and their support network, which may result in the

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			inpatient services, or will complete petitions for court-ordered evaluation (COE) or amendments to standing court ordered treatment (COT). Staff reported the team follows the RBHA ACT manual regarding hospital admissions. Per report, when members are inpatient, staff aim to visit with members every 72 hours (including weekends) and participate in weekly staffings with inpatient staff (e.g., Social Workers and occasionally inpatient Psychiatrist). The team Psychiatrist always contacts the inpatient doctor for coordination as soon as the team learns of member admissions. There was discrepancy in data provided regarding recent member hospital admissions. Based on the outcomes tracking document provided, member psychiatric hospital admissions for a recent three month period included three in July 2017, six in June 2017, and six in May 2017. However, when reviewing recent admissions with the CC, it was reported four members were admitted to a psychiatric setting in each of the months of June and July 2017. Based on data provided by the CC, the team was involved in nine of the last ten reported psychiatric admissions, but other staff estimated the team was involved in seven of the last ten psychiatric admissions, noting some members self-admit without informing the team.	identification of issues or concerns that could lead to hospitalization.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff report they are involved in all hospital discharges, including visits with members every 72 hours, coordinating with inpatient Social Workers, staffings with inpatient team and supports, which the team Psychiatrist may attend, planning for safe living arrangement, transporting members at discharge, and face-to-face contact for five days following discharge. Based on review of recent	

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			admissions, it is evident that the team is actively involved in discharge planning. However, in one record reviewed a member was discharged, but five days of face-to-face contact was not documented.	
O7	Time-unlimited Services	1 – 5 5	All members are served on a time-unlimited basis; two members graduated in the 12 months prior to review, and two to three members are projected to graduate in the next 12 months.	
S1	Community-based Services	1 – 5 5	The Psychiatrist usually provides office-based services, but does visit with members in the hospital. The Nurses offer some office-based services, but often provide services in the community. Though F-ACT staff facilitate multiple clinic-based groups at CBI clinics, staff still provide many direct services to members in the community. Two staff estimated 75% and 95% of their time was spent providing community-based services. Based on review of ten member records, a median of 82% of direct services to members occur outside of CBI facilities, with only one member who received no community-based contacts. Staff have laptops and smart phones to support their provision of community-based services, as well as access to agency cars.	
S2	No Drop-out Policy	1 – 5 5	Per staff interviews, the team usually finds members before needing to close them from ACT services. Based on data provided for the 12 months prior to review, one member left the geographic area without referral, no members refused services, and none were closed due to the inability of the team to locate them and/or after the team determined they could not be served. Staff reported that they conduct outreach for at least six week, but generally do not close members	

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			due to lack of contact. If the team could not locate a person after a period of outreach they would be transitioned off the team into a *navigator status*, but that no members have transitioned off the team to that status.	
S3	Assertive Engagement Mechanisms	1 – 5 5	The team coordinates with Probation or Parole Officers (PO). Some members elect to have urine drug screens completed by the team rather than the location identified by the legal system. The team does not report results unless requested and informs the members of the consequences if they are asked (by PO) to report a positive drug test. Coordination with payee services includes working with members regarding how to interact with payees, but the team does not request that payees hold checks until they make contact with the team. The team also coordinates with guardians, and this was documented in one record reviewed. Staff reported recently utilizing Care Unify to locate a member following contact with an urgent care setting. Staff reported that they do not close members, but that their job is to graduate people. If members are not in contact with the team, staff said they locate them "one way or another". Staff cited an example of the team Program Assistant seeing a member on her way home and calling another staff so they could conduct outreach to the area.	
S4	Intensity of Services	1 – 5 4	The median intensity of service per member was just over 89 minutes a week based on review of ten member records. A subset of members attended one or more F-ACT staff facilitated group during the month, but members also received individualized support in the community. However, most notes reflected service durations divisible by 5 or 15, which seemed to indicate actual service	• Increase the intensity of services to members, with a goal of averaging two hours a week or more of face-to-face contact for each member. • The lack of nuance in the service minutes recorded in member charts suggests that the precise intensity of services may still be

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			time may vary from documented service time.	unknown. To ensure accuracy of member records, review current chart reporting practices with ACT staff.
S5	Frequency of Contact	1 – 5 3	The median weekly face-to-face contact for ten members was 2.75 based on review of ten member records. Reviewers were also provided a plot graph that tracked face-to-face contacts for March through late August 2017. Based on this, the team averaged just over four contacts per week for a recent four week period, but the source of the data was not located on the document. It was not clear why the plot graph tracking and sample member records did not yield similar results.	• Increase the frequency of face-to-face contact with members, preferably averaging four or more face-to-face contacts a week per member. • The ACT CC should periodically monitor documentation and member record for accuracy and timeliness.
S6	Work with Support System	1 – 5 2	CBI offers a Natural Supports Group the second Tuesday of each month. During the team meeting observed the team infrequently (for about seven members) discussed recent or planned team contacts with informal supports. During interviews, staff estimates of those members with informal supports ranged from 41 – 75%, but staff who estimated 75% noted that about half of those members did not want the team to contact the informal supports. For those with informal supports that the team is authorized to interact with, staff estimated contact occurred at least weekly. There was an average of .9 contacts per month documented in the ten member records reviewed.	• Ensure F-ACT staff review with members the potential benefits of engagement with informal supports, and work to engage the supports in treatment, not only when people face challenges, but to celebrate successes. If attendance is low at the Natural Supports Group, consider soliciting feedback from informal supports on what time of the day or evening is preferred; the group flyer notes the group meets from 12:00 p.m. to 1:00 p.m.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Staff reported that all staff provide individualized substance abuse treatment. Based on training records and documented clinical oversight tracking forms, the team received training and ongoing guidance in substance use treatment, focusing on Integrated Dual Disorders Treatment (IDDT), and	• The addition of the second SAS should enhance the team's ability to provide substance abuse treatment to existing members who receive the support, and seek to increase the number of engaged members.

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			including topics such as stage wise treatment, creating wellness plans, the importance to members and staff to align interventions to stage of treatment, engaging members to build relationships, etc. The team reports 71 of the 95 members served by the team face co-occurring challenges. Per report, 43 of those 71 members receive weekly individual treatment (27 with the SAS, and the remaining with other staff on the team). Session durations were estimated by one staff to be around 30 – 60 minutes, but by another staff to fall between 25 – 45 minutes. Individual substance use treatment sessions documented in records tended to reflect 30 minutes in duration, but examples of consistent weekly sessions were not located.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The program has two weekly IDDT groups: one facilitated by the PSS and another led by the HS. Based on training records provided, it appears both the HS and PSS take part in group clinical oversight supervision where IDDT and related topics are discussed. The program also offers multiple other groups, but based on curriculum provided it did not appear all were based in co-occurring treatment, or directed at that sub-group of members served. Group curriculum documents provided for the mindfulness, mood, and art groups did not appear to be based in co-occurring treatment. Additionally, based on sign in sheets, each of those groups was open to all F-ACT members. For example, two of six members who attended a group were not listed on the COD member roster. On the contrary, all members who attended an identified IDDT group were listed as COD, and only one member who attended the PSS	• The addition of the second SAS should enhance the team's ability to provide substance abuse treatment to members diagnosed with a COD. • Focus efforts on groups that are specifically identified for co-occurring treatment, with supervision and guidance to those staff who provide that service to the members who are most likely to benefit – specifically those who face co-occurring challenges.

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			facilitated IDDT group over a four week span was not listed as COD. For the purposes of this review, the two IDDT groups were factored for scoring in this item. Per sign in sheets, about 25% of members with a COD attended at least one of those groups during a recent four week period.	
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 4	There is evidence the team chiefly uses an integrated dual diagnosis model when working with members who have active substance use challenges, to work with members to build awareness of problems associated with use, and to support those who are in recovery. A brief overview of stage-wise treatment is posted at the agency, and staff identified members' stages of change and stages of treatment. The team approach appears to be non-confrontational, with the team seeking to build a working alliance with members, reinforcing honest communication about substance use, or recurrences of use. Treatment plans appeared to reflect member goals, and some incorporated elements of dual diagnosis principles (e.g., learn to identify triggers). However, it did not appear that a consistent approach is in place to identify member stage of change or treatment. During the morning meeting observed, staff seemed to identify stages in the moment without relying on specific assessment criteria. Additionally, there was some discrepancy in documentation, and it was not clear if information related to recent use or relapse was shared with all staff. For example, one staff documented a member experienced a recurrence of use, but another staff documented two days later that the member had been clean and sober for several months. In another record, staff	• As an aspect of ongoing clinical oversight, consider including review of recovery language, for example noting that a person is *maintaining recovery*, or is *drug free* in place of being *clean and sober*. • Ensure all staff are working from a harm reduction approach. The team would benefit from further review of documenting harm reduction tactics and approach in treatment plans and notes. • Formalize the team approach to assessing and documenting stage of change and stage of treatment.

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			documented a member was in the action stage of change (working to remain sober); ten days later another staff documented the member was in the preparation stage of change, but there were no updates to reflect a change in the member's status over that ten day span. Harm reduction efforts were discussed during staff interviews, and staff cited recent examples of the team using harm reduction tactics. However, in some progress notes it was documented that members were to refrain from substance use.	
S10	Role of Consumers on Treatment Team	1 – 5 5	In addition to a Peer Support Specialist, the team has other direct care staff with a lived experience of recovery from substance use, mental illness, and/or direct personal experience with the legal system. Staff share their personal experiences when it may be of benefit to members. Members confirmed it is helpful that staff on the team have similar experiences.	
Total Score:		**4.32**		

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	4
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	5
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	5
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	5
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
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	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.32**	
Highest Possible Score	**5**	