ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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To: Laura Hulcher, Clinical Coordinator
John Hogeboom, CEO

From: Vanessa Gonzalez, BA
Allison Treu, AS
AHCCCS Fidelity Reviewers

Introduction

Arizona Health Care Cost Containment System has contracted with Western Interstate Commission for Higher Education Behavioral Health Program to conduct Fidelity Reviews using an adapted version of the Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Fidelity Scale. ACT is an evidence-based practice (EBP).

Method

On February 14 – 15, 2023, Fidelity Reviewers completed a review of the Community Bridges, Inc. Mesa Heritage ACT team. This review is intended to provide specific feedback in the development of your agency's ACT services in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

Community Bridges, Inc. (CBI) operates several locations throughout Arizona. Services provided include supportive housing, crisis stabilization, ACT, and integrated healthcare. The agency operates three F-ACT teams and three ACT teams in the Central Region of Arizona. 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.

The SAMHSA ACT Fidelity Review tool does not accommodate the delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing and telephone to interview staff and members.

- During the fidelity review, reviewers participated in the following activities:
- Remote observation of an ACT team program meeting on February 15, 2023.
- Individual video conference interview with the Clinical Coordinator (CC).

- Individual video conference interviews with Housing, Rehabilitation, and Peer Support Specialists for the team.
- Individual phone interviews with four 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; Mesa Heritage ACT Phone Directory; F-ACT Re-Engagement Policy* and resumes and training records for Vocational staff.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. It is a scale that assesses the degree of fidelity to the ACT model along three 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 included as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team, including the Psychiatrist, meets five days a week to discuss members. During the meeting observed, multiple staff contributed to the discussion by reporting on recent and planned contacts with members.
- The team has a full-time equivalent Psychiatrist who is providing services to their ACT team and is available after hours.
- The team has a low graduation rate and maintains 99% of their caseload over the past year.
- The ACT team has a clearly defined target population; the CC conducts screenings of referrals and report no outside pressure to admit members to the team.

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

- Intensity of services was an average of 11.5 minutes per week among ten records reviewed. ACT teams should average two hours per week or more of face-to-face contact for each member.
- At the time of the review, no Co-occurring Disorder treatment groups were being offered to members with a co-occurring disorder. Once a Co-occurring Specialist is hired, it is important to hold group therapy sessions for members.
- Increase contacts with natural supports to an average of four per month for each member with a support system. Continue efforts to involve natural supports in member care.
- Several positions on the team (Nurse, two Co-Occurring Specialists, ACT Specialist, and Independent Living Specialist) are vacant. Filling vacant positions as soon as possible helps to reduce burden on team staff and ensures members do not experience disruption in service due to lack of staff.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, there were 5.6 full-time equivalent (FTE) staff, excluding the Psychiatrist, providing direct services to 86 members. The team has a member-to-staff ratio of nearly 16:1. The team is comprised of the Clinical Coordinator (CC), Rehabilitation Specialist (RS), Peer Support Specialist (PSS), Nurse, Housing Specialist (HS), and a Medical Assistant (MA) that provides direct member services 60% of the time or 0.6 FTE.	• If not done so already, agency leadership should prioritize filling open positions on the team to ensure a 10:1 member-to-staff ratio exists. A small caseload size ensures adequate intensity and individualization of services and minimizes the potential burden on staff.
H2	Team Approach	1 – 5 4	Staff interviewed reported all 86 members have contact with at least two ACT staff each week. Staff utilize electronic medical record tools and member calendars to track home visits. Staff have weekly member assignments which is determined by member zip codes. Some members interviewed reported seeing only one staff from the ACT team weekly while others reported seeing multiple staff each week. According to the ten randomly selected member records reviewed, 80% of members received in-person contact with more than one staff in a two-week period.	• Increase contact of diverse staff with members. Ideally, 90% of ACT members have contact with more than one staff in a two-week period. Team staff are jointly responsible for making sure each client receives the services needed to support recovery from mental illness. Diversity of staff interaction with members allows the members access to unique perspectives and expertise of staff., Because of the number of vacant positions, it may be especially important for this team to follow a team approach as it likely would reduce the burden of responsibility of care on staff.
H3	Program Meeting	1 – 5 5	ACT staff reported that the team meets five days a week, Monday through Friday. Staff review all members from the roster during the program meeting.	

			All staff were present during the program meeting observed, except for the Psychiatrist who was out of the office the week of the review. The Program Assistant went through each member calendar and the team provided updates including stage of change for those with co-occurring diagnoses, most recent contact with natural supports, most recent home visit, medication deliveries, and upcoming appointments. All staff equally contributed to the discussion of members' status.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated delivering in-person services to members 10% of their total time. The CC reported conducting outreach, home visits, assisting with finding housing vouchers, and providing members with individual counseling. According to the ten member records reviewed, one record had one in-person interaction with the CC documented, and another showed one phone call with the CC. Two of the four members interviewed reported seeing the ACT CC in the previous two weeks.	• Optimally, the ACT CC delivers direct services to members and should account for at least 50% of the expected productivity of other ACT staff. Increase in-person member contact. • Identify administrative tasks currently performed by the CC that may be transitioned to other administrative or support staff or other staff, if applicable.
H5	Continuity of Staffing	1 – 5 2	Based on the data provided, the team experienced a turnover of 67% during the past two years. There were 16 staff that left the team. Per data reviewed with the CC; the Co-Occurring Specialist was the most challenging positions to retain. Some members interviewed expressed concern regarding the constant turnover of staff.	• Continue efforts to recruit and retain experienced staff. Attempt to identify causes for employee turnover. The agency may want to consider anonymous employee satisfaction surveys and exit interviews to gather and analyze feedback regarding why staff leave, as well as factors that promote retention. Optimally, turnover on ACT teams should be no greater than 20%. • Ensure staff receive training and guidance applicable to their specialty position. Research shows staff remain in positions longer when supported in their roles.

H6	Staff Capacity	1 – 5 2	Per data provided and reviewed with staff, the ACT team had 62 vacant positions in the 12 months prior to the review, operating at 57% staffing capacity. The team had 12 months without two Nurses, 12 months without an ACT Specialist (AS), six months without a second COS, and eight months without an Independent Living Specialist (ILS).	• Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually. • To ensure diversity of staff, adequate coverage, and continuity of care for members, fill vacant positions with qualified staff as soon as possible. Timely filling of vacant positions also helps to reduce potential burden on staff.
H7	Psychiatrist on Team	1 – 5 5	The ACT team has one FTE Psychiatrist that delivers services by telehealth. The Psychiatrist is accessible after hours by phone and attends the daily program meeting remotely. Records reviewed showed the Psychiatrist providing informal substance use disorder treatment and counseling to some members. Members interviewed reported seeing the Psychiatrist once a month or more frequently when there is a need. Per review of ten member records, the Psychiatrist was active with nine members.	
H8	Nurse on Team	1 – 5 3	The ACT team has one FTE Nurse that joined the team the week of the review. Staff interviewed reported the Nurse provides medication management, case management, health risk assessments, primary care provider coordination, administers injections, and attends specialist appointments with members.	• Continue efforts to recruit and retain a second Nurse to ensure consistency of coverage for clinic-based services, as well as community-based services. Having two full time Nurses is a critical component of a successful ACT program.
H9	Co-Occurring Specialist on Team	1 – 5 1	At the time of the review, both COS positions were vacant.	• Optimally, ACT teams are staffed with two COS, each with a year or more of training/experience providing substance use treatment services. When screening potential candidates for the position, consider candidates with experience working with members with co-occurring disorders.

				• Consider exploring opportunities to provide training in delivery of co-occurring disorders treatment by current staff on the team with interest.
H10	Vocational Specialist on Team	1 – 5 2	The team has one Vocational Specialist staff. The RS joined the team in May 2022, and based on the resume provided had no prior experience of providing services to adults with a serious mental illness in rehabilitation or employment services. Training records provided indicated the RS had completed .5 hour of Employment/Rehabilitation training and 1.0 hour of Disability Benefits 101.	• Ideally, ACT teams have two Vocational Specialists on the team to ensure members' interests and needs for employment are met. When hiring Vocational Specialists, consider experience working with adults living with a serious mental illness. • Provide ongoing training, guidance, and supervision to vocational staff related to supports and best practices that aid members in obtaining competitive positions in integrated work settings. Training areas of focus should include job development, individualized job searches, employer engagement, and follow along support. • When the team is in a better staffing position, support Vocational Specialists in attending regional training and support meetings provided by the local mental health authority.
H11	Program Size	1 – 5 3	At the time of the review, the ACT team was composed of 6.6 FTE staff including the Psychiatrist. Vacant positions include both COS, one Nurse, an ILS, and an AS. *This item does not adjust for the size of the client/member roster.*	• Continue efforts to hire and maintain adequate staffing. A fully staffed team, 10 direct service staff, allows the team to consistently provide diverse coverage; help to prevent potential staff burn-out; allows staff to practice their specialties, which can improve job satisfaction; and accommodates the delivery of comprehensive individualized services to each member.

O1	Explicit Admission Criteria	1 – 5 5	The ACT team has a clearly defined target population. Based on interviews with staff, the team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. Staff interviewed reported referrals come from Mercy Care providers, other clinics, and supportive level of care teams within the agency. The team does not feel pressure to admit members by outside sources. The CC will conduct the initial screening and discuss the potential member with the team. The Psychiatrist will complete a doctor-to-doctor to assess member appropriateness. The Psychiatrist and CC decide together whether to admit, although, the member gets the final decision for admission.	
O2	Intake Rate	1 – 5 5	Per data provided, and reviewed with staff, the ACT team admitted three members to the team in the last six months prior to the review. This admission rate is appropriate as there were never more than two new members admitted in a month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team directly provides psychiatric and medication management, employment support, and housing support. The Psychiatrist provides counseling to all members on the team and no members are receiving counseling outside of the team. Based on staff interviews, less than 10% of members are receiving duplicated services from staff at their residence. Staff support members with employment and rehabilitation work by assisting with resume building, mock interviews,	• The team should fully assume responsibility for providing members with formal substance use treatment in an integrated setting according to member preference.

			providing on-going support, transportation support, and by attending new hire training with members and staffings with Vocational Rehabilitation Services. The ACT team is not currently providing formal substance use treatment to members.	
O4	Responsibility for Crisis Services	1 – 5 5	Per interviews with staff, the team provides 24/7 crisis services to members of the team. Staff reported the team rotates on-call responsibilities weekly and the CC is included in the rotation. Interviews with staff indicate initially assessing the situation with the member by phone, attempting to de-escalate. When the member cannot commit to safety, the on-call will go out into the community and coordinate with the CC to help de-escalate. Staff provide members with the *Mesa Heritage ACT Phone Directory* which includes all staff phone numbers and the on-call number. All members interviewed were aware of the 24/7 on-call service.	
O5	Responsibility for Hospital Admissions	1 - 5 3	Based on the data provided and reviewed with the CC, the ACT team was directly involved in 60% of the ten most recent psychiatric hospital admissions. The most recent hospital admissions occurred during a three-month period leading up to the review. The team reports that when a member has an increase in symptoms, or is in a crisis situation, the team will evaluate the situation by getting the member to the clinic to engage with the Psychiatrist for a risk assessment and potential medication adjustment. In some instances, the team coordinates to have the member transported	• Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions. • When members are transported to the hospital by first responders, consider following to ensure the member is supported by the team during the admission process, including providing the inpatient team with the members' medication list and clinical team contacts for coordination of care.

			to the hospital if the situation is not safe. If the member agrees to meet with the Psychiatrist, the team may coordinate with natural supports and guardians to transport to the hospital. When the member is transported to the hospital, the team is present for the full admission process. The team conducts coordination of care with hospital staff within 24 hours of admission. The team will schedule a doctor-to-doctor and visit the member every couple of days upon admission and begin discharge planning with the in-patient team. Based on data provided and reviewed with the CC, three members were taken to the hospital by Law Enforcement and ACT staff were not present for the admission process. One member self-admitted and the team was unable to complete a doctor-to-doctor until 72 hours after the admission.	• If not done so already, maintain regular contact with all members and their support networks. This may result in earlier identification of issues or concerns relating to members, allowing the team to offer additional supports which may result in a reduced need for hospitalization.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff interviewed reported following a five-day follow up protocol with members upon hospital discharge. The hospital discharge policy includes in-person or phone follow up with members for five days after discharge. Member are scheduled with the Psychiatrist within 48 hours of discharge. Based on the data provided and reviewed with the CC for the ten most recent hospital discharges, the team with directly involved in 90%. For the one member the team was not directly involved in discharging, the team was not notified by the inpatient team, rather by the member's family. ACT staff reported they spoke with a social worker at that hospital about the importance of coordination of care in the discharge process for their members. Per the data provided, and	• Ensure ACT staff are consistently coordinating with members' inpatient teams to make certain ACT staff are involved in the discharge planning process. • Ensure the team delivers post psychiatric hospital follow up services and supports as described during interviews.

			reviewed with the CC, all members received a five-day follow up from the ACT team. Eight of the ten most recent discharges met with the Psychiatrist within 48 hours of being discharged. However, it was unclear if one member was seen within 48 hours. According to one of the ten random member records reviewed, ACT staff did not complete the five day follow up exactly as staff had described the protocol.	
O7	Time-unlimited Services	1 – 5 5	Data provided to reviewers showed the ACT team graduated no members during the past year. Staff interviewed reported that the team anticipates graduating seven members in the next year.	
S1	Community-based Services	1 – 5 4	Staff interviewed reported 80 - 100% of in-person contacts with members occur in the community. The results of ten randomly selected member records reviewed showed the team providing services a median of 78% of the time in the community. Per review of ten randomly selected member records, nine had at least one contact in the community documented. Of the nine records, community-based services most often occurred in members' homes. There were instances documented of staff assisting a member getting to a Social Security office to support employment efforts, efforts to support housing retainment by transporting a member to the bank to collect rent monies and transporting to a specialty appointment. All nine records had documentation of home visits with medication deliveries, independent living skills being provided, and	• Continue efforts to increase the delivery of services to members in their communities. ACT teams should deliver 80% or more of their contacts in the community where staff can directly assess member needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting.

			general wellness checks. Three of the four members interviewed reported seeing ACT staff at their home more than at the ACT clinic.	
S2	No Drop-out Policy	1 – 5 5	According to data provided, one member could not be located by the team resulting in a 99% retention rate in the last 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff interviewed reported utilizing the *F-ACT Re-Engagement Policy* for members the team has lost contact with. Staff utilize the re-engagement tool after a member misses an appointment or does not engage with the team for four consecutive days. Efforts to re-engage members include two outreaches a week by phone or email to the member, member's natural supports, probation officers, jails, or hospitals, and two physical outreach attempts a week in the community such as the last known address, or locations frequented by the member including gas stations, shelters, parks, and homeless shelters. During the program meeting observed, the team discussed members that were on outreach, how many weeks they had been on outreach, and which staff were conducting electronic or in person-outreach for the day. Records reviewed indicated staff followed the outreach policy and were completing at least two electronic and two in-person outreaches when a member was difficult to locate.	
S4	Intensity of Services	1 – 5 1	Per review of ten randomly selected member records, during a month period before the fidelity review, the median amount of time the team spends in-person with members per week was 11.5 minutes. The median phone duration was 3.25 minutes. The record with the highest weekly	• ACT teams should provide an average of two hours or more of in-person contact per week to help members with severe symptoms maintain and improve their functioning in the community. This is based on all members across the team; some may

			average of in-person services was 40.5 minutes. One member was incarcerated during the month period and was seen by video conference only as jails continue to limit access to inmates.	require more time and some less, week to week, based on individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 – 5 2	Of the ten randomly sampled records, ACT staff provided in-person contacts across all members a median frequency of 1.5 contacts per week. The highest frequency was 3.25 contacts a week. Staff attempted at least once a week to contact the incarcerated member by video conference. Most members had phone contact documented in records, averaging a median of 1.5 contacts in the month reviewed.	• Increase the frequency of contact with members by ACT staff, to the extent possible, preferably averaging four or more in-person contacts a week per member across all members, with an emphasis on community-based services to support member goals. Members may have different needs/goals and the frequency of contact should be determined by those needs and immediacy.
S6	Work with Support System	1 – 5 2	Data provided by the team identified nine members as having natural supports. Staff reported the team will contact natural supports weekly by phone, email, or in-person if a release of information is on file. Natural support contacts are documented on the member calendars during the program meeting. Staff interviewed reported member natural supports are usually very involved in the member's treatment planning. During the meeting observed, natural support contact or planned contact was identified for nine members. According to the ten records reviewed, there were 0.20 average contacts with natural supports during the month reviewed. Members' reports varied in the ACT team's contact with their natural supports. One member reported having given written permission for a family member but didn't think the team had contacted them. Another member also had given the team	• Continue efforts to involve natural supports in member care. Increase contacts with supports to an average of four per month for each member with a support system. • Ensure consistent documentation of contacts with natural supports, which include contact by phone, email, and text.

			written permission to contact their family member and reported that the team contacts their family consistently. One member did not want the team contacting family, and the other member was not sure if the ACT team contacted their natural support.	
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 2	Per interviews with staff and data provided, there are 71 members on the ACT team identified with a co-occurring disorder. Due to the ACT team having two COS vacancies, staff reported no members are currently receiving structured individualized co-occurring disorder treatment. According to the ten random member records reviewed, some staff were providing co-occurring disorder support to members. Of the ten records reviewed, five members were receiving informal co-occurring disorder treatment from the ACT Psychiatrist during their monthly appointment. There was one instance of the ACT CC providing co-occurring disorder support to a member.	• After COS staff have been hired, work to provide an average of 24 minutes, or more, per week of formal individualized substance use treatment services for all members with a co-occurring disorder diagnosis.
S8	Co-Occurring Disorder Treatment Groups	1 – 5 1	This team is not currently offering co-occurring disorder treatment groups.	• Provide co-occurring disorder treatment groups for members of the ACT team. Groups should reflect an evidence-based approach appropriately suited for the population served. • All ACT staff should be trained in engaging members with a co-occurring disorder to participate in the available substance use treatment group, as appropriate, based on stage of treatment. Ideally, 50% or more of applicable members participate in a co-occurring disorder group.

S9	Co-Occurring Disorders Model	1 – 5 3	All staff interviewed report supporting members in the reduction in use of harmful substances, providing examples of harm reduction tactics used. Staff also reported receiving trainings on *motivational interviewing* which has been utilized to support members in identifying goals. Staff encourage members in achieving their goals and delivers substance use treatment from a harm reduction approach. When members request detox services, staff will refer them to local resources. During the program meeting observed, the ACT staff provided members' stage of change and updates on progress. Although the team did not have any COS at the time of the review, the Psychiatrist provided some substance use treatment to members. However, some records reviewed showed member treatment plans came from an abstinence-based approach rather than harm reduction. Four records reviewed showed staff recommending members to "abstain from substances" when this goal was not documented in the member's treatment plan.	• Provide all ACT team staff with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Treatment for Co-Occurring Disorders, the principles of stage-wise treatment, and motivational interviewing. With high turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate for new or less experienced staff. Identifying a co-occurring disorder treatment model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in their recovery. • Ensure all co-occurring disorder services specified in the Evidence-Based Practice of ACT are provided to members, including group substance use treatment.
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff interviewed reported that at least one staff on the team has lived psychiatric experience and shares their story with members when appropriate. Staff interviewed stated that the PSS supports members and advocates on their behalf during the program meeting to help improve team insight.	
Total Score:		**94**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
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	2
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	1
10. Vocational Specialist on Team	1-5	2
11. Program Size	1-5	3
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	3
6. Responsibility for Hospital Discharge Planning	1-5	4
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	1
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	1
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.36**	
Highest Possible Score	**5**	