ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: February 25, 2019

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AHCCCS Fidelity Reviewers

Method

On February 11-12, 2019, T.J. Eggsware and Karen Voyer-Caravona completed a review of the Community Bridges, Inc. (CBI) Forensic Assertive Community Treatment (F-ACT) Team Two. This review is intended to provide specific feedback in the development of your agency's Assertive Community Treatment (ACT) services, in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

Community Bridges, Inc. (CBI) offers multiple types of services. The agency operates several locations throughout Arizona. Some services available to adults include supportive housing, crisis stabilization, and ACT. The agency operates three F-ACT teams and three ACT teams. The F-ACT teams moved to a new location in the year since the last review.

The individuals served through the agency are referred to as *member*, *patient* or *client*, but for the purposes of this report the term "members" will be used.

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

- Observation of a daily F-ACT team meeting on February 11, 2019;
- Individual interviews with the Clinical Coordinator (i.e., Team Leader), Substance Abuse Specialist (SAS), Employment Specialist (ES) and ACT Specialist (AS);
- Group interview with four members served by the team;
- Charts were reviewed for ten randomly selected members using the agency's electronic medical records system; and,
- Review of documents: member and staff rosters, Clinical Coordinator (CC) productivity log, resumes and training records for Vocational and SAS positions, eight week outreach process guide, substance use treatment handbook and group sign-in sheets, individual substance use treatment tracking, clinical oversight tracking, and the F-*ACT Admission Screening* developed by the Regional Behavioral Health Authority (RBHA).

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team meets four days a week to discuss each member. On the fifth weekday the team meeting allows in-depth discussions for specific members facing challenges. During the meeting observed, staff discussed shared duties as well as their primary role in implementing the services of their specialty positions including employment and substance use treatment.
- The team has two Nurses who provide services to members in the office and in the community. The Nurses coordinate with medical health care providers, take an active role in medication education and delivery, including meeting with members in the community to provide injections. The Nurses also assist members with other areas of life, such as housing or discussing benefits.
- Staff spends the majority of their time providing services to members in the community.
- Staff is knowledgeable of the stage-wise approach to substance use treatment. Clinical oversight is provided regularly in addition to daily guidance available from the SASs. Staff collaboratively discuss member's stages of change and align interventions accordingly.
- The team is staffed with individuals with lived experience of recovery. Members confirmed staff shares personal recovery stories.
- The agency website includes a description of CBI's ACT program and services.

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

- The team should increase the frequency and amount of time spent in face-to-face member contacts, with a sustained focus on community-based services.
- Engage members who experience co-occurring challenges to participate in group and individual substance use treatment through the team, as appropriate, based on each member's stage of treatment. Explore the reasons for low member participation in group treatment.
- Engage informal/natural supports in member treatment. Work with members to identify or cultivate natural supports. Staff reported the team has four contacts a month with informal supports. However, based on staff report, less than half of the members have identified natural supports. During observation of the team daily meeting, staff occasionally referenced recent contacts with natural supports. Few recent contacts with informal supports were documented in the ten member records reviewed.

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of review, 12 full-time staff worked on the team. Excluding the Psychiatrist and integrated Primary Care Physician, the member-to-staff ratio is under 10:1 for the 97 member program.	
H2	Team Approach	1 – 5 4	One staff estimated 40-50% of members meet with more than one staff over a two-week period, based on team meeting discussions and coordination. A review of ten member records showed that 80% of members met with more than one staff over a two week period. One member interviewed reported meeting with one staff the previous week. Another said they visit the office and see staff three to four times weekly. Staff makes visits to members' homes. One member reported contact with about seven staff the week prior to review.	• Evaluate the efficacy of the member contract strategy applied by the team with the goal that 90% or more members have face-to-face contact with more than one staff in any two week period. • Ensure all contacts are identified in the team meeting and documented in records. Due to flexible schedules, not all staff attends each meeting. Consider assigning one staff to look up last documented member contacts during the course of the meeting for accurate team tracking.
H3	Program Meeting	1 – 5 5	Staff said that the team meets four days a week to discuss all members. On the fifth day the team meets for in-depth discussions of members who are inpatient or face unique challenges. The Psychiatrist attends team meetings four days per week by phone. Other than the CC, staff work four ten hour days to allow for extended daily and weekend coverage. Staff attends the meeting on weekdays they are scheduled to work. As a result of schedules that overlap in the middle of the week, those meetings have higher attendance. During the meeting observed, there were four staff present and all members were discussed.	
H4	Practicing ACT Leader	1 – 5 3	The CC estimated that recently up to 20% of her time is spent providing direct services. A report of direct services by the CC over a recent month timeframe showed approximately 20% of her time	• Work with the CC to identify and shift administrative duties (outside of necessary supervisory or other program leader functions) to allow for increased direct

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			was spent providing direct services. The CC reported that coordinating services for the members, staff vacations and administrative tasks can result in less time to provide direct services. In ten member records there were examples of the CC providing direct services to members in the office and community. Community-based contacts by the CC included meeting with members at a jail, shelter, and a meeting with another provider.	service provision.
H5	Continuity of Staffing	1 – 5 3	The team experienced nearly 42% turnover, with ten staff leaving the team in the past two years. The team experienced turnover at the Psychiatrist and Vocational Specialist positions. Multiple staff filled each of those positions and departed from the team.	• Screen and orient potential staff to assess their preparedness to deliver F-ACT services. Examine employees' motives for resignation. Optimally, ACT teams experience no greater than 20% turnover during a two year period.
H6	Staff Capacity	1 – 5 4	In the past 12 months, the ACT team operated at approximately 88% of full staffing capacity. The second SAS, the ILS and HS positions were vacant for multiple months.	• Fill vacant positions as soon as possible to ensure diverse coverage and continuity of care for members.
H7	Psychiatrist on Team	1 – 5 5	The team has an assigned Psychiatrist who works four, ten-hour days. Staff said the Psychiatrist is accessible, including weekend and after hour's availability. The Psychiatrist provides the majority of services via telemedicine. Staff said the Psychiatrist typically does visit the office once a month, meeting some members in person. Members reported they usually meet with the Psychiatrist monthly. During a month time period, the Psychiatrist met at least once with a slight majority of members whose records were reviewed.	
H8	Nurse on Team	1 – 5 5	The team has two full-time Nurses. Staff said the Nurses are accessible in person, by phone and that the whole team coordinates using a group chat thread. The Nurses rotate after hour and weekend	

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			coverage. Staff said the Nurses conduct traditional Nursing activities such as monitoring member health status and coordinating care, providing injections and medication education, in addition to assisting members with other areas such as employment, annual paperwork updates and supportive housing services. Staff reported that the Nurses provide community and office-based services. Examples of community-based services were located in records, including contacts with members in their homes and a day program.	
H9	Substance Abuse Specialist on Team	1 – 5 5	The team is staffed with two full-time SASs. Both have more than one year experience providing substance use treatment. One is a Licensed Professional Counselor and the other a Licensed Associate Counselor. The SASs seems well positioned to cross train other staff in effective substance use treatment engagement strategies, treatment and stage-wise staff activities.	
H10	Vocational Specialist on Team	1 – 5 3	The team has two Vocational Specialist (VS) staff, classified as an ES and Rehabilitation Specialist (RS). The ES started with the team in February 2018 and the RS came to the team in June 2018. During the morning meeting one of the Vocational Specialist staff was present and discussed assisting members with employment goals and active job searches. Other than their time in their respective roles, it does not appear either have specific training or experience in assisting members to obtain employment in competitive settings. One has experience in business management and the other has experience in social services, but not specific to supportive employment. Training records were	• Ensure both vocational staff receives regular training, guidance, and supervision related to vocational supports, best practices, and strategies to engage members to pursue and obtain competitive positions. Participating in meetings with other VS staff may aid them to share job leads or strategies based on their job development activities. Investigate opportunities in the system of care where those collaborative meetings may be occurring.

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			provided and showed one staff participated in nine and a half hours of rehabilitation services training, but the other staff participated in no employment training.	
H11	Program Size	1 – 5 5	Twelve full-time staff serve on the team: Psychiatrist, CC, two Nurses, two SASs, ES, RS, AS, Independent Living Skills Specialist (ILS), Housing Specialist (HS), and Peer Support Specialist (PSS).	
O1	Explicit Admission Criteria	1 – 5 5	Staff reported referrals to the team originate through the criminal justice system and Mercy Care (i.e., the RBHA). Staff said they utilize the RBHA's *F-ACT Admission Screening* tool. The CC, or other experienced staff, meets with potential members for screening and the Psychiatrist makes the final determination if members join the team. On rare occasions, staff that is not part of the ACT team, the Clinical Lead, is involved. Staff said that the team controls admissions with no organizational pressures to admit. One staff gave an example of a referral deemed inappropriate for F-ACT. The member did not join the team. Staff said they suggested alternative interventions to the referring source. Due to the high member census and regular rate of referrals, there was little active recruitment reported.	
O2	Intake Rate	1 – 5 5	In the past six months, the admission rate did not exceed six members per month. Admissions peaked during August 2018 at three, followed by two during November 2018, one per month for September, October and December 2018, but none in January 2019.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The team provides case management, psychiatry services and medication management, employment services, substance use treatment, and counseling is available. The ES and RS support	• The majority of supportive housing services should be provided by the team. Work with members in staffed residences to ensure they are in a setting of their choice. If not,

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			member employment goals, and other specialists assist as well. During the team meeting staff referenced members' employment status and plans. One staff said two members elected to continue counseling started with external providers before they joined the team. Individual substance use treatment is provided to many of the members identified with a co-occurring diagnosis and group substance use treatment is available. Staff reported no members receive substance use treatment from other providers. Though, some members reside in settings that may require participation in activities to address substance use (e.g., Alcoholics Anonymous) and there is one member in a substance use treatment facility. Based on staff report, more than 10% of members reside in residences where external staff are located or visit regularly. Based on interviews, members in treatment settings range from one to four; in settings that are independent, but where staff from other providers may provide services ranged from one to seven; and, in other staffed residences, ranged from six to ten members.	assist them to explore other settings where the team can provide supportive housing services.
O4	Responsibility for Crisis Services	1 – 5 5	Specialists work four ten-hour days. This affords two staff to work each on Saturday and Sunday. Nurses rotate after hour coverage and staff can contact them if needed. Members said staff is available after hours and over the weekend. A sheet with staff names, contact numbers, and the on-call number is provided to members. It notes the on-call is for emergency only and that texts should not be sent to the number. It is not clear if members have a shared understanding of emergencies. In two records, there were notes	• Consider adding a brief clarifying statement on the contact sheet to identify the events when the on-call should be contacted. Consider including what hours or days the on-call number is the primary means of contact with staff. Additionally, some teams provide a more detailed contact sheet to members including a succinct description of specialist roles and duties.

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			that members contacted the on-call during regular business hours and were told their situation was not appropriate for the on-call.	
O5	Responsibility for Hospital Admissions	1 – 5 2	Staff said they assist members with voluntary admissions, offer them the CBI facility, Access Point, as a safe place, or initiate involuntary admissions. Staff estimated the team is involved in 50% – 60% of member hospital admissions. Some members elect to self-admit. They may be out of contact with the team before an admission. Staff reported visiting members within 24 hours after learning of an admission and every 72 hours thereafter. Staff said they coordinate with inpatient staff. The Psychiatrist completes doctor to doctor coordination. Depending on the situation, a F-ACT Nurse coordinates with an inpatient Nurse. Based on evaluation of recent member psychiatric hospital admissions, the team was involved in three of ten.	• Work with members and their support networks to discuss how the team can support them in the event of a psychiatric hospital admission, especially if members have a history of hospitalization without team support. • Increasing member engagement through a higher frequency of contact and intensity of service may afford staff more opportunities to assess and provide interventions to reduce psychiatric hospitalizations, or to assist in admissions when indicated. This may also offer more opportunities for staff to engage and build rapport with natural/informal supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff said they are involved in 95% or more of member psychiatric hospital discharges. Staff said at discharge they transport members, ensure they have medications and are aware of their appointment with the Psychiatrist, which should occur within 24 hours. Staff stated they meet members face-to-face for five days after discharge. Based on staff summary, the team was involved in seven of ten recent member psychiatric hospital discharges. In a record for a member who experienced a psychiatric hospital admission, contact every 72 hours during the inpatient stay was not documented. The member called staff and requested visits to discuss discharge. There was also a gap in five day discharge face-to-face contact.	• Monitor team involvement in hospital discharges. Ensure member treatment requests are addressed and resolved. Monitor team adherence to hospital discharge processes. • Ensure all services are documented.

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O7	Time-unlimited Services	1-5 4	Over the prior year, two members graduated from the team, and in the upcoming year the team expects five to graduate, three of who are currently in process to transition off the team. Staff reported service plans are completed every three months and are modified to reflect the plan for staff contact with members and services through team.	• Optimally ACT members are served on a time-unlimited basis with less than 5% expected to graduate annually.
S1	Community-based Services	1 – 5 5	Staff estimated spending most of their time in the community (70-80%). Members interviewed reported meeting with staff at their homes and in the office. Based on records, over a month timeframe, a median of 80% of services occurred in the community. Contacts with members occurred in their homes, at member run programs, and other settings. Certain members received few contacts, but interactions were in the community.	
S2	No Drop-out Policy	1 – 5 5	Staff said few members dropped-out of F-ACT services in the year prior to review. Three were not located and transitioned off the team to the Navigator level of care. One left the geographic area with a referral to a provider in their new area, and one left the area without a referral. After the member and team made contact with a provider in the new area, an inter-RBHA transfer occurred.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff said outreach to members usually occurs within a week or less of no contact. In records, contact or outreach was not documented for a week or more for four members. An email dated August 2017 was provided to the reviewers. It listed efforts that should occur over the eight-week outreach process. At least one community-based outreach is required weekly. In the email, feedback was solicited on how staff felt the process could be improved. It is not clear if	• Consider prompting for more community-based outreach during the eight-week process. • If members are not seen at the frequency indicative of ACT, consider starting outreach efforts earlier. Assertive outreach for members who are not in contact with the team may offer more opportunities for purposeful, face-to-face contacts directed at aiding members in achieving goals.

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			revisions occurred. If applicable, the member's probation and court ordered treatment status is listed on the calendar used by the team to track service contacts. One staff reported that the criminal justice system was too accommodating to member transgressions.	• Regularly re-orient staff to their clinical and supportive role, advocating for members to be as independent as possible in the least restrictive environment. Highlight success stories of staff efforts aiding members to reduce recidivism.
S4	Intensity of Services	1 – 5 3	The median intensity of service found in records was slightly over 73 minutes a week. Two members received an average of more than 120 minutes of service time per week, another three received more than 100 minutes, but three received less than 20 minutes per week.	• Increase direct service time to members to at least two hours per week, on average. • Review with staff to ensure they accurately document services rendered. Identify barriers preventing increased service intensity.
S5	Frequency of Contact	1 – 5 3	The median weekly face-to-face contact for ten members was almost 2.4 contacts per week based on review of member records. The team averaged four or more contacts with three members, nearly four with another, but less than two contacts per week with five others. Based on sample member contact tracking calendars, certain members had multiple contacts with staff each week, but for others there were gaps in contact for a few days up to a week or more.	• Increase the frequency of face-to-face contact with members by staff to average four or more per week. Contacts should be purposeful, directed at aiding members in achieving recovery goals, and preferably occurring in the community. • Earlier assertive outreach for members who are not in contact with the team may offer more opportunities for face-to-face contact with members.
S6	Work with Support System	1 – 5 2	Staff said around 31%-40% of members have support systems. Staff reported the team has weekly contact with informal supports for those members with support systems. Documentation in member records showed few staff contacts with informal supports, less than one contact a month. This frequency includes three outreach phone calls to informal supports. During the team meeting, staff cited contacts or planned outreach to natural supports for roughly 16% of all members.	• The team should encourage members to develop and identify their support systems. Discuss with members the benefits of involving those supports in their treatment. • Seek training and guidance, to enhance strategies for engaging informal supports. Optimally, staff has contact with informal supports an average of four times or more monthly as partners in supporting members' recovery goals.
S7	Individualized Substance Abuse Treatment	1 – 5 4	Based on records, it appears individual substance use treatment is regularly offered and provided. Staff identified 63 members with a co-occurring	• Optimally, an average of 24 minutes or more per week of formal individual treatment is provided to members with a

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			diagnosis and 14 members in the relapse prevention stage of treatment. The majority of the 63 members diagnosed by the team with co-occurring concerns are assigned to individual treatment from one of the SASs. Less than 5% are assigned to other staff and almost 16% are incarcerated. Based on data provided, about 20 minutes of individual substance use treatment is provided per week across the 63 members. Some members in the maintenance stage receive individual treatment. Only members identified by the team with a current substance use diagnosis were considered in the average service time.	substance use diagnosis. Sustain efforts to engage members in individual substance use treatment. The team appears well positioned to reach the target threshold.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Each SAS facilitates a weekly substance use treatment group. One is targeted at members in earlier stages of treatment and the second for those in later stages of recovery. In records there were examples of SAS staff encouraging members to attend substance use treatment group. One member missed group, but none attended a substance use treatment group. Staff reported around 14-16% of the 63 members with a co-occurring diagnosis attended a group at least once in the prior month. Based on sign-in sheets, 13% of the 63 members identified with a co-occurring diagnosis participated. Only members identified by the team with a substance use diagnosis were considered when factoring attendance.	• Staff should engage members with a co-occurring diagnosis to participate in treatment groups based on their stage of treatment. Optimally, 50% or more of dually-diagnosed members attend at least one substance use treatment group monthly. • Explore the reasons for low member participation in group treatment. Evaluate staff engagement efforts to determine if other practices can be adopted to increase participation. Consider adding substance use groups or seeking input from members on their preferences for days, times or alternative CBI locations for groups.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 5	The team is familiar with the stage-wise approach to treatment, the stages of change model, and staff interventions. Staff interviewed identified activities that align with members' stages of change and treatment. Staff gave examples of harm reduction tactics. The treatment manual staff primarily utilize is *Integrated Dual Disorders*	• Continue to monitor member service plans to ensure they include stage-wise treatment interventions. For example, regularly discussing sample service plans and potential enhancements in clinical oversight meetings.

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			Treatment (IDDT) Recovery Life Skills Program. A tracking sheet was provided that shows the applicable members' stages of change and treatment. Staff said they discuss stage of change with members and seek input from them on their status. Stages of change were collaboratively discussed during the morning meeting. Stage of change is listed on the member calendars used to track contacts. Staff discussed their justification for nuanced differences in assessments of specific members. On one occasion, the SAS re-oriented staff to their clinical role rather than the team serving as an extension of the criminal justice system. Staff interviewed were familiar with the contexts in which withdrawal management (i.e., detoxification) may be medically indicated. Staff reported some members participate in AA or similar programs: the team does not actively recruit members to participate in those programs but for some, participation may be required through their residence. Training records showed that staff participated in applicable trainings, including: Addiction Society of Addiction Medicine (ASAM), integrated treatment for co-occurring disorders, and motivational interviewing. Clinical oversight is regularly provided in related topics, such as: stage-wise interventions and engagement when working with members at risk of self-harm, engagement strategies in a stage-wise approach, building rapport with members based on stage of change,	

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			incorporating stage of change information in documentation, substance use and trauma, and screening instruments. Staff document assessed stages of change in member contact notes. Most treatment plans for applicable members reviewed included individualized goals, person specific needs, with a reference to substance use treatment.	
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff said that the team employs individuals with a lived experience of substance use and at least one with lived experience of psychiatric recovery. Staff confirmed that they share aspects of their lived experience story with members, if appropriate. Staff reported they all have the same performance expectations. Members interviewed were familiar with staff on the team with lived experience of psychiatric or substance use recovery.	
Total Score:		**4.07**		

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	3
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
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	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	5
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	3
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	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	5
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.07**	
Highest Possible Score	**5**	