ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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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, an evidence-based practice (EBP).

Method

On September 27 – 28, 2022, Fidelity Reviewers completed a review of the Community Bridges Incorporated (CBI) Forensic Assertive Community Treatment Three (FACT 3) 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.

CBI provides community and inpatient behavioral health services, and housing supports to adults 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.

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

- Remote observation of the FACT 3 team program meeting September 27, 2022.
- Individual interview with the Clinical Coordinator (CC).
- Individual interviews with the ACT Specialist, two Co-Occurring Specialists, and the Nurse 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: resumes for Co-Occurring Specialists staff, *F-ACT III Phone Numbers*, and *Mercy Care ACT Admission Criteria*.

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 SAMHSA ACT Fidelity Review tool does not accommodate 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 or telephone to interview staff and members.

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 FACT 3 team has a low rate of admission. During a time of low staffing, admissions were limited.
- Crisis services are available to members of the team. Staff will meet with members in the community after hours to provide support and transportation if required.
- The team succeeds at directly supporting members by providing wraparound services upon discharge from psychiatric hospitals/units.
- Staff work to establish and maintain strong therapeutic relationships with members, promoting retention over time.
- There is at least one staff on this team with personal lived psychiatric experience. This staff shares their story when appropriate with members.

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

- Several of the low scoring items can be directly related to the low staffing rate of this team and high turnover.
    - Team Approach – increasing in-person contact with members by diverse staff provides members with experiences and knowledge from a wide range of staff and helps to alleviate potential burden on staff.
    - Continuity – High turnover impacts team cohesion and member investment in the program. Work to retain staff.
    - Community Based Services – few members are receiving services in their community, rather, members often are engaged in services while at the clinic. Increase delivery of community-based services.
    - Intensity/Frequency of Services – ACT members are not successful with traditional case management, requiring frequent and often intense support to address long standing problems. Increase the frequency of contacts and the duration of those contacts.
    - Co-Occurring Disorders Group – at the time of the review, the team was not providing any therapeutically supportive treatment groups for members with a Co-Occurring Disorder. Provide at least one group for FACT 3 members.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, excluding the temporary coverage by Prescribers (2), the team had 4.9 full time equivalent staff serving 78 members on the team, resulting in an approximate 16:1 member to staff ratio. Staff on the team include the CC, ACT Specialist, two Co-Occurring Specialists, a .5 FTE Nurse, and a .4 FTE Behavioral Health Technician that also has administrative responsibilities.	• Agency leadership should prioritize filling open positions on the team to make certain a 10:1 member to staff ratio exists. Small caseload size ensures adequate intensity and individualization of services and minimizes the potential burden on staff.
H2	Team Approach	1 – 5 1	Staff interviewed reported members are seen by more than one staff in a two-week period 85 – 90% of the time. However, staff stated some members seem to be resistant to coming into the clinic to meet with staff. Staff relate that barrier to the effects of the Public Health Emergency. Per review of the documentation entered into ten randomly selected member records for a specific two-week period reviewed, none of the members were seen by more than one staff. The team does provide integrated care to members by providing a Family Nurse Practitioner for general medical health needs. Several member records reviewed showed evidence of that service delivery.	• Increase in-person contact of diverse staff with members. Ideally, 90% or more members have in-person contact with more than one staff over a two-week period. Diversity of staff interaction with members allows the members access to unique perspectives and the expertise of staff. Because of the number of vacant positions, it may be especially important for this team as it likely would reduce the burden of responsibility of care on staff. • Confirm that outreach attempts and successful contacts are documented in member records.
H3	Program Meeting	1 – 5 4	The FACT team meets four days a week to discuss all members assigned to the team. One day a week the team meets to discuss clinical needs of members as well as treatment plans. During the meeting observed, staff provided input on recent member interactions and developed plans for follow-up care. The team uses member	• An ACT Psychiatrist should attend at least one program meeting weekly where all members are discussed.

			calendars during the program meeting to track team activity which was observed by reviewers. Part time staff attend the meeting at least twice a week, however, temporary staff (i.e., Prescribers) do not attend any program meetings.	
H4	Practicing ACT Leader	1 – 5 2	The CC joined the team the month prior to the review and estimated delivering in-person services to members 60 - 70% of the time however was working remotely at the time of the review. Direct in-person services typically delivered were described as delivering medications to clients in their homes, transportation, and meeting with clients at the office when the team is out in the community. During the meeting observed, the CC provided input on several members and planned to participate in an inpatient hospital staffing remotely. Review of ten member records did not show documented interactions delivered by the CC. Reviewers requested a productivity report for the CC for a recent month period but was not received.	• Under ideal circumstances, the CC's delivery of direct services to members should account for at least 50% of the expected productivity of ACT staff. • Practicing ACT leaders can engage in a range of member care needs including providing counseling/psychotherapy, facilitating or co-facilitating co-occurring groups, providing support and advocacy at mental health court, participating in inpatient psychiatric staffings, shadowing and mentoring specialists delivering community-based services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery.
H5	Continuity of Staffing	1 – 5 1	There was over 100% turnover of staff since the last Fidelity Review (April 2021). Three positions, the CC, the Peer Support, and the Rehabilitation Specialists, had three turnovers each. Data for the history of the two Nurse positions was not received from the team.	• If not done so already, attempt to identify causes for employee turnover. Optimally, turnover should be no greater than 20% over a two-year period.
H6	Staff Capacity	1 – 5 2	Per the data provided and reviewed with the CC, the team had 71 positions vacant during the past 12 months. For three months in a row, the team had fewer than three staff providing services to the members on the team roster.	• 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 2	At the time of the review, two part time Prescribers were providing temporary coverage to the members of the FACT 3 team. The combined FTE of each Prescriber equates to approximately 23% given the size of the member roster. The previously assigned prescriber had documented in five member records providing services. Members interviewed reported to being scheduled monthly with the Prescriber and that services were delivered in-person and via telehealth. Staff report that the temporary Prescribers are delivering services via telehealth (videoconference) with support from the team for members that do not have the technology, bandwidth, or skills to participate on their own. One member reported that they are able to meet with the Prescriber without staff presence. It was reported that some members are able to participate in scheduled appointments with the Prescribers privately in their homes. There was no Prescriber attending the meeting observed, however, staff did discuss scheduling members for medication management appointments. Members interviewed reported to meeting with the Prescriber once every 30 days.	• Hire a permanent Psychiatrist/Psychiatric Provider to be assigned to the team full time to provide services to members. ACT teams should have at least one full-time, fully integrated Psychiatrist/Psychiatric Provider assigned to serve as the medical director for the team. Continuity supports therapeutic relationships between the member and the prescriber and helps develop team cohesion.
H8	Nurse on Team	1 – 5 2	The team has one .5 FTE temporarily assigned Nurse to work with the 78 members. During the meeting observed, the Nurse provided updates on several members and requested coordination from staff on several others. The Nurse only works in the office and administers injections, completes lab work, and provides coordination of care for primary care/specialty physicians and inpatient teams. In addition, review of records showed the	• Fill the vacant Nurse positions. Ideally the team would have 2 FTE Nurses assigned to work with the members of the team with expectations to deliver services at the office and in the community.

			Nurse providing a food box referral and addressing co-occurring disorder issues. For members that require an injection but are unable or unwilling to come to the office, a medical assistant assigned to the team will administer those injections to members in the community. *This item was adjusted for the size of the member roster.*	
H9	Co-Occurring Specialists on Team	1 – 5 5	The team has two Co-Occurring Specialists assigned to the team. Both staff have more than one year of experience providing substance use treatment services. The first Co-Occurring Specialist has been with the team since May 2022 and the second since June 2022. Both have completed training related to delivering substance use treatment in the past 16 months (since the last review, April 2021) which includes Motivational Interviewing, Co-Occurring Disorder Treatment, and Harm Reduction.	
H10	Vocational Specialist on Team	1 – 5 1	The Employment Specialist and Rehabilitation Specialist positions were both vacant at the time of the review.	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met.
H11	Program Size	1 – 5 3	At the time of the review the team had the Psychiatrist, 1.5 Nurse, Employment Specialist, Rehabilitation Specialist, Independent Living Specialist, Peer Support Specialist, and the Housing Specialist positions vacant. The team is not adequately staffed to deliver services to the FACT 3 team roster. *This item does not adjust for the size of the member roster.*	• Seek to recruit and retain qualified staff. Ideally, ten or more direct service staff work on an ACT team.

O1	Explicit Admission Criteria	1 – 5 5	The team follows the *Mercy Care ACT Admission Criteria.* Although the team has only had one admission in the past six months, and none since the CC joined the team, it was reported that all referrals would be screened by the team with the CC and Prescriber having the final decision whether referrals are appropriate. The team receives referrals from the Regional Behavioral Health Authority and Maricopa County Probation.	
O2	Intake Rate	1 – 5 5	During the past six months the team has only admitted one new member to the team in March 2022. This is an appropriate rate of admission.	
O3	Full Responsibility for Treatment Services	1 – 5 4	Upon review of member records and interviews with staff, in addition to case management services, this team is directly providing psychiatric services/medication management, counseling, most housing supports, co-occurring disorders treatment, and employment/rehabilitation supports. At the time of the review, the team had at least ten members in residences where there is a duplication of ACT services. Several of these clients are in transitional services working toward independence and may not have other housing options available to them. The team conducts coordination of care for these members and recognizes the duplication of services. Although the Housing Specialist position is vacant, the team works to assist members in applying for low-income housing options in the region, recognizing the shortage of safe and affordable housing options, especially because the members of this team have a criminal history. It was reported that	• Monitor the number of members in staffed residences so that, optimally, no more than 10% reside in settings with other social service staff. Evaluate members' circumstances and housing options before they are referred to staffed residences over independent living with ACT staff providing housing support. Enlist natural supports as a resource to assist in identifying housing options. • Continue efforts to seek safe and affordable housing for members of the FACT team, enrolling members in rent subsidy programs, and coordinating with current providers of housing/residential services as appropriate.

			75 – 80% of the members on the team are unhoused.	
O4	Responsibility for Crisis Services	1 – 5 5	The FACT team provides 24/7 crisis services to members. Members are provided the on-call number upon admission and when necessary are provided a sheet with the team contact and on-call numbers. Staff will assist members entering the on-call number into their phones to facilitate ease of access to the team. Members interviewed were aware of the team's availability and the phone number. One member reported calling the on-call in the very early morning hours and was provided support. Staff interviewed reported the team will go into the community to provide support to clients when needed, the CC is back-up on weekdays, and the agency has rotating CC back-up support for the weekends. When there is a potential risk assessed, the team will request law enforcement support. The team identifies as *first responders* to the members assigned. When the local crisis line is contacted regarding members assigned to the team, the crisis line will contact the FACT 3 on-call, reassigning responsibility to the team.	
O5	Responsibility for Hospital Admissions	1 – 5 3	When members are experiencing an increase in symptoms and may require inpatient care, the team will attempt to have them triaged by the Nurse and may be assessed by a Prescriber as well. Other times the team may send two staff out to assess the member in the community and provide necessary transportation to the unit of member's choice. Assessment of data provided and reviewed with staff show the team was involved in 50% of the ten most recent psychiatric hospital admissions. Several of the admissions occurred	• Increasing member engagement through a higher frequency of contact and intensity of service may provide ACT staff with opportunities to assess and provide intervention 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 supports.

			while the CC was in new employee orientation and was unaware of how those members arrived at the inpatient unit. All of the hospitalizations occurred within the month of August and September. In one member record, the Nurse documented coordination of care with the inpatient team as soon as the team was notified of a recent admission. In another record, a Co-Occurring Specialist participated in weekly staffings with the inpatient team.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	One staff interviewed reported the team is constantly reaching out to inpatient teams to coordinate discharge planning for members. Staff reported that the CC will coordinate with the inpatient teams several times a week and the Prescriber at least once. The Nurse will do at least one Nurse to Nurse coordination for each hospitalized member to discuss medications and behaviors exhibited. Staff transport each member when discharged and provide five days of follow up care. Members are scheduled with the Prescriber within 72 hours, Nurse within seven days, and an appointment with their primary care physician is also scheduled. Of the ten most recent psychiatric hospitalization discharges, the team was directly involved in 100%. In the data reviewed, staff assisted with intake to residential settings five times, four members were seen the same day of discharge by the Prescriber, and staff also assisted members by transporting to a pharmacy upon discharge.	
O7	Time-unlimited Services	1 – 5	Per review of data provided and verified with staff, the team graduated two clients during the past	

		5	year, supporting a time-unlimited service for members.	
S1	Community-based Services	1 – 5 1	Staff interviewed reported 15% of in-person contacts with members occur in the community. Staff stated that due to the large percentage of members that are unhoused, those members rely on the ability to meet with staff at the office in order to express needs. At least one staff expressed concern regarding the reliability and maintenance of agency vehicles. Agency policy relating to transporting members in personal versus agency vehicles was unclear. Additionally, one member interviewed reported lack of support from the team to transport for reasons such as obtaining groceries and getting to work. The part time Nurse assigned to the team does not go into the community. Members interviewed stated that most contacts occur at the office rather than in the community. One member reported it had been 2 – 3 months since the last visit by the team to their home. The results of ten randomly selected member records reviewed verified what staff reported and showed that staff provided services a median of zero percent of the time in the community. Two members had 100% of in-person contacts in the community and the other records showed all other in-person contacts occurring at the office.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities. Avoid over-reliance on clinic contacts for housed members as a replacement for community-based contacts. • When new group activities are developed, avoid reliance on the clinic as the location of that activity. Provide individualized services to support members to achieve their goals.
S2	No Drop-out Policy	1 – 5 4	During the past year, a total of eight members dropped out of programming with the team resulting in approximately 91% retention rate. There were six members that requested a transfer to another team and the team was in the process of supporting one other member at the time of the	• ACT teams should ideally retain 95% of the entire caseload year to year. Several factors can impact this number positively including admission policies, consistency in staffing, natural support involvement, assertive

			review. Two additional members were closed due to long term incarceration.	engagement practices, and taking a recovery perspective with member care.
S3	Assertive Engagement Mechanisms	1 – 5 3	During the meeting observed, the team identified members that were out of contact with the team. Members were identified by the number of weeks the team had been outreaching. Staff informed of efforts made to locate each member. Tasks were assigned to staff for completion. However, one member record reviewed showed staff attempting to connect with a member out of contact with the team. Documented contacts ranged from 6 – 12 days between efforts made by the team. The treatment plan for this member identified supports, yet no efforts appeared to be taken to reach out to those natural supports by the team. Staff reported if staffing were more appropriate the team could have reached out further to members and their supports, formal and natural.	• Ideally, outreach should be carried out by multiple ACT staff, drawing from motivational interviewing skills, allowing members a diverse group with whom to connect. • Monitor documented outreach and contacts with members. It may be useful to assign one staff to spot-check documentation in member records during the team meeting to confirm recent contacts or outreach efforts are documented. This may enable the team to proactively assign staff to outreach in the event of lapses.
S4	Intensity of Services	1 – 5 1	Per review of ten randomly selected member records for a month period before the fidelity review, the median amount of time the team spends in-person with members per week is 9.5 minutes. The member record with the highest weekly average was 48 minutes.	• The ACT team should provide members an average of 2 or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average service time delivered. Ensure services are accurately documented.
S5	Frequency of Contact	1 – 5 1	Members interviewed reported having frequent contact with team staff by phone. One member reported to having daily contact by phone but only seeing the team once a week. Most members interviewed reported having weekly contact with the team at the office. One member record reviewed had four out of seven contacts conducted via videoconference with the team. No other members had documented videoconference contacts with the team.	• Increase the frequency of contact with members by ACT staff, to the extent possible, preferably averaging 4 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 frequency of contact should be determined by the immediacy of those needs.

			Of the ten records randomly sampled, ACT staff provided an average frequency of .5 in-person contacts to members per week. *The fidelity tool does not accommodate delivery of telehealth services.*	• Ensure staff are trained on appropriate documentation standards so that services are accurately reflected in the members' medical records.
S6	Work with Support System	1 – 5 2	Reviewers were provided a list of 13 members that had natural supports identified. However, staff estimated that 25 - 50% of members assigned to the team have a natural support. During the meeting observed, natural supports were identified for 39 members but with little mention of contact with those supports. The results of ten member records reviewed showed little documentation regarding team interaction with member's supports. Two member records had documentation of team interaction with member supports. The two members interviewed with natural supports reported that the team does not have contact with their natural supports.	• Continue efforts to involve natural supports in member care. Increase contacts with supports to an average of 4 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. • Assist members in developing a natural, community-based support system. Active participation with peer run programs are a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact.
S7	Individualized Co-Occurring Treatment	1 – 5 4	There were 11 members identified as having a co-occurring disorder (COD) diagnosis initially by the team. During the interview process, staff estimated a more accurate rate is 85%. Co-Occurring Specialists split the caseload with each having around 34 members with a COD. Staff interviewed reported that 32 clients are meeting regularly to discuss their substance use individually. Some of those members meet more often, i.e., weekly, while others may only meet less frequently depending on how open they are to discuss their behaviors. Staff will reach out to members by phone to offer support as well as meeting them in the community, as was seen in member records reviewed. Co-occurring	• Evaluate if Co-Occurring Specialists sharing in other duties, such as to members that do not have co-occurring diagnoses, limits their ability to engage or provide individual substance use treatment. Consider shifting those duties to other staff when the staffing ratio improves. • Work to increase the time spent in individual sessions and increase the number of members engaged so that the average time is 24 minutes or more per week across the group of members with co-occurring diagnoses.

			Specialists reported that due to the low staffing rate on the team, time spent in the specialty role providing COD treatment services is limited.	
S8	Co-occurring Disorder Treatment Groups	1 – 5 1	At the time of the review there were no co-occurring disorder treatment groups being provided by the team.	• Optimally, 50% or more of members with a co-occurring disorder attend at least one co-occurring disorder treatment group each month. All ACT staff should engage members with a co-occurring diagnosis to participate in treatment groups based on their stage of change with content reflecting stage-wise treatment approaches once groups are established. • Consider establishing one group for members in earlier stages and one group for members in later stages, allowing staff to adjust interventions to better serve members in different stages of change.
S9	Co-occurring Disorders Model	1 – 5 3	Staff interviewed reported taking a harm reduction approach with members while using motivational interviewing and cognitive behavioral therapy to support members with a COD. Staff provide members basic education relating to how substance use and mental illness impact each other. Staff report recognizing opportunities to address the COD when members are in vulnerable situations, seeking to support them in the moment. Records reviewed indicate at least one staff may have preconceived notions how members should respond to interactions with staff relating to substance use. Statements of judgment and possible confrontation appeared in records. Other records revealed documentation of staff efforts to engage members in their care and steps toward	• Provide all specialists with annual training and ongoing mentoring in a co-occurring disorders model, such as Integrated Treatment for Co-Occurring Disorders, in the principles of stage-wise treatment, and motivational interviewing. With turnover of staff, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Adhering to a co-occurring disorder model within the team can promote continuity in the approaches ACT specialists utilize when supporting members. • Ensure member treatment plans identify member goals and individualized needs. Ensure members have the ability to identify goals to reduce use when abstinence is not their explicit goal.

			recovery, encouraging them to attend to important matters with team by their side for support. Treatment plans for the six members with a COD ranged from supportive language to more blaming traditional language when referencing substance use and the aligned services the team provides.	
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. Members interviewed were not aware of a peer with personal psychiatric experience on the team. One member stated that there are a lot of new staff on the team.	
Total Score:		**84**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	1
3. Program Meeting	1-5	4
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	1
6. Staff Capacity	1-5	2
7. Psychiatrist on Team	1-5	2
8. Nurse on Team	1-5	2
9. Substance Abuse Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	1
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	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	1
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	1
5. Frequency of Contact	1-5	1
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	4
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	**3.00**	
Highest Possible Score	**5**	