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. ACT is an evidence-based practice (EBP).

Method

On March 7 – 8, 2023, Fidelity Reviewers completed a review of the Copa Health Metro Varsity 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.

Copa Health operates several outpatient centers. Copa Health offers employment-related services, day program activities, integrated health, and residential services. The individuals served through the agency are referred to as members.

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 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 March 7, 2023.
- Individual video conference interview with the Clinical Coordinator (CC).
- Individual video conference interviews with Co-Occurring, Housing, ACT, and Rehabilitation Specialists, and the Counselor for the team.
- Individual phone interviews with three 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*, *8-week Outreach,* co-occurring disorder treatment resource *Integrated Dual Disorders Treatment Recovery Life Skills Program*, resumes and training records for Vocational and Co-Occurring Specialist staff, Clinical Coordinator Productivity Report, and Members of the Metro ACT Clinical Team handout.

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 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 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 ACT had an appropriate intake rate admitting no more than three members in a month period. In a six-month period, the team admitted seven new members to the team.
- The team is available to provide crisis support by phone and in the community 24/7. Members interviewed were knowledgeable about the teams ACT on-call number, and some reported using it.
- The ACT team supports time-unlimited services for all members on the ACT team. The team has a low graduation rate and continues to serve members even if ACT staff do not believe the member needs the intensity of ACT services.

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

- At the time of the review, the ACT team did not have a full-time equivalent Psychiatrist. The team should maintain one dedicated Psychiatrist to serve members.
- The ACT team had 44 months of position vacancies over the past 12 months. The ACT team should identify areas that reduces turnover and work to maintain current staff.
- Records reviewed showed the ACT team delivered services in the community 37% of the time. Continue efforts to provide a majority of services in the community. Optimally members would receive services in the community at least 80% of the time.
- The team delivers services to members in the community a median of 37% of the time. Continue efforts to increase the delivery of services in members' communities.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The team serves 96 members with eight staff that provide direct services, excluding the Psychiatrist and administrative staff, resulting in a member to staff ratio of 12:1. Full-time direct (FTE) staff include the Clinical Coordinator (CC), two Nurses, Co-Occurring Specialist (COS), Rehabilitation Specialist (RS), Housing Specialist (HS), Independent Living Specialist (ILS) and ACT Specialist (AS).	• Optimally, the member to staff ratio does not exceed 10:1 on an ACT team. Continue efforts to hire and retain experienced staff.
H2	Team Approach	1 – 5 4	Staff interviewed reported 80% of members have contact with at least two ACT staff each week. All specialists have an assigned caseload and are expected to see those members every week in addition to a weekly zone rotation of additional members. With this approach most members are seen by multiple staff on the team weekly. Based on review of ten randomly selected member records, 80% received in-person contact with more than one staff in a two-week period. All members interviewed reported seeing more than one staff weekly.	• Ideally, 90% of ACT members have contact with more than one staff in a two-week period. • Continue efforts to ensure all members on the ACT roster have in-person contact with more than one staff in two weeks; a diversity of staff allows members access to unique perspectives and expertise of staff.
H3	Program Meeting	1 – 5 4	Staff interviewed reported all staff, except the temporary Psychiatrist, attend the team's program meeting four days a week and all members are reviewed. During the program meeting observed, all staff contributed updates and recent engagement with members and their natural supports. The team	• ACT Psychiatrists attend the program meeting at least once weekly to support coordination of care among all members, as well as ongoing clinical oversight.

			also discussed hospitalizations, jail visits, group attendance, and outreach attempts.	
H4	Practicing ACT Leader	1 – 5 4	The CC estimated delivering 10 hours of in-person services to members each week. The CC reported conducting medication observations, budget education, and working with members on meeting their goals. Four of ten member records reviewed showed the CC providing direct services in the community and at the clinic. Based on the CC's productivity report for a recent period, the CC delivered six hours per week of direct in-person services to ACT members.	• Continue efforts to provide in-person services to members 50% or more of the expected productivity of other ACT staff.
H5	Continuity of Staffing	1 – 5 3	Based on the data provided and reviewed with staff, 15 staff left the team in the past 24 months, resulting in a turnover rate of 53%. Per the data provided, the Peer Support Specialist (PSS) and Nurse positions were the most difficult to retain.	• Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to building therapeutic relationships with members and their support, as well as reducing potential burden on staff. • If not done so already, consider examining employees' motives for resignation, and attempt to identify factors contributing to employee turnover, as well as opportunities that support staff retention.
H6	Staff Capacity	1 – 5 3	Per data provided, the ACT team had 44 vacancies in the 12 months prior to the review and operated at 69% staffing capacity. Four positions were vacant at the time of the review.	• Continue efforts to retain qualified staff with the goal of operating at 95%, or more, of full staffing annually. • To support retention, ensure staff receive training and supervision in their specialty. Staff remain in positions longer when supported in their roles by being provided supervision and training in their specialty practice.
H7	Psychiatrist on Team	1 – 5	The team does not have a Psychiatrist dedicated to the ACT team. The team is currently receiving	• Continue efforts to recruit and retain a permanent Psychiatrist to be assigned to the

		2	coverage one day a week from another prescriber from the agency. While providing coverage, the Prescriber sees members on the ACT team for medication management, counseling, and hospitalization coordination. Of the ten random records reviewed, five members were seen by the covering Prescriber in the month period reviewed. All members interviewed reported seeing the ACT team's covering Prescriber once a month.	team full time to provide services to members. • Optimally, an ACT Psychiatrist is available to spontaneously collaborate with nursing staff, and to provide education to other specialists on medications, side effects and health issues that members experience.
H8	Nurse on Team	1 – 5 5	The ACT team has two Nurses that work exclusively with members on the ACT team. One Nurse provides injections and assessments at the ACT clinic, and the other Nurse attends appointments with members in the community and provides inpatient coordination. Members interviewed reported seeing the team Nurses a minimum of once a month, most often at the clinic.	
H9	Co-Occurring Specialist on Team	1 – 5 3	At the time of the review the team had one COS with a year of experience in addiction therapy. The COS has completed several trainings related to co-occurring disorders and reported receiving supervision once a week by the Clinical Supervisor in a group setting.	• ACT teams have two Co-Occurring Specialists assigned to provide services to members. When screening potential candidates for the position, consider a year of more of experience working with members with a co-occurring disorder and integrated care. The COS should have the capability to cross train other ACT specialists in this area. • Provide annual training to Co-Occurring Specialists in co-occurring treatment best practices, including appropriate interventions, i.e., stage wise approach, based on members' stage of change.

H10	Vocational Specialist on Team	1 – 5 3	At the time of the review, the team had one Vocational Specialist, an RS. The RS has over five years of experience providing ACT services, including serving in the Employment Specialist position for several years. Training records reviewed indicated one vocational training in the past year. Staff reported that the RS works closely with Vocational Rehabilitation Services and attends trainings on community employment updates.	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met. • Ensure that both vocational staff receive ongoing training in assisting people diagnosed with serious mental illness/co-occurring disorder diagnoses to find and retain competitive employment. Training should include techniques to engage members to consider employment; job development strategies; the importance of supporting in-person employer contact soon after members express an employment goal; and the provision of follow-along supports to employed members.
H11	Program Size	1 – 5 4	At the time of the review, the ACT team was composed of 8.2 FTE staff including the covering Psychiatrist. Vacant positions included the second COS, Psychiatrist, Peer Support Specialist, and Employment Specialist. *This item does not adjust for the size of the client/member roster.*	• Continue efforts to hire and maintain adequate staffing. A fully staffed ACT team consists of 10 direct service staff, which allows the team to consistently provide diverse coverage; helps to prevent potential staff burn-out; allows staff to practice their specialties, which can improve job satisfaction; and accommodates the delivery of comprehensive, individualized service to each member.
O1	Explicit Admission Criteria	1 – 5 5	Based on staff interviews, the team follows the *Mercy Care ACT Admission Criteria*. Multiple staff on the team are trained to complete the screening process then the Psychiatrist conducts an evaluation. Staff report that the temporary Psychiatrist and the CC make the final admission decision but that ultimately, it is the member's choice if they would like to participate. The team	

			reported no organizational pressure to admit new members.	
O2	Intake Rate	1 – 5 5	Per the data provided and an interview with ACT leadership, seven members were admitted to the team in the six months prior to the review. There were no more than three admissions in any one month. This rate of admission is appropriate.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team directly provides psychiatric and medication services, substance use treatment services, and housing support. The team does have a Licensed Associate Counselor partially allocated, 20%, to provide. counseling and psychotherapy to members. It was reported twelve members are engaged in those services; however, this staff only attends one treatment team meeting a week and is not considered a generalist staff among the team. Additionally, staff report at least two members of the ACT team have been referred to outside brokered providers for specialty treatment. Per interviews with staff, the team has 2 - 3 members that participate in Work Adjustment Training provided by non-ACT staff.	• ACT services should be fully integrated into a single team with few referrals to external providers for specialty cases, such as court ordered services. • Ensure vocational service staff receive supervision and training so they can directly assist members to find and keep jobs in integrated work settings rather than relying on vendors. Educate all staff on the benefits of competitive employment versus other services (e.g., WAT). • Consider options to bring qualified staff onto the team with the ability to provide counseling/psychotherapy to Varsity ACT members. Staff on ACT teams have specialty practices, but are also still generalists among the team, meeting members in the community, providing case management services, etc.
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24-hour coverage directly to members of the ACT team. Staff report that the on-call phone rotates between the specialist positions and that the CC serves as the back-up . All members interviewed were aware of the number to call and state staff are readily available. One of the ten member records reviewed included documentation of afterhours crisis services provided by the ACT team.	

O5	Responsibility for Hospital Admissions	1 - 5 4	Per review of the ten most recent psychiatric hospital admissions occurring over a four-month time frame, the team was involved in seven. Staff stated that normally members will contact the team when experiencing an increase in symptoms or seeking hospitalization and are offered an appointment with the provider. When hospitalization is recommended, the team will call for an open bed, transport the member, and remain with them until admitted, if allowed by the hospital. Some hospitals are not allowing staff to wait with members due to the public health emergency. In those cases, staff will provide supporting documentation and hospital staff will contact the team to inform of the result. Of the members that the team was not involved, two sought admissions independently without reaching out to the team. Another member was assessed by the team after expressing suicidal ideation, was offered assistance by the team to be admitted, but the member declined. The member was sent in a taxi; however, the team did not follow along to the hospital.	• Work with each member and their support network to discuss how the team can support members in the event of a psychiatric hospital admission. Proactively develop plans with members on how the team can provide aid during admission, especially for those members that have a history of seeking hospitalization without team support. • 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 a rapport with natural supports. • The team should identify and seek solutions to barriers to direct team involvement in member inpatient admissions. Assess the quality of the therapeutic alliance; maintain stance of acceptance with member's readiness to accept recommended resources, services and supports, including housing and shelter. Focus on building trust and rapport with both members and their natural supports to increase team responsibility for hospital admissions to 100%.
O6	Responsibility for Hospital Discharge Planning	1 – 5 3	Per review of the ten most recent psychiatric hospital discharges, which occurred over a four-month time frame, the team was involved in six. Staff report that they always participate in	• The ACT team, and system partners, should collaborate to resolve barriers to the ACT team being directly involved in 95% or more of psychiatric discharges. ACT teams not only coordinate member discharges, but also meet all members at the hospital on

			discharge staffings with hospitals. Reviewers were informed that the agency policy states that ACT staff cannot transport members during discharge, but instead send them home by cab. However, staff report the team will transport certain members. When the team does assist in transporting members when discharging from an inpatient psychiatric facility; the team will obtain discharge paperwork; address medication changes by use of the on-site pharmacy at the clinic; and the Prescriber will review those changes with the member. The team provides five days of follow up beginning the day after the member is discharged during which the member will see the Psychiatrist again. The team will then meet with the member once a week for the next four weeks. Staff said this is primarily done by telehealth per agency request. Of the most recent hospital discharges, four did not include the five-day follow up being completed after discharge or the Psychiatrist appointment was not made.	the day of discharge to provide immediate support as members return to their community. Often, teams assist with obtaining new medications, ensure no food insecurities exist, and are flexible to provide other supports as members return to their community during this interaction. • Develop plans with members in advance, especially when they have a history of hospitalization without seeking team support. • Continue to build relationships with inpatient staff and use resources available to advocate for member care. Some teams create business cards with team information that members can carry on their person to reference when interacting with other agencies/providers and expedite coordination of care.
O7	Time-unlimited Services	1 – 5 5	Four members graduated from the team in the past 12 months. Of the current roster of members enrolled, it was projected another three members will likely graduate from the team. Staff report there are some members who do not need the intensity of ACT services, but they continue to serve these members per member request.	
S1	Community-based Services	1 – 5 2	Multiple staff interviewed reported 60 - 90% of services are delivered in the community. However, results of ten randomly selected member records reviewed showed the ACT team provided services a median of 37% of the time in the community.	• Continue efforts to increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities.

			Members interviewed reported seeing ACT staff in the office most of the time.	• Ensure all staff engage members in the community at a similar level as what was reported by staff interviewed. • Evaluate what clinic-based activities can transition to occur in members' communities. For members that are coming into the clinic multiple times a week, the team should explore how to deliver those services in the natural settings where members live, where staff can directly assess needs, monitor progress, model behaviors, and assist members to use resources in a natural, non-clinical setting.
S2	No Drop-out Policy	1 – 5 5	According to data provided, one member declined services with the team resulting in a 99% retention rate over a 12-month period.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff report the team follows the *8-Week Outreach Protocol* when members are not engaged in services. During the program meeting observed, staff discussed several members who were "on outreach" and noted plans for searching in the community. Staff interviewed reported multiple strategies including contacting members' natural supports, and checking the last known address, jails, medical examiner's office, and frequented community areas to locate members when on outreach. Records reviewed demonstrated evidence of community outreach attempts. However, there were two records with significant gaps ranging from several days to a couple weeks between documented outreach attempts.	• 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 entered. This may enable the team to proactively assign staff to outreach in the event of lapses.

S4	Intensity of Services	1 – 5 3	Per a 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 55 minutes. The record with the highest weekly average was 210 minutes. The average duration of phone contacts was 6.5 minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the duration of service delivery to members. ACT teams should provide an average of two or more hours of in-person services per week to help members with serious symptoms maintain and improve their functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on their individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 – 5 3	Of the ten records randomly sampled, ACT staff provided a median frequency of 2.63 contacts per week. The record with the highest frequency averaged 5.75 contacts a week and one member record had less than one contact a week.	• Members of ACT teams are not successful with traditional case management services and often require more frequent contact to assess current needs and to receive ongoing support. Improved outcomes are associated with frequent contact. All staff of the ACT team should be invested in delivering a high frequency of contacts to members. Those contacts should be individualized and align with treatment goals identified in member plans. • Increase the frequency of contact with members, ideally averaging four or more in-person contacts a week.
S6	Work with Support System	1 – 5 4	During the program meeting observed, natural supports were discussed for several members. Staff interviewed stated anywhere from 20 – 50% of members have a natural support with which the team has contact once a week. One member interviewed reported ACT staff interacting with their natural support every time they go into the clinic.	• Increase contacts with natural supports to an average of four per month for each member with a support system. As much as possible, contacts with natural supports should occur during the natural course of delivery of services provided to members. • Ensure all staff are documenting contact with natural supports in the EHR.

			Three of the ten member records reviewed were identified as having a natural support. The team documented 14 contacts with those natural supports during a month period reviewed. Contact with natural supports included hospital discharge planning, medication education, and general support.	
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 3	Per data provided, there were 61 members with a Co-Occurring Disorder (COD) diagnosis on the team at the time of the review. Staff responses varied on the number of members being provided formal structured substance use treatment services by COS staff, ranging from 18 – 55. This could be in part due to one of the COS staff members leaving the team the week before review. Staff interviewed indicated members are scheduled for weekly 30 – 45-minute individual sessions. During the program meeting observed, the COS included members' stage of change and attendance to Integrated Co-Occurring Treatment (ICDT) individual sessions. An additional member, not identified as having a COD, was engaged in weekly one-to-one sessions with the COS. Personal wellness, safety, and coping skills were common themes described by the COS. Of the 10 member records reviewed, seven members were identified as having a COD. Of those seven, none had individual IDDT sessions documented.	• Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with a co-occurring disorder diagnosis.
S8	Co-Occurring Disorder Treatment Groups	1 – 5 3	The ACT team COS is providing two ICDT groups at the clinic weekly and one ICDT group in the community weekly. According to sign-in sheets	• Optimally, 50% or more of members with a substance use disorder diagnosis attend at least one co-occurring disorder treatment

			provided by the team, 17 individual members with a COD attended at least one group in a month period reviewed resulting in a 28% attendance rate over all members with a COD. Three of the ten member records reviewed showed evidence of members attending ICDT group. Topics included coping strategies, developing a support network, and managing triggers. Staff reported utilizing the evidence-based practice *Integrated Dual Disorders Treatment Recovery Life Skills Program* as a reference for group facilitation.	group each month. All ACT staff should engage members with a co-occurring disorder diagnosis to participate in treatment groups based on their stage of change with content reflecting stage-wise treatment approaches.
S9	Co-Occurring Disorders Model	1 – 5 3	Staff interviewed were supportive of the COD model, integrating mental health and substance use services for each member's care. The team focused on the members' wellness goals and steps to take to support reaching that goal. Staff spoke of the endorsement of harm reduction tactics as members work to reduce use or use in a safer environment. Staff will step in to offer members other supports, such as job search assistance, when motivated to reduce use and move toward recovery. However, some staff stated that ideally abstinence is the goal. One staff identified the contradiction of hoping for abstinence yet also supporting members' personal goals which may be to reduce use. One staff expressed the COS role was to address substance use, while other staff's role was to address issues relating to mental health. Of records reviewed, three members with a COD had documented language referring to substance which was respectful and supportive of recovery.	• 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. • Ensure treatment plans are from the member's point of view, recovery focused, and outlines steps the team will take to address substance use while supporting the member in recovery.

			However, not all had a treatment plan that reflected how the team would address and support the members in steps toward recovery.	
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, shares the same responsibilities as all other staff, and shares their story with members when appropriate. Staff reported the team member also educates staff on member perspective and advocates for the members. All members interviewed were aware of staff on the team with lived experience.	
Total Score:		**105**		

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	4
4. Practicing ACT Leader	1-5	4
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	2
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	4
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5

5. Responsibility for Hospital Admissions	1-5	4
6. Responsibility for Hospital Discharge Planning	1-5	3
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
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	4
7. Individualized Substance Abuse Treatment	1-5	3
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.75**	
Highest Possible Score	**5**	