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 December 11 - 13, 2023, Fidelity Reviewers completed a review of the Terros Health 23rd Avenue Health Center Assertive Community Treatment 2 (ACT 2) 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.

The ACT 2 team is operated by Terros Health, a comprehensive healthcare organization, integrating behavioral health and primary medical care. The agency has four ACT teams. Two ACT teams, ACT 1 and ACT 2, are located at the 23rd Avenue Health Center in Phoenix, Arizona. The individuals served through the agency are referred to as *clients* or *members* for the purpose of this report, and for consistency across fidelity reports, the term *member* will be used.

The SAMHSA ACT Fidelity Review tool does not accommodate 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 observe meetings, and to interview staff and members.

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

- Remote observation of an ACT team program meeting on December 12, 2023.
- Individual videoconference interview with the Clinical Coordinator.

- Individual videoconference interviews with the Peer Support Specialist, Housing Specialist, two Co-Occurring and two Vocational Specialists.
- Individual phone interviews with five members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator, Site Administrator, Program Analyst, and representative from the contractor with a Regional Behavioral Health Agreement (RHBA).
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: Clinical Coordinator productivity report, resumes and training records for Vocational and Co-Occurring Specialist staff, *Mercy Care ACT Admission Criteria*; *Welcome to Assertive Community Treatment* handout, *Assertive Engagement Protocol*, member calendars, co-occurring disorder treatment group sign-in sheets, and copies of The Cognitive Behavioral Solution, *Co-Occurring Disorder Integrated Assessment and Treatment of Substance Use and Mental Disorders*, and *Counseling for Relapse Prevention* as the referenced co-occurring disorder treatment manuals.

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 with little room for improvement*).

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team is composed of 12 staff, an adequate size to provide necessary staffing diversity and coverage, with no vacant positions on the team.
- The ACT Clinical Coordinator excels at providing direct in-person services to ACT members, which includes in the community.
- The team has a high rate of intensity and frequency in providing direct services to members in a community setting.
- The team receives weekly training related to co-occurring disorders and incorporates the stage-wise approach into treatment interventions.

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

- There is limited involvement by members in individual and co-occurring disorders group treatment provided by the team. Increase engagement of members in individual and group treatment. The entire ACT team is responsible for engaging members in substance use treatment services.
- Increase contacts with natural supports to an average of four (4) per month for each member with a support system. Continue efforts to involve natural supports in member care.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The team has a member to staff ratio of approximately 9:1. The team services 92 members with eleven direct service staff, excluding the Psychiatrist and administrative staff. Staff includes the Clinical Coordinator (CC), two Nurses, Co-Occurring Specialist, Licensed Associate Counselor, Rehabilitation Specialist, Employment Specialist, Housing Specialist, Independent Living Specialist, Peer Support Specialist and ACT Specialist.	
H2	Team Approach	1 – 5 5	Ten randomly selected member records showed 100% of members received in-person contact from more than one staff in a two-week period. Staff reported using a geographic zone approach combined with a member engagement report provided by site administration is used to determine team rotation assignments. All members interviewed reported knowing each team staff and their role on the team. Members reported seeing multiple staff each week.	
H3	Program Meeting	1 – 5 5	Staff reported meeting four days a week to review all members of the team. Meetings are conducted in-person, and all staff are expected to attend. The Psychiatrist leads the meeting and provides direction for care.	

			During the program meeting observed, all staff were in attendance excluding the Psychiatrist, who was on personal time off during the review week. In absence of the Psychiatrist, the CC lead the program meeting; all members on the roster were briefly discussed. The team discussed members' individual needs for housing, appointments, inpatient status, and identified member stage of change, engagement level, and outreach efforts. The CC provided direction to staff and interventions to engage members based on current needs.	
H4	Practicing ACT Leader	1 – 5 4	The CC estimated providing ten hours of direct services to members per week. Reported activities included accompanying members to specialist appointments, hospital visits, and home visits. A review of a productivity report for the CC for a recent month period showed the CC provided direct in-person services 49% of the time expected of other ACT staff. Seven of the records reviewed showed in-person services delivered related to medication observation, employment support, independent living skills, and coordination of care with psychiatric inpatient staff. *This item is dependent on the Provider productivity expectation.*	• Continue efforts to provide in-person services to members. Optimally, the ACT CC delivers direct services to members accounting for at least 50% of the expected productivity of other ACT staff.
H5	Continuity of Staffing	1 – 5 5	Based on the data provided and reviewed with staff, three staff left the team in the past two years resulting in a turnover rate of 13%. The Nurse was the only position that experienced turnover.	
H6	Staff Capacity	1 – 5	In the past 12 months, the team operated at approximately 97% of full staffing capacity. There	

		5	were five months of Nurse vacancies in the past year.	
H7	Psychiatrist on Team	1 – 5 5	The team has a fully dedicated Psychiatrist. Services are delivered in-person at the clinic and in the community. Staff reported the Psychiatrist directs the team on member treatment interventions. The Psychiatrist is readily available to the team in-person, by phone, afterhours, and weekends.	
H8	Nurse on Team	1 – 5 5	Two full-time Nurses are assigned to the team. Each work four 10-hour staggered workdays. Nurses provide medication education, administer injections, attend specialty provider appointments with members, coordinate prescription refills, and complete home visits and annual health assessments. Nurses are accessible to the team in-person, by phone, text message, which includes afterhours. One Nurse is the lead for clinic and staff report this does not diminish their role on the team.	
H9	Co-Occurring Disorder Specialist on Team	1 – 5 5	The team has two Co-Occurring Specialist (COS) staff responsible for providing substance use treatment services to 71 members with co-occurring disorders. One COS is a Licensed Associate Counselor (LAC) and has been in the role since February of 2020. Training records showed recent training related to behavioral health treatment of substance use disorders. The LAC conducts team trainings weekly on Integrated Co-Occurring Disorders Treatment, which includes the stage-wise approach, and motivational interviewing.	

			The second COS has been in been the role since June of 2016. Training records showed recent training related to behavioral health treatment of substance use disorders. In addition, this COS attends the weekly training provided by the LAC.	
H10	Vocational Specialist on Team	1 – 5 5	The team has two Vocational Specialists, an Employment Specialist (ES) and a Rehabilitation Specialist (RS). Both the ES and RS have been with the team since 2019. Training records showed both staff completed recent training related to assisting members in finding competitive employment in an integrated setting. Staff report attending quarterly employment and rehabilitation meetings with Vocational Rehabilitation and RBHA.	
H11	Program Size	1 – 5 5	The team is served by 12 staff, including the Psychiatrist. All specialty roles were filled at the time of the fidelity review, allowing for diversity and coverage.	
O1	Explicit Admission Criteria	1 – 5 5	The team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. Based on interviews, the CC conducts in-person screenings with potential members. The CC utilizes an admission checklist to determine eligibility. The CC will discuss potential new members with the Psychiatrist who will then complete a doctor-to-doctor staffing with the referring entity. The Psychiatrist and CC collaborate to make the final determination for all new admissions. Referrals are received from the RBHA, hospitals, outpatient clinics, and internally within Terros. The CC collaborates with agency staff to recruit new referrals for members with high rates of hospitalization or who may require a higher level of care than standard case management.	

O2	Intake Rate	1 – 5 5	Per data provided, the team has an appropriate rate of admissions. The highest rate of admission was no more than one new member added to the roster a month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team directly provides psychiatric services, counseling/psychotherapy, and substance use treatment. Per staff interviews, approximately 9 - 10 members reside in residential placements that provide similar support services of team staff. Staff reported six members are competitively employed and five members are engaged in job searching. Members' vocational goals are supported by staff through resume building, job search, mock interviews, transportation to interviews, resources for work clothing, speaking with employers when the member requests, mock discussions with employers, and connecting to Vocational Rehabilitation. Two members are connected to a Work Adjustment Training Program that provides vocational training and development, a duplication of ACT services. One member interviewed reported staff helped connect them to a volunteer opportunity at the clinic where work skills are practiced.	• Continue to monitor the number of members in staffed residences. As the designated Permanent Supportive Housing services provider, the ACT team, to the extent possible, should seek to move members to independent housing units in integrated settings where all housing support and case management responsibilities are provided by the ACT team. Optimally, members on ACT teams receive all services and support from the team. • Ensure outside providers (Vocational Rehabilitation) are aware that in the model of ACT members are to receive all services from within the team, i.e., employment services, and that referral to outside agencies/programs is not in alignment with the Evidence-Based Practice (EBP) of ACT.
O4	Responsibility for Crisis Services	1 – 5 5	Based on interviews, the team is available to provide crisis services to members 24 hours a day, seven days a week. Staff rotate on-call responsibilities weekly, with a second staff assigned as back-up to the on-call. When calls are received, staff attempt to deescalate by phone and	

			will meet members or emergency services in the community when needed. Staff will transport members to the hospital and assist with the admission process. Reviewers were provided a copy of the *Welcome to Assertive Community Treatment (ACT)* handout that is provided to members and natural supports. The handout identifies the on-call phone number, staff phone numbers, and a brief description of each role on the team.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff reported the team is directly involved with coordination of psychiatric hospital admissions. When a member is experiencing increased symptoms or in crisis during business hours, staff will meet members in the community and bring them into the clinic. Members will meet with the Psychiatrist and/or Nurse to triage. When needed, staff will transport the member to the hospital and assist with the admission process. Staff provide hospital staff with medication lists, last Psychiatrist progress notes, and team contact information. Staff visit members in the hospital three times a week, and complete nurse-to-nurse calls weekly. Per the data provided and reviewed with staff, the team was responsible for 70% of psychiatric hospital admissions in a month period. For admissions the team was involved with, staff observed increased symptoms and coordinated with team psychiatrist prior to the hospital admission. Staff provided assistance to the members through the admission process and provided the hospital with current medication lists, last prescriber progress notes, and the team's	• ACT teams performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admissions.

			contact information. There were four admissions where the team determined there was reasonable cause to petition for involuntary admission. Three members were admitted without the teams' prior involvement.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Per review of data received and reviewed with staff, the team was directly involved with 100% of member psychiatric hospital discharges that occurred over a month timeframe. Staff reported coordinating discharge planning prior to members leaving the hospital. The team will also coordinate with members' natural support during discharge planning. Upon discharge, members are scheduled to meet with the Psychiatrist within 72 hours, follow up with the Nurse within seven days, and the team coordinates a follow-up appointment with the members' Primary Care Physician. The team will pick the member up from the hospital, transport to the pharmacy, conduct a housing safety check for utilities and food, and then meet the member in-person for five days consecutively to check on progress and medications.	
O7	Time-unlimited Services	1 – 5 5	A review of data provided showed that the team did not graduate any members in the 12 months before the review. Staff reported they did not anticipate graduating any members in the next 12 months. Staff reported that when recommending graduation, the team reviews the member's improvements with psychiatric hospitalizations, medication management skills, improvements in independent living, and if the member expresses	

			the desire for less intensive services. The team, including the Psychiatrist, will meet with the member, and their natural supports, to determine an appropriate step-down process.	
S1	Community-based Services	1 – 5 5	Staff reported that 80 - 90% of in-person contact occurs in a community setting. The results of ten randomly selected member records reviewed show staff provided services a median of 82% of the time in the community. Records reviewed showed staff providing services in member homes, at grocery stores, and conducting community-based counseling. Two records showed all contacts were in the community. Four additional records showed at least 80% of services were delivered in the community.	
S2	No Drop-out Policy	1 – 5 5	According to the data provided and reviewed with staff, the team had a retention rate of nearly 100% over the past year. The team identified three members that moved from the area without referrals and three that were remanded to the Department of Corrections. The team experienced five member deaths.	
S3	Assertive Engagement Mechanisms	1 – 5 5	All Staff interviewed reported attempting contact with members at least four times a week. If appointments are missed or the member was unable to be located, staff attempt two physical and two electronic outreaches a week for eight weeks. Outreach includes a physical search of known hangouts, shelters, and last-known residences. Phone calls are made to medical facilities, jails, the morgue, payee's office, as well as to natural supports, guardians, and probation officers. Staff reported staffing individual scenarios	

			with the Psychiatrist in order to receive next steps for closure or to extend outreach beyond the eight-week protocol. Reviewers were provided with a copy of the team's Assertive Engagement Protocol. During the program meeting observed, staff identified members on outreach, how many weeks of outreach have been completed, and discussed next steps of engagement.	
S4	Intensity of Services	1 – 5 4	Per review of records, during a month period prior to the fidelity review, the median amount of time the team spent in-person with members per week was 103 minutes. The range for intensity was 22 to 221.75 minutes a week. Phone contact was provided at an average frequency of .50 contacts per week. *The fidelity tool does not accommodate delivery of telehealth services.*	• Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. ACT teams provide members with an average of two (2) or more hours of in-person contact weekly.
S5	Frequency of Contact	1 – 5 5	The records reviewed showed a median frequency for in-person contact of 4.13 times per week. The range for frequency was 1.25 to 11.25 contacts weekly. Seven of the ten member records had four or more in-person contacts per week.	
S6	Work with Support System	1 – 5 3	Staff reported that 54% (50) members have natural support. Staff will call or email natural supports once a week. The team tracks natural support contact during the daily program meeting, the member's electronic health record, and in a specific binder the team utilizes to track contact which includes names, contact information, and contact dates.	• Continue efforts to engage members' natural support systems as key contributors to the member's recovery team. Consider the role of staff to model recovery language and provide suggestions to family members and other natural supports how they can support member care.

			Records reviewed showed an average of 1.90 documented contacts with members' natural support in a month period. Five of the ten member records reviewed indicated at least one contact with the member's natural support. Reviewers identified approximately 16 reported contacts to natural supports during the program meeting observed. Members interviewed reported staff will contact natural support in an emergency situation, or that contact with their natural support was unknown.	
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 4	At the time of review, 71 members were identified as having co-occurring disorders. Staff reported both Co-Occurring Specialists provide individual substance use counseling to members identified with co-occurring disorders. Staff reported providing individual substance use counseling to 24 members. Members are scheduled weekly and are seen for approximately 45 – 60 minutes. Staff reported using a *stage-wise approach* to co-occurring disorders treatment and using *motivational interviewing* to help members through the stages of recovery. Calendars provided to reviewers, of a recent month before the review, showed 24 members were scheduled for individual treatment sessions. Schedules did not indicate the actual time spent with the member. Records reviewed identified six members with co-occurring disorders. Of those, two records had documented individual treatment sessions ranging from 43 to 60 minutes.	• Monitor member engagement and participation in individual substance use treatment.

S8	Co-Occurring Disorder Treatment Groups	1 – 5 3	The team provides two substance use treatment groups weekly. One group supports members in the pre-contemplative/preparations stage of change, and the second group supports members in the maintenance stage of change. Staff reported that 24 members attend at least one group per month. A review of group sign-in sheets from a month period before the review showed that approximately 24 unique members (34%) with co-occurring disorders attended at least one group.	• Continue to engage members with co-occurring disorders to participate in group substance use treatment, as appropriate, based on their stage of change. Ideally, 50% or more of applicable members participate in a co-occurring disorder group monthly.
S9	Co-Occurring Disorders Model	1 – 5 5	Staff interviewed reported attending a weekly training that supports awareness and education for the provision of Integrated Co-Occurring Disorders Treatment. Staff provided examples of *stage-wise* interventions and *motivational interviewing* techniques to support members through the *stages of change* based on goals identified by the member. Staff use *harm-reduction* education to help reduce negative outcomes from substance use. The Psychiatrist prescribes all members a standing order for Narcan and will coordinate with Medication Assisted Treatment (MAT) programs. Staff interviewed modeled language that was not shaming or blaming during interviews. Supportive and recovery focused language was also modeled in member records reviewed. Records reviewed identified six members with co-occurring needs. Treatment plans showed varied and unique member interventions for one-to-one counseling, MAT programs, group therapy,	• Continue to provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as Integrated Co-Occurring Disorders Treatment, in the principles of a stage-wise approach to interventions, the EBP of harm reduction, and motivational interviewing.

			attending peer-run services, and engagement with the Peer Support Specialist. Reviewers were provided with cover sheet copies for *Co-Occurring Disorders: Integrated Assessment and Treatment of Substance Use and Mental Disorders,* and *Counseling for Relapse Prevention* as some of the referenced co-occurring disorders treatment manuals.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has at least one staff with lived psychiatric experience that has the same responsibilities as other ACT staff. Most members interviewed reported staff share stories of their living psychiatric experience.	
Total Score:		**131**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	5
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	4
5. Continuity of Staffing	1-5	5
6. Staff Capacity	1-5	5
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Co-Occurring Specialist on Team	1-5	5
10. Vocational Specialist on Team	1-5	5
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	4
6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5

Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	5
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	5
6. Work with Support System	1-5	3
7. Individualized Co-Occurring Disorder Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	5
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.68**	
Highest Possible Score	**5**	