ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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Introduction

Arizona Health Care Cost Containment System has contracted with the 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 August 26 – 28, 2024, Fidelity Reviewers completed a review of the Community Bridges, Inc. (CBI) – Mesa Heritage ACT team. This review is intended to provide specific feedback in the development of your agency's ACT services in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

CBI was founded in 1982 and has multiple locations across Arizona. CBI offers a range of services such as supportive housing, crisis stabilization, ACT, and integrated healthcare.

The individuals served through the agency are referred to as *client* or *member*, but for the purpose of this report, and for consistency across fidelity reports, the term *member* will be used.

The SAMHSA ACT Fidelity Review tool does not accommodate 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 August 27, 2024.
- Individual videoconference interview with the Clinical Coordinator.
- Individual videoconference interviews with Co-Occurring Disorders, Housing, Vocational, Peer Support, and ACT Specialists.
- Individual phone interviews with two members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator, and representative(s) from the contractor with a Regional Behavioral Health Agreement.
- Charts were reviewed for 10 randomly selected members using the agency's electronic health records system. The sample included members from the following health plans: Mercy Care, Developmental Disabilities Division, and Other (Medicare, Private, other source of coverage).
- Review of documents: *Mercy Care ACT Admission Criteria*; copies of cover pages from the *Integrated Dual Diagnosis Treatment (IDDT)* and *Recovery Life Skills Program* manuals*;* co-occurring disorders treatment group sign-in sheet; resumes and training records for the Vocational and Co-Occurring Disorders Specialist staff; Clinical Coordinator productivity Report, and a copy of the agency re-engagement protocol.

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 meets in person four days a week to review all members, discuss immediate needs, and plan staff interventions.
- The team was involved in 100% of the ten most recent psychiatric hospital discharges.
- The team has a low graduation rate and maintained 96% of the member caseload over the past year.
- The team has at least one staff member with lived psychiatric experience that shares their lived experience.

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

- Identify factors that contributed to staff turnover and implement a protocol that supports retention. The team experienced a staff turnover rate of 104% during the past two years.
- Develop standards for how the team would be directly involved in supporting members, and their natural supports, when potentially requiring inpatient psychiatric care. The team was involved in psychiatric admissions 60% of the time.

- Increase the intensity of services delivered to members. The team averaged 59 minutes for intensity of services weekly. ACT services average two (2) hours or more of in-person services weekly. ACT services are responsive to members, adjusting in intensity as it relates to their individual needs and preferences.
- Increase the frequency of contact delivered to members. The team provided a median of 1.5 direct weekly contacts. ACT staff provide services to every member on average four (4) times a week.
- 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 co-occurring disorders group monthly.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, the team served 90 members with eight (8) full-time equivalent (FTE) direct service staff, excluding the psychiatric provider and administrative staff. The member-to-staff ratio is approximately 11:1. The team is composed of a Clinical Coordinator, Nurse, Employment Specialist, Housing Specialist, ACT Specialist, Independent Living Specialist, Peer Support Specialist, and a Co-Occurring Disorders Specialist.	• Ensure necessary staffing for a member to staff ratio of no greater than 10:1, excluding the Psychiatric Prescriber.
H2	Team Approach	1 - 5 3	Staff reported 80% of members have contact with at least two staff over a two-week period. Staff use a geographic zone approach to plan engagement. The areas staff are assigned rotate every one to two weeks. Based on 10 randomly selected member records for a month period, a median of 60% of members received in-person contact from more than one specialist in a two-week period. Members reported typically meeting with two or more staff each week.	• Ideally, 90% of ACT members have in-person 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 every two weeks; a diversity of staff allows members access to unique perspectives and expertise of staff.
H3	Program Meeting	1 – 5 5	Staff reported meeting in person four days a week and discussing the entire member roster. All staff, including the psychiatric prescriber, attend meetings on scheduled workdays. The program meeting observed by reviewers occurred in person. The Clinical Coordinator led the meeting and provided staff with direction	

			and treatment planning. The psychiatric prescriber provided staff with updates on members' mental and physical health and recommended treatment interventions. Staff engaged in discussion and planning about members' current needs, contact with natural supports, service plan updates, medication updates, and outreach planning.	
H4	Practicing ACT Leader	1 – 5 2	The Clinical Coordinator estimated delivering in-person services to members one hour a week. The Clinical Coordinator reported delivering services to members through activities such as creating a budget, public transit assistance, food pantry assistance, and engaging members at their homes and hospital settings. According to the Clinical Coordinator productivity report, for a 30-day period, the Clinical Coordinator provided seven percent of the 28 hours per week team expectation of providing direct service. Of the 10 records reviewed, one showed the Clinical Coordinator attending an in-person hospital staffing. Additionally, three records showed phone coordination with hospital staff. *The fidelity tool does not accommodate delivery of telehealth services. This item is dependent on the Provider productivity expectation.*	• Optimally, the ACT Clinical Coordinator delivers direct services to members and accounts for at least 50% of the expected productivity of other ACT staff. Increase in-person member contact. Practicing ACT leaders can engage in a range of member care needs including providing counseling/psychotherapy, facilitating or co-facilitating co-occurring disorders treatment groups, providing support and advocacy at mental health court, participating in inpatient psychiatric staffing, shadowing and mentoring specialists delivering community-based services, such as assertive outreach, hospital visits, and skill building activities designed to promote integration and recovery. • The Clinical Coordinator and agency may consider identifying administrative functions not essential to the Clinical Coordinator that could be performed by the program assistant or other team members.
H5	Continuity of Staffing	1 – 5	The team experienced turnover in each specialty position, including two Psychiatric Providers and two Clinical Coordinators. Based on data	• Ideally, turnover should be no greater than 20% over a two-year period. Consistency in staffing contributes to

		1	provided and reviewed with staff, 26 staff left the team during the past two years, resulting in a turnover rate of 108%.	building therapeutic relationships with members and their supports, as well as reducing the potential burden on staff. • Support specialty staff to work in their area of interest and expertise with members. Research shows staff remain in positions longer when supported in their roles by being provided supervision and training in their specialty practice.
H6	Staff Capacity	1 – 5 3	In the past twelve months, the team operated at approximately 69% of full staffing capacity. There was a total of 44 vacant positions. The Vocational Specialist position was vacant for eleven months, and the Co-Occurring Disorders Specialist position for nine months.	• Continue efforts to retain qualified staff with the goal of operating at 95%, or more, of full staffing annually. • When applicable, fill vacant positions with qualified staff as soon as possible. In an effort to support retention, ensure staff receive training and supervision for their specialty.
H7	Psychiatrist on Team	1 - 5 5	The team has a fully dedicated Psychiatric Mental Health Nurse Practitioner (Prescriber). The Prescriber works four 10-hour days a week and attends all program meetings. Services are delivered in-person at the clinic, in the community, and by videoconference as needed. Staff reported the Prescriber is directly involved in member treatment planning and is accessible in person and by phone, during office hours.	
H8	Nurse on Team	1 – 5 3	The team has one dedicated Nurse who works four 10-hour days a week. The Nurse provides services in the office and the community. The Nurse provides case management, medication education, administers injections, attends other health provider appointments alongside members, and completes annual health assessments. The Nurse rotates with other	• Ensure appropriate ACT team coverage of two full-time 100% dedicated Registered Nurses per 100 members.

			agency Nurse staff to provide after-hours phone coverage for the agency. Seventy percent of member records reviewed showed office and community-based services which included: providing injections, blood draws, medication education, hospital follow-up, and health assessments.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 3	The team has one Co-Occurring Disorders Specialist. Per resume and staff interview, the Co-Occurring Disorders Specialist has at least one year of work experience in providing substance use treatment services. Training records for a two-year period show staff completed five hours of training relating to substance use treatment.	• ACT teams are staffed with two Co-Occurring Disorders Specialists for a roster of 100 members, each with one year or more of training/experience providing substance use treatment services. • Co-Occurring Disorders Specialists are provided with eight (8) hours of annual training in co-occurring disorders treatment best practices, including appropriate interventions, i.e., *stage-wise approach*; the evidence-based practice of *harm reduction*; and *motivational interviewing*. On ACT teams, Co-Occurring Disorders Specialists have the capability to cross-train other staff, providing guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorders model utilized by the team.
H10	Vocational Specialist on Team	1 - 5 2	The team has one Employment Specialist. The resume and training records provided did not evidence training, or experience related to supporting individuals with a serious mental illness in obtaining and retaining jobs. According to interviews, the Employment Specialist staff participates by phone in a monthly, agency-wide	• Optimally, 100-member ACT teams are staffed with two Vocational Specialist staff. • Ensure that both vocational staff receive ongoing training in assisting people diagnosed with serious mental illness/co-occurring disorders to find and retain competitive employment.

			Vocational Specialist training and resource sharing.	
H11	Program Size	1 – 5 4	The team was comprised of nine FTE staff and sufficiently sized to provide diversity and coverage to members. Current vacant positions include one Co-Occurring Disorders Specialist, one Rehabilitation Specialist, and one Nurse. *This item does not adjust for the size of the member roster. (include when scored down)*	• Continue efforts to hire and maintain adequate staffing. A fully staffed team, with a minimum of 10 direct service staff, 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	The team uses the *Mercy Care ACT Admission Criteria* to assess eligibility for potential new admissions. Referrals come from local contractors with a Regional Behavioral Health Agreement (RBHA), hospitals, outpatient clinics, and within the agency. Based on interviews, the Clinical Coordinator receives referrals, reviews supporting documents to screen for initial eligibility, and completes a staffing with referring entity. A team staff will conduct an in-person meeting with the potential member, reviewing information about hospitalizations, daily living activities, employment, criminal justice involvement, medication management, housing, and any other concerns or service needs. The Prescriber and Clinical Coordinator have the final say in admitting new members. When an eligible member declines ACT services, the team will outreach the member three times to provide additional opportunities to accept the service.	

			When a referral is not accepted, the team initiates a complex case review prior to declining the referral.	
O2	Intake Rate	1 - 5 5	Per data provided, the team has an appropriate rate of admission. The highest intake rate occurred in March, with four (4) new members admitted.	
O3	Full Responsibility for Treatment Services	1 - 5 3	In addition to case management, the team provides psychiatric services and medication management, and employment and rehabilitative services. More than 10% of members reside in housing settings where ACT services are duplicated. Staff reported providing members housing services such as locating residential options, completing housing applications, lease agreement and housing inspection support, and talking to landlords. One member reported that staff assisted with finding their current housing. Counseling/psychotherapy is not provided by the team; members in need of counseling are referred off the team. One member reported receiving counseling from non-ACT staff and expressed the desire to receive this service from the team. Staff reported approximately 11% of members with co-occurring disorders receive substance use treatment off the team. Brokered services include intensive outpatient treatment programs and inpatient treatment.	• Ensure ACT staff coordinate treatment and services delivered to members that receive support from other agency programs. • 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. • Counseling/psychotherapy is made available to members on ACT teams and is provided by ACT staff. This staff will also act as a generalist within the team. • ACT teams fully assume responsibility for providing members with formal substance use treatment in an integrated setting staying within the team approach of the EBP.

O4	Responsibility for Crisis Services	1 - 5 5	Staff reported the team offers 24-hour on-call crisis services. Members are provided with a handout with the phone numbers for staff and the after-hours line. Staff rotate on-call phone coverage weekly. Members can call the after-hours line for any reason. When a member contacts the line, staff attempt to de-escalate the situation by phone. When members remain escalated, the team will staff with an on-call ACT agency Clinical Coordinator and team staff will meet members in the community to provide direct support. The Members interviewed reported awareness of after-hour availability.	
O5	Responsibility for Hospital Admissions	1 - 5 3	Per interviews, when members report increased symptoms, staff will go into the community for an in-person assessment. Staff will coordinate a videoconference call with the Prescriber. When inpatient stabilization is recommended, staff transport members to a hospital. Staff provide support to members during intake and gives intake staff medication lists and team contacts. Staff will stay with member till admission. Per data reviewed with staff, the team was involved in 60% of the 10 most recent psychiatric hospital admissions that occurred over a one-month time frame. Of the hospitalizations in which the team was not involved; a natural support submitted a petition for a court evaluation without seeking assistance from the team, and three members self-admitted.	• ACT teams, performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admissions. Evaluate what contributed to members not seeking team support prior to self-admission. • Maintain regular contact with members and their support networks, both natural and formal. This may result in earlier identification of issues or concerns relating to members, allowing the team to offer additional support, which may reduce the need for hospitalization. Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions.
O6	Responsibility for Hospital	1 – 5	Staff reported discharge planning begins within 24 hours of admission. Staff coordinate care through sharing records, staffing with the member and hospital discharge planners, and	

	Discharge Planning	5	doctor to doctor consultation. Staff visit members every 72 hours. Upon discharge, staff meet members for a warm handoff, transport them to the store or pharmacy, if needed, and then to the planned discharge location Staff will conduct safety checks of the members' homes upon arrival. Members are scheduled to see the Prescriber and Nurse within 72 hours of discharge. Staff follow up with the member in-person for five days following discharge. Per data reviewed with staff, the team was involved in 100% of the 10 most recent hospital discharges that occurred over a one-month time frame.	
O7	Time-unlimited Services	1 – 5 5	The team provides time-unlimited services. Members choose how long they receive services. The data collected and reviewed with staff, show three members graduated in the past 12 months. Staff reported four members are expected to transition to lower levels of care in the next 12 months.	
S1	Community-based Services	1 – 5 2	Staff reported 80% of in-person contacts with members occur in a community setting. Results of 10 randomly selected member records reviewed show staff provided services a median of 38% of the time in the community. Per records reviewed, community-based services included safety checks, hospital visits, medication education, blood draws, transportation from hospitals, and updating annual documents. Three member records showed zero community contact.	• ACT programs in good fidelity emphasize contacts in natural, community settings for optimal status monitoring and skill development. Skills demonstrated in clinic-based groups, designed primarily for socialization and to offer meaningful activities, may not transfer to community settings, where challenges are more likely to occur. Increase total services to at least 80% delivered being in the community.

			Members interviewed reported seeing staff, including the Nurse, most often in their community.	
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team had four members leave the program in the past year. Three members were incarcerated, and one could not be located. The team retained 96% of the total number of members served in the past 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Reviewers were provided a copy of the agency re-engagement Protocol. Per staff interviews, when members miss appointments, engagement efforts begin within 24 hours. Outreach is conducted at a minimum of eight weeks of attempts to re-engage the members. With four outreach attempts each week: two in the community and two electronic. Staff go to last known addresses, areas members are known to frequent, community centers, and parks. Staff will make phone calls to natural support, payees, probation officers, hospitals, jails, and the medical examiner's office. Records showed contact attempts by phone, home visits, communication with paid and natural supports. Eight of the records documented efforts ranging between 5 - 11 days apart.	
S4	Intensity of Services	1 - 5 3	Per a review of 10 randomly selected member records, over a 30-day period, the median amount of time the team spent in-person with members per week was approximately 59 minutes. The average ranged from 0 - 91 minutes. The median phone contact per member is .50 calls per week.	• Increase the duration of service delivery to members. ACT teams provide an average of two (2) or more hours of in-person services per week. This is based on all members across the team; some may require more time and some less,

			The fidelity tool does not accommodate delivery of telehealth services.	week to week, based on individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 – 5 3	Per records reviewed, staff provided a median frequency of 1.50 weekly in-person contacts to members. The record with the highest frequency was 2.50 in-person contacts per week; two records showed zero weekly contacts.	• Increase the frequency of contact with members, ideally averaging four (4) or more in-person contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact.
S6	Work with Support System	1 – 5 3	Staff reported 71 members have natural support. Staff contact natural supports weekly to monthly. Natural supports are invited to treatment planning meetings and some clinic-based groups allow natural supports to attend alongside the member. During the program meeting observed, the team reported on recent contacts with natural support for the purpose of coordinating housing placements, court hearings, intensity of services step-down process, and during a home visit. One member reported that staff having contact with their natural support is helpful and their natural support can contact the team directly. Per review of 10 member records, the ACT team has an average of 1.8 contacts with members' natural support in a month period.	• Increase contacts with natural supports to an average of four (4) per month for each member with a support system. As much as possible, contact natural supports during the natural course of delivery of services provided to members. • Evaluate methods of tracking or monitoring staff documentation of contacts with Natural Supports.
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	According to data provided and reviewed with staff, there are 47 members with co-occurring disorders; staff reported 20 of these members are currently engaged in individual substance use treatment. Each Member is scheduled for a weekly individual session that ranges from five minutes to an hour, depending on the member's	• Continue efforts to provide an average of 24 minutes, or more, per week of structured individualized substance use treatment services for all members with co-occurring disorders.

			desired intensity. Staff reported referencing the *Integrated Dual Diagnosis Treatment (IDDT) model,* and the *Recovery Life Skills Program* manuals when providing substance use treatment to members. Five members were identified as having a co-occurring disorder of the ten reviewed; three records evidenced weekly, individual substance use treatment; sessions ranged 38 - 90 minutes in length.	• Monitor member engagement and participation in individual substance use treatment.
S8	Co-Occurring Disorders Treatment Groups	1 – 5 3	The team provides one clinic based co-occurring disorders group weekly. Staff reported eight members attend one group each month. A review of group sign-in sheets for a month prior to the review showed that 8% (four) unique members with co-occurring disorders attended a group.	• Optimally, 50% or more of members with a substance use disorder attend at least one co-occurring disorders treatment group each month. On ACT teams, all staff engage members with co-occurring disorders to participate in treatment groups, based on their stage of change, with content reflecting stage-wise treatment approaches. • Consider offering groups so that at least one is structured for members in earlier stages, and one is available for members in later stages of recovery. Interventions should align with a stage-wise approach (drawing from best practices in co-occurring disorder treatment).
S9	Co-Occurring Disorders Model	1 – 5 4	Staff reported using rapport-building, harm-reduction strategies, and stage-wise approaches for members with co-occurring disorders. Some staff reported a lack of awareness regarding the team's approach to addressing co-occurring disorders. However, staff will refer to the Co-Occurring Disorders Specialist, Nurse, Peer Support, or Prescriber for treatment	• 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*.

			interventions. Treatment planning is based on individual member goals and personalized to their needs. Staff reported encouraging reduction of use rather than the goal of abstinence. The team will refer to detox when medically necessary, and when a member expresses interest in peer-run programs, staff will offer to accompany the member. Of the five records identified as having co-occurring disorders, all had treatment plans with substance use goals; goals and interventions varied from engaging with peer support, developing coping skills, identifying triggers, participating in residential substance use treatment, and attending groups. Two of those treatment plans included traditional language, such as referring to sobriety as a requirement for obtaining housing and inpatient substance use treatment for managing sobriety.	• Consider adopting a team identified co-occurring model. Implementing a comprehensive model may help the team to maintain consistent service if Co-Occurring Disorders Specialist transition off the team and ensure staff draw from the same treatment resources. • Support Co-Occurring Disorders Specialist staff to provide the team with mentoring and modeling of an integrated co-occurring disorders model. Providing daily support to the team in best practices may improve the level of engagement in services by members.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has at least one staff who shares their personal lived or living psychiatric experience with recovery with members. This staff has the same responsibilities as other staff on the team. Both members interviewed reported awareness of having a Peer Support on the team and its benefits. One member reported the Peer Support is assisting with them with training to become a peer support specialist themselves.	
Total Score:		**TOTAL 102**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	4
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	1
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	3
9. Co-Occurring Disorders Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	2
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	3
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	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	3
7. Individualized Co-Occurring Disorders Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.64**	
Highest Possible Score	**5**	