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 April 11 – 12 2023, Fidelity Reviewers completed a review of the Copa Health Gateway 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 *clients* or *members*, 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 interview staff and members.

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

- Remote observation of an ACT team program meeting on April 11, 2023.
- Individual video conference interview with the ACT Clinical Coordinator.
- Individual video conference interviews with the Co-Occurring Specialist, Rehabilitation Specialist, and Peer Support Specialist.
- Individual phone interviews with three members participating in ACT services with the team.
- Ten randomly selected member charts were reviewed using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; *ACT handout*, sign-in sheets for co-occurring disorder groups, resumes for Vocational staff and Co-Occurring Specialist, *8-Week Outreach 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*).

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 has two Nurses that work exclusively with the members assigned to the team, delivering services in the community.
- The team has a fully dedicated Psychiatrist that is available 24-hours each day and is the team leader proving staff direction for member care.
- The ACT team provides Co-Occurring Disorder treatment groups where 56% of members with a co-occurring disorder attend.
- The ACT team has at least one staff member with lived psychiatric experience on the team that shares their stories.

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

- Several positions on the team (Employment Specialist, Housing Specialist, Co-Occurring Specialist, and ACT Specialist) are vacant. Work to fill vacant positions as soon as possible to help to reduce the potential burden on team staff and ensure members do not experience frequent turnover or disruption in services.
- Increase in-person contacts in the community directly supporting members. ACT services are best provided in the community where challenges are more likely to occur and where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural non-clinical setting.
- Increase the intensity of service and frequency of contact as it relates to members' individual needs and preferences.
- Increase engagement with natural supports as partners in supporting members' recovery goals. Staff may then be able to advise natural supports how they can reinforce healthy recovery behaviors and use recovery language when interacting with members.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	At the time of the review, there were seven full-time equivalent (FTE) staff on the team, excluding the Psychiatrist. It was reported that there are 98 members on the team, leaving the member-to-staff ratio of 14:1. The direct staff includes the Clinical Coordinator (CC), two Nurses, an Independent Living Specialist, a Peer Support Specialist, a Rehabilitation Specialist, and a Co-Occurring Specialist (COS).	• Ensure necessary staffing for a member-to-staff ratio of no greater than 10:1, excluding the Psychiatrist.
H2	Team Approach	1 – 5 4	Staff interviewed estimated 85 - 100% of members are seen by more than one staff in a two-week period. The team utilizes a zone rotation approach, where staff are assigned a new zone each day to ensure members have contact with every specialist on the team. Of ten randomly selected member records reviewed, a median of 80% of members received in-person contact with more than one staff in a two-week period.	• 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 5	Per staff report, the team meets Monday through Friday and discusses each member daily. One of the five days, the team holds longer meetings where members' needs are discussed more in-depth, and training is provided to staff, sometimes led by the team's COS. All staff attend on days they are scheduled to work, including the Psychiatrist. During the meeting observed, the CC lead the meeting and staff reported on stages of change for members with a co-occurring disorder, individual needs for housing, employment, and contacts with natural supports. The Psychiatrist provided the	

			team with direction and information on members' medication changes, medication side effects, and reported important factors for team staff to consider when engaging the members.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated delivering in-person services to members 50% of the time. Per report, services are provided to members in the community, the office, by email, and over the phone. Reported activities include housing support, home visits, and engaging with members at the clinic. Other services include coordination of care with inpatient teams, guardians, and natural supports. Of ten records reviewed, one member record showed the CC attending an in-person staffing for hospital discharge planning. Documentation requested of the CC's productivity was not received by reviewers. *The fidelity tool does not accommodate delivery of telehealth services.*	• Optimally, the CC's delivery of direct services to members should account 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 disorder treatment 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. • Identify administrative tasks currently performed by the CC that may be transitioned to other administrative or support staff, if applicable.
H5	Continuity of Staffing	1 – 5 3	Based on the data provided, 12 staff left the team in the past two years resulting in a turnover rate of 50%. Per staff interviews and data reviewed, the Nurses and (ILS were the most difficult to retain.	• If not done so already, attempt to identify factors that contributed to staff turnover or that support retention. 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 supports, as well as reducing potential burden on staff.

H6	Staff Capacity	1 – 5 4	The team operated at approximately 84% of staff capacity during the past 12 months. There was a total of 23 vacant positions in the past 12 months.	• Continue efforts to retain qualified staff with the goal of operating at 95% or more of full staffing annually.
H7	Psychiatrist on Team	1 – 5 5	The team has a full-time Psychiatrist that works Monday thru Friday. The Psychiatrist attends program meetings at least four times a week and delivers services to members in the community one day each week. The Psychiatrist is available to the team by phone, text, email, in-person, and afterhours. Staff interviewed reported the Psychiatrist is the leader of the team, provides clinical oversight, participates in treatment planning, and provides direction to staff on rehabilitation efforts.	
H8	Nurse on Team	1 – 5 5	The team has two Nurses that work exclusively with the members of the team and attend program meetings four times a week. At the time of the review one Nurse was in the process of onboarding the team. The Nurses work four, ten-hour days. Staff reported that the Nurses provide services in office and in the community, administering injections, completing laboratory test blood draws, providing medication education, and coordinating medical appointments. The Nurses are accessible to the team in-person, by phone, email, and are available by phone after hours.	
H9	Co-Occurring Specialist on Team	1 – 5 3	The team is staffed with one COS. The COS has been with the team since June 2020.The COS is provided with group clinical supervision weekly and completes annual co-occurring disorders training through Relias.	• Fill the vacant second COS position. Optimally, ACT teams are staffed with two COS for a roster of 100 members, each with a year or more of training/experience providing substance use treatment. • Provide annual training to COS 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. The Rehabilitation Specialist has been with the team for 13 months. The Rehabilitation Specialist completed training provided by Mercy Care and another trainings on employment-related services.	• Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met. • Ensure vocational staff, regardless of experience, receive ongoing training and supervision in assisting people diagnosed with serious mental illness/co-occurring diagnoses to find and retain competitive employment.
H11	Program Size	1 – 5 4	At the time of the review, the team had eight staff including the Psychiatrist. Four positions were vacant, the second Co-Occurring Specialist position, the Housing Specialist, the ACT Specialist, and the Employment Specialist. *This item does not adjust for the size of the client/member roster.*	• Hire and maintain adequate staffing. A fully staffed team, 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 utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. New referrals are received from the Regional Behavioral Health Authority (RBHA), hospitals, Copa Health supportive teams, and other provider network organizations. Screenings of new referrals are conducted by ACT staff. Interviewees reported the Psychiatrist makes the final decision when the member is appropriate for the team. Staff reported that when a member has reservations about joining the team, staff will complete up to three screenings with a diversity of	

			staff from the team to provide additional information and answer any questions pertaining to services.	
O2	Intake Rate	1 – 5 5	Per data provided, and reviewed with staff, the team has an appropriate admissions rate. The months with the highest admissions rate during the past six months were February and March, with three new members added each month to the team roster.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric and medication services. No members receive psychiatric services outside the team. The team has one COS to provide both individual and group substance use treatment to 63 members with a co-occurring disorder. At the time of the review, the Employment Specialist position was vacant. The Rehabilitation Specialist, along with other team staff, provides employment support to 12 members. Four of those members are competitively employed. Two members are in a work adjustment training program, and no members are referred off the team for employment services. Counseling/psychotherapy for the team members is provided by a non-team staff assigned to work with 6 – 10 members. One Member interviewed reported being engaged in counseling services with another provider. Per observations, records reviewed, and interviews with staff, approximately 11 members	• ACT services should be fully integrated into a single team, with referrals to external providers only for specialty cases, such as court-ordered services. • Consider hiring staff that would be fully assigned to the team with the capability to provide counseling to members and also able to perform the generalist role on the ACT team. • ACT staff should first engage directly with members to support rehabilitation and competitive employment goals rather than refer to outside resources. Offer individualized engagement and assistance. Evaluate the benefit of the employment group or Work Adjustment Training (WAT) through brokered providers. Ensure vocational staff receive ongoing training in best practices to engage and support members to find and retain competitive employment in integrated settings.

			reside in staffed locations, where there is a duplication of ACT services, including Community Living Placements, group homes, assisted living, and sober living that requires programming.	
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24 - hour coverage directly to members of the team. Staff report that the on-call phone rotates between the specialist positions and that the CC serves as the back-up. When calls are received staff will assess the situation and help members with coping skills. When needed, staff will meet members in the community. Staff will contact the Psychiatrist to assess the need for inpatient treatment and transport the member to the nearest hospital when advised. All members interviewed reported receiving the *ACT handout* with the teams on call number, and indicated staff are readily available.	
O5	Responsibility for Hospital Admissions	1 - 5 4	Per review, the team was involved in seven of the ten most recent psychiatric hospital admissions occurring over two months. Staff stated that if members contact the team when in distress or crisis. The team will meet the members in the community. Staff will contact the Psychiatrist to advise if hospitalization is needed. When hospitalization is recommended, staff transport the members and remain with them until admitted. Of the members that the team was not directly involved, three sought admissions independently without reaching out to the team. One of the three was taken by their guardian, who contacted the team during regular business to inform them of the situation.	• Educate members and their support systems about team availability to support members in their communities or to assist with hospital admissions.

O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff stated the team discharge planning begins the moment a member is admitted into the hospital. The team coordinates with the inpatient team through staffings, providing medical records, and a doctor-to-doctor is completed. Upon discharge, the team meets the member at the hospital, ensures the member has medications, transports the member, and conducts a safety check at the member's residence. The team follows an in-person five day follow up protocol following discharge. This includes meeting with the Psychiatrist, Nurse, and home visits conducted by team staff. Based on data provided and reviewed by staff, the team was directly involved in all of the ten most recent hospital discharges over two months. One member record reviewed did not include documentation of the team assisting with the hospital discharge as described in staff interviews or following the five-day post-discharge procedure.	• Ensure the team delivers post-psychiatric hospital follow-up services and support as outlined in policies and procedures. Some teams identify during the program the specialist that will be responsible for contact on that day.
O7	Time-unlimited Services	1 – 5 4	Data provided to reviewers showed the team graduated six members in the last 12 months. Staff reported that they anticipate graduating about 6% of members in the next year. Staff report when considering graduating members from the team, staff explain differences in ACT services to other levels of care and try tapering down service by decreasing in-person contact and increasing phone calls.	• Since ACT teams traditionally serve those with the most complex behavioral health issues and have been unsuccessful in traditional outpatient teams, the ACT team should strive to graduate fewer than 5% of membership annually.
S1	Community-based Services	1 – 5 3	Staff interviewed reported 80% of in-person contacts with members occur in the community. A record review of ten randomly selected member records showed a median of 45% of contacts staff had with members occurred in the community.	• 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

			Review of records show two members being seen only in the office during the review period.	contacts with members as a replacement for community-based contacts.
S2	No Drop-out Policy	1 – 5 5	In the 12 months prior to the review, the team retained 98% of members. One member left the area without a referral, and one member declined services.	
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff report the team follows the *8-Week Outreach Protocol* when members are not engaged in services. Staff interviewed reported multiple strategies to engage members. The team offers community outings to the bowling alley, movie theatre and skills training grocery shopping trips. In addition, the team assists members with obtaining food boxes, and offers cooking groups. When team staff are unable to engage with members, staff conduct outreach four times per week for eight weeks. Outreach attempts include home visits, contacting shelters, jails, hospitals, contact with members' natural support, and frequented community areas. Records reviewed showed one record where phone contact was used for engagement. Eight member records showed significant gaps ranging from 9 – 19 days between documented outreach attempts.	• When members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact, ensure a team discussion occurs during the program meeting to plan follow up care and is documented in member records. • Consider identifying factors that would initiate immediate member follow-up from the team (e.g., missed psychiatric/nurse appointments, missing two scheduled visits with staff specialists). • Ideally, outreach should be carried out by multiple ACT staff, drawing from motivational interviewing skills, allowing members a diverse group with whom to connect.
S4	Intensity of Services	1 – 5 2	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 32 minutes. Nine member records showed a median value of less than two hours per week. The record with the highest weekly average in-person contact was 243.50 minutes. The record with the lowest weekly average was 8.0 minutes. One member	• 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,

			record had documented phone contact of three minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	week to week, based on their individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 – 5 2	ACT staff provided a median frequency of 1.25 contacts to members per week of the ten records randomly sampled. One chart reviewed had four in-person contacts a week. Eight of the ten member records showed two or fewer contacts on average per week over a month timeframe. At least one staff stated that not all contacts are documented in member records. Two interviewed members reported contact with the team five to seven days a week.	• Increase the frequency of contact with members by ACT staff, preferably averaging four 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 those needs and immediacy. • Ensure staff are trained and supported in appropriate documentation standards to ensure that services delivered are appropriately reflected in the members' medical records in a timely manner.
S6	Work with Support System	1 – 5 3	Staff report that 10 - 30% of members have family or other support that they would like involved in their treatment. Staff attempt at least weekly contact with Natural Supports via telephone, email, or in-person. Natural Support contact is tracked by the team on a Natural Support tracking form. Reviewers requested a copy, but it was not received. During the program meeting observed, natural support contacts were discussed for approximately 22 members. Some ways the team engages natural supports are to provide updates on those members at inpatient setting, including jail and court hearings, outreach to members who are disengaged and when members are located. Two members interviewed reported staff having contact with their family and one member reports	• Continue efforts to engage members' natural support systems as key contributors to the member's recovery team. Staff should model recovery language and provide tips to family members and other natural supports how they can support member care. • Ensure that all natural support contacts are documented in member records.

			natural support involvement is discussed at treatment planning meetings. Based on the ten member records reviewed, the team has contact with natural support, averaging .30 contacts per month. Two member records show documented contact with natural supports in the one-month period reviewed, while other records had none	
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 4	Per data provided, there are 63 members on the team identified with a co-occurring disorder. Staff reported that all 63 members meet individually with the COS each week for at least 24 minutes at the members' home or at the clinic. Staff report using Integrated Co-Occurring Disorders Treatment as the therapeutic model for structured substance use treatment sessions. Copies of referenced materials requested by reviewers were not received. Of the ten records reviewed, eight members were identified as having a co-occurring disorder by the team. Four members records reflected formal individual IDDT counseling occurred one to three times in the month period reviewed, ranging from 45 - 60 minutes each.	• Continue efforts to provide an average of 24 minutes or more per week of individualized substance use treatment for all members with a co-occurring disorder diagnosis. • Ensure all services delivered are documented in member records.
S8	Co-Occurring Disorder Treatment Groups	1 – 5 5	The team COS provides two, one-hour, "IDDT" groups following the Integrated Co-Occurring Disorders treatment model focusing on harm reduction and relapse prevention. According to sign-in sheets provided by the team, 35 individual members with a co-occurring disorder attended at least one group in a month period reviewed, resulting in 56% attendance rate overall. Documentation requested for verification of	• Consider offering groups so that at least one is structured for members in earlier stages, and at least one is available for members in later stages of recovery. Interventions should align with a stage-wise approach.

			material used for facilitating groups not received by reviewers. One of the ten member records reviewed reflected member participation in one integrated co-occurring disorder treatment group.	
S9	Co-Occurring Disorders Model	1 – 5 4	Staff interviewed reported that the COS provides training to the team on harm reduction, stages of change, and benefits of the integrated co-occurring disorders treatment model. Staff support members by using a harm reduction approach by suggesting safer alternatives rather than promoting abstinence. Staff build rapport with members by using the stage-wise treatment model, motivational interviewing, non-judgmental approaches, and relapse prevention goals. Staff will support members when seeking peer-run substance use programs and refer to detox when medically necessary to reach member goals. During the Program meeting observed, the team discussed members' stages of change and interventions. In addition, the CC encouraged staff to engage members who would benefit by attending integrated co-occurring disorder treatment groups. Of the eight member records reviewed with a co-occurring disorder, three treatment plans did not address substance use treatment, five had treatment goals that included learning refusal skills, harm reduction, and attending group and individual substance use treatment sessions.	• 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. • Continue to 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.
S10	Role of Consumers on Treatment Team	1 – 5 5	Staff interviewed reported that there is at least one staff with lived psychiatric experience on the team that shares their story when appropriate	

			with clients and other staff. Staff endorsed that these staff maintain the same level of responsibility as other team members. All members interviewed were aware of staff with lived psychiatric experience on the team.	
Total Score:		**TOTAL 109**		

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	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Co-Occurring 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	4
7. Time-unlimited Services	1-5	4
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	2
5. 2Frequency of Contact	1-5	2
6. Work with Support System	1-5	3
7. Individualized Substance Abuse Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	5
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.89**	
Highest Possible Score	**5**	