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 November 27 – 29, 2023, Fidelity Reviewers completed a review of the Lifewell Behavioral Wellness – South Mountain 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.

Lifewell Behavioral Wellness offers residential, outpatient, and community living programs to persons diagnosed with a serious mental illness, general mental health issues, and/or substance use disorders. Some of the services the agency offers include integrated health care, outpatient counseling, psychiatry services, case management, psychosocial rehabilitation, and housing. 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 observe meetings, and to interview staff and members.

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

- Remote observation of the ACT team's program meeting on November 28, 2023.
- Individual videoconference interview with the Clinical Coordinator (CC).

- Individual videoconference interviews with Co-Occurring, and Independent Living Specialists.
- Individual phone interview with the Employment Specialist.
- 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 ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; *CC productivity report*; contact guidelines; ACT brochure; resumes and training records for Vocational and Co-Occurring Specialist staff; co-occurring disorder treatment group sign in sheets; copies of cover pages of co-occurring disorder treatment materials; and member calendars.

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 of sufficient size to provide coverage to the 90 members assigned, with only one vacant position, the Peer Support Specialist. The team has an appropriate member to staff ratio of 9:1.
- The team meets five days a week to discuss all members. The Psychiatric Nurse Practitioner (Prescriber) attends the program meeting four times a week.
- The team is available to provide crisis support coverage by phone and in the community after business hours and weekends. Members interviewed reported the team is readily accessible and are aware of the after-hours number.
- The team was involved in 100% of psychiatric hospital discharges.
- The team-maintained consistency and continuity of care for members with a low admission rate for the period reviewed.

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

- The team experienced 88% staff turnover in the past two years. ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports team cohesion and the therapeutic relationships between members and staff.
- Increase the frequency of contact delivered to members. ACT staff should see every member on average four times a week. Higher frequency of contact correlates to improved outcomes for ACT members.

- Optimally 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 delivery of services to members in their community.
- Improve efforts to connect with member's natural supports, to an average of four per month for each member with a support system. ACT teams work with members to build natural supports.
- Few members with a co-occurring disorder attend the co-occurring treatment group provided by the team. Staff should continue to engage members with a co-occurring disorder to participate in group substance use treatment, as appropriate, based on their stage of change.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team serves 90 members with ten full-time equivalent direct service staff, excluding the Prescriber. Staff includes the Clinical Coordinator (CC), two Nurses, two Co-Occurring Specialists, Rehabilitation Specialist, ACT Specialist, Independent Living Specialist, Employment Specialist, and Housing Specialist. The team has a member-to-staff ratio of approximately 9:1.	
H2	Team Approach	1 – 5 3	Staff reported that daily rotations are assigned using a geographic zone approach to ensure members are seen in the community by more than one staff each week. Per a review of ten randomly selected member records, 50% of members received in-person contact from more than one staff in a two-week period. Two members interviewed reported seeing at least two staff in-person in the last seven days.	• Ensure all members are seen by diverse staff as this is a crucial ingredient of the evidence-based practice. Ideally, 90% of ACT members have in-person contact with more than one staff in a two-week period. Diversity of staff interaction with members allows the members access to unique perspectives and expertise of staff, as well as the potential to reduce burden of responsibility of member care on staff.
H3	Program Meeting	1 – 5 5	Staff reported meeting five days a week, Monday through Friday, to review all members. Once per week, the team meets for an additional hour for training and case oversight. All meetings are conducted in-person. The Prescriber and Nurses attend four days a week. During the program meeting observed, the CC led the discussion, and each member was briefly discussed. Staff provided updates on recent contact with members and natural support. The CC provided direction on next steps for engagement and directed outreach steps.	

H4	Practicing ACT Leader	1 – 5 4	The CC joined the team in October of 2023 and estimated delivering in-person services eight (8) hours per week. The CC reported providing back-up to on-call staff, completing ACT referral screenings, and supporting members in the community with hospital admissions and discharges, as well as completing coordination of care with inpatient teams. According to the *CC Productivity Report*, the CC spent 37% of the time expected of other ACT staff providing direct in-person services to members. Of the ten records reviewed, there were no examples of the CC delivering in-person services over a recent month period. *This item is dependent on the Provider productivity expectation.*	• Optimally, the ACT CC delivers direct services to members and accounts for at least 50% of the expected productivity of other ACT staff. 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.
H5	Continuity of Staffing	1 – 5 1	Based on the data provided and reviewed with staff, 21 staff left the team in the past two years, resulting in a turnover rate of 88%. The position with the highest turnover was the Nurse.	• Ideally, turnover should be no greater than 20% over a two-year period. • 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	In the past 12 months, the team operated at approximately 77% of full staffing capacity. The ACT Specialist position was vacant the longest, with the position remaining unfilled for eight 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	The team has a fully dedicated Prescriber providing in-person services to members at the clinic and in the community. The Prescriber is readily accessible to the team, including after	

		5	hours and weekends. Five member records showed documented services provided by the Prescriber to members at the clinic.	
H8	Nurse on Team	1 – 5 5	There are two fully dedicated Nurses on the team. Nurses provide services at the clinic and in the community. Nurses are readily assessable to the team, including after hours and weekends. Staff reported Nurses conduct Health Assessment Screenings, medication observation and education, administer injections, assist with crisis calls, and complete Nurse to Nurse hospital coordination. Records reviewed showed Nurses providing medication observation and administering injections at the clinic in six member records. One additional record showed these services delivered in the community.	
H9	Co-Occurring Disorder Specialist on Team	1 – 5 4	The team has two Co-Occurring Specialists (COS). One COS joined the team in May 2023. The resume provided showed staff having at least one year of experience providing substance use treatment to individuals with co-occurring disorders. Training records showed recent training relating to co-occurring disorders and Integrated Co-Occurring Disorder Treatment. The second COS joined the team in February of 2023. The resume supplied did not provide evidence of at least one year of supervised experience providing co-occurring disorder services. Training records provided showed recent training relating to motivational interviewing and Integrated Co-Occurring Disorders Treatment.	• Optimally, ACT teams are staffed with two COS, each with one year or more of training/experience providing substance use treatment services. • Provide annual training to Co-Occurring Specialists in co-occurring disorder treatment best practices, including appropriate interventions, i.e., *stage-wise approach;* the evidence-based practice of *harm reduction*; and *motivational interviewing.* On ACT teams, COS 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 disorder model utilized by the team.

H10	Vocational Specialist on Team	1 – 5 3	The team has two Vocational Specialist staff. The Employment Specialist joined the team in September 2023. The resume provided did not show at least one year of experience in rehabilitation or employment services in a community integrated work setting. Training records provided did not show vocational related training in the past two years. The Rehabilitation Specialist joined the team in February 2023. The resume provided showed at least one year of experience in providing services and supporting adults with a serious mental illness in rehabilitation or employment services in a community integrated work setting. Training records provided showed one recent vocational-related training.	• Optimally, ACT teams are staffed with two Vocational staff with at least one year experience providing employment supports. • 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.
H11	Program Size	1 – 5 5	The team is of adequate size to provide coverage to the 90 members assigned. The team is composed of 11 staff including the Prescriber. The Peer Support Specialist position was vacant.	
O1	Explicit Admission Criteria	1 – 5 5	The team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. Based on interviews, all team specialists conduct new referral screenings and then review the findings with the Prescriber who will then complete a doctor-to-doctor staffing with the referring entity. The Prescriber makes the final determination for all new admissions. Referrals are received from the local contractor with a Regional Behavioral Health Agreement (RBHA), hospitals, outpatient clinics, and internally.	
O2	Intake Rate	1 – 5	Per the data provided and reviewed with staff, the team has an appropriate rate of admissions. The	

		5	highest month for admissions was August 2023 with four new members.	
O3	Full Responsibility for Treatment Services	1 – 5 4	The ACT team directly provides psychiatric services and medication management, housing support, substance use treatment, and employment/rehabilitative services, in addition to case management services. Based on interviews with staff, members can receive a referral for counseling/psychotherapy services to a non-ACT licensed counselor within the agency.	• 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.
O4	Responsibility for Crisis Services	1 – 5 5	Per staff interviews, crisis services are available 24/7 to members and their natural supports. Staff rotate on-call responsibilities weekly, and the CC serves as back-up. When after-hour calls are received staff will assess the situation by phone and attempt to de-escalate. When in-person support is needed, on-call staff contact the CC for intervention planning which may include taking the member to a hospital or meeting emergency services on site. The team provides members with a brochure of information about on-call services, including the on-call contact number. Members interviewed were aware of the teams' 24/7 availability.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Based on data provided and reviewed with the CC, the ACT team was directly involved in 70% of the most recent psychiatric hospital admissions that occurred over a three-month period. Staff reported that when a member is experiencing increased symptoms, members are triaged by the Prescriber or Nurse before recommending hospitalization. When the decision is made to psychiatrically hospitalize a member, staff will	• Maintain regular contact with all members and their support network. This may result in the identification of issues or concerns that could lead to hospitalization. Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions. More frequent

			transport the member to the hospital and assist with the admission process. The team provides hospitals with medication lists and contact information for the clinical team. Staff indicated coordinating with the inpatient team daily. Staff and the inpatient team meet for staffings weekly. Prescriber and Nurse phone calls with inpatient providers also occur weekly. Staff visit members in-person every 72 hours. Based on data provided and reviewed with the CC, the team petitioned or amended five members for civil commitment, two members were triaged and transported by team staff, and three members admitted without prior team notification. Per chart review, one member had documentation of psychiatric hospitalization that did not have documented admission coordination and was not included on the data collection form.	and intense individualized provision of community-based services may afford ACT staff further opportunities to assess and provide interventions to reduce psychiatric hospitalizations and to build collaborative relationships with members' informal supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Based on data provided and reviewed with the CC, the ACT team was directly involved in 100% of the most recent psychiatric hospital discharges that occurred over a three-month period. Staff reported coordinating discharge planning with members, hospital staff, and natural supports. Staff meet members at the hospital for discharge and will transport them to the clinic, pharmacy, or desired location. Members are provided with a follow up appointment to see the Prescriber within 72 hours after discharge, as well as follow up appointments with a Nurse and primary care physician are scheduled. Staff will meet with members in-person in the community for five days.	

			Based on the data provided staff assisted members during the discharge process, transported to the clinic for follow up provider appointments and followed the five day follow up procedure.	
O7	Time-unlimited Services	1 – 5 5	Data provided and reviewed with staff showed the team graduated two members during the past year.	
S1	Community-based Services	1 – 5 1	Staff report 80 - 90% of in-person contact occurs in a community setting. Results of ten randomly selected member records reviewed show staff provided services a median of 19% of the time in the community. Records showed that most community services were delivered at members' homes. There was one documented contact of staff engaging with a member while conducting street outreach.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting.
S2	No Drop-out Policy	1-5 4	According to data provided and reviewed with staff, the team had a retention rate of nearly 91% in the past year. Seven members left the program due to connecting to a Behavioral Health Residential Treatment Program, two were incarcerated long term, and the team determined one member could not be served. The team experienced seven member deaths during the past 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 3	Staff reported attempting contact with members three to four times per week. A zone rotation is used to coordinate member contacts. Attempts are tracked on member calendars and within the member records. Staff reported using a caring approach to engage members that fosters rapport building. When members miss scheduled appointments or are unable to be located by staff, staff attempt two physical and two electronic	• When members are not seen at the frequency indicative of ACT services, consider starting outreach efforts immediately after an identified lapse in contact. Discuss and track these efforts during the program meeting. • Ideally, outreach is carried out by multiple ACT staff, drawing from motivational

			outreaches each week for eight weeks. Outreach is attempted by checking locations frequented by the member, shelters, hospitals, jails, the morgue, payee office, last known address, and by contacting natural supports, guardians, and Probation Officers. Reviewers received a copy of the team's contact guidelines that included detailed information about standards for frequency and length of contact with members. Nine of the member records reviewed showed gaps in engagement that ranged 5 to 19 days between attempts. Records reviewed showed outreach by phone was a median of one (1) attempt.	interviewing skills, allowing members a diverse group with whom to connect. • Ensure all outreach efforts, including letters, phone calls, and contact with formal and natural supports are documented in member records.
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, is approximately 19 minutes. The record with the highest intensity was 246 minutes. Five records showed intensity less than 14 minutes.	• 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 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 individual needs, recovery goals, and symptoms. • Ensure the team is assisting members in working on recovery goals as identified. By using *motivational interviewing*, and other techniques, the team can assist members to identify meaningful recovery goals and then offer the supports and services to members to reach those goals.

S5	Frequency of Contact	1 – 5 2	Per review records, during a month period before the fidelity review, the median in-person contact with members was less than one (.63) times per week. The median frequency of phone contact was .25 contacts. *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the frequency of contact with members, preferably averaging four (4) or more in-person contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact. • Improved outcomes are associated with frequent contact. 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. On ACT teams, all staff are invested in delivering a high frequency of contacts with members, and contacts are individualized and align with treatment goals.
S6	Work with Support System	1 – 5 2	Staff reported 44 members have natural support. Natural supports are contacted weekly by phone, email, or in-person during home visits. Contacts are tracked on member calendars and in the member records. During the program meeting observed, staff discussed recent contact and planned outreach for members with supports. Records reviewed showed an average of .80 contacts with natural supports were documented within the period reviewed. Of the members interviewed, one member reported weekly contact with their natural support and feels it is helpful. Member calendars showed contact to natural supports averaging once per month.	• 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. With or without the member present, ACT teams provide support and skills for members informal support network (i.e., persons not paid to support member). • Assist members in developing a natural, community-based support system. Active participation with peer run programs are a good first step in helping members connect to a natural support system, as is assistance in reengaging with natural supports with whom they have lost contact. • Ensure that all natural support contacts are documented in member records.

S7	Individualized Co-Occurring Disorder Treatment	1 – 5 2	Per interviews and data provided, 44 members were identified with a co-occurring disorder. Staff interviewed reported all receive 30 minutes of structured individual counseling per week. Staff reported using the *Integrated Co-Occurring Disorder Treatment (ICDT)* model. The member calendars provided did not indicate if individualized treatment sessions are formal pre-scheduled appointments. Records reviewed identified five members with a co-occurring diagnosis, and none contained documented encounters of individual treatment sessions.	• Provide an average of 24 minutes or more per week of individualized substance use treatment for all members with a co-occurring disorder diagnosis. • Monitor member engagement and participation in individual substance use treatment. Ensure all services delivered are documented in member records.
S8	Co-Occurring Disorder Treatment Groups	1 – 5 2	Staff reported three co-occurring disorder treatment groups are offered. Two groups are based at the clinic, and one group is held in the community. Both COSs facilitate groups. Staff estimated 25 members attend the groups offered weekly. A review of the attendance sign-in sheets for the month period prior to the review showed seven (7) unique members attended the groups for an attendance rate of 16%. Two member records showed attendance of a substance use treatment group held in a community setting.	• Continue to engage members with a co-occurring disorder 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 4	Staff interviewed reported utilizing and integrating dual diagnosis treatment model to support members with co-occurring disorders. Staff reported using harm reduction and utilizing stage-wise treatment approach. Staff reported encouraging members with co-occurring disorders to participate in individual or group co-occurring treatment. Staff do not refer members to peer run substance use programs but will support members that request to attend. When members request	• 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*. • Ensure treatment plans are written from the member's point of view, recovery focused, and outlines steps the team will

			detoxification services or inpatient substance use treatment, the team will refer them to local resources when medically necessary. Reviewers were provided with cover pages for *Veterans Affairs Manage Stress* workbook, *SAMHSA Anger Management for Substance Abuse and Mental Health Clients*, and *The Substance Abuse and Recovery* workbook as materials used for curriculum. Staff reported the team receives ongoing training through Relias, monthly clinical oversite from a licensed agency staff, and receives weekly training from another agency staff to effectively engage members with a co-occurring disorder. Five of the records sampled were identified as having a co-occurring diagnosis. Of those three treatment plans reflected goals to support the members co-occurring disorder diagnosis.	take to address substance use while supporting the member in recovery. • Support members to identify a reduction of use goal when a desire for abstinence is expressed.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has at least one member of staff with personal lived or living psychiatric experience. Staff shares their story of recovery with members as well as advocates from a peer perspective. Members interviewed were unsure of Peer Support staff on the team.	
Total Score:		**103**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	4
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	5
9. Co-Occurring Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	3
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	1
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	3
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	2
7. Individualized Co-Occurring Disorder Treatment	1-5	2
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.68**	
Highest Possible Score	**5**	