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 August 21 - 24, 2023, Fidelity Reviewers completed a review of the Southwest Network Saguaro 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.

Southwest Network provides services to children, adolescents, and adults. The agency operates three ACT teams in the Central Region of Arizona. This review focuses on the Saguaro ACT team. The individuals served through the agency are referred to as "members" or "clients", 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 22, 2023.
- Individual video conference interview with the Clinical Coordinator.
- Closeout discussion with the Senior Director of Integrated Health and Population Management and the Clinical Coordinator.

- Individual video conference interviews with the Peer Support, Employment, Independent Living, and two Co-Occurring Specialists, for the team.
- Individual phone interviews with five members participating in ACT services with the team.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *CC July Productivity Report, Mercy Care ACT Admission Criteria, Southwest Network Lack of Contact Checklist,* resumes and training records for Vocational and Co-Occurring Specialist staff, co-occurring disorder treatment materials, co-occurring disorder treatment group sign-in sheets, sample copy of the team's zoned approach assignments, and *Welcome to Assertive Community Treatment* handout.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. It is a scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries, and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented 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 four days a week to discuss all members. During the meeting observed, multiple staff contributed to the discussion by reporting on recent and planned contacts with members and included current successes and challenges.
- The team has two fully dedicated Nurses and two fully dedicated Co-Occurring Specialists assigned to work with members.
- The team has a clearly defined target population; the Clinical Coordinator conducts screenings of referrals and reported no outside pressure to admit members. The team will arrange for new members, their natural supporters, and any other important parties involved in the member's treatment to meet with the entire team shortly after joining the team.
- The team was involved in 100% of the ten most recent psychiatric hospital discharges.

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

- Increase support to members that receive a lower intensity and frequency of service. ACT teams provide members with an average of two (2) or more hours of in-person service delivery and an average of four (4) or more in-person contacts weekly.
- Increase the delivery of services to members by the Clinical Coordinator. Consider identifying administrative functions not essential to the Clinical Coordinator's time that could be performed by the program assistant or other team members.
- 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.
- There is limited involvement by members in co-occurring group treatment provided by the team. Increase engagement of members in co-occurring group treatment. The entire ACT team is responsible for engaging members in substance use treatment services. Optimally,

50% or more of members with a substance use disorder diagnosis attend at least one co-occurring disorder treatment group each month.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 4	The ACT team serves 87 members with eight full-time equivalent (FTE) direct service staff, excluding the Psychiatrist. The team has a member to staff ratio of approximately 11:1. Staff on the team include the Clinical Coordinator (CC), two Nurses, two Co-Occurring Specialists (COS), Employment Specialist, Independent Living Specialist, and Peer Support Specialist.	• 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 reported following a weekly zone rotation in addition to meeting with their assigned caseload in an effort to ensure members are seen by a diversity of staff. All members interviewed indicated seeing more than one ACT staff in a two-week period. The team tracks contact during the program meeting on member calendars. Per review of ten randomly selected member records, for a two-week period, 80% of members received in-person contact from more than one ACT staff.	• Ideally, 90% of ACT members have contact with more than one ACT 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	Staff interviewed reported meeting four days a week for one hour on Monday, Tuesday, Thursday, and Friday. The ACT Psychiatrist attends the program meeting three days a week, the Nurses attend the days they are scheduled to work. During the program meeting observed, all staff participated in the discussion which included upcoming doctor appointments, home visits, outreach and engagement, hospitalizations, jail visits, employment goals and status, natural	

			support contact, stages of change, and current successes and challenges.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated delivering in-person services to members 50% of the time expected of other staff on the team. The CC reports conducting home visits, assisting with independent living skills, attending staffings, and ensuring individual treatment goals are being addressed. According to the *CC July Productivity Report*, the CC spent 8% of the time expected of other ACT staff providing direct in-person services to members. Of the ten records reviewed, there were three examples of the CC delivering in-person services in the community over a recent month period.	• Continue efforts to provide in-person services to members. Optimally, the ACT CC delivers direct services to members and accounts for at least 50% of the expected productivity of other ACT staff. • The CC and agency may consider identifying administrative functions not essential to the CC's time that could be performed by the program assistant or other team members.
H5	Continuity of Staffing	1 – 5 4	Based on the data provided, seven staff left the team in the past two years resulting in a turnover rate of 29%. The position with the most turnover was the ACT Psychiatrist.	• ACT teams strive for less than 20% turnover rate. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff.
H6	Staff Capacity	1 – 5 3	The team operated at approximately 74% of staff capacity during the past 12 months. There was a total of 37 vacant positions. The Housing Specialist position has been vacant for nine months, the ACT Specialist has been vacant for 10 months, and the Rehabilitation Specialist position has been vacant for 11 months.	• Continue efforts to retain qualified staff with the goal of operating at 95%, or more, of full staffing annually. • The timely filling of vacant positions also helps to reduce the potential burden on staff. Research shows staff remain in positions longer when supported in their roles by being provided supervision and training in their specialty practice.
H7	Psychiatrist on Team	1 – 5 5	The team Psychiatrist works four 10-hour days a week, Tuesday through Friday. After the previous Prescriber left the team, temporary coverage has been provided by a Psychiatrist who continues to provide services via teleconference to 10 members of the team. The fully assigned Psychiatrist is in the process of credentialing with those members'	

			insurance providers. The covering Psychiatrist also attends the team's program meeting on the days assigned members are scheduled with them. Staff reported that the team's Psychiatrist is fully dedicated to members of this ACT team and is accessible to the team in-person, by phone, and email, including after hours and on weekends. Staff reported the Psychiatrist provides services in-person at the clinic, via teleconference when needed, and delivers services to members in the community one day each week. Per review of ten records, a Psychiatrist provided direct service to seven members in the month period reviewed.	
H8	Nurse on Team	1 – 5 5	The team has two Nurses who work exclusively with the members of the team and both work four 10-hour days with staggered schedules. Staff reported that the Nurses are included in the weekly zone rotation and provide case management services, home visits, medication observation and education, administer injections in office and in the community, appointment coordination, and symptom management. Per review of ten records, the Nurses provided direct service to six members in the community and at the clinic in the month period reviewed. Members interviewed reported meeting with the Nurses at the clinic or their home every other week to once a month.	
H9	Co-Occurring Disorder Specialist on Team	1 – 5 5	The team is staffed with two COS who have been in the role on the team since July 2022.	• Provide annual training to Co-Occurring Specialists in co-occurring disorder treatment best practices, including appropriate interventions, i.e., *stage-wise*

			Training records provided showed one COS attended nearly nine hours of training related to evidence-based practices treatment and substance use disorders, co-occurring disorders, and motivational interviewing. The second COS completed one training: *Introduction to Co-Occurring Disorders*. Reportedly, neither COS receives structured clinical supervision by qualified staff.	*approach*; the evidence-based practice of *harm reduction*; and *motivational interviewing*. COS should have the capability to cross-train other staff on the team, 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	At the time of the review, the team had one Vocational Specialist, and an Employment Specialist who joined the team in June 2023. The Employment Specialist has previous experience of providing ACT services, including serving in the Employment Specialist position for several years. Training records reviewed indicated two vocational trainings completed since joining the team.	• ACT teams maintain two full-time Vocational Specialist staff with at least one year experience providing employment supports.
H11	Program Size	1 – 5 4	At the time of the review, the team was composed of nine staff. The Rehabilitation, Housing, and ACT Specialist positions were vacant. *This item does not adjust for the size of the client/member roster.*	• Continue efforts to hire and maintain adequate staffing. A fully staffed team, 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 utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. New referrals are received from the local contractor with a Regional Behavioral Health Agreement (RBHA), hospitals, jails, other teams within the agency, and other provider network organizations.	

			The CC is primarily responsible for screening potential members and is completed in person or by phone. The member is then staffed with the Psychiatrist. The Psychiatrist coordinates with the referring doctor and completes a review of the potential member's chart having the final determination for new admissions to the team. The team will offer services to potential members up to three times when the member declines to be admitted to the team which can include other ACT staff. After an individual is admitted to the team, the team will arrange for the new member, their natural supports, and any other important parties involved in the member's treatment to meet with the entire team, so everyone is familiar with the team and their roles.	
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 admission rate during the past six months were March and June with two members added to the team roster for each month.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the ACT team provides psychiatric and medication management services, co-occurring disorders treatment, housing support, and employment and rehabilitation services. All members interviewed reported services they receive are only provided by the ACT team.	• ACT services should be fully integrated into a single team, with referrals to external providers only for specialty cases. Counseling/psychotherapy should be available to members on ACT teams provided by ACT staff.

			The team has two COSs to provide both Individual and group substance use treatment services to members with a co-occurring disorder. Based on staff interviews, less than 10% of members are receiving duplicated services from staff at their residence. Staff indicated 5 – 6 members are working, and 10 members are engaged in job search activities. Staff support members with employment and rehabilitation by assisting with resume building, mock interviews, assisting with applications, meeting with employers in the community, and providing ongoing support to employed members. Staff interviewed reported 2 – 10 members are receiving counseling/psychotherapy services from another provider.	
O4	Responsibility for Crisis Services	1 – 5 5	Per interviews with the staff, the team provides 24/7 crisis services to members of the team. Staff reported providing the on-call number to members and their natural supports on the *Welcome to Assertive Community Treatment* handout explaining ACT team services, a description of staff roles, staff contact information, and the on-call number. Staff reported the team's availability is reaffirmed to members and their natural supports regularly during home visits and phone conversations. Members interviewed reported the team is readily accessible and are aware of the after-hours number. The on-call phone rotates between ACT staff weekly with the CC as a backup.	

			When calls are received after hours, staff will assess the situation and help members with coping skills. When needed, staff will meet members in the community. Staff will contact the CC to assess the need for inpatient treatment and transport the member to the nearest hospital when advised.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff interviewed reported being directly involved in member hospital admissions. When a member is experiencing an increase in symptoms, or in a crisis situation during business hours, the team will meet with members to assess and have a discussion with the CC. The CC will then discuss the situation with the Psychiatrist to determine the next steps. The Psychiatrist may visit with the member in the community or conduct a teleconference with the member and ACT staff to identify the appropriate course of action. Staff may also transport the member to the clinic to be evaluated by the Psychiatrist. If it is decided that inpatient care is necessary, ACT staff will transport the member to the hospital and will remain with the member until admitted, providing the inpatient team with the ACT Psychiatrist contact note, the member's demographics, and current medications. Based on data provided, and staff interviews, the team was involved in seven of the ten most recent psychiatric hospital admissions occurring over three months. Three members self-admitted without the team's knowledge. The team coordinated care after notification of the admissions.	• Identify barriers and seek solutions to direct team involvement in member inpatient admissions. Assess the quality of the therapeutic alliance; maintain stance of acceptance with member's readiness to accept recommended resources, services and supports. Focus on building trust and rapport with both members and their natural supports to increase team responsibility for hospital admissions to 95%.

O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff stated discharge planning begins the moment a member is admitted into the psychiatric unit. The team completes a staffing with the inpatient team 24 hours after admission and weekly after that. Staff indicated at times it is difficult to gain in-person access to members that are inpatient, therefore the team generally holds staffing's over the phone or via teleconference. One member interviewed reported recently spending over one week inpatient and only had phone contact with the team. The ACT Psychiatrist conducts a doctor-to-doctor consultation with the inpatient provider. Upon discharge, the team meets with the member at the hospital, ensures the member has medications, and transports the member to their desired location. When members' natural supports request to transport the member home, the team is still at the hospital to ensure the discharge is complete. The team follows a five-day follow-up protocol which includes in-person contacts with the Psychiatrist and Nurse within 72 hours and contact with team staff daily with a minimum of one home visit and daily phone calls. Based on data provided, and staff interviews, the ACT team was involved in 100% of the last ten psychiatric hospital discharges. These discharges occurred over a three-month period.	• The ACT team and system partners should collaborate to resolve barriers to the team meeting with members in-person while admitted to inpatient psychiatric units.
O7	Time-unlimited Services	1 – 5 5	Data provided shows that the team graduated five members in the past 12 months. Staff interviewed stated that there are potentially two members on target for graduating in the next year.	
S1	Community-based Services	1 – 5	Staff interviewed reported 75 - 90% of in-person contacts with members occur in the community.	• Increase the delivery of services to members in their communities. Optimally,

		3	Members interviewed reported seeing staff from the ACT team at their home and at the clinic. Records reviewed showed staff delivering independent living skills services, medication observation, transportation to medical appointments, individualized co-occurring disorder treatment, and health education in the community. The results of ten randomly selected member records reviewed showed staff provided a median of 50% of services in the community.	80% or more of services occur in members' communities. • For members that are coming into the clinic multiple times a week, explore how to deliver those services in natural settings where members live.
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team had two members drop out of the program in the past year for a retention rate of nearly 100%.	
S3	Assertive Engagement Mechanisms	1 – 5 5	According to the *Southwest Network Lack of Contact Checklist* provided and staff interviews, when a member is unable to be located, staff complete four outreach attempts each week minimally for eight to twelve weeks. At least two of those outreach attempts are in the community that includes going to the member's last known address, where the member is known to hang out, and shelters. The other two outreach activities include calls to natural supports, probation officers, primary care physicians, morgues, hospitals, and jails. During the program meeting observed, the team had conversations about which staff member was going to outreach a member and how.	
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 spent in-person with members per week was 43.75 minutes. The highest weekly average was	• 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

			113.75 minutes. Seven of the ten member records reviewed had phone contact documented by the team resulting in a median of .88 minutes service duration. *The fidelity tool does not accommodate delivery of telehealth services.*	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.
S5	Frequency of Contact	1 – 5 2	Per review of ten randomly selected member records, during a month period before the fidelity review, the median in-person contact with members was 1.25 times per week with the highest weekly average of 4.25. Staff interviewed reported working Monday through Friday and provided varied responses relating to responsibilities of staff working on the weekends to provide members individualized services. One member interviewed reported the team supports them during weekdays with medication observation and reminders, however, forgets to take medications during the weekend. Records reviewed indicated services were delivered to members on weekdays in the month period reviewed.	• 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. All staff of the ACT team should be invested in delivering a high frequency of contacts to members. Those contacts should be individualized and align with treatment goals identified. • Identify and resolve barriers to increasing contacts with members. Optimally, members receive an average of four (4) or more in-person contacts a week. • If not done so already, consider evaluating staff schedules to ensure members are receiving services based on their needs including weekends. Some teams stagger staff weekly shifts, overlapping the weekend, to ensure members have contact with the team throughout the entire week.
S6	Work with Support System	1 – 5 2	Data provided indicates that 64 members have natural supports. Staff reported that they do not have a formal tracking form to identify when and how often members' natural supports are contacted. During the program meeting observed, the team discussed connecting with 11 member's	• Increase contacts with natural supports to an average of four (4) per month for each member with a support system. As much as possible, contacts with natural supports should occur during the natural course of delivery of services provided to members.

			natural supports. Members interviewed reported the team has infrequent contact with their natural supports. According to the ten member records reviewed, eight of the ten charts identified members with a natural support. In the month period reviewed the team had an average of 0.9 contacts with natural supports.	• Educate members and natural supports on the benefits of collaboration to support members' recovery goals. Some ACT teams describe the PSS as a significant contributor to this effort. • Ensure consistent documentation of contacts with natural supports occurs, which includes contact by phone, email, and text messages, as well as in-person.
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 3	According to data provided, there are 58 members with a co-occurring diagnosis. Staff reported 40 of the 58 members with a co-occurring disorder are participating in individualized substance use treatment sessions ranging from 3 – 30 minutes. Staff report the frequency is determined by preference of the member. Seven member records reviewed were identified with a co-occurring diagnosis. Of those, there were two records with documented individualized substance use treatment sessions ranging from 18 - 26 minutes. COS each reported that four assigned members have standing appointments weekly to bi-weekly. One member interviewed was not aware the ACT team provided individual substance use treatment sessions. The ACT team does not have a system to track which members have received one-on-one sessions or the duration of those sessions.	• Continue efforts to provide an average of 24 minutes, or more, per week of structured individualized substance use treatment services for all members with a co-occurring disorder diagnosis. • Monitor and track member engagement and participation in individual substance use treatment. • Ensure COS staff receive supervision by qualified staff, annual training, and guidance in co-occurring treatment best practices. Optimally, consistent evidence-based co-occurring treatment information is provided and then disseminated, through cross-training, to other ACT staff.

S8	Co-Occurring Disorder Treatment Groups	1 – 5 2	Staff interviewed reported two co-occurring disorder treatment groups are available to members each week from the team. According to the sign-in sheets for the month prior to the review, three (5%) unique ACT members with a co-occurring disorder participated. The team utilizes *DiClemente's Group Treatment for Substance Abuse: A Stages of Change Therapy Manual.* Evidence of group attendance in member records showed that one of the seven members identified with a co-occurring disorder attended at least one co-occurring disorder treatment group during the period reviewed.	• Optimally, 50% or more of members with a substance use disorder diagnosis attend at least one co-occurring disorder treatment group each month. • On ACT teams, all staff engage members with a co-occurring disorder diagnosis to participate in treatment groups, based on their stage of change, with content reflecting stage-wise treatment approaches.
S9	Co-Occurring Disorders Model	1 – 5 4	Of the ten records reviewed, seven were identified as having co-occurring disorders. All seven had treatment plans identifying substance use treatment goals and included member language surrounding treatment goals and treatment plans. The team does not refer members to peer-run substance use programs but will support members who request to attend. The team will refer members to detox when medically necessary for substances such as alcohol, fentanyl, benzodiazepines, and opioids. Staff identified member's stage of change in the program meeting and identified interventions based on that stage. Most staff confirmed the use of the Integrated Co-Occurring Disorders Treatment model and coming from a harm reduction approach to treatment. One staff discussed using an abstinence-based approach. Staff reported that the Nursing staff and Psychiatrist will typically provide supervision and education to the team about substance use treatment services.	• 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 approach* to interventions, the EBP of *harm reduction*, and *motivational interviewing*.

S10	Role of Consumers on Treatment Team	1 – 5 5	The team has at least one staff with personal lived psychiatric experience. Staff reported these individuals share their stories of recovery with the team and members. Members interviewed had knowledge of staff with personal lived psychiatric experience and expressed gratitude and value to the stories that have been shared with them.	
Total Score:		**110**		

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	4
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	5
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	5

7. Time-unlimited Services	1-5	5
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	5
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	3
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	**3.93**	
Highest Possible Score	**5**	