ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: January 5, 2024

To: Tamera Farrow, Clinical Coordinator
Amy Henning, Chief Executive Officer

From: Nicole Eastin, BS
Kristy Crawford, MA, MBA
AHCCCS Fidelity Reviewers

Introduction

Arizona Health Care Cost Containment System has contracted with Western Interstate Commission for Higher Education Behavioral Health Program to conduct Fidelity Reviews using an adapted version of the Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment (ACT) Fidelity Scale. ACT is an evidence-based practice (EBP).

Method

On December 11 – 13, 2023, Fidelity Reviewers completed a review of the Southwest Network San Tan 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 San Tan 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 December 12, 2023.
- Individual videoconference interview with the Clinical Coordinator.

- Individual videoconference interviews with the Housing, Employment, Rehabilitation, and Peer Support Specialists.
- Group videoconference interview with the two Co-Occurring Specialists.
- Individual phone interviews with three members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator and representative 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*; *Southwest Network Lack of Contact Checklist*; *Welcome to Assertive Community Treatment, or ACT* handout; member calendars; copy of a cover page of co-occurring disorders treatment material; co-occurring disorders treatment group sign-in sheets; resumes and training records for Vocational and Co-Occurring Specialist staff.

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 93 members, with only one vacant position, the Independent Living Specialist. The team has an appropriate member to staff ratio of 9:1.
- A median of 90% of member records reviewed received in-person contact from more than one team staff in a two-week period.
- The team experienced a staff turnover rate of only 8% in the past two years.
- The team was involved in 90% of the ten most recent psychiatric hospital admissions, and 100% of the ten most recent psychiatric hospital discharges.
- The team excels (median 100%) at providing services to members in the community, rather than functioning as an office-based program.
- The entire team receives ongoing training and clinical oversight in the co-occurring disorders model and has a shared understanding of co-occurring disorder principles.

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

- Increase support for members that receive a lower frequency of service. ACT teams provide at least four (4) or more in-person contacts weekly.
- Increase engagement of members in co-occurring disorders group treatment. Ideally, 50% or more of members with a co-occurring disorders diagnosis participate in a co-occurring disorders group offered by the ACT team.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 - 5 5	The ACT team serves 93 members with ten full time equivalent (FTE) direct service staff, excluding the Psychiatrist and administrative staff. The team has an appropriate member to staff ratio of 9:1. Staff on the team include the Clinical Coordinator (CC), Housing Specialist, Employment Specialist, Rehabilitation Specialist, Peer Support Specialist, ACT Specialist, two Co-Occurring Specialists, and two Nurses.	
H2	Team Approach	1 - 5 5	To ensure members are seen by multiple staff each week, the team uses a zone approach, with nine identified zones that rotate weekly between each specialist position, including the CC. Staff schedules include weekend coverage to support members. Staff report having an assigned caseload strictly for administrative paperwork purpose only. Of ten randomly selected member records reviewed, for a month period, a median of 90% received in-person contact from more than one staff from the team in a two-week period. All members interviewed reported seeing more than one staff from the team every week, mostly in the community.	
H3	Program Meeting	1 - 5 4	The team meets three days a week in-person to review the entire team roster. The Psychiatrist, on average, attends three times per week, while the Nurses attend an average of twice per week. On Thursdays, the entire team holds a longer meeting	• Increase the number of times the team meets to discuss members. ACT teams meet at least four times a week to discuss all members assigned.

			to review some members more in depth, and clinical supervision is facilitated by the Psychiatrist and Nurses. During the program meeting observed, the CC led the discussion tracking reported information on member calendars. Staff updated the team on individualized recent and planned member services, group attendance, and appointments attended or scheduled with the Psychiatrist and Nurses. In addition, the Psychiatrist and Nurses provided education to the team on medication interactions and side effects.	
H4	Practicing ACT Leader	1 - 5 4	The CC estimated delivering in-person services to members 12.5 hours a week. Reported activities included home visits, teaching independent living skills, discussing healthy eating, walking with members near their home for exercise, assisting with employment goals, engaging with natural supports, and encouraging co-occurring treatment for members with co-occurring disorders diagnoses. Per a review of the CC's productivity report for a four-week period, the CC provided in-person services 39% of the time expected of other ACT staff. Of the ten records reviewed, there was one example of the CC delivering in-person services to one member in the community. *The fidelity tool does not accommodate delivery of telehealth services. This item is dependent on the Provider productivity expectation.*	• Continue efforts to provide in-person services to members 50% or more of the expected productivity of other ACT staff.

H5	Continuity of Staffing	1 - 5 5	Based on the information provided, two staff left the team in the last two years, resulting in a turnover rate of 8%.	
H6	Staff Capacity	1 - 5 4	In the past 12 months, the team operated at approximately 90% of full staffing capacity. The ACT Specialist position was vacant for 10 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 Psychiatrist works four 10-hour days a week, is fully dedicated to the ACT team, and is readily accessible to staff, which includes after-hours and weekends. Members are seen in-person at the clinic and in the community at least once a month. Per review of ten records, the Psychiatrist provided direct services, most of which were in the community, to all ten members in the month period reviewed. Four members were seen by the Psychiatrist twice in the month reviewed. All members interviewed reported the Psychiatrist meeting with them in their home monthly for psychiatric services.	
H8	Nurse on Team	1 - 5 5	The team has two Nurses that support the members on the ACT team. One Nurse works Monday through Friday, and the other Nurse works four 10-hour days. Services are delivered at the clinic and in the community. Staff reported the Nurses provide medication education, symptom management, assist members with filling medications, administer injections, coordinate with primary care physicians and specialists on behalf of members, teach independent living skills, engage members with co-occurring disorders to meet with the Co-Occurring Specialists, and attend medical appointments with members. Based on the records reviewed, there were a total of 25 documented encounters by the Nurses in a	

			month period, 19 of which were in the community. These encounters indicated both Nurses were involved in all aspects of member care, such as reviewing treatment plans, communication with natural supports, and assisting with employment and housing searches.	
H9	Co-Occurring Disorder Specialist on Team	1 - 5 5	The team has two Co-Occurring Specialists (COS) that have each been in the role for more than one year. Clinical supervision is provided weekly by the Psychiatrist and CC. Training records provided show one COS receiving 3.5 hours of co-occurring disorders related training in the past two years, and the other showed 4.5 hours.	
H10	Vocational Specialist on Team	1 - 5 5	The team has two vocational staff, a Rehabilitation Specialist, and an Employment Specialist, that have both been on the team for more than one year. The Employment Specialist started on the team as the Independent Living Specialist and transitioned into the Employment Specialist role in July 2023. The Employment Specialist has previous experience supporting individuals finding competitive employment in integrated settings. Training records provided indicate both vocational staff have recent training related to assisting members in finding competitive employment in an integrated setting. The Rehabilitation Specialist completed 5.25 hours of training, and the Employment Specialist completed nearly eight hours. Staff reported vocational staff also attend the quarterly rehabilitation and employment trainings facilitated by the local contractor with a Regional Behavioral Health Agreement and Vocational Rehabilitation.	

H11	Program Size	1 - 5 5	At the time of review, the team was comprised of 11 staff, including the Psychiatrist, which is an adequate size to provide staffing diversity and coverage for the 93 members. There is one vacant position, the Independent Living Specialist.	
O1	Explicit Admission Criteria	1 – 5 5	The CC is primarily responsible for screening potential admissions to the team. The team utilizes the *Mercy Care ACT Admission Criteria*. Once the screening is completed, the CC will staff potential members with the Psychaitist. The Psychiatrist has the final determination for new admissions to the team. Referrals are received from the local contractor with a Regional Behavioral Health Agreement, hospitals, internally from Southwest Network, and from other network providers. The team does not feel pressured to admit members to the team. The CC reported providing education to the other teams at the clinic about ACT admission criteria for potential new members.	
O2	Intake Rate	1 - 5 5	Per data provided and reviewed with the CC, the team has an appropriate rate of admissions, with one new admission in the months of June, October, and November.	
O3	Full Responsibility for Treatment Services	1 - 5 4	In addition to case management, the team provides psychiatric and medication management, substance use treatment, and employment and rehabilitation. One member on the team receives psychiatric services from an outside agency; however, the team Psychiatrist still meets regularly with the member for symptom management and coordinates care with the other provider. All members with a co-occurring disorders diagnosis	• In the EBP of ACT, services are fully integrated into a single team with no, or very few, referrals to external providers. • 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

			are receiving services from the two COSs on the team; no members are referred to brokered providers. Based on interviews with staff, of the 93 members, 10 – 12 members reside in staffed locations where ACT services are duplicated. One member receives additional services from the *Division of Developmental Disabilities Services*: the team coordinates care with that provider and the member's guardian regularly. There are approximately 11 members that are employed on the team. Ten are supported by the team to maintain employment, one is supported by a brokered provider. Members are supported by completing weekly check-ins to assist with reasonable accommodation requests, teaching members about the advantages of disclosing disabilities, and educating members on disability benefits. Six (6) members are actively looking for work and are supported by the team. Activities include interview coaching, obtaining interview-appropriate attire, helping the members prior to, during, and following interviews, and looking for positions close to members' residences.	responsibilities are provided by the ACT team. Optimally, members on ACT teams receive all services and support from the team.
O4	Responsibility for Crisis Services	1 - 5 5	The team is available to provide crisis services 24 hours a day, seven days a week. The on-call responsibilities rotate between the specialist positions weekly, and the CC provides backup support. The team provides the *Welcome to Assertive Community Treatment, or ACT* handout to members, family, natural supports, and any other important care partners. This brochure provides information about ACT, what the team	

			does, names and contact information for all staff, and includes a brief description of their specialty role, along with the team's on-call number. A review of records showed staff reminding members of the team's 24-hour availability and ensuring the members had the on-call number. In addition, one record showed staff supporting a member after hours by phone. In another record, staff encouraged a member to use the on-call for support when they felt the urge to consume alcohol. All members interviewed were aware of the ACT on-call line, and reported staff are always available.	
O5	Responsibility for Hospital Admissions	1 - 5 4	Based on staff interviews, when a member requests inpatient care or the team determines inpatient care is needed, staff will assess and communicate with the CC and/or the Psychiatrist. If possible, the psychiatrist will directly assess the member. When it is determined the member will benefit from inpatient care, ACT staff will transport the member to the hospital, provide information to the intake coordinator, and remain with the member until admitted. Per review of data relating to the ten most recent psychiatric hospital admissions that occurred over a five-month time frame, the team was directly involved in 90%. One member self-admitted, and coordination of care and discharge planning began as soon as the team was notified.	• Continue to educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions. Develop plans with members in advance, especially when they have a history of hospitalization without seeking team support.
O6	Responsibility for Hospital Discharge Planning	1 - 5 5	The team reports that discharge planning and coordination of care between the ACT and inpatient teams, begins within 24 hours of admission.	

			The Psychiatrist communicates with the inpatient provider within 24 hours. A staffing with the member, inpatient team, ACT staff, and any other persons the member wants involved in their treatment occurs within 72 hours and weekly thereafter. Staff visit with the member in-person twice a week. Staff reported that access restrictions to hospital units have recently increased due to the flu and COVID 19. Once the inpatient and ACT teams determine the member is ready for discharge, the team schedules appointments with the ACT Psychiatrist within 72 hours, and a Nurse within five days. Members will most often see the Nurse before the Psychiatrist to review medications and make any changes to medication sets. All members receive five days of in-person follow-up from the team. This activity is tracked on the members' calendars, and staff are assigned during the program meeting. Member calendars provided by the team showed five-day follow-up documented and completed, which included a visit with the Psychiatrist and a Nurse for those that were discharged in a recent month. Per one record reviewed, the member was aware of the five-day follow-up protocol and questioned staff if they were going to be seen for the next five days due to a medical hospitalization. Per review of data relating to the ten most recent psychiatric hospital discharges that occurred over a five-month time frame, the team was directly involved in 100%.	

O7	Time-unlimited Services	1 - 5 5	Data provided to reviewers indicated that the ACT team graduated four members in the past year. Staff reported that the team anticipates 4 – 5% of members graduating in the next year.	
S1	Community-based Services	1 - 5 5	Staff interviewed reported 75 – 100% of in-person contacts with members occur in the community. All members interviewed reported predominantly meeting with ACT staff in the community and in their homes. The results of ten randomly selected member records reviewed show the ACT team provided services a median of 100% of the time in the community. Six members received 100% of their services in the community for the month reviewed. Documentation of services in the community provided by ACT staff included groups facilitated at a local mall, staff attending medical appointments with the members, providing individual co-occurring disorder treatment sessions, assisting with grocery shopping, and budgeting skills, transporting members to the bank and social security office, Psychiatrist and Nurses providing services at members' homes, and staff assisting with independent living skills.	
S2	No Drop-out Policy	1 - 5 5	According to data provided and reviewed with staff, the team had four members that left the ACT program in the past year, for a retention rate of 97%.	
S3	Assertive Engagement Mechanisms	1 - 5 5	The team reports when a member is unable to be located or misses an appointment, staff will complete four outreach attempts each week, typically for twelve weeks. Two attempts are in the community and two by phone, including calling hospitals, jails, natural supports, guardians,	

			payees, the morgue, and probation officers. The team reported calling jails and hospitals in multiple surrounding counties. Staff also reported reviewing member charts to search for past releases of information and conducting calls to those individuals to ask if they had contact with the member recently. Street outreach consists of driving around shelters and communicating with shelter staff, going to the member's last known address, and going to the member's family or friends' home addresses. To ensure staff's safety, two ACT staff go together when searching areas that members are known to frequent. During the program meeting observed, one member missed their appointment with the Psychiatrist that morning. The Psychiatrist texted the member during the meeting about missing the appointment, and the member reported they were currently on their way to the clinic to meet with the Psychiatrist.	
S4	Intensity of Services	1 - 5 4	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 101 minutes. Four of the records showed members receiving over two hours of in-person contact with the team. One record showed an average of 25 minutes of contact with the team in the month period reviewed.	• Continue efforts to provide intensive services 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.
S5	Frequency of Contact	1 - 5 3	Of the ten records randomly sampled, ACT staff provided a median frequency of 2.13 in-person contacts to members per week during a month	• Increase the frequency of contact with members, ideally averaging four (4) or more in-person contacts a week. Work with

			period before the fidelity review. The member record with the highest frequency of contact was 7.75 contacts per week and the member record with the lowest frequency of contact was 1.25 contacts per week. Seven of the ten records reviewed had phone contact documented by the team, for a total of 20 contacts. *The fidelity tool does not accommodate delivery of telehealth services.*	staff to identify and resolve barriers to increasing the frequency of contact.
S6	Work with Support System	1 - 5 4	Per data provided and staff interviewed, 23 (25%) members of the team have a natural support. Staff interviewed reported contact with natural supports occurs by phone, email, or in-person weekly. Contacts are tracked on member calendars during the program meeting, and when contact has not been completed for the week, the CC ensures a staff is assigned to complete this contact. Member calendars provided for the previous month showed 24 members' natural supports were contacted by the team. Contact ranged from one to five times in the period reviewed. During the program meeting observed, the team discussed multiple contacts with members' natural support, and included planned contact. Of the ten randomly selected charts reviewed, one member was identified with natural support by the team, however, six member charts had natural support contact documented, resulting in an average of 2.10 contacts in the month period reviewed. Natural support contact occurred by	• 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.

			phone, in-person at the member's home, and at the clinic during appointments. Of the members interviewed, one member reported the team has contact with their natural support every couple of days, another reported every other week, and one member reported not having natural supports involved in their treatment. The member service plans have an option for a *Natural Community Support Goal*. Members have the option to specify a goal relating to natural supports, frequency of contact, and strengths/cultural factors to consider when addressing the goal.	
S7	Individualized Co-Occurring Disorder Treatment	1 - 5 4	Per interviews and data provided, 50 members were identified with co-occurring disorders. Staff reported 48 of these members are receiving structured individual co-occurring disorders treatment from a COS once a week ranging from 15 – 60 minutes per session. The manual referenced to provide treatment is *Group Treatment for Substance Abuse: A stages-of-change therapy manual.* One day a week, at a set time, members are scheduled to meet with the COS staff for individual treatment sessions to ensure consistency and consideration of their schedules. Based on member calendars 36 received individual treatment sessions by the teams COS. All 36 showed individual sessions that ranged from one to six times in a recent month. Per record review, five members were identified by the team with a	• 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.

			co-occurring disorder. Three members received individual sessions 2 – 3 times in the month period reviewed, ranging from 57 – 120 minutes per session.	
S8	Co-Occurring Disorder Treatment Groups	1 - 5 3	Staff reported that two co-occurring disorders treatment groups from the team are available specifically to members with co-occurring disorders diagnoses weekly in the community at a local park, mall, and library. According to sign-in sheets for the month prior to the review, eleven (22%) of members attended at least one co-occurring treatment group. Record review showed one of the five members with co-occurring disorders diagnoses attended a group three times in the month period reviewed, and another member, not identified with a co-occurring disorders diagnosis, was also seen in records attending the group. One member interviewed reported attending the co-occurring disorders groups in the community twice a week. Although group attendance was documented in member records, it included other attendee names and specific information about their involvement.	• Continue to engage members with co-occurring disorders to participate in group substance use treatment, as appropriate, based on their stage of change. Ideally, 50% or more of applicable members participate in a co-occurring disorder group monthly. • Consider adapting one group for members in earlier stages and one group for members in later stages, allowing staff to adjust interventions to better serve members in different stages of change. • Documentation of group attendance should only include information pertinent to each specific member. Ensure staff are trained in appropriate documentation standards.
S9	Co-Occurring Disorders Model	1 - 5 5	Staff interviewed reflected the principles of a stage-wise approach when working with members with co-occurring disorders. Staff gave specific instances of strategies and interventions used, as well as reported developing rapport with members through the use of person-centered and nonjudgmental approach. Techniques include harm reduction, motivational interviewing, and	• Continue to provide all specialists with annual training and ongoing mentoring in a co-occurring disorders treatment model, such as Integrated Co-Occurring Disorders Treatment, in the principles of a stage-wise approach to interventions, the EBP of harm reduction, and motivational interviewing.

			active listening. Examples were demonstrated in member records reviewed. When a member requests information on peer-run support groups in the community, staff will first identify and offer additional support to the member and then will support members by locating peer run groups in the community. Members are referred to detoxification services when requested and medically necessary. Of the five member records that had co-occurring disorders, four had treatment plans that identified goals, team interventions, frequency, and reduction plans to support members. During the program meeting, language used by the team was *recovery focused* when discussing members pertaining to their substance use. All staff shared examples of encouraging members to engage in individual and group treatment or reminding members of their scheduled one-to-one and group sessions that week. The team was educated about one member that typically increases substance use during the month of December and suggested to increase contact. Another member was discussed that had reported using substances that morning and one COS reported making time to meet with the member to engage in an individual treatment session the next day. There was no shaming or blaming language used by the team when addressing members that were currently using. The team talked about ensuring members that were using fentanyl had access to Narcan. Additionally, the Psychiatrist	

			educated the team on the dangers of mixing alcohol and a particular medication one member was prescribed and asked the team to increase contact as well as continue to encourage the member to attend the co-occurring groups offered. The entire team receives guidance related to co-occurring disorder treatment regularly from the Psychiatrist and Nurses that includes education about substance use, and interventions to engage members in a particular stage of change, the *stage-wise approach.* All staff interviewed reported completing training in *Relias* related to the co-occurring disorders model and this was shown in training records provided.	
S10	Role of Consumers on Treatment Team	1 - 5 5	The team has at least one staff with lived or living psychiatric experiences who shares their story with members, natural supports, the team, and advocates on the behalf of members and their family, when challenges arise. One of the three members interviewed had knowledge of staff with personal lived or living psychiatric experience and shared the value of staff sharing their own challenges has been enlightening.	
	Total Score:	**128**		

ACT FIDELITY SCALE SCORE SHEET

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

7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	5
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	4
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	4
7. Individualized Co-Occurring Disorders Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	5
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.57**	
Highest Possible Score	**5**	