ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: September 18, 2023

To: Karen Hoffman-Tepper, President, and CEO
Mary Sakajian, Clinical Coordinator

From: Allison Treu, AS
Jasmine Davis, MS
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 August 7 – 9, 2023, Fidelity Reviewers completed a review of the Terros 51st Avenue 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.

Terros offers services that include primary medical care, behavioral health, and substance use treatment care. The agency operates multiple recovery centers in the Central Region of Arizona. The agency operates four ACT teams. This review focuses on the 51st Avenue Recovery Center ACT Team. 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 an ACT team program meeting on August 8, 2023.
- Individual video conference interview with the Clinical Coordinator.

- Individual video conference interviews with the Housing and ACT Specialists for the team.
- Individual phone conference interviews with the Co-Occurring, Employment, and Peer Support Specialist.
- Individual phone interviews with four members participating in ACT services with the team.
- Closeout discussion with Clinical Coordinator and representative from Mercy Care.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*, *Recovery Center Patient Contact Guidelines, ACT Team Introduction Handout, resumes* and training records for Vocational and Co-Occurring Specialist staff, co-occurring disorder treatment materials, Co-Occurring Specialists' calendars, Clinical Coordinator productivity report, co-occurring disorder treatment group sign-in sheets, Natural Support tracking logs, and ACT staff contact 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 ACT Clinical Coordinator is highly engaged in providing direct services to ACT members which includes in the community.
- This team is composed of 12 staff, an adequate size to provide necessary staffing diversity and coverage with no vacant positions on the team.
- A median of 100% of member records reviewed received in-person contact from more than one team staff in a two-week period.
- The majority of services members receive are community based, allowing staff to assess needs in members' natural environments.
- Noticeable improvement of frequency and intensity was seen in member records reviewed. ACT staff provided a median frequency of 3.13 in-person contacts to members per week, and a median of 84.75 minutes of service per week.

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

- The team is not directly providing counseling/psychotherapy. ACT teams provide such services to members rather than refer to other non-ACT agency staff or other agencies.
- Increase delivery of structured individual and group substance use treatment services. Continue efforts to engage members with a co-occurring disorder diagnosis to participate in treatment 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 93 members with 11 full-time equivalent (FTE) direct service staff, excluding the Psychiatrist. The team has an appropriate member to staff ratio of approximately 8:1. Staff on the team include the Clinical Coordinator (CC), two Nurses, two Co-Occurring Specialists (COS), Employment Specialist, Independent Living Specialist, Rehabilitation Specialist, Peer Support Specialist, Housing Specialist, and ACT Specialist.	
H2	Team Approach	1 - 5 5	Staff interviewed reported, to ensure all members have contact with each specialist, a weekly rotation is assigned based on a report provided by the administration. The report shows which members have been visited by the team and the length of each engagement. Of ten randomly selected member records reviewed for a month period, a median of 100% received in-person contact from more than one ACT staff in a two-week period. Members interviewed reported seeing two or more staff from the team each week. One member reported seeing staff seven days a week.	
H3	Program Meeting	1 – 5 5	Based on staff interviews, the team meets four times weekly, Monday through Thursday. All staff attend on scheduled workdays. All members are discussed during each meeting.	

			During the program meeting observed, all members were reviewed. The CC provided direction to staff for member engagement and outreach needs. The Psychiatrist provided the team with insight on changes in member needs and recommended services for member care. Staff discussed recent contacts, outreach efforts, referrals needed, contact with natural and formal supports, and updates on members scheduled or missed appointments.	
H4	Practicing ACT Leader	1 – 5 5	The CC estimated delivering in-person services to members ten hours a week. The CC reported delivering in-person services to members through activities such as home visits, attending psychiatric appointments with members, and engaging with members at the clinic. Seven out of ten records reviewed showed documentation relating to the CC delivering in-person services in the community and the clinic over a recent month. Services documented include the CC providing psychoeducation on harm reduction, utilizing motivational interviewing, engaging with natural supports, speaking with members about their needs, and connecting members to specific team specialists to support the member. The CC productivity report provided to reviewers showed the CC providing direct services an average of (at least) 50% of the productivity of other ACT staff to members in a recent month period reviewed.	

H5	Continuity of Staffing	1 - 5 5	Based on data provided, three staff left the team in the past two years resulting in a turnover rate of 13%.	
H6	Staff Capacity	1 – 5 4	In the past 12 months, the team operated at approximately 88% of full staffing capacity. There was a total of 17 vacant positions in the past 12 months. The Peer Support Specialist position was vacant the longest.	• 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 Psychiatrist works four 10-hour days a week, Monday through Thursday. The Psychiatrist attends program meetings at least three times a week and delivers services via teleconference, in-person at the clinic, and visits members in the community one day a week. The Psychiatrist only sees members of this ACT team and is accessible in-person, by phone, and after hours and weekends.	
H8	Nurse on Team	1 – 5 5	The team has two Nurses. Each work four 10-hour staggered workdays providing coverage to members on the team. The Nurses provide medication education, administer injections, attend specialty provider appointments with members, coordinate prescription refills, complete home visits and annual health assessments, and attend the program meetings on the days scheduled to work. Nurses are available to the team in-office, by phone, and afterhours when needed.	
H9	Co-Occurring Disorder Specialist on Team	1 – 5 4	The team has two COS to provide substance use treatment services to 58 members with a co-occurring disorder. One COS has been with the team since August 2016. Training records provided showed the COS completed one training related to Cognitive Behavioral Therapy (CBT) in substance use treatment.	• Optimally, ACT teams are staffed with two COS, each with a year or more of training/experience providing substance use treatment services. • Provide annual training to COS in co-occurring disorder treatment best practices, including appropriate

			The other COS has been in the role since April 16, 2023. Prior to assuming the role, the COS was the team's Rehabilitation Specialist. Training records provided showed the COS completed one training related to Stages of Change Model in Treatment of Substance Use Disorders. At the time of the review COS staff did not receive clinical supervision.	interventions, i.e., *stage-wise 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. • Ensure COS staff are provided with regular supervision from a qualified professional.
H10	Vocational Specialist on Team	1 – 5 4	The team has two Vocational staff. The Employment Specialist has been delivering employment-related services on the team since September 2016. Staff interviewed reported recently attending the Association of Community Rehabilitation Educator's 16-hour training. The Rehabilitation Specialist has been in this role since June 19, 2023, and does not have previous experience helping individuals find employment in an integrated work setting. Prior to assuming this role, the staff has been with the team since August 2021 as the Housing Specialist. Per interview staff attended the Association of Community Rehabilitation Educators 16-hour training.	• 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 in integrated settings. Ongoing supervision should be provided to support skill development during this first year in the role.
H11	Program Size	1 – 5 5	At the time of the review, the team was composed of 12 staff, an adequate size to provide necessary staffing diversity and coverage with no vacant positions on the team.	
O1	Explicit Admission Criteria	1 – 5 5	The team utilizes the *Mercy Care ACT Admission Criteria* to screen new member referrals. The CC screens potential members for admission; the senior COS and the ACT Specialist will occasionally	

			conduct screenings. Staff reported receiving many referrals from supportive teams. The CC will recruit new referrals with leadership from supportive teams, and from the local contractor with a Regional Behavioral Health Agreement (RBHA). Staff reported the criteria to meet admission to the ACT team is members experiencing frequent hospitalizations, frequently in jail, members diagnosed with a co-occurring disorder, members that are not engaging with their current clinical team, and those wanting to engage in the intensity of ACT services. Members interested in joining the ACT team are staffed with the entire team, including the Psychiatrist. The CC and Psychiatrist will make the final determination on new admissions	
O2	Intake Rate	1 – 5 5	Per data provided, and reviewed with staff, the team has an appropriate admissions rate. The month with the highest admission rate during the past six months was April with two new members added to the team roster.	
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, and housing support. Staff interviewed reported members in need of psychotherapy/counseling are referred to a non-ACT agency staff, who attends one team meeting a week to update the team on members' progress. One member interviewed reported receiving counseling from non-ACT staff and expressed desire to receive this service from the ACT team.	• On ACT teams counseling/psychotherapy is available to members from staff on the team, rather than referring them to non-ACT agency staff or other agencies. • Educate staff on the benefits of ACT staff engaging and directly supporting members with rehabilitation and competitive employment goals rather than engaging them to participate in temporary WAT activities or employment services with brokered providers.

			Staff reported 6 - 8 members are working, and the team provides employment retention support for all. Based on interviews with staff the team assists 2 - 10 members with job search and development, assisting with resume building, internet job search, mock interviewing, clothing, and transportation to interviews. Staff interviewed reported three members attend *work adjustment training* (WAT) programs and one member is working with Vocational Rehabilitation for job search. Five records reviewed showed staff educating members on employment services offered by the team, as well as informing members on Vocational Rehabilitation services and work training programs through brokered providers.	
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24-hour coverage directly to members of the team. There are two on-call phones that rotate between specialists weekly and the CC serves as the back-up for the two staff. Members are provided with the *ACT Team Introduction Handout* with staff and on-call numbers. When calls are received, the on-call staff will assess the member needs by phone, and if needed will meet with the member in the community when the situation cannot be de-escalated by phone. Members interviewed were aware of the 24-hour on-call number and one member reported that their natural support has utilized this service to contact the team.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff interviewed reported that prior to the need for hospitalization, members and natural supports are educated on the support available by the	• Continue to work with each member and their support network to discuss how the team can support members in the event of

			team. Members and their natural support are provided with the team's contact information and asked to contact the team, when possible, before going to the hospital. When a member is experiencing an increase of symptoms during business hours, staff meet the member in the community and transport the member to the clinic to be triaged by the nurse and Psychiatrist. The Psychiatrist may make a medication adjustment, advise service plan recommendations, or recommend hospitalization. Staff will transport members to a hospital that has an available in-patient bed. Staff will remain with the member until admitted, providing hospital staff with any documents requested and team contact information. Per review of data received of the ten most recent psychiatric hospital admissions, that occurred over a two-month time frame, the team was directly involved in 70%. For the hospital admissions the team was not involved, members self-admitted without staff knowledge. Staff interviewed reported providing education to the members on the team's availability to help with hospital admissions.	a psychiatric hospital admission. Proactively develop plans with members on how the team can provide aid during admission, especially for members with a history of seeking hospitalization without team support. • Increase team responsibility for hospital admissions to 95%.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff interviewed reported discharge planning begins at admission. ACT team staff coordinates staffings with the inpatient team within 24 hours of admission. The Psychiatrist coordinates with the inpatient treating psychiatrist, and the team will coordinate aftercare placement options. Upon discharge, members are picked up at the hospital, assisted with filling prescriptions, and transported	• Continue to coordinate with inpatient treatment teams, and both natural and formal supports, to reinforce the benefits of including the team in hospital discharges.

			to their desired location. When possible, the members see the Psychiatrist on the same day of discharge. If not the same day, members are scheduled to see the Psychiatrist and nurse within 72-hours after discharge. Staff identified following a five-day protocol with members upon psychiatric hospital discharge that includes in-person contact daily for five days. Per review of data of the recent ten psychiatric hospital discharges occurring over a two-month time frame, the team was directly involved in 90%. One member was discharged from the hospital and picked up by the member's placement facility without the teams' knowledge of the discharge. The member was seen by the ACT team for the five-day follow up.	
O7	Time-unlimited Services	1 – 5 5	Data provided shows that the team graduated six members in the past 12 months resulting in a graduation rate of 5%. Staff interviewed stated that less than 5% of members are on target for graduating in the next year. Staff interviewed said when considering graduating members, the team considers if the member is able take medication without prompting, if member can manage daily living skills without assistance, and has been able to avoid the need for psychiatric hospitalization. When a member is doing well, the team will meet with them and natural supports to discuss about stepping down to a lower level of care. If the member agrees, the team will update the service plan to reduce frequency of in-person contact and	

			gradually step down in intensity of services until the member feels ready for the transition off the team. The team will coordinate transfer to a supportive level of care. Members are able to return to ACT if needed.	
S1	Community-based Services	1 – 5 4	Staff interviewed reported 80 - 95% of in-person contacts with members occur in the community. Staff report meeting with members at their homes to provide assistance with independent living skills, transporting to specialty doctor appointments and employment interviews, and helping members achieve goals of integrating into their community by walking with some members to increase confidence with being outside of their home. The results of ten randomly selected member records reviewed show staff provided services a median of 77% of the time in the community. Members report seeing team staff at their home for medication observation, psychiatric appointments, and for routine home visits.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team had five members drop out of the program in the past year. The team retained 99% of the total number of members served in the past 12 months.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff interviewed reported coordinating outreach attempts during program meetings. Engagement and outreach efforts to members are conducted four times per week, by at least two different team staff. The team uses street outreach and legal mechanisms to engage members who have not been in contact with the team. Staff report	

			attempting multiple community outreach attempts daily by going to members' homes, searching areas members are known to frequent, contacting probation, guardians, payee, jails, and hospitals, and checking with the morgue. Reviewers received a copy of the team's *Recovery Center Patient Contact Guidelines* which states that the team is to complete outreach attempts each week for eight weeks including two community attempts each week. Records reviewed showed the team attempting home visits and phone calls with members and speaking to natural supports and guardians in an effort to engage members.	
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 spends in-person with members per week is 84.75 minutes. Member records show the lowest weekly average delivery of services was 38.25 minutes and the highest delivery was 119.75 minutes. The team delivered a median of .75 minutes per week of services by phone. *The fidelity tool does not accommodate delivery of telehealth services.*	• ACT teams provide members with an average of two (2) or more hours of in-person contact weekly. Work with staff to identify and resolve barriers to increasing the average service time delivered.
S5	Frequency of Contact	1 – 5 4	Of the ten records randomly sampled, ACT staff provided a median frequency of 3.13 in-person contacts to members per week. The highest median seen in records was 4.50 contacts per week, and the lowest was 2.25 contacts per week of in-person contacts.	• Increase the frequency of contact with members, ideally averaging four (4) or more in-person contacts a week. Work with staff to identify and resolve barriers to increasing the frequency of contact.

			Members interviewed reported meeting with team staff three to seven days of the week at their home or at the clinic.	
S6	Work with Support System	1 – 5 4	Staff reported 58 members have natural support. Of those, the team has frequent contact with 30 on a weekly basis. Per review of ten member records, the ACT team has an average of 3.10 contacts with members' natural supports in a month period. During the program meeting observed by the reviewers, staff provided the team with updates of contact with members' natural supports, sharing name of the contact, the family role and if contact was in person, phone, or email. One member interviewed reported that staff work with their natural supports to coordinate their needs in addition to helping the member to attend religious ceremonies. Another member reported that staff will meet with their natural support during home visits and the natural support is able to reach out to team staff to coordinate services for the member.	• Continue efforts to engage members' natural support systems as key contributors to the member's recovery team. Consider the role of staff to model recovery language and provide suggestions to family members and other natural supports how they can support member care.
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 3	Staff reported 58 members with a co-occurring disorder (COD) diagnosis on the team. Of those members 25 – 30 are receiving formal structured individual substance use treatment by the ACT COS. Individual sessions length can vary depending on members' willingness to engage. Staff reported scheduling members weekly and the average session length is 20 minutes but can range from 5 to 30 minutes. When possible, COS will engage members in individualized substance use	• 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. • Ensure all individualized services delivered are documented in member records.

			treatment on multiple days to meet a minimum of 23 minutes per week. Staff interviewed report using a harm reduction model, motivational interviewing techniques, stages of change, and utilizing the Integrated Co-Occurring Disorder Treatment model. Record review included four member records with a co-occurring disorder. Two member records had documentation of individual treatment sessions for substance use, using motivational interviewing and identifying the current stage of change. Sessions ranged from 12 to 44 minutes.	
S8	Co-Occurring Disorder Treatment Groups	1 – 5 2	The ACT team provides two groups weekly at the clinic for members with a co-occurring disorder diagnosis. At the time of the review, staff reported that approximately ten members attend each group. One COS facilitates both COD groups. The groups are not distinguished by the stage of change of the participants or other criteria. Reference materials provided did not include evidence-based treatments for co-occurring disorders. Group sign-in sheets submitted to reviewers show eight of the 58 members identified as having a co-occurring disorder (14%) attended at least one COD group in a month period prior to the review. Records showed one member attending one substance use treatment group. Two records showed the CC encouraging groups and options for treatment to members with a co-occurring disorder.	• 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. • 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.

S9	Co-Occurring Disorders Model	1 – 5 4	Staff interviewed were familiar with the principles of a stage-wise treatment approach to interventions when working with members with a co-occurring disorder. During the program meeting observed, staff discussed members' stage of change and motivation to participate in co-occurring disorder groups and interest in engagement with the COS. Staff indicated supporting members in reducing the use of harmful substances and were able to provide examples of tactics used. Staff expressed using the stages of change to create interventions that match members motivation and awareness. Staff interviewed reported staff attend a weekly training conducted for 15 minutes per week during the program meeting. A licensed counselor provides team training on co-occurring disorders, stages of change, harm reduction, and motivational interviewing. Records reviewed for the four members identified with a co-occurring disorder diagnosis showed staff using techniques such as motivational interviewing, harm reduction, identifying stages of change and discussing treatment options with the members. Two of the four treatment plans of members with a co-occurring disorder reflected a goal related to substance use treatment, and one was not written from the member's point of view. The other two treatment plans did not identify substance use interventions or treatment goals.	● 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, harm reduction, and motivational interviewing. ● Ensure treatment plans are from the member's point of view, supporting members to identify a reduction of use goal when a desire for abstinence is expressed, supporting the evidence-based practice of harm reduction.

S10	Role of Consumers on Treatment Team	1 – 5 5	Staff interviewed said at least two team staff share their lived experiences to support and encourage members. The ACT team has a Peer Support Specialist that shares the same responsibilities as other ACT staff. Staff share stories of personal lived psychiatric experiences with members when appropriate and provide staff with a peer perspective. Members interviewed report staff sharing personal lived experiences that were relevant to their needs and staff's shared stories are helpful in their own journey.	
Total Score:		**124**		

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	5
4. Practicing ACT Leader	1-5	5
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	4
10. Vocational Specialist on Team	1-5	4
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	4

7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	4
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	4
6. Work with Support System	1-5	4
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	**4.43**	
Highest Possible Score	**5**	