ASSERTIVE COMMUNITY TREATMENT
FIDELITY REPORT

Date: August 14, 2026

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Introduction

The Arizona Health Care Cost Containment System (AHCCCS) contracts with the Western Interstate Commission for Higher Education (WICHE) 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) that uses a multidisciplinary team approach to provide comprehensive, community-based behavioral health services to individuals designated as having a Serious Mental Illness (SMI).

Method

On July 13 – 15, 2026, Fidelity Specialists conducted a review of the **Terros Health (23rd Avenue Health Center) ACT 2 Team**. This report provides targeted feedback on the implementation of the agency's ACT services to support quality improvement and strengthen the delivery of behavioral health services in the community.

The ACT 2 Team is operated by Terros Health, a comprehensive healthcare organization that provides integrated behavioral health and primary care services. The agency operates four ACT teams. ACT 1 and ACT 2 are located at the Terros Health 23rd Avenue Health Center in Phoenix. While the program may use varying terminology to describe individuals receiving services, this and other fidelity review reports use the term "member" to support clarity and consistency.

The SAMHSA ACT Fidelity Review tool does not specifically account for telehealth service delivery. An exception has been made for psychiatric prescriber services due to workforce shortages and limited availability of psychiatric providers in Arizona.

This review was conducted remotely using videoconferencing and telephone to observe meetings and conduct interviews with staff and members.

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

- Remote observation of an ACT team program meeting on July 14, 2026.
- Individual videoconference interview with the Clinical Coordinator (CC).
- Individual videoconference interviews with the Housing, Employment, and Rehabilitation Specialists and one Co-Occurring Disorders Specialist (CODS) for the team.
- Individual telephone interviews with members receiving services from the ACT team; all five (5) members identified were successfully interviewed.
- Closeout discussion with the agency ACT Program Analyst, the CC, and representatives from AHCCCS and the contractor with a Regional Behavioral Health Agreement (RBHA).
- Review of medical records for 10 randomly selected members using the agency's electronic health record (EHR) system. The sample included only members enrolled with the RBHA.
- Review of documents: *Mercy Care ACT Admission Criteria*; copy of ACT outreach, reengagement, and contact guidelines; *Meet Your ACT Team* handout; copies of cover pages of substance use disorder treatment materials; co-occurring disorders treatment group sign-in sheets; resumes and training records for Vocational and CODS staff; and a productivity report for the CC from a recent 30-day period.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how closely a team implements the ACT model using specific observational criteria. The scale measures fidelity to the ACT model across three (3) dimensions: Human Resources, Organizational Boundaries, and Nature of Services. The ACT Fidelity Scale consists of 28 program-specific items. Each item is rated on a five-point scale, ranging from one (1), meaning *not implemented*, to five (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 and Key Recommendations

The program demonstrated strengths in the following areas:

- Psychiatrist on the Team/Nurse on the Team: The team includes one psychiatric prescriber and two Registered Nurses (Nurses) who work exclusively with ACT 2 members. The psychiatric prescriber and nursing staff participate in program meetings on their scheduled workdays, are available for spontaneous collaboration with one another and team staff, and provide in-person services to members in both the community and the office.
- Responsibility for Crisis Services: The team provides comprehensive 24-hour crisis coverage through a structured on-call system that includes telephone support, in-person community response, and coordinated crisis intervention.
- Responsibility for Hospital Discharge Planning: The team is actively involved in discharge planning for members following psychiatric hospitalization. Based on data provided and reviewed with staff, the team participated in discharge planning for 100% of the 10 most recent psychiatric hospital discharges.

- Time-unlimited Services: The team maintained a low graduation rate, with no members graduating during the 12 months prior to the review. Staff described utilizing a gradual, member-centered step-down process to support transitions to lower levels of care when clinically appropriate.
- No Drop-out Policy: The team maintained a high retention rate of 98% during the 12 months prior to the review.

The following program areas will benefit from focused quality improvement efforts:

- Co-Occurring Disorders Specialist on Team/Vocational Specialist on Team: Provide CODS staff and Vocational Specialist staff with annual training in evidence-based practices relevant to their specialty areas, along with ongoing clinical supervision and guidance. Strengthening specialty-specific training and supervision will support consistent implementation of evidence-based practices and enhance the delivery of integrated substance use treatment and vocational support services to members.
- Intensity of Services: Increase the average weekly amount of in-person contact provided to members to at least two hours and ensure services are accurately documented. Delivering more intensive services promotes individualized treatment and supports members with the highest level of need. Records reviewed showed a median of 35.75 minutes of in-person contact per week per member.
- Frequency of Contact: Work with staff to increase the frequency of in-person member contact and routinely review contact data to identify opportunities for improvement. Monitoring contact frequency supports consistent delivery of intensive, individualized ACT services. Records reviewed showed a median of 1.50 visits per week per member.
- Co-Occurring Disorders Treatment Groups: Increase member engagement in co-occurring disorders treatment groups. Ideally, at least 50% of members with co-occurring disorders participate in a minimum of one treatment group per month. Based on data provided by the team, eight members (11%) attended at least one co-occurring disorders treatment group in a recent month.
- Co-Occurring Disorders Model: Implement a consistent evidence-based co-occurring disorders treatment model across the team and integrate its principles into individualized treatment planning. A shared treatment approach, supported by ongoing staff training and recovery-oriented treatment plans, promotes consistent, integrated care for members with co-occurring disorders.
- Role of Consumers on Team: Prioritize filling the vacant Peer Support Specialist position with an individual who has personal lived or living experience of psychiatric care. The Peer Support Specialist role contributes a unique recovery perspective that strengthens person-centered services and promotes hope and self-determination for members of the team.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team was comprised of 10 full-time equivalent (FTE) staff, excluding the psychiatric prescriber and administrative staff. Team staff included one CC, two Nurses, two CODS staff, one Employment Specialist, one Rehabilitation Specialist, one ACT Specialist, one Independent Living Specialist, and one Housing Specialist. At the time of the review, the team served 99 members, resulting in an approximate member-to-staff ratio of 10:1.	
H2	Team Approach	1 – 5 3	Staff reported that approximately 80% of members have in-person contact with more than one team staff during a two-week period. The team works seven days per week, with some staff working eight-hour or 10-hour days. Members interviewed reported interacting with two to seven team staff each week. The team facilitates shared member contact through a geographic zone approach that divides the service area into four sections, with zones rotated daily among specialists. Member contacts are tracked and reviewed during the program meeting, promoting coordination and shared responsibility for member care. A review of 10 randomly selected member records over a one-month period showed that	• Increase contact with diverse staff so that at least 90% of members have contact with more than one ACT staff every two weeks. ACT team staff share responsibility for member care. Varied staff involvement promotes member access to specialized expertise and continuity of services while reducing the burden on individual staff.

			60% of members received in-person contact from more than one team staff within a two-week period.	
H3	Program Meeting	1 – 5 5	Staff reported that the ACT team meets in person four days per week to review all members on the roster. All ACT staff attend program meetings on their scheduled workdays. During the observed program meeting, the CC facilitated discussion and provided clinical guidance to prioritize service delivery. Staff identified the stage of change for members with co-occurring disorders and provided updates for all members regarding recent and planned contacts, medication deliveries and observations, medical and psychiatric appointments, hospitalizations and discharge planning, housing, employment, group attendance, and contacts with natural supports. The team coordinated follow-up activities and adjusted member contacts based on individual member needs.	
H4	Practicing ACT Leader	1 – 5 4	The CC has held this position since 2019 and provides direct, in-person services to members in both the office and the community. Reported services include meeting with members in the hospital and participating in discharge planning, transporting members to specialty medical appointments, providing skills training during shopping trips, and transporting members to obtain food boxes in the community. Interviews indicated that ACT staff are expected to provide 22.5 hours of direct service to	• Continue efforts to provide in-person services by ensuring the ACT CC delivers direct services at a level equivalent to at least 50% of the expected productivity of other ACT staff, with evidence documented in member records. Reassign non-essential administrative functions to the program assistant or other team staff so the CC can prioritize direct service delivery, documentation, and modeling effective clinical

			members each week. Productivity data from a recent 30-day period indicated that the CC provided 31.22 hours of direct service, representing approximately 35% of the monthly direct service time expected of other ACT staff. A review of 10 randomly selected member records found documentation of two in-person contacts by the CC in two records, totaling 53 minutes of direct service. *This item is dependent on provider productivity expectations.*	interventions to other team staff that support member outcomes.
H5	Continuity of Staffing	1 – 5 4	Based on information provided and reviewed with staff, the team experienced a 33% turnover rate during the past two years. Eight staff left the team during this period, including three Nurses, two psychiatric prescribers, one Licensed Associate Counselor, one Independent Living Specialist, and one Peer Support Specialist.	• ACT teams strive to maintain staff turnover below 20% by strengthening staff retention strategies and identifying and addressing factors that contribute to turnover. Consistent staffing promotes continuity of care, strengthens therapeutic relationships and team cohesion, and reduces the need for members to repeatedly build trust with new service providers.
H6	Staff Capacity	1 – 5 4	During the past 12 months, the team operated at approximately 90% of its full staffing capacity. The psychiatric prescriber position was vacant for three months, one CODS position was vacant for seven months, and the Peer Support Specialist position was vacant for five months.	• Continue efforts to screen potential hires for the responsibilities of ACT services with the goal of operating at 95% or more of full staffing annually.
H7	Psychiatrist on Team	1 – 5 5	The team includes a 1.0 FTE Psychiatric Mental Health Nurse Practitioner (Prescriber) who joined the team in March 2026. Staff reported that the Prescriber works four 10-hour days per week and provides services in both the office	

			and the community. Community-based services include scheduled visits on Thursdays and outreach to members who miss scheduled appointments. Videoconference appointments are also available when clinically indicated. Staff and members reported that most members meet with the Prescriber at least once every 30 days, with appointment frequency increasing based on individual needs. Staff described the Prescriber as highly engaged in member care and readily accessible for consultation, including after hours and on weekends. The Prescriber also coordinates member care with the team during program meetings and through impromptu staffings, telephone calls, email, and the team's messaging platform. A review of 10 randomly selected member records found documentation of services provided by the Prescriber in five records during the one-month review period.	
H8	Nurse on Team	1 – 5 5	The team includes 2.0 FTE Nurses who work staggered schedules, with one Nurse working Monday through Friday and the other working four 10-hour days per week. Both Nurses have been on the team for approximately one year and provide services to members in both the office and the community. Nursing services include administering injections, preparing medication bubble packs, performing blood draws for laboratory testing, providing health education, coordinating care with primary care and specialty providers, and transporting members to external medical appointments. Interviews indicated that Nurses facilitate	

			regular health education groups for ACT members. Staff reported that the Nurses are readily accessible for consultation in the office, by telephone, email, and through the team's messaging platform. Interviews indicated that the Nurses are available after hours and on weekends to respond to medication-related questions as needed.	
H9	Co-Occurring Disorders Specialist on Team	1 – 5 3	The team includes 2.0 FTE CODS staff. One CODS has been in the role since August 2024, while the other joined the team in June 2026. Resumes indicated that both CODS staff have multiple years of experience providing substance use treatment services to individuals with co-occurring disorders. Training records indicated that neither CODS staff completed substance use-related training during the 12 months prior to the review.	• Provide eight (8) hours of annual training to CODS staff in co-occurring disorders treatment best practices, including appropriate interventions (e.g., a *stage-wise approach*). (See *AMPM Policy 930 – Implementation and Fidelity Monitoring of SAMHSA Evidence-Based Practices.)* CODS staff should support the team by cross-training staff and guiding interventions based on the members' stages of change and the co-occurring disorders model adopted by the team. • Ensure CODS staff are provided with regular supervision from a qualified professional to support delivery of individual and group substance use treatment services using an integrated treatment model approach.
H10	Vocational Specialist on Team	1 – 5 3	The team includes 1.0 FTE Employment Specialist and 1.0 FTE Rehabilitation Specialist, both of whom have served in their respective roles since 2019. Training records for both specialists did not reflect participation in training related to	• Provide ongoing training, guidance, and supervision to Vocational Specialist staff, including at least four (4) hours of annual training focused on employment and vocational support services. Training should emphasize best practices that help members obtain competitive jobs in

			supporting individuals with SMI in obtaining competitive employment in integrated work settings during the 12 months prior to the review.	integrated settings. Consider focusing training on techniques to engage members to consider employment and job development strategies, the importance of supporting in-person employer contact soon after members express an employment goal, and the provision of follow-along supports to employed members.
H11	Program Size	1 – 5 5	At the time of the review, the team consisted of 11.0 FTE staff, including the Prescriber. The Peer Support Specialist position was the only vacancy.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team serves individuals with an SMI designation who demonstrate significant functional impairment and service needs that have not been adequately addressed through traditional behavioral health services. Reported admission criteria include frequent medical or psychiatric hospitalizations, involvement with law enforcement or probation, chronic homelessness or housing instability, difficulty engaging in treatment, and the need for medication observation. Staff reported that referrals are received primarily from internal sources, although external referrals are also accepted, most commonly from inpatient providers through Mercy Care. The CC completes an admission screening using the *Mercy Care ACT Admission Screening Tool*. Following the screening, the CC and Prescriber independently review the individual's clinical record and jointly determine appropriateness for ACT services after	

			discussing the referral. In some cases, the individual also meets with the Prescriber before an admission decision is made. Staff further reported that the intensity, frequency, and voluntary nature of ACT services, as well as the expectation that members transfer their behavioral health services to the ACT team upon admission, are discussed during the screening process and reinforced before admission. If accepted, the individual is scheduled for an intake appointment with the ACT team.	
O2	Intake Rate	1 – 5 5	Based on data provided and confirmed with staff, the team demonstrated an appropriate rate of admission, with three members joining the team during the six months prior to the review.	
O3	Full Responsibility for Treatment Services	1 – 5 3	In addition to case management, the team is credited for providing substance use treatment and psychiatric and medication management services. The team is not credited with the following services: The team roster did not include a licensed clinician qualified to provide formal psychotherapy. Staff provided varied reports regarding the number of members receiving counseling/psychotherapy services outside of the ACT team. Interviews indicated that up to eight members were receiving these services from agency providers.	*In the evidence-based practice of ACT, all member services are delivered by the ACT team. As a transdisciplinary service delivery model, area specialists are trained and cross trained to provide the core components of ACT: case management, psychiatric services, counseling/psychotherapy, employment and rehabilitation services, housing support, and substance use treatment.* • Make counseling/psychotherapy available to members through clinically licensed ACT staff who also function as generalists within the team. Consider options to include team staff qualified to provide individual counseling to members. • Continue to monitor the number of members in staffed residences. Approximately 10% of members on the

			Approximately 10 members resided in settings that provide additional case management services, resulting in 10.1% of members living in environments where ACT services may be duplicated. Staff reported that approximately five members receive employment and/or rehabilitative supports from the team, while three members receive these services through work adjustment training programs, resulting in approximately 38% of members receiving employment supports from a brokered provider.	team reside in settings in which ACT services are duplicated. The ACT team is the designated Permanent Supportive Housing provider and is responsible for delivering all housing support and case management services. Transition members, when possible, to independent housing in integrated settings where these services are provided directly by the ACT team. Ensure members receive all services and supports from the team. • Ensure vocational services are delivered by ACT team staff in alignment with the EBP. Vocational staff receive training to support members with SMI and co-occurring disorders in obtaining and maintaining competitive employment and, in turn, cross-train other team specialists. ACT teams assume responsibility for assisting members with finding and maintaining employment in integrated community settings according to the member's preferences rather than referring out to brokered programs.
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24-hour crisis support through primary and backup on-call lines staffed by ACT team staff. On-call responsibilities rotate weekly, and the CC serves as an additional backup. Crisis support is provided by telephone or in person based on member needs. Staff reported assessing risk, attempting telephone de-escalation, responding in the community when clinically indicated, and coordinating voluntary or involuntary psychiatric hospitalization when necessary.	

			Reviewers received a copy of the *Meet Your ACT Team* handout, which is provided to members upon admission and includes the team's main telephone number, the on-call/crisis line number, contact information for each specialist, and a description of each team member's role. Four of the five members interviewed reported being aware of the on-call/crisis line, and at least three reported having used it in the past.	
O5	Responsibility for Hospital Admissions	1 – 5 4	Staff reported that when members experience an increase in psychiatric symptoms, the team attempts to assess and stabilize them in the community before hospitalization. Members may be brought to the office for assessment by the Prescriber, who, in collaboration with the team, determines whether psychiatric hospitalization is clinically indicated. When hospitalization is warranted, the team facilitates voluntary admission. When members decline voluntary treatment, staff reported initiating the petition process for involuntary evaluation. Following admission, the team maintains regular contact with inpatient providers through hospital visits, coordination of treatment staffings, and routine prescriber-to-prescriber telephone communication to support continuity of care and discharge planning. Review of data pertaining to the 10 most recent psychiatric hospital admissions that occurred during the one-month period prior to the review showed that the team was directly involved in 70% of admissions. Of the three admissions without ACT team involvement, the team was	• ACT teams performing to high fidelity of the model are directly involved in 95% or more of psychiatric admissions. Evaluate what contributed to members not seeking team support prior to self-admission. • Develop hospitalization plans with members in advance, especially when they have a history of hospitalization without seeking team support.

			notified after the admission occurred on two occasions. For the remaining admission, the member was petitioned and transported by law enforcement, and the team was notified the following day.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Staff reported that the ACT team is actively involved in psychiatric discharge planning and coordination. Interviews indicated that the CC coordinates discharge planning meetings with inpatient providers and includes members' guardians and natural supports, when applicable, as well as the health plan to facilitate collaborative discharge planning. Upon discharge, the team transports members from the hospital to their identified living environment, assesses the setting to support a safe transition, and assists members in obtaining prescribed medications. Following discharge, staff reported attempting daily contact with members for five consecutive days to monitor their transition back to the community and provide additional support as needed. Members are also scheduled to see the team Prescriber within 72 hours of discharge, team nursing staff within one week, and their primary care provider within two weeks of discharge to support continuity of care. Review of data pertaining to the 10 most recent psychiatric hospital discharges that occurred during the three-week period preceding the review showed that the team was directly involved in 100% of discharges.	

O7	Time-unlimited Services	1 – 5 5	No members graduated from the program within the past 12 months, and staff reported that no members are expected to graduate from the team within the next 12 months. Staff reported using a step-down approach rather than directly discharging members from ACT. The CC and Prescriber assess clinical readiness, coordinate with the receiving provider, and gradually reduce service intensity. Transition recommendations are made collaboratively, with members ultimately deciding whether to step down.	
S1	Community-based Services	1 – 5 3	Staff reported that 80% of in-person contacts with members occur in the community. A review of 10 randomly selected member records showed staff delivered a median of 52% of services in the community. Four of the five members interviewed reported receiving services most often at the office. Staff interviews and record review indicated that community-based services include home visits, psychiatric services, medication delivery and education, peer support, independent living skills training, linkage to community resources, transportation and accompaniment to external appointments, hospital visits, and follow-up after psychiatric hospitalization.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in community settings where members live and staff can directly assess needs, monitor progress, model behaviors, and assist members in accessing resources in natural, non-clinical environments. Providing services in community settings, such as members' homes, also creates opportunities for staff to engage with members' natural supports, an essential component of effective ACT service delivery. • Avoid over-reliance on office-based contacts as a substitute for community-based service delivery. Evaluate which services currently provided in the office could instead be delivered in members' natural environments. • For members who routinely come to the office multiple times each week, evaluate

				whether some office-based contacts can instead be provided in members' homes or other natural community settings.
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, two members left the program in the past 12 months. Of those, one member left the area without a referral, and the other was incarcerated in the Arizona Department of Corrections. The team retained approximately 98% of members during this period. The team experienced four member deaths in the past 12 months, which were excluded from program dropouts.	
S3	Assertive Engagement Mechanisms	1 – 5 4	Interviews indicated the team uses an ACT-specific outreach protocol, which was provided to reviewers. Staff reported outreach practices that were consistent with the protocol, including making at least four outreach attempts per week for up to eight weeks to support member re-engagement, with at least two of those attempts occurring in the community. Remaining attempts may occur by telephone, email, or other electronic means. Outreach activities included searching for members in areas they are known to frequent, contacting natural and paid supports (e.g., guardians, payees, and probation officers), and checking county resources, such as the Medical Examiner's Office. During the observed program meeting, approximately 10 members were identified as being on outreach. Staff provided updates regarding their most recent outreach attempts	• Monitor documented outreach and contacts with members. It may be useful to assign one staff to verify documentation in member records (peer review) during the program meeting to confirm recent contacts or outreach efforts are entered. This may enable the team to proactively assign alternating staff to outreach in the event of lapses. • Ensure all outreach efforts, including letters, phone calls, and contact with formal and natural supports, are documented in member records.

			and discussed plans for ongoing outreach efforts. Documentation in seven of the 10 records reviewed contained gaps of 10 to 30 days without documented ACT staff contact or attempted contact. One of those records involved a member who was incarcerated during the review period; however, the record lacked documentation of services provided.	
S4	Intensity of Services	1 – 5 2	Records reviewed indicated that during a 30-day period prior to the fidelity review, the median amount of time the team spent in person with members was 35.75 minutes. The record with the highest weekly average for in-person services was 136.5 minutes, while one record showed no in-person contacts during the review period.	• 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. Ensure services are accurately documented in member records.
S5	Frequency of Contact	1 – 5 2	A review of 10 randomly selected records showed a median of 1.50 in-person contacts per member per week, with weekly frequencies ranging from zero to 6.75 contacts. Members interviewed reported varying frequencies of staff contact, ranging from three to 12 contacts per week.	• Increase the frequency of contact with members, ideally averaging four (4) or more in-person contacts per week. Frequent, individualized contact is associated with improved outcomes and should align with members' recovery goals. Work with staff to identify and resolve barriers to increasing contact frequency. • Teams may benefit from routinely reviewing contact data, assessing barriers to in-person service delivery, and integrating discussions of contact frequency into supervision and team meetings. These efforts can help ensure that contact frequency remains aligned

			The fidelity tool does not accommodate delivery of telehealth services.	with member needs and the expectations of the ACT model.
S6	Work with Support System	1 – 5 3	Data provided indicated that 54 members (approximately 55%) had identified natural supports. Staff reports regarding the number of natural supports the team engaged during the past 30 days ranged from 27 to 40. Contacts typically occur weekly and are conducted most often by telephone, email, or during home visits. The team routinely collaborates with natural supports and, when appropriate, attempts to involve them in service planning and psychiatric hospital staff meetings. Staff reported that many members have re-engaged with family following encouragement and support from the team. Contact with natural supports is tracked and discussed during the program meeting. During the observed program meeting, staff discussed recent or planned contact with natural supports for approximately 12 members and identified an additional six members with natural supports who appeared to be actively involved in their treatment. Members reported varying frequencies of natural support involvement, ranging from weekly to approximately every six months. Records reviewed showed an average of 0.60 interactions with natural supports over a 30-day period. Five of the 10 records (50%) identified members with natural supports. Of those five	• Increase engagement with members' natural supports to an average of four (4) contacts per month for each member that has an identified support system. Provide education, skill-building, and ongoing collaboration (with or without the member present), and incorporate natural support involvement into routine service delivery whenever clinically appropriate. Strengthening relationships with natural supports promotes community integration, enhances stability, and improves long-term functioning by expanding the member's informal network beyond paid providers. • Ensure consistent and timely documentation of all contacts with natural supports (e.g., phone, email, text, and in-person interactions) as they occur and monitor member records to support fidelity.

			records, two documented contacts between ACT staff and the member's natural support. One record included one documented contact, and the other included five documented contacts.	
S7	Individualized Co-Occurring Disorders Treatment	1 – 5 4	Per data reviewed and confirmed with staff, 74 members (approximately 78%) were identified as having co-occurring disorders. Of those members, approximately 42 (58%) reportedly receive structured individual substance use treatment sessions, typically occurring at least once monthly and averaging 30 minutes per session. Record review indicated that seven of the 10 sampled members had co-occurring disorders. Four of those members received between one and four individual substance use treatment sessions from the CODS during the 30-day review period, with sessions ranging from 15 to 45 minutes in length. The remaining three members had no documented individual substance use treatment sessions during the review period.	• Continue efforts to align service delivery with the ACT evidence-based practice by providing members with co-occurring disorders an average of 24 minutes or more of individualized substance use treatment per week. Utilize an evidence-based approach, such as *Integrated Treatment for Co-Occurring Disorders*, while maintaining ACT as a transdisciplinary, self-contained treatment program that provides the substance use services needed and/or requested by members.
S8	Co-Occurring Disorders Treatment Groups	1 – 5 2	The team offers two weekly, in-person, office-based substance use treatment groups that are facilitated by the CODS and tailored to the members' stages of change. Staff reported that the groups incorporate perspectives informed by lived experience and generalized content designed to support members across various stages of change and recovery. Review of group sign-in sheets for a recent 30-day period prior to the review indicated that	• 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 co-occurring disorders groups monthly. • Structure co-occurring disorders treatment groups around an evidence-based curriculum appropriate for individuals with co-occurring disorders.

			eight unique members (11%) attended at least one group session.	
S9	Co-Occurring Disorders Model	1 – 5 3	Staff described using a member-centered, non-confrontational approach that emphasizes meeting members where they are, supporting member-driven reduction of use or abstinence goals, and using motivational interviewing strategies to elicit change talk, reinforce engagement, and support movement through the stages of change. Staff also described providing overdose prevention and safer use education, distributing overdose reversal medication, and other interventions intended to reduce harm while maintaining member engagement. Staff reported providing both individual and group substance use treatment while connecting members to external or agency-based intensive outpatient treatment, Medications for Opioid Use Disorder providers, and withdrawal management services when clinically indicated. Staff also encourage participation in community recovery supports, including peer-run programs. Staff had difficulty identifying specific evidence-based interventions, instead describing the use of materials from peer-run recovery organizations (e.g., Alcoholics Anonymous and Narcotics Anonymous) and local consumer-operated service programs while generally citing SAMHSA guidance. Interviews reflected variation in staff understanding and application of a stage-wise treatment approach.	• Provide all specialists with annual training, at a minimum, and ongoing mentoring in a co-occurring disorders treatment model, such as *Integrated Treatment for Co-Occurring Disorders*, in the principles of a *stage-wise approach* to interventions, and other recognized practices, including *motivational interviewing* and reduction of use. With staff turnover, knowledge and lessons learned are lost. Ongoing training can accommodate new or less experienced staff. Identifying a co-occurring disorders treatment model that the team adheres to can promote continuity in the approach that ACT specialists use when supporting members in recovery. • Ensure treatment plans are written from the member's point of view, recovery-focused, and outline steps the team will take to address substance use while supporting the member in recovery. Support members to identify a reduction of use goal when a desire for abstinence is expressed.

			Review of seven sampled records for members identified with co-occurring disorders reflected inconsistent integration of substance use treatment into individualized service planning. Although substance use was frequently identified as an active treatment need, recovery goal or vision, or reason for participating in ACT services, service plans generally did not translate these needs into individualized substance use treatment goals and interventions. One member participated in multiple substance use treatment groups despite the absence of a corresponding substance use treatment goal on their current service plan.	
S10	Role of Consumers on Treatment Team	1 – 5 1	While interviews indicated that the Peer Support Specialist position is the only current vacancy, staff provided varied reports regarding the presence of lived or living experience of psychiatric care among team staff. Some staff indicated that team staff had personal recovery experience but did not specify that the experience was related to psychiatric care, while others reported that no team staff had lived or living experience specifically related to psychiatric care.	• Fill the vacant Peer Support Specialist (PSS) position. PSS staff have specialized training and provide valuable services to members and their families while bringing a unique perspective to the clinical team. Ideally, this position is filled by staff that has personal lived experience of receiving care for a mental illness. PSS staff provide expertise in symptom management and the recovery process, promote a team culture that supports member choice and self-determination, share their experiences of hope and recovery, and provide rehabilitation and other recovery-oriented support services.
Total Score:		**107**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score
1. Small Caseload	1 - 5	5
2. Team Approach	1 - 5	3
3. Program Meeting	1 - 5	5
4. Practicing ACT Leader	1 - 5	4
5. Continuity of Staffing	1 - 5	4
6. Staff Capacity	1 - 5	4
7. Psychiatrist on Team	1 - 5	5
8. Nurse on Team	1 - 5	5
9. Co-Occurring Disorders Specialist on Team	1 - 5	3
10. Vocational Specialist on Team	1 - 5	3
11. Program Size	1 - 5	5
Organizational Boundaries	Rating Range	Score
1. Explicit Admission Criteria	1 - 5	5
2. Intake Rate	1 - 5	5
3. Full Responsibility for Treatment Services	1 - 5	3
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. Community-Based Services	1 - 5	3
2. No Drop-out Policy	1 - 5	5
3. Assertive Engagement Mechanisms	1 - 5	4
4. Intensity of Service	1 - 5	2
5. Frequency of Contact	1 - 5	2
6. Work with Support System	1 - 5	3
7. Individualized Co-Occurring Disorders Treatment	1 - 5	4
8. Co-occurring Disorders Treatment Groups	1 - 5	2
9. Co-occurring Disorders Model	1 - 5	3
10. Role of Consumers on Treatment Team	1 - 5	1
Total Score	**3.82**	
Highest Possible Score	**5**	