ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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Introduction

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

Method

On July 17 – 20, 2023, Fidelity Reviewers completed a review of the La Frontera Capitol Center 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.

La Frontera offers crisis and community behavioral health services to children, adults, and families. The individuals served through the agency are referred to as "clients" or "patients", 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 July 18, 2023.
- Individual video conference interview with the Clinical Coordinator.

- Individual video conference interviews with Co-Occurring, Housing, Employment, Rehabilitation, ACT, and Peer Support Specialists, as well as the Counselor/Co-Occurring Specialist for the team.
- Individual phone interviews with two members participating in ACT services with the team.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system.
- Review of documents: *Mercy Care ACT Admission Criteria*; resumes and training records for Vocational and Co-Occurring Specialist staff, Co-Occurring Group Sign-in Sheets, *Clinical Coordinator Productivity Report, COS member calendar, Capitol ACT Brochure, Outreach and Engagement, SAMSHA Integrated Treatment for Co-Occurring Disorders,* and *SAS Curriculum – Living in Balance, Substance Abuse and the Stages of Change.*

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 team is fully staffed to provide coverage to 91 members with a staff ratio of 8:1.
- The Psychiatrist provides services to only ACT members of this team both in the community and in the clinic. The Psychiatrist attends all program meetings when scheduled to work.
- The ACT team demonstrates effective assertive engagement mechanisms and 90% of members received in-person contact from more than one ACT staff.

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

- The ACT team had a 40% involvement in the ten most recent member psychiatric hospital admissions. The ACT team should look for ways to develop hospitalization plans in advance with members to better assist them in the hospital admission process.
- The median intensity of services was about 50 minutes a week. ACT staff should aim to provide quality services to members in the community at least two (2) hours a week.
- The median frequency of contact was 2.4 contacts a week with members. ACT staff should try to see every member at least four (4) times a week in the community or clinic.
- ACT staff reported a comprehensive weekly plan to connect with members' natural supports. Records reviewed indicated an average of 0.40 contacts documented with natural supports in the month period reviewed. Ensure contact with members' natural supports is accurately documented.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team serves 91 members with 11 full-time equivalent (FTE) direct service staff, excluding the Psychiatrist and administrative staff. Staff includes the Clinical Coordinator (CC), two Nurses, one Co-Occurring Specialist, one Counselor/Co-Occurring Specialist, one Employment Specialist, one Rehabilitation Specialist, one ACT Specialist, one Housing Specialist, one Independent Living Specialist, and one Peer Support Specialist. The team has an appropriate member-to-staff ratio of approximately 8:1.	
H2	Team Approach	1 – 5 5	Staff interviewed reported all members are seen by more than one ACT staff over a two-week period. Staff reported that the team has implemented a *zone approach* to contacting members. Each day, specialists are assigned a geographic area for home visits and contacts, and the assignments are rotated daily. Per a review of ten randomly selected member records, for a two-week period, 90% of members received in-person contact from more than one ACT staff. Members interviewed reported seeing multiple staff in a two-week period. All staff reported working four 10-hour days, and staff are assigned to cover the weekends.	

H3	Program Meeting	1 – 5 5	Staff interviewed reported meeting four days a week Monday through Thursday to review all members of the team. The meeting observed occurred in person with all staff in attendance including the Psychiatrist. All staff participated in the discussion about members' stage of change, staff contact with natural support, individual service plan needs, medication updates, and outreach planning.	
H4	Practicing ACT Leader	1 – 5 2	The CC estimated delivering in-person services to members 30 to 80 hours a month. The CC reports conducting member outreach, outpatient discharge, and home visits. According to the *CC June Productivity Report*, the CC spent 22% of the time expected of other ACT staff providing direct in-person services to members. Of the ten records reviewed, there were examples of the CC delivering in-person services in the community and at the clinic in two member records over a recent month period.	• Continue efforts to provide in-person services to members. Under ideal circumstances, the ACT CC delivers direct services to members and accounts for at least 50% of the expected productivity of other ACT staff. • The CC and agency may consider identifying administrative functions not essential to the CC's time that could be performed by the program assistant or other team members.
H5	Continuity of Staffing	1 – 5 3	Based on the data provided, 11 staff left the team in the past two years resulting in a turnover rate of 46%. The positions with the most turnover were the Housing Specialist, Employment Specialist, and ACT Specialist.	• If not done so already, consider examining employees' motives for resignation, and attempt to identify factors contributing to employee turnover, as well as opportunities that support staff retention. • ACT teams strive for a less than 20% turnover rate. Maintaining consistent staffing supports team cohesion and the therapeutic relationship between members and staff.

H6	Staff Capacity	1 – 5 3	The team operated at 69% of staff capacity during the past 12 months. There was a total of 10 vacant positions. 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. • The timely filling of vacant positions also helps to reduce the potential burden on staff. Research shows staff remain in positions longer when supported in their roles by being provided supervision and training in their specialty practice.
H7	Psychiatrist on Team	1 – 5 5	The team has one FTE Psychiatrist that works four 10-hour days a week, Monday through Thursday. The Psychiatrist attends the program meeting four days a week and delivers services to members in person at the clinic and on Thursdays in the community. Staff reported the Psychiatrist only sees members of this ACT team and can be accessed by phone after hours and on the weekends when needed.	
H8	Nurse on Team	1 – 5 5	The ACT team has two Nurses to support the team's 91 members. Each Nurse works four 10-hour days. Staff reported the Nurses provide injections, medications, medication education, and coordination of medical appointments. The Nurses only see members of the ACT team and are available by phone after hours if needed. According to the 10 records reviewed, the Nurses only met members in the ACT clinic.	
H9	Co-Occurring Disorder Specialist on Team	1 – 5	Both COS staff have completed several substance use disorder-related training courses on *Relias* within the last two years including Narcan Usage Training and several Integrated Dual Disorders	• Optimally, ACT teams are staffed with two COS, each with a year or more of training/experience providing substance use treatment services.

		4	Treatment modules. One COS has been with the ACT team for six years. The second COS has been with the team for several months and has some previous experience providing substance use treatment groups on another ACT team.	• Ensure unlicensed Co-Occurring Specialist staff are provided with regular supervision from a qualified professional.
H10	Vocational Specialist on Team	1 – 5 3	The team has two Vocational Staff. The Rehabilitation Specialist has been on the team since 2020 and completed several recent trainings related to assisting members in finding employment in an integrated setting. The Employment Specialist joined the team in April 2023, and based on the resume provided has no prior experience in providing services in rehabilitation or employment services. No vocational-related training was located in the training records provided.	• ACT teams maintain two full-time Vocational Specialist staff with at least one year experience providing employment supports. • Ensure that both Vocational Staff receive ongoing training in assisting people diagnosed with serious mental illness/co-occurring disorder diagnoses to find and retain competitive employment. Training should include techniques to engage members to consider employment; 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 was composed of 12 staff, an adequate size to provide necessary staffing diversity and coverage with no vacant positions.	
O1	Explicit Admission Criteria	1 – 5 5	The ACT team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. Referrals are received from hospitals, other provider network organizations, and internally.	

			Based on interviews with staff, all staff are trained to conduct admission screenings. The Psychiatrist has the final determination for new admissions to the team.	
O2	Intake Rate	1 – 5 5	Per the data provided, the team has an appropriate admission rate. The month with the highest intake during the past six months was in February, with five new members added for the month to the team roster.	
O3	Full Responsibility for Treatment Services	1 – 5 4	In addition to case management, the team provides psychiatric and medication management services, psychotherapy/counseling, and co-occurring disorder treatment. All members interviewed reported seeing ACT staff for their psychotherapy and counseling needs and reported only seeing the ACT team Psychiatrist. In addition, members interviewed reported attending co-occurring disorder groups and receiving individualized substance use counseling at least once a month from one of the two COSs on the team. One member interviewed reported receiving services from a brokered provider utilizing the Work Adjustment Training Program. Interviews with staff confirmed there are less than 10% of members receiving employment support outside of the ACT team. Staff interviewed reported five members currently working whom they are supporting.	• Continue to track (or 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 responsibilities are provided by the ACT team. Optimally, members of ACT teams receive all services and support from the team.

			Based on staff interviews and data provided, the team has more than 10%, 14 - 16 members, residing in settings where ACT services are duplicated.	
O4	Responsibility for Crisis Services	1 – 5 5	Per interviews with staff, the team provides 24/7 crisis services to members of the team. Staff reported providing the on-call number to members on the team in person, and members are given the *Capitol ACT Brochure* that lists the ACT team's on-call phone number. The on-call phone rotates between staff and staff reported providing coping skills to members over the phone and will go out into the community when the member needs to be seen in-person. When staff go into the community after hours, the CC is alerted and kept current with the situation. Members interviewed reported knowing about the on-call phone.	
O5	Responsibility for Hospital Admissions	1 – 5 2	Staff interviewed reported that when a member experiences an increase in symptoms, they are first triaged by the Nurse. The Nurse will determine if the member needs to be assessed by the Psychiatrist. When the Psychiatrist determines the need for psychiatric hospitalization, the team will coordinate with the inpatient team, transport the member to the hospital, and remain with the member until admitted. Staff provides the inpatient team with a list of current medications and other necessary information. Staff discusses members that are inpatient during the program meeting and determine which staff will coordinate with the inpatient team and which will visit the member.	• Work with each member and their support network to discuss how the team can support members in the event of 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. • Increasing member engagement through a higher frequency of contact and intensity of service may provide ACT staff with opportunities to assess and provide intervention to reduce psychiatric hospitalizations, or to assist in admissions

			Based on the data provided relating to the ten most recent psychiatric hospital admissions that occurred over a three-month time frame, the team was directly involved in 40%. Six members self-admitted, three members were petitioned by the team, and one member was triaged by the Nurse and Psychiatrist and taken to the hospital by ACT staff.	when indicated. This may also offer more opportunities for staff to engage and build a rapport with natural supports.
O6	Responsibility for Hospital Discharge Planning	1 – 5 3	Staff interviewed reported discharge planning beings when the member is admitted to the hospital. The ACT team coordinates staffings and updates the natural supports. Once a member is discharged, ACT staff will transport them either to the clinic, their home, or wherever they prefer. The member is scheduled within 72 hours with the Psychiatrist and Nurse on the team and receives seven days of contact from the team to support the transition back to the community. Based on the data provided, staff interviews, and records reviews, the ACT team was involved in 60% of the last ten psychiatric hospital discharges. The discharges occurred over a one-month period. Three members did not see the Psychiatrist or the Nurse within 72 hours and were placed on outreach after discharge. One member was discharged and self-admitted a few hours later.	• The ACT team and system partners should collaborate to resolve barriers to the ACT team being directly involved in 95% or more of psychiatric discharges. • Ensure the team delivers post-psychiatric hospital follow-up services and supports as described during interviews.
O7	Time-unlimited Services	1 – 5 5	Data provided showed the team graduated two members in the past 12 months. Staff interviewed stated that there are potentially two members that may graduate in the next year.	

S1	Community-based Services	1 – 5 4	Staff interviewed reported 60 - 98% of in-person contacts with members occur in the community. Members interviewed reported seeing staff from the ACT team at their home and at the ACT clinic. Members reported going into the clinic multiple times a week to three times a month. Records reviewed showed staff delivering independent living skill services, medication education, harm reduction, individualized co-occurring disorder treatment, and health education in the community. Results of ten randomly selected member records reviewed show staff provided services a median of 72% of the time in the community.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities. • For members that are coming into the clinic multiple times a week, explore how to deliver those services in the natural settings where members live, where staff can directly assess needs, monitor progress, model behaviors, and assist members in using resources in a natural, non-clinical setting.
S2	No Drop-out Policy	1 – 5 4	According to data provided and reviewed with staff, the team had six members drop out of the program in the past year. The team retained 93% of the total number of members served in the past 12 months.	• ACT teams ideally retain 95% of the entire caseload yearly. Continue to work to retain membership in ACT. Several factors can impact this number positively including clear admission policies, consistency in staffing, natural support involvement, assertive engagement practices, and taking a recovery perspective with member care.
S3	Assertive Engagement Mechanisms	1 – 5 5	According to the *Outreach and Engagement* protocol provided and staff interviews, when a member is unable to be located staff complete four outreach attempts each week minimally for eight weeks. At least two of those outreach attempts must be in the community. Documented phone and community outreach by ACT staff was located in all 10 member charts. Outreach efforts included contacting local shelters, jails, hospitals,	

			and going to the members' last known location. Staff denied knowledge of a discharge policy, stating cases are rarely closed when a member is on outreach.	
S4	Intensity of Services	1 – 5 3	Per a review of ten randomly selected member records, during a month period before the fidelity review, the median amount of time the team spends in-person with members per week is approximately 50 minutes. Weekly service duration ranged from 39 to 59 minutes. The median duration of phone contact was 15 minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	• Increase the duration of service delivery to members. ACT teams provide an average of two (2) or more hours of in-person services per week to help members with serious symptoms maintain and improve their functioning in the community. This is based on all members across the team; some may require more time and some less, week to week, based on individual needs, recovery goals, and symptoms.
S5	Frequency of Contact	1 – 5 3	The median weekly in-person contact for ten member records reviewed was 2.4 contacts per week for the month period reviewed. Weekly contact frequency ranged from 1.5 to 2.75. Staff reported members are expected to be contacted at least four times per week. Staff report a high number of members that are on outreach and difficult to engage.	• 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. • Improved outcomes are associated with frequent contact. Members of ACT teams are not successful with traditional case management services and often require more frequent contact to assess current needs and to receive ongoing support. All staff of the ACT team should be invested in delivering a high frequency of contacts to members. Those contacts should be individualized and align with the treatment goals identified.

S6	Work with Support System	1 – 5 2	Data provided indicates that 48 members have natural supports. Staff report that weekly contact with these supports occurs mostly by phone or during home visits. Of the ten records reviewed, three members had documentation of coordination by the ACT team with their natural supports. Natural support contact frequency ranged from one to two times in the month period reviewed. Members reported staff communicated with their natural supports at varied frequencies and found the coordination helpful. Natural support contacts for multiple members were discussed in the program meeting observed.	• Increase contacts with natural supports to an average of four (4) per month for each member with a support system. As much as possible, contacts with natural supports should occur during the natural course of delivery of services provided to members. • Educate members and natural supports on the benefits of collaboration to support members' recovery goals. Some ACT teams describe the PSS as a significant contributor to this effort. • Ensure consistent documentation of contacts with natural supports occurs, which includes contact by phone, email, and text, as well as in-person.
S7	Individualized Co-Occurring Disorder Treatment	1 – 5 4	According to the data provided, there were 79 members with a co-occurring diagnosis. Seven records reviewed identified co-occurring diagnoses, of those, there were six records with documented one-to-one individualized substance use treatment sessions with varying duration. One COS schedule was provided to reviewers showed in the month period reviewed, 16 individual substance use treatment sessions. Sessions were at least 30 minutes or longer. Staff interviewed stated that the *SAMSHA Integrated Treatment for Co-Occurring Disorders Manual* is used to guide treatment.	• 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.
S8	Co-Occurring Disorder Treatment Groups	1 – 5	According to data provided for the review, 23% of members with a co-occurring diagnosis attended at least one of the four co-occurring groups	• Continue to engage members with a co-occurring disorder to participate in group substance use treatment, as appropriate,

		3	offered each week during the month period reviewed. The curriculum used for the group provided by staff included the *SAMSHA Integrated Treatment for Co-Occurring Disorders Manual, Living in Balance: Moving from a Life of Addiction to a Life of Recovery,* and *Substance Abuse Treatment and the Stages of Change: Selecting and Planning Intervention.* Of the member records reviewed identified as having a co-occurring disorder, none had documentation of attending a co-occurring disorder treatment group in the 30-day period reviewed. Staff report implementing creative strategies to engage members in group, such as making meals together.	based on their stage of change. Ideally, 50% or more of applicable members participate in a co-occurring disorder group monthly. • Staff may benefit from training on strategies to engage members in group substance use treatment. Ensure all specialists engage members with a COD to consider group treatment.
S9	Co-Occurring Disorders Model	1 – 5 4	Of the ten records reviewed, seven were identified as having co-occurring disorders. Of those seven, six had treatment plans identifying substance use treatment goals. These charts included member language surrounding treatment goals, thus, when a member reported wanting to be "sober," this language was used throughout the charts. Staff confirmed this approach, stating they take a harm-reduction approach to treatment, and if a member specifically wanted to have abstinence as a goal, they would support that goal. During the program meeting observed, staff referred to members' stage of change. This language was also documented in the members' charts.	• 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, and motivational interviewing. • Although clients may use stigmatizing language when referencing substance use disorders, ACT teams show leadership and model accepting and affirmative language as a replacement in an effort to inspire hope and recovery.
S10	Role of Consumers on Treatment Team	1 – 5	The team has at least two staff with personal lived psychiatric experience. Staff reported that these individuals share their stories of recovery with the team and members. These staff share the same	

		5	level of responsibility as other staff. Members interviewed had varied responses of knowledge about these staff. Some members were unsure if there was a staff member with lived psychiatric experience while others recalled staff personally sharing their story of recovery.	
Total Score:		**111**		

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	2
5. Continuity of Staffing	1-5	3
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Co-Occurring Specialist on Team	1-5	4
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	4
4. Responsibility for Crisis Services	1-5	5
5. Responsibility for Hospital Admissions	1-5	2
6. Responsibility for Hospital Discharge Planning	1-5	3

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	4
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	3
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Co-Occurring Disorder Treatment	1-5	4
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.96**	
Highest Possible Score	**5**	