ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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Introduction

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

Method

On August 21 – 23, 2023, Fidelity Reviewers completed a review of the La Frontera – EMPACT Tempe 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-EMPACT provides crisis and behavioral health services to adults, children, and families. The Tempe ACT team is a standalone ACT team, and the location is fully dedicated to members of the Tempe ACT Team. 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 August 22, 2023.
- Individual video conference interview and Fidelity Review Close out discussion with the Clinical Coordinator and representative from the contractor with a Regional Behavioral Health Agreement.

- Individual video conference interviews with the Licensed Professional Counselor/Co-Occurring, Housing, Peer Support, Rehabilitation, and Co-Occurring Specialists, as well as the ACT Generalist for the team.
- Individual phone interviews with four (4) 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 Specialists, Co-occurring Specialist scheduling calendar, and cover pages of reference materials used for co-occurring disorder treatment, i.e., *Seeking Safety*.

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.

<u>Summary & Key Recommendations</u>

The agency demonstrated strengths in the following program areas:

- The team has a Psychiatrist and two Nurses fully dedicated to work with the 88 members of the team.
- Through assertive engagement practices and procedures, the team did not have any members drop out of the program in the past year.
- The team has two Co-Occurring Specialists assigned to the team. One of these staff is qualified to provide general counseling services to members assigned to the team.

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

- Training: Ensure Co-Occurring Specialists and Vocational staff receive annual training in evidence-based practices related to their specialty. Co-Occurring Specialists and Vocational staff on ACT teams are the subject matter experts of the team and provide cross training to other specialists.
- Intensity of Services: The median amount of time the team spends in-person with members per week is 28.13 minutes. Increase the duration of service delivery to members. Improved outcomes are associated with frequent contact. 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.
- Frequency of Services: The median frequency of contact with members by the team was 1.25 per week. Increase the frequency of contact with members, ideally averaging four (4) or more in-person contacts a week. This may provide the team with opportunities to provide support to members experiencing an increase in symptoms or distress, thereby, more likely to be involved when members seek psychiatric hospitalization.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team serves 88 members with ten (10) full-time direct service staff, excluding the Psychiatrist. The team is comprised of the Clinical Coordinator (CC), two Nurses, one Licensed Professional Counselor/Co-Occurring Specialist, one Co-Occurring Specialist (COS), one Rehabilitation Specialist, one Peer Support Specialist, one Independent Living Specialist, one ACT Generalist, and one Housing Specialist. The team has an appropriate member to staff ratio of approximately 9:1. Not included in this count is the Integrated Family Nurse Practitioner that serves the members of the team.	
H2	Team Approach	1 – 5 4	Staff report that members are seen by multiple staff each week citing the use of a rotating regional assignment approach. Two members interviewed reported typically meeting with two staff each week. One member had not seen any staff in more than a week. Of ten (10) randomly selected member records reviewed for a month period, a median of 70% received contact from more than one staff in a two-week period.	• Ideally, 90% of ACT members have contact with more than one staff in a two-week period. Continue efforts to ensure all members on the ACT roster have in-person contact with more than one staff in two weeks; a diversity of staff allows members access to unique perspectives and expertise of staff.
H3	Program Meeting	1 – 5 5	Per staff interviewed, the team meets four days a week to discuss all members assigned. All staff are expected to attend on days scheduled to work, including the Psychiatrist that works four 10-hour days. During the program meeting observed, led by the CC, staff referenced a printed roster, reciting plans for contact.	

H4	Practicing ACT Leader	1 – 5 3	The CC reports providing in-person services approximately 25% of the time expected of other specialists. Examples seen in the records reviewed included providing support in the community for independent living skills development, connecting with Natural Supports by phone and email in two records, and an attempted home visit with a member. Other reported activities include accompanying members to specialty appointments, being *Social Security Income/Social Security Disability Income Outreach Access and Recovery* certified, assisting with applying for benefits, and supporting efforts to obtain or maintain employment. *The fidelity tool does not accommodate delivery of telehealth services.*	• Continue efforts to provide in-person services to members. Optimally, the ACT CC delivers direct services to members and accounts for at least 50% of the expected productivity of other ACT staff. • Consider identifying administrative tasks currently performed by the CC that may be transitioned to other ACT or administrative staff, if applicable.
H5	Continuity of Staffing	1 – 5 4	Based on information provided, the team experienced turnover of 29% during the past two years. Seven staff left the team during this time. Everyone works four 10-hour days, excluding the CC. The team's low turnover was partially attributed to this scheduling method. Positions of high turnover frequency include the Rehabilitation Specialist and the Nurses.	• Continue efforts to recruit and retain experienced staff. Support staff in their specialty roles by ensuring they receive training and guidance applicable to their specialty position. Ideally, turnover should be no greater than 20% over a two-year period.
H6	Staff Capacity	1 - 5 4	In the past 12 months, the team operated at 90% of full staffing capacity. The team experienced 14 months of vacant positions. The Nurse positions experienced the most vacancies.	• 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	Staff report that the team has a fully dedicated Psychiatrist to serve members of the team, working a four day 10-hour schedule. The Psychiatrist has the ability to provide services via telehealth and does for those that make the	

			request but prefers to see members in person. During the meeting observed the Psychiatrist was engaged in discussions relating to members' care and provided guidance to the team. Staff reported it is typical for the Psychiatrist to be involved in level of care discussions and to suggest interventions. Member records review show two members were seen in office during the month period reviewed. One record shows the Psychiatrist discussing employment, natural supports, and reducing the use of substances.	
H8	Nurse on Team	1 – 5 5	The team has two Nurses assigned to work with the members of the ACT team. The Nurses schedules are staggered, attending the program meeting on days assigned to work. Nurses are available to the team after hours and weekends, but member needs are assessed through the CC first. Nursing staff meet with members in the community.	
H9	Co-Occurring Disorder Specialist on Team	1 – 5 4	The team has two Co-Occurring Disorder Specialists. One specialist is a Licensed Professional Counselor (LPC) having more than one year of experience providing substance use treatment services and participated in recent training in co-occurring disorders, motivational interviewing, and medication-assisted treatment, as well as, a recent three day in-person training related to substance use treatment. The second COS has been in the role for more than one year. Training documentation lacked evidence of recent participation in training related to providing services to persons with a co-occurring disorder, the integrated co-occurring disorder treatment model, or in the evidence-based	• Provide annual training to Co-Occurring Specialists in co-occurring disorder treatment best practices, including appropriate interventions, i.e., *stage-wise approach;* the evidence-based practice of *harm reduction*; and *motivational interviewing*. On ACT teams, COS 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 Co-Occurring Specialist staff are provided with regular supervision from a qualified professional.

			practice of harm reduction. This COS is not receiving clinical supervision related to the delivery of substance use treatment services.	
H10	Vocational Specialist on Team	1 - 5 2	The team has one Vocational Specialist staff providing services to members. The Rehabilitation Specialist has been working with members from this team for over one year. There was no recent training completed relating to supporting members obtain work in an integrated work setting.	• ACT teams maintain two full-time Vocational Specialist staff with at least one year of experience providing employment support. • Provide ongoing training, guidance, and supervision to Vocational Specialist staff related to support and best practices that aid members to obtain competitive positions in integrated work settings. Training areas of focus should include job development, individualized job searches, employer engagement, and follow-along support.
H11	Program Size	1 – 5 5	At the time of the review, the team was composed of 11 staff, an adequate size to provide necessary staffing diversity and coverage. The Employment Specialist position was vacant.	
O1	Explicit Admission Criteria	1 – 5 5	Staff interviewed reported receiving referrals internally, externally and from hospitals. The team utilizes the *Mercy Care ACT Admission Criteria* to assess potential admissions. The CC conducts the initial screenings. The CC will contact the referred member to determine the person's needs and if the potential new member is indeed interested in ACT services. If agreed, the Psychiatrist will review the member's chart and make the final decision if the member is appropriate for the team. When the Psychiatrist declines a referral, a complex case review is conducted which includes the referring Psychiatrist and team Psychiatrist. The contractor of the Regional Behavioral Health Agreement will	

			determine if the new referral is onboarded to the team.	
O2	Intake Rate	1 – 5 5	Per data provided, and reviewed with staff, the ACT team has an appropriate rate of admissions with less than six members per month admitted to the team. The ACT team accepted a total of nine admissions over the previous six months, with February of 2023 being the highest with three new members.	
O3	Full Responsibility for Treatment Services	1 - 5 4	In addition to case management services, the team directly provides psychiatric services and medication management, counseling/psychotherapy, and substance use treatment. All members are served by the Psychiatrist for medication management. Staff reported 5 - 6 members receive counseling through the LPC/COS, that is Eye Movement Desensitization and Reprocessing (EMDR) trained, and that no members receive counseling from brokered providers. Records reviewed show one member engaged in EMDR. The two COS provide both individual and group substance use treatment services to members, with none seeking services outside the team. Staff report 3 - 16 members are employed. The team accommodates working members' schedules when arranging to meet and schedule appointments with the Psychiatrist. Several members (5 – 8) are engaged in a sheltered workshop, i.e., work adjustment program (WAT). Two records reviewed did show staff encouraging work exploration and providing job retention support.	• Ensure Vocational Specialist staff receive supervision and training so that they can directly assist members to find and keep jobs in integrated work settings rather than relying on vendors. • Support Vocational Specialist staff to provide cross training on the benefits of competitive employment versus other sheltered services (e.g., WAT). • Continue efforts to help members find safe and affordable housing. Housing Specialists on ACT teams play an integral part in supporting members in their recovery by assisting with obtaining and maintaining housing.

			Staff report at least six (6) members live in housing that duplicates ACT services. Another seven (7) are in an inpatient substance use treatment facility.	
O4	Responsibility for Crisis Services	1 – 5 5	The team provides 24-hour crisis intervention services to members. Most staff participate in the weekly after-hours rotation of the on-call line. The LPC/COS, Psychiatrist, and Nurses do not participate. Staff report that not all calls to the on-call line are crises. Some clients contact the team for general needs. When a member is in distress, staff will attempt to de-escalate and when needed, will consult the CC to determine the need to assess the member in the community as a team. Members are provided with a business card with after-hours contact details as well as the number being included in members' individual crisis plans. All of the members interviewed were aware of the after-hours crisis services available from the team.	
O5	Responsibility for Hospital Admissions	1 - 5 3	When a member is experiencing an increase in symptoms, efforts are made to have them come to the clinic to be triaged by a Nurse and the Psychiatrist. When admission is recommended and members agree, the team will do a direct admission, providing transportation to the unit and sitting with the member until admitted. After admissions, the CC takes the role of coordinating with the inpatient psychiatric hospital/facility team ensuring the inclusion of guardians and advocates involvement. Per review with staff of data relating to the ten most recent psychiatric hospital admissions, which occurred over a one-month time frame, the team was directly involved in 60%. For the admissions that the team was not involved, members self-	• Maintain regular contact with members and their support networks (both natural and formal). This may result in earlier identification of issues or concerns relating to members, allowing the team to offer additional support, which may reduce the need for hospitalization. • Educate members and their support systems, to include natural supports, about team availability to support members in their communities or, if necessary, to assist with hospital admissions.

			admitted without reaching out to the team first. Member records revealed one additional member was recently admitted and discharged without team involvement.	
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	Staff interviewed report discharge planning begins upon admission. Staffings typically occur within the first 72 hours and weekly thereafter. The Psychiatrist will coordinate with the treating prescriber 1 - 2 times per admission. The CC does the coordination with the inpatient team and ACT team staff attend the staffing meetings at the psychiatric unit. Upon discharge, the team will provide a five day follow protocol, ensuring the member is supported in obtaining medications, food supplies, and sometimes assisting with making utility or rent payments by applying for emergency resources. Per review of data relating to the ten most recent psychiatric hospital discharges with staff, which occurred over a one-month time frame, the team was directly involved in 100%. Staff interviewed report discharge planning begins upon admission. Staffings typically occur within the first 72 hours and weekly thereafter. The Psychiatrist will coordinate with the treating prescriber 1 - 2 times per admission. The CC does the coordination with the inpatient team and ACT team staff attend the staffing meetings at the psychiatric unit. Upon discharge, the team will provide a five day follow protocol, ensuring the member is supported in obtaining medications, food supplies, and sometimes assisting with	• Develop plans with members and their supports in advance, especially when members have a history of hospitalization without seeking team support. Some teams provide ACT "business" cards to members to facilitate discharge coordination when uninvolved during admission.

			making utility or rent payments by applying for emergency resources. Importantly, member records revealed one additional member was recently admitted and discharged without team involvement, negatively impacting this score.	
O7	Time-unlimited Services	1 – 5 5	Data provided show one member graduated in the past 12 months. No more than two members are expected to graduate in the coming year. Staff report that when a member is considered for graduation the team will introduce a graduation plan for six months, reducing the number of in-person visits to help prepare the member for the supportive level of care.	
S1	Community-based Services	1 – 5 3	Staff interviewed reported 80 – 90% of in-person contacts with members occur in the community. Results of ten randomly selected member records reviewed show staff provided services a median of 43% of the time in the community. Nursing appointments are primarily office based. Records show other staff supporting members by providing life skills training, assisting with shopping, conducting a community-based group, and attending an intake meeting with a housing voucher agency.	• Increase the delivery of services to members in their communities. Optimally, 80% or more of services occur in members' communities. • Ensure all staff engage members in the community at a similar level as what was reported by staff interviewed.
S2	No Drop-out Policy	1 – 5 5	According to data provided and reviewed with staff, the team did not have any members drop out of the program in the past year. The team did assist three members move to a lower level of care, one went to a higher level of medical care, and one moved out of the area with a referral. The team experienced five deaths of members during the past 12 months.	

S3	Assertive Engagement Mechanisms	1 - 5 5	Staff interviewed reported that the team makes four attempts each week to re-connect with members that have lost contact with the team. Reviewers were provided with the policy and witnessed staff updating the team on outreach attempts during the program meeting observed. Approximately 10% of the census was on outreach at the time of that meeting. Records reviewed showed documentation of staff efforts to re-connect with members with few days between documented efforts. Records demonstrated staff outreach attempts by phone and in person. Outreach included hospitals, shelters, jails, medical examiner's office, payees, known hangouts, probation officers, natural supports, and advocates.	
S4	Intensity of Services	1 – 5 2	Per review of ten (10) 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 28.13 minutes. The member with the highest intensity was about 130 minutes on average weekly. Seven member records had documentation of the team reaching out by phone to provide support. One member was incarcerated, and the team provided support and substance use treatment services through videoconference. *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. • Ensure the team is assisting members in working on recovery goals as identified. By using *motivational interviewing*, and other techniques, the team can assist members to identify meaningful recovery goals and then offer the supports and services to members to reach those goals.
S5	Frequency of Contact	1 – 5	Staff reported using a regional system to ensure members are seen by multiple staff each week. In the ten records reviewed, the median frequency of	• Increase the frequency of contact with members by ACT staff, optimally averaging four (4) or more in-person contacts a week

		2	contact with members by the team was 1.25 per week. One of the ten (10) member records reviewed was incarcerated for the month period reviewed. Members interviewed reported seeing no more than two staff a week. One member reported not seeing any staff the previous week.	per member across all members, with an emphasis on community-based services to support member goals. Members may have different needs/goals and frequency of contact should be determined by those needs and immediacy.
S6	Work with Support System	1 - 5 2	Staff interviewed reported that members' Natural Supports are contacted weekly by assigned staff. During the observation of the program meeting, plans to connect with Natural Supports were expressed frequently, however, few actual contacts were noted. Although reviewers were provided with multiple documents relating to team procedures and tracking related to contact with natural support, only two (2) member records had documentation of attempted contact in the medical record. Three (3) member records had documentation of actual contact with natural supports. The CC reached out several times to connect with Natural Supports.	• Continue efforts to involve natural supports in member care. Ensure consistent documentation of contacts with natural supports occurs, which includes contact by phone, email, and text, as well as in-person. ACT teams have four or more contacts per month for each member with a community support system. • Ensure that all natural support contacts are documented in member records.
S7	Individualized Co-Occurring Disorder Treatment	1 - 5 4	The team has 58 members diagnosed with a Co-Occurring Disorder. The specialists try to see each member 2 – 3 times a month and report all members attended at least one session in the previous month. Reviewers were provided with one COS's scheduling calendar, but the length of the sessions were not noted. Twenty-seven (27) members were seen in a recent month period by one COS. The LPC COS focuses on delivery of service to those in the later stages of change while the other COS focuses on those in the earlier stages. It was reported sessions typically average 25 minutes.	• 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. • All staff on ACT teams engage members with co-occurring disorder diagnoses to consider participating in substance use treatment. Explore training on strategies to engage members.

			Some members will be seen for shorter periods of time and COS will then see them more frequently. Reviewers were informed that the COS are no longer able to provide services via telehealth because the public health emergency has ended. A review of member records shows five (5) sessions occurred in the month period reviewed and two (2) were with a member that was not identified as having a COD diagnosis. One member record shows COS staff encouraging participation in "IDDT" and the member later engaging in individual substance use treatment services. One incarcerated member received substance use treatment services via videoconference.	
S8	Co-Occurring Disorder Treatment Groups	1 - 5 2	Staff interviewed reported that at least ten (10) members regularly attend one of the three different substance use treatment groups offered weekly by either of the Co-Occurring Specialists on the team. Two groups are centered around relapse prevention and the other is focused on members in the pre-contemplation/contemplation stages of change. Member records reviewed show one member attended two groups while another member attended one. Manuals referenced by staff for group facilitation included *Seeking Safety* for persons with history of trauma, and another manual that was not developed for persons with COD. Sign-in sheets provided identified eleven (11) unique members attended at least one group during a recent month period.	• 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. • On ACT teams, all staff participate in engaging members with a co-occurring disorder diagnosis to participate in treatment groups. Ensure specialists, not only the COS, engage members to consider group treatment.

S9	Co-Occurring Disorders Model	1 - 5 3	The team does not appear to be cohesive in the approach to delivering integrated substance use treatment services. Reviewers were told that services delivered follow an Integrated Treatment for Co-occurring Disorders model utilizing motivational interviewing, recognizing the stages of change (Transtheoretical Model) and the interventions that align with those stages. All staff interviewed endorsed the value of harm reduction, but the end goal for the member differed. Some staff on the team adhere to an abstinence goal mindset for members. Staff provide information on peer-run support groups in the community when requested specifically by members. Nearly all treatment plans reviewed for members with a co-occurring disorder had substance use treatment interventions listed. One member is engaged in Medication-Assisted Treatment, an evidence-based practice, with an outside provider. Another member is prescribed medication by the Psychiatrist to reduce cravings. Treatment plan language tended to focus on the goal of "sobriety" rather than supporting steps toward *recovery*. Staff reported the team will refer to detox when medically appropriate and five of the seven treatment plans for members with a COD listed inpatient rehabilitation as an intervention. No documentation from non-COS staff reflected recovery talk, except for the Psychiatrist.	• 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*, the EBP of *harm reduction*, and *motivational interviewing*. • 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. ACT teams opt to provide members care while in their community, when possible, rather than refer to inpatient substance use treatment facilities.
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has several staff with personal lived psychiatric experience. Most share their story of recovery with members when appropriate. All staff with "peer" status share the same responsibilities	

			across other specialists. One member interviewed was aware of peer staff on the team.	
Total Score:		**110**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources		Rating Range	Score (1-5)
1.	Small Caseload	1-5	5
2.	Team Approach	1-5	4
3.	Program Meeting	1-5	5
4.	Practicing ACT Leader	1-5	3
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 Specialist on Team	1-5	4
10.	Vocational Specialist on Team	1-5	2
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	3
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	3
2.	No Drop-out Policy	1-5	5
3.	Assertive Engagement Mechanisms	1-5	5
4.	Intensity of Service	1-5	2
5.	Frequency of Contact	1-5	2
6.	Work with Support System	1-5	2
7.	Individualized Co-Occurring Disorder Treatment	1-5	4
8.	Co-occurring Disorders Treatment Groups	1-5	2
9.	Co-occurring Disorders (Dual Disorders) Model	1-5	3
10.	Role of Consumers on Treatment Team	1-5	5
Total Score		**3.93**	
Highest Possible Score		**5**	