ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: August 27, 2024

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AHCCCS Fidelity Reviewers

Introduction

Arizona Health Care Cost Containment System has contracted with the 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 22 – 24, 2024, Fidelity Reviewers completed a review of the La Frontera EMPACT – Comunidad 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 operates several outpatient centers that offer a variety of services. The Comunidad team is the focus of this review. The individuals served through the agency are referred to as "members" or "clients", but for the purpose of this report and for consistency across fidelity reports, the term *member* will be used.

The SAMHSA ACT Fidelity Review tool does not accommodate delivery of telehealth services. An exception has been made for delivery by psychiatric prescribers due to the lack of availability in Arizona. This review was conducted remotely, using videoconferencing and telephone to observe meetings and to interview staff and members.

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

- Remote observation of an ACT team program meeting on July 23, 2024.
- Individual videoconference interview with the Clinical Coordinator.

- Individual videoconference interviews with two Co-Occurring Disorders Specialists, the Rehabilitation Specialist, ACT Specialist, and Peer Support Specialist for the team.
- Individual phone interviews with three (3) members participating in ACT services with the team.
- Closeout discussion with the Clinical Coordinator, ACT Program Manager and two representatives from the contractor with a Regional Behavioral Health Agreement.
- Charts were reviewed for ten randomly selected members using the agency's electronic health records system. The sample includes members from health plans that are contracted to provide behavioral health services to members with an SMI designation.
- Review of documents: *Mercy Care ACT Admission Criteria;* copy of outreach and engagement expectations from Mercy Care; copy of the agency's outreach policy; copy of the form used to track outreach attempts; copy of the psychiatric and medical hospitalization contact tracker; copy of the spreadsheet used to track the team's daily/weekly contact with members; copy of the spreadsheet used by Co-Occurring Disorders Specialists' staff to track members with co-occurring disorders participation in weekly group and individual substance use treatment; copies of Co-Occurring Disorders Specialists' calendars and group sign-in sheets; copies of cover pages of materials used in the provision of individual and group substance use treatment; and resumes and training records for Co-Occurring Disorders and Rehabilitation Specialists.

The review was conducted using the SAMHSA ACT Fidelity Scale. This scale assesses how close in implementation a team is to the ACT model using specific observational criteria. It is a scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries, and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented with little room for improvement*).

The ACT Fidelity Scale was completed following the review. A copy of the completed scale with comments is included as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The team is of sufficient size to provide coverage to 93 members, with only one vacant position, the Employment Specialist.
- The Psychiatrist has an active role on the team; exclusively serving members of the ACT team, attending program meetings on scheduled workdays, providing after-hours support, and acting as the medical director for the team.
- The team experienced staff turnover of less than 17% over the past two years and operated at approximately 94% of full staffing capacity during the past 12 months.
- Each week, the team provides four (4) substance use treatment groups designed to offer different levels of support to members at various stages of change. Additionally, both Co-Occurring Disorders Specialists lead monthly cross-training sessions for team staff.
- The team maintains an appropriate admission rate and has retained approximately 97% of the members served over the past year.

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

- Increase contact of diverse staff with members. The team approach of ACT ensures continuity of care for members and creates a supportive environment for staff, potentially reducing the burden of responsibility.
- 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 functioning in the community.
- Increase the frequency of contact with members, ideally averaging four (4) or more in-person contacts a week.
- Provide annual, ongoing training to Vocational and Co-Occurring Disorders Specialists. On ACT teams, these specialists are valuable resources to the team and provide cross-training in their areas of expertise.
- Develop capacity to ensure members that may benefit from counseling/psychotherapy have the service available from ACT staff.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	At the time of the review, the team served 93 members with 10 full-time equivalent (FTE) direct service staff, excluding the Psychiatrist and administrative staff. The team has an appropriate member-to-staff ratio of approximately 9:1. The team is composed of a Clinical Coordinator, two Registered Nurses, a Rehabilitation Specialist, a Housing Specialist, an ACT Specialist, an Independent Living Specialist, a Peer Support Specialist, and two Co-Occurring Disorders Specialists.	
H2	Team Approach	1 - 5 3	Staff report utilizing a geographic zone strategy and rotating daily to ensure members engage with diverse staff. The Nurses and Psychiatrist do not participate in these rotations. Staff report maintaining caseloads for administrative purposes and to ensure members are receiving contact with other specialists. Results of the ten randomly selected member records reviewed, for a month period, showed the median of 50% of members received in-person contact from more than one staff from the team in a two-week period.	• Increase contact of diverse staff with members such that 90% have contact with more than one staff from the team every two weeks. All ACT team staff are jointly responsible for making sure each member receives the services needed to support recovery from mental illness. Diversity of staff interaction allows members access to unique perspectives and expertise of staff, as well as the potential to reduce burden of responsibility of member care on staff.
H3	Program Meeting	1 - 5 5	The team meets in person five days a week and discusses all members on the roster; all team staff, including the Psychiatrist, attend on scheduled workdays. Per interviews, the ACT Program Manager and Clinical Coordinator	

			share joint responsibility for the operation of the meeting. During the program meeting observed, the ACT Program Manager announced member names from the roster, and staff reported on recent/planned member engagements and outreach attempts. The ACT Program Manager provided clinical direction to staff relating to the prioritization of service delivery to meet member needs. The Clinical Coordinator is responsible for identifying follow-up items, tracking member needs, and staff assignment.	
H4	Practicing ACT Leader	1 - 5 2	The Clinical Coordinator joined the team in July 2024. Per interviews, reported activities since joining the team include providing support and direction to on-call staff, community-based support to a member with increased symptoms, and assistance with inpatient psychiatric care. A productivity report was not available for review. The member records reviewed did not evidence direct services provided by the current or previous Clinical Coordinator. *This item is dependent on the Provider productivity expectation.*	• 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. Practicing ACT leaders can engage in a range of member care needs, including providing counseling/psychotherapy, facilitating or co-facilitating co-occurring disorders treatment groups, providing support and advocacy at mental health court, participating in inpatient psychiatric staffings, shadowing and mentoring specialists delivering community-based services such as assertive outreach, hospital visits, and skill-building activities designed to promote integration and recovery.
H5	Continuity of Staffing	1 - 5 5	Based on information provided and reviewed with staff, four staff left the team during the past two years, resulting in a turnover frequency of approximately 17%. The Employment Specialist position had the highest turnover.	

H6	Staff Capacity	1 - 5 4	In the past 12 months, the team operated at approximately 94% of full staffing capacity. The Nurse position experienced one vacancy for nine 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 has one dedicated Psychiatrist, meeting with members in the office monthly or occasionally via videoconference. The Psychiatrist attends team program meetings four times a week and is available to staff for spontaneous collaboration in person, by phone, text messaging, and email, including after hours and on weekends. Staff interviewed reported the Psychiatrist serves as the team Medical Director, provides clinical oversight, participates in treatment planning, and educates staff on symptomology, medications, and comorbid conditions. In the program meeting observed, the Psychiatrist directed treatment recommendations and provided insight regarding interventions for members' service needs.	
H8	Nurse on Team	1 - 5 5	The team has two full-time Registered Nurses that provide services to all 93 members of the team. Staff report both Nurses are accessible to the team during office hours in person and by phone. Nurse duties include meeting with members in the office to administer injectable medications, take vitals, conduct blood draws, provide medication education, and perform annual health assessments. Nurses also assist with primary and specialty care coordination and provide services in community settings when members are unable to come into the office.	

H9	Co-Occurring Disorders Specialist on Team	1 - 5 4	The team is staffed with two Co-Occurring Disorders Specialists that are responsible for providing individual and group substance use treatment services to 63 members identified with co-occurring disorders. Both specialists have been in their roles for more than one year. Staff reported that the Co-Occurring Disorders Specialists provide monthly training sessions to the team on co-occurring disorders best practices, stage-wise approach techniques, and make suggestions for engagement approaches with members. The training records provided for the Co-Occurring Disorders Specialists evidenced one specialist completing eight hours of recent training relating to substance use treatment services.	• Provide eight (8) hours of annual training to Co-Occurring Disorders Specialists in co-occurring disorders treatment best practices, including appropriate interventions, i.e., stage-wise approach; the evidence-based practice of harm reduction; and motivational interviewing. On ACT teams, CODS have the capability to cross-train other staff, providing guidance on appropriate interventions, based on members' stage of treatment, and in the adopted co-occurring disorders model utilized by the team. • Ensure Co-Occurring Disorder Specialist staff are provided with regular supervision from a qualified professional.
H10	Vocational Specialist on Team	1 - 5 2	There is one vocational staff assigned to the team. The Rehabilitation Specialist (RS) has been on the team for more than eight years. Staff reported training related to vocational support is completed through online platforms and in person with the ACT Program Manager. The RS attends quarterly meetings with the regional behavioral health authority and Vocational Rehabilitation. The training records provided did not indicate any recent vocational-related training.	• Optimally, 100-member ACT teams are staffed with two Vocational Specialist staff. Maintain two full-time Vocational Specialists on the team to ensure members' interests and needs for employment are met. • Provide ongoing training to vocational staff in assisting people diagnosed with a serious mental illness (SMI) to find and retain employment in integrated work settings.
H11	Program Size	1 - 5 5	At the time of the review, the team was comprised of 11 staff, including the Psychiatrist. The team is sufficiently sized to provide diversity	

			and coverage to members. There was one vacant position: Vocational Specialist. *This item does not adjust for the size of the member/member roster.*	
O1	Explicit Admission Criteria	1 - 5 5	Staff report the team has a three-part admission process. The CC reviews new member referral packets for appropriateness based on the *Mercy Care ACT Admission Criteria*. Within 48 hours, the CC contacts the referring entity to staff the referral and to gather additional information. The second screening occurs with a team specialist meeting the member in the community or in a hospital setting to discuss their needs and desire for ACT intensity of services. The Psychiatrist and CC collaborate when making a final decision on admissions. If agreed, the team schedules an intake for onboarding of the new member. Staff reported instances of referrals not being accepted, resulting in a complex case review with the local contractor with a Regional Behavioral Health Agreement. In these cases, the Psychiatrist conducts a peer-to-peer review, and a final decision is subsequently made.	
O2	Intake Rate	1 - 5 5	Per data provided, the team maintains an appropriate rate of admission. The highest intake rate occurred in March and January, each with three new admissions.	
O3	Full Responsibility for Treatment Services	1 - 5 4	In addition to case management, the team provides psychiatric services and medication management, housing support, substance use treatment, and employment/rehabilitative services.	• Counseling/psychotherapy is made available to members on ACT teams and is provided by ACT staff. This staff will also act as a generalist within the team.

			The team does not provide counseling/psychotherapy services to members. Approximately 7% of members are referred off the team for this service. During the observed program meeting, the team discussed referral options for a member to access counseling services.	Ensure future staffing includes a person with qualifications to provide counseling/psychotherapy to members on the team.
O4	Responsibility for Crisis Services	1 - 5 5	The team provides 24-hour crisis support directly to members on the team. On-call responsibility rotates daily among specialists. Members are provided with a business card with staff phone numbers and the on-call phone number. When calls are received, the on-call staff will assess members' needs by phone, attempting to de-escalate the situation. When community assistance is required, staff contact the Clinical Coordinator for guidance on the next steps. Staff will meet members and emergency services in the community when involved, provide the member with transportation to the hospital when necessary, and stay with the member until admitted. Members interviewed confirmed awareness of the availability of the team after hours. Of the ten member records reviewed, 30% showed staff providing members with information about the on-call line.	
O5	Responsibility for Hospital Admissions	1 - 5 3	Staff reported that the team provides members with education on team protocol and process for hospitalization. When a member is experiencing an increase in symptoms during business hours, staff transport members into the office to meet with the Psychiatrist for assessment and clinical	• ACT teams performing to high fidelity of the model, are directly involved in 95% or more of psychiatric admissions. • Maintain regular contact with members and their support networks, both natural and formal. This may result in earlier

			recommendations. When hospitalization is required, staff will transport members to the hospital of the member's choice and stay with the member until admitted. The team coordinates care with hospital staff by providing a list of current medications and team contact information. Staff report that some members prefer to bypass team intervention and directly self-admit. Reviewers requested information for ten of the most recent admissions, which occurred over four months. The team was involved in 40% of admissions. Of the admissions the team was not involved in, one member self-admitted, one was admitted through a court-ordered evaluation by an unknown party, and two were admitted with the support of their guardians without seeking support from the team.	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 about team availability to support members in their communities or, if necessary, to assist with hospital admissions.
O6	Responsibility for Hospital Discharge Planning	1 - 5 4	Staff reported that discharge planning begins upon admission. Staff coordinate staffings with the inpatient team within 24 to 48 hours of admission. Follow-up staffings are scheduled weekly until discharge. The team Psychiatrist conducts peer-to-peer phone calls with the inpatient treating psychiatric prescriber. Members are provided with follow-up appointment dates for the Psychiatrist, Nurse, and primary care physician. Staff meet members at the hospital upon discharge for a warm handoff and transport them to their preferred discharge location. Following discharge, staff contact natural supports and guardians with	• ACT teams performing to high fidelity of the model, are directly involved in 95% or more of member discharges.

			updates and meet with the member in person for five days to facilitate a smooth transition. Reviewers requested information for ten of the most recent discharges, which occurred over four months. The team was involved in 80% of hospital discharges. One member record reviewed evidenced coordination of follow-up appointments, including the member attending an in-office appointment with the Psychiatrist, staff conducting well checks, and providing the member with contact information for the on-call phone. Of the discharges in which the team was not involved, one member discharged against medical advice and did not contact the team prior to leaving the hospital.	
O7	Time-unlimited Services	1 - 5 5	Data indicated that zero members graduated from the team in the past 12 months. Staff report that before recommending graduation, members are assessed for frequency of hospitalizations in the past year, use of crisis services, criminal justice contact within the past two years, ability to manage and fill medications independently, housing stability, employment, and the potential impact of reduced team contact on the member.	
S1	Community-based Services	1 - 5 4	Staff interviewed reported 80% 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 67% 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.
S2	No Drop-out Policy	1 - 5	According to data provided and reviewed with staff, the team retained approximately 97% of	

		5	the total number of members served in the past 12 months.	
S3	Assertive Engagement Mechanisms	1 - 5 5	Staff reported outreach is conducted in-person and by phone four times a week, following the guidelines of the RBHA outreach policy. Per interviews, when members miss appointments or cannot be located, staff make two physical and two electronic attempts every week during the eight weeks of outreach. Staff conduct physical searches of known hangouts, shelters, and last-known residences. Staff make phone calls to medical facilities, jails, the morgue, payee offices, natural supports, guardians, and probation officers. If staff are unable to locate a member after completing eight weeks of outreach attempts, the team Psychiatrist will decide whether to continue outreach or transfer the member to a Navigator level of service. During the program meeting, staff identified seven members on outreach; staff reported the number of weeks on outreach for each member and described the attempts made to engage with the member and plans for future staff engagement. One member record reviewed evidenced a member missing an appointment and staff completing outreach the same day. Staff followed the engagement protocol as reported and made successful contact with the member after several attempts.	
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 is 72.75 minutes per week. The highest weekly average	• 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

			for in-person services was 223.75 minutes, and the lowest was zero minutes. Alternative contact methods such as phone and video conferencing are also used by the team. One record showed three 25-minute videoconference calls occurred. Four records showed members were contacted by phone once per week, and the median amount of time spent on those calls was 0.38 minutes. *The fidelity tool does not accommodate delivery of telehealth services.*	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. • Evaluate how the team can engage or enhance support to members that receive a lower intensity of service. Documented service time is significantly higher for some members than for others.
S5	Frequency of Contact	1 – 5 2	Per records reviewed, staff provided a median frequency of 1.75 weekly in-person contacts to members. The record with the highest frequency was 2.25 in-person contacts per week. One record showed zero in-person contacts occurred during the period reviewed.	• 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.
S6	Work with Support System	1 - 5 3	The staff report that 20 members have natural support. Staff engage with natural support through phone calls, weekly home visits, and in-office visits when accompanying the member to appointments. The team engages natural supports during the outreach and treatment planning processes. Contact with natural supports is documented in the member's record and reviewed during daily program meetings. Members interviewed report that their natural support is an emergency contact. Records reviewed showed an average of 0.70 documented contacts with members' natural supports over a one-month period. 40% of the ten member records reviewed included at least	• Continue efforts to engage members' natural support systems as key contributors to member recovery team. Consider the role of staff to model recovery language and provide suggestions to family members and other natural supports how they can support member care. • Evaluate methods of tracking or monitoring staff documentation of contacts with Natural Supports.

			one contact with member natural supports. Two records evidenced staff encouraging the members to attend community groups to support the development of natural support. During the program meeting observed, staff reported recent direct contact with approximately four (4) members' natural support.	
S7	Individualized Co-Occurring Disorders Treatment	1 - 5 4	According to data provided and reviewed with staff, there were 63 members on the team with co-occurring disorders at the time of the review. Staff reported all 63 receive structured, individualized substance use treatment for 30 – 45 minutes weekly, with sessions structured upon a stage-wise approach, ranging from rapport building to formal Integrated Co-Occurring Disorder Treatment. Reviewers received copies of the cover pages of the materials used. In the program meeting observed, staff identified one member not ready for individual substance use counseling, and the specialist reported engaging the member using a stage-wise approach. A review of Co-Occurring Disorders Specialists individual calendars evidenced 15 members scheduled for individual substance use counseling in a month period. The majority of members were scheduled for 30 minutes each week. Per record review, five members were identified by the team as having co-occurring	• Work to increase the time spent in individual treatment sessions and increase the number of members engaged so that the average time is 24 minutes, or more, per week across the group of members with co-occurring disorders.

			disorders. One record showed two individual 30-minute sessions in the month period reviewed.	
S8	Co-Occurring Disorders Treatment Groups	1 - 5 3	The team provides four substance use treatment groups each week: two in the community and two in the office. Staff report the groups are designed to offer different levels of support, catering to members in both the early and later stages of change and treatment. Staff reported that approximately 10 members attend at least one group per month. During the program meeting, staff reported that four members had recently participated in the groups. One record evidenced the attendance of a substance use treatment group. Three records evidenced staff, not only the Co-Occurring Disorders Specialists, encouraging members to join the treatment groups. A review of group sign-in sheets from a month period before the review revealed approximately 22% of members identified with co-occurring disorders attended at least one group in a month period.	• 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 group monthly.
S9	Co-Occurring Disorders Model	1 - 5 4	Per the program meeting and staff interviews, the principles of a stage-wise approach were reflected when working with members with co-occurring disorders. The team reported using a person-centered, individualized approach that emphasizes harm reduction based on member need rather than expecting abstinence. Staff provided specific examples of how harm reduction techniques are used. Staff reported rapport-building and encouraging members with co-occurring disorders to participate in	• Support members to identify a reduction of use goal when a desire for abstinence is expressed, supporting the evidence-based practice of *harm reduction*. Consider reviewing with staff techniques to introduce recovery language into conversation with members and support systems. Consider monitoring documentation for use of recovery language.

			individual or group co-occurring disorders treatment. Staff do not refer members to peer-run substance use programs but will support members that request to attend. Both specialists provide the team with monthly cross-training on co-occurring disorder best practices and the stage-wise approach. Of the five member records that were identified as having co-occurring disorders, one referenced reduction of use and harm reduction goals. Four treatment plans and contact notes referenced traditional recovery language of *achieve and maintain sobriety, abstinence,* and references to *substance dependency.* Three records show staff encouraging participation in peer-run community groups, and it was unclear if this aligned with those members' goals.	
S10	Role of Consumers on Treatment Team	1 - 5 5	The team has at least two staff with lived or living psychiatric experience; both staff share their stories of recovery with members, when appropriate, and share the same level of responsibility as other ACT staff. One member reported awareness of one peer staff being on the team.	
Total Score:		**114**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	5
6. Staff Capacity	1-5	4
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Co-Occurring Disorders 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	4
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	3
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	3
9. Co-occurring Disorders Model	1-5	4
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**4.07**	
Highest Possible Score	**5**	