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*For any general SMI protocols that are not discussed in the ACT Manual please refer to the Mercy
1. ACT Fidelity Scale and Protocols

Provider will self-monitor and evaluate the below metrics every 6 months. Additionally, the provider will participate in an annual outside ACT fidelity review conducted by an outside contractor determined by AHCCCS and Mercy Maricopa. Refer to the SAMHSA scoring grid for specific scoring instructions and thresholds.

Providers will aim for high fidelity ACT services and comprehensively implementing the ACT model with the goal of an 80% score (4.0) and above. Providers should access and review the Evaluating your ACT Program Kit as needed on the SAMHSA website. [https://store.samhsa.gov/shin/content//SMA08-4345/EvaluatingYourProgram-ACT.pdf](https://store.samhsa.gov/shin/content//SMA08-4345/EvaluatingYourProgram-ACT.pdf)

Human Resources: Structure and Composition

**H1: Small Caseload:**
ACT Teams should maintain a low member to staff ratio in the range of 10:1 to ensure adequate and individualization of services.
Per Case Management Plan in Maricopa County the maximum ACT caseload assignment size is 1:12.

**H2: Team Approach:**
Provider group functions as team rather than as individual ACT staff; ACT team specialists know and work with all members. The entire team shares responsibility for each member: each clinician/behavior health technician contributes expertise as appropriate. Members will be seen by at least two different staff in a two week time period.

**H3: Program Meeting:**
Meets at least 4x a week and reviews each member each time, even if only briefly. Meeting should allow for ACT specialists to discuss members, solve problems, plan treatment and rehabilitation efforts, ensuring all members receive optimal service. Teams should use the member calendar to drive the program meeting discussion to ensure services are completed as scheduled. Teams should review all members A-Z and then Z-A on alternating days to ensure each member gets equal attention during the program meeting during the week. Additionally updates should be clinically relevant and report on the specialty services provided along with the members current status during those interactions. Program meetings should be on average 60 minutes and teams should staff members who need more in depth clinical conversations during the weekly staffing meeting. Staff is held accountable for follow through. (See Program Meeting Process for further explanation).

**H4: Practicing ACT leader:**
Supervisor (Clinical Coordinator - CC) provides direct services at least 50% of the time. The CC should schedule out face to face services during the week. The CC should shadow and monitor staff in the field to provide direct feedback and supervision.

**H5: Continuity of Staffing:**
Teams should keep the same staff to provide continuity of services to members. Agencies should work to prevent staff burnout and high turnover rate. Teams should have less than 20% turnover in 2 years. Maintaining consistent staff enhances team cohesion: additionally, consistent staffing enhances the therapeutic relationships between members and providers.

**H6: Staff Capacity:**
Per fidelity, teams should be operating at least 95% or more of full staffing to score a 5 with fidelity. Maintaining consistent, multidisciplinary services requires minimal position vacancies.

**H7: Psychiatrist on Team:**
Teams should have at least 1 full time psychiatrist assigned directly to a 100 member program. Psychiatrist serves as the medical director for the team. In addition to medication monitoring, the psychiatrist functions as a fully integrated team member participating in treatment planning and rehabilitation efforts. The Psychiatrist should have at least one day scheduled to provide community, hospital and jail visits each week.

**H8: Nurse on team:**
Teams should have 2 full time nurses assigned directly to a 100 member program. The RN functions as a full member on the team, which includes conducting home visits, treatment planning and daily meetings. Nurse can help administer needed medications, and serve to educate the team about important medication issues. Nurses should be working with those members with medical issues, attending specialty appointments, doing coordination of care with providers, ER visits and hospital visits. It is recommended that one RN remains in the office and one RN is scheduled for the aforementioned community visits each day. RN's can also be in the medication observation schedule.

**H9: Substance Abuse Specialist:**
Teams should maintain at least 2 staff members on the ACT team with at least 1 year of training or clinical experience in substance abuse treatment, per 100 member program. Provider must ensure the staff meets the SAMHSA requirement for this position. See Staff Composition and Specialty in the ACT Operational Manual for position specific guidelines.

**H10: Vocational Specialist on Staff:**
(Employment Specialist and Rehabilitation Specialist)
Program must include at least 2 staff members with at least 1 year of training/experience in vocational rehabilitation and support. ACT teams emphasize skill development and support in natural settings. Provider must ensure the staff meets the SAMHSA requirement for this position. See Staff Composition and Specialty in the ACT Operational Manual for position specific guidelines.

**H11: Program Size:**
Program is of sufficient size to consistently provide necessary staffing diversity and coverage. It is critical to maintain adequate staff size and disciplinary background to provide comprehensive, individualized service to each member. Programs should have at least 10 FTE staff per fidelity metric. In the Mercy Maricopa staffing protocol, teams should have a total of 13 FTE positions. If a Provider is going to add additional positions above the SAMHSA and Mercy Maricopa
requirement they must get approval from Mercy Maricopa. Refer to Staffing requirements section of the ACT Manual for listing of all required positions.

Organizational Boundaries

**O1: Explicit Admission Criteria:**
Program must have clearly defined criteria to screen out inappropriate referrals. Please refer to Mercy Maricopa admission criteria which are aligned with SAMHSA. Admission criteria included are pattern of frequent hospital admissions, frequent use of emergency services, members discharged from long term hospitalizations, co-occurring substance use disorders, homelessness, involvement with the criminal justice system, not adhering to medications as prescribed, not benefitting from traditional mental health services. ACT teams should ensure members on the team who are admitted align with high acuity needs the ACT team can address by providing high fidelity services listed under the Nature of Service fidelity section. Members do have the right to decline services based upon member choice. In the case where a member who is determined to benefit from ACT services upon assessment has declined the service, the expectation is that the initiating Provider shall work with the member, family and involved parties to address ongoing treatment plan needs and engage members and families in services to which they are agreeable at the supportive or connective level of care.

**O2: Intake Rate:**
Program takes on members at a low rate to maintain a stable service environment. The team should take no more than 6 members each month.

New or Expansion teams should be onboarding 20 members month 1, 20 members month 2 and 10 member’s month three. Once teams are at 50% capacity they should align their intake referral rate with SAMHSA fidelity which is 6 referrals a month.

**O3: Full Responsibility of treatment services:**
ACT team should directly provide psychiatric services, medication management, counseling/psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services in addition to case management services. ACT teams should not broker out services that should be provided per the ACT model. High fidelity teams provide 90% of all services within the ACT program. The ACT team should only refer out for services when the clinical need cannot be provided within their ACT program or the member is requesting an outside referral to meet their needs (example: Member needs EMDR Trauma Therapy and no licensed EMDR certified clinician is employed on the team). If the member (guardian/advocate) is requesting a high number of outside referrals that do not align with the ACT model, the team is to hold a staffing to discuss how they can meet the member’s needs and requests and still align with the ACT model. The ACT team assumes responsibility for providing psychiatric rehabilitative services to members. These services focus on targeted skills training in the areas of community living which include skills needed to maintain independent living (ex. shopping, cooking, budgeting and transportation), socialization (ex. enhancing social and/or romantic relationships, recreating and leisure pursuits that contribute to community
integration). Psychiatric rehabilitation should address functional deficits as well as lack of necessary resources all of which are identified in the assessment process. ACT staff should provide consistent skills training which typically includes staff demonstration, member practice/role plays and staff feedback as well as ongoing prompting and cueing for learned skills in more generalized settings.

The team provides dual disorders treatment to members where there is then little need for members to access such services outside the team. Core services include systematic and integrated approach screening an assessment and interventions tailored to those in early stages of change readiness (ex. engagement, outreach, motivational interviewing) and later stages of readiness (ex. Cognitive Behavioral Therapy and relapse prevention).

O4: Responsibility for crisis services:
Program has 24 hour responsibility for covering psychiatric crises. Team will carry an on call phone and respond to all calls within 15 minutes. The on call phone should be on at all times and should not be turned off during traditional business hours. The Provider must develop their own protocols and policies to ensure the safety of staff, members and the community in crisis situations. Additionally, the members and family supports (pending ROI) should be provided all cell phone numbers for the ACT Team staff on the team.

O5: Responsibility for hospital admissions:
ACT team is closely involved in hospital admissions. Member should be seen by the prescriber of the ACT team before going inpatient during business hours. If a member needs to go inpatient after business hours, team will facilitate that admission and staff the case with the ACT Psychiatrist or On-call Psychiatrist along with the Clinical Coordinator.

O6: Responsibility for hospital discharge:
ACT team is involved in all hospital discharges. Discharge planning should begin from the time a member goes inpatient. Teams should be visiting the member while inpatient within 24 hours of admission and/or notification, and every 72 hours thereafter and attending a weekly staffing. Doctor’s should do a weekly doctor to doctor phone call while inpatient and should do telephonic coordination with the inpatient attending within first 24 hours of admission during business hours.

O7: Time Unlimited services (graduation rate):
All members are served on a time unlimited basis, with fewer than 5% expected to graduate annually. ACT teams should evaluate a member’s readiness to graduate on an ongoing basis and at minimum address in the annual assessment. Team uses explicit criteria for the need to transfer to less intensive services (ACT graduation criteria). Transition is gradual and individualized with assured continuity of care and the option to return to the team if needed. Forensic ACT (FACT) teams should obtain a member’s recidivism risk score on an annual basis at minimum to ensure they still need and meet the forensic component of ACT. If a member still needs ACT services the FACT team will facilitate a transfer to that level of care. Mercy Maricopa may send inpatient (medical and behavioral) and emergency room utilization claim information to help guide the teams in identifying members potentially able to graduate.
**Nature of Services**

**S1: Community Based services:**
Program works to monitor status and develop skills in the community, rather than function as an office based program. A minimum of 80% total face to face contacts must be in the community. It is recommended that one of the RN’s work in the community each day and that the psychiatrist has a scheduled day for community, hospital and jail visits each week. Skill building groups should be in the community where members will utilize those skills. The Integrated Dual Disorders Treatment (IDDT) treatment groups can be held in the clinic due to the confidential nature of treatment being discussed.

**S2: No Dropout Policy:**
Program engages and retains members at a mutually satisfactory level. 95% or more of caseload is retained over a 12 month period.

**S3: Assertive Engagement Mechanisms:**
Program uses street outreach, legal mechanisms and other techniques to ensure ongoing engagement. Members are not immediately discharged from the program due to failure to keep appointments. Retention of member is a high priority for ACT teams. Persistent, caring attempts to engage members in treatment help foster a trusting relationship between the member and the ACT team.

Team should use an array of techniques and interventions to engage members such as collaborative, motivational interventions to engage members and build intrinsic motivation for receiving services from the team. Also ACT Staff should use therapeutic limit setting interventions to create extrinsic motivation for receiving services deemed necessary to prevent harm to Members or others. When therapeutic limit setting interventions are used, there is a focus on instilling autonomy as quickly as possible. The team should have a thoughtful process for identifying the need for assertive engagement; measure the effectiveness of the chosen techniques and modifying approach when indicated.

Per Mercy Maricopa protocol when a member is on outreach, the team should do 4 outreach attempts each week with half of those at minimum being in the community and doing street outreach. Outreach will be clinically indicated, individualized to the member’s needs and, for example, could range from 4 attempts each week to multiple attempts each day.

**S4: Intensity of Service:**
Program will provide a high amount of face to face service time as clinically indicated. High fidelity services is a minimum of 2 hours of face to face contact each week however if a member does not need high fidelity act services the team should document the clinical reason for the decreased contact in the member’s ISP. For example: Member is in the process of graduating from ACT, team will do two FACE TO FACE contacts a week for the next 4 weeks.
**S5: Frequency of Contact:**
Teams should provide a high amount of face to face service contacts as clinically indicated. When screening members for ACT team services, the member should have high acuity service needs with the goal to provide at least 4 face to face contacts with members each week. Frequent contacts are associated with improved member’s outcomes. If a member does not need high fidelity act services the team should document the clinical reason for the decreased contact in the member’s ISP. For example: Member is doing well and is only requesting an hour a week of FACE TO FACE support from the ACT team. Psychiatrist is in agreement to decreased contact to support self-determination.

ACT teams will submit the average number of face to face contacts for all members on their team on a monthly basis to Mercy Maricopa. Teams whose average is below a 3.1 may be subject to disciplinary action for providing low fidelity services.

**S6: Works with informal support system:**
Program provides support and skills for member’s informal support network (people not paid to support the member). Teams should have 4 or more contacts with informal supports, each month for those with a support system.

For those without a support system, the team should work with the member to develop informal supports in the community. It is recommended teams document contact with natural supports on the member schedule, in addition to documenting in the EMR and discuss briefly in program meeting updates.

Additionally, teams should offer a natural support and family psychoeducation group monthly at minimum. ACT teams will ensure they are in accordance with the Health Information Portability and Accessibility ACT (HIPAA), 45 CFR 160.103

**S7: Individualized Substance Abuse Treatment:**
One or more members of the team, primarily the Substance Abuse Specialists, will provide direct treatment and substance abuse treatment for member’s with substance use disorders. Teams should provide/ofer a minimum of 24 minutes each week in formal substance abuse treatment. Each team must keep a list of members with a dual diagnosis and schedule 30 minute formalized weekly 1:1 with that member for substance abuse treatment. If the member is at a pre-contemplative stage of change or declines to participate, the ACT staff will engage in other needs during those sessions.

**S8: Co-Occurring disorder treatment groups:**
Program will use group modalities as a treatment strategy for people with substance use disorders. For fidelity 50% or more of member’s with substance use disorders attend at least 1 substance abuse treatment group meeting/month.
Teams should be offering at least one substance abuse group per week and track which member’s attend the groups (ex. sign in sheet) so they are aware of who to engage and have not attended the SAS group during the month. Teams should have different dual diagnosis treatment groups each week dependent on the member’s stage of change. Providers should have a curriculum that aligns with IDDT and template the staff is to use to guide their treatment group.

**S9: Dual Disorders Model:**
Teams should be fully based in dual disorders treatment principles, with treatment provided by ACT staff members.

Providers must ensure their staff receives training on IDDT and the stage wise approach, as part of their new employee orientation working on the ACT team. ACT staff must get ongoing case specific clinic supervision on the dual disorders model on a monthly basis at the minimum. Additionally all ACT staff must receive an annual refresher on IDDT. Unlicensed staff and associate level licensed Substance Abuse specialists, and anyone on the team providing counseling, must receive ongoing clinical oversight according to state licensing guidelines.

The full team uses the dual disorders approach that is stage wise and non-confrontational. The team considers interactions between mental illness and substance abuse, does not have absolute expectations of abstinence and supports harm reduction. The team should understand and apply stage of change readiness in treatment, be skilled in motivational interviewing and follow cognitive behavioral principles.

Per IDDT, Providers will be responsible for implementing dual diagnosis screening and assessment tools that are universal, standardized, routine and integrated. The screening and assessment must be completed by a competent Provider and will be used to determine readiness for change and the need (or rule out the need) for dual disorders treatment.

Providers are responsible for choosing their own assessment and screening tools and ensuring they align with the IDDT Model. Some potential tools are:

- PHQ2
- GAD2
- Modified MINI Screen (MMS)
- CAGE-AID
- AUDIT-C
- DAST-10
- Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)
- Global Appraisal of Individual Need (GAIN) Short Screener (GAIN-SS)
Some resources, tips and guides for Co-Occurring Treatment can be found at:

https://store.samhsa.gov/shin/content/SMA13-3992/SMA13-3992.pdf


Some resources for screening tools from SAMHSA are:

**S10: Role of Members on Team:**
Consumers are members of the team, with full professional status, who provide direct services. Each team will have at least one FTE Peer Support Specialist. Peers must complete the Peer Support Specialist Certification training to be in this position and will use their lived experience to shape recovery interactions with the members and the ACT team.
<table>
<thead>
<tr>
<th>Criterion</th>
<th>Ratings Anchor Likert Scale</th>
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<tbody>
<tr>
<td><strong>Human Resources</strong></td>
<td>1</td>
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<tr>
<td><strong>H1 Small caseload:</strong> Member to provider ratio = 10:1</td>
<td>50 Members/team member or more</td>
</tr>
<tr>
<td><strong>H2 Team approach:</strong> Provider group functions as team rather than as individual ACT team members; ACT team members know and work with all</td>
<td>Less than 10% Members with multiple team face-to-face contacts in reporting 2-week period</td>
</tr>
<tr>
<td><strong>H3 Program meeting:</strong> Meets often to plan and review services for each Member</td>
<td>Service-planning for each Member usually 1x/month or less</td>
</tr>
<tr>
<td><strong>H4 Practicing ACT leader:</strong> Supervisor of Frontline ACT team members provides direct services</td>
<td>Supervisor provides no services</td>
</tr>
<tr>
<td><strong>H5 Continuity of staffing:</strong> Keeps same staffing over time</td>
<td>Greater than 80% turnover in 2 years</td>
</tr>
<tr>
<td><strong>H6 Staff capacity:</strong> Operates at full staffing</td>
<td>Operated at less than 50% staffing in past 12 months</td>
</tr>
<tr>
<td>Human Resources</td>
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<tr>
<td><strong>H7 Psychiatrist on team:</strong></td>
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<tr>
<td>At least 1 full-time psychiatrist for 100 Members works with program</td>
<td>Less than .10 FTE regular psychiatrist for 100 Members</td>
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<td><strong>H8 Nurse on team:</strong></td>
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<tr>
<td>At least 2 full-time nurses assigned for a 100-Member program</td>
<td>Less than .20 FTE regular nurse for 100 Members</td>
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<tr>
<td><strong>H9 Substance abuse specialist on team:</strong></td>
<td>-</td>
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<tr>
<td>A 100-Member program with at least 2 staff members with 1 year of training or clinical experience in substance abuse treatment</td>
<td>Less than .20 FTE S/A expertise for 100 Members</td>
</tr>
<tr>
<td><strong>H10 Vocational specialist on team:</strong></td>
<td>-</td>
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<tr>
<td>At least 2 team members with 1 year training/experience in vocational rehabilitation and support</td>
<td>Less than .20 FTE vocational expertise for 100 Members</td>
</tr>
<tr>
<td><strong>H11 Program size:</strong></td>
<td>-</td>
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<tr>
<td>Of sufficient absolute size to consistently provide necessary staffing diversity and coverage</td>
<td>Less than 2.5 FTE staff</td>
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<tr>
<td>Organizational Boundaries</td>
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<tr>
<td><strong>O1 Explicit admission criteria:</strong></td>
<td>Has no set criteria and takes all types of cases as determined outside the program</td>
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<tr>
<td>Has clearly identified mission to serve a particular population. Has and uses measurable and operationally defined criteria to screen out inappropriate referrals.</td>
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<tr>
<td><strong>O2 Intake rate:</strong></td>
<td>Highest monthly intake rate in the last 6 months = greater than 15 Members/month</td>
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<tr>
<td>Takes Members in at a low rate to maintain a stable service environment</td>
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<tr>
<td><strong>O3 Full responsibility for treatment services:</strong></td>
<td>Provides no more than case management services</td>
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<tr>
<td>Organizational Boundaries</td>
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<td>rehabilitative services</td>
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<tr>
<td><strong>O4 Responsibility for crisis services:</strong> Has 24-hour responsibility for covering psychiatric crises</td>
<td>Has no responsibility for handling crises after hours</td>
</tr>
<tr>
<td><strong>O5 Responsibility for hospital admissions:</strong> Is involved in hospital admissions</td>
<td>Is involved in fewer than 5% decisions to hospitalize</td>
</tr>
<tr>
<td><strong>O6 Responsibility for hospital discharge planning:</strong> Is involved in planning for hospital discharges</td>
<td>Is involved in fewer than 5% of program Member discharges planned jointly with program</td>
</tr>
<tr>
<td><strong>O7 Time-unlimited services (graduation rate):</strong> Rarely closes cases but remains the point of contact for all Members as needed</td>
<td>More than 90% of Members are expected to be discharged within 1 year</td>
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<td>Nature of Services</td>
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<tr>
<td><strong>S1 Community-based services:</strong></td>
<td>Less than 20% of face-to-face contacts in community</td>
</tr>
<tr>
<td>Works to monitor status, develop community living skills in community rather than in office</td>
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<tr>
<td><strong>S2 No dropout policy:</strong></td>
<td>Less than 50% of caseload retained over 12-month period</td>
</tr>
<tr>
<td>Retains high percentage of Members</td>
<td></td>
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<tr>
<td><strong>S3 Assertive engagement mechanisms:</strong></td>
<td>Passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms</td>
</tr>
<tr>
<td>As part of ensuring engagement, uses street outreach and legal mechanisms (probation/parole, OP commitment) as indicated and as available</td>
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<tr>
<td><strong>S4 Intensity of service:</strong></td>
<td>Average 15 minutes/week or less of face-to-face contact for each Member</td>
</tr>
<tr>
<td>High total amount of service time, as needed</td>
<td></td>
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<tr>
<td><strong>S5 Frequency of contact:</strong></td>
<td>Average less than 1 face-to-face contact/week or fewer for</td>
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<tr>
<td>High number of service contacts, as needed</td>
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<td>Nature of Services</td>
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<td>----------------------------------------</td>
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<tr>
<td></td>
<td>each Member</td>
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<td><strong>S6 Work with informal support system:</strong></td>
<td>With or without Member present, provides support and skills for Member’s support network: family, landlords, employers</td>
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<tr>
<td><strong>S7 Individualized substance abuse treatment:</strong></td>
<td>No direct, individualized substance abuse treatment provided</td>
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<tr>
<td><strong>S8 Co-Occurring disorder treatment groups:</strong></td>
<td>Fewer than 5% of Members with substance-use disorders attend at least 1 substance abuse treatment group meeting a month</td>
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<td>Nature of Services</td>
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<tr>
<td><strong>S9 Dual Disorders (DD) Model:</strong></td>
<td></td>
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<td>Uses a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence</td>
<td>Fully based on traditional model: confrontation; mandated abstinence; higher power, etc.</td>
</tr>
<tr>
<td><strong>S10 Consumers on team:</strong></td>
<td>Consumers not involved in providing service</td>
</tr>
</tbody>
</table>
2. General Organizational Index (GOI)

Providers will monitor and review the metrics in the SAMSHA GOI for ACT every 6 months and report the outcomes to Mercy Maricopa. Providers should reference the SAMHSA website for the scoring matrix for the GOI:
https://store.samhsa.gov/shin/content//SMA08-4345/EvaluatingYourProgram-ACT.pdf

G1: Program Philosophy

Committed to clearly articulated philosophy consistent with specific evidence-based model based on these five staff:

- ACT leader (Clinical Coordinator)
- Senior staff (ex. Executive Director, Chief Clinical Officer, ACT Manager or Director)
- Teams members providing the evidence-based practice (EBP)
- Members and families receiving the EBP
- Written materials (ex. brochures, website, informational pamphlets)

G2: Eligibility/Member Identification:

Provider is to develop an internal protocol where all members with a serious mental illness in their outpatient behavior health (such as those who could step down from residential treatment or flex care settings, staffed community living placements, high utilizers of inpatient settings and emergency room) are screened to determine whether they qualify for their ACT program using standardized tools. Mercy Maricopa may also send claims data for review such as the CORE and the Integrated Care Management (ICM) department will also use utilization data to help the teams identify a member(s) who may benefit form ACT.

G3: Penetration:

Provider will measure the maximum number of eligible members in their outpatient behavior health program (if they are not a stand-alone ACT team) as defined by the following ration: Number of members receiving ACT divided by the number of members eligible for ACT.

G4: Assessment:

Full standardized assessment of all members who receive ACT services. Assessment must include:

- History and treatment of medical, psychiatric and substance use disorders
- Current stages of all existing disorders
- Vocational history
- Any existing support network
- Evaluation of biopsychosocial risk factors
- All AHCCCS and CMRRT required assessment and treatment metrics
G5: Individualized Treatment Plan:

For all ACT members, an explicit, individualized treatment plan exists related to the ACT services and is consistent with assessment and updated as clinically indicated but no less than every 6 months. The SAMHSA requirement for updating treatment plan is every 3 months and Providers should aim for this intensity if feasible within their program.

G6: Individualized treatment:

All ACT members receive individualized treatment according to their clinical needs and wide array of services according to the ACT model. Members have a right to self-determination in their service delivery.

G7: Training:

All new team members (inclusive of Psychiatrist and RN’s) receive standardized training in Evidence Based Practices for 16 hours (at least a 2 day workshop or equivalent within two months of hiring. Existing team members receive annual refresher training of at least 8 hours (1 day workshop or equivalent). Providers will track this metric and must include training on the below topics in the total hour requirement for EBP however, training should not be solely limited to the following topics:

- Assertive Community Treatment
- Family Psychoeducation
- Integrated Dual Disorders Treatment
- Illness Management and Recovery
- Trauma Informed Care
- Permanent Supportive Housing
- Supported Employment
- Motivational Interviewing

The ACT Provider also needs to ensure that staff members complete all mandated trainings that are required apart from the aforementioned ACT training requirements for an EBP.

Additionally, it is recommended ACT staff also receive training and ongoing supervision distinct from EBP on the below topics within their Provider:

- Clinical Coordinator and ACT Director/Manager receives leadership and coaching skills within their agency
- Integrated Care
- Medical effects of drugs, alcohol, obesity, diet, exercise, diabetes and other chronic health conditions
- Recovery and Resiliency
- Team Building

*recommended this training be done prior to IDDT
Lastly all ACT staff should be trained on and always implement the 9 Guiding Principles.

9 Guiding Principles

1. Respect
2. People choose their services
3. Focus on the whole person and natural supports
4. Independence
5. Integration, collaboration, participation in community
6. Partnership between individuals, staff, family members and natural supports
7. People define their own successes
8. Services are strength-based, flexible and responsible
9. Hope

G8: Supervision:

ACT team members receive structured weekly supervision (group or individual formal) from a team member experienced in a particular EBP. Supervision should be member centered and explicitly address the EBP model and its application to specific member situations. A supervisor must be present for these sessions. Additionally until the team scores a 5, high fidelity on the Dual Disorders Model on their Annual Fidelity Review, the weekly supervision on an EBP should be on case specific implementation on the IDDT model. All staff, not just the Substance Abuse Specialists, should participate in this weekly supervision.

G9: Process Monitoring:

Supervisors and ACT leaders monitor process of implementing EBPs every 6 months and use the data to improve the program. Monitoring involves a standardized approach using the fidelity scale. Providers will submit the monitoring results of the 28 ACT fidelity metrics and the GOI to Mercy Maricopa annually at minimum, but preferable every 6 months. This data will be reviewed during the Quality Action Plan (QAP) audit scheduled by Mercy Maricopa's System of Care team and will be scheduled annually at minimum.

G10: Outcome Monitoring:

Providers monitor program outcomes and submit to Mercy Maricopa on the 5th of the month report via Secured File Transfer Program (SFTP). Examples of the key outcomes that are monitored are arrests/bookings, inpatient medical and behavior health hospitalizations, employment status, stage of change, living situation, duplication of service and graduation rate. Providers must also submit a signed attestation attesting to the validity of their self-report. Refer to Provider Manual for deliverable and SFTP guidelines.

Additionally, Providers will submit a member census and staff roster on a weekly basis via email to the Senior ACT Manager and ACTReferrals@mercymaricopa.org mailbox. The monthly outcomes should be reviewed with the entire ACT team on a monthly basis and leadership must track and trend outcomes.
that will be discussed on a monthly call with the Senior ACT Manager and requested as part of Quality Action Plan audits.

G11: Quality Assurance:

Provider has a QA committee or implementation steering committee with an explicit plan to review ACT and components of the program every 6 months.

G12: Member choice about service provision:

All members receiving ACT are offered choices; ACT staff members consider and abide by member preferences for offering and providing services.

3. ACT Contact and Paperwork Guidelines

Member Calendar:

Teams will provide the member with a weekly schedule/calendar that is developed in conjunction with the member specifying the contacts for that week and what services will be provided along with the location of the service. From the member calendar, a daily staff calendar will be developed to organize service delivery for the day. ACT Providers should use the Monday through Sunday time period when scheduling services and reporting on weekly contacts.

Members’ calendars should be specific to that member’s identified goals in their ISP. Members should not be required to participate in activities or groups that do no align with their service needs.

Intensity of Service:

Members should, on average, receive 120 minutes of face to face service delivery each week. The intensity should be individualized to their clinical need with a minimum of 30 face to face minutes spent with members each week.

Example: A member who is the process of graduating may only be seen one time a week for 30 minutes or a member who has high acuity needs may need an hour or more of face to face support each day.
**Frequency of Contacts:**

Members should, on average, receive 4 face to face visits each week and visits should be scheduled according to clinical need. Members on ACT will receive a minimum of one face to face contact each week and may receive multiple face to face visits during a day if clinically indicated. If a member does not need high fidelity ACT services, the team should document the clinical reason for the decreased contact in the member’s ISP along with the ongoing rationale for continued need of ACT level of care.

**Home Visits:**

Home visits shall be based upon the clinical need of members, however minimally members should receive a weekly home visit.

The ACT staff should help members build activities of daily living (ADL) skills in vivo in their homes and the community.

During a home visit ACT staff should assess the member’s current ability to meet their basic needs and complete an assessment of the quality of the living environment and assess for any hazards.

Examples of hazards the teams should address immediately are:

- Residence does not have running water or electricity
- During excessive heat days the air conditioner is not working or during winter months if the heating system is not working properly
- Identify and address any other hazards that have a reasonable potential to place the member at significant risk if not immediately addressed

ACT Providers must develop detailed protocols and policies for their staff to address safety risks for both the staff and the members.

ACT Providers should also maintain general home visit requirements for staff along with clinical interventions such as a possible court ordered evaluation if needed to address safety risks for the member and/or community.

Such protocols should include housing resources available to help the member secure alternative housing and placement until safety hazards are corrected and which leadership are to be contacted in certain scenarios. If it is necessary to terminate a home visit or leave the members home out of concern for personal safety, ACT staff should contact a supervisor immediately.

Staff members of the ACT team must follow their agencies policy on safety during home and community visits.
**Duplication of Service Living and Residential Settings:**

The ACT team must complete a Supplemental Form for any housing/residential application that will be a duplication of services that are to be provided in house on the ACT team such as with 24 hour residential treatment, Flex Care Settings and Community Living Placement with outside ACT supports. This will be reviewed by the Senior ACT Manager and/or ACT Liaison.

If the member is in a duplication of service setting named above, there should be a weekly staffing, to ensure that both service providers are completing their service requirements to the member as stated in their ISP. This weekly meeting is for coordination of care, service delivery accountability and to make any changes as necessary to the service delivery array/frequency. Guardian/advocates and the member should be present to talk about progress made and the plan moving forward. Guardians/advocates can participate telephonically in the weekly staffing or allow the team and Service Providers to proceed without their direct input but the member and ACT team staffs need to be there in person to participate. Guardians/advocates must participate and be agreeable if there is any change in treatment planning.

**Overall ACT Clinical Contact Fidelity Guidelines: Nature of Services:**

- **4 face to face contacts each week average** (high fidelity if clinically indicated, if a member does not need high fidelity please document in their service plan and visit according to their clinical need. However when a member is on ACT there should be a *weekly F2F at minimum*. Ex: some members may need 3 F2F a day for support, others 4x a week and some members only 1x a week. The ACT team weekly average should be 3.1 face to face each week for all members in which a monthly deliverable is submitted to Mercy Maricopa via the Secured File Transmission Program (SFTP)

- **120 minutes of direct face to face services delivered each week** (high fidelity if clinically indicated, if a member does not need high fidelity please document in their service plan. Team should aim for F2F visits about 30 minutes in duration and according to their clinical need. Providers should not that visits of less than 15 minutes are not necessarily enough time to do counseling or skill development with members and are primarily case management

- **Members with substance abuse/dual diagnosis need minimum of 24 minutes of individualized substance abuse treatment each week.** Mercy Maricopa needs providers to schedule 30 minute weekly 1:1 sessions with any member with a dual diagnosis and the SAS completes these weekly sessions. SA sessions should be structured and formalized. These counseling sessions should be scheduled in the EMR as are Dr./RN appointments and if the member declines to do 1:1 counseling for substance abuse, the staff should use this time for other skill development

- **Members with substance abuse/dual diagnosis attend at least one substance abuse group each month.** Mercy Maricopa recommends a weekly group be held at minimum for members and also separating out by stages of change for the weekly Substance Abuse treatment group ex. one for pre-contemplation/contemplation and one for action

- **If member has any natural/informal supports, the ACT team should contact them 4x a month.** This should be assigned to one staff weekly to ensure the contact happens and is documented (ex. the Program Assistant)
- Family psycho education should be scheduled one time a month and family support group one time a month
- Weekly home visit at minimum, more if clinically indicated
- Psychiatrist visits as clinically indicated but at minimum every 30 days
- RN visit as clinically indicated but at minimum every 30 days
- PCP visit at least one time a year at minimum recommended 3x a year

Teams should be utilizing a member schedule to ensure all nature of service fidelity metrics are met and are scheduled with the member ahead of time according to the member’s needs. Teams should be using the member calendar to drive service delivery and utilize it during the program meeting.

**Outreach and engagement:**
- If member is on outreach/missing, ACT team is to complete 4 outreach attempts each week minimally for 8 weeks. At least two of those outreach attempts must be in the community. If not located, the case should be staffed with the Regional (or equivalent) and CMO over the team to discuss closure from the ACT Team or if more outreach is clinically indicated. Teams should adhere to NOA/NOD guidelines in regards to stepping a member off of ACT. Members will not be closed in the RBHA system rather they will be transitioned over to a Navigator Level of Care once outreach is completed unless they meet any of the closure requirements below:
  - Incarceration in prison – after 3 months stay
  - Member moved out of State and move was completed with coordinated efforts from treatment team
  - Has transitioned to ALTCS
  - Member has requested decertification (last resort and should be thoroughly discussed with member by treatment team
  - Member death

The ACT team is responsible for transitioning over the member care to an agency that Provides Navigator Level of care and will do that by only giving basic demographic information for contact or outreach. The Navigator Provider shall add the member to their panel using the Mercy Maricopa web portal application. The ACT team will utilize the portal to remove the member from their ACT panel.

**Substance Abuse diagnosis:**
- Substance abuse screening within 30 days of intake and every 6 months thereafter
- Identify stage of change monthly for those with substance abuse diagnosis
- Substance abuse assessment within 30 days of screening for a co-occurring substance use disorder
- 24 minutes of substance abuse individual treatment each week (also stated above in Nature of Services). Team is to schedule 30 minute 1:1 counseling sessions with anyone with a dual diagnosis. These counseling sessions should be scheduled in the EMR similar to Dr./RN appointments and need to be structured and formalized. If the member chooses not to engage
in the 1:1 substance abuse treatment counseling, staff will document in the progress note and work on other skill building and engagement during this session

- Member to attend at least one substance abuse group each month which is provided by the team
- It is recommended that the two Substance Abuse Specialists split the caseload of members with a dual diagnosis so they can provided 1:1 weekly counseling to their member on their IDDT caseload for continuity in therapy and counseling goals

Emergency Room (ER):

- ACT team should be involved in members admitting to the ER and transport members if medically safe to transport and indicated by the team Psychiatrist
- ACT staff will remain in the ER to provide coordination of care until the member is assessed and a treatment decision is made
- If a member self admits to the ER, ACT staff will be available for consultation from the Provider conducting the ER Behavior Health Consult. ACT staff must answer the on call phone or return a v/m within 15 minutes. ACT staff should have access to the EMR to coordinate current medications and access to the ARCP
- If the Hospital Behavior Health Consult determines the member does not meet admission criteria for behavior health reasons, the ER consult staff will contact the ACT team. The ACT staff should be present for discharge and transport the member home or to a safe environment.
  - If the member is going home the team should do a home visit upon discharge to ensure safety in the home environment and that the member has ample supports
- If the member is going to be admitted for behavior health reasons but is awaiting a bed placement and holding in the ER, the ACT staff will visit them within 24 hours and every 24 hours while holding in the ER for psychiatric inpatient placement
  - The ACT Psychiatrist will complete a telephonic discussion with the attending psychiatrist/physician within the first 24 hours of being admitted to the ER and awaiting placement. If the member is holding for bed placement longer than 24 hours the Psychiatrist will complete a telephonic discussion with the attending psychiatrist/physician every 72 hours until the member is transported to an inpatient psychiatric or medical facility upon which the team will transition to the inpatient protocol

Sub-Acute Facilities:

- The ACT team should not refer members to sub-acute facilities during or after traditional business hours for routine medication issues and should utilize the team or on call Psychiatrist to resolve
- If a member self admits to a sub-acute facility and is on the observation unit the team will provide telephonic consultation upon notification of the admission
- A member should always see the team Psychiatrist before being referred to a sub-acute during traditional hours unless the member is an acute safety risk and danger to self or others. The
team should transport the member to a Sub-Acute facility upon direction from the team Psychiatrist

- If a member is being discharged from the sub-acute facility, the ACT team will be present on site for that discharge and transport the member home or to a safe community setting of the member choice
  - If the member is going home the team should do a home visit upon discharge to ensure safety in the home environment and that the member has ample supports.
  - If the member is transferred over to the inpatient unit, the team will refer to the inpatient protocol

**Psychiatric or Medical Hospital admission:**

- ACT team visit face to face (F2F) with member, within 24 hours of admission
- Notify PCP upon hospital admission
- Clinical visit member every 72 hours minimum after the initial hospital visit
- Contact with social worker at minimum every 72 hours
- Telephonic discussion with the attending psychiatrist/physician within first 24 hours of admission
- Weekly telephonic discussion with the attending psychiatrist/physician if member is inpatient longer than 7 days
- Update ARCP upon hospital discharge
- Contact guardian/OHR advocate upon hospital admission/discharge, include in all treatment/discharge planning
- No person shall ever be discharged from an Inpatient facility to a shelter without prior approval from the site Clinical Director or Regional staff overseeing the ACT team

**Hospital (Medical and Behavioral) Discharge Follow up:**

- Face to face contact daily for the 5 days following discharge from medical or psychiatric hospitalization, minimum of 3 contacts must be community based/home visits
- Psychiatrist visit within 72 hours of discharge, preferably within 24 hours
- RN visit within 10 days of discharge
- If member is readmitted within 30 days of discharge, ACT CC, Psychiatrist and relevant ACT specialist, meet with member (guardian and advocate if applicable) for clinical consultation, evaluate if Individual Service Plan (ISP) needs to be updated and evaluate for increased service delivery
- Notify PCP of hospital discharge
- If inpatient for a medical hospitalization, upon discharge follow up appointment with PCP within 7 days
- If inpatient psychiatric hospitalization, upon discharge visit with PCP within 30 days
- ACT team will be present and transport member home from all hospital discharges. If a member chooses to have family/natural support transport them, the ACT team should be present at discharge to obtain paperwork, ensure the member receives their discharge medications from
the pharmacy and is strongly recommended a home/community visit is scheduled the same day to support the member.

**Jail/Incarceration ACT Contact Guidelines**

**Jail:**
- Visit members within 24 hours of notification of incarceration at Maricopa County Jail
- Contact Mercy Maricopa court services team within 24 hours of initial visit
- Send over medication list to Correctional Health Services (CHS) within 24 hours of notification of arrest/booking
- Send copy of COT (Court Ordered Treatment paperwork if applicable) to Correctional Health Services (CHS) within 24 hours of notification of booking.
- If incarcerated more than 7 days, weekly visit at minimum or more often as clinically indicated
- ACT team to coordinate with Correction Health Services (CHS) prior to release and the ACT team needs to be available 7 days a week, including holidays to pick a person who is releasing from jail.
- Psychiatrist appointment within 72 hours of jail release

**Psychiatric Inpatient while incarcerated:**
- Psychiatrist appointment within 24 hours if released on a Sunday through Thursday, and then if released on Friday/Saturday psychiatrist appointment within 48 hours
- Notify on call psychiatrist of any release on Saturday/Sunday
- ACT team to notify PCP of incarceration/inpatient stay upon admission and release from IP incarceration unit
- Telephonic discussion with the attending psychiatrist/physician to be completed for coordination of care within 24 hours of arrest and admission to jail psychiatric unit
- Weekly telephonic discussion with the attending psychiatrist/physician if incarcerated and inpatient longer than 7 days
- ACT team to contact (may be via email) the correctional health counselors every 72 hours while member is incarcerated and inpatient

**Prison:**
- Maintain weekly contact with Corizon release planner for ACT members enrolled.
- Work with Corizon release planner to coordinate and complete a monthly prison visits.
- ACT team to coordinate release planning and provide ride for the member upon release from prison if there is not family available
- Psychiatrist appointment within 72 hours of prison release
- Persons sentenced to prison are not to be closed if sentence (including time served) is less than 3 months
- If sentence is longer than 3 months (including time served) prior to closure of services with the ACT team – contact Court Services to verify sentence information
- If person sentenced to prison for more than 3 months – contact Corizon Release planner to notify of ACT status so that person can be reopened and referred back to an ACT team prior to release.
- Release from prison need to see PCP within 7 days

**Mental Health Court Guidelines:**
- ACT staff member attend pre-hearing staffing
- ACT staff member attend hearing
- Submit status report prior to hearing/staffing including detailed treatment plan recommendations as directed by the Court Liaison

**ACT Paperwork requirements:**
- Individual Service Plan (ISP) updated every 6 months or more often if clinically indicated
- Full Comprehensive Assessment preferred (or Part E) annually at minimum, update as clinically indicated
- Substance Abuse Screening within 30 days of onboarding member to the team. Assessment, if indicated from the screening within two weeks of the screening date
- If diagnosed with Substance abuse/dual diagnosis, evaluate stage of change monthly at minimum to ensure the team is applying stage wise interventions
- At Risk Crisis Plan (ARCP) updated prior to hospital discharge, jail release and at minimum every 6 months
- Member calendar provided to member weekly and utilized to drive program meeting and service delivery by team
- Abide by all CMRRT and AHCCCS requirements in treatment and assessment planning
- Refer to Provider Manual for specific documentation guidelines [https://www.mercymaricopa.org/providers/resources/manual](https://www.mercymaricopa.org/providers/resources/manual)

**Court Ordered Treatment Paperwork:**
- 45 day status report due to the court 45 days after the start of Court Ordered Treatment (COT)
- Judicial review must be offered to the member, 60 days after being placed on COT and offered every 60 days thereafter
- Final COT Status report is due no later than 60 days prior to COT end date
- If the ACT team wants to renew the Persistently Acutely Disabled (PAD) or Gravely Disabled (GD) COT – then the Psychiatric Report for Annual Review must be filed with the court along with Petition to Continue COT with at least 31 days left on the COT when this is filed
4. ACT Referrals

Newly SMI and reopened PRE SMI referrals from the SMI Determination Provider:
Mercy Maricopa will send a referral email to the appropriate ACT team with the expectation that member will be screened within 48 hours. If screened and accepted, care is expected to begin immediately. If ACT Provider denies the referral, a NOA/NOD will be sent per RBHA requirements dependent on titled status according to guidelines. Refer to Mercy Maricopa Provider Manual for guidelines.  [https://www.mercymaricopa.org/providers/resources/manual](https://www.mercymaricopa.org/providers/resources/manual)

Regular outpatient referrals:
ACT outpatient transfers must be completed within 21 days, whether that is an ACT to ACT or supportive to ACT transfer. The ACT team should screen the member within 7 days of receiving the referral packet for supportive members.

Members who are already on ACT level of care will not require an additional screening as they already have been certified to meet the ACT level of care by the sending Psychiatrist.

Outpatient Transfers between and to ACT teams (ex: supportive to ACT, ACT to ACT and ACT to FACT) are expected to be completed in less than twenty-one (21) days from the time the receiving ACT team receives the transfer request. The ACT team should screen members within two weeks of receiving the outpatient referral to ensure they meet ACT criteria. If the member meets ACT Criteria and the transfer is not completed in the 21 day timeline, [smimemberservicesrequest@mercymaricopa.org](mailto:smimemberservicesrequest@mercymaricopa.org) should be contacted. For Inpatient Level 1 referrals and Newly Determined SMI ACT referral protocols please refer to the ACT Operational Manual  [https://www.mercymaricopa.org/assets/pdf/providers/manuals/ACT-Operational-Manual-eng-508.pdf](https://www.mercymaricopa.org/assets/pdf/providers/manuals/ACT-Operational-Manual-eng-508.pdf)

- ACT team will contact the member/guardian/advocate to set up an initial ACT screening. It is recommended that the supportive team be present at this ACT screening to provide additional information that could assist with the assessment
- If the member is initially declining ACT services, the ACT team should make two more engagement attempts. It is also recommended that the Peer Support Specialist be utilized for members who may be initially resistive or decline ACT level of care


- The clinical director/site administrator of the referring clinic will ensure that documentation is prepared and delivered to the receiving clinic within 7 days of the request for transfer. All transfer activities will be documented in the medical record
- The person or guardian and OHR (if applicable) will be notified of the transfer referral by the referring clinic with the intention that the receiving clinic assign the person to a clinical team within the required timeframes. This will be documented in the medical record
• The referring clinic shall prepare a transfer packet to include the following medical record information:
  - Transfer of care cover sheet
  - Part E
  - Part D
  - AUD
  - ARCP
  - Med sheet
  - Last 3 Doctor note
  - Last three progress notes
  - Face sheet
  - COT/Special Assistance or guardianship paperwork
  - A progress note indicating a conversation with the member or member’s guardian with the transfer request

General ACT screening Protocol:
• ACT teams should make 3 engagement attempts to screen the member before closing out a referral.
• It is recommended if a member is resistant to ACT level of care at the first screening, other specialists, such as the Peer Support Specialist should meet with the member for the remaining two attempts to build rapport and engage into the ACT model.
• Teams should be using the uniform ACT Admission Criteria for ACT referrals located on Mercy Maricopa website mercymaricopa.org
• FACT will use the uniform FACT screening criteria which is inclusive of a member’s recidivism risk score and can be located on the Mercy Maricopa website mercymaricopa.org
• MACT (Medical ACT) will use the uniform MACT screening criteria which is inclusive of chronic medical conditions and also can be located on the Mercy Maricopa website mercymaricopa.org
• For all transfers, if the ACT team has already met their intake capacity for the month they will waitlist the member, after screening and determining they meet ACT criteria. The member will be given the soonest transfer date to align with SAMHSA’s intake rate
• If a member has a guardian/advocate they must be included in the screening process and any notification resulting from that screening
**Level 1 (Hospital) referrals:**
Must be screened within 72 hours of receiving email from Mercy Maricopa (ACT team needs to work with supportive team to get ROI and packet). If accepted person must be transferred to ACT within 7 days of screening date even while inpatient (IP).

- The inpatient social worker will send the name and basic information below to ACTreferrals@mercymaricopa.org. Mercy Maricopa will then forward this information to supportive team, the ACT team and copy the person who made the referral on that email.

**Member’s Name:**

**Member’s Current Location:**

**Contact Number to reach member:**

**Person sending the referral:**

**Member’s current clinic:**

**Member’s cross roads/zip code:**

- The current supportive/connective team will ensure that an ROI is signed, any critical information is shared immediately such as the member having an advocate, guardian, needing an interpreter and that packet is sent to the ACT team within 24 hours. The inpatient social worker should assist in this process if able to expedite the screening.
- Best practice would be for a member of the supportive team to be present at the time of the ACT screening and if applicable guardian/advocate must be present.
- If the member is in need of a specialty ACT team (FACT/MACT) and the referral is received while in a Level 1 facility, the Level 1 timelines are applicable.
- ACT team screen member within 72 hours of receiving the email/packet and on board the member to ACT services within a week of the screening date if they meet criteria and wish to receive ACT services. If the ACT team has already met their intake capacity for the month they will waitlist the member, after screening and determining they meet ACT criteria. The member will be given the soonest transfer date to align with SAMHSA’s intake rate.
- ACT team to email Mercy Maricopa ACTreferrals@mercymaricopa.org back to report the screening date, if denying or accepting member and the transfer date if accepting.
ER/ED referrals:
- The ER/ED Hospital Behavior Health Consult Provider will email the ACTreferrals@mercymaricopa.org mailbox the below information from the template:

  Member's Name:

  Member’s Current Location:

  Contact Number to reach member:

  Person sending the referral:

  Member's current clinic:

  Member’s cross roads/zip code:

  - Email will be sent by Mercy Maricopa to current clinical team and the ACT team with the below information. Subsequently, the two teams will coordinate the screening, ROI and sending over a packet. Mercy Maricopa does not need to be involved in setting up the screening but the supportive and ACT team should coordinate this together in conjunction with the member. The ACT Provider must report the screening date, if denied or accepted and if accepted the transfer date
  - ER/ED referrals should be processed with the same timelines as Level 1 ACT referral
  - Best practice would be for a member of the supportive team to be present at the time of the ACT screening
  - ACT team to email Mercy Maricopa ACTreferrals@mercymaricopa.org back to let us know screening date, if accepting member and the transfer date

Forensic ACT (FACT) referrals:
- The referring party probation/parole/CHS will send the name and basic information below to ACTreferrals@mercymaricopa.org, Mercy Maricopa will then forward this information to supportive team, the ACT team and copy the person who made the referral on the email request
- The current supportive/connective team will ensure that an ROI is signed, any critical information is shared immediately such as the member having an advocate, guardian, needing an interpreter and that packet is sent to the ACT team within 72 hours. The referring party can assist in this process of getting the ROI signed, if able to expedite the screening however any dissemination of the ROI needs to be provider to provider and Mercy Maricopa will not be coordinating that aspect
- Best practice would be for a member of the supportive team to be present at the time of the ACT screening
- ACT team to email Mercy Maricopa to report the screening date, if denying or accepting member and if accepting the transfer date
- If member has no upcoming court/release date and is facing significant charges, the ACT/FACT team can screen and hold a potential spot for the member. Transfer would not occur until the member has a release date with ACT/FACT team accepting responsibility for care 30 days prior
to release to build relations and d/c plan appropriately

- Transfer will need to occur at either court dates, mental health court, or in jail/prison with participant from supportive team member, ACT/FACT member, correctional health member, and member if the member is incarcerated.

**Medical ACT (MACT referrals):**
- The same process is used for general screening timelines as outpatient referrals however the MACT team has their separate MACT screening tool which is inclusive of chronic medical conditions

**Newly SMI determination and Pre SMI Referrals:**
- A Provider, currently Crisis Preparation and Recovery (CPR), completes the SMI and Pre-SMI evaluations prior to sending onto Crisis Response Network (CRN for the official SMI determination. CPR will flag members as ACT appropriate based off their in depth evaluation
- Once/If the member is determined SMI or reopening as pre-SMI; Mercy Maricopa receives their packet from CRN and assigns an ACT team to screen the member for ACT Level of Care within 48 hours of opening with the RBHA. The ACT team will immediately onboard the member to the ACT team if they meet criteria and have not met their transfer/onboarding threshold for the month. The goal being to provide the most clinically appropriate level of care from onset of receiving SMI services from the RBHA

**Once a member is accepted and transfers to your ACT program:**
- The ACT leader, Psychiatrist, RN and other specialists who may potentially work closely with the member meet with the member to explain the program and assess the person’s initial needs in the transfer appointment. The program explanation may have been completed prior as part of the ACT referral and screening
- ARCP is updated during the transfer appointment to reflect current ACT team and members needs
- Multiple team members meet with the member as the work of meeting the member’s initial needs begins. During these contacts, team members gather information for the comprehensive assessment and treatment plan
- After 30 days, team members meet to pool information and to complete the comprehensive assessment and treatment plan (ISP)
- Based on the comprehensive assessment, team members plan what they will do and document in the treatment plan. This plan specifically includes what will be done by whom, at what times, on what days
- A team member meets with the member (guardian/advocate if applicable) to review and achieve consensus about the plan and include them in the planning and interview meeting
- The activities in the treatment plan are translated into a weekly schedule of contacts between the member and the team
5. ACT Staffing Criteria

ACT teams are comprised of a transdisciplinary team of staff members. Transdisciplinary teams blend the knowledge and skills of professionals from multiple disciplines. They transcend the typical provider-member relationship by supporting members in self-determination and giving them voice in which services they receive and how they receive them.

This model allows Providers to deliver a comprehensive and integrated array of services to members who have complex needs.

Each Provider should develop a Skills and Competency Checklist that should be completed within 2 months of hire for all ACT staff. Each staff should have an individualized checklist according to their specialty position and desired skillset. A supervisor and/or Team Leader will observe the staff providing in vivo services as part of the skills and competency process before signing off the staff member meets the requirement.

ACT Staff Composition and General ACT duties per position:

- **1 Full time Psychiatrist**
  - Qualified by state law to prescribe medications
  - Board certified in psychiatry
  - Relevant experience working with SMI members
  - Credentialed with Mercy Maricopa
  - At least monthly (every 30 days) assessment and treatment of members symptoms and response to medications including side effects
  - Providers brief therapy
  - Provides diagnostic and psychiatric medication education to members, with medication decisions based in a shared decision paradigm
  - Coordination and consults with outside Providers (medical and behavioral)
  - Monitors/is aware of members non-psychiatric medical conditions and non-psychiatric medications
  - Provides psychiatric back to the program after hours and weekends (may be a rotating basis as long as other psychiatric care providers who share on call responsibilities have access to members current status and medical records/current medications)
  - One day scheduled for community, jail and hospital visits

- **2 Registered Nurses**
  - Recommended at least one RN has medical experience in a prior employment setting
  - One RN should have scheduled time in the field daily
  - Communicate and coordinate services with other medical providers
  - Screen and monitor members for medical problems/side effects
  - Engage in health promotion, prevention and education activities
- Educate other team members to help them monitor psychiatric symptoms and medication side effects
- When members are in agreement develop strategies that maximize the taking of medications as prescribed (ex. behavioral tailoring, develop of individual cues and reminders)

**1 ACT Specialist**
- Recommended this staff be trained on forensic issues
- If this staff is licensed they would be able to provide the general counseling and psychotherapy services
- Senior ACT staff that has a wide range of ACT or rehabilitative experience

**1 Independent Living Specialist**
- Works with members on activities of daily living

**1 Peer Support Specialist**
- Must complete Peer Certification Training prior to hire
- Coaching and consultation to members to promote recovery and self-direction (ex. preparation for role in treatment planning meetings)
- Facilitating wellness management and recovery strategies (ex. Wellness Recovery Action Plans (WRAP), Illness Management and Recovery (IMR) and other deliberate wellness strategies
- Participate in all team activities (treatment planning, chart notes) and has equivalent professional status as the other ACT Specialists
- Modeling skills for and providing consultation to fellow team members
- Provide cross training to other team members in recovery principles and strategies
- Uses their lived experience to help guide treatment and be an active voice for recovery

**1 Housing Specialist**
- Help find suitable shelter
- Support housing once established
- Develop relationship with landlord
- Demonstrates knowledge of the VI-SPDAT; may complete the VI-SPDAT
- Knowledge of RBHA housing and housing options within the community
- Understanding of community resources that may benefit our members and can assist in navigating the member to the applicable resources
- Understands the importance of member choice; knows how to help uphold this in a clinical setting
- Participates regularly in Housing Specialist meetings scheduled by Mercy Maricopa
- Provide direct services to members
- Help member report maintenance issues to the housing provider
- Help address and rectify any health and safety and/or lease violations

**1 Rehabilitation Specialist**
- Must meet SAMHSA requirement for Vocational Specialist of 1 year training/experience in vocational rehabilitation and support prior to hire on ACT team in Rehabilitation Specialist Position
Prior experience may be job development, job coaching, supported employment
- Refer to job specifics below for the Employment Specialist as the Rehabilitation Specialist should also be able to fulfill those duties according to the SAMHSA ACT Model
- Completion of Vocational Activity Profile (VAP) or similar tool for identifying vocational preferences/needs.
- Serves as a resource manager of rehabilitation services
- Educates ACT Team on the importance of rehabilitation & vocational services and meaningful community activities
- Works with individuals to determine rehabilitation readiness, goals and values
- Offers options and engages individuals in meaningful community activities, (i.e. volunteering, employment, etc.)
- Educates membership regarding and explores Social Security work incentives (i.e. DB101 consultation) and other public assistance programs
- Provides pre-employment service interventions
- Works in conjunction with the RSA/VR Counselor to access, navigate and augment specialized rehabilitation services
- May provide job retention services (i.e. Job Coaching)
- Provides disclosure and accommodation consultation for membership (i.e. ADA bylaws, accommodation request letters, etc.)
- Routinely coordinates care and treatment progress with ancillary service providers

1 Employment Specialist
- Must meet SAMHSA requirement for Vocational Specialist of 1 year training/experience in vocational rehabilitation and support prior to hire on ACT team in Employment Specialist position
  - Prior experience may be job development, job coaching, supported employment
- Core Employment services in lieu of RSA/VR:
  - Engagement
  - Vocational assessment
  - Job development
  - Provide pre-employment services
  - Act as a liaison with employers and educates employers regarding inclusive workforce practices and Tax Incentives
  - Job placement (including going back to school, classes)
  - Job coaching and follow along supports (including supports in academic settings)
  - Benefits counseling
  - Support employment
  - Honoring and exercising core principals of SAMHSA Evidence-Based Supported Employment

- Within the team the Employment Specialist should:
- Available for modeling skills and consultation
- Cross training to other staff on the team to help them to develop supported employment approaches with members on the team
- Attending all Program Meetings during work days
- Attending all treatment planning meetings or staffings for members with employment goals or those whom participate with ancillary service providers

1 Program Assistant
- Available to facilitate the day’s operations in a support manner to both the team and member
- Primary functions should include:
  - Monitoring and coordinate daily team schedule
  - Providing direct support to staff both in the office and the field
  - Actively participating in the Program Meeting
  - Assisting with compiling deliverables (census and 5th of the month reports)
  - Liaison between members and staff ex. answering calls in regards to scheduling and transportation or facilitating walk in appointments

1 Clinical Coordinator (Team Leader)
- Full clinical, administrative and supervisory responsibility to the team
- Provides direct face to face services to members 50% of the work week
- Shadows and mentors staff on the team while providing face to face services with members
- Attends all mandated Clinical Coordinator RBHA meetings and trainings

2 Substance Abuse Specialists (SAS)
- Must meet SAMHSA requirement for Substance Abuse Specialist of 1 year training or clinical experience in substance abuse treatment prior to hire on ACT team in SAS position
- One licensed staff is recommended
- Serves as the subject matter expert on IDDT
- SAS is a key member in the service planning process for members with a dual diagnosis and performs the following functions within the team:
  - Modeling skills and consultation
  - 1:1 Dual Diagnosis counseling
  - Group Dual Diagnosis treatment
  - Cross training to other staff on the team to help them develop dual disorders assessment and treatment planning
  - Attending all Program Meetings during scheduled days
  - Attending all treatment planning meetings for members with dual disorders

It is strongly recommended that there be at least one staff on the team (in addition to the Psychiatrist) who is licensed by the State of Arizona to provide individualized counseling and (psycho)therapy to members on the team so the team can provide the full responsibility of treatment services according to the ACT model.
6. Core ACT Specialty Service Components

Medication Support
- Educate about medications
- Order medications from pharmacy
- Deliver medications to members
- Organize medications
- Monitor adherence and side effects
- Monitor use of medications
- Psychiatric and RN appointments

Psychosocial Treatment
- Take a problem-oriented approach to counseling/psychotherapy
- Manage illness
- Maintain crisis intervention — Be available 24/7
- Treat co-occurring disorders
- Coordinate care (example: hospital, jail, community)

Community Living Skills
- Practice good hygiene
- Follow proper nutrition
- Buy and care for clothing
- Use transportation
- Housekeeping
- Manage money
- Manage activities of daily living (ADL’s)
- Enjoy social relationships and leisure activities

Health Promotion
- Conduct preventive health education
- Ensure medical screening
- Schedule health maintenance visits
- Act as liaison for acute medical care
- Hospital and ER visits while member is admitted

Family Services
- Manage crises
- Provide family Psychoeducation
- Actively engage family members and family of choice in members’ recovery (pending ROI and member choice)

Housing
- Find suitable shelter
- Support housing once established
- Develop relationship with landlord (pending ROI and member choice)
- Discussing important considerations in choosing housing:
- Security deposit
- Rent
- Utilities
- Accessibility to transportation
- Laundry
- Stores
- Safety
- Personal preferences.

- Looking for leads in the paper or by contacting property owners that the team or member knows
- Driving by to check out the location of rentals
- Coaching and rehearsing with members how to best present themselves on the phone or in face-to-face contacts with property owners
- Accompanying the member to meet the landlord, if appropriate and necessary; and
- Securing leases and ensuring that the member pays the rent

**Employment**

- Provide support and assistance in finding work
- Act as liaison with employers and educate employers
- Serve as job coach (if not open with Vocational Rehabilitation in Arizona or provides job support if VR Job coaching subsides, if they are open with VR Provider ACT team assists in case management role while coordinating with VR Employment Provider)
- Support employment
- Direct placement in competitive jobs
- Promote member interest and motivation to work by:
  - talking about work
  - stimulating thinking about work
  - raising expectations to work
  - offering formal and informal interactions with working members to help them realize that they can work
  - determining members’ work interests and competencies
  - finding work opportunities for members to boost their confidence
Crisis Intervention

- Ensuring the safety and protection of the member or other
- Providing emotional support
- Structuring the member’s time and activity
- Treating specific symptoms (ex. pharmacological)
- Evaluating symptoms in a controlled environment
- Evaluating and treating coexisting medical problems and substance abuse

Acute medical/behavioral health care

- Provide interpersonal support,
- Ensure financial coverage,
- Facilitate admissions,
- Communicate with medical and behavioral health providers,
- Ensure that members understand and communicate their choices
- Facilitate discharge after care.

7. Program Meeting Processes

- During the team’s daily meeting, a designated team member checks the *Weekly Member Schedule* for each member that the team serves. The team member writes each scheduled activity for that day in the appropriate time slot. If a particular team member is scheduled to carry out an activity that person’s initials are written next to the activity

- Next, the person who drafts the *Daily Team Schedule* checks for appointments that are not part of the regular activities on the *Weekly Member Schedules*. These might be appointments to apply for benefits, follow up on a job lead, or look at an apartment that has become available — activities that the team provides support for, but which do not recur. These are also written on the *Daily Team Schedule* in the appropriate time slot. If a particular team member should attend the appointment, that person’s name is written next to the activity

- The person who drafts the schedule also checks for crisis situations and members who are hospitalized. These are events that the team will respond to, but that are not part of the pre-planned activities or appointments.

- The team begins the meeting by using the member calendar/schedule. A team member calls out each member’s name. When a name is called, anyone who had contact with that person in the past 24 hours describes the contact and the outcome briefly in behavioral terms. By doing this, the team is engaged in a process of continuously adding to the information they learned when doing the comprehensive assessment and timeline and reassessing the effectiveness of the member’s treatment plan

- During the daily team meeting, if team members report that a member is having a difficulty, the team will strategize about how to address the problem if it can be addressed quickly. If the problem is more involved and requires extensive discussion, the team will schedule a separate meeting outside of the daily meeting
• Once all the scheduled activities, special appointments, and any crisis response for the current day have been noted, the team will make any changes in the schedule that are needed to ensure that all the things that must happen that day are taken care of. For example, as the members are discussed, the team may decide that a team member who was initially scheduled to meet with one member is needed more urgently to intervene with another. Someone else will have to cover the original appointment.

• Program Meeting should be held 4x a week

• Program Meeting should average 60 minutes and start on time

• Teams should review all members A-Z and then Z-A on alternating days to ensure each member gets equal attention during the program meeting during the week

8. Telemed

For ACT teams, Mercy Maricopa does not support the use of Telemed as a permanent option for the FTE psychiatrist position. If a team is in need of a psychiatrist and cannot identify one, Telemed can be used for an interim option up to a maximum of 6 months while actively recruiting a FTE psychiatrist for the team. The team will have a monthly telephonic meeting with the ACT Manager to discuss the hiring status.

When a team is utilizing Telemed as an interim option the must:

• Use in the community/field not at the mental health center or office setting
• Adhere to confidentiality regulations
• Adhere to federal/state billing restrictions/complications
• Integrate Psychiatrist into team meetings and staffing’s
• Sufficient technology to support the process

If your team is using an LT for the ACT position please highlight them yellow when sending in the weekly census.

Also will set up monthly call to discuss the progress of hiring a permanent psychiatrist or it will be included in the Provider Specific ACT Monthly Telephonic Meeting.

Provider to refer to Mercy Maricopa Provider Manual for general Telemed protocols
https://www.mercymaricopa.org/providers/resources/manual
9. Medication Education, Observation and Assistance in the Self-Administration of Medications

- ACT staff must be trained and certified as competent by their Provider before completing medication education and observation of self-administration of medications with members
  - Providers will develop their own internal training to ensure staff has the skillset and knowledge to perform this role and they must receive an annual refresher at minimum.
- Providers must develop policies and procedures that are in accordance with the State of Arizona Administrative Code on the assistance in the self-administration of physical health and behavioral health medications, as well as transportation of medications, in order to protect the health and safety of the patient and staff.
- Providers should develop a process for providing the member information about the medication including:
  - Anticipated results
  - Potential adverse reactions
  - Potential side effects
  - Potential adverse reactions that could result from not taking the medication as prescribed
- Provider should develop procedures for preventing, responding to and reporting:
  - Medication error; MAR's need to be accurate and up to date
  - Adverse reaction to medication
  - Medication overdose
  - Procedures to ensure that the medication observation schedule is reviewed by the Psychiatrist and an order is written. If the team is going to observe physical health medications that are prescribed by a staff outside of the team, they must also obtain an order and telephonic discussion must be completed between the Psychiatrist and Physical Health Provider
  - Procedures for documenting assistance in the self-administration of medication
  - Procedures for assisting the member in obtaining medication
  - Procedures in assistance in the self-administration of medication on premises
- When the ACT team is assisting in the self-administration of medications, general guidelines are listed below but should also be specified in policy by the ACT Provider
  - Reminder when it is time to take the medication
  - Observing the member while they remove the medication from the container
  - Verifying that the medication is taken as ordered by the member’s prescriber by confirming that:
    - The member taking the medication is the individual stated on the medication container label
    - The member is taking the dosage of the medication stated on the medication container or label
- The member is taking the medication at the time stated on the medication time or label
- Observing the member while the member takes the medication
- Sign off sheet documenting the observation of self-administration for each medication taken which is signed by staff and the member

- Training for an ACT Staff member must be done by a BHMP or RN:
  - Demonstration of the ACT staff’s skills and knowledge necessary to provide assistance in the self-administration of medication must be documented and kept in their training file
  - Identification of medication errors and medical emergencies related to medication that require emergency medication intervention must be trained
  - Process for notifying appropriate entities when an emergency medical intervention is needed
  - Training must be completed before ACT staff provides assistance in the self-administration of medications
  - Assistance in the self-administration of medication provided to a member must be in compliance with a Physician/Psychiatrist order, documented in their medical record and in their ISP
  - Assurance that the member’s medication observation is scheduled appropriately to accommodate the member’s schedule and the prescriber requirement. Members should not be required to take medication based on ACT team staff’s schedules, but the scheduled times the medications should be taken.

- Administrator for the Provider must ensure:
  - Current drug reference guide is available for use by all ACT staff
  - Current toxicology reference guide is available for ACT staff
  - Medication is stored according to licensing guidelines if kept on site and stored according to instructions on the medication container
  - Policies for receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication by the appropriate staff according to licensing guidelines