

Fidelity & Quality Improvement: Applications of the TMACT

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Session Overview

1. Overview of the TMACT (8:30-9:45)
 - Relevance of program fidelity
 - From the DACTS to TMACT: How we got here
 - What the data tell us so far
 - Review of the evaluation process
 - Review of the TMACT summary scale

----- 15-minute break (9:45-10:00)
2. Using the TMACT to guide QI consultation (10:00-11:30)
3. Tools for training ACT staff in fidelity evaluation (11:30-12:00)

Need for ACT in US

- “Healthcare system is broken, must be reinvented” (US Inst. of Medicine, Quality Chasm Report, 2001)
 - Prevalence of chronic rather than acute conditions
 - System fragmentation
 - Translation – science to service takes too long (17 years)
- Persons with most severely disability require integrated services
- Diffusion of responsibility and lack of coordination remain problems
 - Need for ACT continues

Changing Landscape for ACT

- Historically, for persons with high psychiatric disabilities, ACT is the evidence-based practice (EBP) with longest, greatest amount of evidence
- Developed in the context of the US mental health system – which has evolved (recovery, EBPs)
 - Earlier treatment goals were more limited
- Recent evidence weaker
 - England; studies of non-hospitalization outcomes
- Variations in models
 - E.g., Netherlands FACT; hybrid models
- Treatment should align with chosen outcomes – and be measured for them

ACT Research Findings Across Studies

- ACT’s most robust outcomes:
 - ✓ Decreased hospital use
 - ✓ More independent living & housing stability
 - ✓ Retention in treatment
 - ✓ Consumer and family satisfaction
- Variable evidence in other areas
 - Employment · Substance use · Quality of life
 - Psychiatric symptoms · Criminal justice involvement
- Possible sources of variability
 - Secondary areas not targeted in services
 - Variable evidence of fidelity

Fidelity (In Brief)

- Definition: The degree to which a program includes features that are critical to achieving the intended outcomes & excludes detrimental features
- General purposes of fidelity measures
 - Ensure optimal implementation & guide quality improvement
 - Refine knowledge development via research
- Fidelity positively correlated with outcomes
 - ACT e.g.s: More cost-effective (Latimer, 1999).
 - decrease in hospital days (McHugo et al., 1999)
- Provides empirical reference and conceptual base for informed adaptation and innovation

Dartmouth ACT Scale (DACTS)

(Teague, et al., 1998)

- Most widely used ACT fidelity measure
- 28 items/ 5-point anchored scales
 - (1 = not implemented; 5 = fully implemented)
- 3 subscales (structure informed by McGrew et al., 1994)
 - Human Resources
 - Organizational Boundaries
 - Services
- Incorporated into Evidence-Based Practices (Toolkit) Project
- Sometimes used for accreditation/funding

Need for an Alternative ACT Fidelity Measure

- Earlier form of the DACTS was developed as study-specific research component
 - Expanded, extended to other ACT studies as DACTS
- Use became widespread
 - ACT manual not yet available
 - Format useful for training
 - Effective tool for differentiating ACT
- Limited attention to omissions/limitations
 - Distinction between fidelity measure and program specifications not always appreciated

DACTS Concerns

- Not fully consistent with National ACT Standards
- Little grounding in program theory
- Primary focus on structure (vs. process)
- Specific measurement gaps:
 - Assessment & treatment planning
 - Team & staff functioning
 - Recovery orientation
 - Treatment & rehabilitation interventions
 - Item calibration

Potential Threats to Practice & Research

From Gaps in Fidelity Specifications

- Providers use fidelity measure as guide, overlook omitted program features
- Selective regulatory & fiscal incentives weaken program integrity
- Programs become less effective
- Incomplete coverage leaves critical ingredients unobserved
- Omission of critical features reduces capacity to differentiate better and worse programs
- Weaker program theory, compromised specifications for EBP, weaker evidence

Theoretical Framework for ACT Fidelity Measurement: Underlying Factors (Program Theory)

- Recovery orientation
 - Consumers' goals / motivational strategies / alliance
 - Focus on satisfying, independent life in community
 - Movement toward eventual graduation embraced
- Flexible, individualized application of resources
 - Intensity, timing, targeted high-quality (EB) practices
 - Adapted to momentary need in long-term context
 - Delivered in consumers' communities, in their lives
- Provider team & teamwork
 - Multidisciplinary team providing targeted services
 - Collaboration – trans-disciplinary, integrated approach

How Completely Can/Should We Specify/Measure the Model?

- Current versions of evolving visions for ACT are not yet fully tested
 - Recovery orientation; flexible, individualized incorporation of EBPs; team functioning in this context
- Need to balance risks of over- vs. under-specifying, efficiency vs. effectiveness in measurement
- ACT model should always be a work in progress
 - Incorporates the best understanding of optimal care
- So should the specifications (including fidelity measurement)
 - Based on best theory, always provisional & tested

From DACTS to TMACT: Changes ★

DACTS = 28 items

- Revised (20 items)
 - Rescaled anchors
 - Modified assessment
- Removed (6)
 - Items not particular to ACT
 - Folded into another
- Added (25)
 - New items judged critical to ACT
 - Extracted/ expanded concepts embedded in earlier items

TMACT = 47 items

Scope of Changes in TMACT

- Assessment of processes for high fidelity ACT
 - Recovery-oriented services
 - Evidence-based practices
 - Functions promoting a trans-disciplinary team
- Measurement of specific features
 - Recovery-oriented practices, esp. person-centered planning (vs. practitioner-centered medical model)
 - Specific treatment & rehabilitation interventions
 - Team functioning (vs. team structure)
 - Staff roles in treatment & team (e.g., vs. staff FTE)
- Recalibration as needed
- Improved reliability, validity, sensitivity, guidance

TMACT sets a higher bar.

The TMACT in WA: Findings

- To be added

Pilot Conclusions (WA & Elsewhere)

- TMACT sets a higher bar for ACT program performance than DACTS
- TMACT more sensitive to change
- Variations across subscales match expectations of challenges in implementing ACT components
- Cross-state scores are consistent with differences in policy, training, and resource environments
- Overall measure and selected subscales correlate significantly with recovery orientation
- Measure is feasible and valuable in current form, but strategies for efficiency are being evaluated

Toward Quality Improvement in ACT: Premises

- Knowledge about treatment practices emerges continuously over time
 - Pre-service training is insufficient
 - In-service learning is crucial
 - Professionals work in varying degrees of isolation
- Implementation needs to be an ongoing process
- Resources are scarce
 - EBPs optimize outcomes and investment
 - Need to monitor implementation quality continuously to reevaluate models, treatment options (R&D)
- Change in living systems is largely endogenous
 - Cf. self-help, recovery, complex adaptive systems

What does the tool look like and how is an evaluation typically conducted?

Overview of the TMACT

- 47 items; 5-point anchored scales
- 6 subscales:
 1. Operations & Structure (OS): 12 items
 2. Core Team (CT): 7 items
 3. Specialist Team (ST): 8 items
 4. Core Practices (CP): 8 items
 5. Evidence-Based Practices (EP): 8 items
 6. Person-Centered Planning Practices (PP): 4 items

19

TMACT Protocol: This is the scale!

- Part I: Introduction
 - Checklists & timelines to prepare for & conduct fidelity review
 - Step-by-step methods
- Part II: Item-by-item breakdown
 - Data sources
 - Specific interview questions
 - What to look for within each data source
 - Guidelines for scoring
 - Explicit inclusion & exclusion criteria
 - Specification of full vs. partial credit
 - Case examples
 - Formulae for ratings
- Appendices
 - Additional forms & templates (e.g., orientation letter, agenda, data collection forms, report template)

20

Before the review...

- Two fidelity reviewers
 - Work in tandem through most of review & divide up as necessary
- Send orientation letter and two data collection forms for completion prior to review:
 - Team survey
 - Excel spreadsheet
- Conduct optional pre-fidelity review phone interview with team leader based on some of the data in team survey and other areas
- Collaboratively develop two-day agenda with TL

21

During the review...

- Use TMACT protocol & data collection forms
- Refer to/cross-reference team survey & Excel spreadsheet data
- Review of randomly selected charts (~20% sample) & charts of 2 graduated consumers
- Review daily team meeting tools
- Observe at least one daily team meeting
- Observe one treatment planning meeting
- Interview team members
- Interview 3-5 consumers
- Community observation
- Debrief with team based on initial impressions

22

After the review...

- Reviewers independently rate/develop consensus ratings for final scoring
- Write comprehensive report with focus on quality improvement
 - Identified strengths
 - Recommendations for improvement
- Send draft report to team for initial input
- Conduct fidelity feedback meeting with team
- Finalize report based on feedback meeting input

23

Brief review of the TMACT
Summary Scale

Please return in 15 minutes!

Using the TMACT to Guide Quality Improvement Consultation

Overview of Part II of Institute

- Overview of the evolution of the TMACT as a quality improvement instrument
- Item rating exercises
 - East ACT Team's Dual Disorder Program
- Using TMACT findings to guide quality improvement consultation
 - Comparison of East (lower) and West (higher) fidelity ACT teams
 - Generating meaningful recommendations
- Training ACT evaluators in fidelity assessment and consultation.
 - Incorporating ACT leadership into evaluation process.

What is Quality Improvement?

- Fidelity measurement --- are you implementing the practice as intended, per the model definition?
 - High-fidelity implementation leads to better consumer outcomes (empirical & theoretical basis to assumption)
- Quality improvement (adaptation of FADE Model):
 - Identify and focus on a single model → ACT
 - Analyze the model as implemented, looking for problems and root causes → TMACT
 - Develop strategies for improvement
 - Execute changes and further evaluate model fidelity and outcomes) → Strategic planning and follow-up TMACT

Goals of TMACT Evaluation

- Accurately measure performance of the team and compare to best practice standards (i.e., "5" ratings)
- Focus recommendations on a select few areas that, if changed, would have the largest impact
 - What are the underlying issues that may account for several low-rated items?
 - What resources exist that can be used more efficiently and effectively? What resources may be needed?
- Provide feedback in a manner that brings down defenses and builds motivation for change
- Conclusion of recommendation process sets the stage for team's strategic planning

Evolution of a Quality Improvement Tool

More detailed guidance in discerning levels of practice allows for more specific and accurate recommendations.

- Detailed rating guidelines
 - case examples
 - descriptive information for no, partial, and full credit item criteria

Evolution of a Quality Improvement Tool

- Development of a standardized report template
 - item-level details to better illustrate relative strengths and weaknesses
 - suggested areas of performance to comment on
- Supplementary handouts
 - Prewritten description of areas of practice commonly a focus of consultation
 - Refer to Person-Centered Planning Handout example

Importance of Accurate Ratings

Inaccurate ratings may lead to erroneous feedback and diminish your credibility as an evaluator.

Steps to making accurate ratings:

- ☑ Know the model!
- ☑ Careful consideration of all evidence across relevant data sources
- ☑ Weigh suggested primary data source more heavily than other sources
- ☑ Attend to the construct of that particular item – i.e., what it is trying to measure (e.g., see item definition and rationale)
- ☑ Refer to Rating Guidelines section for each item
- ☑ Consensus rating process: independently rate, reason through differences, and agree on most valid rating

Dual Disorder Treatment Items

Dual Disorder Program Items

- ST1. Substance Abuse Specialist on Team
- ST2. Role of Substance Abuse Specialist In Treatment
- ST3. Role of Substance Abuse Specialist Within Team
- EP1. Full Responsibility for Dual Disorder Services
- EP4. Integrated Dual Disorder Treatment (IDDT) Model

ST1. Substance Abuse Specialist on Team

Criteria considered when determining the rating for ST1:

- Reported time per week in position (i.e., FTE),
- Actual time devoted to specialty-related activities while in the position, and
- Qualifications of the specialist(s).

Charles was identified as the East Team's substance abuse specialist. He is employed with the team full-time. He reported that ~50% of his consumer contacts involve a dual disorder related intervention, inclusive of assessment and engagement tactics; other data sources (e.g., progress notes, daily team meeting report) supported this estimate.

Given the formula provided in protocol, Charles' adjusted FTE is 0.60 FTE. Charles is a licensed substance abuse specialist and has 8 years experience as a substance abuse counselor, including 5 years working at an outpatient substance abuse facility. He has been with the East ACT team for 3 years.

ST1 is rated a "3."

ST2. Role of SA Specialist In Treatment: Collected Data (PT 1)

[Refer to "Item Rating" Handout]

SA Specialist interview:

Describe your dual diagnosis treatment philosophy.
Well, I try to listen and pay attention to where someone is at in their use and whether they appear to want to make a change --- whether they see their use as a problem at all. Based on that, I either focus on relationship building and focusing on what they are wanting from me and the team, looking for opportunities to build a little insight into how their use may be getting in the way of what they want. Or, if they recognize that they have a problem, work with them to make some changes.... Starting with clarifying what the change would look like and what in their life is supportive or hindering that change. In general, I feel like I follow an integrated, stage-wise approach to treatment. I've received some training in motivational interviewing and really try to use that approach with folks in earlier stages of change.

ST2. Role of SA Specialist In Treatment: Collected Data (PT 2)

Let's say you're working with a consumer who doesn't think he has a substance use problem. What would be your typical approach to working with him? I'd be focused on building a good relationship where, when opportunity arises, I can nudge him into a discussion about his use. What he is getting out of it, what problems come with it? Wanting to change his use has to be his goal, not mine.

What about your approach to working with a consumer who has stopped actively using? I focus on relapse prevention... Helping them develop very clear plans for how they spend their time, journaling when they have cravings, how long they last, how they get through it. We discuss new coping techniques. Acknowledge what they may miss and don't miss about using. How their view of themselves has changed with each day of sobriety. I enlist them to become active in self-help groups, and co-lead our DD group.

ST2. Role of SA Specialist In Treatment: Collected Data (PT 3)

Are there circumstances where you would not provide a service given active substance use? (pause) I can't think of any.... We do have some rules about being sober during group. Yes, we saw (on Excel sheet) that groups are offered. Tell me more about this group, what the focus is and how you decide who attends. It's a more active treatment and relapse prevention group. We have been careful about who is invited to attend, making sure they are appropriate given their acknowledgement of use and wanting to change. I would like to start a second group that is more of a persuasion group.

Do you ever assist consumers to self-help meetings? I've often given consumers meetings times, especially during group. I haven't ever accompanied a consumer to a meeting.

ST2. Role of SA Specialist In Treatment: Collected Data (PT 4)

What type of assessment do you use? We have an intake we all help out in completing—I typically complete the substance abuse section. I also complete a SATS with every dually diagnosed consumer at time of the treatment plan review. Will we see these forms in the chart? You should. What do you do with the information gained from the SATS? It informs our thinking about how to work with consumers given where they are at in wanting to change. Do you pull this information together to track change over time? No.... I hadn't thought to do that.

What resources do you use in individual and group treatment? I rely pretty heavily on the IDDT Toolkit. I've also drawn from the IMR Toolkit for group.

ST2. Role of SA Specialist In Treatment: Collected Data (PT 5)

Other data sources:
Charts: Some charts had the intake assessment; the section evaluating substance use included questions that considered the interrelationship between substance use and mental health. SATS was located in most charts of those consumers with a dual disorder. Where documented, Charles' approach to treatment was consistent with SATS and his SATS ratings appeared to fit with consumer's stage of change readiness.
Observations of daily team meeting: Charles provided his input and guided discussions relevant to substance use. His comments reflected an understanding of stage appropriate treatment.

ST2. Role of SA Specialist In Treatment: Criteria to Rate

Service	Credit (No, Partial, Full)		
	N	P	F
1) conducting comprehensive substance use assessments that consider the relationship between substance use and mental health		X	
2) assessing and tracking consumers' stages of change readiness and stages of treatment;		X	
3) Using outreach and motivational interviewing techniques;			X
4) Using cognitive behavioral approaches and relapse prevention;			X
5) Treatment approach is consistent with consumer's stage of change readiness.			X

1	2	3	4	5
Substance abuse specialist provides 1 or fewer dual disorder services.	2 dual disorder services provided (ie 3 services are absent)	3-4 dual disorder services provided (ie 1 or 2 services are absent), OR ALL 5 services, but more than 2 are PARTIALLY provided	ALL 5 dual disorder services, but up to 2 services are only PARTIALLY provided	ALL 5 dual disorder services FULLY provided (see under definition)

ST3. Role of Substance Abuse Specialist Within Team: Criteria to Rate

Function	Credit (No or Yes)	
	N	Y
1) modeling skills and consultation;		X
2) cross-training to other staff on the team to help them develop DD assessment and treatment skills;		X
3) attending all daily organizational team meetings;		X
4) attending all treatment planning meetings for consumers with DD.		X

1	2	3	4	5
Substance abuse specialist does not perform any of the 4 functions within the team	1 function performed within the team	2 functions performed within the team	3 functions performed within the team	ALL 4 functions performed within the team (see under definition)

EP1. Full Responsibility for Dual Disorder Services

Definition: The team assumes responsibility for providing dual disorders (DD) treatment to consumers, where there is little need for consumers to have to access such services outside of the team. It is expected that the ACT Substance Abuse Specialist will assume the majority of responsibility for delivering DD treatment, but ideally other team members also provide some DD services.

EP1. Full Responsibility for Dual Disorder Services

ITEM RESPONSE CODING: Scoring of item EP1 is based on the percentage of individuals receiving dual disorder treatment from the team given the estimated number of individuals who want and/or need that dual disorder services.

$$\frac{\text{\# of consumers receiving service directly from team}}{\text{\# of consumers needing and/or wanting service (i.e., calculate \# in need using base rate listed below)}} \times 100$$

EP1. Full Responsibility for Dual Disorder Services

Full Responsibility for Dual Disorder Services (EP1) Excel Spreadsheet Definition and Instructions:

"(DD Services) include services provided by the substance abuse specialist as well as other team members well-versed in integrated, stage-wise treatment for co-occurring disorders.

Core services include: (1) systematic and integrated screening and assessment and interventions tailored to those in (2) early stages of change readiness (e.g., outreach, motivational interviewing) and (3) later stages of change readiness (e.g., CBT, relapse-prevention).

NOTE: To be considered a group participant, consumer attends group at least 1 time per month. To be counted as an individual therapy participant, the duration and frequency of therapy sessions should be at least 20 minutes per week. Be sure to include consumers whom the team is attempting to actively engage if these attempts are documented in the consumer's chart.

EP1. Full Responsibility for DD Services: Determining # of Consumers who Need/Want DD Services

Use the larger of these two:

Team's reported number of consumers with a dual disorder,

OR

40% of the total consumer caseload

Research suggests that the rate of comorbid substance use among adults with SMI is between 40 – 60%. Rates may be higher in select areas (e.g., inner city) and/or select population may be the focus of the team; thus, higher rates reported by team should be used in lieu of the 40% estimate.

EP1. Full Responsibility for Dual Disorder Services:

The team reported that 29 of 49 (59%) consumers have a DD. Of those 29, 22 (76%) are reportedly receiving group and/or individual DD services from team (tentative "4" rating).

However, the evaluators judged this to be an overestimate given the following information:

- 5 of 6 reviewed charts were of consumers with a DD. However, only 3 of these 5 charts had a progress note reflecting a DD service.
- Other team members commented on their limited role in providing any substance use services.

1	2	3	4	5
Less than 20% of consumers in need of dual disorders treatment are receiving them from the team	20 - 49% of consumers in need of dual disorders treatment are receiving them from the team	50 - 74% of consumers in need of dual disorders treatment are receiving them from the team	75 - 89% of consumers in need of dual disorders treatment are receiving them from the team	90% or more of consumers in need of dual disorders treatment are receiving them from the team

EP4. Integrated Dual Disorder Treatment Model

Definition: The FULL TEAM uses a stage-wise treatment model that is non-confrontational.

Rating Guidelines: This item is intended to be a rough measure of the team's adherence to the IDDT model, both philosophically (i.e., do they embrace these principles within their core belief set) and in practice (i.e., they apply these principles in their work with consumers). Judgment of whether a specific criterion is Fully vs. Partially met should consider multiple data sources. This item is focused on the practice/beliefs of entire team. As it's unlikely that you'll be able to interview each team member, use team leader interview as primary data source, but also consider information gathered from substance abuse specialist, other clinicians, progress notes, and discussions observed during daily team meeting.

EP4. IDDT Model: Collected Data (PT 1)

[Refer to "Item Rating" Handout]

Team Leader Interview:

What treatment model does the team use to treat consumers with dual or co-occurring disorders? *We try to work with people where ever they are at in their use, not pushing them towards abstinence if they are not wanting to stop using. This way of thinking has been a shift for some of us, but I think we all embrace the importance of using non-confrontational approaches and paying attention to where someone is at in their readiness to make a change in their use. So it sounds like you are familiar with a stage-wise approach to substance use treatment... Can you give some examples of how your program uses this approach?* *We try to use motivational interviewing when working with consumers who are not quite ready to stop using. (Can you tell me more about that?) We try to help people develop a better understanding of the pros and cons of using.*

EP4. IDDT Model: Collected Data (PT 2)

If someone is interested in reducing or stopping their substance use, what types of interventions would you use to assist them? *We'd help them look at their environment, to see what may need to change in regard to person, places, and things supporting their use. We would also focus on helping them develop coping skills to manage cravings, maybe connect them to a local AA or NA group. If medical detox was in order, we would help them get admitted to a local program.*

What are some examples of harm reduction tactics your team has used with consumers? *(pause) One of our consumers, Joe, was wanting to lose weight and as part of this plan he wanted to cut back on beer. We helped him develop a chart that monitored his food and beverage intake, and tracked it across time. (Great, any other examples?) Not that I can think of right now.*

EP4. IDDT Model: Collected Data (PT 3)

SA Specialist Interview:

Could you summarize your fellow team members' views of treating consumers with comorbid substance use problems? *I feel like we are generally all on the same page Using a stagewise approach to treatment. Anyone on team with a noticeable difference of opinion on how to best work with consumers with dual disorders? A nurse and the vocational specialist have at times been in disagreement with myself and other team members. (Prompt for examples) Recently, Tamara was objecting to help an actively using consumer get a job – insisting that the next best step for treatment would be to refer him to a more intensive inpatient facility to address his cocaine use. Jane (nurse) also tends to ignore the fact that many of our consumers do not see their use as a problem.... She spends a lot of time commenting to them about their use. Other team members are supportive of a stagewise model; in fact, another team member helped the one consumer find a job given that Tamara was hesitating to do so.*

EP4. IDDT Model: Collected Data (PT 4)

Clinician interview:

What treatment model does the team use to treat consumers with substance abuse problems? *We focus on what the consumer is wanting, and if they are using, help them see how their use may be getting in the way of what they want. Is confrontation ever used? No, I don't think so. I think we have been working hard to adopt a stage wise approach... using more gentle approaches to help build some awareness and motivation for those in earlier stages of change readiness. Would you say the entire team shares this perspective? Mostly. We have a couple of people who are kind of stuck in the old way of thinking... expecting our consumers to stop using and take a more blunt approach to discussing substance use.*

EP4. IDDT Model: Collected Data (PT 5)

If someone is interested in reducing or stopping their substance use, what types of interventions would you use to assist them? *I'd work with them to process why they are wanting to stop, whether they tried stopping in the past, what seemed to work and not work when they attempted to stop before.... I would help them identify what their triggers are, and how they can cope with negative feelings that arise when they abstain.*

Other data sources:

Charts: *A team member (social worker) initiated a conversation about a consumer's use --- remarking on empty beer bottles in living room --- with a consumer who was clearly in a precontemplative stage of change. This interaction resulted in the consumer getting angry and defensive, eventually asking the team member to leave. Another team member (therapist) appeared to skillfully use motivational interviewing with a consumer, helping consumer identify how housing stability may be a negative consequence of ongoing drug use and her acquaintances.*

EP4. IDDT Model: Collected Data (PT 6)

Observations of daily team meeting: *A consumer who is actively using received team's assistance in locating new apartment. Another consumer who has been sober for a few months received transportation to a AA meeting---the team member commented on discussing money management strategies to minimize relapse risks along the way.*

Other staff/consumer interviews: *The vocational specialist commented on how active substance use would prevent her from "eagerly jumping in" to help with finding work....citing concerns about burning bridges with employers. One consumer noted to the evaluators that she felt like the team has been a little nosy with regard to her "socializing with friends" (later referring to her choice to smoke pot).*

EP4. IDDT Model: Criteria to Rate

Credit (No, Partial, Full)			
Service (The FULL team:)	N	P	F
(1) considers interactions between mental illness and substance abuse;			X
(2) does not have absolute expectations of abstinence and supports harm reduction;			X
(3) understands and applies stages of change readiness in treatment;		X	
(4) is skilled in motivational interviewing;		X	
(5) follows cognitive-behavioral principles.		X	

1	2	3	4	5
Team primarily uses traditional model (e.g. 12-step programming, a focus on abstinence). Criteria not met	Only 1 - 3 criteria are met	4 or 5 criteria are met at least PARTIALLY	Team primarily operates from IDDT model, meeting at 5 criteria, with up to 2 PARTIALLY met.	Team is fully based in IDDT treatment principles, FULLY meeting all 5 criteria (see under definition)

Comparison of Low and High Fidelity ACT Programs

Developing Recommendations: Synthesize Findings and Identify Underlying Themes

- Collected data are used to make finite ratings (criteria and items)
- Easy to provide pointed recommendations organized around each item and respective criteria. However, from team's perspective:
 - Overwhelming – where to begin?
 - Questionably helpful --- “increase frequency of services”
- Instead, review the findings across items and consider underlying themes

Developing Recommendations: Synthesize Findings and Identify Underlying Themes

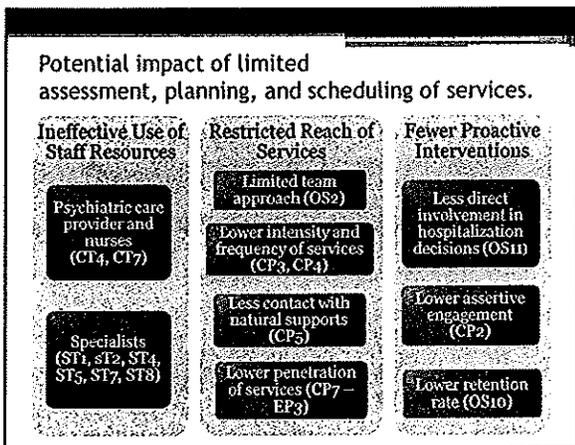
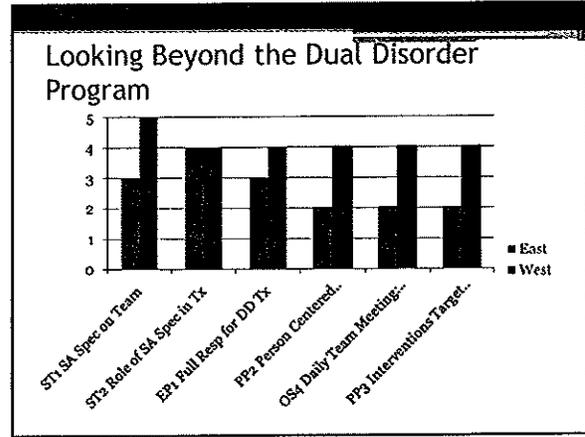
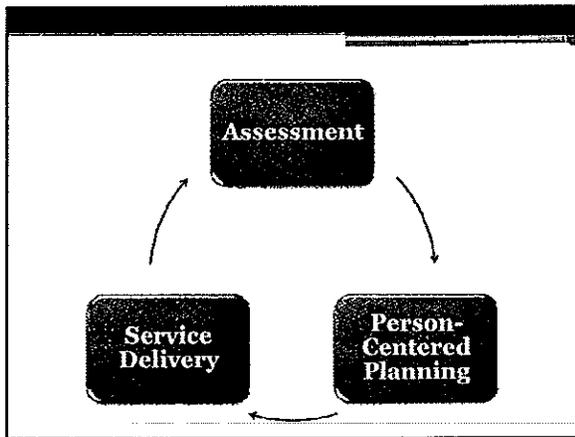
- Evaluation process itself leaves larger impressions.
 - Take a step back from the evaluation and consider what may lead to lower-scoring items
 - Consider the following as possible factors influencing areas of poor performance:
 - Resources (e.g., access to needed equipment, staffing)
 - Skills/Competence (leadership, topic-specific expertise, clinical savvy)
 - Attitudes/Culture (recovery-orientation, openness to change, motivation to deliver best practices)

East ACT Team Evaluation Dual Disorder Program

Item	Final Rating
ST1. Substance Abuse Specialist on Team	3
ST2. Role of Substance Abuse Specialist In Treatment	4
ST3. Role of Substance Abuse Specialist Within Team	4
EP1. Full Responsibility for Dual Disorder Services	3
EP4. Integrated Dual Disorder Treatment (IDDT) Model	3

EAST vs. West ACT Teams
[Refer to Handout East vs West TMACT Ratings]

	EAST ACT	WEST ACT
Operations and Structure	3.7	4.6
Core Team	3.7	5.0
Specialist Team	2.5	4.0
Core Practices	2.8	4.0
Evidence-Based Practices	2.9	4.3
Person-Centered Planning & Practices	2.5	4.3
TMACT Index	3.1	4.4



Better meet consumers' individualized needs via improved assessment, treatment planning, and assignment of staff resources.

- ### Major Recommendation #1: Better meet consumers' individualized needs via improved assessment, treatment planning, and assignment of staff resources.
- 1a. Integrate comprehensive and ongoing assessment into routine practice
 - 1b. Revise the process for developing person-centered treatment plans
 - 1c. Schedule staff assignments according to the more specified consumer treatment plan
 - 1d. Revise daily team meeting processes.

Better specify person-centered plan interventions that will likely advance towards consumers' goals and be a clear direction for day-to-day staff assignments.

Major Recommendation #1: Better specify person-centered plan interventions that will likely advance towards consumers' goals and be a clear direction for day-to-day staff assignments.

- 1a. Individual Treatment Teams (ITTs) assume lead responsibility for assessment and treatment planning processes.
- 1b. Revise Daily Team Meeting processes to better ensure planned treatment interventions are provided.

1a. Individual Treatment Teams (ITTs) assume lead responsibility for assessment and treatment planning processes.

- The ITT, rather than the primary care provider and/or entire team, works together to pull together assessment data and develop interpretive summary
- ITT drafts tentative plan, drawing from previous contacts with consumer and knowledge of what s/he wants, and presents to consumer and natural supports for revision/endorsement.
- Plan includes highly specific content about the who, what, when of interventions

1b. Revise Daily Team Meeting processes to better ensure planned treatment interventions are provided.

- Specific information noted in plans are transferred to Consumer Weekly Schedules
- The Daily Team Schedule is developed from these Consumer Weekly Schedules
 - In addition to simply knowing whether a consumer is seen on Tuesday, the entire team should know *why* (what is being addressed; intervention to be delivered), by *who* (Jack, the peer specialist), and *when* (late afternoon)
- Greater specificity of interventions promotes greater alignment with plan, continuity of care, and accountability for team.

Making an Impact: Frame Feedback to Enhance Team's Openness to Recommendations.

- Assume that everyone is striving for the same thing—to better the lives of people served
- Recognize that we all want to believe that we are doing our best
- Emphasize people's strengths before commenting on areas in need of improvement
- Highlight positive changes the team has made in the past
- Normalize areas that are in need of improvement and comment on effects of extraneous factors that the team may have little control over
- Positive reframes: "Areas for improvement," rather than "weaknesses" or "limitations."

In ACT Fidelity Assessment and Consultation

TMACT Evaluators

Ideal qualifications:

- Thorough understanding of ACT
- Independent of the team being evaluated
- Strong interviewing and data collection skills
- Able to synthesize data
- Proficient in QI consultation

Commitment expectations:

- Able to carry out a site-based project
 - Initial contact (pre-fidelity) to final feedback typically spans 3 – 4 months
- Travel to sites
- Onsite for 2 days
- Protected time to complete fidelity report

Who has been serving in this role?

1. Government authorities
2. Training and technical assistance centers
3. Partnership between #1 and #2
 - Washington
 - Maryland
4. ACT Program Leadership (Peer Evaluators)
 - Florida
 - Minnesota

Peer Evaluation Model

- ACT Leadership (team leaders, clinical directors) are trained as TMACT evaluators
- Exchange evaluation services within their network
- Florida project used a Train-the-Trainer model
 - Florida ACT (FACT) leadership were trained by a "Master Trainer."
 - FACT leadership in turn trained other FACT leaders in TMACT evaluations, with ongoing support from "Master Trainer."

Benefits of Peer Evaluation Model

- Shared and/or reduced costs
 - Central authorities rarely have budgets adequate to meet the real needs for monitoring, training, and quality improvement
- Advanced training and skill building
- Perceived credibility of evaluator
- Strengthen network of providers
- Team ownership of & commitment to QI process

Benefits of Peer Evaluation Model

Cost Benefits:

- More cost-effective
- Staff are deployed in evaluator role as needed, rather than maintaining a steady FTE
- Shared costs
 - Grant money supported training and ongoing support
 - Government authorities financed travel expenses
 - MH agencies released staff from work to conduct evaluations

Competency Benefits:

- Enhanced understanding of ACT
- Develop expertise when made the expert
- Shadowing one of the more effective training mechanisms
- Opportunities for immediate transfer of specific knowledge (e.g., observe an innovative practice used in one site, apply to others)

Benefits of Peer Evaluation Model

Credibility Benefits:

- ACT Peer Evaluators *may* be perceived as:
 - Having a better understanding of real-world ACT, along with ideal ACT, per TMACT
 - Having greater empathy for the struggles of community work and navigating the larger system
 - More motivated to help, than to punish

Coalition Benefits:

- Networking among peers
- Development of a more formal Learning Collaborative
- Using TMACT data to identify common areas of need, which in turn influence local trainings

Limitations of Peer Evaluation Model

- Costs!
 - Training and travel
- Peer selection process may be difficult
 - Meets, or has potential to meet, "ideal characteristics"
 - Respected by peers
 - Is centrally located
- Peer evaluator turn over
- Agencies may carve-out time for staff, but peer evaluators state that the day-to-day demands eat up that protected time to complete off-site tasks

Proposed Solutions: Strengthening the Peer Evaluation Model

- More efficient use of peer evaluator time
 - Pilot-testing a Team Leader phone interview to reduce onsite evaluation time
 - Developing strategies that lend to immediate consensus ratings and report development
 - Abbreviating report development time
 - Structured TMACT Report Template
 - Standardizes feedback process
 - Reduces writing time
 - Begin completing at the time of consensus ratings

Proposed Solutions: Strengthening the Peer Evaluation Model

- Decrease Training Costs
 - Develop more web-based training options to supplement more limited in-person training
 - Continue to invest in a Train-the-Trainer model
 - Expanding the scope of the network reduces travel time and diffuses costs across programs.
- Develop a partnerships between peer evaluators and government authorities and/or TA staff
 - Added benefit of different perspectives and skill sets
 - Non-ACT staff better able to “manage” the evaluation project given typical job duties
 - Formal authority ensures accountability for process

Other Evaluation Model Considerations: Clarifying Roles and Responsibilities

- TMACT evaluation purpose
 - Auditing, performance improvement, or both?
 - Essential component of CQI process, also including outcome measurement/monitoring
 - Participation in practice-based research
- Distribution of TMACT results
 - What is shared with whom, and when
 - Entire report, summary of ratings, total TMACT rating
 - Immediately following the review or after all teams in region are reviewed?

Looking Ahead: Proposed Next Steps

- Development of web-based training tools
- Articulation of support platform/model for TMACT training and utilization, including:
 - More explicit incorporation of learning collaborative strategies
 - Strategies for efficient use of TMACT over time
- Expansion of research collaboration
 - Multi-state fidelity/implementation/outcomes
 - Fidelity measure refinement

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