

**Fidelity & Quality Improvement:
Applications of the TMACT**

Gregory B. Teague, Ph.D.
*Louis de la Parte
Florida Mental Health Institute
University of South Florida*

Maria Monroe-DeVita, Ph.D.
*The Washington Institute for
Mental Health Research & Training
University of Washington
School of Medicine*

Lorna Moser, Ph.D.
*Services Effectiveness
Research Program
Duke University
School of Medicine*

27th Annual Assertive Community Treatment Conference
Chicago, IL
June 18, 2010

Overview of Today's Presentation

1. What is fidelity and why does it matter?
2. DACTS to TMACT: How did we get here and what was changed?
3. Overview of the TMACT
4. Pilot studies of TMACT reliability and validity
5. Applying the TMACT for QI purposes in several states
6. Re-examining the relationship between fidelity and outcomes
7. Conclusions & next steps

Program Fidelity

What is it & why does it matter?

Fidelity: An overview

- Definition: The degree to which a program includes features that are critical to achieving the intended outcomes
- Many purposes of fidelity measures
 - Our focus: To guide quality improvement efforts
- Fidelity is positively correlated with outcomes
 - More cost-effective (Latimer, 1999)
 - Decreases hospital days (McHugo et al., 1999)
- Provides a 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

Example DACTS Item:
04. Responsibility for Crisis Services

Domain	Rating				
	1	2	3	4	5
Responsibility for Crisis Services	Not responsible for handling crises after hours	Emergency service has program-generated protocol	Program available by phone; consult role	Program provides emergency service backup	Program provides 24-hour coverage

DACTS Concerns

- Original intent: multi-site study of ACT for COD
- No ACT program manual available when developed
- Little grounding in program theory
- Doesn't fully match up with the National ACT Standards
- Focus is on structure vs. process
- Specific measurement gaps:
 - Recovery-oriented practices (vs. medical model)
 - Team functioning (vs. team structure)
 - Staff roles (e.g., vs. staff FTE)
 - Specific treatment & rehabilitation interventions
 - Recalibration of some items

From DACTS to TMACT

How did we get here (TMACT)
from there (DACTS)?

Washington State ACT Implementation

- WA richly funded 10 ACT teams in 2007
- WA chose & adapted National ACT Standards
- Needed to address concerns about a potentially coercive or paternalistic model
- Rich training & TA with focus on:
 - Promoting a culture of recovery within teams on Day 1
 - Getting ACT basics down, but quickly moving to clinical skill-building (e.g., MI, IDDT, SE)
- Speaks to need for a fidelity tool that captures these essential processes
- Implications outside of WA State

Our approach to scale development

- Applied the DACTS template & approach
- Crosswalked WAACT Standards with DACTS
- Built on the initial work of ACT Center of Indiana
- Worked collaboratively with national experts on core content development
- Ongoing Vetting & Feedback:
 - Practicing ACT clinicians
 - National experts in related areas
 - Fidelity reviewers who piloted the scale
 - Interested & future pilot sites
- Piloted 52-item version with 2 WA teams; refined through further piloting in WA, PA, NY, NE, & FL

Our Aims

- Better assess processes consistent with high fidelity ACT
 - Recovery-oriented services
 - Evidence-based practices
 - Functions promoting a transdisciplinary team
- Improve the reliability and validity of the assessment
 - Minimize subjectivity
 - Offer more guidance with concrete examples and decision rules
- Create a more nuanced measure of ACT
 - Distinguish between low, moderate, and high fidelity ACT teams

The Tool for Measurement of ACT (TMACT)

What did we change & why?

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

13

Summary of Items Added

- **Evidence-based practices**
 - ACT is a platform for delivering comprehensive services
 - Many effective services available for adults with severe mental illness
- **Staffing roles in treatment and within team**
 - A warm, qualified body not enough!
 - More specification about what services are to be delivered
 - Creating a true transdisciplinary team
- **4 items assessing person-centered planning practices**
 - If misused, ACT services have the potential for being coercive and paternalistic.
 - Operating from a recovery model arguably epitomizes high fidelity ACT

The Tool for Measurement of ACT (TMACT)

What does it look like?

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
 - Includes 1 Supportive Housing item under development
 6. Person-Centered Planning Practices (PP): 4 items

14

Operations & Structure (OS)

- OS1. Low Ratio of Consumers to Staff
- OS2. Team Approach
- OS3. Daily Team Meeting (Frequency & Attendance)
- OS4. Daily Team Meeting (Quality)
- OS5. Program Size
- OS6. Priority Service Population
- OS7. Active Recruitment
- OS8. Gradual Admission Rate
- OS9. Graduation
- OS10. Retention Rate
- OS11. Coordination of Hospitalization
- OS12. Dedicated Office-Based Program Assistance

17

OS4. Daily Team Meeting (Quality): Team uses its daily team meeting to: (1) Conduct a brief, but clinically-relevant review of all consumers & contacts in the past 24 hours AND (2) record status of all consumers. Team develops a Daily Staff Assignment Schedule for the day's contacts based on: (3) Weekly Consumer Schedules, (4) emerging needs, AND (5) need for proactive contacts to prevent future crises; (6) Staff are held accountable for follow-through.

1	2	3	4	5
Daily team meeting serves no more than 1 function	Meeting FULLY serves 2 functions	Meeting FULLY serves 3 functions	Meeting FULLY serves 4 or 5 of the functions.	Daily team meeting FULLY serves ALL 6 functions (see under definition).
OR	OR	OR		
2 functions served, at least PARTIALLY.	3 functions served, at least PARTIALLY.	5 functions served, at least PARTIALLY.		

Core Team (CT)

- CT1. Team Leader on Team
- CT2. Team Leader is Practicing Clinician
- CT3. Psychiatric Care Provider on Team
- CT4. Role of Psychiatric Provider (In Treatment)
- CT5. Role of Psychiatric Provider (Within Team)
- CT6. Nurses on Team
- CT7. Role of Nurses

CT4. Role of Psychiatric Care Provider (In Treatment): In addition to providing psychopharmacologic treatment, the psychiatric care provider serves the following functions in TREATMENT: (1) typically meets with consumers at least monthly to conduct assessment of consumers' symptoms & response to medications, including side effects; (2) provides brief therapy; (3) provides medication education to consumers; (4) monitors all consumers' non-psychiatric medical conditions and non-psychiatric medications; (5) if consumers are hospitalized, communicates directly with consumers' inpatient psychiatric care providers to ensure continuity of care; & (6) conducts home/community visits.

1	2	3	4	5
Psychiatric care provider performs no more than 2 functions total.	Psychiatric care provider performs 3 or 4 functions.	Psychiatric care provider performs 4 functions, which include function #1 OR performs 5 functions (#2 - #6).	Psychiatric care provider performs 5 functions, which includes function #1.	Psychiatric care provider performs ALL 6 treatment functions (see under definition).

CT5. Role of Psychiatric Care Provider (Within Team): 1) supervises the psychiatric treatment of consumers on the team; (2) educates non-medical team members on medications and their side effects; (3) attends majority of treatment planning meetings; (4) attends daily team meetings in proportion to time allocated on team; (5) actively collaborates with RNs; and (6) provides psychiatric back-up to the program after-hours and weekends.

1	2	3	4	5
Psychiatric care provider performs no more than 2 team functions.	Psychiatric care provider performs 3 team functions.	Psychiatric care provider performs 4 team functions.	Psychiatric care provider performs 5 team functions. If two providers, ONE must perform these 5 team functions & there is a mechanism for communication between providers.	Psychiatric care provider performs ALL 6 team functions. If two providers, ONE must perform all 6 team functions & there is a mechanism for communication between providers.

Specialist Team (ST)

- ST1. Substance Abuse Specialist on Team
- ST2. Role of SA Specialist (In Tx)
- ST3. Role of SA Specialist (Within Team)
- ST4. Vocational Specialist on Team
- ST5. Role of Voc Specialist (In Employment Services)
- ST6. Role of Voc Specialist (Within Team)
- ST7. Peer Specialist on Team
- ST8. Role of Peer Specialist

ST8. Role of Peer Specialist: (1) coaching and consultation to consumers to promote recovery and self-direction (e.g., preparation for role in treatment planning meetings); (2) facilitating wellness management strategies (e.g., WRAP, IMR); (3) full participation in all team activities (e.g., tx planning, chart notes); and (4) cross-training of other team members in recovery principles and strategies.

1	2	3	4	5
No Peer Specialist staffing on team OR Peer Specialist does not perform any of the 4 functions within the team.	Peer Specialist FULLY performs 1 function within the team OR 2 functions, at least PARTIALLY.	Peer Specialist FULLY performs 2 functions within the team OR 3 - 4 functions, at least PARTIALLY.	Peer Specialist FULLY performs 3 functions within the team.	Peer Specialist FULLY performs ALL 4 functions within the team (see under definition).

Core Practices (CP)

- CP1. Community-Based Services
- CP2. Assertive Engagement Mechanisms
- CP3. Intensity of Service
- CP4. Frequency of Contact
- CP5. Freq. of Contact with Natural Supports
- CP6. Responsibility for Crisis Services
- CP7. Full Responsibility for Psychiatric Services
- CP8. Full Responsibility for Rehab Services

CP8. Full Responsibility for Rehabilitative Services: Rehab. services are directly provided by the ACT team rather than by an external program or provider. These services include: social & communication skills training, functional skills training to enhance independent living (e.g., activities of daily living, meals, safety planning, chores), transportation planning/navigation skill building, & money management.

1	2	3	4	5
Less than 30% of consumers in need of rehabilitation services are receiving them from the team.	30 - 59% of consumers in need of services are receiving them from the team.	60 - 79% of consumers in need of services are receiving them from the team.	80 - 89% of consumers in need of services are receiving them from the team.	90% or more of consumers in need of rehabilitation services are receiving them from the team.

Evidence-Based Practices (EP)

- EP1. Full Responsibility for DD Services
- EP2. Full Resp. for Vocational Services
- EP3. Full Resp. for Wellness Management
- EP4. Integrated Dual Disorders Tx Model
- EP5. Supported Employment Model
- EP6. Engagement & Psychoeducation w/ Natural Supports
- EP7. Empirically-Supported Psychotherapy
- EP8. Supportive Housing Model (new!)

EP4. Integrated Dual Disorders Tx (IDDT) Model: The FULL TEAM (1) considers interactions between mental illness and substance abuse; (2) follows cognitive-behavioral principles; (3) does not have absolute expectations of abstinence and supports harm reduction; (4) understands and applies stages of change readiness in treatment; and (5) is skilled in motivational interviewing.

1	2	3	4	5
Team primarily uses traditional model. (e.g., 12-step programming, focus on abstinence). Criteria not met.	Only 1 - 2 criteria are met.	Only 3 criteria are met.	Team primarily operates from IDDT model, meeting 4 criteria.	Team is FULLY based in IDDT treatment principles and meets all 5 criteria (see under definition).

EP6. Engagement & Psychoeducation with Natural Supports: The FULL TEAM works in partnership with consumers' natural supports. As part of their active engagement of natural supports, team (1) provides education about their loved one's illness; (2) teaches problem-solving strategies for difficulties caused by illness; and (3) provides &/or connects natural supports with social & support groups.

1	2	3	4	5
Team does not use any of the specified strategies with consumers' natural supports.	Team uses 1 or 2 specified strategies with consumers' natural supports.	Team uses 3 specified strategies with consumers' natural supports, but 2 strategies are only PARTIALLY provided.	Team uses 3 specified strategies with consumers' natural supports, but 1 strategy is only PARTIALLY provided.	Team works in partnership with consumers' natural supports and engages them using ALL 3 strategies (see under definition).

Person-Centered Planning Practices (PP)

- PP1. Strengths Inform Treatment Plan
- PP2. Person-Centered Planning
- PP3. Interventions Target a Broad Range of Life Goals
- PP4. Consumer Self-Determination & Independence

PP2. Person-Centered Planning: Includes: (1) development of formative treatment plan ideas based on initial inquiry and discussion with consumer; (2) conducting regular treatment planning meetings; (3) attendance by key staff, consumer, & anyone else s/he prefers, tailoring number of participants to fit with the consumer's preferences; (4) meeting is driven by consumer's goals & preferences; & (5) provision of coaching & support to promote self-direction and leadership within the meeting, as needed.

1	2	3	4	5
Team provides no more than 1 element of person-centered planning OR 1 element provided, at least PARTIALLY.	Team FULLY provides 2 elements of person-centered planning OR 2 elements provided, at least PARTIALLY.	Team FULLY provides 3 elements of person-centered planning OR provides 4 elements, at least PARTIALLY.	Team FULLY provides 4 elements of person-centered planning.	Team FULLY provides ALL 5 elements of person-centered planning (see under definition).

TMACT Protocol: This is the scale!

- Part I: Introduction
 - Checklists to prepare for fidelity reviews
 - Methods
 - Reporting guidelines
- 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
 - Tables & checklists
 - Case examples
 - Formulae for ratings
- Part III: Appendices
 - All additional forms

Checklist review forms, etc.

OS1. Low Ratio of Consumers to Staff : Team maintains a low consumer-to-staff ratio of 10:1, including all direct service staff.					
DATA SOURCES					
Team	See item #2: # of full-time ACT staff. See item #8: # of consumers presently served				
Survey:					
ITEM RESPONSE CODING					
Inclusion Criteria:	<ul style="list-style-type: none"> • ACT Staff: Count all staff who provide direct services (substance abuse specialist, vocational specialist, and team leader) EXCEPT the psychiatric care provider. Part-time or temp staff must work exclusively with the team for at least 16 hrs/wk & attend the daily team meeting at least 2x per week. • Consumers: In counting the current caseload, include all "active" or "enrolled" consumers. The caseload totals should include any consumer who has been formally admitted, even if it is as recent as the last week. This count should NOT exclude consumers currently enrolled on the team who are difficult to engage and have not had recent contact with the team. The definition of active status is determined by the team, but note that the count will affect other fidelity items, such as frequency of visits. 				
Exclusion Criteria:	<ul style="list-style-type: none"> • Do not include psychiatric prescriber in count. • Do not include administrative support staff, such as the program assistant or other managers assigned to provide administrative oversight to the team. • Do not count staff who are technically employed by the team but who have been on extended leave for <u>3 months</u> or more. 				
Formula:	(# CONSUMERS PRESENTLY SERVED) / (# FTE STAFF)				
OS1. Low Ratio of Consumers to Staff	1	2	3	4	5
	26 consumers per team member or more.	19-25	14 - 18	11-13	10 consumers per team member or fewer.

ST3. Role of Substance Abuse Specialist (Within Team) : Substance abuse specialist serves the following functions WITHIN THE TEAM: (1) modeling skills & individual consultation; (2) cross-training other team members to help them identify substance use issues, monitor progress in treatment, & provide stage-wise treatment for dual disorders; (3) attending all daily team meetings & (4) attending all treatment planning meetings for consumers with dual disorders.					
DATA SOURCES (* Denotes primary data source)					
Substance Abuse Specialist Interview*	How often do you attend the daily team meetings? Do you ever attend treatment planning meetings for the consumers? How do you select the ones you attend? Have you provided more formal trainings on assessment and stage-wise treatment interventions to the team? When, how often, what was the topic?				
Clinician Interview:	Do you ever provide more individual consultation with team members? Ask for an example. How has your work with consumers been influenced by the substance abuse specialist?				
ITEM RESPONSE CODING					
General Frequency Guidelines:	<ul style="list-style-type: none"> • Cross-training: Provided in the past 6 months • Consultation: Provided at least monthly • Attendance at Daily Team Meetings: Evidence that there is regular attendance at all daily team meetings (except pre-planned activities that conflicted with meeting). • Attendance at Treatment Planning Meetings: Attendance at vast majority of treatment planning meetings for consumers with dual disorders. 				
Rating Guidelines:	Use interview with the substance abuse specialist as primary data source. Cross-reference with interview with clinician. Reconcile any discrepancies with follow-up questions with team leader.				
ST3. Role of Substance Abuse Specialist (Within Team)	1	2	3	4	5
	No substance abuse specialist staffing on the team OR does not perform any of the 4 functions.	Substance abuse specialist performs PARTIALLY 1 or 2 functions within the team.	Substance abuse specialist performs 2 functions within the team.	Substance abuse specialist performs 3 functions within the team.	Substance abuse specialist performs ALL 4 functions within the team.

OS9. Graduation	
Criteria	Guidelines & Examples
(1) Team conducts regular assessment of need for ACT services	<ul style="list-style-type: none"> • Team members regularly assess for readiness for graduation and improvement across all areas of clinical and role functioning. • Team includes discussion about consumer's readiness for transition from ACT as part of their regular treatment plan reviews. • Team may use a level of care system to categorize consumer readiness for discharge & regularly review as a team or IIT.
(2) Team uses explicit criteria or markers for need to transfer to less intensive option.	<ul style="list-style-type: none"> • Use of fewer or less intensive services such as hospitals or emergency rooms • More independent functioning in major role areas (e.g., work, social, self-care)
(3) Transition is gradual & individualized, with assured continuity of care	<ul style="list-style-type: none"> • Gradual transition may begin with a "Transition Group," comprised of other ACT consumers who are getting ready for graduation. • Consumer may try out services in another program for brief periods of time (e.g., a few hours or one day) while still receiving ACT services. • Team should have some mechanism for communicating with transition service provider. • Even when consumer transitions, there are mechanisms for him/her to contact the ACT team.

OS9. Open-Ended Services/Graduation (Continued)	
Criteria	Guidelines & Examples
(4) Status is monitored following transition, per individual need.	<ul style="list-style-type: none"> • Team continues to communicate with transition service provider regarding consumer's status. NOTE: These do not have to be formal meetings, but need to at least be some form of checking in on the consumer's status. • If needed, team members visit consumer to assess status in transition services after graduation.
(5) There is an option to return to the team as needed.	<ul style="list-style-type: none"> • Team may reserve 1-2 slots for re-enrollment of consumers who graduate from the program for a limited period of time (e.g., 3 months post-discharge from ACT).

Examples of Stage-Wise Substance Abuse Treatment Interventions			
Early Stages of Change Readiness		Later Stages of Change Readiness	
Pre-Contemplation	Contemplation and Preparation	Action	Maintenance
Consumer does not recognize that s/he has a problem with substance use or has no interest in modifying use at this time. Focus of treatment is outreach, assessment, and building a working alliance. Services are provided regardless of ongoing use.	Consumer recognizes that substance use is causing some problems & is considering a change. Contemplation Stage : Consumer is more aware about the pros & cons, but ambivalent about change. Preparation Stage : Consumer is planning for change. Focus of treatment is education about substances, mental illness, & their interactions, and identifying pros & cons of use. Motivational interviewing techniques: <ul style="list-style-type: none"> • Express empathy • Offer reflective listening • Assist with goal-setting • Develop discrepancy between goals & substance use • Develop pros & cons • Roll with resistance • Emphasize personal choice 	The consumer is committed to reducing or discontinuing substance use. Focus of treatment is helping her/him make change & sustain it: <ul style="list-style-type: none"> • cognitive-behavioral therapy • managing social environments • identifying & managing triggers and cravings • relapse/ coping skills • money management to avoid using • problem solving to reduce stress 	The consumer has abstained from substance use for at least 6 months. Focus of treatment is maintaining abstinence: <ul style="list-style-type: none"> • develop a relapse prevention plan • help consumer attend self-help groups • help build and maintain social supports for sobriety • maintain awareness of vulnerability to relapse • help expand recovery to other areas of life (parent group, vocational supports)

Fidelity Review Method

- Review in pairs of two; independent ratings & consensus on final team rating
- Currently takes 1.5 days per fidelity review
- Primary data sources:
 - Team survey & Excel spreadsheet (before review)
 - Observation of daily team meeting & treatment planning meeting
 - Chart review (random selection of 10)
 - Interviews with most staff
 - Interviews with consumers (3-5)
- Use enhanced protocol & data collection forms
- Feedback targets performance improvement

Training & Supervision of Reviewers

- Training on ACT – need to know the model! *Train the Trainer*
- Orientation to TMACT protocol
- Conduct evaluations
 - Sit in on 1-2 fidelity assessments, participating side-by-side with fidelity reviewers
 - Participate in consensus ratings during training
 - Team up with an experienced fidelity reviewer for first independent reviews
- Peer review of fidelity ratings & reports
 - Check accuracy of ratings and quality of item-level feedback
 - Provide coaching in how to synthesize data to make meaningful recommendations
- Maintaining and improving quality of evaluation process
 - Assessor training and work performance checklist (ACT Toolkit)
 - Booster training to prevent drift

Written Reports: Mastering the Skill of Providing Thoughtful Feedback

- Comprehensive written reports (20 – 30 pages)
 - Item level ratings with some feedback and rating justification
 - Synthesized feedback on the team's strengths and areas recommended for improvement.
- Feedback provided at both the macro and micro level
 - Review data to identify major themes that capture areas in need of improvement
 - Major areas of improvement may not be directly assessed by the TMACT, but if remedied, will have an impact across several items.

Examples of Major Themes from one report:

- Expand the scope of individualized, evidence-based services delivered to ACT consumers
- Refocus team member's efforts towards the consumers who would benefit most from their particular area of expertise and/or therapeutic relationship.
- Develop greater team cohesion so that the full array of team resources are being accessed, and team members' practice philosophies both compliment and correct one another.

Written Reports: Mastering the Skill of Providing Thoughtful Feedback

Example of micro-level feedback subsumed under major theme:

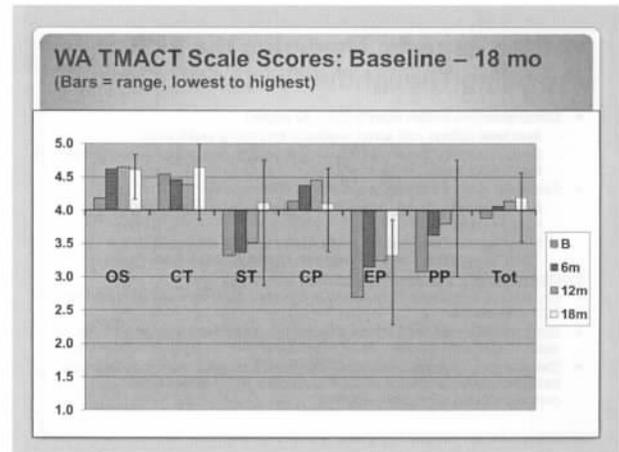
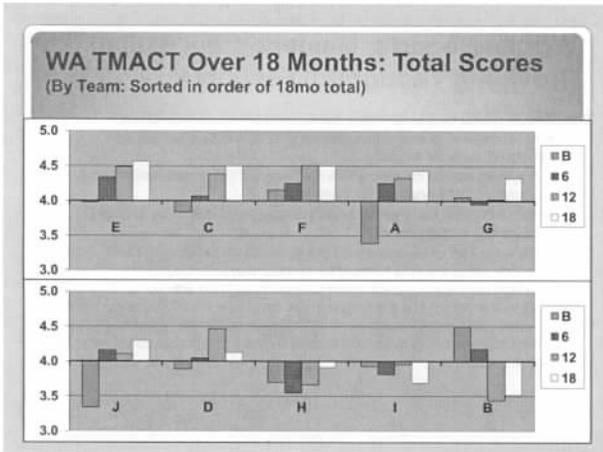
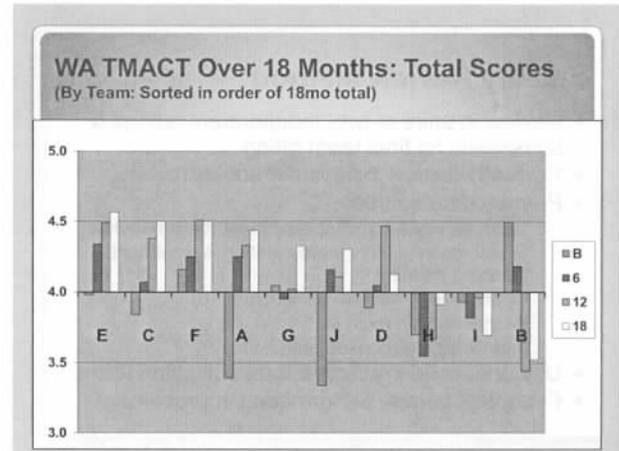
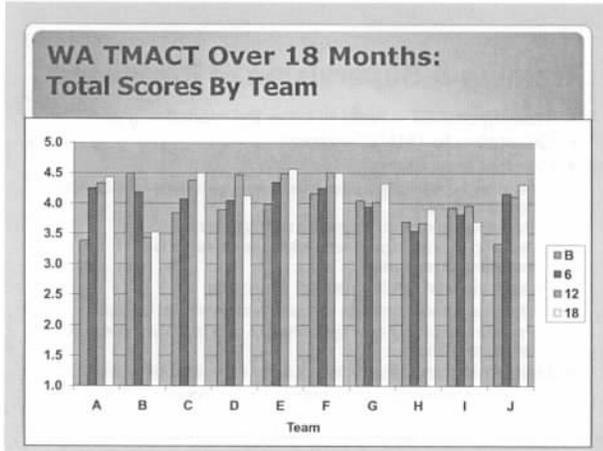
- We recommend re-evaluating the use of Wednesday afternoons for paperwork days for all staff.
- A system can be created where staff request paperwork time when it becomes more pressing for them to have it.
- A rotating shift management role can also provide time for staff to get caught up on paperwork.
- If a large part of paperwork demands center on developing plans, then try to fully utilize the ITTs to meet for an hour weeks before a plan is due, to sketch out the plan given conversations they'd had with consumer leading up to this point. The meeting with the consumer then becomes more a review, where the consumer modifies the tentative plan already drafted. This process tends to reduce burden for the primary care coordinator for that consumer.

Piloting the TMACT

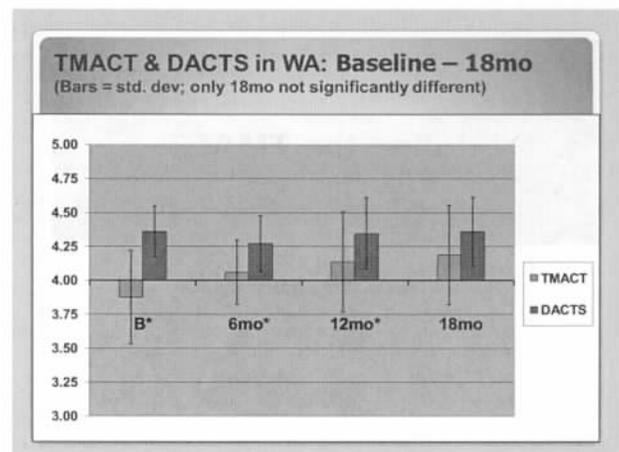
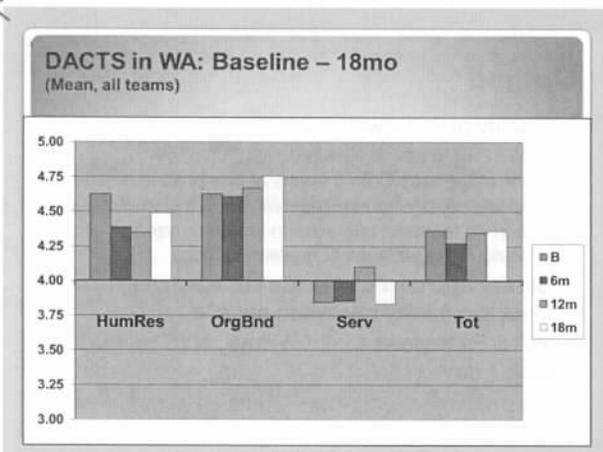
What have we found so far?

Method

- Fidelity reviews with TMACT in three states:
 - WA: 10 teams at baseline, 6m, 12m, 18m
 - PA (Allegheny Co): 6 teams at one point in time (analyzed at various stages/ages of implementation)
 - NY: 49 teams at one point in time (analyzed at various stages/ages of implementation)
- Similar approaches to data collection, using at least two fidelity reviewers per site
- WA & PA reviews took 1½ days; NYS reviews took 1 day

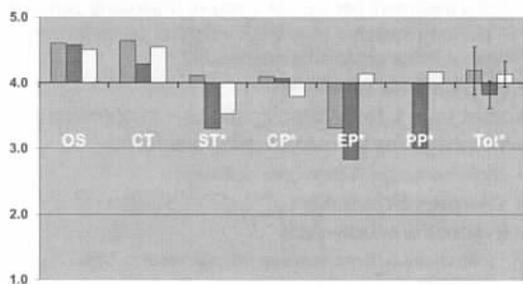


Comparisons



TMACT in Three States

(* = Significant variance among States)



Applying the TMACT for Quality Improvement

Our experience in several states

Themes Across States

- Recently piloted TMACT in WA, NE, FL, & PA
- Varied plans for using TMACT for QI purposes
 - State-driven QI vs. QI at local level
 - Some tied to outcomes
- Varied selection of trainees/fidelity reviewers
 - ACT team members and/or outside entities
- Generally consistent training model
 - 1-day orientation to the TMACT (some orientation to ACT model if needed)
 - 1½ days side-by-side training during fidelity review
 - Group consensus ratings & report peer-review
 - Repeated at least 1x per training cohort
- Varied approaches to training sustainability

State of Washington

- 10 teams statewide
- Primary goal: QI (with some tie to contracts)
 - Driven by the State
 - University provides training & TA to teams
- Trainees/fidelity reviewers:
 - Trained 7 reviewers statewide
 - Two reviewers per review: 1 State rep; 1 university rep
- Training model consistent w/ previous description
- University provides booster training of reviewers
- Plan to tie fidelity review data to outcomes – collected separately, analyzed by UNC

State of Nebraska

- Three teams statewide
- Primary goal: QI
 - Driven by the State
 - Plan to bring in consultants for ongoing training/TA
- Trainees/fidelity reviewers:
 - State ACT lead staff, MCO, local regions, Medicaid & team leaders
 - Future reviews will likely include team leaders
- Training model consistent w/ previous description (x3)
- Discussed ways to apply fidelity tools to collect some outcome data

State of Florida

- 31 teams statewide; 10-year history; tight funding
- Goal 1: QI via peer-review/consultation network
 - State: requested evaluation; facilitates; modest support
 - University provides initial training in fidelity evaluation
- Goal 2: Determine outcomes & relation to fidelity
 - Plan to link fidelity & outcomes: multiple databases, consumer survey; control group; University analyzes
- Trainees/fidelity reviewers statewide:
 - 5 trainee/trainer-reviewers; 8 more trainee-reviewers
 - Two reviewers per review: mostly team leaders
- Training model generally consistent w/ previous description, cascading to 2nd-generation trainees

Why Do We Bother?

- We still have something of a black box problem
 - Need to learn more about how ACT functions
- Recent research shows smaller effect sizes, e.g.,
 - UK studies – integrated community care, principally hospitalization outcomes
 - ICM – fewer specialists, higher caseloads
 - Specific EBPs (IDDT, SE)
- Possible sources of difference
 - Context: policies; community/culture; treatment system differences (including improvements in practices)
 - Selection: not all consumers should be recruited
 - Suboptimal implementation (poor fidelity)

Not seeing that ACT has sig. advantage

Suboptimal Implementation?

- Background: ACT...
 - Not a treatment per se, but a way of organizing services
 - A platform intended to accrete whatever contemporary best-practice treatments are needed
 - Needs to keep up with field
- Inadequate fidelity specifications – in combination with incentives – weaken potential for...
 - Implementation & thus care delivered
 - Recovery for consumers
 - Evidence of effectiveness
 - Inferences & conclusions re: program design, best practices

Possible Transformal Factors
 • Recovery oriented
 • Flexible, ind. app of evidence
 • Provider teams + community

Needed

- Adequate standardized measure of features theorized to be critical
- Participation across multiple settings / states
- Compatible measures of a range of outcomes
- Integrated analysis
 - Program processes, consumer characteristics, service system context, outcomes
 - Intent: identify empirically critical features and relationships to context & person variables
- Evidence to support and/or help reevaluate
 - Organizational, treatment, & boundary features
 - Person /program matching

Next Steps

Where do we go from here?

Next Steps

- Minor changes & call it done (for a while...)
- Continue current use & extend
 - WA (30-mo. reviews) & other states
 - Additional regions, states, countries
- Prepare/refine training materials & protocol
- Intended research (with additional support)
 - Fidelity measurement: reliability/validity; value added
 - Outcome research as described
- Enduring questions
 - ACT: benefit/cost; absorption of new technology
 - Fidelity: models; methods, intensity, timing

Summer this year

We Wish To Thank...

- Our initial funders at the Washington State Mental Health Division
- Our colleagues in PA: Kim Patterson, MSW & Emily Heberlein, MS - Allegheny HealthChoices, Inc., PA
- Our colleagues in NY: Molly Finnerty, MD, Jennifer Manuel, PhD, Candice Stellato, MSEd, & Ana Zanger – New York State Psychiatric Institute, Office of Mental Health
- Washington State ACT Fidelity Reviewers:
 - Robert Bjorklund, LICSW, MPA
 - Shannon Blajeski, MSW
 - Casey Jackson, MSW
 - Trevor Manthey, MSW
 - Diane Norell, MSW
 - David Reed, MAT
 - Summer Schultz, M.Ed.
 - Bill Voss, Ph.D.
 - Yura Yasui, Ph.D.