USING ACT FIDELITY REPORTS TO IMPROVE PROCESSES THAT DRIVE OUTCOMES

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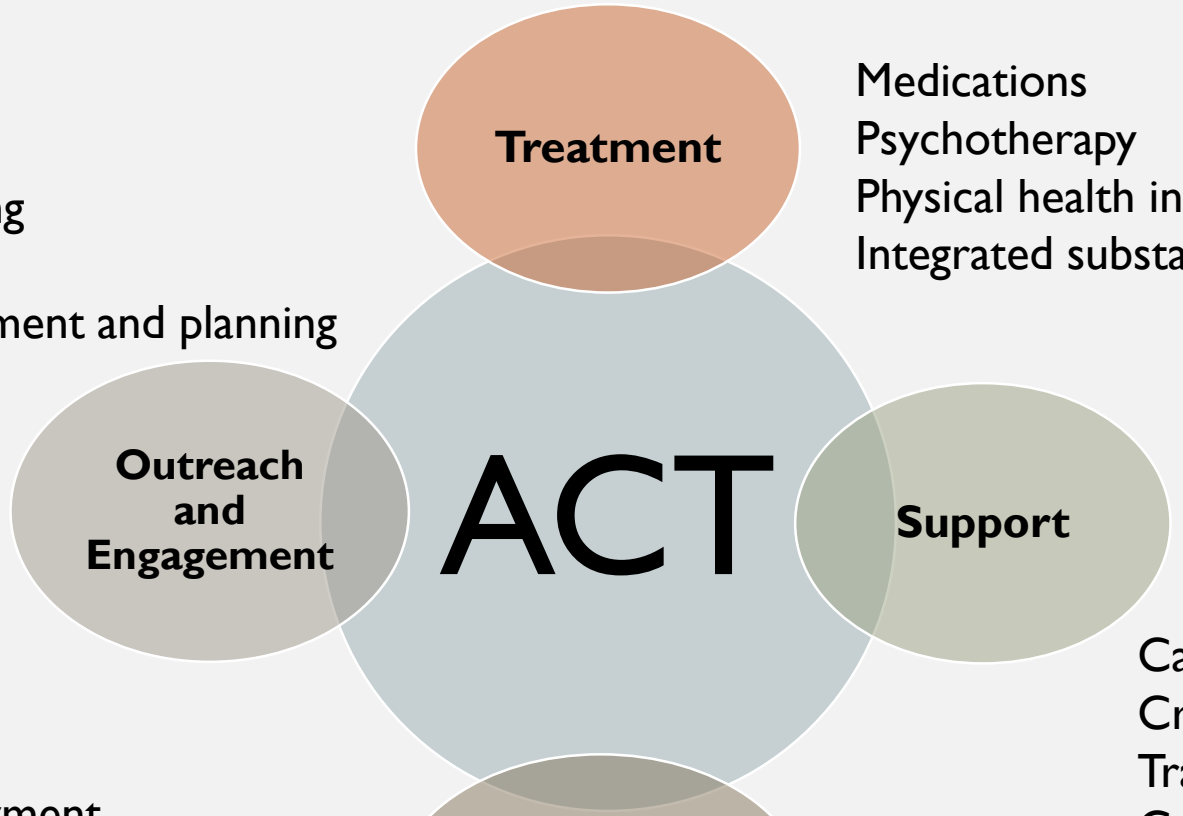
OBJECTIVES

- 1) Better understand what is entailed in a TMACT evaluation, and basic information on the intended use of the TMACT and its inherent limitations as a program fidelity measure.
- 2) Recognize typical benchmarks for NC provider practice, reviewing items that may often be misunderstood.
- 3) Increase knowledge in how to review the findings of a TMACT review to better direct quality improvement efforts and recognize "red flag" concerns embedded in the review findings.

ACT IS A WAY OF ORGANIZING AND DELIVERING BEST PRACTICES



Medications
Psychotherapy
Physical health interventions
Integrated substance abuse treatment

Motivational Interviewing
Assertive engagement
Person-centered assessment and planning

Case management
Crisis services
Transportation
Coordination with hospitals and criminal justice system
Family education and support

Supported employment
Skill-building
Wellness management and recovery
Supportive Housing

PROGRAM FIDELITY MEASUREMENT

- Program or practice must be well-defined
- Well-done research shows that the program or practice gets desired outcomes
- "Fidelity" refers to the degree to which the program and practice are implemented as intended
  - Key ingredients are implemented (quality and dose) – think of a recipe and it's ingredients

VALUE OF PROGRAM FIDELITY

Quality	Higher-fidelity teams yield better outcomes
$	More cost-effective
Research	Helps ensure (or question) reliability and validity of research findings, and helps with exploring relevant contextual factors impacting fidelity.
Innovation	Provides a conceptual base from which to make informed adaptations and innovations

ACT FIDELITY MEASURES

National Alliance on Mental Illness (NAMI) ACT Standards

IF-ACT

Dartmouth Assertive Community Treatment Scale (DACTS)

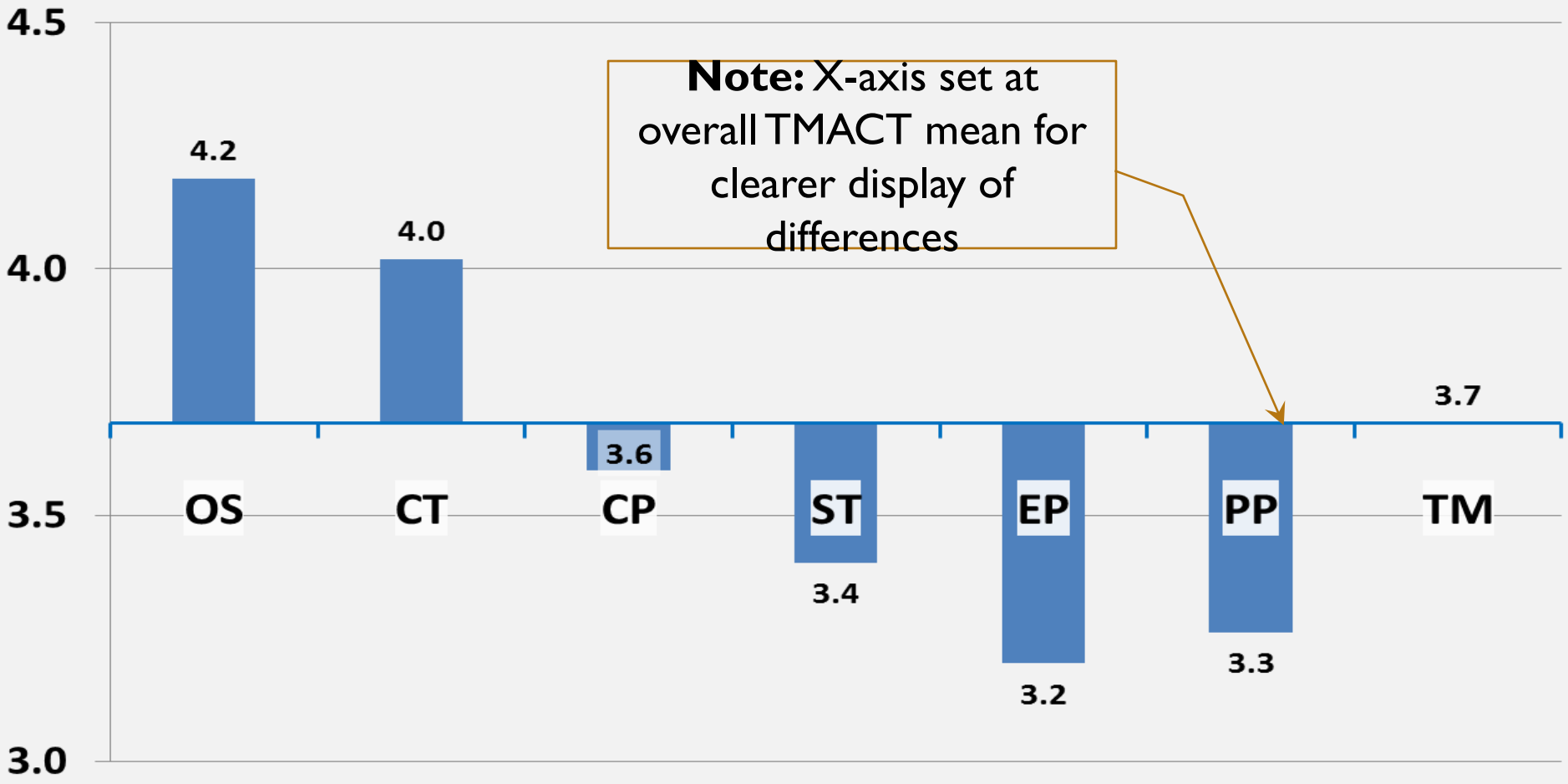
Tool for Measurement of ACT (TMACT)

UNPUBLISHED STUDY (TEAGUE, MOSER, MONROE-DEVITA (2015)

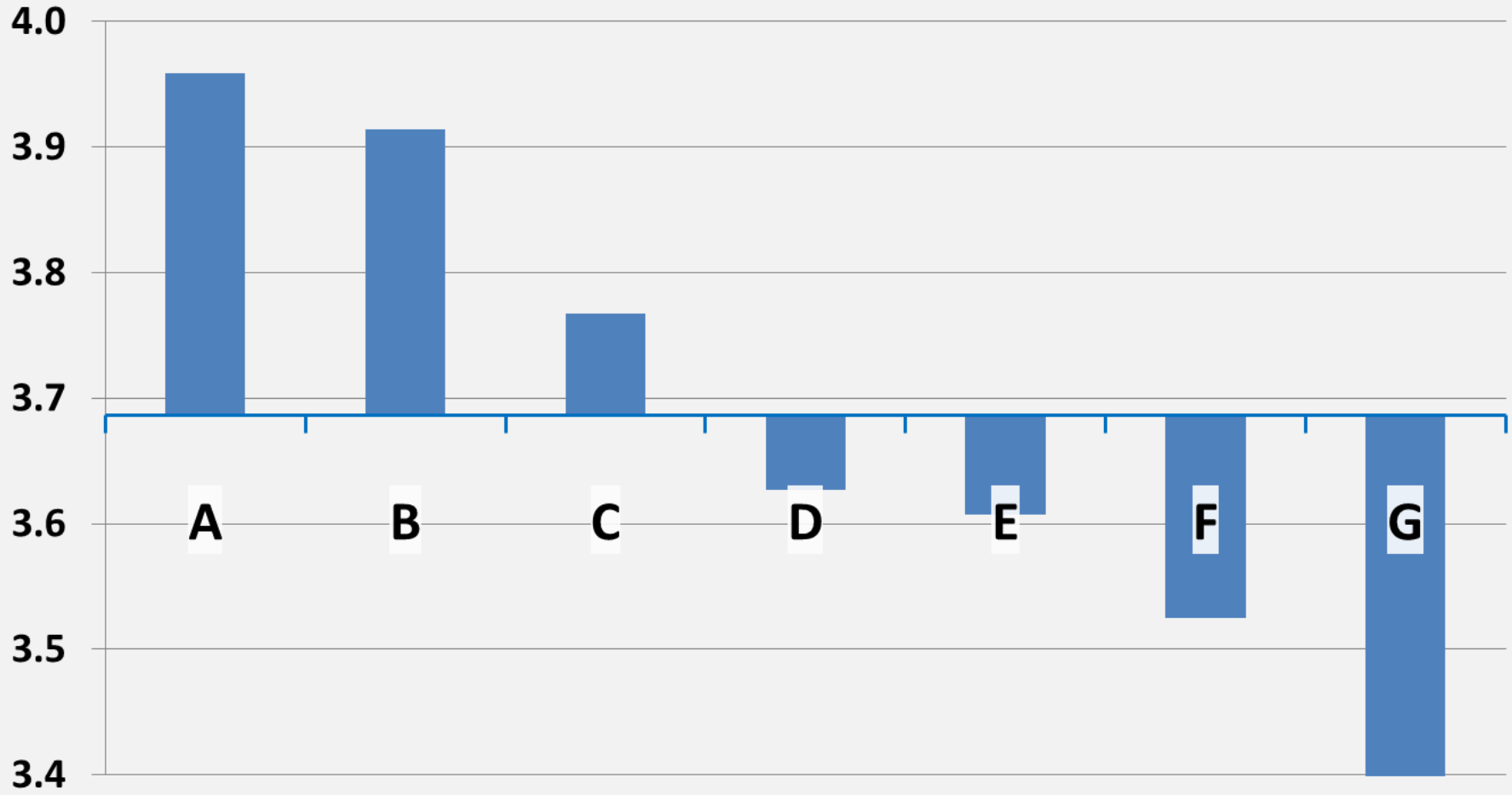
- N = 144 teams with TMACT total scores => 3.0
- 7 states in U.S.
- History with TMACT
  - Range of 1 to 7 years
  - Various uses in oversight and quality improvement

- Data
  - TMACT ratings by trained reviewers
  - Data provided by teams as part of review (N = 84, 2 states)
    - De-identified data on individual clients
    - Team-level summary information

MEAN TOTAL SCORES BY SCALE (N = 144 SITES IN 7 U.S. STATES)



MEAN TOTAL SCORES BY STATE



GROWTH IN NC

TMACT Ratings	Review #1 (# of teams)	Review #2 (# of teams)	Change (Reviews 1 to 2)
	91	74	
< 3.0	12 (13%)	1(1%)	11 fewer teams not certified
3.0 – 3.3	20 (22%)	5 (7%)	21 fewer teams in provisional certification
3.4 – 3.6	23 (25%)	17 (23%)	
3.7 – 3.9	20 (22%)	28 (38%)	15 more teams in full certification
4.0 – 4.2	11 (12%)	16 (22%)	
> 4.3	5 (5%)	7 (9%)	

OVERVIEW OF REVIEW PROCESS

Data from team ahead of time	Onsite visit 2 – 3 trained evaluators	Interview multiple sources with semi-structured interview	Chart sample review
Observe Practices	Debrief with team	Independently rate followed by consensus call	Draft report reviewed; contesting process

TMACT AND OUTCOMES

Longitudinal Study (WA, N=10 teams, 18 mo.)

- Higher fidelity was associated with:
  - Fewer state hospital days per month
  - Fewer local hospital days for high users
  - Fewer crisis stabilization unit days

Cuddeback, G. S., Morrissey, J. P., Domino, M. E., Monroe-DeVita, M., Teague, G. B., & Moser, L. L. (2013). Fidelity to recovery-oriented ACT practices and individual outcomes. *Psychiatric Services*.

Correlational Studies

- Higher-fidelity ACT associated with higher retention rates and higher rates of individuals in competitive employment (examination of both WA and NC ACT teams; Teague, Moser, Monroe-DeVita, 2015)
- Examination of NC ACT Data (77 teams):
  - No significant difference in fidelity for urban vs non-urban teams (teams in cities with population density of 50,000+ = "urban")
  - No significant differences in fidelity given team size (small, medium, or large)
  - Longer standing NC ACT Coalition members had significantly higher fidelity than non-members or more recent members

FIDELITY MEASUREMENT – CREATING A RELIABLE AND VALID MEASURE IS A CHALLENGE ….

- Can't anticipate every scenario; will miss clear examples where practices antithetical to the model are not being captured in ratings
- Balance of honoring the integrity of the tool and protocol guidelines, while inserting common sense interpretation of the measure's intent
- Any measure is only as good as the integrity of the data itself
  - Goal is to not have "missing data"
  - Comparing data across multiple sources to get most accurate picture
  - At times, needing to exclude data due to serious questions about integrity

WHAT OTHER "CONTEXTUAL FACTORS" IMPACT A TEAM'S PROGRAM FIDELITY?

Money	Client population	Policy alignment
Catchment area	Neighboring services / alternative programs	Other ideas?

POLICY AND FIDELITY – WHERE SHALL THE TWO MEET AND PART WAYS?

Policy.

Sets minimal standards for accepted practice. Expectations align with financing and resources.

Fidelity.

Captures best practices, some of which may be obtainable, some aspirational given current system.

TMACT: A SNAPSHOT

- 47 items that assess 120+ elements
- Look at the structural features of the team (staffing, boundaries of care, target population, level of care, types of service provided)
- Evaluate the quality of care
  - Are staff able to operate within their areas of specialty?
  - Are staff knowledgeable and skilled in psychosocial evidence-based practices?
  - Is treatment person-centered and promoting individual's self-determination and independence?

TMACT SUBSCALES

CP6. Responsibility for Crisis Services: The team has 24-hour responsibility for directly responding to psychiatric crises. Team is evaluated on whether they meet the following criteria: 1) The team is available to individuals in crisis 24 hours a day, 7 days a week; 2) The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging); 3) The team accesses practical, individualized crisis plans to help them address crises for each individual; and 4) The team is able and willing to respond to crises in person, when needed.

1	2	3	4	5
Team has no responsibility for directly handling crises after-hours.	Team meets up to 2 criteria at least PARTIALLY.	Team meets Criterion #1 and PARTIALLY meets 2 to 3 criteria.	Team meets 3 criteria FULLY and 1 PARTIALLY.	Team FULLY meets all 4 criteria (see under definition).

Operations & Structure (OS)	12 items Examples: Team Approach (OS1); Daily Team Meeting-Quality (OS4); and Transition to Less Intensive Services (OS9)
Core Team (CT)	7 items Examples: Team Leader (CT1); Role of Psychiatric Care Provider in Treatment (CT4); Role of Nurses (CT7)
Specialist Team (ST)	8 items Examples: Co-Occurring Disorders Specialist on Team (ST1); Role of Employment Specialist Within Team (ST6); Role of Peer Specialist (ST8)
Core Practices (CP)	8 items Examples: Community-Based Services (CP1); Assertive Engagement Mechanisms (CP2); Intensity of Services (CP3)
Evidence-Based Practices (EP)	8 items Examples: Full Responsibility for Employment and Education Services (EP2); Engagement & Psychoeducation with Natural Supports (EP6); Empirically-Supported Psychotherapy (EP7)
Person-Centered Planning & Practices (PP)	4 items Examples: Person-Centered Planning (PP2); Interventions Target Broad Range of Life Domains (PP3); Client Self-Determination & Independence (PP4)

EXAMPLE FULL VS. PARTIAL CREDIT (FUNCTION #1)
CONDUCT A BRIEF, BUT CLINICALLY-RELEVANT REVIEW OF ALL CONSUMERS & CONTACTS IN PAST 24 HRS.

No Credit	Partial Credit	Full Credit
• Team does not review all consumers (this includes when the report is organized by each staff member taking turns reporting out on who they saw, skipping over those not seen, whether scheduled or not); or • Only one or two team members simply read through the previous day's recorded contacts for all consumers (rather than each team member reporting on their own contacts to the team, which is then recorded).	Team reviews all consumers, but the content of the report is either: • Too brief to give enough information to the team about status and possible next steps, or • Too lengthy to provide enough time to review all consumers in an efficient manner (ie., excessive time is spent on several consumers, which results in rushed reports on other consumers), or • Too extensive in that they repeatedly review consumers who were seen more than 24 hours prior to the meeting Partial credit may be warranted if the meeting was unfocused and/or generally poorly attended to by staff (e.g., many side conversations ensued)	If consumer was scheduled and seen the previous day/weekend, each team member describes mental status, relevant behaviors, & staff interaction with consumer. If consumer was not seen, team may note barriers to contact (e.g., timing of the day) or concerns about missed appointment. If consumer was not scheduled, no report is typically given. Ideally, this meeting is focused, but also incorporates some dynamic staff interaction that facilitates ongoing clinical assessment and planning.

SELECT TMACT ITEMS

Common Challenges and How MCO Can Support Best Practice

OPERATIONS & STRUCTURE (OS)

OS1. Low Ratio of Client 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. Transition to Less Intensive Services

OS10. Retention Rate

OS11. Involvement in Psych Hospitalization Decisions

OS12. Dedicated Office-Based Program Assistance

WHO IS COUNTED ON THE ACT TEAM? RELEVANT FOR OS1 AND OS5… IMPLICATIONS FOR SEVERAL OTHER ITEMS

- Staff must work with team at least 16 hours per week and attend at least 2 daily team meetings.

- Staff are not simply "available" to the team – they are predictably present working as part of the team.

CHALLENGES AND SUPPORTS

- This has improved over time across reviews.
- Sharing of staff across programs making it challenging to determine exactly how much time a part-time staff is with ACT
  - This has been observed most often with the psychiatric care provider
- Periodically check teams' staffing – who comprises the team and what hours
  - Not intended to create opportunities for paybacks (large amount paybacks can kill a team!)

DAILY TEAM MEETING (OS3 AND OS4)

5 days a week; all staff present and in person*

Share and document assessment data from previous 24 hours

Create plans of action based on information shared

Develop a team schedule based on monthly client schedules and plans of action

Client Logs are a tool for the team to use – not intended to be something shared with funders

Daily Team Meetings are not the same as treatment team meetings or treatment planning meetings

CHALLENGES AND SUPPORTS

- Some teams overuse 4X10 hour shifts leaving a day a week thinly staffed
- Not skillful in using daily team meeting tools to fulfill the function of sharing assessment information and guide person-centered scheduling
- Inadequate person-centered planning – no clear directions being created that translate into a schedule
- Operating under the pressure to hit their billable units only the "four a month " – this drives service delivery more than anything

- Encourage teams to individualize the schedule and interventions based on client needs and seek TA when needed
- Avoid being prescriptive around the documents teams use to plan and schedule services
- Discourage teams from using two separate offices for the DTM (staff tele-conferencing into meetings should not be a regular occurrence).

PRIORITY SERVICE POPULATION (OS6) AND GRADUAL ADMISSION RATE (OS8)

- Schizophrenia, other psychotic disorders (schizoaffective, and bipolar I with continues high service needs.
- Exclusive of sole or primary diagnosis of intellectual disabilities, brain injury, or personality disorders.
- Team has authority to be the gatekeeper on admissions
- Team admits clients at a low rate to maintain a stable service environment.
- Without an alternative level of care, some people have no other option than ACT (system problem)
- ACT not intended to be an overlay on longer term residential settings (ACT + ALF?)
  - Exceptions may exist – ACT actively assisting with transitions out of residential housing; ACT + residential really is the least restrictive alternative for a given person

CHALLENGES AND SUPPORTS

- Teams are pressured by agency to admit high numbers of clients a month (over 4)
- External referral sources can push teams to take clients that report psychosis or have high number of hospitalization, but are best treated with other services (primary personality disorders, Intellectual Disabilities, TBI)

- Assist teams in identifying other services for clients that are not the target population.
- Support teams by referring clients that would most benefit from the intensity of ACT services

TRANSITIONING FROM ACT (OS9)

- Routine and systematic assessment of transition readiness
- Assessment conducted using a standardized tool– results guide conversation
- Once identified as being transition ready, a planned process developed and followed, ideally no less than 3 months
  - Decreasing number of visits
  - Increasing office-based contacts
  - Commence engagement with next provider
- Monitoring post discharge is good practice for some
- Option for expedited return to team if determined transition was not proving to be successful

CHALLENGES AND SUPPORTS

- Teams are expected by funders to successfully treat clients (who have had negative experiences with hospitals, severe mental illness, and history of not engaging in services) within one to two years
- Some clients, due to paranoia, might not even open their door to ACT staff for six-months
- Clients can be viewed as ready for discharge, because the team has provided interventions and supports to reduce the client's hospitalizations, start a job, or find housing- These benchmarks are often just the start in the team working with the client toward recovery

- Developing/utilizing programs for clients that are not appropriate for ACT
- Understanding that ACT is a rehabilitative long-term service, not brief treatment
- Allow teams and clients to be first in determining graduation readiness

RETENTION RATE (OS10)
HOSPITALIZATIONS (OS11)

- Teams are serving clients well (engagement, building rapport, meeting service needs)
- Low retention rate can reflect broader systemic issues beyond control of the team!
- There should be a close examination as to *why* a team has a lower retention rate (look at team staff turnover!)

- It is essential for the team to be involved in hospitalization decisions and processes
- Admission
- Discharge

- What compels inpatient staff to coordinate with outpatient staff?

CHALLENGES AND SUPPORTS

- Hospitals not allowing ACT staff to visit clients while inpatient
- Inpatient staff not contacting or returning calls from ACT staff
- High turn-over of staff -clients are frustrated and do not trust that new staff will be around long enough to help them

- Advocate for inpatient providers to allow ACT staff on the unit and to improve communication- continuity of care is very important for ACT clients when they are in crisis
- Work with agencies to identify and address reasons for high staff turn-over

CORE TEAM (CT)

CT1. Team Leader on Team

CT2. Team Leader is Practicing Clinician

CT3. Psychiatric Care Provider on Team

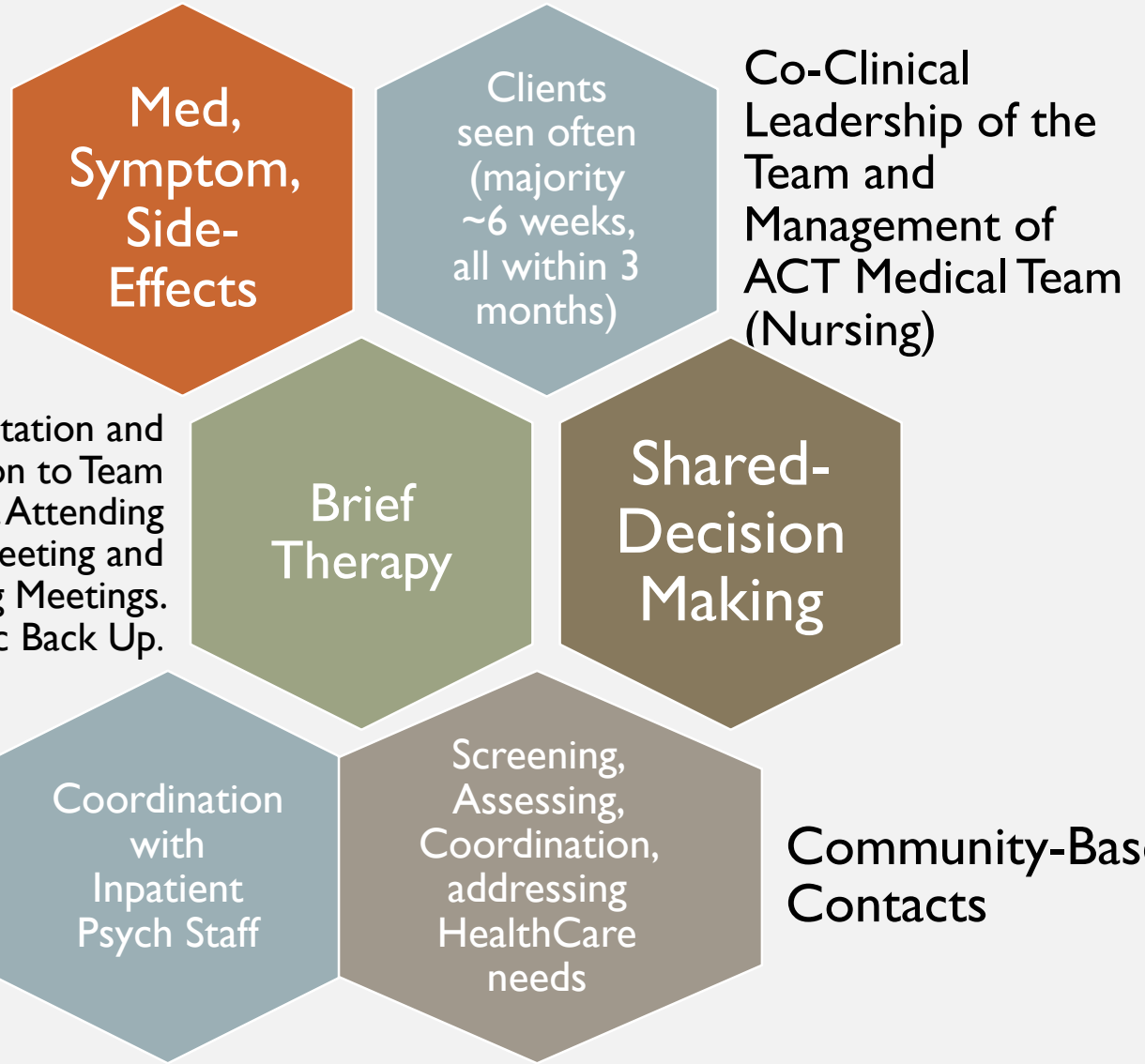
CT4. Role of Psychiatric Care Provider in Treatment

CT5. Role of Psychiatric Care Provider Within Team

CT6. Nurses on Team

CT7. Role of Nurses

PSYCHIATRIC CARE PROVIDER SERVICES (CT4 AND CT5



CHALLENGES AND SUPPORTS

- Limited psychiatric provider time with the team (other responsibilities, difficulty finding providers). This is a state-wide issue.
- Psychiatric Providers only attend a part of the daily team meeting
- Psychiatrist and/or physician extenders only focus on the mental health symptoms of clients; leaving physical concerns to medical providers that are not familiar with the client or the client does not want to see
- Psychiatric provider requires another staff to accompany him/her in the community, further limiting the staffing resources of the team

- Support teams in identifying strategies to recruit and maintain ACT psychiatrist
- Encourage agencies to provide dedicated ACT hours to the psychiatric provider
- Provided training on integrated care to ACT psychiatrists and physician extenders.

SPECIALIST TEAM (ST)

ST1. Co-Occurring Disorders (COD) Specialist on Team
ST2. Role of COD Specialist In Treatment
ST3. Role of COD Specialist Within Team
ST4. Employment Specialist on Team
ST5. Role of Empl Specialist In Employment Services
ST6. Role of Empl Specialist Within Team
ST7. Peer Specialist on Team
ST8. Role of Peer Specialist

EMPLOYMENT SPECIALIST

Engagement	Career Profile	Job Development
Job Placement	Follow-Along Supports	Benefits Counseling

CHALLENGES AND SUPPORTS

- Client is determined to be recovered by the funder once the employment specialist helps the client find employment
- The team does not allow the Employment Specialist time to meet and build relationships with employers
- Employment Specialists are not supported by other ACT staff (believe employment is not a priority, do not think clients can work)

- Provide incentives if a certain percentage of clients obtain employment with the teams assistance
- Notify teams of employers that might be receptive to hiring ACT clients
- Continue approving authorizations for clients that are starting on their journey toward maintaining compeat8ve employment
- Encourage ACT Employment staff to connect with agency IPS staff

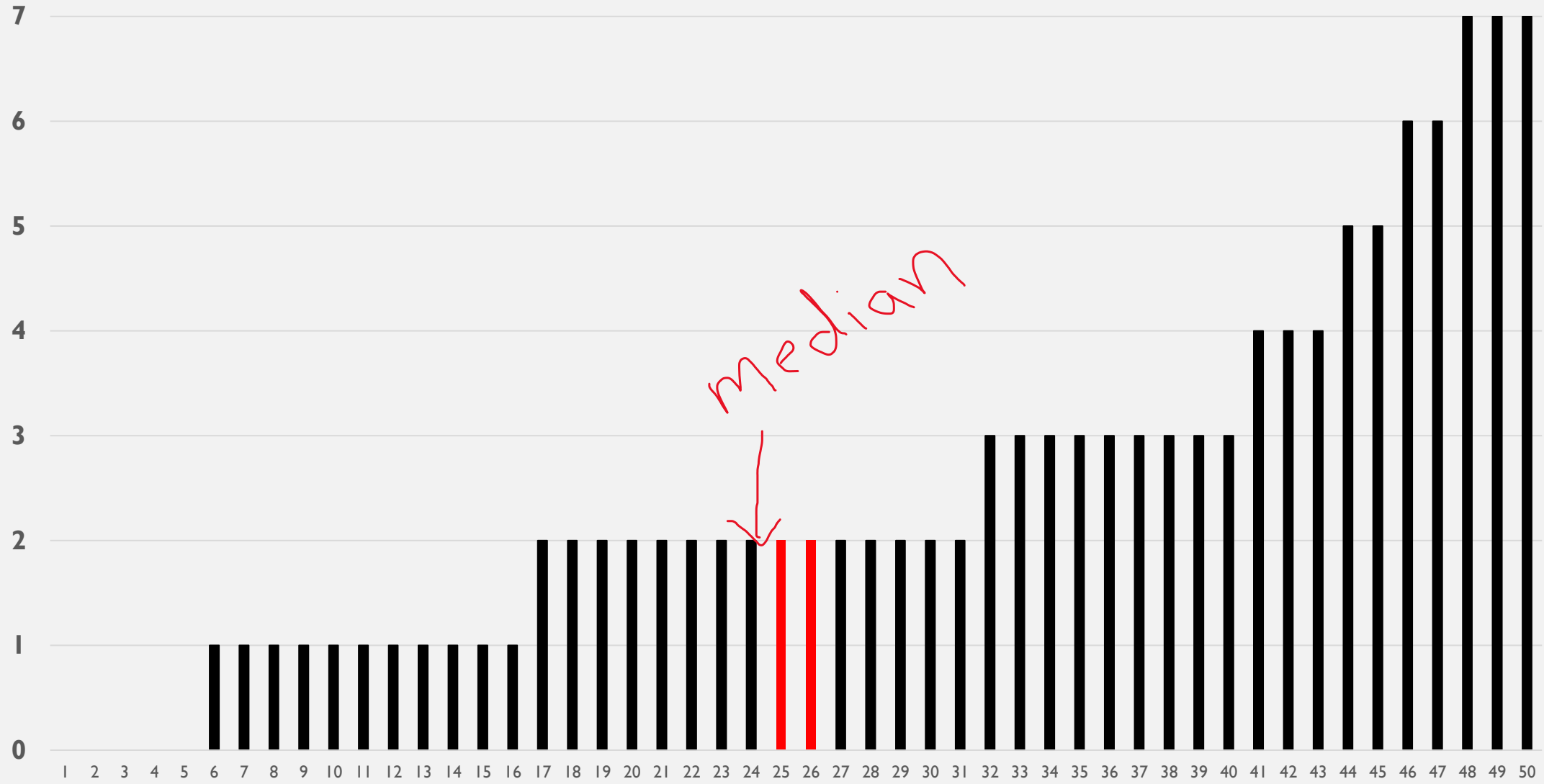
CORE PRACTICES (CP)

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 Psychiatric Rehab Services

INTENSITY AND FREQUENCY OF SERVICES

- When considering *the* *average* *(median) across all served,* how many face-to-face contacts should an ACT team be spending with individuals? (CP4)
- When considering *the* *average* *(median) across all served,* how much time should an ACT team be spending with individuals? (CP3)
- How many ACT team members should an individual client see in a month? (OS2)
- What percentage of contacts should be in the community? (CP1)

Arriving at a median of 2 contacts per week



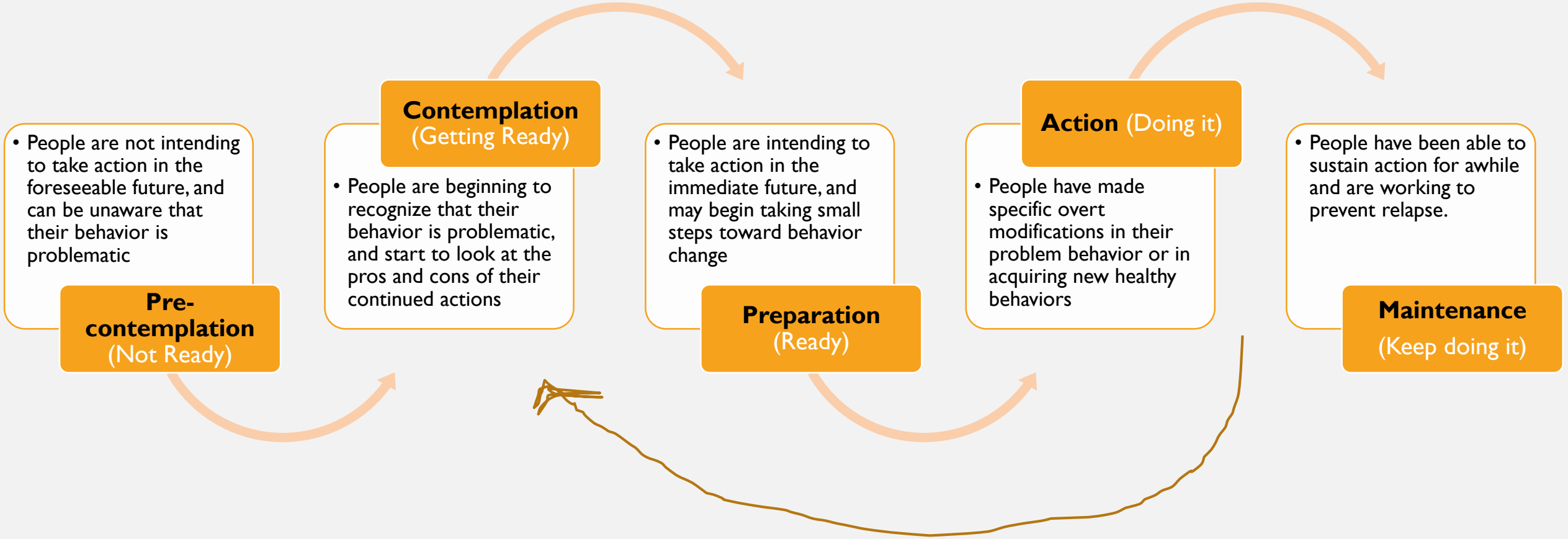
EVIDENCE-BASED PRACTICES (EP)

EP1. Full Responsibility for Integrated Tx for Co-Occurring Disorders Services
EP2. Full Resp. for Employment and Education 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

CO-OCCURRING TREATMENT

Assessment	Stage-wise	Outreach and MI	CBT and Relapse Prevention
• Comprehensive substance use assessments that consider the relationship between substance use and mental health	• Assesses and tracks individuals' stages of change readiness and stages of treatment • Ensures that treatment approach is consistent with individual's stage of change readiness.	• Uses outreach and motivational interviewing techniques for those in earlier stages of change in particular	• Uses cognitive behavioral approaches and relapse prevention for those in later stages of change – **group work is important! Assisting with self-help groups** may be important!

STAGES OF CHANGE



WORKING WITH NATURAL SUPPORTS (CP5 AND EP6)

- What percentage of clients, should the natural support system by contacted by the team at least once a month? (CP5)
- Planned education to natural supports
- Proactive problem-solving techniques
- Connecting natural supports with support groups

CHALLENGES AND SUPPORTS

- Teams do not provide planned interventions to natural supports, as they view the treatment as specific to the client (only collateral information from family)
- ACT staff are often limited in their identification of natural supports and insist that the client has no one (missing church members, neighbors, the local convenience store clerk-who helps the client out)

- Encourage teams to involve natural supports, especially for clients that are difficult to engage
- Notify ACT teams of trainings around working with natural supports, as ACT staff are often not thought of when these trainings occur for child/family services
- Facilitate connections with NAMI and other local support groups

EMPIRICALLY SUPPORTED PSYCHOTHERAPY (EP7)

Team deliberately provides psychotherapy

Team uses empirically-supported techniques

40% of the clients over the course of a year

CHALLENGES AND SUPPORTS

- NC does not require ACT teams to have a therapist on the team (in addition to the team lead)
- Most people are not familiar with therapy approaches for clients with SPMI

- Encourage teams to hire an additional therapist that can assist the team
- Understand that some clients are not ready for therapy and requiring therapy of ACT clients deviates from person-centered care
- Make sure teams are aware they can seek a waiver for a client to get therapy outside of the team

PERSON-CENTERED PLANNING & PRACTICES (PP)

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

CHALLENGES AND SUPPORTS

- Treatment planning in NC is closely tied to authorizations
- ACT teams are worried about the client being approved for the service rather then identifying strengths the client can build on
- ACT staff and other entities using treatment planning meetings to confront the client about what they are not doing

- Avoid denying clients ACT service when the staff highlight client strengths
- Encourage goals based on client preference not provider/payer goals (staying out of the hospital, adherence with medications, meeting with ACT staff, abstaining from substance use)

THANK YOU!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