Common Issues with Assessing Fidelity to Complex Multi-Modal Programs: Lessons Learned from Assessing Fidelity to the ACT Model

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

Seattle Implementation Research Conference (SIRC)
Seattle, WA
May 17, 2013

With credit to my collaborators

Lorna Moser, Ph.D.
ACT Technical Assistance Center
Center for Excellence in Community Mental Health
Department of Psychiatry
University of North Carolina School of Medicine

Gregory B. Teague, Ph.D.
Louis de la Parte
Florida Mental Health Institute
Behavioral & Community Sciences
University of South Florida

Getting on the same page

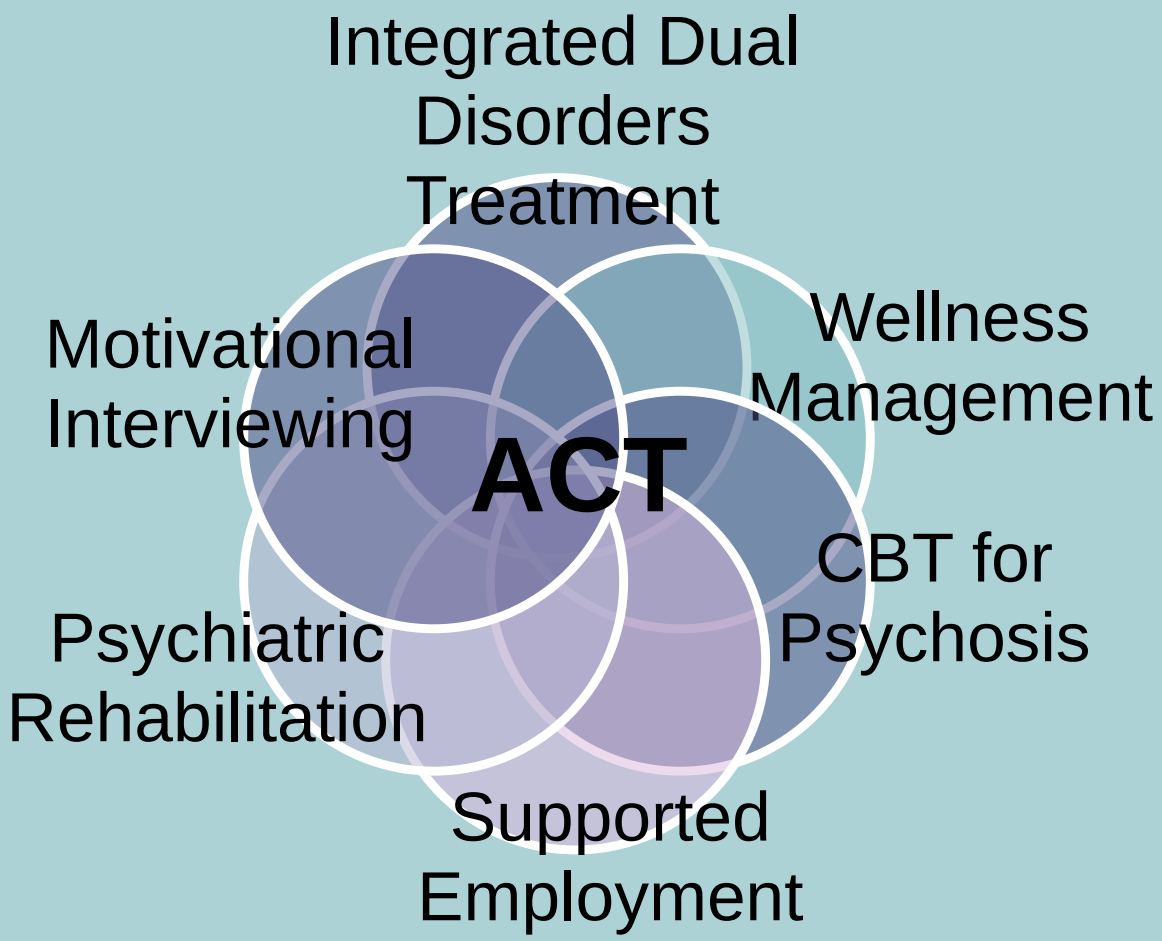
What ACT is… and what it's not

ACT: An Overview

- An evidence-based practice (EBP) for adults with serious mental illness (SMI)
- Multidisciplinary team shares caseload; no brokering
- Services primarily provided *in vivo*
- Capacity for multiple contacts 24/7
- Provides more than just case management; integrates other ESTs, EBPs, & psychiatric rehabilitation approaches
- Person-centered, recovery-oriented practices balanced with therapeutic limit-setting strategies when needed

Inherent Dilemmas with Fidelity to ACT

- Many team members delivering interventions
- Interventions carried out any time of day… multiple times a day
- Service setting is clients' homes and communities
- Most recovery-oriented approaches have a strong philosophical basis but the specific practice components vary or are not well-articulated
- A variety of interventions (EBPs, EBTs) may be provided based on client need
  - Many have their own adherence and fidelity tools
  - Some of those other EBPs have other interventions bundled within them


Integrated Dual Disorders Treatment
Wellness Management
CBT for Psychosis
Supported Employment
Psychiatric Rehabilitation
Motivational Interviewing
ACT


MI
Integrated Dual
Disorders
Treatment
MI
Wellness
Management
Motivational
Interviewing
ACT
CBT for
Psychosis
Psychiatric
Rehabilitation
Supported
Employment
MI


CBT
MI
Integrated Dual Disorders Treatment
MI
Wellness Management
Motivational Interviewing
ACT
Psychiatric Rehab
CBT for Psychosis
Psychiatric Rehabilitation
Supported Employment
MI

An Outdated ACT Fidelity Tool

- Dartmouth ACT Scale (DACTS, Teague et al., 1998)
- 28 items/ 5-point anchored scales
- One-day site review using multiple data sources
- Original intent: multi-site study of ACT for COD
- No ACT program manual at the time
- Doesn't match up with National ACT Standards
- Specific measurement gaps:
  - Team functioning and communication
  - Team member roles
  - Specific treatment & rehabilitation interventions
  - Person-centered, recovery-oriented practices

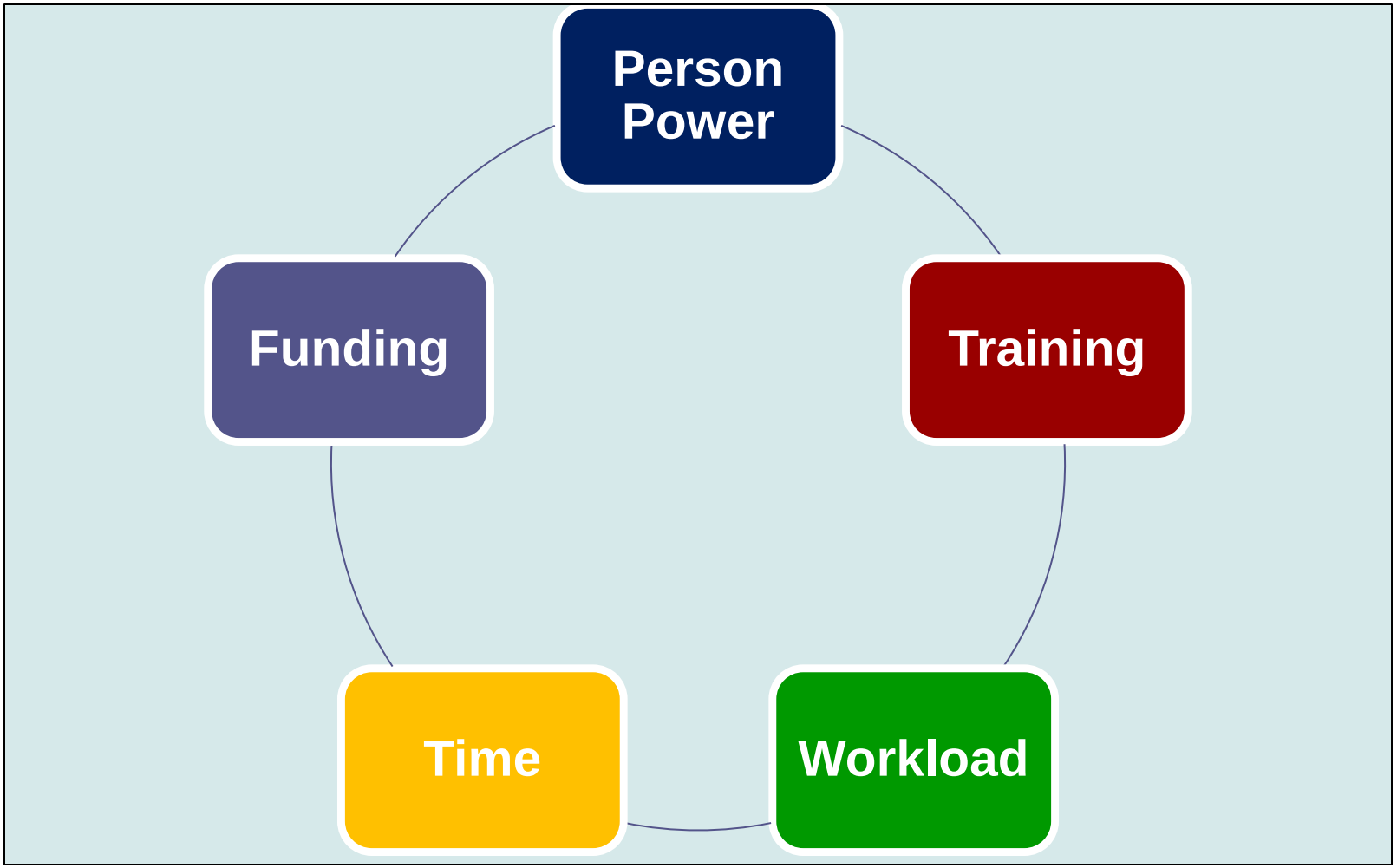
Example DACTS Item:
O4. Responsibility for Crisis Services

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

Our Primary Aims

1. Better assess processes consistent with high fidelity ACT
2. Improve the reliability and validity of assessment
3. Create a more nuanced measure of ACT
4. Enhance capacity for performance improvement

Broadening scope may cause some pain…



Approach to Scale Development

- Used the DACTS template & approach
- Cross-walked DACTS w/ National Standards
- Built on work from the ACT Center of Indiana
- Infused what was available in the literature
- Ongoing Development & Vetting:
  - National experts in ACT & related areas
  - Practicing ACT clinicians
  - Fidelity reviewers who piloted the scale
  - Interested & future pilot sites
- Piloted 52-item version with 2 WA teams
- Refined through further piloting in 10 U.S. states & Norway

From DACTS to TMACT

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

Overview of the TMACT

- Each item rated on a 5-point anchored scale
- 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*

Overview of the TMACT

- 47 items; same 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***

ACT Fidelity Measure Development Dilemmas

How did we deal with them?

TMACT Method & Data Sources

- Completed q 6 months first two years; then annually
- Two independent reviewers
- Team completes survey & spreadsheet before review
- Typically 1 ¾ days on-site
  - Review randomly selected charts (~20%)
  - Observe one daily team meeting
  - Observe one treatment planning meeting
  - Conduct semi-structured interviews w/ team members
  - Conduct semi-structured interview w/ clients
  - Observe staff during home/community visits
- Reviewers independently rate/come to consensus
- Write feedback report, focused on performance improvement recommendations – meet w/ team

Assessing Structure AND Process

We know it's important to assess the extent to which core structural and organizational elements of ACT are in place…

- DILEMMA: But what about assessing the nature and quality of those core ACT elements?
- OUR APPROACH: We cheated a little
  - Bundled criteria within items that assess a common construct
  - Developed rating guidelines for each of those criteria

PP2. Person-Centered Planning: Includes: (1) development of formative treatment plan ideas based on initial inquiry and discussion with client (prior to the formal tx planning meeting); (2) conducting regular treatment planning meetings; (3) attendance by key staff, client, & anyone else s/he prefers, tailoring number of participants to fit with the client's preferences; (4) meeting is driven by client's goals & preferences; & (5) provision of guidance & support to promote self-direction and leadership within the meeting, as needed.				
1	**2**	**3**	**4**	**5**
No more than 1 element of person-centered planning OR 2 elements provided, at least PARTIALLY.	2 to 3 elements of person-centered planning provided.	4 elements of person-centered planning provided (i.e., 1 is absent) OR Provides 5 elements, with 3 or more PARTIALLY provided.	ALL 5 elements of person-centered planning are provided, with up to 2 PARTIALLY provided.	ALL 5 elements of person-centered planning are FULLY provided (see under definition)

Rating Guidelines for Element #5 in Person-Centered Planning:
Provision of guidance and support to promote self-direction and leadership within the meeting.

No Credit	Partial Credit	Full Credit
There is no evidence either within the meeting or outside of the meeting that the team provides coaching and support to clients to promote self-direction and leadership. The client is left to use their own existing skills.	There is some evidence of team guidance and support to promote client self-direction and leadership within the treatment planning meeting, but it appears to be absent at times (e.g., you observe a missed opportunity for guidance when a client is asked how the team can be more helpful in supporting his goal to go back to school and he just says "I don't know;" the team moves on with what they would like to put in the treatment plan rather than querying more and providing examples to choose from such as sitting down side-by-side and completing college applications).	It is clear that the team has either previously provided or currently provides guidance and support to the consumer within the meeting with a focus on promoting self-direction and leadership. May include education and guidance about: • What the treatment plan is and how it fits with the client's goals; • The client's role in his or her own treatment with the ACT team and how to take an active lead in this process; • What to expect in the treatment planning meeting and how to self-advocate and have a more active voice in the process.

Integrating other EBPs/EBTs

- ACT is a platform for delivering a comprehensive set of services based on individual treatment needs.
- Ideally, other EBPs/EBTs are integrated to address those needs.
- DILEMMA: How to assess other interventions, many of which have their own fidelity or adherence tool.
- OUR APPROACH:
  - Assess quality of interventions delivered by specific team members (Specialist Role – ST – items)
  - Examine the extent to which the full team embraces the philosophy and practice of each type of intervention (Evidence-based Practice – EP – items)
  - Evaluate penetration rate of each type of intervention (EP)

Supported Employment Model: The full team: (1) values competitive work as a goal for all clients, and believes that: (2) a client's expressed desire to work is the only eligibility criterion for employment services; (3) on-the-job assessment is more valuable than extensive prevocational assessment; (4) placement should be individualized and tailored to a client's preferences; and (5) ongoing supports and job coaching should be provided when needed and desired by client.				
1	**2**	**3**	**4**	**5**
Team does not embrace supported employment model.	Only 1 - 3 criteria are met.	4 or 5 criteria are met at least PARTIALLY	Team primarily embraces SE model, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team fully embraces SE model and FULLY meets all 5 criteria (see under definition).

Rating Guidelines for Criterion #2 for Supported Employment Model:
The full team believes that a client's expressed desire to work is the only eligibility criterion for supported employment services

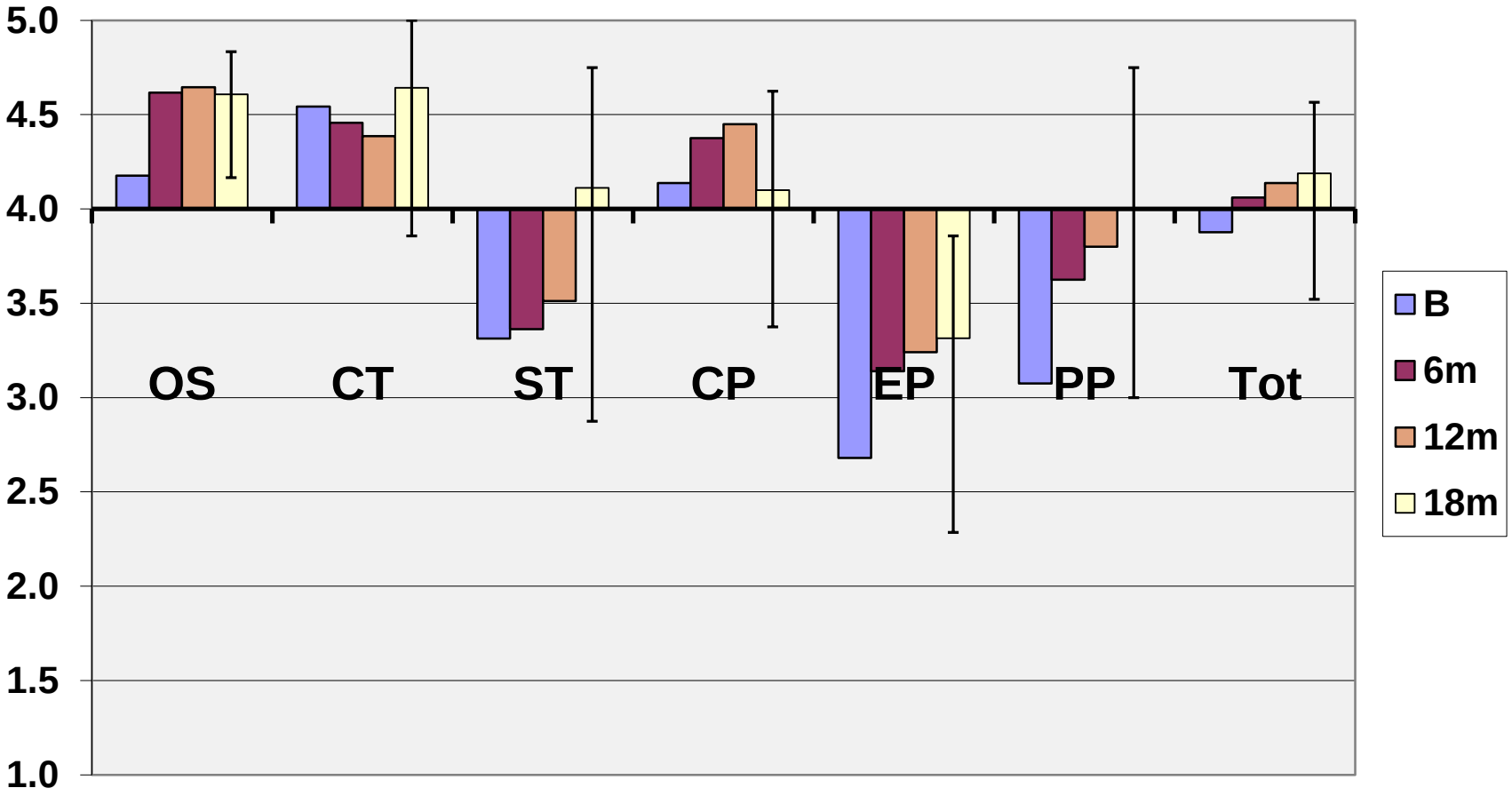
No Credit	Partial Credit	Full Credit
Most team members appear to value "work readiness" criteria other than client's expressed desire to work. These other "work readiness" criteria may include sobriety, medication adherence, and symptom stability (e.g., no active hallucinations, motivation and follow-through).	Evidence appears to be mixed: some team members appear to hold other less consequential "work readiness" criteria as more important than client's expressed desire to work.	All team members appear to believe that the client's expressed desire to work is the only eligibility criterion for SE services, as reflected in both their expressed values and work with clients.

TMACT Pilot Results

What does our experience and the data tell us so far?

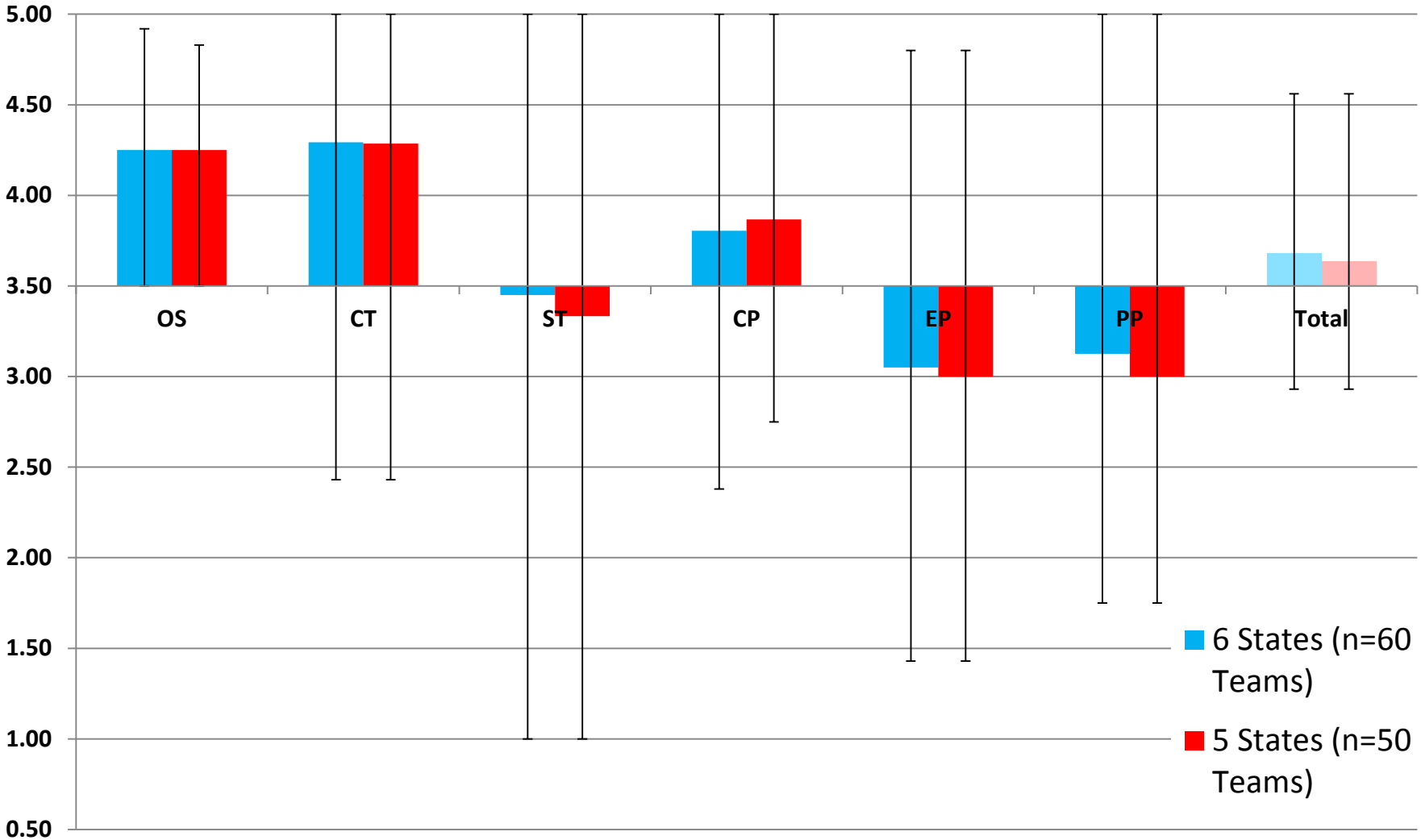
WA TMACT Scale Scores: Baseline – 18 mo

(Bars = range, lowest to highest)



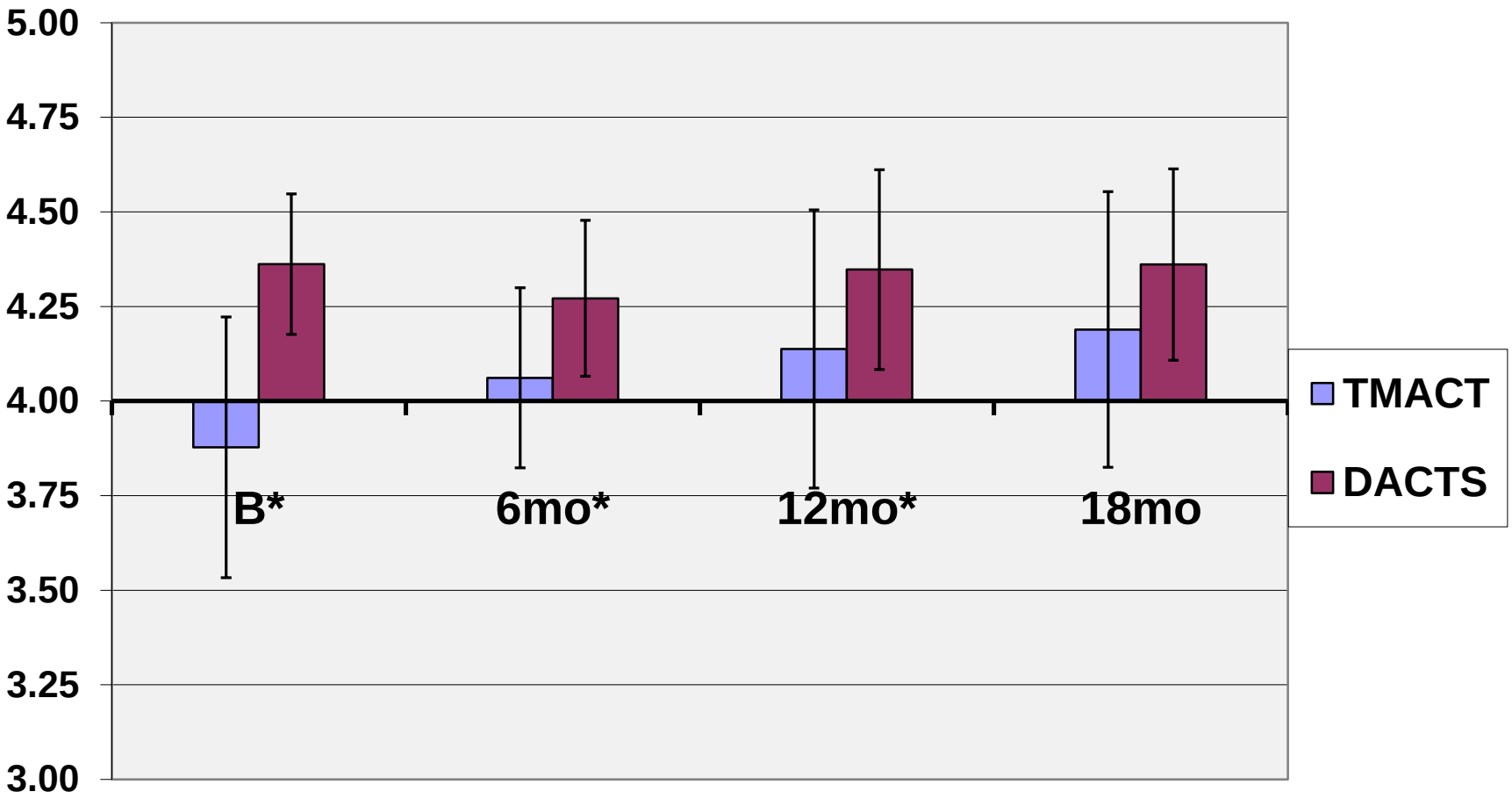
(Monroe-DeVita, Teague & Moser, 2011)

TMACT Subscale & Overall Medians & Ranges in 6 States (n=60) and 5 States (n=50)



TMACT & DACTS in WA: Baseline – 18mo

(Bars = std. dev; only 18mo not significantly different)



TMACT Fidelity & Outcomes (WA, N=10 teams, 18 mo)

- Higher TMACT scores were associated with
  - Fewer state hospital days per month
  - Fewer local hospital days for high users
  - Fewer crisis stabilization unit days
- Probability of use not affected
- Note: WA teams generally had high fidelity and little variability, so findings are conservative estimates

(Cuddeback et al., 2013)

Next Steps

Where do we go from here?

Development, Training, Research

- Continue current piloting/ extension to other states & countries
- Refine training materials & protocol
- Develop research (with external support)
  - More extensive development and pilot-testing of core components
  - Psychometric assessment
  - Multi-site evaluation of fidelity vs. outcomes
- Incorporate new technology for dissemination & implementation

TMACT References

Monroe-DeVita M., Teague, G.B., Moser L.L. (2011). The TMACT: A New Tool for Measuring Fidelity to Assertive Community Treatment. *Journal of the American Psychiatric Nurses Association, 17,* 17-29.

Teague, G. B., & Monroe-DeVita, M. (2011). Not by outcomes alone: Using peer evaluation to ensure fidelity to evidence-based assertive community treatment (ACT) practice. In J. L. Magnabosco & R. W. Manderscheid (Eds.), *Outcomes measurement in the human services: Cross-cutting issues and methods* (2nd ed.). Washington, DC: National Association of Social Workers Press.

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 consumer outcomes. *Psychiatric Services, 64,* 318-323.

Moser, L., Monroe-DeVita, M., & Teague, G.B. (2013). Evaluating integrated treatment within assertive community treatment programs: A new measure. *Journal of Dual Diagnosis*, *9,* 187-194.

Thank you!

Maria Monroe-DeVita, PhD
University of Washington
206.604.5669
mmdv@uw.edu