METHODS

Tool for Measurement of ACT (TMACT)²

Why a new ACT fidelity measure? Gaps in fidelity measurement threaten research & practice ¹

- Gaps leave some critical ingredients unobserved
- Critical ingredients not identified as such
- Weaker program theory & EBP specifications
- Routine measurement of fidelity threatens to monitor & improve quality

TMACT 3 pairs of FACT team leaders in using fidelity measure for

- Initial training by outside ACT fidelity expert for two pairs of FACT team leaders in using fidelity measure for evaluation and consultation
- Each pair develops skills through use, then trains two other pairs; consultation available from original trainee; all FACT teams evaluated
- Peer consultation/training provided

RESULTS & CONCLUSIONS

Intended Business/Research Capacity (Project currently underway)

- Establish statewide organizational capacity to document, track, and improve fidelity & outcomes
- Link data on program processes with concurrent and archival data on outcomes
- Establish practice-research capacity to identify critical elements
- Develop an ongoing quality-improvement network to maintain this capacity through collaboration among providers in partnership with authority/purchaser & university-based researchers

Pilot Findings on TMACt (WA & elsewhere)

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

PRELIMINARY EVALUATION FINDINGS (FL)

- Fidelity (1/3 of teams assessed) & outcomes
- Fidelity consistent with limited training & other resources
- Expected reductions in hospitalization, emergencies
- Within range for ACT teams with QI needs
- Facilitative practices & peer consultation:
  - Teams & administrators value benefits of process
  - Steep learning curve impacts assessment pace
  - Peer consultation role requires new skills
- Initial training & consultation; resources now lacking

- Efficient feedback/reporting needs modular approach

INTERIM CONCLUSIONS/IMPLICATIONS

- Effective long-term implementation of EBPs requires ongoing adherence to concurrent fidelity standards
- Fidelity monitoring goes beyond structural features and include a focus on critical processes as currently defined

- Attention should be continued and relatively continuous
- The need for high-quality services presupposes the existence of well-informed communities of practice

- The need for quality monitoring & improvement typically exceeds available resources

- Self-help strategies can help to fill the gap: internalized QI
- Improvements in knowledge dissemination & technology & practice are needed – e.g., expand use of web-based IT

- A similar approach may apply well to other EBPs

REFERENCES


ACMHA – The College for Behavioral Health Leadership
SUMMIT – March 16-18, 2011
New Orleans, LA

Self-Help Quality Improvement as a Disruptive Intervention
- Using a Facilitated Network of Providers as Peer Evaluators to Drive High-Fidelity Services

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

BACKGROUND

Assertive Community Treatment (ACT)

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