Self-Help Quality Improvement as a Disruptive Intervention

- Using a Facilitated Network of Providers as Peer Evaluators to Drive High-Fidelity Services -

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BACKGROUND

Assertive Community Treatment (ACT)

For persons with the most challenging problems

- Severe and persistent mental illness
- Significant difficulty doing the everyday things needed to live independently in the community, or
- Continuously high service need

Practice principles

- ACT is a service delivery model, not a case management program as such
- Serves as a "platform" for the provision of services that consumers may need, including other EBPs
- Primary goal is recovery through community treatment and habilitation
- Has evolved with intent to provide state of the art in services for persons with serious mental illnesses

Service model characteristics

- Fixed & separate point of responsibility
- A multidisciplinary/transdisciplinary team approach
- A shared, small caseload: 10-12 professionals, ~100 consumers
- Comprehensive treatment, rehabilitation, & support services delivered "in vivo"
- Flexible service delivery
- Crisis management available 24 / 7
- Time-unlimited services

The Florida ACT (FACT) program

- In existence ~10 years; 31 teams; ~3,000 consumers
- Organizational settings of teams vary widely
- Initial training & consultation; resources now lacking for quality monitoring and improvement
- Common service/outcome data, not closely examined

Context: A Quality Challenge

- Valid implementation of EBPs requires protracted attention to quality, esp., fidelity
  - High fidelity is a precondition for optimal outcomes
  - Quality of ongoing implementation of EBPs is at risk and must be actively supported
  - Measures of fidelity must target critical processes; structural features alone are insufficient
- Dedicated (esp. centralized) quality assurance/ improvement resources are scarce
  - Determining fidelity of complex interventions requires both expertise and effort
  - Program monitoring can be infrequent and poorly linked to quality improvement

METHODS

Tool for Measurement of ACT (TMACT)[1]

Why a new ACT fidelity measure? Gaps in fidelity measurement threaten research & practice[1,2]

- Gaps leave some critical ingredients unobserved
  - Critical ingredients not identified as such
  - Weaker program theory & EBP specifications
  - Role of measure as bundled set of indicators diminished in context of funding incentives
- Gaps limit program implementation & effectiveness
  - Selective incentives weaken linkage between measured and unmeasured aspects
  - Providers use fidelity measure as guide, prioritize specified & rewarded elements, overlook omitted program features
- Inadequate specification weakens research
  - Lesser differentiation of better and worse programs
  - Lower effect sizes, less significant differences
  - Increased risk of Type II error in comparative effectiveness studies

Goals of TMACT vs. previous measure (DACTS)[3]

- Assess processes consistent with high fidelity ACT
  - Recovery-oriented services
  - Incorporation of evidence-based practices
  - Functions promoting a transdisciplinary team
- Improve reliability and validity of assessment, improve sensitivity, differentiate degrees of fidelity

Structure

- 47 items, individually anchored 5-point rating scales
- 6 subscales
  - Operations & Structure (OS)
  - Core Team (CT)
  - Specialist Team (ST)
  - Core Practices (CP)
  - Evidence-Based Practices (EP)
  - Person-Centered Planning and Practices (PP)
- Detailed protocol

Outcome Data

- Medicaid and other publicly funded behavioral healthcare enrollment, assessment, and services
- Employment, education, arrests
- Web-based consumer ratings of recovery orientation

Intervention: Train-the-Trainers in Fidelity Evaluation within QI Network[4]

- 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 trainer; 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 and in partnership with authority/purchaser & university-based researchers

Pilot Findings on TMACT (WA & elsewhere)

- TMACT sets a higher performance bar 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

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
- Feasibility & acceptability
  - Teams & administrators value benefits of process
  - Steep learning curve impacts assessment pace
  - Peer consultation role requires new skills
  - Efficient feedback/ reporting needs modular approach

Interim Conclusions/Implications

- Effective long-term implementation of EBPs requires ongoing adherence to concurrent fidelity standards
  - Fidelity monitoring should go beyond structural features and include a focus on critical processes as currently defined
  - Attention should be close 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 using external referents with effort largely already in play
  - Fidelity and related materials can serve as objective tools
  - 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

DISRUPTIVE INNOVATION?[5]

ACT – A Transdisciplinary Team Model

- Itself originally a disruptive innovation
  - New business model: operated outside of the existing care settings (market was public purchasers & advocates)
  - Has now largely replaced care as (then) usual for the most psychiatrically disabled population; continues to evolve
  - Value proposition: Treat *disabilities* in real life, real time
- When fully implemented, provides both intuitive and empirical care in a hybrid business model
  - Solution shop (highly individualized assessment and care provided by integrated, multidisciplinary team)
  - Value-adding process shop (e.g., capacity to offer EBPs)
- ACT is high-intensity, but transdisciplinary team models apply widely at varying levels of intensity

Provider-as-Peer-Based Quality Improvement (PBQI)

- Potential QI-focused business model innovation
  - Facilitated network of providers: a (de)center of excellence
  - Value network facilitated by purveyor of QI tools/ processes in partnership with centralized authority/purchaser
  - Technological enabler: anchor is set of articulated indices, processes, & other guidance for performance optimization
- Self-help is inherently disruptive
  - Self-help empowers participants, ameliorates negative by-products of vertical relationships
  - E.g., PBQI disrupts authority-subordinate dynamic, frequently characterized by defensiveness and complacency
  - Operates in alternative behavioral "market"
- Addresses jobs that programs & staff are trying to do (per internal & external mandates)
  - High quality & effectiveness for consumers (business market success, professional fulfillment & self-esteem)
  - Active participation in QI effort (adherence to performance expectations, connections & recognition among peers)

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