FY 2006 Fidelity Review Report
Executive Summary

The Department of State Health Services (DSHS) Community Mental Health and Substance Abuse Services, Quality Management Unit completed a fidelity review of all thirty-eight Local Mental Health Authorities (LMHAs) in August 2006. DSHS required each Local Mental Health Authority to conduct a fidelity self-assessment of evidence-based practices. The following service models were reviewed for adults: Texas Implementation of Medication Algorithms (TIMA) - Patient and Family Education, Cognitive Behavioral Therapy, Psychosocial Rehabilitation and Assertive Community Treatment. Children and adolescent service models included TIMA Patient and Family Education, Cognitive Behavioral Therapy, Skills Training, and Wraparound Planning.

Resiliency and Disease Management (RDM) was implemented on August 31, 2004. The first fidelity assessment, completed in August 2005, was a self-assessment by the LMHAs to evaluate key structural elements such as staff credentials, staff training, and staff supervision.

The purpose of the fidelity assessment in RDM is to ensure that all elements deemed critical to the effectiveness of each Evidence-based Practice (EBP) are appropriately implemented. It is expected that high fidelity to the EBPs will result in improved client outcomes. System measures of implementation and adherence are important to understand outcome data and to provide DSHS with the ability to support the most effective practices throughout the State. Systematic and regular monitoring of fidelity will improve implementation by presenting useful information for providers to improve programs and practice.

The FY 2006 review by DSHS evaluated service delivery through LMHA self-assessment of client records using the fidelity scales. This was not considered a full fidelity review in that a limited number of elements were rated through review of client records. A comprehensive fidelity review includes an onsite program review involving evaluation of staff training records; team communication logs; and staff supervision notes as well as interviews with clients, family members, and provider staff. DSHS is using the FY 2006 fidelity review results as a baseline of Resiliency and Disease Management (RDM) implementation on which to measure future performance.

Overall, the statewide averages met adequate implementation for all the adult service models except the Patient and Family Education Program. However, none of the child and adolescent service models met adequate level of fidelity implementation. Because EBPs involve highly structured and interactive sessions that focus on skill development, it requires clinicians to engage clients in a partnership, identify goals and strategies, and document the detailed interventions and the client's response over time. Without completing a comprehensive review, it is difficult to determine if the low fidelity implementation results are due to the lack of staff competencies (training), inadequate resources (low number of staff, staff turnover), or the lack of organizational support and structure.

DSHS will modify evidence-based practices as needed, identify and remove barriers to implementation, and provide training and technical assistance to improve implementation. At least two comprehensive onsite fidelity reviews will be completed by DSHS in FY 2007 to evaluate program characteristics and implementation practices.

FY 2006 Fidelity Review Report

Overview

The Department of State Health Services (DSHS) FY 2006 Performance Contract with Local Mental Health Authorities (LMHA) required contractors who did not meet the service outcome minimums at the close of the second quarter to conduct a fidelity self-assessment. DSHS provided each LMHA a sample of thirty clients who had been authorized for evidence-based practices within FY 2006 (September 1, 2005 through February 28, 2006). All thirty-eight LMHAs submitted fidelity assessment results for both child and adult services.

The FY 2006 fidelity review focused on program implementation as evidenced by the client's record. Progress notes were the primary source of information for the fidelity review; communication logs; staff training records; and client, family, and staff interviews were not used. The fidelity self-assessment results are being used by DSHS to identify programs with significant outliers in order to provide oversight and to identify programs with successful implementation strategies. DSHS will use the results to identify training and technical assistance needs. The fidelity assessment results should also be used by each LMHA to identify and prioritize strategies to improve fidelity to each of the evidence-based practice models.

This report provides an analysis of the LMHA's self-assessment findings and desk review completed by DSHS Quality Management and Program Services. The report will be shared with all LMHAs and posted on the DSHS website. As DSHS monitors program implementation over time, review results will allow comparisons a) between programs, b) across regions of the state (e.g., rural versus urban), c) between individual sites and state averages, and d) within programs and groups of programs over time. The comparisons will help identify specific areas in which the state as a whole has difficulty meeting established thresholds; regional differences that may be reflective of varying populations, resources, local practices, or other factors; and individual sites that may have exceptionally well-implemented programs, worthy of recognition (Bond, et al, 2000).

Methodology and Data Collection

Self-Assessment - The fidelity self –assessment is a review process that the LMHAs completed for the following service models, for adults: Patient and Family Education (PFEP), Cognitive Behavioral Therapy (CBT), Psychosocial Rehabilitation and Assertive Community Treatment (ACT). Children and adolescent service models reviewed include Patient and Family Education, Cognitive Behavioral Therapy, Skills Training, and Wraparound Planning. ACT Alternative for adults was also included in the fidelity review, although it is not an evidence-based practice. ACT Alternative is provided by LMHA's who have been granted a waiver from ACT services by DSHS. This waiver is based on geographical distribution of clients recommended for ACT. The implementation of the algorithm system, Texas Implementation of Medication Algorithms (TIMA) was not included in this review since a statewide TIMA self-assessment review occurred in November 2005 and February 2006.

DSHS selected a random sample of clients who were authorized for services during the second quarter of FY 2006 (December 2005 through February 2006). Each LMHA received a record review sample of thirty clients, fifteen clients for children service models and fifteen clients for adult service models. The client sample included up to five persons for each service model. LMHAs that did not serve any clients in a service model received a larger sample number in other service models based on the percentage authorized for those service models. The client sample also included the Texas Recommended Assessment Guideline (TRAG) dimensions so the reviewer could easily determine which fidelity elements were applicable.

Fidelity scoring utilizes a Likert scale with scores of "5" representing optimal implementation, "4" is good implementation, "3" is adequate, "2" is fair, and "1" is poor implementation. Some elements are scored either "Yes" or "No" to indicate whether evidence is present. Reviewers were instructed to leave fidelity elements blank and note in the comment section that a particular element was not applicable if the TRAG score did not indicate an assessed need or if documentation indicated that the client refused services.

LMHA Quality Management staff were instructed by DSHS to oversee the fidelity self-assessment process with the provider staff (Program Supervisors or Managers) most familiar with each service model completing the client record reviews using the fidelity assessment instruments. The LMHA QM staff compiled the data from each record review and entered the results into an Excel spreadsheet (Fidelity Scorecard) to determine the total aggregate fidelity score for each service model. The provider record reviews and LMHA aggregated results were submitted to the Department of State Health Services on June 5, 2006.

Desk Review - DSHS selected five Local Mental Health Authorities with the highest fidelity scores to substantiate the self-ratings and to identify LMHAs with greater implementation of evidenced-based practices. DSHS selected the four service models that each of the five LMHAs scored highest. Three clients with the highest ratings for each service model were also selected by DSHS. The LMHAs were instructed to submit documentation for the selected sample that best demonstrated service delivery of the evidence-based practice. The desk review was a quality improvement activity to ensure that programs with the highest fidelity scores are implementing evidence-based practice models as defined and to corroborate fidelity results.

Analysis and Trends

Self assessment results

DSHS entered the fidelity scorecards from each LMHA into a database to determine overall average scores for each fidelity element and for each service model. This database produced performance results for each LMHA and as well as overall statewide performance.

During the course of examining the record review instruments and comments submitted by the LMHA providers, DSHS discovered incorrect scoring of fidelity elements. DSHS decided that although the process of changing scores and correcting the database would delay completion of the Fidelity Review Report, it was important to establish valid baselines for future fidelity evaluations.

Changes to the LMHA scoring occurred primarily to fidelity elements scored as "No" or "1" when the element should have been left blank to indicate "N/A" or "not applicable." This change improved scores. Another area where scores were revised by DSHS occurred in the service models for children and adolescents. DSHS changed LMHA self-assessment scores from "Yes" to "No" when the provider's written comments indicated that TIMA materials were not used for education for those with either Attention Deficit Hyperactivity Disorder or Major Depression Disorder.

DSHS used the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) to determine each client's diagnosis and age in order to correct client records that should have been scored for anxiety or depression, as well as, score elements only applicable for a child or adolescent. After revising and recalculating scores, DSHS found the changes did not affect the overall statewide averages; however some LMHA's fidelity averages changed significantly. Revised self-assessment scores were posted on the File Transfer Process (FTP) server for each LMHA to retrieve their changed fidelity scorecard.

Desk Review Results

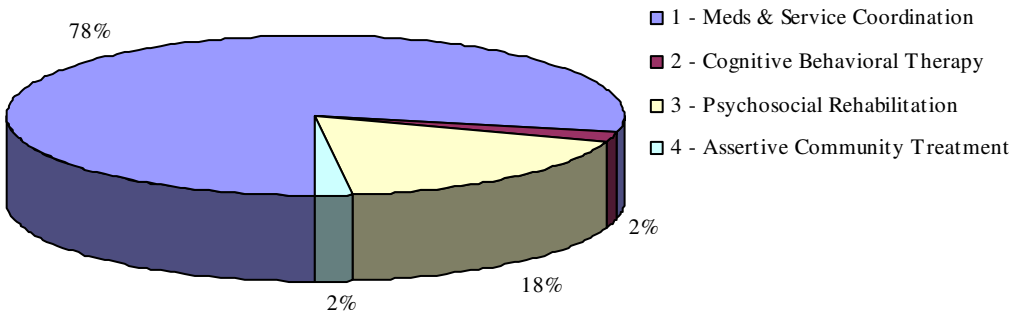
DSHS Quality Management and Program Services staff reviewed the five highest scoring LMHA's desk review materials to identify good implementation practices and to substantiate fidelity results. The desk review materials were scored by DSHS and compared with the LMHA's self-assessments to determine reliability of self-ratings. Reliability is the extent to which everyone interprets questions and scoring in the same way. Without reviewing the complete client record and interviewing clients and staff it is difficult to determine inter-rater reliability.

Desk review analysis substantiated three of the five LMHA's self-assessment ratings, the Center for Health Care Services, Denton County MHMR Center, and Central Plains Center. Each of the five LMHAs received feedback on their desk review materials. DSHS did not change LMHA scores based on the desk review.

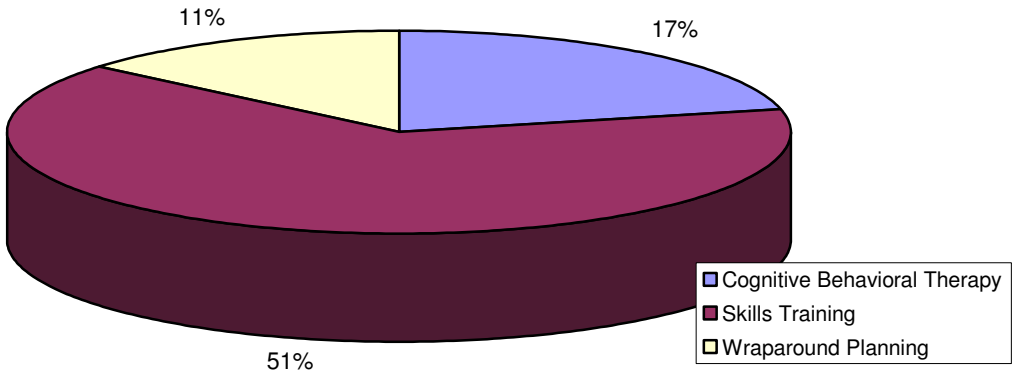
Statewide Results

At the end of the FY 2006 second quarter, the percentage of the adult and children and adolescent populations authorized into the evidence-based practices are identified in the following charts.

Adult Population authorized by Evidence-Based Practice for February 2006

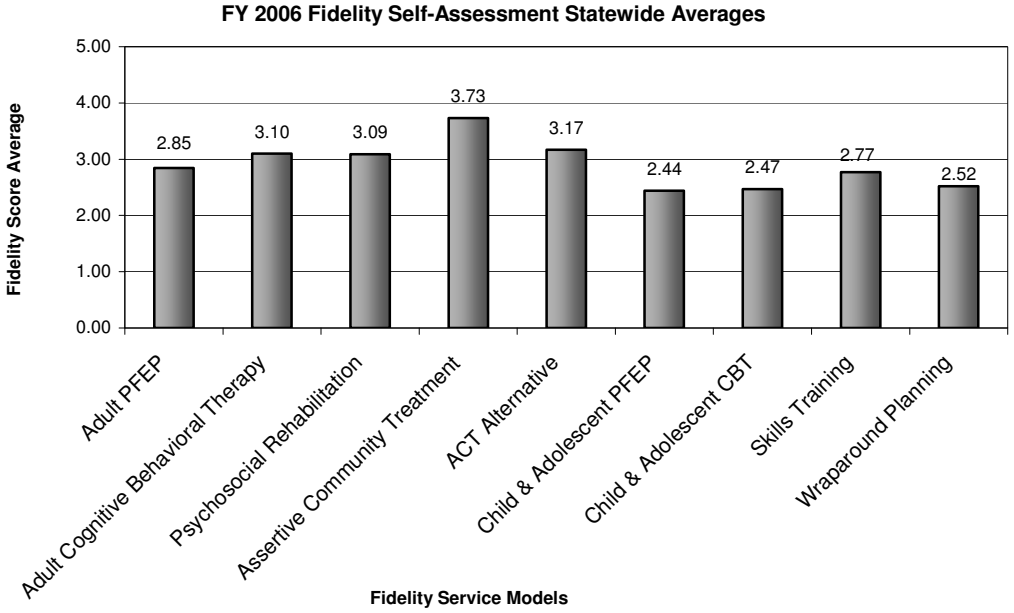


Children & Adolescent Populations authorized by Evidence-Based Practice for February 2006



The following results present the overall averages from the thirty-eight LMHAs self-assessment scores after DSHS revision. The overall statewide averages are based on "1" representing poor implementation, "2" representing fair implementation, "3" representing adequate implementation, "4" representing good implementation and "5" representing optimal implementation. It is important to take into account that patient and family education is expected to be provided for all individuals regardless of the authorized service package or service model.

The results from the FY 2006 fidelity review are consistent with previous reviews. The service model needing the most attention and improvement is patient and family education for both adult and child populations. Assertive Community Treatment demonstrates the best overall statewide performance scoring 3.73 and has been a required service for at least ten years. Cognitive Behavior Therapy for adults also demonstrated adequate statewide performance scoring 3.10.



A. Adult Patient and Family Education Program (PFEP)

Patient and Family Education is a component of the Texas Implementation of Medication Algorithms (TIMA). Each adult authorized for services is expected to receive patient and family education. Patient and family education is vital to the disease management approach to treating mental illness. Education provides the consumer with the information necessary to be an active participant in treatment decisions that promote his or her recovery. By understanding treatment risks and benefits, patients and families can communicate with staff changes in symptoms, side effects, and progress towards recovery, allowing staff to tailor treatment to meet the client's needs. Through education and practice, clients will be able to identify and utilize effective self-care strategies to manage problems associated with their illness.

Patient and Family Education Program fidelity results indicate additional work is needed to ensure providers have the training and understanding necessary to put into practice the essential educational components. Comments noted on review instruments indicate that LMHAs are providing education but are not using TIMA materials. The use of the Disorder Fact Sheet is an educational tool; it should be used during initial diagnosis, with any ongoing use dependent on the client's understanding and

cognitive ability. If a medication treatment is not included as part of Micromedex, a pharmaceutical database, then clinicians should use pharmaceutical materials that have been approved by DSHS.

The physician's initial visits with the client (and family when possible) should cover the diagnosed disorder and emphasize its etiology and key symptoms. Prescribed medications should be clearly discussed, including basic information regarding the purpose of the medication, directions for use, beneficial effects, and potential side effects. Progress notes should reference the sharing and review of the symptom monitoring sheet and the client's understanding or response to information. Documentation should indicate efforts to provide the client's family with educational material or that the client does not want or have any family involvement. Documentation should indicate that the benefit of family involvement was explained (e.g., family education leads to better understanding and support).

See **Exhibit A** in the Appendix for the statewide averages of the adult PFEP fidelity elements. The overall statewide average for adult PFEP is 2.85 out of 5.0 on the fidelity scales.
Fidelity elements with the highest statewide averages are:

- Individual education on treatment (3.34)
- Individual education on self-monitoring & self-management (3.13)

Fidelity elements with low statewide averages that need improvement are:

- Education is offered to family members (1.99)
- Individual education on disorder (2.88)

B. Adult Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy is a brief, structured therapeutic treatment approach in which clients with Major Depressive Disorder are taught strategies to recognize and alter dysfunctional thinking patterns and behaviors and to solve current problems.

Thirty-five out of thirty-eight LMHAs provide Cognitive Behavioral Therapy. Several LMHAs had between two and three clients authorized for CBT for the review period. Self-assessment results indicate that although clients were authorized for this service some did not receive any counseling. Reasons for no service included client refusal and/or no show for appointments.

Desk review found that progress notes often did not describe details such as the topics for the agenda that should be set at the beginning of each session and did not describe the therapist seeking client feedback to ensure understanding and reaction to the session. It is important for therapists to individualize goals and document progress on goals addressed in each session.

See **Exhibit B** in the Appendix for the statewide averages of the adult CBT fidelity elements. The overall statewide average for adult CBT is 3.10 out of 5.0 on the fidelity scales.
Fidelity elements with the highest statewide averages are:

- Structured and goal-oriented sessions (3.38)
- Behavioral interventions (3.29)
- Identifying automatic thoughts (3.28)

Fidelity elements with low statewide averages that need improvement are:

- Preparation for termination and relapse prevention (1.94)
- Identifying and modifying schemas (2.90)

C. Adult Psychosocial Rehabilitation

The Psychosocial Rehabilitation model offers an integrated therapeutic team whose low caseload and training allows extensive coordination, advocating, and delivery of broad-based rehabilitative services. Enhancing skill development and working towards integration of clients into their community requires more than simply following the steps in skill training manuals. It is essential to use spontaneous interactions and real-life issues of the day to provide skills training. The use of coaching, modeling, simple rehearsal, role-play rehearsal, verbal feedback, reinforcement, and homework assignments all provide effective skill acquisition when custom tailored for the individual and their environment.

The supported employment measures were the lowest scoring elements. Even though some clients TRAG dimension for employment needs were rated as "5" (high), providers noted on the review instruments that clients refused services or were not interested in seeking employment. When a client no longer wants to seek employment the client should be reassessed and the TRAG dimension scored as a "1" (no need or desire to work).

The fidelity element "zero exclusion" means that the LMHA does not require that the client meet any job readiness criteria before receiving supported employment services. This is either a "Yes" or "No" rating; and was often left blank without an explanation or scored as "No" even though the TRAG did not have an employment need.

Desk review found evidence of skills training but primarily instruction only without modeling, role playing, and repetition. Clients with employment and substance use issues did not receive services based on their assessment.

See **Exhibit C** in the Appendix for the statewide averages of the adult Psychosocial Rehabilitation fidelity elements. The overall statewide average for Psychosocial Rehabilitation is 3.09 out of 5.0 on the fidelity scales.
Fidelity elements with the highest statewide averages are:

- Recovery orientation (4.62)
- Range of services (4.17)
- In-vivo service delivery (3.86)

Fidelity elements with low statewide averages that need improvement are:

- Individual job search (1.63)
- Rapid job search (1.85)
- Service Intensity (1.94)

D. Adult Assertive Community Treatment (ACT)

Assertive Community Treatment offers the most extensive level of services. The ACT multidisciplinary staff works as a team and provide the majority of treatment, rehabilitation, and support services. Literature supports that ACT programs with high fidelity have higher rates of retention in treatment, greater remission from substance use disorders, and fewer hospitalizations. There are seventeen LMHAs who provide ACT services. The adequate measure of fidelity for service intensity is an average of 10.7 hours per month per consumer.

Desk review found comprehensive progress notes documenting frequent and intense services. However, clients with employment and substance use issues did not receive services based on their assessed needs.

See **Exhibit D** in the Appendix for the statewide averages of the adult ACT fidelity elements. The overall statewide average for ACT is 3.73 out of 5.0 on the fidelity scales.
Fidelity elements with the highest statewide averages are:

- Needs based services (4.86)
- Team approach (4.67)
- Responsible for crisis services (4.46)

Fidelity elements with low statewide averages that need improvement are:

- Intensity of services (2.72)
- Secondary interventions for treatment non-responders (2.76)
- Stage-wise interventions (2.84)

E. Adult Assertive Community Treatment Alternative

ACT Alternative is provided by twenty-one LMHA's who have been granted a waiver from ACT services by DSHS. This waiver is based on geographical distribution of clients and numbers of clients who are recommended for ACT that are too low to support a dedicated team. LMHAs that provide ACT Alternative are required by the Performance Contract to deliver Psychosocial Rehabilitation services and also provide 80% of services in-vivo and the team must provide an average of 10 hours of services per client per month and a minimum of 4 hours of service per client per month.

See **Exhibit E** in the Appendix for the statewide averages of ACT Alternative. The overall statewide average for ACT Alternative is 3.17 out of 5.0 on the fidelity scales.
Review elements with the highest statewide averages are:

- Recovery orientation (4.58)
- Range of services (4.58)
- Zero exclusion criteria (4.96)

Review elements with low statewide averages that need improvement are:

- Rapid job search (1.47)
- Individual job search (1.71)
- Benefits planning (1.91)

F. Child and Adolescent Patient and Family Education Program (PFEP)

Patient and Family Education is a component of the Texas Implementation of Medication Algorithms (TIMA). Patients and family members need to have an understanding of the youth's mental illness and of treatment options in order to play an active role in treatment planning and self-management. Increased understanding and active participation are also expected to increase the likelihood that the patient will follow through with treatment recommendations. Education can also increase the patient's and family's awareness of symptoms and side effects and provide them with terminology to better communicate with clinicians so that treatment can be fine-tuned, or tailored, to the individual's needs. The education program also aims to teach youth and families coping strategies.

Several LMHA providers left Patient and Family Education Program fidelity elements for children and adolescents blank or "N/A" if the client was not on medication. Even though the client was not on a medication they should have received education on their disorder, coping with their disorder, and other education related elements. DSHS changed these blank or "N/A" scores to "No". Fidelity results indicate a misunderstanding about the need for education on the disorder even though there

are not any TIMA disorder materials for diagnoses other than Attention-Deficit/Hyperactive Disorder and Depressive Disorders. LMHAs may identify appropriate disorder information materials and medication treatment that is not included as part of the TIMA algorithms or PFEP, and seek approval for alternate materials from DSHS.

Desk Review results found education on the disorder but no mention of TIMA materials. It was also very difficult to determine if education about the disorder was incremental, individually tailored, and developmentally appropriate from progress notes.

See **Exhibit F** in the Appendix for the statewide averages of child & adolescent PFEP fidelity elements. The overall statewide average for child & adolescent PFEP is 2.05 out of 5.0 on the fidelity scales.
Fidelity elements with the highest statewide averages are:

- Individual education on medication treatment (3.18)
- Education is developmentally appropriate (2.82)
- Individual education on disorder (2.80)

Fidelity elements with low statewide averages that need improvement are:

- Videotape information about the disorder (1.11)
- Referral to support groups (2.05)
- Individual education on coping with the disorder (2.46)
- Individual education on self-monitoring (2.48)

G. Child and Adolescent Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy is a collaborative approach based on the theory that thoughts, behaviors, and emotions are inter-related, and that faulty information processing can lead to the emotional and behavioral symptoms of depression and anxiety. CBT is structured and focuses on teaching new skills, in-session practice of skills, and feedback until skills are demonstrated. LMHAs have requested a better definition of "reward system".

The desk review generally found very good implementation, but some progress notes were not individualized to clearly document what occurred during the session. Sessions should be numbered based on the actual sessions and not on the sequence numbering of the curricula. If a therapist needs more than one session to address a session in the curricula, the content that was covered and/or any topics that needed additional practice should be documented.

See **Exhibit F** in the Appendix for the statewide averages of child & adolescent CBT fidelity elements. The overall statewide average for child & adolescent CBT is 2.47 out of 5.0 on the fidelity scales.
Fidelity elements with the highest statewide averages are:

- Structured sessions (3.62)
- In-session practice (2.97)
- Self-monitoring (2.90)

Fidelity elements with low statewide averages that need improvement are:

- Graduated Exposure (anxiety) (1.18)
- Reward System (1.49)
- Relaxation strategies (1.75)

H. Child and Adolescent Skills Training

Skills training is for children and adolescents who exhibit non-compliant, defiant and anti-social disorders and their parents and caregivers. Because skills training involves highly structured and interactive sessions it requires the clinician to engage clients in a partnership; inspiring hopefulness and connecting in a personal, supportive relationship. Most skills training modules should be taught across several sessions.

Desk review analysis indicates a lack of documentation to reflect a connection between client goals and what was addressed during skills training sessions or day to day life. There was also a lack of participation with the parent/caregiver in behavioral management training. Improvement in documentation is needed in the following areas:

1) identifying home practice assignments that relate to the skills taught or previously taught and review at the next session;
2) application of skills taught to specific problems identified by client or caregiver;
3) when there is a lack of cooperation with parent/caregiver, there should be a discussion with client on how to self-reward or appreciate the progress they are making when the parent/caregiver is not providing that praise.

See **Exhibit F** in Appendix for the statewide child & adolescent Skills Training fidelity elements. The overall statewide average for child & adolescent Skills Training is 2.77 out of 5.0 on the fidelity scales.

Fidelity elements with the highest statewide averages are:

- Structured and goal-oriented sessions (3.89)
- Social and general problem solving skills (3.36)
- Skills to express feelings (3.13)

Fidelity elements with low statewide averages that need improvement are:

- Unreasonable beliefs (Defiant teens) (1.56)
- Problem-solving skills (Defiant teens) (2.27)
- Communication skills (Defiant teens) (2.36)

I. Child and Adolescent Wraparound Planning

Wraparound planning is a collaborative team-based process for services and supports with the family teams comprised of a number of individuals selected by the children, adolescents and their families who offer informal and formal supports. One of the critical elements that need improvement is the first family team meeting where the team completes the wraparound assessment and identifies key information.

LMHAs comments on the review instruments indicate that Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) requirements impact what skills are taught as well as the appropriate use of the treatment model. Apparently service requirements delineated in the memorandums of understandings between each LMHA and TCOOMMI vary across the state. The desk review found that additional training is needed on the wraparound process and the use of family partner. Documentation indicates that crisis planning is not occurring as required. A crisis plan should identify natural supports that are available during crises as the first response as opposed to the use of the hotline or 911.

See **Exhibit F** in the Appendix for the statewide child & adolescent Wraparound Planning fidelity elements. The overall statewide average for child & adolescent Wraparound Planning is 2.52 out of 5.0 on the fidelity scales.

Fidelity elements with the highest statewide averages are:

- Provision of unconditional care (3.42)
- Family Inclusion (3.30)
- Individualized Service Plan (3.08)

Fidelity elements with low statewide averages that need improvement are:

- Strengths based strategies (1.91)
- First Family Team Meeting (1.87)
- Discharge Readiness Criteria (1.94)
- Flexible Resources (2.04)
- Community-based Crisis Plan (2.08)

LMHA Oversight and Improvement

LMHAs should use the fidelity self-assessment results to identify and implement plans to improve service delivery systems. Ongoing self monitoring with plans of improvement should help identify and prioritize areas that need additional training and supervision. Ongoing program reviews and oversight by Program Supervisors as well as Quality Management should help to familiarize staff with fidelity expectations and to inspire staff in working toward achievement of recovery for the clients they serve.

Recommendations

Strategies to improve fidelity across all EBP:

1. Identify staff member(s) who are responsible for PFEP implementation across all providers;
2. Design efficient, standard way to document use of educational materials (if change in TIMA forms, obtain DSHS approval);
3. Develop strategies to support peer groups (contract with local consumer groups, offer meeting space, food, supervision);
4. Offer stipends for peer volunteers to help with their travel and time;
5. Develop specific forms to prompt staff in documenting detailed requirements. *Denton County MHMR Center* uses a Family Needs Assessment Form that is completed at time of initial and 90 day treatment plan review to document desire for family involvement and recommendations for family education and referrals;
6. Supervision is a critical factor in promoting positive clinical change in service delivery. Several articles have stressed the importance of front line supervision to help translate theory into daily action and increase EBP implementation (Torrey, et al, 2001);
7. Passive educational approaches such as didactic presentation and dissemination of practice guidelines are ineffective at producing changes in practice. There must be interactive and experiential training with ongoing supervisor feedback;
8. Provide greater specificity in treatment plans and progress notes. Evidence-based practices necessitate specific strategies and techniques that require detailed documentation. Treatment plan and progress note formats should be designed to facilitate documentation. Desk review results indicate that Central Plains Center has a good treatment plan and progress note format to assist providers in documentation for CBT and Wraparound Planning. The Center for Health Care Services also has a comprehensive treatment plan format for Psychosocial Rehabilitation and ACT services;
9. Provide refresher classes to increase staff understanding of recovery and evidence-based practices; and

10. Organizational support for engaging clients and families including:
    a. modify center operating hours to allow flexible access to services,
    b. utilize family partner to provide engagement support, and
    c. adjust caseloads to allow greater partnering and relationship building.

Quality Improvement and Follow-up

The purpose of the fidelity assessment in Resiliency and Disease Management is to ensure appropriate implementation of Evidence-Based Practices (EBP) and to promote recovery. System measures of implementation and adherence are important to demonstrate the validity of outcome data and to provide DSHS with the ability to support the most effective practices throughout the State. Critical to the success of the fidelity process is detailed feedback and recommendations to providers that can be used to improve services.

DSHS is in the process of creating a formalized process for LMHAs to seek and obtain approval for alternate TIMA and PFEP materials. DSHS has also created a unit to provide training and technical assistance for providers. Suggestions from LMHAs requesting web-based training and patient and family education materials on DVDs and in Spanish will also be explored.

DSHS has gradually increased the scope of fidelity reviews to inform providers of the expectations for the provision of evidence-based practices. Onsite reviews with multiple reviewers examining multiple sources of information are the best methods to evaluate fidelity; however it requires additional resources in terms of time and staff experienced in the evidence-based practices.

At least two comprehensive onsite fidelity reviews will be completed by DSHS in FY 2007 to evaluate program characteristics and implementation practices. The purpose of the reviews will be to identify best practices and to determine the relationship between program implementation and outcome measures.

References

1. Bond, G., Williams, J., Evans, L. Salyers, M., Kim, H., & Sharpe, H. (2000). Psychiatric Rehabilitation Fidelity Toolkit. (HSRI Toolkit). Cambridge: the Evaluation Center@HSRI.

2. Torrey, W. C., Drake, R. E., Dixon, L., Burns, B. J., Flynn, L. , Rush, A.J., Clark, R.E., and Klatzker, D. (2001). Implementing Evidence-Based Practices for Persons with Severe Mental Illnesses. Psychiatric Services, 52: 45 - 50.