Tool for Measurement of Assertive Community Treatment (TMACT)

PROTOCOL

Part I: Introduction

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Tool for Measurement of
Assertive Community Treatment (TMACT)

Protocol Overview

The Tool for Measurement of Assertive Community Treatment (TMACT) is based on the Dartmouth Assertive Community Treatment Scale (DACTS).[1] This protocol is intended to guide your administration and scoring of the TMACT and is divided into the following two parts: Part I: Introduction and Part II: Itemized Data Collection Forms. Both parts are accompanied by an Appendix that provides additional tools and resources.

Part I: Introduction

This part of the protocol provides an overview of Assertive Community Treatment (ACT) and answers the basic questions "who/what/when/how" as they pertain to the scale and its administration. There is also a checklist of suggestions for what to do before, during, and after the fidelity assessment that should lead to the collection of higher quality data, more positive interactions with respondents, and a more efficient data collection process. Following a checklist can lead to more reliable and valid ratings, in addition to a more effective quality improvement consultation based on the evaluation findings.

Part II: Itemized Data Collection Forms

Part II of the protocol is organized according to the six TMACT subscales listed to the left within the following table:

Table 1. TMACT Subscales		
Subscale	**Description**	**Example Items**
1. Operations & Structure (OS)	12 items assess the organization and structure of the ACT team.	• Team Approach • Daily Team Meeting
2. Core Team (CT)	7 items assess the dedicated full-time equivalency (FTE) and roles of the team leader and medical staff.	• Team Leader on Team • Role of Nurses
3. Specialist Team (ST)	8 items assess the FTE and roles of the team specialists.	• Employment Specialist on Team • Role of Peer Specialist
4. Core Practices (CP)	8 items assess more general ACT services, which include the direct provision of those services (vs. brokering), as well as the nature, frequency, and intensity of services.	• Intensity of Service • Full Responsibility for Psychiatric Rehabilitation Services
5. Evidence-Based Practices (EP)	8 items assess specialized services, which include the direct provision (vs. brokering) of those services, as well as the degree to which the full team embraces the philosophy and practice of core evidence-based practices for clients typically served within ACT.	• Full Responsibility for Wellness Management and Recovery Services • Integrated Treatment for Co-occurring Disorders
6. Person-Centered Planning & Practices (PP)	4 items assess core practices that facilitate recovery by enhancing client self-determination and utilizing person-centered treatment planning and service delivery.	• Person-Centered Planning • Strengths Inform Treatment Plan

Part II includes the following information for each TMACT item:

- _Definition and rationale:_ These items have been derived from a comprehensive review of relevant literature and research, as well as expert opinion regarding high fidelity ACT practices and team characteristics. Our experts included technical consultants proficient in fidelity evaluation, mental health services researchers, ACT team leaders, psychiatric care providers, and administrators of ACT teams.

- _Data sources:_ For each item, the protocol includes a list of recommended data sources (e.g., chart review, clinician interview, and observation of the daily team meeting). The suggested primary data source is noted with an asterisk (*); when there is inconsistent information across data sources, we suggest giving more weight to the primary data source.

> **Note:** Part II of the TMACT protocol is intended to serve as a workbook for evaluators to use for each fidelity evaluation.
>
> Space is provided for evaluators to make note of specific program information, including writing notes and responses to interview questions as they are conducting the evaluation.

- _Interview and probe questions:_ Interview and probe questions are included to help elicit the critical information needed to score each fidelity item. **Bold, italicized** typeface questions were specifically generated to help fidelity evaluators collect bias-free information from respondents. Additional follow-up questions (in _regular, italicized_ typeface) should also be asked, as needed, to obtain the necessary information to judge whether item criteria are met. Over time, seasoned fidelity evaluators will develop their own styles and may use these sample questions more as a guide rather than asking them verbatim. Note that the 30-minute team leader phone interview can be conducted before the onsite evaluation to gather more objective data and allowing the onsite review to be as efficient as possible. Please see page vii in Part II of the Protocol for page references for each question.

- _Decision rules and rating guidelines_: As fidelity evaluators collect information from various sources, these rules and guidelines will help to determine the appropriate rating for each item. Rules and guidelines may include more detailed item definitions, data inclusion and exclusion specifications, formulas for calculation (with a companion TMACT Formula Workbook), and concrete examples of program features that meet full, partial, or no credit for a specific criterion. For items that include the option of granting full or partial credit for specific criteria, we have included tables and/or checklists to help organize and better specify guidelines for each level of practice (e.g., see Table under ST5. Employment Specialist in Services Role).

- _Additional Data Collection Forms:_ While there is space to document interview responses and other data within each specific item in Part II, there are several data collection forms included at the back of Part II of the protocol to assist with documentation related to specific data sources.

Appendix

This section includes several forms to help the evaluator organize the fidelity site visit and data collection:

- _Appendix A. Sample Fidelity Orientation Letter:_ This letter provides the team with information about what the fidelity evaluator will need and what to expect during a fidelity assessment. In addition to what is listed here, it will be important to individually tailor information about the purpose of the specific fidelity assessment, as well as identify who will have access to the written report based on the assessment.

- *Appendix B. Team Survey & Sample Excel Spreadsheet:* These documents specify data for the team to collect and report prior to the fidelity review. The purpose is to assist the evaluators in conducting a more efficient on-site evaluation, as the evaluators can prepare follow-up questions beforehand and reference these data throughout the evaluation (e.g., during interviews, while conducting chart reviews, while observing team processes).

- *Appendix C. Sample Fidelity Review Agenda:* This sample agenda provides an outline of the various activities of the fidelity review process. Each agenda should be tailored to each team, particularly with respect to scheduling observation of their regularly scheduled daily team meetings and treatment planning meetings, as well as scheduling team member and client interviews at their convenience. Similar to the practice of ACT, the fidelity review schedule is tentatively specified so that the review can be responsive to changes in the team's schedule on both days.

- *Appendix D. Sample Fidelity Feedback Report:* This report is included to provide an illustration of the type of feedback typically given to teams in a written format. We recommend that it should be provided to the team within two months after the review is complete and before their feedback session is held. This sequence ensures that the team has time to review and provide feedback on the report in advance.

- *Appendix E. DACTS-TMACT Crosswalk:* This section includes the full DACTS summary scale as well as all data sources available within the TMACT. This allows for the calculation of each DACTS item so that a full DACTS scale can be rated and used as a comparison to the TMACT or to provide historical continuity. This may be useful for evaluators who are using the TMACT as a research tool, with the intent of comparing TMACT and DACTS ratings. Parallel TMACT and DACTS ratings may also be desirable in states where the DACTS is a requirement for licensing, certification, or other purposes, but also where the team is using the TMACT as guidance for quality improvement.

Tool for Measurement of Assertive Community Treatment (TMACT)
Introduction

ACT Overview

ACT is a program model that uses a transdisciplinary team[2] to provide comprehensive services to address the needs of persons with severe mental illness (SMI). Since its original implementation in Madison, Wisconsin in the 1970s,[3] a fundamental charge of ACT is to be the first-line, if not sole provider of all the services that ACT clients need. Extensive research showing ACT's positive effect on client outcomes, particularly regarding reduced hospitalization, earned ACT the prestigious evidence-based practice (EBP) status in the 1990s.[4,5]

However, since ACT's inception and subsequent designation as an EBP, we have learned a great deal about what ACT clients want and need, as well as the most effective services for meeting those needs. More specifically, the field's concept of possible goals and outcomes desired by ACT clients has evolved. Early on, there was much greater emphasis on substantially slowing the revolving hospital door; we now have a greater focus on helping clients become more active in their communities, obtaining competitive employment, and improving self-sufficiency so that dependence on ACT and other professional services gradually decreases -- all goals inherent to the concept of recovery.[6,7]

Another important change in the field entails increased knowledge about how to best assist clients in achieving such goals—in particular, the growing body of evidence for the kinds of practices clinicians serving this population should employ. Neither the technology of EBPs nor the vision of recovery were known or embraced in the early years of ACT development and dissemination,[8] but the model was nonetheless defined in terms of providing the best possible practice at the time.

Although there continues to be emerging research in the modification and application of ACT with select clinical populations (e.g., forensic,[9,10] children and youth with serious emotional disturbances[11]), it is assumed that ACT is most appropriate for individuals with SMI (e.g., schizophrenia, bipolar disorder) who have continuing high service needs (e.g., multiple or long-term hospitalizations) and significant functional impairments, which often include lack of engagement and/or insight, that make it difficult for them to navigate a complex treatment system and transfer learning across environments. It is similarly assumed that individuals appropriate for ACT will have multiple needs that span from basic survival in the community (e.g., access to housing, food) to psychosocial treatment.

The view of ACT offered through the TMACT is a contemporary update[12] that comprises the following:

(1) *Flexible and individualized application of resources*, where the team delivers highly responsive, individualized, biopsychosocial and rehabilitative services in clients' natural environments that address clients' goals and needs and are provided with appropriate timing and intensity;

(2) A *team approach to treatment delivery,* where a multidisciplinary group of providers with individual areas of expertise share responsibility for meeting clients' complex service needs, integrating care, and providing an armory of service interventions; and

(3) *Recovery-oriented services as the focus of care,* where the team promotes self-determination and respects clients as experts in their own right.

TMACT Overview

The TMACT is based on the DACTS, which was developed to measure the adequacy of ACT team implementation. Differences from the earlier scale variously reflect important but previously omitted features of ACT, refinements in measurement, and evolution of the model. Compared to the DACTS, the TMACT is more sensitive to change,[13] as the TMACT is a more nuanced measure of ACT program fidelity and sets a higher bar for ACT program performance. Recent research further suggests that higher fidelity scores on the TMACT were associated with reductions in state hospital and acute crisis unit stays.[14]

The TMACT has 47 program-specific items. Each item is rated on a 5-point scale ranging from 1 ("not implemented") to 5 ("fully implemented"). Standards used for establishing the anchors for the "fully-implemented" ratings were determined by a combination of expert opinion and the empirical literature. As described previously, the TMACT items fall into six subscales:

(1) Operations and Structure (OS);

(2) Core Team (CT);

(3) Specialist Team (ST);

(4) Core Practices (CP);

(5) Evidence-Based Practices (EP); and

(6) Person-Centered Planning and Practices (PP).

Items are approximately evenly divided between aspects of program performance that are directly quantifiable across the team, a selected group of staff, or a sample of clients. Furthermore, others are measured through a synthesis of observations or reports of practice across a number of related dimensions.

This scale is intended to be used to assess the ACT team's work with *enrolled* clients (vs. clients identified for transition to ACT), with the exception of those items that focus on screening, admission, and transition processes. Further, scale ratings are based on *current* behaviors and activities (vs. planned or intended behaviors). For example, to get full credit for CP6 (Responsibility for Crisis Services), it is not enough that the team is currently developing an on-call plan.

Intended Use of the TMACT

The intended use of the TMACT is to glean a snapshot of current ACT team structure, staffing, and practices to compare with a contemporarily defined ACT model (i.e., program fidelity). The ultimate purpose of this comparison is to guide quality improvement consultation while providing reliable quantitative indicators of critical dimensions of performance for potential research and evaluation.

The detailed specification of practice within the TMACT, as well as accompanying tools, can help guide those involved in ACT implementation to identify core areas of relative strengths and weaknesses to target ongoing performance improvement efforts. The developmental progress of the team can be captured in a repetitive series of these fidelity assessments.

Some states and agencies tie fidelity scores to specific certification or licensing standards. While this approach may help to ensure consistency between the two types of standards, it should not be assumed that teams should receive the highest score (i.e., 5) on all items. That is, if the purpose of licensing and certification is to set a minimum standard of performance, then teams should not be

held to the maximum score possible. Instead, teams should be held accountable to a threshold score or an acceptable range, with specific performance improvement expectations tied to lower scores.

Unit of Analysis

The TMACT is appropriate for organizations that serve clients with SMI and for assessing adherence to ACT. If the scale is intended for use at an agency that does not have an ACT team, a comparable service unit should be measured (e.g., a team of intensive case managers in a community support program). This scale measures fidelity at the *team level* (vs. individual or agency level)*.

Elements Not Assessed

It is important to note that some elements of the ACT team are not directly assessed within the TMACT, but are likely indirectly assessed across several items. Other elements are excluded because they are macro-level features of the team; these elements may not be rated, but are still worthy of evaluators' attention for the purpose of quality improvement consultation.

Practice of Each Individual ACT Team Member. Not all staff that typically comprise the ACT team (e.g., mental health professionals, rehabilitation specialists, case managers) are specifically assessed by the TMACT. This is not to say that these individuals are unimportant within ACT.

However, what we find nationally is that many teams tend to employ more generalist staffing by default, but have more difficulty with fully integrating other core staff such as the specialists, psychiatric care providers, and nurses on the team. This makes these individuals more essential to evaluate and holds the team accountable for their inclusion.

Furthermore, these other staff roles (e.g., mental health professionals, rehabilitation specialists, case managers) are assessed and/or assumed within other items such as Empirically-Supported Psychotherapy (EP7) and Full Responsibility for Psychiatric Rehabilitation Services (CP8). Teams would typically perform poorly on these two items if they did not have staff with clinical expertise on the team. Further, the TMACT does assess overall program size (please see OS5. Program Size) to ensure that teams are not too small for the number of clients they are serving. Clinicians and case managers are assumed within that team size.

Importance of a Generalist Approach. While many TMACT items focus on the staffing and role of specialists within ACT, there are no items that specifically focus on the importance of a generalist approach. This is primarily because many teams tend to focus on a generalist approach at the expense of ensuring that team specialists are functioning within their specific role and targeting their interventions toward their specialty area.

A generalist approach is important within ACT, and many specialists can address their specialty area even within the context of providing generalist services (e.g., an employment specialist can talk about work interests on the way to the grocery store with a client). Likewise, "generalist" staff may assume greater responsibility for providing a specialty service. Rating guidelines prompt evaluators to assess generalists' contributions to a specialty area of service in relevant items (e.g., ST1. Co-Occurring Disorders Specialist on Team and ST4. Employment Specialist on Team), thereby giving credit to teams who may assume more of a generalist approach to service delivery.

Administrative or Personnel-Related Elements. Reflecting the complexity of ACT, the TMACT includes the assessment of 47 distinct elements that represent over 120 specific criteria. Despite this breadth, feasibility has necessitated limiting what is measured, thus emphasizing program features specific to the ACT model and omitting formal measurement of more general or non-specific features, even if the latter might be associated with well-performing teams. For example, two items previously included in the DACTS (H5. Continuity of Staffing, and H6. Staff Capacity) are not included within the TMACT.

Nonetheless, we do encourage fidelity evaluators to attend to more macro-level program features that are not specific to ACT but may have a significant impact on ACT practice (e.g., staff turnover, administrative leadership). Observations about these and other aspects of program context can potentially be essential to the recommendations provided, resulting in a higher quality consultation.

Application of Telecommunications. Telehealth applications are viewed as an important new direction for mental health providers, particularly those who provide services in rural areas. As this is still an emerging area for ACT specifically, the TMACT does not currently incorporate consideration of these technologies in specific ratings at this time.

Assessing Psychiatric Rehabilitation Services: We recognize that ACT is firmly grounded in the philosophy and practice of *psychiatric rehabilitation* (i.e., helping people develop and access skills and resources that will help them to live more fully and independently in the community). While these services focus on living, working, learning, and socializing, the TMACT assesses these four domains across several service-related items that also address these four domains. The domains of working and learning are assessed within the employment service items, while some aspects of living and socializing are captured within the wellness management services item (e.g., Illness Management and Recovery [IMR] also targets skills training in these domains) as well as in another item more specifically looking at psychiatric rehabilitation interventions not otherwise assessed elsewhere.

How the Rating is Completed

To be valid, a fidelity assessment should be conducted in person through a site visit (except for the brief, team leader phone interview). The data collection procedures include chart review, observation of the daily team meeting and a treatment planning meeting, community visits, and semi-structured interviews with the team leader, team clinicians, specialists, and clients served by the team. Using two fidelity evaluators, we estimate that an evaluation can be completed between one and a half to two days.

Some items require calculation of either the mean or the median value of service data (e.g., median number of community-based contacts). Specific calculation instructions are provided for individual items (see below and within Part II of the protocol).

Who Completes the Fidelity Review

Number of Evaluators. We recommend that at least two evaluators administer the TMACT to facilitate a complete and efficient fidelity assessment. Two to three evaluators have more capacity to collect more impressionistic data and discuss which rating best fits their collective impressions. This process produces more reliable and valid item ratings, especially where subjective impressions weigh more heavily into rating judgments. Also, a great deal of information is exchanged during interviews and data are often more accurately captured if one evaluator assumes the lead responsibility for that interview while the other takes more responsibility for taking notes.

TMACT evaluators typically work together during much of the evaluation (e.g., both observe the daily team meeting and interview the team leader together, which is the most time-consuming interview), but they may part ways to collect other data independently if time considerations and/or staff scheduling conflicts are a concern (e.g., one evaluator stays in the office to interview the employment and peer specialist while the other rater goes on a site visit with the co-occurring disorders specialist, conducting an interview *en route*). The evaluators may regroup at the time of the chart review, where they complete the chart

review forms on their allotted charts.. Independently collected data (e.g., notes from interviews, observations, and charts) are then shared at the end of the visit so that each evaluator can score items on their own, followed by consensus-rating on final scores at a later time.

Program Affiliation of Fidelity Evaluators. We recommend that the fidelity evaluators are independent of the agency or, at a minimum, independent of the team. External evaluators are more likely to conduct a more objective and valid assessment. Internal evaluators may tend to overestimate and inflate ratings. This bias may be due to incentives associated with receiving a higher rating.

Such bias may also be due to the likelihood that internal raters rely more heavily on their own familiarity and pre-existing impressions of the team. This may lead to them conducting a less comprehensive assessment that could have revealed significant inconsistencies across data sources. We understand that circumstances will dictate decisions in this area, but encourage agencies to choose a review process that fosters objectivity in ratings (e.g., by involving a staff person who is not centrally involved in providing the service).

Competency of Fidelity Evaluators. We recommend that evaluators have a thorough understanding of the ACT model. As noted previously, several items involve some rater judgment based on overall impressions; therefore, a valid rating will be more likely if the evaluator understands the underlying philosophy of that particular element of ACT.

Ideal Evaluator Characteristics:
- Thorough understanding of ACT
- Independent of the team being evaluated
- Strong interviewing and data collection skills
- Able to synthesize data
- Proficient in QI consultation

Further, for the TMACT to be effectively used as a quality improvement tool, the evaluator will be competent in the ACT model and able to provide useful feedback in areas of deficiency. Fidelity assessments should also be administered by individuals who have experience and training in interviewing and data collection procedures (including chart reviews), in addition to how to use the TMACT.

A **recommended training model** includes the following:

(1) A didactic one-day workshop on the TMACT;

(2) Participatory training where the trainees assist more skilled fidelity evaluators in conducting a fidelity assessment using the TMACT (e.g., they simultaneously collect data, help review charts, rate items independently, participate in establishing consensus ratings, and review and edit written fidelity reports);

(3) Trainee-led evaluation of a team while being shadowed by a skilled fidelity evaluator; and

(4) A plan for supervising trainees' oral and written feedback to assure reliability and validity of ratings and the development of consultation skills for the reviewed teams.

Real World Evaluation Issues: Prorating and Dealing with Missing Data

Given that these data are collected within the field in an uncontrolled environment, we recognize that there are bound to be measurement and data issues. While attempts have been made to directly address some of these possible issues within specific items, we also provide general guidelines for addressing these issues as they come up in the fidelity assessment.

Rating a Newly Established Team: For ACT teams in the start-up phase, the time frame specified in individual items may not be met. For example, item OS8 asks for the number of new clients admitted during the last six months. Assessors should prorate time frames for teams that have been in operation for a shorter duration than specified in the individual items. If the normal procedure for selecting charts would result in 10 or fewer charts, review <u>all</u> charts instead of 20% of the total number of charts (Please see instructions for specific items). Other items may be rated lower as a result of the recent implementation, which would be expected and commented on in the feedback.

Prorating and Extrapolation: Item anchors that rely on quantifiable data are typically based on a 100-client ACT team. As most ACT teams do not serve exactly 100 clients, formulas are provided where needed to calculate a prorated result given the number of clients served.

Missing Data: With a few select exceptions, which are discussed below, this scale is designed to be comprehensive (i.e., no missing data). It is essential that raters obtain the required information for every item, unless otherwise indicated within this protocol, as well as accurately recording responses provided by the interviewees. If information cannot be obtained at the time of the site visit, it will be important for the raters to collect it within a week of the onsite evaluation. If there is concern that observed data are clearly invalid, it may be more appropriate to not rate that item, omitting it from all final rating calculations. For example, a team that includes travel time (without client present) in documentation of service duration should not be rated on CP3. Intensity of Services.

Omitting specialist "role items" from TMACT subscale and total rating calculations: Each of the specialist "staffing items" (ST1, ST4, and ST7) are followed by one or two staff "role items" that assess practice with clients (i.e., Role in Treatment/Employment Specialist), as well as practice with fellow team members (i.e., Role Within Team).

If no staff person is in the position (rating a "1" on the respective staffing item, e.g., ST1), it can be assumed that the role items (e.g., ST2 and ST3) would also be rated as "1" given that no one is hired into the position to perform these functions. Likewise, newly hired specialists may be engaged in training and orientation, resulting in precluded role items.

Note: These conditions *do not* apply to Core Team (CT) staffing items.

The following conditions are intended to protect against penalizing teams who experience normal staff turnover and seek to fill these positions in a timely manner; such conditions are intended to enhance the overall validity of the TMACT.

- o *Vacant Position:* If no one has been hired into one of the assessed Specialist Team Staffing items (ST1, ST4, and ST7), then rate the respective item a "1."

  - If the position has been <u>unfilled for 6 months or less</u>, do <u>not</u> rate associated "role item(s)."

  - If this position has been <u>unfilled for more than 6 months</u>, continue to rate the respective "role item(s)" accordingly (i.e., rating "1" for each role item).

- o *Recently Filled Position:* If a specialist was recently hired into one of the assessed Specialist Team Staffing items (ST1, ST4, and ST7), rate the respective item according to the Rating Guidelines, which take into account the time spent delivering specialty services (and would be expected to be lower for newly hired staff).

  - If the specialist has been in the position for <u>2 months are less</u>, do <u>not</u> rate the associated "role item(s)."

  - If the specialist has been in the position for <u>more than 2 months</u>, rate the "role item(s)" accordingly (i.e., assess those practices and functions carried out, e.g., ST2 and ST3).

- o When calculating subscale and total ratings, any excluded "role items" are not included in the count. For example, if the co-occurring disorders specialist position was unfilled for two months, the team is rated a "1" on ST1 and not further assessed on ST2 (Role of Co-Occurring Disorders Specialist in Treatment) or ST3 (Role of Co-Occurring Disorders Specialist within Team). When calculating the Specialist Team (ST) subscale score and total TMACT score, the item scores are summed and divided by 6 items (rather than 8) and 45 items (rather than 47), respectively.

Fidelity Evaluator Checklist

<u>**Before the Fidelity Site Visit**</u>

Fidelity assessments require careful coordination of efforts and good communication, particularly if there are multiple fidelity evaluators and stakeholders involved in the review process. The following checklist provides necessary activities leading up to the fidelity review.

It may be useful to individually tailor this list for your specific fidelity assessment needs. For instance, the timeline might include a note to make reminder calls to all parties involved in the review process to confirm interview dates and times.

1. ***Establish a contact person for the ACT team.*** You should have one key person within the team who arranges your visit and communicates the purpose and scope of your assessment to program staff in advance. This key person is typically the ACT team leader.

2. ***Establish a shared understanding regarding the purpose of the review.*** It is <u>essential</u> that the fidelity assessment team communicates the goals of the fidelity assessment to the team and agency; assessors should also inform the team about who will see the report, whether the team will receive this information, and exactly what information will be provided.

   The most successful fidelity assessments are those that have a shared goal among the assessors and the program site personnel to understand how the program is progressing according to evidence-based principles. If administrators or line staff at the team's agency fear that they will lose funding or look bad if they don't score well, then the accuracy of the data may be compromised. The best arrangement is where all parties are interested in getting at the reality of current practices to facilitate quality improvement.

3. ***Inform the contact person that internal agency agreements/consents may be needed.*** It is best to be able to observe the ACT team delivering their services across a range of settings, as well as to be able to talk with clients about their experience with the ACT team.

   Agencies may differ in terms of the level of authorization and protocol required for access to agency-operated service settings and residences, as well as internal consent procedures for interviewing clients on the team. For example, some agencies may require only verbal consent from clients, whereas others may require more formal, written consent. Some agencies may require that a HIPAA Business Association Agreement (BAA) is signed by the agency for whom the fidelity evaluators work. It is important for the contact person to understand that this may take some time to prepare, and that they should communicate about this with the team well ahead of the scheduled fidelity review. Agency administrators should also be consulted in advance where applicable.

4. ***Provide a general orientation to the fidelity review process,*** *particularly if this is the first fidelity review conducted with the team or there has been extensive staff turnover.* Holding such a meeting with at least the team leader prior to the fidelity review can be beneficial for not only establishing some of the details described previously, but to also discuss what will be needed to prepare for the review, what the review will entail, and how the data will be used. This will also provide an opportunity to answer any questions. If a meeting isn't feasible before the fidelity review, we suggest reserving some time toward the beginning of the review (e.g., before observation of the daily team meeting) to orient the team and/or team leader to the fidelity review process.

5. ***Schedule the fidelity review (at least one month prior).*** Exercise common courtesy in scheduling the fidelity review well in advance. Establish the dates of the fidelity assessment with all participants, including the co-fidelity evaluator, the ACT team, and any other program administrators who may be interested in participating in the debrief session at the end of the second day.

6. ***Send the fidelity orientation letter/email to the established contact person (4-6 weeks prior).*** You will need to briefly describe the information you will need, who you will need to speak with, and how long each interview and other observations will take to complete (please see Appendix A for a sample fidelity review orientation letter/email). The following list provides what you will plan to do and ask for during the review:

   - Chart reviews of a random selection of a minimum 20% sample (but no fewer than 10);
   - Review of daily team meeting tools and documentation, including Weekly Client Schedules, Daily Staff Schedules, and any communication logs used by the team;
   - Team member interviews with the team leader, psychiatric care provider, nurse(s), employment specialist(s), co-occurring disorders specialist(s), peer specialist(s), and the two most experienced clinicians, which should include the team therapist (based on the team leader's recommendation) within the team;
   - Client interviews, preferably in a group setting;
   - Observation of at least one daily team meeting;
   - Observation of one treatment planning meeting; and
   - Community visits with one to two team members while they work with clients.

   > **Note:** Evaluators should query the team leader (in the orientation letter and when developing the agenda) regarding whether any non-specialist staff members have additional expertise in the specialty areas, and therefore should be included in relevant specialist interviews.
   >
   > Although the qualifications standard may not be met, up to one additional team member may be counted toward the specialist FTE calculation.

7. ***Send pre-fidelity review materials (4-6 weeks prior).*** We recommend sending the pre-fidelity review materials along with the orientation letter/email. Pre-fidelity review materials include the Team Survey and Excel spreadsheet (Appendix B). We recommend that the team leader work collaboratively with other team members to accurately complete various portions of these documents. For example, the program assistant may be helpful in compiling staffing and client census information, while the co-occurring disorders specialist may take the lead in completing information about each client's stage of change readiness and the specific types of co-occurring disorder treatment services they are currently providing to each client. Teams will be asked to create a unique client identifier for each person they serve and to use that unique ID to fill out the client-level data in the Excel spreadsheet and the psychiatric hospitalization data in the Team Survey. The team will be asked to keep a copy of the actual client names and their corresponding unique client ID's and to make them available on site for each interview during the fidelity review, as team members will be asked to talk about their experience in working with several of the clients listed. These methods protect against any Protected Health Information (PHI) taken off site during the fidelity review.

8. *Develop the fidelity review agenda (2-4 weeks prior).* As shown in the fidelity orientation letter (please see Appendix A), it is helpful for the evaluator to ask a series of questions about the timing of various team activities such as the daily team meeting and treatment planning meetings team. Respect the competing time demands on team members and ensure that they work the fidelity review around the team's schedule and needs. For example, if a team's daily team meeting is typically scheduled in the afternoon, be sure to schedule other data collection around that meeting time (vs. asking for it to be completed at a different time to meet evaluator needs).

> **Who *is* part of the ACT team?** Using data received from the pre-fidelity Team Survey, begin to determine whether any of the listed team members fail to meet minimal TMACT requirements for team inclusion. See inclusion guidelines for items OS1 and OS5. In summary:
> - Part-time staff must work with the team at least 16 hours per week and attend at least 2 daily team meetings.
>   - In addition to the above, interns must be assigned to the team for at least 6 months.
> - For teams with more than one psychiatric care provider, each provider must work with the team at least 8 hours per week.
> - Only count the scheduled hours of work; availability to the team alone does not contribute to the staff's full-time equivalency with the team.

The team should <u>not</u> significantly modify usual care or daily team processes during the onsite evaluation to accommodate the evaluators' schedules. With this information, the evaluator can develop a draft agenda, which can be further developed with collaboration with the team leader. For example, the fidelity evaluator may include specific times for regular team activities within a draft agenda, but then specify placeholder times for the team leader to choose when to schedule specific interviews with team members. Please see Appendix C for an example of a fidelity review agenda.

The following are specific scheduling considerations:

- **Team leader interview.** The team leader interview ideally occurs toward the beginning of the first day of the fidelity review, as this is the lengthiest interview and provides the most comprehensive information about the team, therefore creating some context for the rest of the review. Splitting this interview into two sessions is also ideal, as scheduling with other staff interviews typically disrupts the team leader interview, and a couple of TMACT items (e.g., please see CP2. Assertive Engagement Mechanisms) are best followed-up with the team leader near the end of the evaluation, especially when the evaluators have several concrete examples from other data sources on hand.

- **Chart review.** The chart review ideally occurs near the middle of the evaluation (e.g., the middle or end of Day 1) so that evaluators will have an opportunity to review this significant data source before conducting several staff interviews. The information gleaned from the chart review will serve as an important point of reference for tailoring interview questions. We also recommend evaluators plan for additional chart review time on Day 2,

> **Team Leadership.** For teams with multiple layers of leadership (e.g., a program director, team leader, and assistant team leader), it is important to clarify who the team leader is prior to the visit.
>
> A *single* person is to be identified as the team leader. In the event the team operates with an **assistant team leader**, it may make sense to include both the assistant team lead in the team leader interview. However, only consider the practice of the team leader when rating CT1 and CT2. Newly hired team leaders may lack historical knowledge of team practices; in such events, including middle management who is familiar with the team's practices will likely produce more valid data.

even if evaluators need to split up with one conducting an interview and the other completing the chart review.

- **Observation of daily team meeting**. If it is determined that only one day of observation is feasible or needed, then schedule observation of the daily team meeting on the first day of the review and observe it during the time that it is regularly scheduled to ensure that both fidelity reviewers are available to observe during this time.
- **Plan for room accommodations.** Sufficient space is needed for evaluators to comfortably spread out materials when reviewing charts, as well as provide enough privacy for staff interviews to be held in confidence. If available, a board or conference room is preferred.

9. (Optional) *Schedule a phone interview with the team leader* (please see page vii in Part II of the Protocol for page references for questions). This interview is ideally conducted in the days prior to the onsite evaluation, and following receipt of the pre-fidelity survey materials (see above). The phone interview is intended to gather more objective and straightforward data, which can save time during the onsite evaluation. The interview takes approximately 30 minutes to complete.

10. *Complete the Program Information Cover Sheet.* This sheet can be completed as part of the optional team leader phone interview prior to the fidelity review or as part of the process of organizing the fidelity review. The Program Information Cover Sheet is useful for organizing your fidelity assessment, identifying where the specific assessment will be completed, and providing general descriptive information about the site, which may also guide follow-up consultation to the team. You may need to tailor this sheet for your specific needs (e.g., unique data sources, purposes of the fidelity assessment).

11. *Examine pre-fidelity review data (2-4 days prior).* It is important to ask to receive all fidelity review materials prior to the onsite evaluations. This ensures that there is adequate time to examine the data, make initial calculations, formulate follow-up questions for the interviews, and ask for clarification as needed (e.g., if it appears clear that an Excel item may have been misinterpreted, resulting in an underestimate of a service).

During Your Fidelity Site Visit

1. *Observe at least one daily team meeting.* It is recommended that you observe the daily team meeting during the time that it is regularly scheduled. If the team is unfamiliar to the fidelity evaluators and/or if there is a need to clarify rating of items that pertain to the daily team meeting or other core team processes, then schedule observation of the daily team meeting on both days of the review. In order to accomplish this within the limited two-day timeframe, both evaluators should observe the daily team meeting on the first day, with one evaluator observing on the second day while the other evaluator conducts other parts of the fidelity assessment (e.g., finishing chart reviews or beginning to tabulate chart data). Document your findings in the Daily Team Meeting Observation Form provided at the back of Part II of the Protocol.

> **Be an unobtrusive observer:** During the onsite evaluation, it is important that a typical day's practice is observed. It is critical that the evaluators take great care to practice as an "unobtrusive observer" during the evaluation and interview process so that team members are minimally influenced by the evaluators' presence and feel more comfortable during interviews.
>
> While observing meetings, sit away from the clinical team and silently observe practice, taking notes along the way. If using a laptop or notepad to take notes, we suggest that the note taker be sensitive to the experience of the interviewee.
>
> When the two evaluators conduct interviews together, we recommend that one evaluator take the lead as the interviewer and the other as note taker.

2. ***Review daily team meeting tools and documentation:*** This documentation may include Weekly Client Schedules, Daily Staff Schedules, and any communication logs used by the team. Review the Weekly Client Schedules of the same clients whose charts were reviewed. You may also want to scan other Weekly Client Schedules to assess their quality and the extent to which they tie to that particular day's Staff Schedule. Access these documents throughout the review to cross-reference team processes and interventions. Work with the team leader to ensure you are accessing them when they are not in active use by the team. Information gleaned can be documented in Part I of the Chart Review Log (i.e., Does this client's weekly schedule match the treatment plan?), as well as in the Daily Team Meeting Observation Form (Note tools used to guide daily team meeting and daily staff schedule), both of which are included in the back of Part II of the Protocol.

3. ***Observe one treatment planning meeting.*** It is recommended that you observe this meeting during the day and time that it is regularly scheduled. We encourage evaluators to schedule their visit when a treatment planning meeting has already been scheduled, or when several plans are up for review. This may increase the odds that such a meeting will occur during the visit. In the event that you are unable to schedule observation of a treatment planning meeting because of scheduling difficulties or the client does not wish to be observed, please refer to the other data sources to be used for rating this item (PP2. Person-Centered Planning). Document your findings in the Treatment Planning Meeting Observation Form provided at the back of Part II of the Protocol.

4. ***Conduct community*** *visits with one to two team members while they work with clients.* These visits will run anywhere between 30 minutes to over an hour, depending on staff and client availability. To make best use of the time, it may be desirable for one evaluator to attend community visits with previously interviewed team members or a team member who is not scheduled to be interviewed at all. It may not be ideal to simultaneously schedule a team member interview during a community visit, since the interview can be distracting for the driver. We discourage evaluators from requesting staff to significantly deviate from their planned schedule, which ultimately impacts the care that clients receive. We also discourage accompanying staff in the field when it is known that the total time in the field will exceed 120 minutes. In addition to making notes in the space provided in Part II of the Protocol where specified, document your overall impressions in the Community Visit Observation Form provided at the back of Part II of the Protocol.

5. ***Obtain a random sample of charts.*** Charts should be selected at random to enhance the generalizability of the sample and reduce potential bias. A process for random selection is suggested below. It is important to make sure to only review charts for clients admitted to the team at least 90 days prior to the visit.

   - Prior to the site visit, use the pre-fidelity review Excel spreadsheet (which should list all de-identified clients) to randomly select a minimum of 20% of client charts, or a minimum of 10 charts (for teams serving fewer than 50 clients). Attend to the second column of the Excel spreadsheet so that clients admitted to the team within the past 90 days are not selected for chart review. Random number generators can be found online; when a client is randomly selected who has not been with the team for at least 90 days, select the very next client name. http://stattrek.com/statistics/random-number-generator.aspx

- For all teams, a subset of 6 charts will be reviewed fully (i.e., both Chart Log Parts I and II will be completed), with the remaining charts more narrowly reviewed (i.e., Chart Log Part I) to obtain basic contact data to rate the following items: Team Approach (OS2), Priority Service Population (OS6), Community-Based Services (CP1), Intensity of Service (CP3), and Frequency of Contacts (CP4).

- When to substitute a chart for one from the original sample:

  a) If in review of the chart data, you see that the client had indeed been enrolled to the team within the past 90 days.

  b) If, by chance, the random sampling process results in a significant number of institutionalized (hospital or jail) clients. We suggest being conservative when deciding to substitute for this reason, as chart tally calculations evaluate the median unit across charts, which controls for outliers. However, if 20% or more of sampled charts are for clients who were institutionalized for the entire review period (and this clearly does not represent a typical practice of the team), then reduce this number by half, substituting in new charts selected at random.

    Examples include the following:
    - If, among the 10 charts reviewed for a 50 client caseload, 2 were in the hospital for most of the review period, then substitute 1 of those charts;
    - If, among the 18 charts reviewed for a 90 client caseload, 5 were in the hospital or jail for the review period, then substitute 2 of those charts.

Chart Selection and Review Reminders and Tips:

- Randomly select the greater of the following: 20% of consumer charts OR 10 charts (i.e., for teams serving fewer than 50 clients).
  - Note that full chart reviews (i.e., completing both Chart Review Logs I and II) only need to be completed for a subset of 6 charts.

- Select a 4-week time period (28 days, which includes weekend days, *not* an entire month).

- The 4-week review period should fall within 90 days prior to the onsite evaluation, as close to the review dates as possible.

- Determine the point at which charts are most current, allowing some time for notes to be documented and filed to better assure that evaluators are reviewing completed charts.

- Ask the team leader to orient evaluators to chart organization, especially: where various assessments are found, where treatment plans and reviews are filed, whether psychiatric care provider notes are filed separate from other team members' progress notes, and where service contact location and duration are documented.

- Cross-walk staff progress note entries with list of team members to be sure not to include non-ACT staff notes; be sure to exclude team members who do not meet TMACT guidelines for ACT team inclusion (e.g., employed fewer than 16 hours a week; intern on a 3-month rotation, etc.).

- Start with charts selected for the brief review using the Chart Review Log I; only data from progress notes are reviewed and documented. Although only face-to-face contacts with clients are counted in relevant items, it can be helpful to make note of all contacts and then go back through to edit out (e.g., cross out) those that need to be excluded (e.g., telephone calls, contacts with collaterals, attempts to contact, transportation with no meaningful intervention provided). This provides a fuller picture of services provided in that month, which can be shared in the qualitative feedback if it is noteworthy.

- If conducting a follow-up review with a previously assessed team, then modify the random sampling process to best ensure that the same clients are not selected for review each time.

> ***Again, limit such substitutions if there is a notable number of clients served by the team (i.e., 10% or more of entire caseload) who are in institutions, as this is likely indicative of some characteristic of the team's performance, which needs to be evaluated.

- If the team uses a level of care system where every client is classified or stratified, and if this level of care is related to intensity of services, then the preferred sampling method is to stratify the sample according to the level of care. For example, suppose the team has 50 Level One, 30 Level Two, and 20 Level Three clients. Then select 10 Level One, 6 Level Two, and 4 Level Three clients, using a random sampling strategy within each level.

- Conduct the same stratified sampling approach if the team is knowingly serving distinctly separate regions or areas, possibly using select staff to serve only those areas. Stratified sampling will help to ensure that clients living in select service areas – and possibly the select staff providing services to them - aren't over- or under-sampled in the chart review.

- Chart review time period: In some cases, there may be a lag between when a service is rendered and when it is documented in the client's chart. When sampling chart data, try to gather data from the most recent 4-week (i.e., 28-day) time period where documentation is completed in full. This allows for the most accurate representation of services rendered. The most up-to-date time period might be ascertained by asking the team leader, clinicians, or administrative staff. The point is to avoid getting an inaccurate sampling of data where office-based services (e.g., nursing visits or weekly groups) might be charted more quickly than services rendered in the field (e.g., case manager progress notes). We strongly recommend that the start of the review period not exceed 90 days prior to the day of the evaluation.

6. ***Complete chart reviews using the appropriate data collection*** *forms (please see the back of Part II of the Protocol).* Three forms need to be completed during and/or following the chart review:
   - Chart Review Log: Most of the data collected during the chart review will be documented in the Chart Review Log. Each chart will be reviewed using this form.

     - *Part I* of the Chart Review Log is used to document quantitative data in the charts related to client contacts (e.g., number and duration of contacts) and will be completed for the 20% sample of charts. For smaller teams serving fewer clients (e.g., 50 or fewer), this section of the Chart Review Log will only be completed for 10 charts.

     - *Part II* of the Chart Review Log is used to collect more qualitative data and will be completed for 6 charts (a randomly selected subset of the larger chart review sample).

- Chart Review Tally Sheets Part I and Part II: These forms are used to compile all of the data from its corresponding Chart Review Log completed for each chart.

7. ***Conduct team member interviews***. Interview team members, as specified in Part II of the Protocol (please see TMACT Fidelity Review Interview Checklist on p. vii). These interviews typically include the following:

    - Team leader (2 hours, typically divided into two segments - 1 ½ hours in the morning of the first day and 30 minutes the afternoon of the second day);
    - Psychiatric care provider(s) (45 minutes);
    - Nurse(s) (30 minutes);
    - Employment specialist(s) (60 minutes);
    - Co-occurring disorders specialist(s) (60 minutes);
    - Peer specialist(s) (45 minutes);
    - The two experienced clinicians, at least one being a therapist (based on the team leader's recommendation) within the team (90 minutes); and
    - The Housing Specialist, if the team has one (30 minutes).

    If there are multiple people in each position, interview all of them at once, if possible. When scheduling interviews, be sure to take into account whether any team members only work during one of the days of the review and schedule them for that particular day.

8. ***Conduct client interviews.*** Group client interviews may be best facilitated by taking the last 30 minutes of a scheduled group treatment session and asking consenting clients the fidelity assessment questions identified in Part II of the protocol. If a group session is not available, it is recommended that the fidelity evaluator work with the team leader to convene a group of consenting clients. Individual interviews may also be used, particularly during home and community visits with ACT staff, but may not provide as much opportunity to gather information from a larger number of clients. When scheduling these interviews in subsequent years, it is important to get the perspective of different clients, which may have an impact on which group the evaluators use as the basis for engaging clients to interview.

Suggested ways of opening team member interviews:

- Begin by reviewing the purpose of the evaluation (e.g., to guide performance improvement).

- "The specific information you provide to us in this interview will not be shared in a way that will be tied back to you unless it makes sense to share feedback that is particularly positive."

- "The information gleaned from this fidelity evaluation will only serve to help your team and the consumers you serve, so we encourage open disclosure about your team's practices. The more factual information we receive, the better our feedback to your program to help you move forward in a positive way."

Reminder: Although likely not meeting qualifications standards, a team member who provides support to a designated specialist (i.e., co-occurring, employment and peer) should also participate in the relevant specialist interview and considered in the specialist item ratings.

9. ***If discrepancies between sources occur,*** *query the team leader to get a better sense of the team's performance in a particular area:* The most common discrepancy is likely to occur when the team leader interview provides a more idealistic picture of the team's functioning compared to the chart and observational data. For example, on item CP1, the chart review may show that client contact takes place largely in the office; however, the team leader may state that the clinicians spend the majority of their time working in the community. To understand and resolve this discrepancy, the evaluator may say something like, "Our chart review shows xx% of client contact is office-based, but you estimate the contact at yy%. What is your interpretation of this difference?" The final rating should be based on the overall clinical impression from all data sources, taking into account the relative reliability of each source (e.g., incomplete charts), while still giving more weight to chart data if designated as the primary source (noted with an asterisk* in the item itself).

> **Tailor terminology used in the interview to the site:** By adopting the local terminology, the evaluator will improve overall communication with the team is in a sense demonstrating respect for that team. For example, every agency has specific job titles for particular staff roles or may refer to clinical staff as "practitioners" instead of "clinicians." Similarly, use the same terms the team uses for the consumers they serve (e.g., "member" or "participant").

10. ***Incorporate reports generated by the team as appropriate****:* In some cases, the team, agency or other local/regional oversight entity may offer to provide reports on similar data generated by the client chart review. Service data averages for the entire caseload would be preferred, but the concern is that agency-generated reports will not consider the same query conditions as those guidelines provided to fidelity evaluators when reviewing the sample of client charts.

For instance, with performance data reports, it can be difficult to ascertain whether contacts designated as "face-to-face" in a note are accurately capturing face-to-face contacts as opposed to phone or contact attempts, or whether a listing of multiple contacts with a client by three different team members in a given day does not actually reflect a single contact where more than one team member was present, such as during a crisis assessment or treatment planning meeting. Therefore, evaluators may refer to caseload averages, as reported by the agency, only after taking steps to establish the reliability and validity of these averages given survey guidelines.

To proceed, we recommend the following:

- Conduct a chart review as usual, per the guidelines for sampling and item-level instructions.
- Request that a report of electronic data be generated that lists the following contact information for each of the sampled clients' charts during the identified 4-week window: all ACT team member face-to-face contacts with clients, noting the contact date, location, duration, and staff making the contact. Thus, non-ACT staff members are excluded, and only face-to-face contacts with clients (not collateral contacts) are included.
- Cross-check client-level data obtained from the chart review with those from the report. If the two are very similar (i.e., nearly no differences), the evaluators can have greater faith in the reliability and validity of data generated from a report on the entire caseload when using the same query methods.
- If agency-generated reports are deemed valid and reliable, the last important step is to make sure to evaluate those data by using the same statistics as the chart review data. That is, it is essential to calculate the median (vs. the mean) to guard against skewed distributions and outliers in those data (e.g., a small subset of clients who happen to receive an extremely high

number of contacts compared with the remaining caseload who receives much less in terms of services).

11. ***Conduct a debriefing session****.* While you will not yet know final fidelity ratings before you leave the fidelity review, it is important to provide initial feedback to the team regarding their overall strengths and general recommendations. Such feedback will only be impressionistic at this point and should not contradict later findings based on specific ratings. Such debriefing sessions may include the full team as well as agency staff who oversee the ACT team.

12. ***Before you leave, check for missing data****.* It is a good idea to check in with the team leader at the end of the visit to review and resolve any discrepancies when possible. In some cases, you may need to make a plan to follow up on any missing data that could not be captured during the review (e.g., rescheduling a particular team member's interview because she was ill during the fidelity review).

After Your Fidelity Site Visit

1. ***Follow up on any missing data****.* This would include follow up emails or phone discussion with the team leader about any discrepancies among data sources that arise after the visit has been completed.

2. ***Develop consensus ratings****.* Each fidelity evaluator should independently rate the fidelity scale soon after the fidelity review.

> **Item Rating Tips:**
> - Where available, refer to Rating Guidelines' Tables to determine whether item criteria are met, either partially or fully. Although descriptive information is provided to help differentiate levels of implementation for select practices, clinical judgment is still necessary to gauge overall level of implementation. Evaluators are encouraged to carefully read the no credit, partial, and full credit characterizations.
> - When rating items, begin by comparing your findings with the highest anchor (5), then work downward to figure out anchor best fits with the evidence.

Some of these ratings can be completed throughout the course of the fidelity review as time is available. The assessors should then compare their ratings, resolve any disagreements and reach a consensus rating for each item.

3. ***Send a draft fidelity feedback report to the team.*** As shown in Appendix F, the fidelity report provides information on how the team was rated on each item, subscale, and the full scale. The report also provides an overall interpretation of the assessment, highlighting both strengths and recommendations. The report should be informative, factual, and constructive, with a focus on performance improvement. The recipients of this report will vary, but would typically include the team and key agency administrators. It may be desirable for the team leader to initially review the draft report, providing him or her with an opportunity to challenge ratings and/or seek additional clarification before agency administrators see the report.

> **What does this rating *mean*?**
> The TMACT total rating, which is a mean across all 47 items indexing overall practice, ranges from 1.0 – 5.0.
>
> We propose the following descriptive language for varying levels of ACT implementation.
>
>   4.4 - 5.0 = Exemplary fidelity
>   4.0 - 4.3 = High fidelity
>   3.7 - 3.9 = Moderately high fidelity
>   3.4 - 3.6 = Moderate fidelity
>   2.7 - 3.3 = Low fidelity
> Below 2.7 = Not ACT

The team and agency should be given some time to respond to the report before scheduling a fidelity feedback session. If the fidelity assessment is conducted repeatedly, it is often useful to provide a visual representation of a team's progress over time by graphing the average overall fidelity score using an Excel spreadsheet, for example. This graph may be included in the fidelity report.

4. ***Schedule and conduct a fidelity feedback session.*** Once the team and agency administrators have had the opportunity to review the draft report, schedule a fidelity feedback session in order to more systematically review and finalize the report. It is up to each agency and/or team to decide who will participate in this meeting other than the evaluators. We recommend that it be held with the team leader and agency administration, which allows for more thorough discussion about potential administrative issues that may come up about specific team members. These sessions typically take approximately one hour and may be conducted by phone or in person, depending on the feasibility and timing. The feedback report is not considered final until after this meeting.

5. ***Work with the team on routinely collecting and using fidelity data.*** For sites that routinely receive fidelity assessments, assessors can strategize with the team on ways to systematically gather fidelity assessment data while also using the interim information during supervision. For example, the team leader may want to routinely access through the agency or directly collect specific information on services delivered by each team member. This can then be used to guide his or her approach to supervision with those team members, while also supporting completion of the pre-fidelity review Excel spreadsheet at the next review.

Endnotes

[1] Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry*, *68*, 216-232.

[2] The team is comprised of professionals from various training backgrounds who complement the team with their specific areas of expertise, but who do not hold to rigid role delineations; all team members' roles and responsibilities transcend their specific boundaries of professional training, which are facilitated and further developed via the team approach to care and ongoing cross-training. The result is a team of specialists who are also able to operate as generalists.

[3] Stein, L. I., & Test, M. A. (1980). Alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, *37*, 392-397.

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[6] Drake, R. E. & Deegan, P. E. (2008). Are assertive community treatment and recovery compatible? Commentary on 'Act and recovery: Integrating evidence-based practice and recovery orientation on assertive community treatment teams. *Community Mental Health Journal*, *44*(1): 75-77.

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[9] Lamberti, J. S., Weisman, R., & Faden, D. I. (2004). Forensic assertive community treatment: Preventing incarceration of adults with severe mental illness. *Psychiatric Services*, *55*, 1285–1293.

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[11] Lamb, C. E. (2009). Alternatives to admission for children and adolescents: Providing intensive mental healthcare services at home and in communities: What works? *Current Opinion in Psychiatry*, *22*, 345-350.

[12] Teague, G. B., Moser, L. L. & Monroe-DeVita, M. (2011). Letter to the editor: Established and emerging elements in the TMACT: Measuring fidelity to an evolving model. *Journal of the American Psychiatric Nurses Association*, *17*(1), 34-36.

[13] 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*(1): 17-29.

[14] 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 client outcomes. *Psychiatric Services*, *Psychiatric Services*, 64, 318-323.