Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Practical Approaches to Measuring Fidelity in Coordinated Specialty Care for First Episode Psychosis

Wednesday, May 13, 2015 2:00pm Eastern
Did the Intervention Happen?
Practical Ways to Assess Fidelity
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Disclosures

• Dr. Essock is an employee of Columbia University and the NYS Office of Mental Health

• Dr. Essock’s employers offer training in matters related to the material being discussed.
What is fidelity?

• **Fidelity** to treatment or **intervention fidelity** refers to the degree to which an intervention or treatment program is delivered as intended.

• Adopting evidence-based practices means that you are doing the practices, that you are implementing the intervention with fidelity, that you are walking the walk so that you can expect to achieve the outcomes the evidence base associates with the intervention.

Who cares about fidelity?

- Diverse stakeholders want to know:
  - Has the program been implemented as planned?
  - Does participation in the program result in the expected outcomes?
Fidelity Stakeholders

- **Payers** want to know if they are getting what they are paying for.

- **Trainers/supervisors** want to know if the training took - are clinical staff implementing the interventions as intended over time.

- **Clients/families** want to know if the services they are investing their time/effort/finances in are up to par and can reasonably be expected to promote the outcomes they care about (school/work/friends/health).
How can we give these stakeholders answers without breaking the bank?

- Identify information sources from routinely available clinical and administrative data
- Increase the value of the data by using it, including exception reports to the clinical teams
- Budget for it: Include performance monitoring in core costs
- Include data reporting requirements in contracts
- Define the floor before reaching for the heights
RAISE-CP Governing Principles

• Limit disability/maximize recovery

• Focus on recovery

• Use shared decision-making
Connection Team: Overview
(*consider implications for fidelity*)

- 1.0 FT Team Leader (Master’s-level clinician)
- 1.0 FT Supported employment/supported education specialist
- 0.5 FTE FT Recovery Coach.
- 0.2 Psychiatrist
Connection Team: Overview
(*consider implications for fidelity*)

• Grounded in Critical Time Intervention model

• While clinic based, some services provided in the community

• Financed with State dollars

• Caseload of 25-30 individuals
Connection Team Interventions
(aka fidelity domains)

Outreach/Engagement

Evidence-based Pharmacological Treatment

Supported Employment/Education

Recovery Skills (SUD, Social Skills, FPE)

Family Support/Education

Suicide Prevention

Shared Decision Making

Recovery
Selecting Fidelity Measures

- Identified key components of the intervention
- Worked with intervention leads for those components to identify performance expectations
- Agreed on how to operationalize those performance expectations
  - Included identifying data sources
  - Prompted revisions of some clinical tools (“How would you know if this is happening?”)
  - Defined “minimally adequate” performance
5 Performance Domains
(from Appendix 12 of NIMH CSC Implementation Manual

- Team structure and functioning
- Psychopharmacology
- Recovery coach or equivalent clinician
- Working with families
- Individual Placement and Support Specialist (supported employment/supported education specialist)
## Program Component and associated Expectations

<table>
<thead>
<tr>
<th>Staffing. Teams hire and maintain the required staff.</th>
<th>Operationalization of Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 FTE Team Leader who is a licensed clinician</td>
<td></td>
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<tr>
<td>1.0 FTE IPS Specialist</td>
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<tr>
<td>0.5 FTE Skills Trainer who is a licensed clinician</td>
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</tr>
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<td>0.2 FTE Psychiatrist</td>
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<tr>
<td>Vacancies are filled within 30 days</td>
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**Caseload size.** Teams maintain a caseload that is small enough to allow for intensive and highly individualized services while, at the same time, serving as many clients as possible within these service demands.

Caseload does not exceed 30

**Staff meet as a team.** These meetings are for strategic clinical thinking and reviewing the status and “next steps toward goals” for each person on the team’s caseload.

Full team meets at least weekly.

**Intake occurs promptly**

Intake occurs within 1 week of referral.

**At least one member of the team is available 24/7**

Team has on-call system for after-hours availability and service logs show that any given month includes services on nights and weekends.

**Outreach.** Teams see clients in the field as needed.

At least 10% of participants have at least one visit in the community with the Team leader, psychiatrist, and/or recovery coach.
### Performance Expectations for the Team’s Structure and Functioning, con’t

(from Appendix 12 of NIMH CSC Implementation Manual

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<td><strong>Safety assessment.</strong> All clients assessed for suicide risk and safety plans are formulated and implemented for those determined to be at risk.</td>
<td>The HASS Demo or equivalent screening tool is completed with every participant at intake and whenever concerns about possible suicide are raised. For those who meet or exceed the specified threshold indicating a risk of suicide, a safety plan developed the same day of the screening is included in the chart.</td>
</tr>
<tr>
<td><strong>Discharge.</strong> The team provides a critical time intervention rather than a source of services for people well along in their recovery. Clients transition from the team to routine services as soon as clinically appropriate. The team follows up with discharged clients and with post-discharge providers as appropriate to help assure a smooth transition to routine community services.</td>
<td>Median and average length of stay with Connection Team of all participants to be calculated at the end of each quarter. Mean length of stay for discharged clients will not exceed 30 months. Individual length of stay for any participant will not exceed 36 months. At least 90% of participants plan for discharge with Team (as opposed to leaving precipitously). At least 90% percent of discharged participants attend their first appointment with a mental health service provider within 30 days of discharge.</td>
</tr>
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## Performance Expectations for the *Psychopharmacology Intervention*

(from Appendix 12 of NIMH CSC Implementation Manual


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<td><strong>Psychotropic Medications.</strong> Pharmacotherapy is a core component of treatment. Because many clients with FEP are reluctant to try medication, teams work to develop trusting relationships and provide education about medication options and best practices for medication treatment for FEP so that clients are willing to try antipsychotic medications.</td>
<td>Antipsychotic medication is prescribed for at least 60% of participants on the team at any given time. At least 75% of participants have had at least one trial of an antipsychotic medication prescribed for at least 4 weeks within the recommended dosage range.</td>
</tr>
<tr>
<td><strong>Assessment of medication effects.</strong> Psychiatrist and client regularly review medication effectiveness and side effects.</td>
<td>At least quarterly, psychiatrist and client review medications. Psychiatrist records symptoms and side effects using standardized assessment scales in a manner that facilitates monitoring changes over time. Weight gain of over 1 BMI prompts consideration of a change (in medication, dosage, or behavioral intervention).</td>
</tr>
<tr>
<td><strong>Assessment of weight</strong></td>
<td>Weight is assessed monthly.</td>
</tr>
<tr>
<td><strong>Assessment of fasting glucose/HbA1c and lipids</strong></td>
<td>Assessment of fasting glucose/HbA1c and lipids conducted at intake, 2 months after, and then annually. Schedule repeated if new antipsychotic started.</td>
</tr>
</tbody>
</table>
### Domain and Expectation

**Recovery Coach provides flexible, motivational interventions.** Recovery Coach works with clients and families, supporting resiliency and skill building in illness management and recovery treatment and treatment for substance use.

### Operationalization of Expectations

- Recovery Coach’s service logs indicate the provision of both group and individual sessions in illness management and recovery.

- At least 75% of clients participate in at least one session provided by the Recovery Coach.

- At least 20% of clients have one or more family members participate (whether or not client is present) in at least one session provided by the Recovery Coach.

- Recovery coach’s service logs indicate the provision of substance abuse treatment to at least 25% of clients.
### Performance Expectations for the Family Intervention

(from Appendix 12 of NIMH CSC Implementation Manual

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| **Working with families.**
Team discusses with each client ways family might be involved in the client’s treatment and determines each client’s preferences and reassesses these preferences periodically. Team documents family’s participation in treatment over time. | Team has conversation with all participants regarding their preferences for family involvement as part of intake and at least quarterly thereafter. Service logs note when family member is present. Service logs indicate that, in any given quarter, at least 50% of clients have one or more family members meeting with a member of the team at least once. |

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<td>IPS specialist focuses exclusively on supported employment and supported education.</td>
<td>IPS specialists provide only employment and education services. Service logs indicate that less than 10% of the IPS specialist’s time is devoted to case management and crisis services, administrative duties, or other duties not directly related to employment or education.</td>
</tr>
<tr>
<td>Team leader provides intensive, outcome-based supervision</td>
<td>Team leader conducts biweekly IPS supervision to review client situations and identify new strategies and ideas to help clients in their work lives. IPS records document at least 2 such meetings per month.</td>
</tr>
<tr>
<td>Team leader reviews employer contact logs with IPS specialist at least twice per month and helps IPS specialist think of plans to follow up with employers and teachers/instructors. IPS records document at least 2 such meetings per month.</td>
<td>Team leader reviews current client outcomes with IPS specialist and sets goals to improve program performance at least quarterly, with monthly review. Team maintains a list of performance goals and associated performance over time.</td>
</tr>
<tr>
<td>Zero exclusion criteria. All clients interested have access to IPS regardless of readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, and personal presentation.</td>
<td>IPS specialist has met with at least 90% of clients at least once. Current case load of IPS specialist includes individuals actively using substances (unless the very unlikely situation exists wherein no clients on the team are abusing drugs/alcohol).</td>
</tr>
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<td><strong>Competitive jobs and mainstream education promptly pursued.</strong> IPS specialists help clients pursue permanent competitive jobs and academic opportunities in mainstream, integrated educational settings. Acceptable jobs include seasonal jobs and temporary jobs that are part of the community’s regular labor market.</td>
<td>Team monitors rates of being in school or employed and at least 50% of clients are either in school pursuing a degree or competitively employed.</td>
</tr>
<tr>
<td><strong>Individualized follow-along supports.</strong> IPS specialist helps client problem solve work/school issues, based on a job/education support plan. The IPS specialist assists the client to seek out and benefit from natural supports (e.g., tutoring services, coworkers, family, etc.). Support is based on client preferences, work history, needs, and demands of the work/school environment. At client’s request, IPS specialist provides employer supports or intervenes at an academic institution (e.g., educational information, job accommodations). The IPS specialist promotes career development, assisting clients in the pursuit of education and training, more desirable jobs and more preferred job duties. Most contact is face-to-face.</td>
<td>At least 80% of the time, there is at least one visit with the IPS specialist between the job/academic start and end dates. If there exists at least one face-to-face meeting by the IPS worker during the client's job tenure/time in school, then the standard of follow along supports has been met. If there is no such service, then the standard hasn't been met. If the job/school lasted only one day, omit from the computing of this measure. At least 50% of IPS specialist’s time is in community settings (outside the mental health center), devoted to engagement, employer and educational institution contacts, providing follow-along support, etc.</td>
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How did RAISE CP Teams Perform?

- Published in


Examples of Performance Monitoring from Each Treatment Domain

- Team structure and functioning
- Psychopharmacology
- Recovery coach or equivalent clinician
- Working with families
- Individual Placement and Support Specialist (supported employment/education specialist)
Expectation: Teams see clients in the field as needed

Percentage of clients with at least 1 visit in the community with the team leader, psychiatrist, or recovery coach

- **July 2011-March 2013**
  - Site 1: n=20/31
  - Site 2: n=28/34

- **Jan-March 2013**
  - Site 1: n=5/21
  - Site 2: n=10/24

Expectation: 100%
Expectation: Clients have an adequate trial of antipsychotic medication

Percentage of clients prescribed an antipsychotic for at least 4 continuous weeks within the recommended dosage range

- **Site 1**: n=27/31
- **Site 2**: n=26/34
- **Expectation**: n=16/21

Time periods:
- **July 2011-March 2013**
- **Jan-March 2013**
Domain: Recovery Coach or Equivalent Clinician

Expectation: Recovery Coach provides flexible, motivational interventions

Percentage of clients who participated in at least one session provided by the recovery coach

<table>
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<th>Time Period</th>
<th>Site 1</th>
<th>Site 2</th>
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<tr>
<td>July 2011-March 2013</td>
<td>n=28/31</td>
<td>n=31/34</td>
</tr>
<tr>
<td>Jan-March 2013</td>
<td>n=21/21</td>
<td>n=23/24</td>
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Expectation: Clients' family members meet with members of the team

Percent of clients who had at least 1 family member attend a meeting

- **Site 1**: n=30/31
- **Site 2**: n=32/34
- **Site 1**: n=21/21
- **Site 2**: n=23/24

Data periods:
- July 2011-March 2013
- Jan-March 2013

Expectation line:
- 50%
Expectation: IPS specialist contacts a client’s employer on behalf of the client when requested by the client

Percent of clients who had documentation of an employer contact made on their behalf at least once

July 2011-March 2013:
- Site 1: 16/31
- Site 2: 14/34

Jan-March 2013:
- Site 1: 1/21
- Site 2: 3/24
RAISE CP queried clients as to whether the intervention happened. (Similar items could be built into client satisfaction surveys.)

- *Items vetted by the intervention developers*
- *Expect low but non-zero endorsement of some items*
- *Expect high rates of endorsement for others*
When you and your Connection Team talked about your treatment...

...how much did you feel that decisions about your treatment were joint decisions between you and your Connection Team?

[Bar chart showing responses: Not at all - 0%, A lot - 60%, A moderate amount - 30%, A little - 10%]
In the past month, how much did your Connection Team talk with you about how you would like your family or other important people in your life involved with your treatment?

- Not at all
- A lot
- A moderate amount
- A little
In the past month, how much did your Connection Team help you practice how to handle real life situations that you care about?

Not at all | A lot | A moderate amount | A little
---|---|---|---
0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100%
In the past month, how much did your Connection Team…

- make you feel that decisions about your treatment were joint decisions between you and the team? (A lot: 37%)
- Psychiatrist bring up the topic of medication side effects? (A lot: 37%)
- respond as quickly as you wanted? (A lot: 37%)
- Psychiatrist involve you in decisions about what medications to take? (A lot: 37%)
- pay attention to your preferences regarding a job and or school? (A lot: 37%)
- help you practice how to handle real life situations you care about? (A lot: 37%)
- help you make a plan to stay safe? (A lot: 37%)
- talk with you about how your family or other important people in your life could help support you in reaching your goals? (A lot: 37%)
- help you talk with your family about your thoughts and feelings? (A lot: 37%)
- talk with you about how you would like your family or other important people in your life involved with your treatment? (A lot: 37%)
- help you to get or keep a job or go to or stay in school? (A lot: 37%)
- help you get along better with your friends? (A lot: 37%)
- talk with you about whether you have had thoughts of harming or killing yourself? (A lot: 37%)
- talk with you about any concerns you might have about your use of drugs or alcohol? (A lot: 37%)
- help you figure out your finances, including getting any benefits you may be entitled to? (A lot: 37%)
- go with you to your job or school? (A lot: 37%)
Fidelity 101

- Be parsimonious
  - *Don’t let the best be the enemy of the good*
  - *Set your criteria for “minimally acceptable” and begin by measuring those*
- Get buy in on the measures and the process
- Piggy-back on existing data sources
- Triangulate
- Have measures serve many masters
Data Sources

Most objective and *cheapest in the long run*:

- Reports derived from data that exist anyway
  - electronic claims and other administrative data (e.g., visits, field visits, collateral present, weekend visits, case loads, intensity of services, discharge status, “teamness”, continuity of care, hospitalizations, crisis services)
- Reports derived from EHRs (e.g., count e-signatures indicating form completed; weight/metabolic measures)
- Piggyback on ongoing client satisfaction surveys to incorporate questions about whether key components of the intervention happened
Data Sources

Also acceptable (but cumbersome to set up and maintain):

- Structured chart abstraction from required forms (i.e., no interpretative reading of progress notes)
  - Done by site visitors or by clinic staff
  - With data reported (ideally, via an electronic portal) and summarized centrally
- Site visits to confirm performance data provided by the program (“Show me how you got this number”)
  - Handy to incorporate tracer methodology to follow a handful of randomly selected clients longitudinally to confirm receipt of core components of the intervention
- Most measures derive from client-level data, so contracts must provide for client-level viewing and reporting
- Trust but verify; verify and verify
• If you could only know 10 things, which would you pick?
  • *If you can’t narrow your list to 10, require reporting of more and then audit a random 10*

• What we worry most about varies with payment incentives, so pick measures accordingly

• Salient bad outcomes have to make the “must count” list
Appendix 12

Coordinated Specialty Care for First Episode Psychosis

Manual II: Implementation

National Institute of Mental Health

RAISE
Recovery After an Initial Schizophrenia Episode
A Research Project of the NIH

How did RAISE CP Teams Perform?

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