MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

January 29, 2019

Hon. Nancy J. King, Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
Annapolis, MD 21401

Hon. Maggie McIntosh, Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401

Re: Joint Chairmen's Report, p. 83—Report on Fidelity Audits of SE and Act Programs

Dear Chairs King and McIntosh:

Pursuant to the Joint Chairmen's Report, p. 83, the Maryland Department of Health respectfully submits the attached report detailing the effect of fidelity audits on evidence-based practices, such as supported employment (SE) and assertive community treatment (ACT).

If you have any questions regarding this report, please contact Deputy Chief of Staff Webster Ye at (410) 767–6480 or webster.ye@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

cc: Sarah Albert, Department of Legislative Services

Report on Fidelity Audits of Supported Employment and Assertive Community Treatment Programs

Submitted by the Maryland Department of Health
January 29, 2019

2018 Joint Chairmen's Report (p. 83)

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I. Executive Summary

This report addresses the 2018 Joint Chairmen's Report, p. 83, requesting the Maryland Department of Health to "submit a report on the effect of fidelity audits on evidence-based practices, such as supported employment (SE) and assertive community treatment (ACT)." In response to this request, the reported data depicts the penetration rates of evidence-based practices in the area of SE and ACT (*e.g.*, enhanced mobile treatment), the number and percentage of teams that met eligibility as a function of the number of teams assessed, the number and percentage of teams who met eligibility conditionally, and the number and percentage of teams who were determined ineligible.

This report describes the fidelity tools used, the training required to apply these tools, and ongoing quality improvement and training efforts to ensure quality and consistency in the application of the evidence-based practice fidelity model and in the use of the fidelity tools. The data sources for this report include the national, empirically supported fidelity scales and assessment protocols followed by the Maryland Behavioral Health Administration (BHA) fidelity assessment team: (1) the ACT and SE Evidence-based Practice Toolkits developed and issued by the Substance Abuse and Mental Health Services Administration (SAMHSA),[1] (2) the Tool for Measurement of Assertive Community Treatment (TMACT) Manual and fidelity scale,[2] (3) the Dartmouth Assertive Community Treatment Scale (DACTS) Manual and fidelity scale,[3] (4) specific fidelity assessment team guidelines, (5) provider-specific fidelity assessment reports, and (6) data gathered and maintained by the BHA fidelity assessment team in support of the fidelity assessment process.

II. Introduction: Definition and Relevant History

Evidence-based practice (EBP) is a systematic approach to delivering services that has been shown by research to yield improved outcomes for service recipients. EBP generally consists of a well-defined set of core principles, essential program elements, and prescribed interventions that are derived from rigorous scientifically controlled research. To qualify as an EBP, the research must have been conducted by multiple independent investigators and published in peer–reviewed journals. The prescribed interventions which comprise the EBP are standardized and replicable and can be applied in routine behavioral health settings with a distinct target population. And, most importantly, the EBP, when delivered as intended, otherwise known as implemented with fidelity to the model, leads on average to a measurable improvement in outcomes for recipients of the service intervention. Successful implementation of EBP interventions can be measured by use of a fidelity scale, which measures the extent to which the practice is delivered as prescribed by the model. In addition, the EBP has existing resource materials, including a detailed practice manual or toolkit and training tools that have been tested and are readily available for use and implementation by the program delivering the EBP intervention.

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[1] Substance Abuse and Mental Health Services Administration, Series Evidence-Based Practices KITS (2018), online at https://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs (all Internet materials as last visited June 28, 2018).

[2] UNC Institute for Best Practices, Tool for Measurement of ACT (TMACT) (2018), online at http://www.institutebestpractices.org/tmact-fidelity/.

[3] Case Western Reserve University, online at https://www.centerforebp.case.edu/resources/tools/act-dacts.

III. Evidence-based Practices in Maryland

BHA has a long history of implementing the SAMHSA endorsed EBPs of ACT and SE within the Maryland Public Behavioral Health System (PBHS). BHA was one of the first state behavioral health authorities in the country to recognize the opportunities and promise offered by the EBP movement to positively impact the quality and delivery of mental health services.[4] As a reflection of its strong commitment to ensuring that services delivered to its citizens have been demonstrated by research to be effective, BHA established the Evidence-Based Practice Center (EBPC) at the University of Maryland (UMD) School of Medicine, Department of Psychiatry. This is due in part to the internationally respected mental health systems researchers located in Maryland with whom BHA routinely collaborates. One of the most extensive and accepted demonstrations of the gap between science and practice was led by Dr. Anthony Lehman of the UMD School of Medicine with the release of the Schizophrenia Patient Outcome Research Teams (PORT) Project results in 1998.[5] This research contributed significantly to the mounting discomfort with "business as usual" in the mental health service community. Subsequently the Surgeon General's Report, with Dr. Howard Goldman (also of the UMD School of Medicine) as its senior scientific editor, was released in 1999.[6] This report continued the emphasis on the effectiveness of research-based practices and the problem with inconsistent implementation.

In 2000, BHA decided, in consultation with Drs. Lehman and Goldman, to participate in the National Evidence-Based Practice Project (NEBPP), designed to address the gap between research findings and their implementation in practice. Subsequently, considerable resources, time, attention, and thought have been invested in EBPs in Maryland, resulting in the implementation and monitoring of SE, ACT, and Family Psychoeducation (FPE) with fidelity to each respective model. In 2006, BHA made a critical decision impacting extant and future EBP implementation efforts. BHA established fiscal incentives for EBPs by adopting enhanced reimbursement rates for community behavioral health providers that deliver certain EBPs with fidelity to the model, as measured by independent BHA fidelity assessors. By tying fidelity to higher rates, BHA has built in a mechanism to prevent drift and assure continued fidelity to the model. Over the years, BHA has continued to build on its commitment to quality and to expand EBP penetration in Maryland, confident that the lessons learned from its participation in the NEBPP to date serve as fertile soil in which to plant additional implementation efforts.

In order to qualify for the enhanced rates and to be designated as an EBP program by BHA, community behavioral health programs, by submitting to a fidelity assessment conducted by BHA designated fidelity assessors, must demonstrate that they adhere to the fidelity standards that are set forth by SAMHSA and BHA specific to each EBP. Programs that meet the established fidelity standards for a certain EBP are eligible for the enhanced rate of reimbursement associated with that practice. Initially, a program is eligible for a one-year EBP designation. If at any point, a program fails to meet the full fidelity standards, it may qualify for a six-month conditional

[4] Goldman, Ganju, Drake, Gorman, Hogan, Hyde, & Morgan, Policy implications for implementing evidence-based practices, Psychiatric Services, 52(12), 1591–7 (2001).
[5] Lehman & Steirvwachs, Patterns of usual care for schizophrenia: Initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey, Schizophrenia Bulletin, 24(1), 11–20 (1998).
[6] Goldman**,** Rye, Sirovatka, Satcher, & Shalala, Mental Health: A Report of the Surgeon General, Diane Publishing Company (2000).

eligibility status, if it otherwise meets a certain lower threshold on the fidelity scale, during which time it remains eligible for the enhanced rate of reimbursement. If the program fails to meet the established lower threshold on the fidelity scale, the program is deemed to not be delivering the EBP as intended and it is therefore ineligible to receive the enhanced rate for the service. If after qualifying for conditional eligibility at two consecutive fidelity assessments the program is unable to meet the full fidelity standards at the time of the third consecutive fidelity assessment, the program is ineligible for a third conditional eligibility and is thus no longer eligible to receive the enhanced rate for the service. Programs that meet the established fidelity standards at two consecutive annual fidelity assessments are eligible to be reviewed on a biennial schedule until such time as the program no longer meets the full fidelity standards.

A. Assertive Community Treatment

Mobile treatment services (MTS) and ACT are intensive, comprehensive, community-based behavioral health services delivered by a mobile, multidisciplinary team that provides assertive outreach, treatment, rehabilitation, and support to individuals with serious mental illness who may be without a home or for whom more traditional forms of outpatient treatment have been ineffective. Services are designed for individuals with severe and persistent mental illnesses who are most at risk of psychiatric crisis, hospitalization, and involvement in the criminal justice system. Because such individuals may be reticent to engage in office-based treatment during customary office hours, treatment and rehabilitation services are delivered in the individual's natural environment (e.g., home, street, shelters), and are available to the participant on a 24/7 basis.[7] MTS and ACT teams provides treatment and support in the least intensive setting that can meet the participant's clinical needs.

In Maryland, MTS programs that meet established EBP ACT fidelity criteria are designated as ACT programs. ACT is an enhanced, more robust version of MTS that is appropriate for individuals who experience the most intractable symptoms of severe and persistent mental illness and the greatest level of functional impairment.[8] The ACT model emerged in the early 1970's in the era of deinstitutionalization as an alternative to psychiatric hospitalization. Conceptualized as a "hospital without walls," the intent was to replicate within naturalistic, community-based settings the intensive, comprehensive, interdisciplinary treatment team approach typically only available at that time in an inpatient psychiatric treatment facility.[9] ACT, when implemented with fidelity to the model, results in decreased utilization of inpatient psychiatric hospitalization.[10] ACT has been found to be effective for individuals with behavioral health and housing needs, leading to increased housing stability and improved mental health.[11]

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[7] Beacon Health Options: Maryland Provider Manual, online at http://maryland.beaconhealthoptions.com/provider/manual/CH06_05-MH-Mobile-Treatment-&-Asse.pdf.

[8] Phillips, Burns, Edgar, Mueser, Linkins, Rosenbeck, Drake, & McDonnell-Herr, Moving assertive community treatment into standard practice, Psychiatric Services, 52(6), 771–9 (2001).

[9] Schmidt, Pinninti, Garfinkle, & Solomon, Assertive Community Treatment Teams in Modern Community Mental Health: An Interdisciplinary Approach, New York: Oxford University Press, pp. 293–301 (Yeager, Cutler, Svendsen, & Sills eds., 2013).

[10] Bond, Drake, Mueser, et al., Dis-Manage-Health-Outcomes, 9: 141 (2001).

[11] Meisler, Blankertz, Santos, & McKay, Impact of Assertive Community Treatment on Homeless Persons with Co-Occurring Severe Psychiatric and Substance Use Disorders, Community Mental Health Journal, 33 (2), 113–122 (1997).

ACT is provided by a self-contained, trans-disciplinary team staffed with a team leader, psychiatrist, nurses, social workers, therapists, and specialists in domains such as co-occurring substance use disorder treatment, employment and educational services, supportive housing, and peer-support services. Team members work closely together to help adults with severe and persistent mental illness live in their own homes instead of an institution or the streets. They provide a comprehensive array of services, including but not limited to assisting participants to engage in and make informed choices about behavioral health treatment, to find and maintain safe and affordable housing, to secure and retain jobs, to develop practical life skills, and to pursue an individualized path to recovery. ACT teams also assist with the holistic health care needs of participants, collaborating with their families and other natural supports to enhance the participant's overall health and wellness.

To be most effective, ACT is a recovery-oriented, strengths-based, and person-centered service approach, informed by and consistent with housing first and harm reduction principles. In such an approach, access to housing or other services are not contingent on abstinence from illicit or non-prescribed substances or behavioral health treatment compliance. Treatment is "assertive" in that the team is proactive and persistent in their efforts to engage and retain individuals in ACT services by utilizing motivational interviewing techniques to facilitate the achievement of their self-identified recovery goals, while reducing the overall risk of harm to the individual. To provide intensive, comprehensive, and flexible services, small and large teams serve no more than 50 and 120 individuals, respectively, with 10 or fewer participants per staff member.

Annual or biennial fidelity assessments are performed by BHA approved fidelity assessors, applying the Dartmouth Assertive Community Treatment Scale (DACTS), to ensure that programs meet established EBP ACT fidelity standards. The Tool for Measurement of Assertive Community Treatment (TMACT) has been developed as a recovery-oriented revision of the DACTS. This tool is presently utilized in conjunction with the DACTS fidelity scale in Maryland; however, the BHA EBP ACT designation is based on the MTS team performance on the DACTS. BHA's ultimate plan is to fully transition to the TMACT in place of the DACTS to assess MTS teams for eligibility for the EBP designation and, by extension, for the differential ACT rate.

B. Supported Employment

SE programs in Maryland provide job development, job coaching, and ongoing employment support services to individuals with serious mental illness for whom competitive employment has not occurred, has been interrupted, or has been intermittent. These individualized services are provided to enable eligible individuals to choose, obtain, maintain, or advance within independent competitive employment within a community-integrated work environment, consistent with their interests, preferences, and skills.

Evidence-based supported employment services (EBP SE) are based on the Individual Placement and Support (IPS) Model[12] and are designed to assist individuals in securing competitive employment in the community that pays at least minimum wage and that is available to anyone

[12] Luciano, Bond, a Drake, Does employment alter the course and outcome of schizophrenia and other severe mental illnesses? A systematic review of longitudinal research, Schizophrenia Research, 159 (2–3), 312–321 (2014).

with or without a disability. Unlike the traditional supported employment approaches, individuals are not required to complete certain mandatory vocational evaluations, work trials, or work preparatory classes, which have little bearing on their ability to successfully hold a job, before being given the opportunity to work. Individuals are not excluded from EBP SE based on their perceived readiness for employment but are presumed to be "work ready" the moment that they express an interest in competitive employment.

The overriding philosophy of EBP SE is the belief that every individual with a serious mental illness is capable of working competitively in the community if the right kind of job and work environment can be found. Rather than trying to sculpt individuals into becoming "perfect workers," through extensive prevocational assessment and training, individuals are offered help finding and keeping jobs that capitalize on their personal strengths and motivation. The primary goal of SE is not to change individuals but to find a natural "fit" between individuals' strengths and experiences and the jobs available in the community.

Job choices are based solely on the individuals' experiences, strengths, interests, and preferences and not solely the prevalence or availability of jobs in the general labor market. Benefits counseling, also called work incentives planning, is part of the employment decision-making process. SE specialists ensure that individuals are offered comprehensive and personalized benefits planning, including information about how work may affect their disability and government benefits. Once a job is acquired, the EBP SE service continues to provide ongoing support based on the individual's needs, assisting the individual to retain the job, to secure a new or better job, and to establish a career trajectory.

In order to coordinate and integrate supported employment efforts with mental health treatment, the employment specialist regularly meets with members of a multidisciplinary treatment team, including the case manager, the rehabilitation counselor, the therapist, the psychiatrist, and any other individuals who may be involved in the treatment and rehabilitation of the individual.

The SE service, funded under Maryland's PBHS and the Maryland State Department of Education, Division of Rehabilitation Services (DORS), consists of the following reimbursable, mutually exclusive service phases, which are all direct SE interventions. Job readiness services are not reimbursable as part of the SE service.

1. Pre-Placement Phase (reimbursed by the PBHS for both EBP and non-EBP programs): This includes, at a minimum, a person-centered vocational assessment, referral to the DORS, the state vocational rehabilitation agency; benefits counseling; discussions of the risks and benefits of disability disclosure and informed choice; and the development of an individual vocational plan (IVP).

2. Job Development Phase (reimbursed by DORS for both EBP and non-EBP programs):[13] This includes individualized weekly person-to-person job search assistance; assistance with identifying job leads and contacting, visiting, and educating prospective employers; interview coaching and support; assistance with completing applications and developing

[13] Milestone Funding for EBP programs.

and revising a resume; assistance with employer follow-up after a job interview; and assistance in the development of personal employment networks related to the job search.

3. Placement in a Competitive Job (reimbursed by the PBHS for both EBP and non-EBP programs): This includes assisting the participant in negotiating with the employer a mutually acceptable job offer and advocating for the terms and conditions of competitive employment, to include any reasonable accommodations and adaptations requested by the individual.

4. Intensive Job Coaching Phase (reimbursed by DORS for both EBP and non-EBP programs):[14] This includes the use of systematic intervention techniques designed to help the supported employment participant learn to perform job tasks to the employer's specifications and to develop the interpersonal skills necessary to assume the employee role and be accepted as a full-status employee at the job site and in related community-based settings. Job coaching may also be used as a preventative intervention to assist the enrollee in preserving the job placement, resolving employment crises, and stabilizing the employment situation for continuing employment. In addition to direct job skills training, job coaching includes related job analysis and environmental assessment, vocational counseling, employer education and advocacy, mobility skills training, and other support services as needed to promote job stability and social integration within the employment environment.

5. Ongoing Support Services Phase (reimbursed by the PBHS for both EBP and non-EBP programs): This includes proactive employment advocacy, supportive counseling, and ancillary support services at or away from the job site, to assist the enrollee in maintaining continuous, uninterrupted, competitive employment and to develop an employment-related support system. This includes encouraging the development and use of natural supports to the maximum extent possible.

6. Psychiatric Rehabilitation Program Services to Enrollees in SE (reimbursed by the PBHS for both EBP and non-EBP programs): This includes those psychiatric rehabilitation service interventions needed to assist the enrollee in improving coping skills, assertiveness skills, interpersonal skills, and social skills necessary to function adaptively in the work environment or to develop compensatory strategies to minimize the impact of the enrollee's mental illness on his or her behavior while on the job.

7. Clinical Coordination (Reimbursed by the PBHS for EBP programs only): This includes direct or indirect efforts on behalf of the consumer to coordinate and to integrate the consumer's supported employment services with psychiatric rehabilitation and treatment services through regular meetings and contact with members of the individual's multidisciplinary treatment team, shared responsibility for employment outcomes, and integrated and congruent planning, intervention, and services delivery.

   The following goals have been identified for the clinical coordination service:

[14] Milestone Funding for EBP programs.

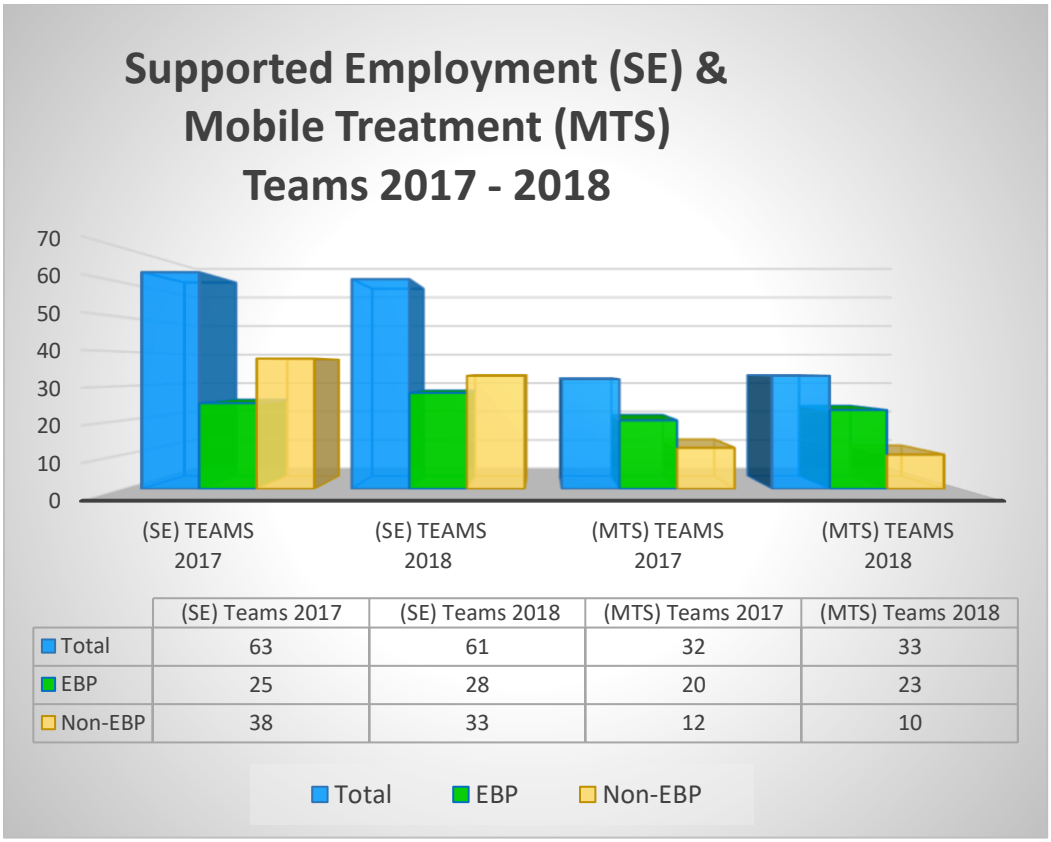
- In pursuit of the consumer's goals for competitive employment, to establish a working alliance with the clinician and to enlist his or her support for the consumer's interests and desires;
- To enhance the program's ability to engage and to retain consumers in supported employment through assertive engagement and follow-up;
- To facilitate effective, efficient communication between the consumer and clinical, rehabilitation, and treatment providers as a means to coordinate care;
- When desired by the consumer, to encourage timely, fully integrated interventions which collectively support the individual in identifying and selecting employment options; and
- To incorporate employment-related issues in treatment and rehabilitation plans and to ensure congruence of rehabilitation and treatment goals, interventions, activities, and plans.

Annual fidelity assessments are performed by BHA approved fidelity assessors to ensure that programs meet established EBP SE fidelity standards. EBP SE designation by BHA and, by extension, eligibility for the differential EBP SE rate is based on the SE team's performance on the Dartmouth Supported Employment Fidelity Scale.

IV. Reported Data

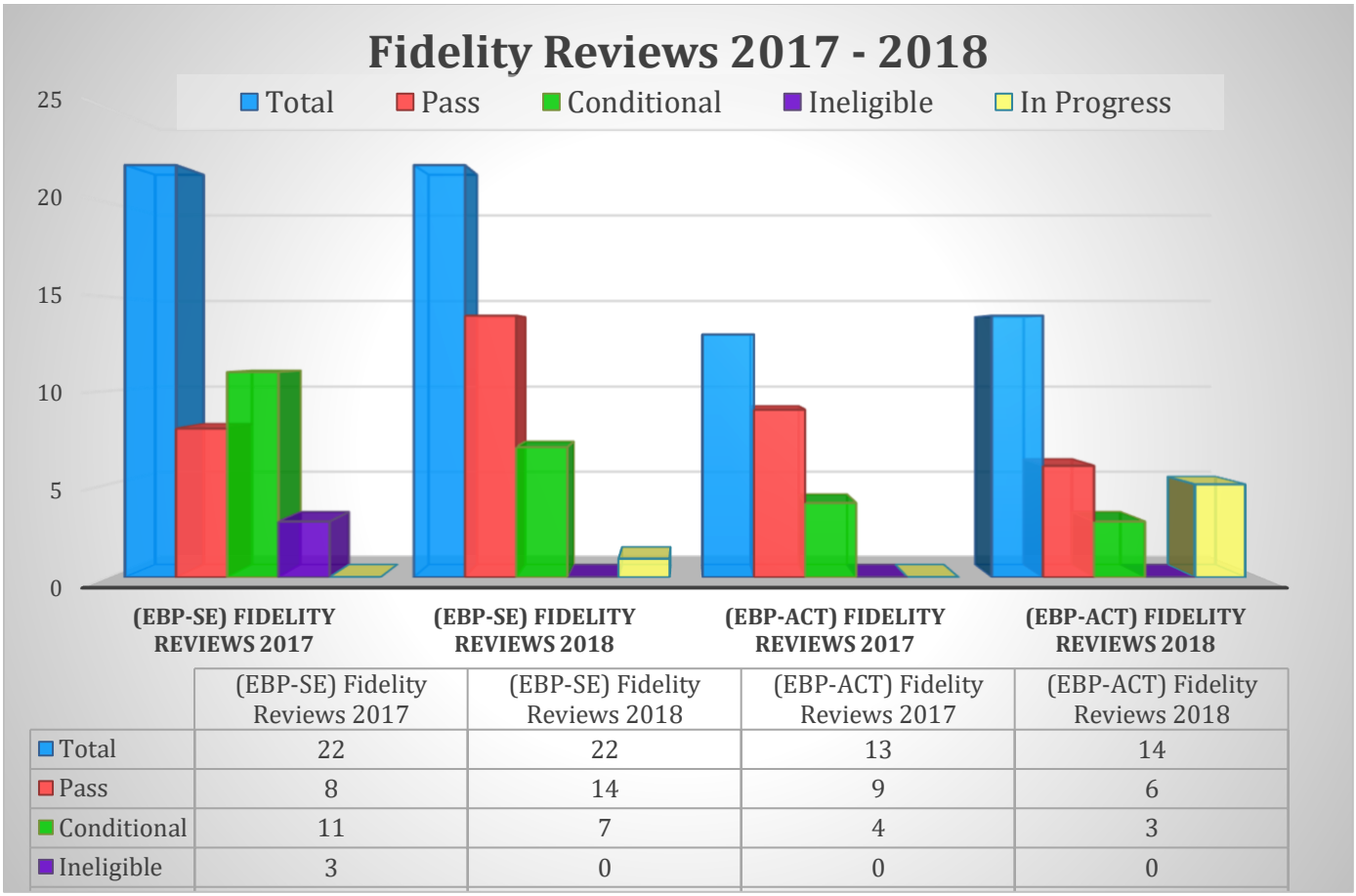
Mobile Treatment Teams		
	2017	**2018**
Percentage with EBP designation	**63%**	**69%**
Total number operating in the State	**32**	**33**
Number designated as ACT	**20**	**23**

SE Programs		
	2017	**2018**
Percentage with EBP designation	**40%**	**46%**
Total number operating in the State	**63**	**61**
Number designated as EBP	**25**	**28**



	(SE) Teams 2017	(SE) Teams 2018	(MTS) Teams 2017	(MTS) Teams 2018
Total	63	61	32	33
EBP	25	28	20	23
Non-EBP	38	33	12	10

Fidelity Reviews		
	2017	**2018**
Total number of fidelity reviews conducted	**35**	**36**
Number that met eligibility	**17**	**20**
Number placed on conditional status	**15**	**10**
Number that were ineligible	**3**	**0***
*As of December 31, 2018, 6 of 36 reports are in progress		



	(EBP-SE) Fidelity Reviews 2017	(EBP-SE) Fidelity Reviews 2018	(EBP-ACT) Fidelity Reviews 2017	(EBP-ACT) Fidelity Reviews 2018
Total	22	22	13	14
Pass	8	14	9	6
Conditional	11	7	4	3
Ineligible	3	0	0	0

V. Fidelity Assessor Training

BHA employs fidelity assessors whose qualifications, as evidenced by prior work experience, academic credentials and supervisory observations, include strong analytical, time management, organizational, data collection, report writing, and interpersonal communication skills. Professional work experience related to behavioral health treatment and service provision to individuals with serious mental illness is required. EBP knowledge and experience with specified EBPs is preferred. The majority of EBP fidelity assessors have direct work-related experience in the provision of one or more EBP services that are the focus of the BHA fidelity assessment process; however, all EBP fidelity assessors receive a minimum of two days training in each, specified EBP, to include training, as needed, from the University of Maryland EBPC consultant and trainer assigned to that practice. Fidelity assessors also participate in BHA sponsored EBP trainings provided on an annual basis featuring nationally recognized experts, trainers, and consultants.

Fidelity assessors receive intensive training and consultation in the use and application of EBP-specific fidelity tools from national EBP Training and Technical Assistance Centers focused on the dissemination and implementation of the specified practices being evaluated by BHA. In addition, fidelity assessors receive systematic didactic and experiential training on chart reviews, interview protocols, interview techniques, field observation, process assessment and program

evaluation methods. Fidelity assessors engage in a series of experiential training activities before their first participation in a fidelity site visit as an official member of the fidelity assessment team. Dependent on their prior background and experience, novice fidelity assessors shadow more experienced fidelity assessors for a minimum of one to three fidelity reviews. Then fidelity assessors in training practice co-rating items on each fidelity scale for one or more fidelity reviews until the novice fidelity assessor is able to independently reach consensus with an experienced fidelity assessor on the constituent fidelity item ratings and the overall fidelity score. This is followed by the novice assessor co-leading a fidelity site visit with a more experienced fidelity assessor and then finally functioning as the team lead on a site visit with guidance and mentoring from the more experienced co-leader.

Fidelity assessor training for conducting ACT fidelity assessments consists of in-person training with Dr. Lorna Moser, co-developer of the TMACT and Director of the ACT Technical Assistance Center for the University of North Carolina, Department of Psychiatry, Center of Excellence in Community Mental Health (UNC Center of Excellence) on the ACT fidelity tools. This training permits the assessor in training to jointly complete with Dr. Moser an ACT fidelity assessment, with Dr. Moser providing technical assistance and feedback on item rating, fidelity scoring, and report development. Dr. Moser is also available to the BHA fidelity assessment team for individual consultation and technical assistance on fidelity item rating and interpretation, as unique issues arise in the field which require further clarification. The BHA Program Manager, EBP Services and Quality Management and fidelity assessment team members participate in the listserv hosted by the ACT Technical Assistance Center of the UNC Center of Excellence to stay abreast of the latest developments in states across the nation who are implementing ACT.

Fidelity assessor training for conducting SE fidelity assessments consists of in-person training by the IPS Employment Center at the Rockville Institute. The IPS Employment Center helps state implementation teams learn how to provide effective IPS training and conduct SE fidelity reviews so that SE program staff can achieve good employment outcomes. The BHA Program Manager, EBP Services and Quality Management, participates in monthly calls hosted by Deb Becker, co-developer of the IPS model and Director of the IPS Learning Community of the IPS Employment Center at The Rockville Institute. Participation in these calls includes representatives from states and countries that are implementing EBP SE with fidelity to the IPS model. Fidelity assessors consult the Supported Employment Fidelity Review Manual as a reference guide.[15] Ms. Becker and Dr. Gary Bond, developer of the Dartmouth Supported Employment Fidelity Scale, are available to the BHA fidelity assessment team for individual consultation and technical assistance on fidelity item rating and interpretation, as unique issues arise in the field which require further clarification.

VI. Inter-rater reliability

The fidelity manuals and protocols for each of the EBPs include specific guidelines and checklists to address decision rules and rating guidelines. BHA adheres to the ACT and SE fidelity assessment protocols, both of which prescribe that at least two fidelity assessors perform the fidelity assessment and evaluation. This allows for BHA fidelity assessment team capacity to

[15] Becker, Swanson, Reese, Bond, & McLeman, Supported Employment Fidelity Review Manual, Dartmouth Psychiatric Research Center (3rd ed. 2015).

collect more objective data, for each fidelity assessor to independently rate each fidelity item, and for the fidelity assessors to discuss which rating best fits their collective impressions prior to arriving at a consensus rating for each fidelity item. This process produces more reliable and valid item ratings.

Rich and robust data and information gathered from multiple sources through chart reviews, direct observation of team meetings, semi-structured interviews, and field observation of service provision form the basis of the EBP fidelity review process. Fidelity assessors independently review the data and information collected from the fidelity review and rate each fidelity item in accordance with established fidelity criteria on the EBP-specific fidelity scale. They then compare their individual ratings, resolve any disagreements, devise a consensus rating for each fidelity item, and tabulate a composite fidelity score. Individual item ratings are based on the convergence of data from two or more sources. In Maryland, fidelity assessors are independent reviewers, as recommended in the EBP protocols for ACT and SE, with no current affiliation with the provider agency or the EBP training entity. The protocol indicates that impartial external evaluators are more likely to conduct a more objective and valid assessment.

Regular planned individual and group supervision and oversight of fidelity assessment team members helps to assure reliability and validity of the ratings. The BHA EBP program manager reviews and provides written and oral feedback on all fidelity assessment reports. If the composite fidelity score on the fidelity scale indicates that a given provider is not adhering to essential ingredients of the EBP model, the report is reviewed by another BHA manager who has knowledge and experience in the EBP criteria for ACT and SE. The fidelity assessment team seeks consultation from national experts to resolve any internal conflict and to ensure consistency in the application of fidelity criteria. National experts periodically review fidelity assessment reports for internal consistency and adherence to empirically supported fidelity criteria. For example, Dr. Moser of the UNC Center of Excellence completes reviews and provides individualized feedback to each of the fidelity assessors for at least one fidelity assessment report per year.

VII. Continuous Quality Improvement

The BHA EBP program manager reviews and provides feedback on all fidelity assessment reports. Fidelity report data is also shared with Dr. Moser, who periodically conducts an analysis of the TMACT scoring distributions of the Maryland ACT Teams in relationship to those of the North Carolina ACT Teams. She conducts a comprehensive analysis of team level distributions of each item to identify any item for which Maryland fidelity assessors have rated below the mean for the fidelity subscale and to further characterize those item ratings as typical or atypical in comparison to what is generally seen for similar ACT teams nationally. This allows the BHA EBP program manager to work individually with the fidelity assessors to focus on rating anomalies in an effort to minimize any potential fidelity item rating errors.

The fidelity review process in Maryland also includes a review and analysis of the draft EBP fidelity assessment report by the designated University of Maryland EBPC consultant and trainer prior to dissemination of the report to the provider. Following an internal quality assurance review by BHA and a corresponding review by the designated EBPC consultant and trainer, the draft EBP fidelity report is released to the provider for review in advance of the scheduled Exit Conference

with the provider and the designated EBPC consultant and trainer. Within the context of the Exit Conference, the provider can dispute any fidelity item rating that it believes has been rated unfairly or inaccurately. If contested, the underlying fidelity assessment data is reviewed, to include any additional data requested by BHA, and internal or external consultation is sought, as necessary, to determine if a change in the fidelity rating is warranted. The final fidelity assessment report is distributed to the provider, the applicable local Core Service Agency (CSA) or Local Behavioral Health Authority (LBHA), the Administrative Services Organization (ASO) and, for SE, the Division of Rehabilitation Services (DORS).

The designated EBPC consultant and trainer is responsible for collaborating with the provider to develop and enact a fidelity action plan based on the fidelity assessment findings and recommendations. The BHA fidelity assessment team and the University of Maryland EBPC consultant and trainers meet on a regular basis to review trends and new developments and to address systemic and program-specific barriers to implementation and expansion of EBP services.

VIII. Conclusion

The fidelity assessment process and protocols established in Maryland create and support an environment of continuous quality improvement for EBP ACT and EBP SE providers. Fidelity assessment data for calendar years 2017 and 2018 demonstrate the effectiveness of this process in facilitating high-quality EBP implementation. Year over year data show an increased penetration rate for EBP ACT from 63% to 69% of all licensed MTS programs and for EBP SE from 40% to 46% of all licensed SE programs. Of those programs that received the BHA EBP designation, a greater number of EBP programs received full EBP designation in 2018 than in 2017. EBP SE programs with full EBP designation increased from 36% to 64% from calendar year 2017 to calendar year 2018, with one fidelity assessment report outstanding. Since five fidelity assessment reports remained outstanding at the time of this report, it is not possible to reliably calculate any change, if any, in the percentage of EBP ACT programs that achieved full EBP designation in calendar year 2018 relative to calendar year 2017.

The data further suggest that the conditional eligibility status for EBP designation is an effective mechanism for improving service quality and enhancing program adherence to EBP fidelity criteria over time. The conditional eligibility status identified as part of the fidelity protocol in Maryland is utilized as a Continuous Quality Improvement (CQI) tool to drive improvement in service delivery and measurable outcomes for individuals receiving EBP services. During the six-month period of conditional eligibility status, the program continues to be eligible for the enhanced EBP rate and can access more intensive and focused technical assistance and consultation from the designated University of Maryland EBPC consultant and trainers. The EBPC consultants and trainers, in collaboration with the program, are responsible for formulating and implementing fidelity action plans based on the fidelity assessment recommendations to improve program performance.

The Maryland fidelity assessment protocol incorporates mechanisms to ensure the accuracy, consistency, and integrity of fidelity assessment ratings. Similar mechanisms for improving the quality of EBP fidelity assessment reports and enhancing of the skills of the BHA fidelity assessment team members are also used. This includes systematic and ongoing fidelity assessment

training, supervision, oversight, and fidelity assessment report review to foster inter-rater reliability. Fidelity assessor training is competency-based and includes both didactic and experiential components. Fidelity assessors are given progressively increasing levels of responsibility in the fidelity assessment process based on their demonstration of competency in certain skill domains. The fidelity assessment protocol includes the review and analysis of the draft fidelity assessment report by the designated EBPC consultant and trainer. External consultation is solicited from the EBP model and fidelity assessment scale developers for clarification of EBP fidelity scoring protocols and to reconcile any conflicts in scoring. Maryland fidelity scores are compared with national benchmark fidelity data to identify any fidelity items that may require focused attention and to minimize the possibility of fidelity assessment errors.

The CQI process evident in the Maryland fidelity assessment process and protocol is emblematic of BHA's overarching commitment to improving the quality of care in the PBHS. Successful program outcomes require a combination of proven, evidence-based practice interventions and effective implementation strategies. BHA has demonstrated the value of systematic fidelity monitoring and evaluation and individualized training, technical assistance and consultations as drivers for EBP sustainability and EBP program improvement. BHA intends to use this existing framework as a template to expand the number and array of EBPs available to service recipients in the PBHS and, in so doing, to elevate the quality of care across the system.