TMACT 1.0 REVISION 3

Overview of Updates to Revision 1

THIS IS *NOT* A TMACT TRAINING

This training is intended for those previously trained in the use of the TMACT and are wanting to understand changes that have been made to previous versions, amounting to this Revision 3 release.

We strongly recommend training in the TMACT from a Master Trainer. Models of training are listed in TMACT Part I: Introduction, pp. 10 – 11.

Currently there is no formal TMACT evaluator endorsement, certifying that they meet an adequate level of competency. No user is authorized to provide TMACT training while also financially benefiting from this training without a written agreement by at least two of the TMACT authors endorsing this individual as a capable TMACT Trainer.

For questions related to Revision #3, eTMACT release, or about training and consultation, please contact both: Lorna at lorna_moser@med.unc.edu and Maria at mmd@uw.edu

A TMACT Facebook group was formed to serve as a place to receive updates, as well as "talk through" evaluator challenges. You can locate this group and send request to join here: https://www.facebook.com/groups/418932028537386/

An International ACT Listserv has been formed, which includes access to a Discussion Forum. This can be another resource for those interested in best ACT practices, and the TMACT: Complete this survey to join: http://www.institutebestpractices.org/sign-up-form/

WHY CHANGE?

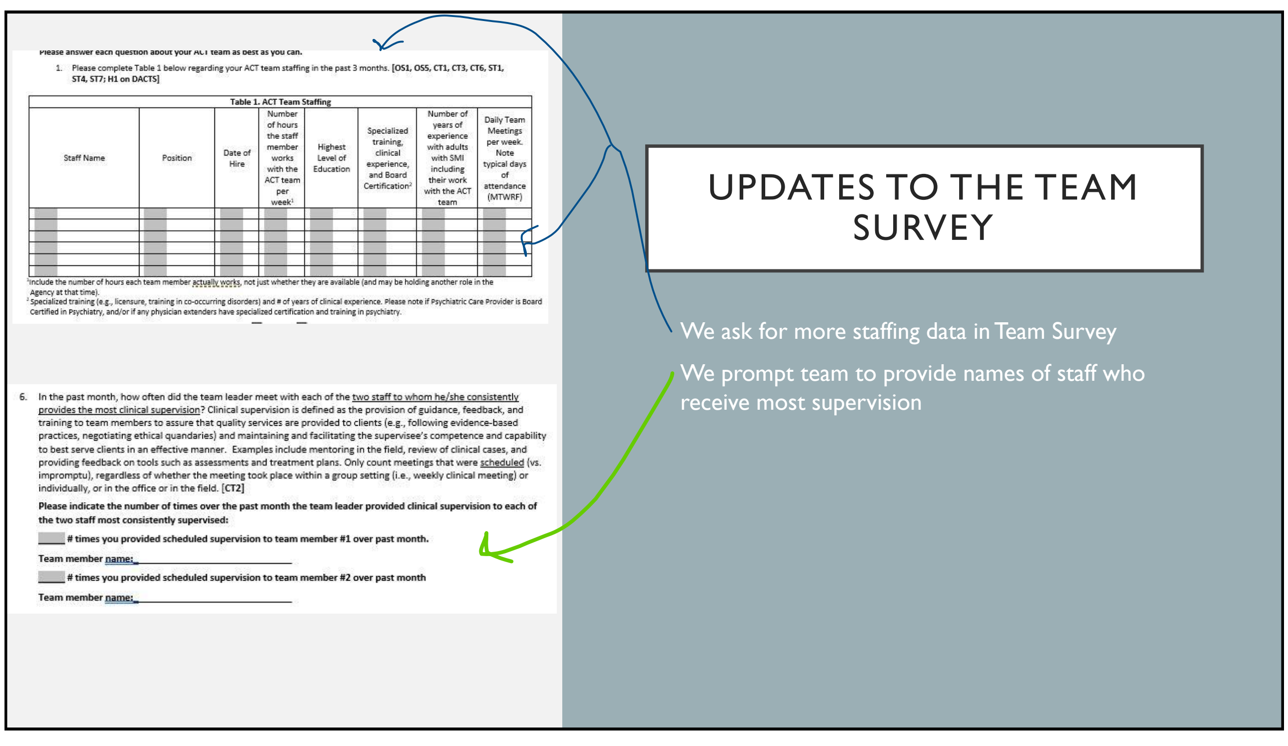
- Keeping up with language
- Reformatted to allow for easier note-taking
- Clarified wording
- More direct questions
- Less reliance on non-bold interview questions (optional)
- Added more examples
- Seeking "gold-star" examples throughout
- Need to be in-synch with eTMACT (it's coming!)

WHAT CHANGES WERE MADE THROUGHOUT TMACT 1.0 REVISION 3?

- Language (e.g., clients, co-occurring disorders specialists)
- Cosmetic changes: Note-taking field to the right
- More **direct** question (less reliance on optional questions)
- Questions seeking "gold-star" examples
- More explicit references to individual treatment teams (ITTs)

ANY UPDATES MADE TO THE **METHODS**?

- Not many, but we encourage you to read through TMACT Part I: Introduction, and check out the Appendix, which includes an updated (fictional, yet real) final TMACT report. Both can be found here: http://www.institutebestpractices.org/tmact-fidelity/more-about-the-tmact/
- We clarified further who we mean by "clinician" as a data source.
  - We encourage (if available) 2 to 3 team members who are in the following roles to be interviewed during the scheduled "clinician" meeting: ACT team therapists, rehabilitation-type team members, and generalists. It is becoming more common for teams to have a "housing specialist;" this person may be interviewed in the "clinician" slot, but also add on the Housing Specialist interview questions (EP8) to the clinician interview list.
- We extended a few recommended interview times for staff (e.g., Psychiatric Care Provider and Peer Specialist are now 45 mins)
- We removed much of the language prompting for DACTS, but retained the information collected for DACTS ratings in Team Survey (this information is helpful for QI feedback for TMACT) and also retained the TMACT-DACTS Crosswalk in Appendix
- We further stress asking the team upfront to run data reports that you can use to cross-check with chart sample data to determine if the data provided through the report can be used (always better to have population data, rather than sample; data but need to verify you can use the population data). See TMACT Part I; Intro (page 21) for guidance on how to use team-generated reports.



Please answer each question about your ACT team as best as you can.

1. Please complete Table 1 below regarding your ACT team staffing in the past 3 months. **[OS1, OS5, CT1, CT3, CT6, ST1, ST4, ST7; H1 on DACTS]**

Table 1. ACT Team Staffing

Staff Name	Position	Date of Hire	Number of hours the staff member works with the ACT team per week[1]	Highest Level of Education	Specialized training, clinical experience, and Board Certification[2]	Number of years of experience with adults with SMI including their work with the ACT team	Daily Team Meetings per week. Note typical days of attendance (MTWRF)

[1]Include the number of hours each team member actually works, not just whether they are available (and may be holding another role in the Agency at that time).
[2] Specialized training (e.g., licensure, training in co-occurring disorders) and # of years of clinical experience. Please note if Psychiatric Care Provider is Board Certified in Psychiatry, and/or if any physician extenders have specialized certification and training in psychiatry.

6. In the past month, how often did the team leader meet with each of the two staff to whom he/she consistently provides the most clinical supervision? Clinical supervision is defined as the provision of guidance, feedback, and training to team members to assure that quality services are provided to clients (e.g., following evidence-based practices, negotiating ethical quandaries) and maintaining and facilitating the supervisee's competence and capability to best serve clients in an effective manner. Examples include mentoring in the field, review of clinical cases, and providing feedback on tools such as assessments and treatment plans. Only count meetings that were scheduled (vs. impromptu), regardless of whether the meeting took place within a group setting (i.e., weekly clinical meeting) or individually, or in the office or in the field. [CT2]

Please indicate the number of times over the past month the team leader provided clinical supervision to each of the two staff most consistently supervised:

____ # times you provided scheduled supervision to team member #1 over past month.

Team member name:___________________________

____ # times you provided scheduled supervision to team member #2 over past month

Team member name:___________________________

UPDATES TO EXCEL SPREADSHEET

Column	Older	TMACT 1.0 Rev 3
(First column)	ACT Consumer (first three letters of name and last name first initial)	ACT Client (Use unique identifier, NOT name).
Column N	(absent)	Does the client receive health/lifestyle intervention services directly from the ACT team? (See definition) If yes, please specify the type of service provided and targeted condition or behavior.
Column O		Added: "If the client is currently unsheltered (street homeless) or emergency sheltered, please type in HOMELESS"
Column V	Does the individual receive oral medications on his/ her own, without direct involvement of the team (e.g., pharmacy delivers to home, individual or natural support picks up from pharmacy)? For all individuals, indicate the amount of oral medications the individual receives at a given time (e.g., daily, 2X/wk, weekly, monthly)	Please indicate how individuals are receiving oral psychiatric medications: (1) on own; (2) from natural supports; (3) from residential staff; (4) from ACT Team. If from ACT Team, please also indicate the amount of oral medications the individual receives at a given time (e.g., daily, 2X/wk, weekly, monthly)
Column W		Added: "Please note the IM injection medication name."
Language updated throughout and Definitions updated		

WHAT CHANGES WERE MADE TO THE INTERVIEW CHECKLIST (P.VII)

- Re-ordered items to improve overall flow
- Clinician interview, ask how their work has been impacted by 3 specialists (in sequence) rather than jumping back and forth
- We added additional team members as interview sources for some items (most often with psychiatric care provider and peer specialist)

WERE ANY CHANGES MADE TO THE **INTRODUCTION INTERVIEWS (P.1)**

- Introductory summary to discuss confidentiality and purpose of the review
- Ask about changes made since last review, if relevant
- Include checklist of items we asked for in orientation letter/email, which includes copy of Client ID key

SUMMARY OF MORE SIGNIFICANT CHANGES TO TMACT ITEMS

OS1. LOW RATIO OF CLIENTS TO STAFF

We gather more information (via Team Survey and Interviews) to clarify who meets "team inclusion" criteria.

Wording was added to clarify that you only count listed staff as team members if they are actually working with the team – not those who merely have accepted a position or received an offer.

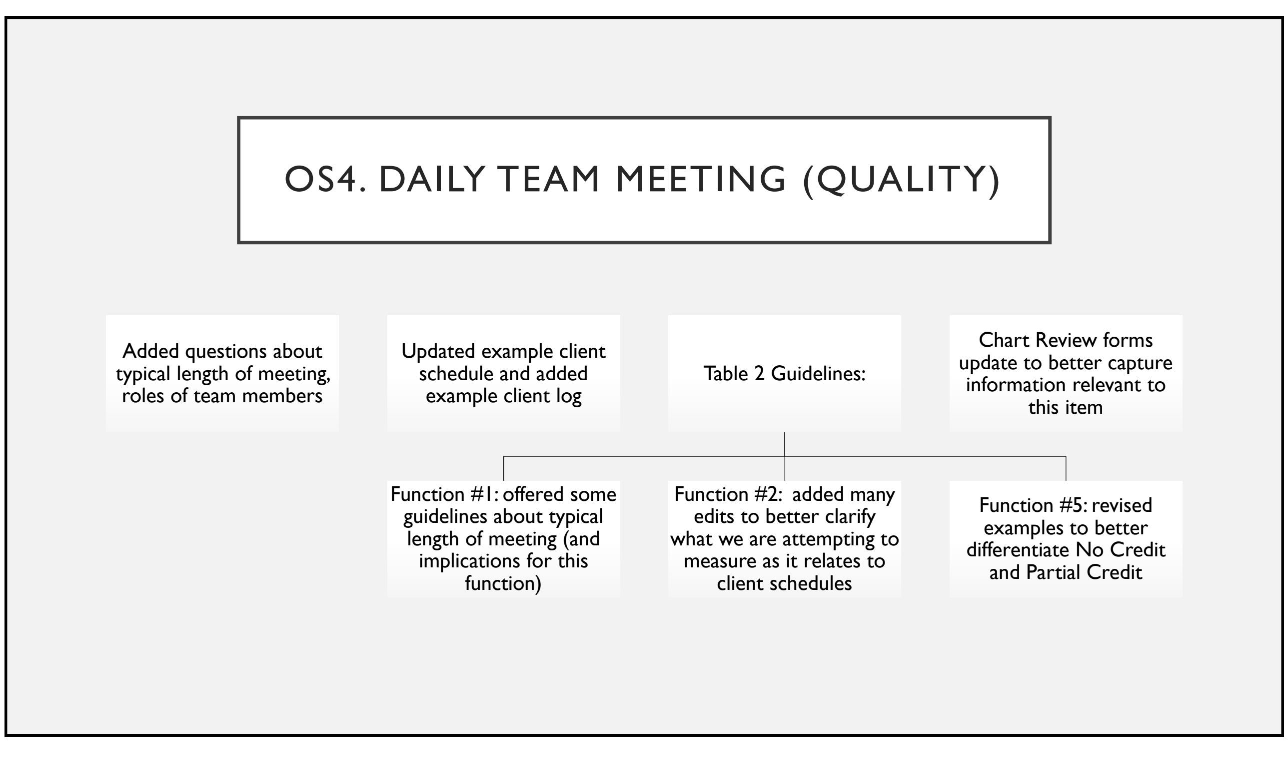
We also clarify that you are not to count permanent staff on leave FTE along with any interim (temporary) staff filling in for that position.

OS2. TEAM APPROACH

- Reminder to access team's EMR-generated reports, if available
- Exclude charts with no contacts in 4-week period from final calculations for this item
- Include more explicit guidelines around selecting 4-week chart review period
  - "Use the most recent and complete 4-week period from the chart (within 3 months of the site visit dates), and attempt to avoid time frames that do not represent typical team service provision (e.g., during a recent holiday or multiple staff training days)."

OS3. DAILY TEAM MEETING (FREQUENCY AND ATTENDANCE)

- Clarified what constitutes a "daily team meeting" vs some other admin or clinical meeting
  - "To count as a daily team meeting, most team members need to be present and scheduled meeting times facilitate meaningful review of client status over the past 24 hours (e.g., the meeting is consistently scheduled at approximately the same time each day). If a team meets in the morning on Monday and Tuesday, the afternoon on Wednesday, and then meets again in the morning on Thursday and Friday, do not count the Thursday meeting as one of the Daily Team Meetings."
  - "Do not include administrative or treatment planning meetings for this item. If a team reports holding a daily team meeting five days a week, but it is later revealed that one such meeting is an administrative meeting and there is no basic review and planning of service contacts, rate based on four daily team meetings per week."
- Added more questions to understand attendance (and also asked in Team Survey Staffing Table)
- Added questions to understand scheduling of Daily Team Meeting and offer guidance when there is inconsistent scheduling
- Added language to clarify what "sufficient communication" means
- To receive credit for attendance, an ACT team psychiatric care provider not only attends at least twice per week, but stays for the entire meeting



OS6. PRIORITY POPULATION

- We added several interview questions to the Psychiatric Care Provider interview (formerly not a data source for this item):
  - Who are the most appropriate clients for ACT?
  - Can you give us examples of clients who would not be appropriate for ACT?
  - What is your role in making sure the team is serving those who most need ACT services?
- Table 3, we reframe Criterion #1 to read as the percent meeting (rather than not meeting) diagnostic criteria.

OS7. ACTIVE RECRUITMENT

Table 4, Criterion #3 – we reframed percentages to read as the percent of slots filled (vs. percent unfilled/open)

Revised anchor 2

to address a rating gap

2
1 criterion is FULLY met (2 are absent) OR 2 criteria met, with both criteria PARTIALLY met OR 1 criterion is PARTIALLY met and 1 FULLY met (1 is absent).

- Team Leader and clinician questions were added to better understand why <u>or why not</u> people have transitioned from team (as graduation), and what the process is like.
- In Rating guidelines, we added this:
  - "For established teams that have not transitioned anyone, there should be compelling data speaking to intentions if considering ratings higher than partial rating criteria."
- Criteria #3 and #4: More explicit language around importance of individualizing processes (having some agency protocol is fine, but not if leading to a "one-size-fits-all model")

OS11. INVOLVEMENT IN PSYCHIATRIC HOSPITALIZATION DECISIONS

Added to rating guidelines: "Use some discretion in determining which "events" are considered (e.g., a transfer from one hospital to another hospital may not need to count as two distinct events for this item – one discharge to another admission)."

OS12. OFFICE-BASED PROGRAM ASSISTANCE (PA)

Added Team Leader questions to better get at PA function. Also prompted to interview PA directly. Process is to request that PA come in for 15 minutes of the Team Leader Part I interview

We moved out the 1.0 FTE from the Rating Guidelines Table and incorporated within anchors themselves (it was awkwardly placed before within the N/P/F criteria)

Clarified that staff counted towards the function of this position not necessarily held to same team inclusion criteria (i.e., at least 16 hours with this team and attending two daily team meetings per week)

CT2. TEAM LEADER IS PRACTICING CLINICIAN

- More guidance in interview questions to understand # of direct care reported:
  - ***I see that you reported*** *(# of hours of direct clinical work)*. **How did you come to calculate this number?** [If the number is clearly high (8+ hours), inquire how it came to be so high. If clearly low (under 5 hours), inquire why it is so low].
- Added all Specialists to interview schedule - asking about their supervision

- Board-Eligible counts for qualifications (previously indicated "certified"). Added language around qualifications for physician extenders
  - (1) Licensed by state law to prescribe medications; and
  - (2) Board certified or eligible (i.e., completed psychiatric residency) in psychiatry/mental health by a national certifying body recognized and approved by the state licensing entity. For physician extenders, must have received at least one year of supervised training (pre- or post-degree) in working with people with serious mental illness.
- We added interview questions for Psych Care Provider (who previously had none):
  - **What is your typical weekly schedule with this ACT team? What days do you work, and what time do you start and end your day?** [See if hours and schedule corroborate with what is reported in Team Survey, as well as the level of time commitment and integration on to the team itself (e.g., they are scheduled for blocks of time with the team throughout the week)]
  - [Refer to Team Survey Item #1 reported qualifications and experience]. **I see here you have approximately** (insert number of years) **experience working with people with serious mental illness. In what settings have you worked prior to working on this team?**
  - **Are you currently board certified in psychiatry?** [If no] **Where did you complete your psychiatric residency?**
- **Added more clarifications in rating guidelines**

CT3. PSYCHIATRIC CARE PROVIDER ON TEAM (CON'T)

- **Added more clarifications in rating guidelines:**
  - For teams with more than one psychiatric care provider, each provider must have at least 0.20 FTE (i.e., at least 8 hours per week) of clinical time to be considered part of the team (e.g., do not count reports of significant distant administrative support time, such as 8 hours off-site reviewing assessments and plans). If this standard is not met, do not count them toward the FTE calculation. Psychiatric residents do not yet meet qualifications and will not count towards the FTE in this item, but if they are at least 8 hours per week with the team, they may be counted as part of the team (e.g., in FTE for Program Size, and contacts for Intensity and Frequency of Services).
  - The expectation is that the psychiatric care provider has designated time with the team throughout the week, and those designated times include clinical work, interactions with the team, and other onsite administrative duties (it does not include days exclusively scheduled for "administration and paperwork," for example).
  - If the psychiatric care provider sees clients across agency programs throughout the day and week (e.g., appointments with ACT clients are commonly intermixed with appointments with other clients), attempt to adjust actual FTE to reflect time dedicated to ACT only.

CT4. ROLE OF PSYCHIATRIC CARE PROVIDER IN TREATMENT

- This is added under Chart Review Data source prompt:
  - Look at the extent to which the psychiatric care provider is delivering integrated healthcare and brief therapy. Of consideration, it is unlikely that brief contacts (e.g., 10 – 15 minutes) affords much time to provide integrated healthcare and brief therapy.
- Function #1 – Moved to Chart Log I and looking at last two contacts across the whole sample. We consider two time periods – time between onsite evaluation and most recent psychiatric care provider progress note, and then time between the two most recent progress notes. Refer to Chart Review Log I Tally Sheet.
- We revised questions as it relates to shared-decision making (Function #3)
  - *How do you talk with clients about the medications you are prescribing to them? Describe how they have a say in what you prescribe or how it is administered?* [Prompt for whether they provide any education and the extent to which they work from a **shared decision-making approach**. Also inquire as to how decisions around antipsychotic injections are made. Inquire as to whether anyone is currently refusing all medications, and how the psychiatric care provider is addressing this choice. Also ask if the psychiatric care provider is prescribing Clozaril to anyone, and to how many].
- *Do you use a lab or monitoring service to assess medication adherence or substance use - where blood, urine, or saliva is sampled and sent to a laboratory?* [If yes] *Describe how it is determined who such services are used with and implications for treatment.*

CT5. ROLE OF PSYCHIATRIC CARE PROVIDER WITHIN TEAM

- Added further clarification on whether to credit for certain functions in Rating Guidelines:
  - **If two or more psychiatric care providers share this role:** Rate this item from the perspective of the team in terms of whether they have adequate access to each of these functions, thereby strengthening the team, given the commitment and role of the collective body of psychiatric care providers. If one provider is clearly stronger than another in a particular function, and this appears to have a negative consequence for the team (e.g., the former provider is at a lesser FTE), then do not give credit for that function. Note that credit for daily team meeting attendance should consider the expected minimal coverage given the size of the team. Two examples: (1) A team serving 100 clients should have access to at least 32 hours of psychiatry and attendance of psychiatric care provider staff at a minimum of 4 days per week. If a team this size, however, had a psychiatrist at 16 hours and attending 2 days a week, they would not meet this standard (of 4 daily team meetings given the size of the team). (2) A team with two psychiatric care providers at an aggregate 32 hours of psychiatry time (0.80 FTE) should have psychiatric care provider attendance for at least 4 daily team meetings per week, regardless if they share in this responsibility equally (e.g., both attends 2 meetings per week) or not (e.g., one attends once a week, and the other 3 times per week).

CT7. ROLE OF NURSES

Reminder to refer to Excel Columns:

- Refer to team report on health/lifestyle interventions provided (Column N)
- Refer to team's practices around oral medication management and monitoring (Column V) and IM injections (Column W).

Function #1 – Managing med system. We decided to invert the number and keep the focus on those who are getting meds on their own or have other (e.g., residential) assistance – i.e., percent of clients who have less direct involvement of team when it comes to medication management and monitoring. Check out the changes, but **here is how Full credit reads**

"Nurses take the lead on filling prescription orders, storing and putting together medication deliveries and packets, managing IM injection schedules and administering injections, and ensuring that the Medication Administration Record (MAR) and all other documentation related to medications is accurate and up-to-date. Thirty percent (30%) or less of the caseload should be independently managing medications on their own (e.g., picking up and storing monthly medications at their home) and/or receive these medications directly from residential staff."

CT7. ROLE OF NURSES (CON'T)

- **Better clarify Function #2** (Screen/monitor med conditions), which includes removing examples related to assessment that "lived" in other functions to here. Full credit reads:
  - *Nurses conduct regular screening for medical conditions and side effects of medications and monitor existing or newly-identified medical conditions as clinically indicated and/or as physical health status changes, and at least annually. Examples of screening and monitoring for medication side effects include:*
    - *Completion of the abnormal involuntary movement scale (AIMS) to assess and monitor tardive dyskinesia;*
    - *Measuring waist circumference and blood pressure, and completing/ordering lab work on triglycerides, HDL cholesterol, and fasting glucose to assess for metabolic syndrome secondary to certain second generation antipsychotic medications;*
  - *Examples of screening and ongoing monitoring for medical conditions include:*
    - *Ensuring all immunizations and medical exams are up-to-date;*
    - *Assessing health/medical risk factors or conditions (e.g., assessing for obesity, diabetes, hypertension, high cholesterol) and associated wellness management skills;*
    - *Tracking all age-related and family history health screens (e.g., a colonoscopy at age 50, prostate exam for men at age 50 or earlier if African-American or a family history; a mammogram for women at age 40).*

Function #5: Clarified that Full Credit Practice involves more intentional and assertive engagement strategies, not just reacting to team's requests for information. "Education efforts are intentionally inserted into work rather than reflect passive responses to team questions."

ST1 CO-OCCURRING DISORDERS SPECIALIST
ST4. EMPLOYMENT SPECIALIST
ST7. PEER SPECIALIST

Added guidance on how to use and compare chart data.

- "Cross-walk what specialists report as the percent of contacts that involve specialist services with what is observed in the review of progress note entries (e.g., what percent of progress note entries by co-occurring disorders specialist have some notation of integrated treatment for co-occurring disorders, inclusive of assessment and engagement?). Significant discrepancies may warrant an adjustment from what was reported and what was observed in the chart (e.g., specialist reports 90%, and chart review data finds only 50%; in such a case, given what other data sources indicate (e.g., scheduling practices), reducing to 70% may be a more accurate reflection of how the specialist is used in his or her role)."

  See corresponding Chart Review Tally (Part III)

ST2. ROLE OF COD SPECIALIST IN TREATMENT

- We offer more examples and prompts to consider if you receive many vague responses to more open questions.
  - ***"Please describe your treatment philosophy in working with those with both severe mental illness and substance use disorders, as well as the range of services you provide.*** [Depending on their response, you may want to follow-up with the following questions. If you receive more global or generic responses (e.g., "meet them where they are at"), inquire further to determine level of understanding and practice. Use client-specific information gleaned from chart reviews and/or discussion in the daily team meeting to ask follow-up questions about where selected clients are regarding stages of change readiness and examples of recent interventions. Assess for whether they are using stage appropriate interventions. Are they using outreach, MI, and harm reduction for clients in earlier stages? How is MI being used when working with clients in later stages? Are they using cognitive behavioral approaches and relapse prevention with clients in later stages?]"
- We added this question: "***Can you identify a client who is continuing to use, but has some awareness that her use is creating problems? Describe for me ways in which you are interacting and working with this client.***
- *We also added this:* ***What about your approach to working with a client who has stopped actively using and is trying to be sober/abstinent. What types of services or interventions are offered?*** [Prompt to hear about specific examples of clients with whom the specialist is currently working; if not offered, ask about relapse prevention planning.]
- We added this: "***If we have not yet heard of it yet, can you share with us an example of your practice that you think best reflects your work as the team's COD specialist?*** [With this example, try to clarify how far back the example dates.]
- We updated Table 14 (Examples of Stage-Wise Dual Disorders Treatment Interventions)
- Ratings Guidelines (Table 15): Clarified that it must be the COD Specialist conducting assessments to receive credit (Service #1) and expanded examples for Service #5.

ST3. COD ROLE WITHIN TEAM

- Added questions asking about what their role is in various meetings – Daily Team and PCP (not that they just attend) – although this isn't explicitly incorporated into rating guidelines, it will be in TMACT 2.0.
- See Rating Guidelines as we added a bit more explanation for some functions:
  - **Cross-training:** Includes formal training (e.g., didactic, skill-based teaching) to other team members at least 20 minutes in duration provided at least one time in the past 6 months. To receive credit, the topic area should be judged to be relevant and helpful given the evidence-based practice guidelines.
  - **Daily Team Meetings:** Regularly attends all daily team meetings (except when pre-planned activities conflict with meeting),) at a rate commensurate with their hours and schedule with the team. If the team meets 4 days a week, which is the rate at which the specialist attends, credit for this function. However, if the team is meeting less often than 3 days a week, then do not credit for this function. Similarly, credit if the specialist works a 4 X 10 hour shifts each week and attends 4 days per week.

ST5. EMPLOYMENT SPECIALIST IN SERVICES

- We enhanced many interview questions by adding more prompts, definitions, examples. We removed the opening interview question asking about particular philosophy.
- We added "Gold Star" question: "***If we have not yet heard of it yet, can you share with us an example of your practice that you think best reflects your work as the team's employment specialist?*** [With this example, try to clarify how far back the example dates.]"
- In Rating Guidelines and Examples under Service #1 Engagement, we speak more to the use of motivational interviewing skills. Under Service #2, we speak to actually using (not just completing) the Career Profile/Voc assessment and removed the idea it was necessarily documented in the client's chart.
- Added more to Service #5 Full Credit
  - "Per the client's preferences and consent, specialist provides support on/offsite to assist client in training and learning skills needed for job, can serve as a liaison between client and employer, and problem-solves issues as they arise. Although examples of onsite job coaching are not necessary for full credit, the absence of job coaching should not be due to a lack of skills on the part of the specialist. This role also includes providing supports in academic settings."
- Added more to Service #6:
  - …"There is also expectation that the specialist understands enough about how work impacts benefits to correct misinformation, and to use educational strategies as part of engagement"

ST8. ROLE OF PEER SPECIALIST

- More questions and prompts related to how they interact with and influence the team:
  - Observe whether and how the peer specialist contributes to discussions related to wellness management and recovery services and principles during the daily team meeting. Do they appear to be referred to within the team for guidance and/or consultation?
  - ***Do you feel like you are treated as an equal professional on the team? Are there some things that you are not able to do because of your position? Is your opinion valued as much as other team members?*** *[if no, ask for examples]*
  - ***Do you ever provide formal training to other team members? [If yes]: When and what kinds of topics do you cover?***
  - ***Do you ever provide consultation to other team members to help them to better understand your role or the services you provide? Or to help them to also learn to provide some of those services themselves?*** [Prompt for examples where the peer specialist may have advocated for a client, even if in opposition to team members.]
  - ***If we have not yet heard of it yet, can you share with us an example of your practice that you think best reflects your work as the team's peer specialist?*** [With this example, try to clarify how far back the example dates]

ST8. ROLE OF PEER SPECIALIST (CON'T)

Updated Guidelines Table:

Function #1 (Coaching and consultation to clients to promote recovery, self-direction, and independence).

Full Credit now reads: *The peer specialist consistently works with ACT clients by assisting them with building skills that help promote their own recovery and self-sufficiency. Examples include but are not limited to:*

- *Providing education to clients about how to take an active role in their own treatment and treatment planning;*
- *Teaching self-advocacy skills, including how to assert preferences and values with team, family, and others (e.g., not wanting to take select medications);*
- *Providing coaching regarding independent living skills (e.g., activities of daily living [ADLs]), safety planning, transportation planning/navigation skill building, money management).*

Function #2 *(Facilitating wellness management and recovery strategies).*

Full credit now reads: The peer specialist takes a lead role within the team on implementing WMR strategies. These can be formal/manualized or informal strategies:

Formal/Manualized:

- *Group or individual IMR;*
- *Group or individual WRAP;*
- *Facilitating Psychiatric Advance Directives*

Informal:

- *Working with clients on all of the following:*
- *Providing targeted psychoeducation about mental illness and medications*
- *Identifying early warning signs for relapse and lapses;*
- *Identifying triggers for relapses and lapses; and*
- *Developing a relapse prevention plan.*

- Prompted to evaluate and document if person seen in an "**institution**" – definition is provided in the Chart Log I. You still rate "institution" as "community" for the sake of rating this item. Bigger changes relevant to separating these two locations out are planned for TMACT 2.0.
  - "For the current purpose of this rating, contacts in institutions (hospital, jails, assisted living facilities) will be treated as community contacts. However, this information may be used to guide qualitative feedback (e.g., a high percent of "community" based contacts that are in residential institutions may suggest a departure from the intent of ACT to focus efforts on helping people live and succeed in more integrated, community-based settings)."
- Guidelines were modified so you are only **calculating a percent with charts where there was at least one face-to face contact made.** This update applies to this item and also applied to OS2. Team Approach. It does not apply to CP3 and CP4, where you rate considering all charts sampled (not just ones with at least one face-to-face contact).

CP2. ASSERTIVE ENGAGEMENT

Added a bit more explanation and prompts to you (evaluators)

What other techniques does the team use to reach out to clients? *[*Look for language that suggests motivational. It is important to give team leader an opportunity to offer a range of techniques.]

If no therapeutic limit-setting techniques are offered on his or her own, consider following-up with:

What is the team willing to try out when these more motivational and softer approaches are not working – the person remains poorly engaged and your concerns for safety and risks remain or are increasing? What then is the team willing to do to engage such clients?

Added to Full Credit in Guidelines Table 22 "*Note: A team's management of a "high-risk" or

"watch-list" does not on its own earn full credit for this practice. Such a list must clearly be operational in guiding what the team is doing as it relates to assertive engagement."

Added to rating guidelines:

Clients who receive extensive monitoring at the clinic because of a long-acting injection (e.g., Zyprexa Relprevv) should not be credited for the 180 minutes of monitoring time unless that time includes delivering of other services beyond passive and periodic monitoring. It is suggested that 60 minutes are credited when no other clear services are provided during this monitoring period.

If the team does not separate out travel time (without client present) from service contact time, you should not rate this item, excluding it from the final TMACT ratings.

CP6. RESPONSIBILITY FOR CRISIS SERVICES

- We broke out questions for the Team Leader:
  - What is the ACT team's role in providing 24-hour crisis services? How is the ACT team involved in crisis assessment and response during after-hours and on weekends?
  - Do calls come in directly to the on-call staff? [If not, clarify who receives calls and level of triaging, about what percent of calls are connected to the ACT on-call staff.]
  - In what ways does the on-call staff have access to crisis plans? Can you give an example of how crisis plans have been useful during a crisis?
  - Can you describe the most recent example where on-call staff responded to a crisis during after-hours and/or on weekends?

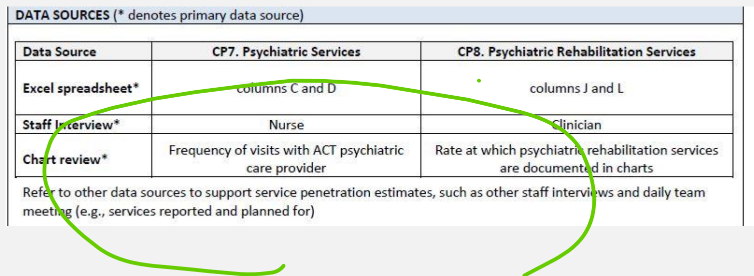
CP7. FULL RESPONSIBILITY FOR PSYCHIATRIC CARE SERVICES

See the Worksheet (pp. 120 – 121) that accompanies this item. We added in this consideration when judging "penetration" of these services

C. Percent of clients who are seen by the psychiatric care provider less often than every 3 months, per chart review. To determine this approximate percent:

- For those client charts where the team was reported to provide psychiatric care services (Column C) and who had not been excluded from the count per Steps A and B above, compute the percent of client charts with inadequate follow-up by psychiatric care provider. "Inadequate follow-up" includes those client charts observed with 3+ months between contacts, which includes clients where the most recent documented contact date was beyond 3 months from the chart review period, in addition to clients where there were 3+ month timespans between two most recent psychiatric care provider contacts.
- **Evaluator discretion is an option** when it comes to counting a client not seen within 3+ months against the provider. In example, clients not seen often with a rationale in line with best practice (e.g., a client who has been in jail for the previous 4 months, but has been having contact with other team members; two clients who were seen within 14 weeks because of missed attempts, with all remaining clients reviewed seen within 6 weeks).

CP8 – EP3. FULL RESPONSIBILITY ITEMS



DATA SOURCES (* denotes primary data source)

Data Source	CP7. Psychiatric Services	CP8. Psychiatric Rehabilitation Services
Excel spreadsheet*	columns C and D	columns J and L
Staff Interview*	Nurse	Clinician
Chart review*	Frequency of visits with ACT psychiatric care provider	Rate at which psychiatric rehabilitation services are documented in charts

Refer to other data sources to support service penetration estimates, such as other staff interviews and daily team meeting (e.g., services reported and planned for)

- Chart data was always a data source, but made more explicitly so in more recent updates.

CP8 – EP3. FULL RESPONSIBILITY ITEMS

Method 1 may seem more familiar to TMACT users. This is where we compare the percent of all clients the team reported delivering a service to with the percent of all sampled charts where we indeed found that service to be delivered. If there was a significant discrepancy (ideas for such are offered), then we adjust what the team originally reported.

Method 2, by comparison, is looking specifically at the sampled charts of clients the team endorsed as receiving the service of interest, and examining what percent of that subsample were found to indeed receive that service, per documentation in the 4-week period under review.

"To compute the rate at which psychiatric rehabilitation services are provided by the team, first start by examining the rate at which the team reports to be delivering this service themselves (column J). If there is a clear discrepancy between what the team reports and what is observed in the chart data, evaluators are encouraged to adjust the reported percent given the weight of other data sources. We offer two methods below for comparing data sources and determining the most accurate estimate of actual performance. The first method **(Method 1 in Worksheet 2)** compares the team's report with all sampled charts (regardless if those individual charts were of clients to whom the team reported delivering the service); Method 1 can detect potential underreporting by the team in column J, but may be more likely to produce incorrect estimates if the sample is not representative of all clients reported to receive that service. The second method **(Method 2 in Worksheet 3)** examines the presence of psychiatric rehabilitation services only for those clients the team reported affirmatively in column J; Method 2 may be more accurate when the team reported a low penetration rate to begin with (e.g., the team reported less than 20% of clients as receiving the service), as the odds of sampling a representative sample may be compromised, or generally if sample is not representative of what the team reported in service delivery. Method 2 may be more likely to produce incorrect estimates if the timespan of chart review dates considerably predates the time of when the team completed the Excel spreadsheet."

EXAMPLE 1

CHART LOG I **TALLY** PAGE 1 – EXAMPLE TEAM FULL RESP DATA ENTRY

CHART REVIEW TALLY SHEET (Part I) - Tally list of 20% (minimum of 10) client charts.

***Reminder: Only count toward these items those face-to-face client contacts made by staff who met ACT team inclusion guidelines (See OS1 and OS5; e.g., exclude staff who work less than 16 hours with the team). Review each Chart Review Log PT I to exclude non-ACT staff before tallying data here. Also, for OS2 and CP1, only consider those charts with at least one contact.

CT7, CP8, EP1 - EP3 Full Responsibility for Service Items, and EP7 — For each chart, code the following:

- + = If indicated by team as receiving this Service (Excel Spreadsheet)
- H = Evidence of Higher Quality best practice services; L = Evidence of Lower Quality best practice services
- * = If service systematically provided (i.e., there is a deliberate pattern of service delivery).

Unique Client ID	OS2: Team Approach – Total # of ACT team members in contact with client during a 4-week period (*DACTS Standard is more than 1 team member in first 2 weeks)	OS6. Priority Service Population – Does diagnosis fit w/ ACT criteria? If not, note diagnosis.	CT4. Psychiatric Provider Contacts (and CP7) – How often seen by ACT psychiatric care provider?[1] Code: 1 = within 6 weeks; 2 = within 3 months; 3 = 3+ months (add * if therapy)	CP1: Community-Based Services – % of total contacts that are community-based (collapse "community" and "institution" together) (Total # face-to-face community-based contacts/Total # of face-to-face office & community-based contacts)	CP3: Intensity of Service – Mean/average # of minutes per week over 4-week period (Total minutes/4)	CP4: Frequency of Contact – Mean/average # of face-to-face contacts (office and community) per week over 4-week period	Integrated Tx for Co-Occurring Disorders (EP1)	SEE services (EP2)	Psych Rehab Services (CP8)	WMR Services (EP3)	Psycho-therapy (EP7)	Health (CT7)
1. 5							+ L *	+ H *	+			
2. 11								+ L *	+ L *			
3. 7									+	+		
4. 21							+ L		+			
5. 28							+					
6. 41								L	+ L			
7. 46							+ H *		+			
8. 51								+ H *	+			
9. 3									+ L			
10. 14								+ H	+			
11. 36							+		+ L *			
12. 49										+		
13.												
14.												
15.												
16.												
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18.												
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20.												
21.												
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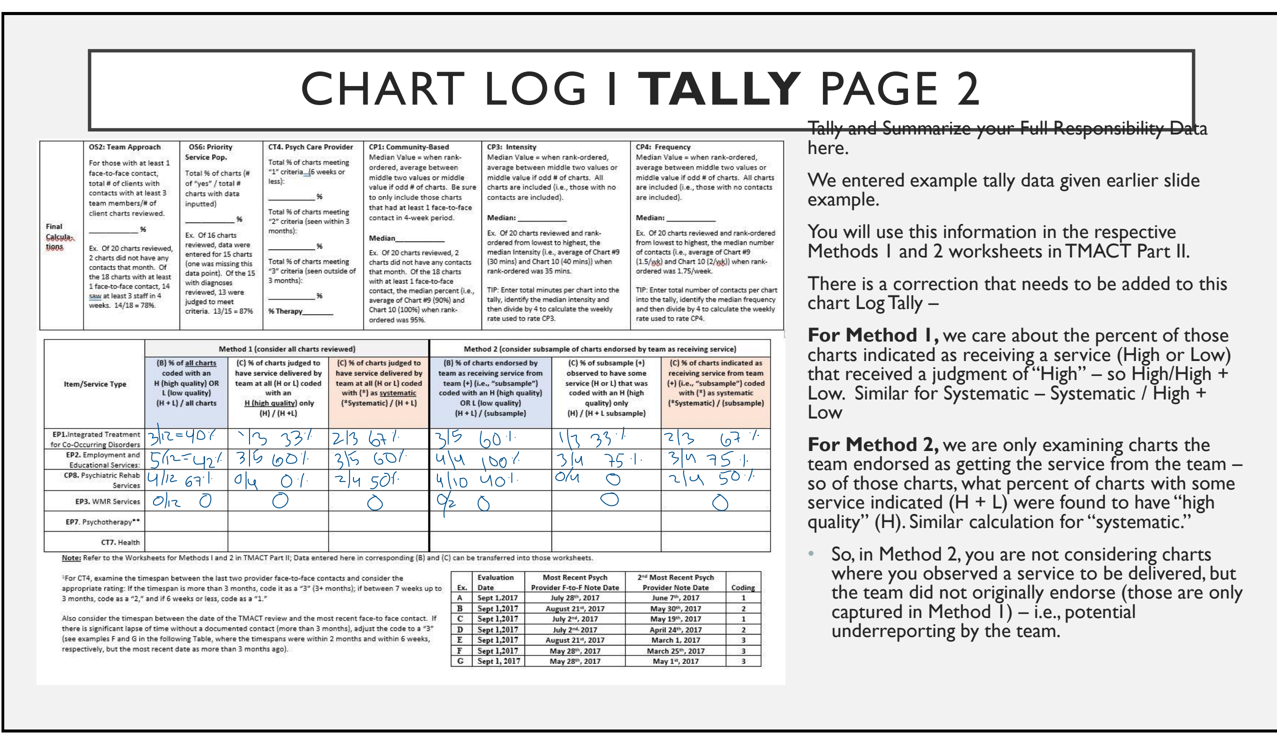


Final Calculations	OS2: Team Approach	OS6: Priority Service Pop.	CT4. Psych Care Provider	CP1: Community-Based	CP3: Intensity	CP4: Frequency
	For those with at least 1 face-to-face contact, total # of clients with contacts with at least 3 team members/# of client charts reviewed. ________ % Ex. Of 20 charts reviewed, 2 charts did not have any contacts that month. Of the 18 charts with at least 1 face-to-face contact, 14 saw at least 3 staff in 4 weeks. 14/18 = 78%.	Total % of charts (# of "yes" / total # charts with data inputted) ________ % Ex. Of 16 charts reviewed, data were entered for 15 charts (one was missing this data point). Of the 15 with diagnoses reviewed, 13 were judged to meet criteria. 13/15 = 87%	Total % of charts meeting "1" criteria (6 weeks or less): ________ % Total % of charts meeting "2" criteria (seen within 3 months): ________ % Total % of charts meeting "3" criteria (seen outside of 3 months): ________ % **% Therapy** ________	Median Value = when rank-ordered, average between middle two values or middle value if odd # of charts. Be sure to only include those charts that had at least 1 face-to-face contact in 4-week period. Median ________ Ex. Of 20 charts reviewed, 2 charts did not have any contacts that month. Of the 18 charts with at least 1 face-to-face contact, the median percent (i.e., average of Chart #9 (90%) and Chart 10 (100%) when rank-ordered was 95%.	Median Value = when rank-ordered, average between middle two values or middle value if odd # of charts. All charts are included (i.e., those with no contacts are included). Median: ________ Ex. Of 20 charts reviewed and rank-ordered from lowest to highest, the median Intensity (i.e., average of Chart #9 (30 mins) and Chart 10 (40 mins)) when rank-ordered was 35 mins. TIP: Enter total minutes per chart into the tally, identify the median intensity and then divide by 4 to calculate the weekly rate used to rate CP3.	Median Value = when rank-ordered, average between middle two values or middle value if odd # of charts. All charts are included (i.e., those with no contacts are included). Median: ________ Ex. Of 20 charts reviewed and rank-ordered from lowest to highest, the median number of contacts (i.e., average of Chart #9 (1.5/wk) and Chart 10 (2/wk)) when rank-ordered was 1.75/week. TIP: Enter total number of contacts per chart into the tally, identify the median frequency and then divide by 4 to calculate the weekly rate used to rate CP4.

Item/Service Type	Method 1 (consider all charts reviewed): (B) % of all charts coded with an H (high quality) OR L (low quality) (H + L) / all charts	Method 1: (C) % of charts judged to have service delivered by team at all (H or L) coded with an H (high quality) only (H) / (H +L)	Method 1: (C) % of charts judged to have service delivered by team at all (H or L) coded with (*) as systematic (*Systematic) / (H + L)	Method 2 (consider subsample of charts endorsed by team as receiving service): (B) % of charts endorsed by team as receiving service from team (+) (i.e., "subsample") coded with an H (high quality) OR L (low quality) (H + L) / (subsample)	Method 2: (C) % of subsample (+) observed to have some service (H or L) that was coded with an H (high quality) only (H) / (H + L subsample)	Method 2: (C) % of charts indicated as receiving service from team (+) (i.e., "subsample") coded with (*) as systematic (*Systematic) / (subsample)
EP1. Integrated Treatment for Co-Occurring Disorders	3/12=40%	1/3 33%	2/3 67%	3/5 60%	1/3 33%	2/3 67%
EP2. Employment and Educational Services:	5/12=42%	3/5 60%	3/5 60%	4/4 100%	3/4 75%	3/4 75%
CP8. Psychiatric Rehab Services	4/12 67%	0/4 0%	2/4 50%	4/10 40%	0/4 0	2/4 50%
EP3. WMR Services	0/12 0	0	0	0/2 0	0	0
EP7. Psychotherapy**						
CT7. Health						

Note: Refer to the Worksheets for Methods I and 2 in TMACT Part II; Data entered here in corresponding (B) and (C) can be transferred into those worksheets.

[1] For CT4, examine the timespan between the last two provider face-to-face contacts and consider the appropriate rating: If the timespan is more than 3 months, code it as a "3" (3+ months); if between 7 weeks up to 3 months, code as a "2," and if 6 weeks or less, code as a "1."

Also consider the timespan between the date of the TMACT review and the most recent face-to face contact. If there is significant lapse of time without a documented contact (more than 3 months), adjust the code to a "3" (see examples F and G in the following Table, where the timespans were within 2 months and within 6 weeks, respectively, but the most recent date as more than 3 months ago).

Ex.	Evaluation Date	Most Recent Psych Provider F-to-F Note Date	2nd Most Recent Psych Provider Note Date	Coding
A	Sept 1,2017	July 28th, 2017	June 7th, 2017	1
B	Sept 1,2017	August 21st, 2017	May 30th, 2017	2
C	Sept 1,2017	July 2nd, 2017	May 19th, 2017	1
D	Sept 1,2017	July 2nd, 2017	April 24th, 2017	2
E	Sept 1,2017	August 21st, 2017	March 1, 2017	3
F	Sept 1,2017	May 28th, 2017	March 25th, 2017	3
G	Sept 1, 2017	May 28th, 2017	May 1st, 2017	3

METHOD 1 EXAMPLE

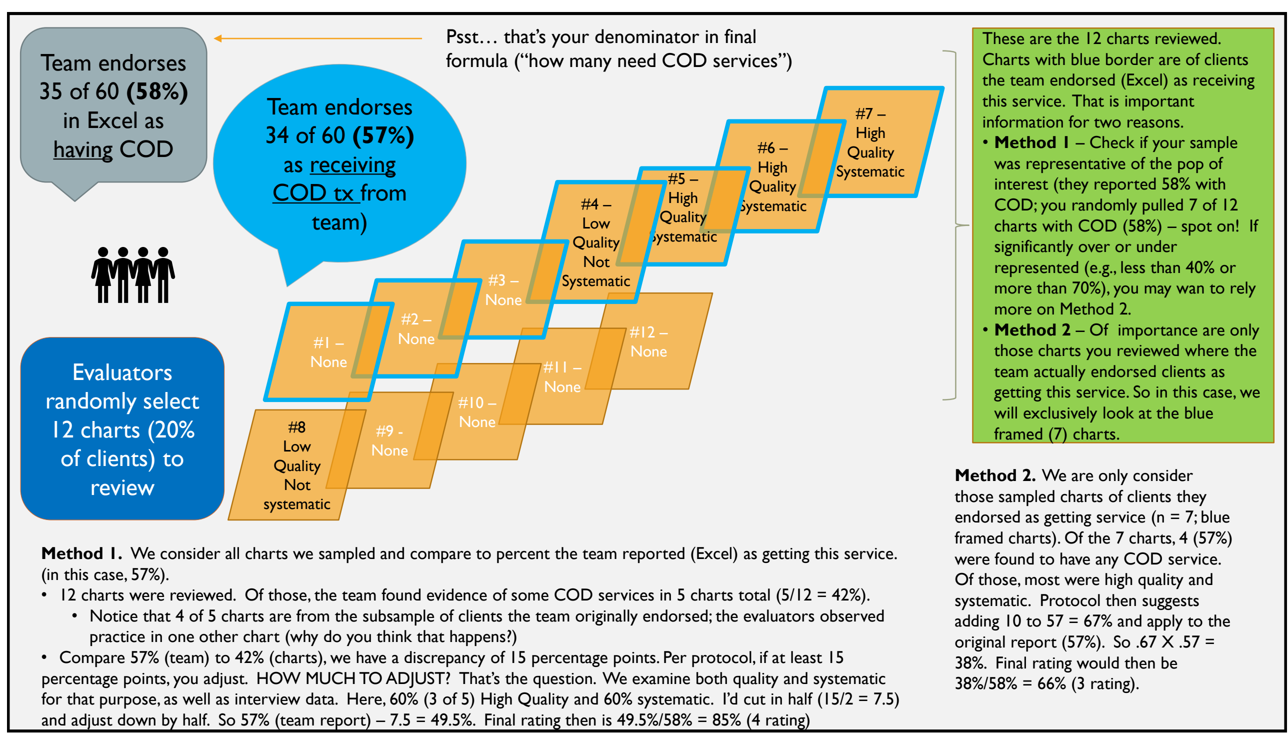
Worksheet 4. Method 1 **Calculating the number of clients receiving integrated treatment for COD (EP1) from the team (numerator).**	Percent of clients	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving integrated treatment for co-occurring disorders (COD) from the team (**Excel spreadsheet, column B**)? Percent is calculated by counting the number of clients reported to be receiving this service from the team and divide by the total number of clients served. • Engagement-related services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5. • If client noted as also receiving services from a **non-ACT provider (see column B)**, selectively exclude from this count those clients who, after follow-up questioning to team leader or other staff, are accessing these non-ACT services in lieu of team's emphasis of integrated treatment for COD (however, exclude complimentary programs, such as detoxification, residential integrated treatment for COD, and self-help groups).	**Team Reports: (A)** 42%	38/60 63%
Team Hope example. The team reported that 42 of the 100 clients (42%) were receiving integrated treatment for COD from the team.		
B. What percent of all charts reviewed were observed to have any integrated treatment for COD at all (i.e., regardless of it being systematically provided and regardless of quality was judged high or low)? **Chart Review Tally Sheet Part I** (Please refer to the TMACT Calculation Workbook to enter and compute these data).	**Chart Review Results: (B)** 25%	40%
The results of **Team Hope's** Chart Review found that 5 of 20 (25%) charts were judged to provide some integrated treatment for COD, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of integrated treatment for COD? (this information may inform how much of an adjustment to make to team's report) • Calculate the percent of charts observed with "high quality" examples of integrated treatment for COD (i.e., # of those judged high quality / # judged to have some integrated treatment for COD). • Calculate the percent of charts observed with "systematic delivery" of integrated treatment for COD (i.e., # of those judged systematic / # judged to have some integrated treatment for COD). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned integrated treatment for COD interventions in person-centered plans and/or client schedules, and reliance on other non-ACT COD services.	**Other Data: (C)** 20% "high quality;" 40% "systematic;" and other examples judged to be weak	33% High 67% syst OK
The results of **Team Hope's** Chart Review found that 1 of 5 charts (20%) were judged to be of "high quality," and that 2 of 5 (40%) were systematically delivered. There was limited notation of planned integrated treatment for COD interventions in client schedules, and examples tend to be vague and somewhat mixed in regard to reflecting appropriate stage-wise treatment.		
Calculating percent of clients receiving service (numerator): Compare Steps **A** with **B**. If there is a significant discrepancy (e.g., a **difference of 15 percentage points or more**) between these two estimates, adjust from their original reported penetration in the direction of data observed in Step B (chart data). The extent of this adjustment depends on other data sources (see Step C). We recommend using either thirds or quarters to adjust team's reported percent (e.g., a discrepancy of 30 points could be divided in thirds (10, 20, 30), and how many "thirds" used to adjust would depend on other data sources (see Step C)); clear "moderate" findings may suggest cutting the difference in half. Also, refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. Other Tips: • If team reports that all/nearly all clients are receiving the service, then consider adjusting closer to chart review data as the sample would be representative of reported practice (i.e., by default, it reflects Method 2 described below). • If the timeframe of the chart review predates the timing of when the Excel spreadsheet is completed, there may be more discrepancies; in such cases, we recommend more careful consideration of all data sources to understand current practices in addition to review of chart data. • Regardless if using Method 1 or 2 to calculate percent receiving integrated treatment for COD services, if examples cited are clearly a departure from best practices (e.g., all noted examples were judged to be of "low quality" due to there being a high use of confrontational, active treatment only services), consider rating a "1" for this item.	Estimated percent of those receiving integrated treatment for COD from the team **(Numerator)**: 31%	63 − 40 = 23 Need to adjust given 23 percentage point discre-pancy. Consider that 33% judged high quality and 67% systema-tic. Interview examples ok (not great) Therefore cut the difference in thirds (23/3 = 7.6) Add 7.6 to chart review (40) = 47.6% Final penetration estimate is 47.6%/63% = 76% (4 rating)
As an example, there was a discrepancy of 17 percentage points between what **Team Hope** reported (42%) and what was observed in the charts (25%), with other data sources overall suggesting a lower level of practice. Given what was observed in Step C, evaluators chose to cut the difference in thirds, dividing 17 by 3 (17/3 = 5.7) and reducing the team's report by two-thirds the difference (i.e., 11.4 percentage points (42-11.4 = 30.6%, or 31%).		

METHOD 2 EXAMPLE

Worksheet 5. Method 2. **Calculating the percent of clients receiving integrated treatment for COD (EP1) from the team (numerator).**	Number or Percent of clients	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving integrated treatment for COD from the team (**Excel spreadsheet, column B**)? Percent is calculated by counting the number of clients reported to be receiving this service from the team and divide by the total number of clients served. • Engagement-related integrated treatment for COD services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • If client noted as also receiving services from a **non-ACT provider (see column B)**, selectively exclude from this count those clients who, after follow-up questioning to team leader or other staff, are accessing these non-ACT services in lieu of team's emphasis of integrated treatment for COD (however, exclude complimentary programs, such as detoxification, residential integrated treatment for COD, and self-help groups). • Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5.	**Team Reports: (A)** 42%	38/60 63%
Team Hope example. The team reported that 42 of the 100 clients (42%) were receiving integrated treatment for COD services from the team.		
B. What percent of those indicated as receiving integrated treatment for COD from the team (Excel spreadsheet, column B) were found to receiving such services, per the chart review? Refer to the **Chart Review Tally Sheet Part I** (Refer to the TMACT Calculation Workbook to enter and compute these data).	**Chart Review Results: (B)** 63%	3/5 60%
Team Hope example: In the sample of 20 charts reviewed, 8 charts (40%) were of clients to whom the team had reported to be providing integrated treatment for COD services. The results of Team Hope's chart review found that 5 of 8 (63%) charts were judged to provide some integrated treatment for COD services, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of integrated treatment for COD? (This information may inform how much of an adjustment to make to team's report.) • Calculate the percent of charts observed with "high quality" examples of integrated treatment for COD (i.e., # of those judged high quality / # judged to have some integrated treatment for COD). • Calculate the percent of charts observed with "systematic delivery" of integrated treatment for COD (i.e., # of those judged systematic / # judged to have some integrated treatment for COD). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned integrated treatment for COD interventions in person-centered plans and/or client schedules, and reliance on other non-ACT COD services.	**Other Data: (C)** 20% "high quality;" 40% "systematic;" and other examples judged to be weak	1 of 3 (33%) judged high quality. 2 of 3 (67%) judged syste-matic
Team Hope's chart review found that 1 of 5 charts (20%) were judged to be of "high quality," and that 2 of 5 (40%) were systematically delivered. There was limited notation of planned integrated treatment for COD interventions in client schedules, and examples tend to be vague and somewhat mixed in regard to reflecting appropriate stage-wise treatment.		
Calculating percent of clients receiving service (numerator): If the percent found in Step B was at least 90%, then we recommend using the percent the team reported in Step A as the numerator. If the percent found in Step B is lower than 90%, consider adjusting the team's report using these guidelines: If other data sources are moderate to high (Step C), then you will apply the percent found in Step B following these rules: • Take the percent found in Step B and add 10 to it (e.g., 63% + 10 = 73%) *Why add 10? As we are generalizing the findings from the sample to the total caseload, adding 10 helps reduce potential error if the sample underrepresented the work of the team. When other data sources are generally favorable (Step C), we are more inclined to add in this margin of potential error.* • Apply this percent to what the team reported in Step A. For example, 73% is applied to the team's original report of 42%, which is 0.73 X 0.42 = 0.31 (X 100) = 31% If other data sources are low to moderate (Step C), then you will apply the percent found in Step B following these rules: • Take the percent found in Step B and apply this percent to what the team reported in Step A. For example, 63% is applied to the team's original report of 42%, which is 0.63 X 0.42 = 0.26 (X 100) = 26%. • If other data sources (Step C) indicate a lower quality overall, the evaluators have discretion to reduce the percentage in Step B down by 10. As an example, if Step C was judged to be overall low (very few to no examples judged high quality, nearly none systematic, and weak to generic examples provided), then the 63% may be reduced to 53%. The final adjustment then would be 0.53 X 0.42 = 0.22, or 22%. Refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. Other Tips: • If the timeframe of the chart review predates the timing of when the Excel spreadsheet is completed, there may be more discrepancies; in such cases, we recommend more careful consideration of all data sources to understand current practices in addition to review of chart data. • If there is reason to believe the team underreported their services, consider relying more on Method 1 process. Regardless if using Method 1 or 2 to calculate percent receiving integrated treatment for COD, if examples cited are clearly a departure from best practices (e.g., all noted examples were judged to be of "low quality" due to there being clear departures from best practices, such as high use of urine drug analyses or screens and use of confrontation, consider rating a "1" for this item.	Estimated percent of those receiving integrated treatment for COD from the team **(Numerator)**: 26%	
For **Team Hope,** 63% of the subsample were found to have documented integrated COD services. Other data sources (Step C) were not favorable, indicating a lower level of systematic delivery with majority having lower quality examples of work. Evaluators applied the 63% to the team's report of 42% (A), resulting an adjusted rate of 26% (0.63 X 0.42), thereby rating a "2." Likewise, they considered reducing further by 10 to 53% due to Step C results, and found that 0.53 X 0.42 = 0.22, or 22%, still rating a "2."		

As of now our data suggests that only 60% of those reportedly getting COD services are doing so. The question becomes how much do we extrapolate/generalize to the whole caseload (Excel) based on this sample. We typically want to account for some potential sampling error. Since only 1/3 of charts were judged as high quality and 2/3rds systematic, you could stay with 60%. You then apply this to the original report (63%). 60% X 63% = 38%. Final rating will be based on 38%/63% (recall that was the original report of people with COD) = 60%. This would rate a "3."

EXAMPLE 2



RECONCILING DISCREPANCIES BETWEEN METHODS 1 AND 2

- In these examples, Method 1 found a higher penetration rating (and rating) than Method 2. If and when this occurs, consider the following:
  - Method 1 is able to pick up on some underreporting of a service, which was the case with these examples. Also, Method 1 may be more forgiving when your chart review period is further out in time from the date of the visit (e.g., over 2 months prior to the visit).
  - If there is a question as to how representative is the sample (e.g., via random sampling, you under-selected for this attribute), Method 2 may be more accurate.
  - Always also consider other data sources speaking to the presence and penetration of this service, including what was reported in interview data and observed in the daily team meeting
  - **It's ok to estimate a likely range when providing feedback and establishing a rating when charts data clearly does not support what team reported**. In this team's case, I would report that the data reviewed in the charts suggested that the team is serving between 50% - 74% of those needing this service from the team.

EP4. INTEGRATED TREATMENT FOR COD

- Broke out questions for Team Leader
- Added questions for Peer, not previously was an interview source.
- Clinician interview also broken up, similar to Team Leader interview
- Added in more examples and prompts for specifics on CBT and MI

- Criterion #1 Full: All or nearly all team members appear to consider the interaction between mental illness and substance abuse co-occurring disorders, and recognize the importance of simultaneously addressing both. The team works to understand how substance use, mental health symptoms, and environment may be influencing one another, both positively and negatively. No team member believes in parallel or sequential treatment of mental illness and substance use disorders.

- Criterion #4 Full: All or nearly all team members appear to understand and accurately practice motivational interviewing techniques when working with consumers with substance abuse problems. (MI) techniques when working with clients with co-occurring disorders. Examples of MI techniques include: use of open-ended questions; use of affirmations; use of reflective listening; use of summaries; examining pros and cons of us (decisional balance); scaling desires and abilities.

SUPPORTED EMPLOYMENT AND EDUCATION

- Added questions for Peer, not previously as source.
- Added "Believes and **Supports**" to many of the Function definitions (before, language too focused on attitude only)
- Clarified some of the full criteria in Rating Guidelines Table:
  - Criterion #2: All or nearly all team members appear to believe that the client's expressed desire to work is the only eligibility criterion for SEE services, as reflected in both their expressed values and work with clients. No team member appeared to hold less consequential "work readiness" criteria as more important than client's expressed desire to work. "Work readiness" refers to expecting clients to address/reduce/resolve symptoms and behaviors (poor self-grooming, substance use, medication adherence) before assisting with SEE.
  - Criterion #4: All or nearly all team members appear to believe that placement should be individualized and tailored to a client's preferences, as evidenced by their expressed values and observed practices (e.g., efforts to identify and share a range of employment opportunities in community). It appears that client's preferences are being attended to, as indicated by a broad array of competitive job settings, per the Excel spreadsheet (e.g., not all are fast food).

EP6. ENGAGEMENT & PSYCHOEDUCATION WITH NATURAL SUPPORTS

Added to Full Credit criteria:

"Examples suggest this work is occurring across more than a select group of clients."

EP7. EMPIRICALLY-SUPPORTED PSYCHOTHERAPY

- Table of Example therapies was updated
- MAJOR CHANGES IN RATING GUIDELINES – PARTIAL CREDIT OPTIONS ADDED. See table (anchors updated, too)

Table 29. Empirically-Supported Psychotherapy

Criteria	Examples/Guidelines		
	No Credit	Partial Credit	Full Credit
Criterion #1: Team deliberately provides individual and/or group psychotherapy, as specified in the treatment plan	Team does not provide any psychotherapy or all psychotherapy is provided "on the fly" with little to no tie to clients' treatment plans.	Data sources provide some evidence that at least one licensed team member is deliberately providing psychotherapy on a regular basis, but this is only evident in a few of those data sources (e.g., examples were reported in staff interviews, but little to no evidence of such observed in the chart review). These sessions are still regularly scheduled with the client to address a problem or advance toward a goal outlined in the treatment plan, where the therapeutic intervention is clearly noted in the plan. Alternatively, the team may not have a licensed therapist, but some team members appear adept at using therapeutic techniques (e.g., CBT) in their work.	Data sources provide strong evidence that at least one team member is deliberately providing psychotherapy on a regular basis, and this person is licensed to provide therapy. Data attesting to this practice is observed in staff interviews, chart reviews, and client/team schedules. Sessions must be regularly scheduled with the client to address a problem or advance toward a goal outlined in the treatment plan, where the therapeutic strategy or strategies are clearly noted in the plan. Alternatively, although there is no licensed therapist on the team, the team is strongly adept at core therapeutic techniques (CBT and MI) and application of these techniques was evident across multiple data sources.

EP7. EMPIRICALLY-SUPPORTED PSYCHOTHERAPY (CON'T)

- Updates to Criterion #2
- This was also added to Criterion #3 (assessing penetration of therapy):
  - *Do not credit the team for individuals reported to be receiving empirically-supported psychotherapy when the team is not providing it (No credit on #1 and #2)

Criteria	No Credit	Partial Credit	Full Credit
Criterion #2: Team uses empirically-supported techniques to address specific symptoms and behaviors	Team either: • does not provide empirically-supported therapy, or • provides examples of only providing therapy that is atheoretical and ill-defined ("supportive counseling") and/or not empirically-supported for this population (e.g., psychodynamic approaches) and/or • demonstrates inappropriate application of techniques (e.g., using person-centered (i.e., Rogerian) therapy to address a phobia or psychosis, which could more effectively be treated with CBT).	Data sources provide some evidence that team clinicians are adept at delivering empirically-supported psychotherapy for specific symptoms and/or behaviors, but there is a mix of use of atheoretical and/or ill-defined ("supportive counseling") approaches.	Data sources provide enough evidence that team clinicians are adept at delivering empirically-supported psychotherapy for specific symptoms and/or behaviors. Such evidence includes specific and appropriate examples of interventions and the type of symptoms and behaviors addressed, as well as application of resources and/or training in these particular interventions (please see Table 30 for guidance).

PP2. PERSON-CENTERED PLANNING

- We swapped order of what was Functions #4 and #5 and further clarified
- We pared down number of questions we were asking clients
- Added Team Leader as interview source: ***Can you walk us through how the team comes to determine which interventions they will be providing to each client?*** [Query further to determine how plans come to be created and who is involved in that process, how often it is occurring.]
- Chart Review (Log II) you will see more prompts to collect examples from plan – that information should also be used to rate the process here

Function	Examples/Guidelines		
	No Credit	Partial Credit	Full Credit
Function #4: Provision of guidance and support to promote self-direction and leadership within the meeting, as needed.	There is little to no evidence either within the meeting or outside of the meeting that the team provides coaching and support to clients to promote self-direction and leadership. The client is left to use their own existing skills.	There is some evidence of team guidance and support to promote client self-direction and leadership within the treatment planning meeting, but it appears to be absent at times (e.g., you observe a missed opportunity for guidance when a client is asked how the team can be more helpful in supporting their goal to go back to school and the client just says "I don't know;" the team moves on with what they would like to put in the treatment plan rather than querying more and providing some examples to choose from such as sitting down side-by-side and completing college applications).	While the treatment team may take an active role in facilitating the treatment planning meeting, the client's voice is heard and reflected and the team actively solicits his or her input throughout. It is clear that the team has either previously provided or currently provides guidance and support to the client within the meeting. Such guidance and support should focus on promoting self-direction and leadership within the meeting and in the client's treatment. Examples include: • Education about what the treatment plan is and how it fits with the client's recovery and life goals; • Education and guidance about the client's role in his or her own treatment with the ACT team and how to take an active lead in this process; • Education and guidance about the treatment planning meeting and how to self-advocate and have a more active voice in the process.
Function #5: Treatment plan is clearly driven by the client's goals and preferences and is structured in a manner to inform person-centered practices.	The treatment plan is not person-centered. Goals do not appear to reflect what client's wishes are, and remaining elements of the plan also do not appear to capture the client's preferences. stated in the team's words.	The evidence for the plan being driven by the client's goals and preferences is inconsistent throughout the plan (e.g., the goal appears recovery-centered, but remaining elements of the plan are not clearly person-centered).	The treatment team does not overly dictate the content of the treatment plan. The client's treatment and recovery goals and preferences (e.g., who they want to work with, what they want to work on) drive the content of the treatment plan, as indicated by the following: • Client's goals are stated in their own words, quoted or not; • Client's preferences for treatment are specified (e.g., which team members they'll work with, where they'd like to meet). • Interventions appear meaningfully tied to the client's stated goals.

PP3. INTERVENTIONS TARGET A BROAD RANGE OF LIFE DOMAINS

- Chart Log II – you will see a listing of life domains (codes) that you then select and list.
- We changed wording from "symmetry" to "alignment." We wrote in that at least 50% of what is planned shows up in progress notes, this is met (we train on this, but wasn't previously included)

PP4. CLIENT SELF-DETERMINATION & INDEPENDENCE

- Added a few more questions, such as:
  - **Have you ever intentionally withheld information from a client for the purposes of steering them towards a decision or behavior?** [If yes] **Can you tell me more about those instances?**
  - **Can you describe the last client the team helped move from a supervised setting to more independent setting? When was that and what types of supports were provided upon their move?**

CHART REVIEW LOGS AND TALLY SHEETS

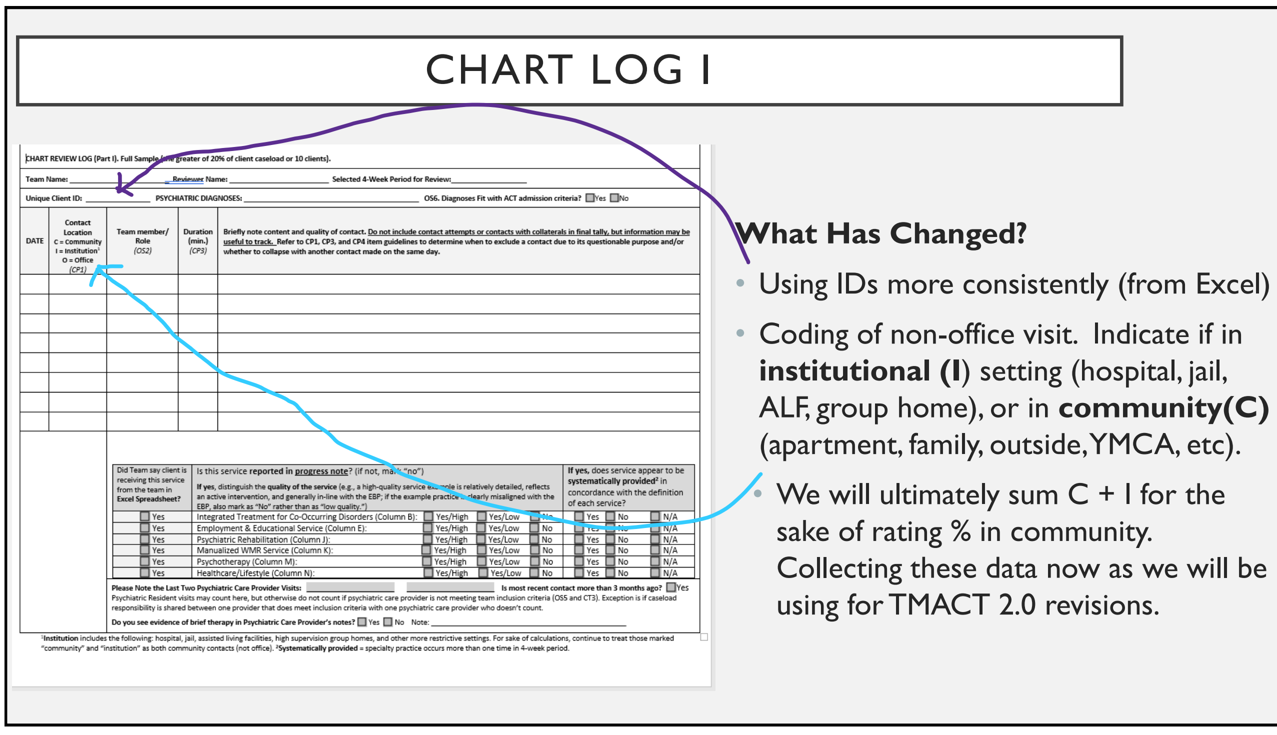


CHART LOG I
CHART REVIEW LOG (Part I). Full Sample (the greater of 20% of client caseload or 10 clients).
Team Name:
Reviewer Name:
Selected 4-Week Period for Review:
Unique Client ID:
PSYCHIATRIC DIAGNOSES:
OS6. Diagnoses Fit with ACT admission criteria? Yes No
DATE
Contact Location C = community I = Institution O = Office (CP1)
Team member/ Role (OS2)
Duration (min.) (CP3)
Briefly note content and quality of contact. Do not include contact attempts or contacts with collaterals in final tally, but information may be useful to track. Refer to CP1, CP3, and CP4 item guidelines to determine when to exclude a contact due to its questionable purpose and/or whether to collapse with another contact made on the same day.
Did Team say client is receiving this service from the team in Excel Spreadsheet?
Is this service reported in progress note? (if not, mark "no")
If yes, distinguish the quality of the service (e.g., a high-quality service example is relatively detailed, reflects an active intervention, and generally in-line with the EBP; if the example practice is clearly misaligned with the EBP, also mark as "No" rather than as "low quality.")
If yes, does service appear to be systematically provided in concordance with the definition of each service?
Integrated Treatment for Co-Occurring Disorders (Column B):
Employment & Educational Service (Column E):
Psychiatric Rehabilitation (Column J):
Manualized WMR Service (Column K):
Psychotherapy (Column M):
Healthcare/Lifestyle (Column N):
Yes
Yes/High
Yes/Low
No
N/A
Please Note the Last Two Psychiatric Care Provider Visits:
Is most recent contact more than 3 months ago? Yes
Psychiatric Resident visits may count here, but otherwise do not count if psychiatric care provider is not meeting team inclusion criteria (OS5 and CT3). Exception is if caseload responsibility is shared between one provider that does meet inclusion criteria with one psychiatric care provider who doesn't count.
Do you see evidence of brief therapy in Psychiatric Care Provider's notes? Yes No Note:
Institution includes the following: hospital, jail, assisted living facilities, high supervision group homes, and other more restrictive settings. For sake of calculations, continue to treat those marked "community" and "institution" as both community contacts (not office). Systematically provided = specialty practice occurs more than one time in 4-week period.
What Has Changed?
Using IDs more consistently (from Excel)
Coding of non-office visit. Indicate if in institutional (I) setting (hospital, jail, ALF, group home), or in community(C) (apartment, family, outside, YMCA, etc).
We will ultimately sum C + I for the sake of rating % in community. Collecting these data now as we will be using for TMACT 2.0 revisions.

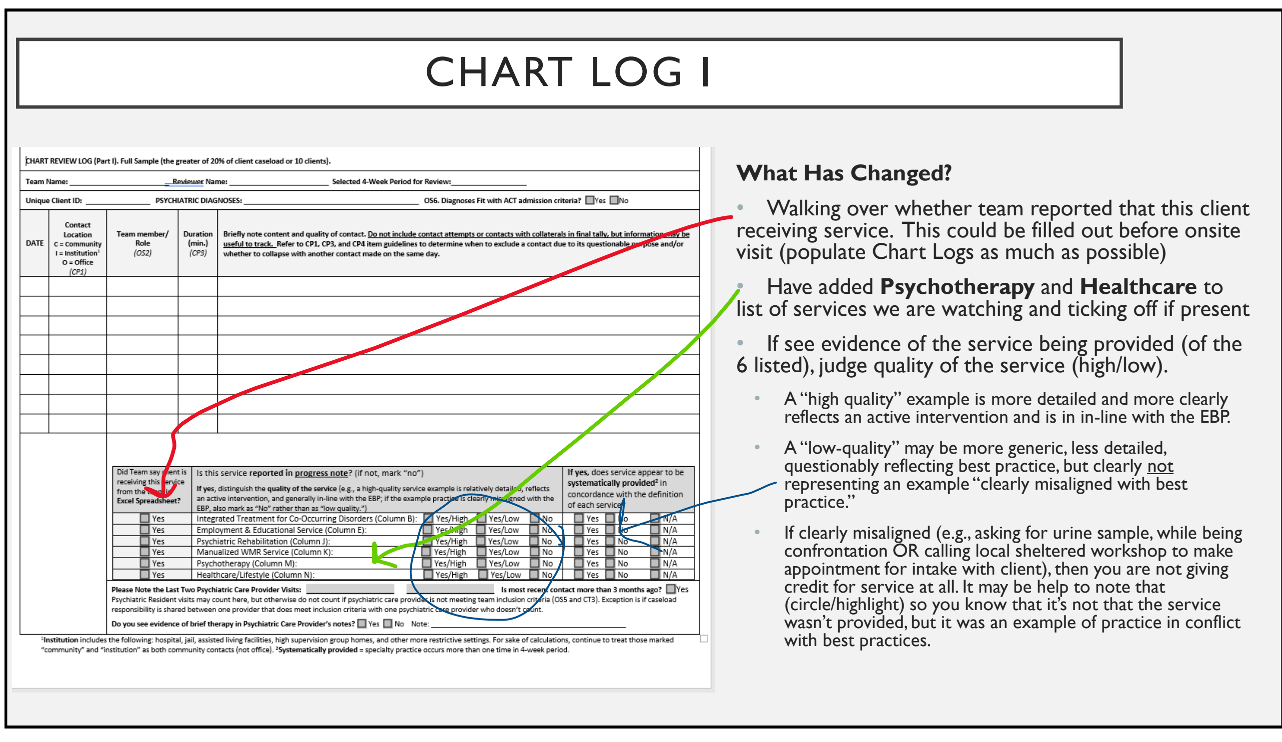


CHART LOG I
CHART REVIEW LOG (Part I). Full Sample (the greater of 20% of client caseload or 10 clients).
What Has Changed?
Walking over whether team reported that this client receiving service. This could be filled out before onsite visit (populate Chart Logs as much as possible)
Have added Psychotherapy and Healthcare to list of services we are watching and ticking off if present
If see evidence of the service being provided (of the 6 listed), judge quality of the service (high/low).
A "high quality" example is more detailed and more clearly reflects an active intervention and is in in-line with the EBP.
A "low-quality" may be more generic, less detailed, questionably reflecting best practice, but clearly not representing an example "clearly misaligned with best practice."
If clearly misaligned (e.g., asking for urine sample, while being confrontation OR calling local sheltered workshop to make appointment for intake with client), then you are not giving credit for service at all. It may be help to note that (circle/highlight) so you know that it's not that the service wasn't provided, but it was an example of practice in conflict with best practices.

CHART LOG I

CHART REVIEW LOG (Part I). Full Sample (the greater of 20% of client caseload or 10 clients).

Team Name: ____________ Reviewer Name: ____________ Selected 4-Week Period for Review: ____________

Unique Client ID: ________ PSYCHIATRIC DIAGNOSES: ____________ OS6. Diagnoses Fit with ACT admission criteria? ☐Yes ☐No

DATE	Contact Location C = Community I = Institution[1] O = Office *(CP1)*	Team member/ Role *(OS2)*	Duration (min.) *(CP3)*	Briefly note content and quality of contact. Do not include contact attempts or contacts with collaterals in final tally, but information may be useful to track. Refer to CP1, CP3, and CP4 item guidelines to determine when to exclude a contact due to its questionable purpose and/or whether to collapse with another contact made on the same day.

Did Team say client is receiving this service from the team in **Excel Spreadsheet?**	Is this service **reported in progress note**? (if not, mark "no") **If yes**, distinguish the **quality of the service** (e.g., a high-quality service example is relatively detailed, reflects an active intervention, and generally in-line with the EBP; if the example practice is clearly misaligned with the EBP, also mark as "No" rather than as "low quality.")				**If yes,** does service appear to be **systematically provided[2]** in concordance with the definition of each service?		
☐ Yes	Integrated Treatment for Co-Occurring Disorders (Column B):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A
☐ Yes	Employment & Educational Service (Column E):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A
☐ Yes	Psychiatric Rehabilitation (Column J):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A
☐ Yes	Manualized WMR Service (Column K):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A
☐ Yes	Psychotherapy (Column M):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A
☐ Yes	Healthcare/Lifestyle (Column N):	☐ Yes/High	☐ Yes/Low	☐ No	☐ Yes	☐ No	☐ N/A

Please Note the Last Two Psychiatric Care Provider Visits: ________ ________ **Is most recent contact more than 3 months ago?** ☐Yes
Psychiatric Resident visits may count here, but otherwise do not count if psychiatric care provider is not meeting team inclusion criteria (OS5 and CT3). Exception is if caseload responsibility is shared between one provider that does meet inclusion criteria with one psychiatric care provider who doesn't count.

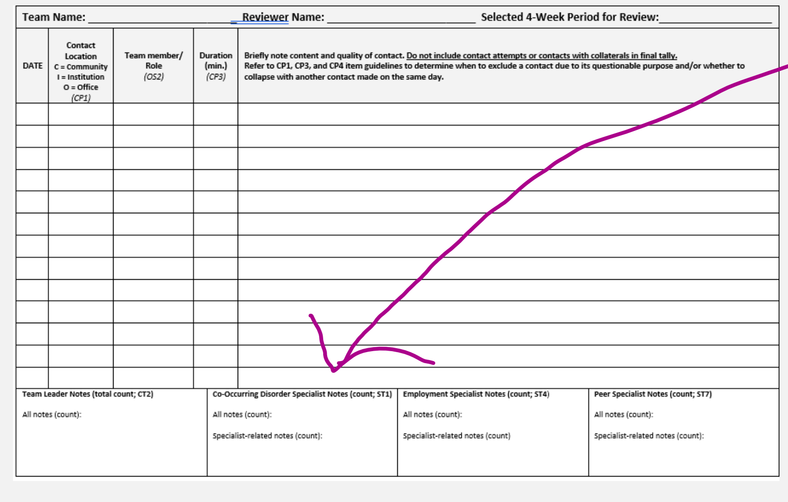
Do you see evidence of brief therapy in Psychiatric Care Provider's notes? ☐ Yes ☐ No Note: ____________

[1]**Institution** includes the following: hospital, jail, assisted living facilities, high supervision group homes, and other more restrictive settings. For sake of calculations, continue to treat those marked "community" and "institution" as both community contacts (not office). [2]**Systematically provided** = specialty practice occurs more than one time in 4-week period.

What Has Changed?

- We are collecting data on the **last 2 psych contacts** for all 20% sample (not just last 6 charts). We had begun doing this informally on our own the past year.
- We are also making note if we saw evidence of brief therapy in the Psych Care Provider documentation.
  - Reminder: When rating the psych care provider, this is one source of data – consider all data sources to determine if brief therapy is provided.

CHART LOG I (BACK PAGE)



Team Name: ____________ Reviewer Name: ____________ Selected 4-Week Period for Review: ____________

DATE	Contact Location C = Community I = Institution O = Office *(CP1)*	Team member/ Role *(OS2)*	Duration (min.) *(CP3)*	Briefly note content and quality of contact. Do not include contact attempts or contacts with collaterals in final tally. Refer to CP1, CP3, and CP4 item guidelines to determine when to exclude a contact due to its questionable purpose and/or whether to collapse with another contact made on the same day.

Team Leader Notes (total count; CT2)	Co-Occurring Disorder Specialist Notes (count; ST1)	Employment Specialist Notes (count; ST4)	Peer Specialist Notes (count; ST7)
All notes (count):	All notes (count):	All notes (count):	All notes (count):
	Specialist-related notes (count):	Specialist-related notes (count)	Specialist-related notes (count):

Back page of Log I has space to summarize count of specialist note entries, and then number of note entreis where specialty service is documented by specialist. Also count any team leader entries (to help corroborate that there is some indication of direct care). This info is later tallied in Chart Log III Tally

CHART LOG I **TALLY** PAGE 1

- We are now examining two time periods. Time between time of the review and most recent note reflecting f-to-f contact with ACT psych care provider, and also time between most recent two f-to-f contacts. To capture this, we added the following coding system. Protocol includes guidelines for how to code if most recent appointment is <u>over</u> 3 months (see next slide).
- Reformatted this section to better capture the Full Responsibility information

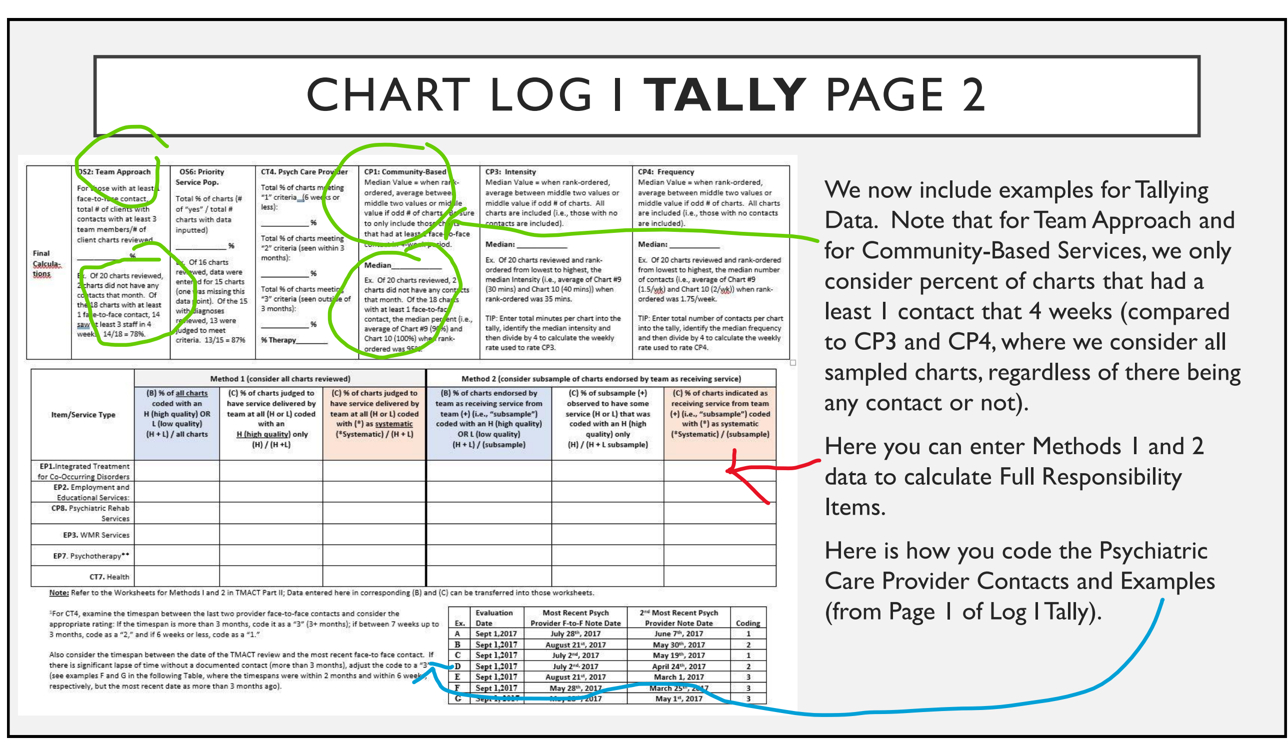


CHART LOG II (PAGE 1)

CHART REVIEW LOG (Part II). Partial Sample (i.e., 6 clients). TEAM__________ Client ID__________ Reviewer Name__________

ST2. Co-Occurring Disorders & MH Assessments CLIENT INDICATED AS HAVING A SA DIAGNOSIS? ☐Yes ☐ No (Note: if team didn't indicate, but other data sources clearly indicates, mark "yes")

Assessments Exist?
Intake? ☐Yes ☐ No
Embedded in broader assessment or stand-alone?
Ongoing? ☐Yes ☐ No
Embedded in broader assessment or stand-alone? ______
Most recent date of ongoing assessment: ______
Who Completed Assessment? ______

Assessment Quality?
Does the assessment examine the interrelationship between substance use and mental health symptoms and behaviors? ☐Yes ☐ No
How would you rate the quality of the content captured in the Substance Use assessment? ☐low ☐moderate ☐high

Stages of Change Readiness or Treatment?
Documentation of Stages of Change Readiness or Treatment anywhere in the chart? ☐Yes ☐ No (Where? ______)
Does the completion of Stages of Change Readiness or Treatment assessment appear routine and updated (i.e., you see more than one assessment for a given client)? ☐Yes ☐ No
Did the Stages of Change for this client appear to align with apparent client readiness and/or treatment strategies being used by the co-occurring disorders specialist? ☐Yes ☐ No ☐Unsure

Any **additional observations** regarding substance use assessments reviewed (e.g., timeliness, quality of the assessments) or assessment of stages of change readiness?

ST5. Employment and Education Assessment CLIENT INDICATED AS RECEIVING ANY EMPLOYMENT/EDUCATIONAL SERVICES? ☐Yes ☐ No (If no, then skip this section) | **Other Assessments**

Assessments Exist?
Intake? ☐Yes ☐ No
Embedded in broader assessment or stand-alone? ______
Ongoing? ☐Yes ☐ No
Embedded in broader assessment or stand-alone?
Most recent date of ongoing assessment: ______
Who Completed Assessment? ______

Is the assessment being used the IPS Career Profile* or a close version of the Career Profile? ☐Yes ☐ No
How would you rate the quality of the content captured in the assessment? ☐low ☐moderate ☐high
Does the assessment appear to be updated and used for the purpose of job search and ongoing supports? ☐Yes ☐ No
See a copy of Career Profile here for reference: https://www.ipsworks.org/resources/programs/program-tools/

Any **additional notes** about the employment assessment, such as whether Career Profile is used to seek good job matches, provide follow-along supports, when it is being completed (ideally, it is completed when someone voices interest in work)?

Other Assessments Observed (e.g., Nursing, Functional Skill Assessment, Violence Risk Assessment):

OS4. Daily Team Meeting: Client Schedules (Criterion #3). Examine whether the client schedule serve as a functional bridge between plans and what is being delivered. Summarize what is observed - are they formatted so that they can be shared with the client; are they organized by week or month; what level of detail is included in who (staff), when (day, even time of day), and why (intervention) the client is being seen?

- Still only completing these for 6 charts (randomly selected from sample).
- Broke up Log II into two pages rather than attempting to gather everyone on one page!
- Check-off if this client indicated as receiving this service from team (Excel)
- Capturing whether observed COD and Employment assessments are stand-alone or embedded in larger assessment, and if only completed at intake, or completed on a continual basis.
- Capture more recent dates and who completed.
- More systematically capture information on the quality of assessment tool and information captured.
- Place to capture other assessments observed (blank copies may have been offered; look for updated and completed examples in charts)
- Capture information on whether Client schedules exist, type and level of information captured, and whether schedule information appears to link to the person-centered plan, and if there is evidence schedule actually drives the daily team meeting schedule.

CHART LOG II (PAGE 2)

PP1. Strengths Inform Planning | **CP6. Crisis Planning**

Rate the extent to which documented strengths and resources are both personal and rich in quality:[1]
☐ Poor
☐ Moderate
☐ Good
☐ No Strengths Assessed

List examples of documented strengths and resources:

Do you see evidence of strengths and resources informing the development of action steps and/or interventions within the plan itself? (e.g., if a person is noted to be artistic, is there deliberate effort to draw upon this when addressing other needs or challenges in the plan?) ☐Yes ☐ No

(If Marked "Yes" in previous column:) List examples of how strengths/resources informed planning:

How well does the crisis plan appear to capture practical and individualized crisis planning information, including signs of increased distress or illness, options for how to best address emerging crisis?
☐ Poor
☐ Moderate
☐ Good
☐ No Crisis Plan

PP2. Person-Centered Planning

Two most recent plan dates: ______ ______
Revisions or Addendum Dates: ______

Write down example Recovery or Long-Term goal from this plan

Write down example Short-Term goals/Objectives from this plan

Indicate other observations of the plan itself, such as the overall flow of the plan -- do interventions relate (upstream) to objectives/goals? Do objectives/short-term goals logically relate to the long-term/recovery goal? Are interventions personalized, relatively specific, and reflect what the team is going to do (not the client)? Do the plans appear to follow from a person-centered process?

PP3. Interventions Target a Broad Range of Life Domains. Assess the extent to which planned and delivered interventions target a broad range of life domains. We are interested in **life domains** other than medication management and symptom monitoring. For Criterion A, refer to planned interventions not the goals. For Criterion B, do not include documented passive observations, such as "presented with poor hygiene," as an intervention.

Life Domains:	PP3. Criterion A	PP3. Criterion B	PP3. Criterion C
1) Distressing symptoms and/or challenging behaviors addressed by psychotherapy 2) Employment and Education 3) Healthcare management and prevention (this includes dental) 4) Housing access and resources 5) Family Relationships 6) Finances/Budgeting 7) Functional daily living skills - household maintenance 8) Functional daily living skills - self-care (e.g., grooming, hygiene) 9) Functional daily living skills—social/interpersonal skills, leisure, and/or mobility 10) Legal aid and supports 11) Psychoeducation for symptom management 12) Relapse prevention for mental health symptoms (using WMR) 13) Substance use	**Life domains** that were addressed with a planned intervention **in the person-centered plan** (list numbers from previous column):	**Life domains** that were addressed with an intervention, per the reviewed **progress notes** (list numbers from previous column):	Are at least 50% of the planned interventions (A) present in delivered interventions (B), indicating alignment?" ☐Yes ☐ No

[1] "Good quality" examples would list at least 8 personal strengths, e.g., has a great sense of humor, is attentive to details, completed High School, has a supportive family, takes good care of her dog. "Good patient" attributes, such as "engaged in treatment and takes medications," should not receive credit.

- More nuanced judgment of the quality of strengths, if observed to be documented
- Specific prompt to cite examples if giving credit for strengths informing the plan itself
- Gathering more examples of what is observed in the person-centered plan. Examples can help gauge the person-centeredness of the process, and help with providing qualitative feedback.
- List the Life Domain #s in each of these cells (criteria A and B)

CHART LOG II **TALLY** (PAGE 1)

Chart Review Tally Sheet (Part II) – Partial Sample (i.e., 6 charts). TEAM: ____________

Co-Occurring Disorders (COD) Assessments (ST2)

Client ID	SA Indicated by Team?	Summarize the following (across the 6 charts, and/or those indicated as having SA): 1) What is observed at **intake** (quality (i.e., examine interrelationship), timelines, who is completing); 2) What is observed for **ongoing (COD) assessments** (quality (i.e., examine interrelationship), timelines, who is completing); 3) **Stages of Change** Readiness and Treatment assessed? (indicate where, if appearing accurate, updated); and 4) Any notable **other observations** related to assessment and treatment of CODs?

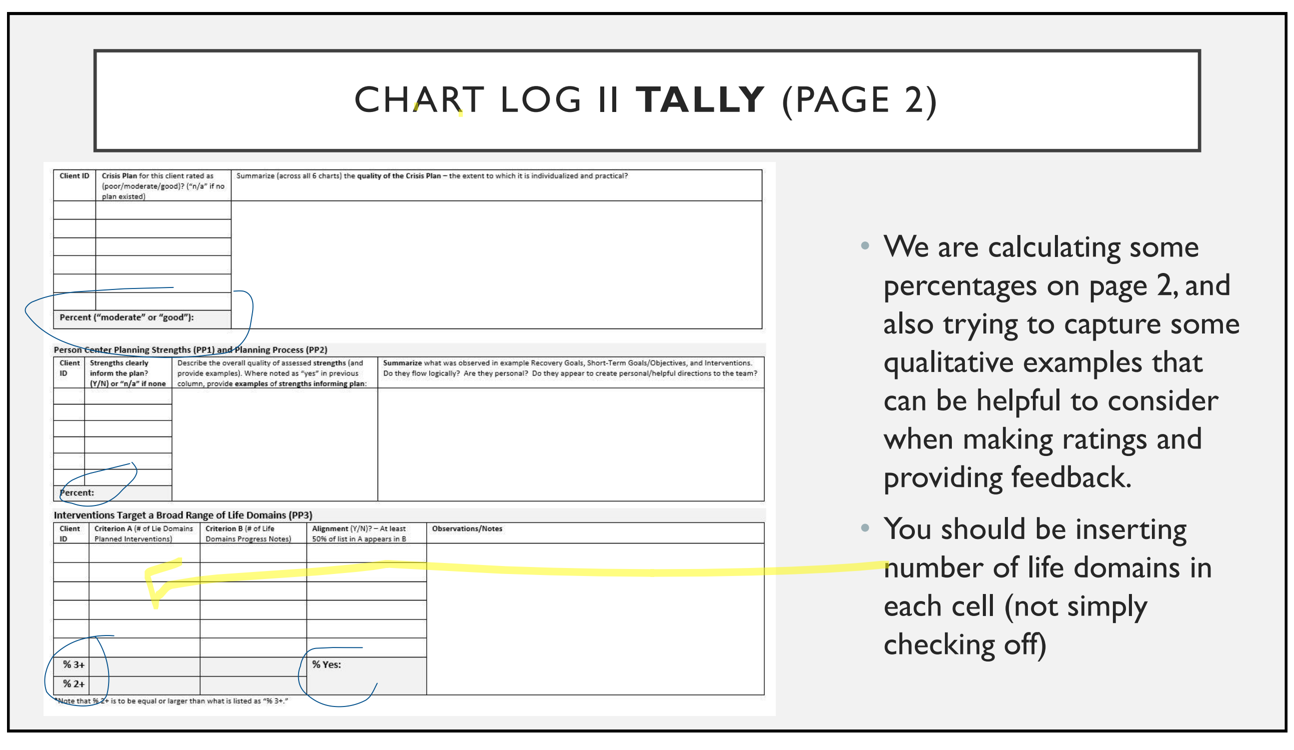
Employment and Education Assessment (ST5)

Client ID	EE Services Indicated by Team?	Summarize the following (across the 6 charts, and/or those indicated as receiving EE Services): 1) What is observed at **intake** (quality, timelines, who is completing); 2) What is observed for **ongoing EE assessments** (i.e., examine quality, timelines, who is completing); 3) Any evidence suggesting the EE assessment is being used to **guide job placement and supports**; and 4) Any notable **other observations** related to EE assessment and services

Client Schedules (OS4)

Summarize Client Schedules **(OS4)** To what extent is the client schedule: 1) detailed; 2) derived from planned interventions; and 3) appears to inform what is scheduled out each day in team meeting)?

- Summarizing the information captured in Log II (notice there is a row for each client)
- Tried to spread out the information we are collecting across multiple sheets. Much of what we are prompting you to document was of interest or documented previously, just not this systematically.
- Have space to capture if client was indicated by team as getting service (Excel).
- Qualitative data is to be captured here, responding to prompts.
- Nothing on this sheet (page 1) is specifically calculated for a rating.



Client ID	**Crisis Plan** for this client rated as (poor/moderate/good)? ("n/a" if no plan existed)	Summarize (across all 6 charts) the **quality of the Crisis Plan** – the extent to which it is individualized and practical?
Percent ("moderate" or "good"):		

Person Center Planning Strengths (PP1) and Planning Process (PP2)

Client ID	Strengths clearly inform the plan? (Y/N) or "n/a" if none	Describe the overall quality of assessed **strengths** (and provide examples). Where noted as "yes" in previous column, provide **examples of strengths informing plan**:	**Summarize** what was observed in example Recovery Goals, Short-Term Goals/Objectives, and Interventions. Do they flow logically? Are they personal? Do they appear to create personal/helpful directions to the team?
Percent:			

Interventions Target a Broad Range of Life Domains (PP3)

Client ID	**Criterion A** (# of Lie Domains Planned Interventions)	**Criterion B** (# of Life Domains Progress Notes)	**Alignment** (Y/N)? – At least 50% of list in A appears in B	**Observations/Notes**
% 3+			**% Yes:**	
% 2+				

*Note that % 2+ is to be equal or larger than what is listed as "% 3+."

CHART LOG III **TALLY** (FROM PAGE 2 OF

Chart Review Tally Sheet (Part 3). Calculating the Use of Staff within their respective Roles (see Chart Log I)

ITEM	Team Member (insert name)	(A) Total # of Note Entries Across all charts	(B) Total # of Specialty-Related note entries	Percent of Note Entries with a service reflecting area of specialty (B/A).
CT1 and CT2	Team Leader:		n/a	n/a
ST1	COD 1:			
	COD 2:			
ST4	Emp Spec 1:	18	9	50%
	Emp Spec 2:			
ST7	Peer Spec 1:			
	Peer Spec 2:			

Cross-walk reported and observed time spent in specialist services (e.g., what percent of progress note entries by co-occurring disorders specialist have some notation of integrated treatment for co-occurring disorders, inclusive of assessment and engagement, which may not be overtly documented?).

Significant discrepancies may warrant an adjustment from what was reported given what was observed in the chart (e.g., specialist reports 90%, and chart review data finds only 50%; with this example, and depending on what other data sources indicate (e.g., scheduling practices), reducing to 70% may be a more accurate reflection of how the specialist is used in his or her role. As you only have data from a 20% sample and lack information to know how representative the dataset is for that given specialist, use chart data judiciously when adjusting reported percentages, and consider other sources (team scheduling practices, overall competency of specialist (if they clearly do not understand their area of specialty, it is more difficult to make a case that they are used in their specialty role, many observed missed opportunities to use the specialist)

- Here, you are adding up what you documented on page 2 of Log I and entering information here into this Log to see what percent of note entries by each appeared to reflect specialty area.
- As an example, you sampled 10 charts. You noted on each Chart Log I the following for the employment specialist:
- 4 charts had no contacts by the employment specialist
- Chart 5: 3 notes by EE, of which 2 were EE services involved
- Chart 6: 2 notes by EE, of which 0 were EE services involved
- Chart 7: 5 notes by EE, of which 4 were EE services involved
- Chart 8: 1 note by EE, of which 0 were EE services involved
- Chart 9: 3 notes by EE, of which 1 were EE services involved
- Chart 10: 4 notes by EE, of which 2 were EE services involved
  - You observed 18 service note entries by EE specialist, of those 9 were EE service related (50%)

WHAT IS ETMACT?

A secure web-based application and database is in development, and slotted for beta testing Fall, 2018. eTMACT is designed to both significantly cut down on the resources needed to complete a review, and improve rater reliability.

With eTMACT, fidelity review data will be stored, along with optional outcome data the provider inputs. Comparative reports will be periodically generated for all users (i.e., where the respective service area is compared to (de-identified) other users' service areas).

eTMACT is comprised with several sections, including a secure provider portal where ACT teams submit data ahead of the onsite review, a chart review application, which calculates needed performance metrics to rate items, an interview platform completed live at the time of staff interviews, a ratings section where all relevant performance data collected populates into one area for review and independent ratings are made, automated item ratings selections to reduce rater error, identification of ratings across independent evaluators where consensus call needs to focus, and final report template that is personalized by the lead reviewer.

eTMACT will be available for annual user's license by an "area" (this can be a State, County, Agency, Country) who will assume the administrative lead deciding who has access to eTMACT database and platform for their respective area.

Stay tuned!

WRAP-UP!

THIS WAS *NOT* A TMACT TRAINING

As a reminder, this training was intended for those previously trained in the use of the TMACT and are wanting to understand changes that have been made to previous versions, amounting to this Revision 3 release.

We strongly recommend training in the TMACT from a Master Trainer. Models of training are listed in TMACT Part I: Introduction, pp. 10 – 11.

Currently there is no formal TMACT evaluator endorsement, certifying that they meet an adequate level of competency. No user is authorized to provide TMACT training while also financially benefiting from this training without a written agreement by at least two of the TMACT authors endorsing this individual as a capable TMACT Trainer.

For questions related to Revision #3, eTMACT release, or about training and consultation, please contact both: Lorna at lorna_moser@med.unc.edu and Maria at mmd@uw.edu

A TMACT Facebook group was formed to serve as a place to receive updates, as well as "talk through" evaluator challenges. You can locate this group and send request to join here: https://www.facebook.com/groups/418932028537386/

An International ACT Listserv has been formed, which includes access to a Discussion Forum. This can be another resource for those interested in best ACT practices, and the TMACT: Complete this survey to join: http://www.institutebestpractices.org/sign-up-form/

THANK YOU!