TMACT 1.0 Revision 3 (Feb 2018)

Outline of major changes from TMACT 1.0rev1 and TMACT 1.0rev3

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Welcome to TMACT 1.0 Revision 3! We hope that you find this Q&A handout helpful. We capture here changes made since Revision 1 (2013)[1]. This latest revision (1.0rev3) is one of our most major updates as we are concurrently working to develop eTMACT, which will be a secure web-based fidelity evaluation tool[2]. TMACT revisions typically include enhancements and clarifications to rating guidelines, as well as corrections to "rating gaps" in the item anchors (e.g., "I have no idea how to rate this team with a one No Credit, three Partial Credits, and one Full Credit!"). We have also added interview questions, revised questions for clarity, and re-ordered questions for better flow. Major updates are reserved for the eventual TMACT 2.0[3].

Q. What changes were made throughout the TMACT 1.0rev3?

- Both the **TMACT Introduction** (where we discuss methods of conducting a review) and the **Appendix** received edits and updates worth checking out, but not discussed in detail here. There were not significant updates to the fidelity review methods other than clarifying "who" we are intending for the clinician interview. 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). We also made updates to example forms in the Appendix, including extending interview times for some sources (psychiatric care provider and peer specialist are now both 45-minute interviews). We also include an updated example report.
- We removed many references to the DACTS throughout the TMACT. We retain the cross-walk in the Appendix to assist with rating a team on the DACTS while using data collected via a TMACT review (and retain Team Survey items specific to DACTS, primarily as they are helpful in making more pointed recommendations (e.g., team with high staff turnover may explain other problems with fidelity)
- We made many **cosmetic changes** in Part II, based on feedback we received. We understand this format may not appeal to everyone, but we wanted to create more open note-taking space. Previously, we almost had to anticipate how much space to leave you under each question given anticipated response (or we reformatted it awkwardly for the sake of page numbers). Current cosmetic changes include:
    - Updated font type and size throughout
    - Reformatted note-taking space so there is a running right column for your notes
- We updated our **language** to align with more contemporary choices (in U.S.), and more accurately capture what we are attempting to measure.
    - Use "clients" instead of "consumers" throughout
    - Updated staff position titles and modified references to other EBPs (see employment and substance abuse items)
        - Substance Abuse Specialists are now referred to as "Co-Occurring Disorders Specialists"
        - Vocational Specialists are now referred to as "Employment Specialists"
        - Supported Employment is now referred to as "Supported Employment & Education"
        - Integrated Dual Disorders Treatment (IDDT) is now referred to as "Integrated Treatment for Co-Occurring Disorders"
    - Further simplified the wording of questions, especially those in the Client Interview, and use more open-ended questions rather than closed-ended followed by [If yes].

[1] Since revision 2 was only partly disseminated, we decided to be more inclusive of updates made across Revisions 2 and 3 in this Q&A. This Q&A was developed in part before the final copy-editing of Revision 3 was completed -so you may see slight variations in wording between what is captured here and what is in the final cut of Revision 3.

[2] eTMACT is scheduled to undergo beta testing in September, 2018. For more information, contact lorna_moser@med.unc.edu

[3] TMACT 2.0 release is still years away. We intend to collect data through eTMACT to perform more psychometric testing of items, as well as pilot test newly developed items.

- We added **more direct questions** to help ensure we are getting the data we are seeking.
    - Reduced the presence of questions prompting you to reference the item definition/criteria, and instead now include specific questions about those functions.
    - Took what were once optional follow-up questions (non-bold, italic) and made them required (bold font). Rationale was the "optional" choice was we hope for more open-questions to lead to receiving desired information in a free-flowing manner, but if you did not hear any relevant responses, the optional questions are there to assist you. However, we received feedback that there is a tendency to skip over optional questions all together.
    - Worked in questions seeking good or "gold-star" examples of practice, if we otherwise have yet to hear (e.g., psychiatric care provider as it relates to integrated care work).
    - More explicitly talked about individual treatment teams (ITTs), such as in Team Approach (OS2)
- Revised any items that referred to "temporary staff" as we ultimately only care about whether these staff meet the team inclusion criteria (at least 16 hrs/week and attending at least 2 daily team meetings per week), not whether they are considered permanent or temporary. We also add further guidelines around not counting both the permanent staff on leave and the temporary staff filling in.

Q. What changes were made to the Interview Checklist?

- You may notice some changes in the interview checklists. First, we reordered a few items to improve the flow and stream of the questions.
- We also added a few new team member sources to a given item, which results in more items populating under a give team member interview (we in turn, made some updates to recommended interview lengths). As an example, we now ask the Team Leader questions about planning in PP2, we now ask the psychiatric care provider questions about their role in client admissions (OS6), and included the peer specialist as a source for information in items relating to integrated co-occurring disorders treatment (EP4) and supported employment and education (EP3). Finally, we now ask all interviewed staff about any clinical supervision they are receiving.

Q. Were any changes made to the Introduction Interview Questions in the Protocol Part II (p. 1)?

Yes, we worked in an introductory summary on confidentiality and the purpose of review (revise as you need to fit your purpose), and also include questions asking about changes made since the last review (if relevant). We also include a checklist of items to ensure you have from the team leader; a more recent addition is asking for a copy of the Client ID key with client names to reference during the review. We had updated both the Excel Spreadsheet, Team Survey, and Fidelity Review Orientation Letter to prompt the team to create a unique client identifier to be used in lieu of even partial client names or initials, both of which are considered Protected Health Information (PHI). We ask teams to provide a key onsite that allows for the team and reviewers to crosswalk the unique client ID to a name or initials that allow the team to identify the client so that information can be used during the team interviews. Fidelity reviewers do not take the client ID key off-site after the review.

Below is a summary of the more significant changes made to the TMACT items in Part II.

OS1. Low Ratio of Clients to Staff

- We now ask about staff who were with the team in past 3 months, but not currently. These updates are included in the Team Survey. Reason is we need to know who to count for chart review purposes. We recommend that you ask clarifying questions about hours with team, daily team meeting attendance, to be sure these previous team members who may show up in the chart review met our 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

- We include prompts and reminder to use the team's EMR-generated reports in substitution for sample chart calculations if the data appear reliable and valid. We include rules in Part I of TMACT on how to cross-check and verify data generated by the team's report.
- Revised criteria charts included for final calculation:
    - Exclude charts with no contacts in that 4-week period from the final tally. Of those remaining (where there was at least one face-to-face contact in reviewed 4 weeks), calculate the percent of client charts where at least 3 team members met with the client in the 4-week period (i.e., the denominator number may be fewer than the total number of charts reviewed if at least one reviewed chart had no contacts documented).
        - A similar update is included in Community-Based Services (CP1). The rationale for the update is that selecting in charts with no contacts certainly may represent other issues we want to measure and capture in our evaluation, but risks skewing what we are attempting to measure here (e.g., Is the team using a Team Approach to service-delivery and are they oriented to providing services in the community vs. the office?).
- We now include in Part II more explicit guidance around selecting the 4-week chart review window, previously embedded in Part I (TMACT Introduction).
    - "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)

- We attempt to better clarify what constitutes a daily team meeting (without making it convoluted with quality measurement/OS4)
    - "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."
- We added questions to better understand attendance, which is also included on the Team Survey Staffing Table:
    - "Inquire during staff interviews of possible discrepancies between what was reported in the Team Survey and what was observed (e.g., a major life event for a client was commented on, and a team member reacts as if hearing this for the first time even though this life event occurred two weeks ago). Follow-up inquiry would explore reasons for this discrepancy, such as the team member may just be returning from vacation, this team member's typical attendance may be lower than reported, the team is not meeting daily as reported, and/or the quality of information shared during a typical meeting may be inadequate."
- We added questions to better understand scheduling of daily team meeting and whether the time changes from day-to-day. Rating guidelines include directions for rating if two daily team meetings are nearly back-to back (e.g., an afternoon meeting is then following by a morning meeting the next day).
- We further clarified what constitutes "sufficient communication."
    - **"Sufficient Communication**: There should be adequate processes in place to ensure communication of relevant information for those not in attendance. If there are routine absences due to two separate shifts or staff with 4 X 10 hour shift coverage, the team should ensure that most team members are in attendance. This may require changing the time of the daily team meeting or changing staff scheduling patterns to ensure more team member attendance. As described in OS1, if a person does not attend a daily team meeting at least twice a week, they are not to be considered as part of the team."
- We added emphasis that in order for the psychiatric care provider to receive credit for attendance, they need to attend the full meeting rather than just dropping by for a part of that meeting.

- Reminder: Unlike other team members, we do not require that the psychiatric care provider attend the daily team meeting to be counted as part of the team. However, their daily team meeting attendance is relevant to rating this item (OS3) where a psychiatric care provider (ie, if there are two, one comes one day the other may come a second day) must be in attendance at least twice a week for "full attendance" standard to be met. It is also relevant to rating the psychiatric care provider on "Within Team" item (CT5).

OS4. Daily Team Meeting (Quality)

- We added a few questions to team leader interview regarding the typical length of the meeting, roles of team members during the meeting, and what staff are instructed to share. We further refer to this information in the Rating Guidelines Table.
- We updated the example client schedule and now include an example client log for reference.
- Table 2, Function #1 – we offer some broad guidelines of how long a typical, well-run daily team meeting would be as it often reflects this function of conducting a brief, but clinically relevant roll call.
- Table 2, Function #3 – we made the most edits here to help clarify what we are most interested as it relates to the client schedules and daily team schedules. Here is how full-credit reads:
  - "Client weekly/monthly schedules exist and these schedules serve as a bridge between the interventions listed in the person-centered plan and what is created for the daily staff (team) schedule. Client schedules are formatted and updated in a manner to capture planned interventions, who is to deliver these interventions, and when the interventions are delivered. The format is also conducive to sharing with clients so they may have a copy of their own schedule. Example: If the person-centered plan indicates attending Illness Management and Recovery (IMR) group as an intervention, that in turn is more specifically scheduled in the client schedule (e.g., listed as an activity for Wednesday from 10 – 11 with Beth, the peer specialist), and then in turn shows up as an activity for Beth to complete on the Wednesday daily staff (team) schedule. For full credit, client schedules exist and:
    - are formatted to be shared with clients;
    - have sufficient detail capturing the nature of the intervention, who is delivering it, and when it is delivered;
    - appear to drive the daily staff (team) schedule content and appear to approximate interventions in the person-centered plan."
- Table 2, Function #5 – we revised wording in Example/Guidelines to better differentiate No Credit and Partial Credit practice.
  - No Credit: "The team discusses concerns in the daily team meeting without developing a plan to either address the concern in a currently scheduled contact or plan to add a contact with the client in the daily staff schedule. Teams who are not meeting consistently inherently create a communication gap resulting in poorer coordination around proactive contacts."
  - Partial Credit: "There is evidence that the team follows up on making proactive contacts with clients, but they are inconsistent in doing so (e.g., both types of examples were observed in the meeting). Teams that operate like individual case management teams (minimal team approach) may communicate less with each other to coordinate services overall. In such cases, it will be important to understand how well each team member is being responsive to proactive contacts on their own."
- Updates were made to the Chart Review forms as it relates to better capturing data relevant to Daily Team Meeting Functions (Refer to Log II and Tally II).

OS6. Priority Pop.

- 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

OS8. Gradual Admission Rate

- No changes. A reminder – we understand that newly developed teams may need to take on more clients per month (to fulfill their available time and resources, and create some income flow). The team should be rated the same per guidelines, likely resulting in a lower rating. Qualitative feedback in report can speak to whether the practice appears to reflect a problem or a consequence of the team's circumstance (i.e., not requiring specific feedback and recommendations).

OS9. Transition to Less Intensive Services

- Team leader and clinician questions added to better understand why or why not 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 (protocol is fine, but not if leading to a "one-size fits all model")

OS11. Involvement in Psych Hosp 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 TL 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 Table and incorporate 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 clients to which they provide direct care:
    - ***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 asking about their supervision

CT3. Psych Care Provider on Team

- This is the **biggest change.** We no longer expect that a psychiatrist is board certified to receive credit for qualification, and we further describe what it means for a nurse practitioner or physician assistant to qualify for this role. Qualifications now read:
    - (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:
    - **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?**
    - [If a physician extender] **Can you describe the supervision and training you received in working with people with psychiatric diagnoses?**

- **We added more clarification 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 Psych 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 Psych Care Provider Within Team

- Added further clarification on whether to credit for certain functions in Rating Guidelines (emphasis added):
    - **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."
- Prompted to refer to the Full Credit Rating Guidelines for the listed functions to inform follow-up questions. "[For next several questions, refer to Full Credit column in Table 11 on pp. 61-63 to help determine the extent to which nurses are fulfilling these functions.]"
- 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

- 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.

ST4. Empl Spec on Team – similar changes as ST1 above.

ST5. Empl Spec 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 ~~consumer's~~client's preferences and consent, specialist provides support on/offsite to assist ~~consumer~~client in training and learning skills needed for job, can serve as a liaison between ~~consumer~~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:
  - "Every step of the way, specialist is providing counseling to the ~~consumer~~client regarding ~~his/her~~their benefits and how they are affected by varying levels of employment, providing ~~consumers~~clients with information to help them to make informed decisions about returning to work. NOTE: The expectation is not for the specialist to know all of the in's and out's of SSI/SSDI, but it is important for them to at least know the fundamentals and be actively involved in working with the ~~consumer~~client to schedule meetings with a benefits counselor who may know more of these specifics. 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"

ST7. Peer Spec on Team – ditto to ST1

ST8. Role of Peer Spec

- 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]

- See Rating Guidelines. We tried to better distinguish practices across functions #1 and #2.

Function #1: Coaching and consultation to ~~consumers~~clients to promote recovery ~~and~~, self-direction, and independence.	There is no evidence that the peer specialist provides any coaching or consultation to ~~consumers~~clients to promote recovery and self-direction.	The peer specialist provides some coaching and consultation to ~~consumers~~clients to promote recovery and self-direction, but it is less consistently provided.	The peer specialist consistently works with ACT ~~consumers~~clients by assisting them with building skills that help promote their own recovery and self-sufficiency. Examples include but are not limited to: ~~• Social and communication skills training (e.g., practicing skills on how to strike up a conversation with a consumer who wants to meet more people in his neighborhood)~~ ~~• Functional skills training to enhance~~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~~)~~ • ~~Providing education to consumers about how to take an active role in their own treatment and their role in their treatment planning meeting, which includes asserting preferences and values, even if not well received by some team members (e.g., not wanting to take select medications)~~).
Function #2: Facilitating wellness management and recovery strategies	There is no evidence that the peer specialist is facilitating any specific wellness management strategies with ~~consumers~~clients served on the team.	The peer specialist provides some wellness management and recovery services, but it is limited (e.g., they are only working with a few ~~consumers~~clients on WRAP or IMR or provide fewer ~~than two~~ informal wellness management and recovery strategies than are listed in the next column for full credit). The peer specialist may be accessing manualized WMR material, but in a very informal and inconsistent manner (note: targeted use of IMR is an acceptable use of this evidence-based practice, where carefully selected modules are focused on for a given client).	The peer specialist takes a lead role within the team on implementing wellness management and recovery strategies. These can be formal/manualized or informal strategies: **Formal/Manualized:** • Group or individual Illness Management & Recovery (IMR); • Group or individual Wellness Recovery Action Planning (WRAP); • Facilitating Psychiatric Advance Directives **Informal:** Working with ~~consumers~~clients on ~~at least three~~all of the following: ~~• Recovery strategies;~~ • Providing targeted psychoeducation about mental illness and~~/or the stress-vulnerability model~~ medications; ~~• Building social support;~~ • Identifying early warning signs for relapse and lapses; • Identifying triggers for relapses and lapses; • Developing a relapse prevention plan; ~~• Using medication effectively;~~ ~~• Coping with stress;~~ ~~• Coping with problems and symptom management;~~ ~~Getting needs met within the mental health system and community, which includes self-advocacy~~

CP1. Community-Based Services.

- 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."

CP3. Intensity of Services

- 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 Resp 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

- In chart review, you are now prompted to not only mark "yes," but judge quality (high vs low). Definition is in Chart Log, but basically it's richness of example and how representative it is of EBP. Select "low" when what is documented is more abstract, generic, or not clearly in line with best practice (but not clearly departing). Do not select "low" when what is documented reflects a clear departure from best practice, instead you are indicating ged a "no." "low" is more abstract or generic documentation, or not totally in line with best practice, but not clearly departing from it.
- Chart log sheets also include an "n/a" column for systematic – the final tally will look at – of those where service is present (high or low), what percent systematic (this is relevant to Worksheet directions, talked about below). Logs also include column to designate whether or not client was reported to be getting this service from team, per Excel. This is important for Method 2 calculation (see below) – reason for gathering more data is to better guide our adjustments when there is a discrepancy.
- We worked in two Methods for comparing Chart data with what team reports. Method 1 is the way you are most familiar with (comparing percent observed in all sampled charts with the percent of all clients the team reported to be getting services). Method 2 is one many of us have been trying out – explained more clearly here. You are only looking at the subsample of charts you selected of clients the team reported to be delivering the service to – did you actually see evidence of the service in your chart review? There is a lead in paragraph that speaks more to these Methods. I worked in a Team Example across all 4 items and their respective "Method Worksheets" to help show how to consider data and come up with an estimated percent (numerator) for final calculation.
  "To compute the rate at which integrated treatment for co-occurring disorders are provided by the team, first start by examining the rate at which the team reports to be delivering this service themselves (Column B). 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 the team reported delivering the service to); Method 1 can detect potential underreporting by the team in Column B. The second method **(Method 2 in Worksheet 3)** examines the presence of integrated dual disorder services only for those clients the team reported affirmatively in Column B; 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. It also may be more accurate if random sampling did not result in a representative sample."

Later on there is further explanation of choosing Methods:
Which Method to Use? Evaluators are encouraged to compute estimated service penetration rates using both Methods 1 and 2. It is common that both result in the same rating. There are times where they could result in different ratings, as is the case for both EP2. SEE and EP3. WMR services above. In such cases, the next step is to round back to "Other data" to re-review the overall weight of the information and how it impacted decisions in how much to adjust the Team's reported service penetration rate (and refer to Table 25 below). Another step is to consider the impact of a non-representative sample (Method 2 is often then more accurate).

EP4. Integrated Treatment for COD

- Broke out questions for the Team Leader
  - What do you think is the goal for clients with co-occurring disorders with respect to substance use?
  - How does your team view abstinence versus reduction of use? [Attend to whether goals are individualized and vary from more immediate abstinence to harm reduction given clients' stages of change readiness.]
  - [Select from Excel three clients noted to be in an early stage of change, cross-reference the ID key to have name available, and for each:] What is the team's understanding of how (insert client) use is impacting their mental health? How is their mental health impacting their use? What other reasons might (client's name) be using?
  - Does your team employ harm reduction tactics?" [If "yes"] What are some
  - examples? [Prompt to get at least five examples.]
  - In what ways is confrontation used?
  - Are you familiar with a stage-wise approach to substance use treatment?
  - [If yes:] Can you give some examples of how your program uses this approach? (Attend to discussion of engagement and MI strategies and also active substance use counseling. Is the team directly providing services or referring out?)
  - In what ways does your team use urine drug screens or other types of monitoring?
  - If someone is interested in reducing or stopping their substance use, what types of interventions would you use to assist them? [Listen for examples of cognitive behavioral techniques.]
  - Who would you refer to AA, NA or any other self-help groups? What about detox programs? [Seek examples.]
- Added question for Peer, not previously was source.
  - How would you describe your team's approach to supporting people with co-occurring substance use and mental health disorders?
- Clinician interview also broken up, similar to Team Leader interview
  - Now we are going to talk about your team's work with people with co-occurring substance use.
  - [Select from Excel three clients noted to be in an early stage of change, cross-reference the ID key to have name available, and for each:] What is the team's understanding of how (insert client) use is impacting their mental health? How is their mental health impacting their use? What other reasons might (client's name) be using?
  - What do you think is the goal for clients with COD with respect to their substance use? How does your team view abstinence versus reduction of use? [attend to whether goals are individualized and vary from more immediate abstinence to harm reduction given clients' stages of change readiness.]
  - Does your team employ harm reduction tactics? [If yes:] What are some examples?
  - In what ways is confrontation used?
  - Are you familiar with a stage-wise approach to substance use treatment? [If yes:] Give some examples of how your program uses this approach. [Attend to discussion of engagement and MI strategies and also active substance use counseling. Is the team directly providing services or referring out?]
  - In what ways does your team use urine drug screens or other types of monitoring?
  - If someone is interested in reducing or stopping their substance use, what types of interventions would you use to assist them? [Listen for examples of cognitive behavioral techniques.]
  - Who would you refer to AA, NA or any other self-help groups? What about detox programs?

- 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.

EP5. 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 & Psychoed with Natural Supports

Added this to Full Credit criteria:

Team seeks opportunities to educate ~~consumers'~~clients' natural supports about their loved one's illness. This is done both informally (through phone calls, prearranged meetings, chance encounters) and through more structured psychoeducation meetings (individual and/or group). Examples suggest this work is occurring across more than a select group of clients.
Team embraces their role as an interventionist by proactively addressing problems that exist in the natural support system, including teaching ~~consumers'~~clients' supports problem-solving strategies (e.g., to reduce conflict and increase a sense of a shared mission. Examples suggest this work is occurring across more than a select group of clients.

EP7. Empirically-Supported Psychotherapy

- Questions remain pretty much the same.
- Table of Example therapies was updated
- MAJOR CHANGES IN RATING GUIDELINES – PARTIAL CREDIT OPTIONS ADDED. See table below (anchors updated, too)

Table 29. Empirically-Supported Psychotherapy			
Criterion	**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 ~~consumers'~~clients' treatment plans.	~~No partial credit given.~~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 towards 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 ~~must~~ provide ~~enough~~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 ~~consumer~~client to address a problem or advance towards 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.
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 ~~and/or~~ • demonstrates inappropriate application of techniques (e.g., using person-centered (i.e.,	~~No partial credit given.~~ 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).

Table 29. Empirically-Supported Psychotherapy			
Criterion	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
	Rogerian) therapy to address a phobia or psychosis, which could more effectively be treated with cognitive-behavioral therapy).		
Criterion #3: Team maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to ~~consumers~~clients in need of such services (See Excel spreadsheet Column M)	In the past year, less than 25% of ~~consumers~~clients have received a deliberate, empirically-supported psychotherapeutic intervention. *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)	In the past year, 25-39% of ~~consumers~~clients have received a deliberate, empirically-supported psychotherapeutic intervention. *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)	In the past year, at least 40% of ~~consumers~~clients have received a deliberate, empirically-supported psychotherapeutic intervention. *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)

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 an 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

~~Element~~Function #4: ~~meeting~~treatment plan is clearly driven by the ~~consumer's~~client's goals and preferences and is structured in a manner to inform person-	~~The treatment planning meeting is primarily driven by the treatment team. Little to no consumer input is taken into account for treatment plan development.~~The treatment plan is not person-centered. Goals do not appear to reflect what client's wishes are,	The ~~consumer's~~evidence for the plan being driven by the client's goals and preferences ~~at times drive the meeting or treatment plan content; at other times, the treatment team dictates~~is inconsistent throughout the ~~content~~plan (e.g., the goal appears recovery-centered, but remaining elements of the ~~meeting at the expense of~~	The treatment team does not overly dictate the content of the ~~meeting or~~ treatment plan ~~development~~. The ~~consumer's~~client's treatment and recovery goals and preferences (e.g., who ~~s/he wants~~they want to work with, what they want to work on) drive the content of the ~~meeting and the~~ treatment plan~~.~~, as indicated by the following: • ~~While the treatment team may take an active role in facilitating the treatment planning meeting, the consumer's voice is heard and reflected and the team actively solicits his or her input throughout.~~Client's goals are stated in their own words, quoted or not;

centered practices	and remaining elements of the plan also do not appear to capture the client's preferences. stated in the team's words.	~~consumer input.~~plan are not clearly person-centered)	• 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.
~~Element~~Function #5: 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 ~~consumers~~clients to promote self-direction and leadership. The ~~consumer~~client is left to use their own existing skills.	There is some evidence of team guidance and support to promote ~~consumer~~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 ~~consumer~~client is asked how the team can be more helpful in supporting ~~his~~their goal to go back to school and ~~he~~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 ~~consumer~~client within the meeting. Such guidance and support should focus on promoting self-direction and leadership within the meeting and in the ~~consumer's~~client's treatment ~~and may~~. Examples include: • Education about what the treatment plan is and how it fits with the ~~consumer's~~client's recovery and life goals; • Education and guidance about the ~~consumer's~~client's role in his or her own treatment with the ACT team an 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.

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. Self-Determination

- 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?**

Check out Chart Logs I and II updates, mentioned throughout this update.

Check out updated corresponding Tally Sheets.

All updates are written to be in alignment with content and methods in eTMACT.