Tool for Measurement of Assertive Community Treatment (TMACT)©

PROTOCOL

Part II: Itemized Data Collection Forms

Version 1.0
Revision 3

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Contact Information for the TMACT:

For more information regarding the TMACT, including training and consultation options in administering this fidelity tool, please contact one of the following TMACT authors:

Lorna Moser, Ph.D.
lorna_moser@med.unc.edu

Maria Monroe-DeVita, Ph.D.
mmdv@u.washington.edu

Gregory B. Teague, Ph.D.
teague@usf.edu

Please refer to *TMACT Protocol Part I: Introduction* for an overview of the fidelity review process, as well as guidelines and restrictions as it relates to training in the TMACT.

TMACT Fidelity Review

Program Information Cover Sheet

Date: _____ **Fidelity Evaluator(s):** _____

Program and Team Name: _____

Address: _____

Catchment Area: _____

Contact Person: _____

Telephone: _____

Email: _____

# of staff (all): _____

# of clients at time of review: _____

# of clients one year ago: _____

Maximum capacity of clients: _____

Date of team start-up: _____

Funding source: _____

Approximate monthly funding per client: _____

Data Sources Used:

- ☐ Chart Review
- ☐ Daily Team Meeting Observation
- ☐ Treatment Planning Observation
- ☐ Home/Community Visits (#: __)
- ☐ Team Leader Interview
- ☐ COD Specialist Interview (#:__)
- ☐ Employment Specialist Interview (#:__)
- ☐ Peer Specialist Interview (#:__)
- ☐ Nurse Interview (#:__)
- ☐ Psychiatric Care Provider Interview (#:__)
- ☐ Mental Health Therapist Interview (#:__)
- ☐ Client Interview(s) (#:__)
- ☐ Family Member Interview (# interviewed)
- ☐ Other (specify): _____
- ☐ Other (specify): _____
- ☐ Other (specify): _____

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Introduction Interview Questions:	
DATA SOURCES	
Team Leader	
Before we begin, let's make sure we have a copy of the forms we requested for this fidelity review, as we may be referring to them during our visit. [Introductory Statement] ***We also want to make sure the purpose of this fidelity evaluation is clear to you:*** [insert purpose here.] ***The specific information you provide to us will not be shared in a way that's tied back to you. An exception is us sharing feedback that is particularly positive. Also, our goal is to give you the most accurate feedback to help your team. The more factual the information we receive, the better we are at making targeted recommendations. Do you have any questions?*** [If this is a new team or team leader:] ***We'd like to start by asking what do <u>you</u> think the purpose and philosophy behind Assertive Community Treatment (or ACT) is or should be?*** [If this is a follow-up fidelity review with this team:] ***Tell us about some of the changes your team has made since the last review.***	☐ *admission criteria and screening tools;* ☐ *assessments;* ☐ *treatment plans;* ☐ *crisis plans;* ☐ *transition readiness (i.e., graduation) assessment or a list of transition readiness criteria;* ☐ *a recently completed daily team schedule;* ☐ *an example of a team member individual schedule;* ☐ *a de-identified (i.e., cross-out name[s]) copy of a client log page;* ☐ *a de-identified copy of a weekly/monthly client schedule;* ☐ *any health communication forms used to correspond with non-ACT providers; and* ☐ *any relevant agency or program policy guiding your work.* *A copy of a Client ID key with client names listed to reference during interviews.*
Clinicians	
[If helpful, provide the same introductory statements about confidentiality as noted above.] ***We'd like to start by asking what do <u>you</u> think the purpose and philosophy behind Assertive Community Treatment (or ACT) is or should be?*** [If this is a follow-up fidelity review with this team:] ***Tell us about some of the changes your team has made since the last review.***	

Psychiatric Care Provider	
[If helpful, provide the same introductory statement about confidentiality as noted above.] [If this is a new team or psychiatric care provider:] ***We'd like to start by asking what do <u>you</u> think the purpose and philosophy behind Assertive Community Treatment (or ACT) is or should be?*** [If this is a follow-up fidelity review with this team:] ***Tell us about some of the changes your team has made since the last review.***	
Clients	
Thank you for meeting with us today. We're visiting this ACT team to better understand what they're doing well and what they could be doing better. We're interested in your experience with this ACT team. Your individual responses will be kept confidential. Do you have any questions? [If the agency or situation requires it, review the agency's provided confidentiality/consent form and ask them to sign. The strong preference is for this interview to be completed without ACT team members present.] ***Generally, what do you think about the ACT team?*** ***How have they helped you?*** ***Can you share any concerns you have about the ACT team?*** ***What would you like them to do differently, if anything at all?***	

OS1. Low Ratio of Clients to Staff

Definition: The team maintains a low client-to-staff ratio, not to exceed 10:1, which includes all direct service staff except for the psychiatric care provider. The staff count does NOT include other administrative staff such as the program assistant or other managers assigned to provide administrative oversight to the team.

Rationale: ACT teams are intended to serve a high service-need clinical population and to be the primary service provider across a range of service domains. Therefore, ACT teams should maintain a low client-to-staff ratio to ensure adequate intensity and individualization of services.

DATA SOURCES (* denotes primary data source)

Team Survey*

See item #1 regarding staff FTE _____ and item #7a regarding number of clients currently enrolled_____.

Team Leader Interview*

Briefly review and confirm whether each staff/team member meets inclusion criteria below, and identify which staff were employed with the team in past three months, but are no longer (this information will be helpful when conducting the chart review). Ensure that all current staff are clearly listed in the Team Survey.	

ITEM RESPONSE CODING

Inclusion Criteria

ACT Staff:

- Count all part- and full-time staff that provide direct services (e.g., COD specialist, employment specialist, team leader) who work exclusively with the ACT team at least 16 hours a week (16/40 = 0.40 FTE) and attend the daily team meeting at least twice a week.
- Count only staff who have started work with the team at the time of the on-site review (i.e., do not count staff who have merely received, or accepted, a job offer).
- Count interns if they meet above criteria and will work with the team for at least six months.
- In the event a team member is on extended leave and the team has filled this position with interim staff, only count the permanent staff person on extended leave (i.e., do not credit both the permanent and temporary staff member for this one position).

Clients:

- Include all clients enrolled on the team, even very recent admissions. Do not exclude clients currently enrolled on the team who are difficult to engage and have not had recent contact with the team.

Exclusion Criteria

Do not count the following staff in this rating:

- Psychiatric care provider (i.e., psychiatrist, nurse practitioner, or physician assistant serving in the role of the psychiatric care provider).
- Administrative support staff, such as the program assistant, or other managers assigned to provide administrative and/or clinical oversight to the team.
- Staff who are employed by the team, but who have been on extended leave for three months or more.

Note: Evaluate whether staff FTE reflects actual hours worked vs. time available to the team (i.e., count hours worked, not mere availability)

Formula: # of clients currently enrolled # FTE staff	Note: 1.0 FTE equals the hours worked by one team member on a full-time (i.e., 40 hours a week) basis. To calculate the FTEs across all team members, you may need to first convert number of hours worked to FTEs (e.g., 32 hours a week is 0.8 FTE. Formula: 32/40 = 0.8), then add all team member FTEs together.

OS1 Low Ratio of Clients to Staff	**1**	**2**	**3**	**4**	**5**
	26 clients per team member or more.	19 – 25	14 – 18	11 – 13	10 clients per team member or fewer.

OS2. Team Approach

Definition: ACT staff work as a transdisciplinary team rather than as independent team members; ACT staff know and work with all clients rather than carry individual caseloads. Although the entire team shares responsibility for each client, each team member contributes expertise as determined by client goals and needs identified in the person-centered plan, and carried out by each individual treatment team (ITT).

Rationale: The team approach ensures continuity of care for clients, and creates a supportive organizational environment for team members. Furthermore, given that each client has personal goals and a broad range of service needs, deliberate scheduling of service interventions delivered by those team members with the most expertise and skill in those areas suggests the need for such a team approach to service delivery.

DATA SOURCES (* denotes primary data source)

Chart Review* - Chart Review Log Part I (p. 195-196) and Chart Review Tally Sheet Part I (p.197-198)

Review randomly selected charts (at least 20% sample or a minimum of 10 charts in smaller teams). 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).

Count the number of direct service ACT team members, including the psychiatric care provider, who have had a face-to-face contact with the client during this time; exclude any staff predetermined to not meet inclusion criteria specified in item OS1 and OS5. Include team members who are no longer employed by the team at the time of the on-site visit, but were employed during the chart period.

Note: If the team can provide reliable and valid data from their electronic medical record for all individuals served by the team, these data can be used to rate this item, using the same four-week calendar period. Refer to TMACT Part I for further instructions.

Daily Team Meeting - Observation Form (p. 189-192)

Observe how staff members are scheduled to provide services to clients. Ideally, staff assignments will vary naturally based on each client's treatment plan and careful matching of individual client needs with staff expertise and established rapport; however, the team should also try to diversify staff scheduling to foster ongoing relationships between each client and several team members. Note how the use of geographical location break-outs or grids inform staff scheduling patterns.

ITEM RESPONSE CODING

Rating Guidelines

Use the chart review as the primary data source, unless the team can provide full caseload data that has been judged to be reliable and valid. The evaluator may judge whether select contacts should be included given the quality of contacts (e.g., a team leader documents a contact that appears to be an unplanned run-in at the agency, with no apparent purpose). If the information from various sources is inconsistent (e.g., daily team meetings seem to point to a higher rate of shared caseloads than do the records), ask the team leader to help you understand the discrepancy.

Refer to observations within the daily team meeting regarding the quality of a team approach (e.g., thoughtful assignment of staff according to treatment plans and individual treatment teams (ITTs), which is recommended, or random assignment of staff, which is not recommended). Overall low frequency of contacts could decrease the opportunity for a true team approach, as well. Such information can guide quality improvement feedback.

For the final tally, calculate the percent of client charts where at least 3 team members met with the client in the 4-week period, but exclude charts with no documented face-to-face contacts in that period. As an example, 15 charts are reviewed, with 2 charts having no face-to-face contacts. Ten (10) charts were observed to have face-to-face contacts with at least 3 team members. The final rating is then 10/13 = 77%.

Formula:

$$\frac{\text{\# of clients with face-to-face contacts with at least 3 team members in a 4-week period}}{\text{Total \# of charts reviewed (include only those with at least 1 face-to-face contact)}} \textbf{ (X 100)}$$

Refer to the TMACT Calculation Workbook or to the Chart Review Tally Sheet to enter and compute these data.

	1	2	3	4	5
OS2 Team Approach	Fewer than 25% of clients have face-to-face contacts with at least 3 team members in 4 weeks.	25 – 52%	53 - 74%	75 - 89%	90% or more clients have face-to-face contact with at least 3 team members in 4 weeks.

OS3. Daily Team Meeting (Frequency & Attendance)

Definition: The team meets daily to review and plan services. To this end, most team members should be present to effectively carry out such a review. To constitute a daily team meeting, it must meet the following criteria: there is a review of each client's status; there is planning for future services; most team members are present.

Rationale: Daily team meetings allow ACT staff to briefly discuss clients' status over the past 24 hours (or weekend), problem-solve approaches to address current or prevent future crises, and discuss planned treatment and rehabilitation contacts, ensuring that all clients receive the best possible services. Regular, consistent, in-person attendance by all staff ensures optimal information-sharing and continuity, and promotes team cohesion.

DATA SOURCES (* denotes primary data source)

Team Survey

Refer to Table 1 (Item #1) where the number of daily team meetings attended by staff per week should be listed.

Daily Team Meeting - Observation Form (p. 189-192)

Note who attends the meeting, for how long, and whether conversations indicate that the team has met in previous days to share their assessment and service delivery information. 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.

Team Leader Interview

How often does the ACT team meet as a full group to review and plan daily services?	
Do scheduled daily team meeting times vary throughout the week? [If yes, inquire reasons for variation and how meetings may change in focus and attendance across the week.]	
What are the expectations for staff attendance? How do you maximize staff attendance? [Prompt for team's use of multiple service shifts and/or staggered staffing across the week (e.g., using 4x10-hour shifts) and how that may affect attendance in the daily meeting.]	
How is information shared or passed on to staff members who are <u>not</u> in attendance? In what way is telecommunication used? [Refer to the Team Survey and inquire about days that appear to have fewer team members present.]	

How does the attendance we observed at the daily team meeting compare with typical attendance?	

ITEM RESPONSE CODING
Inclusion Criteria
Frequency credit considerations: 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. **Full attendance credit considerations:** ○ **Attendance:** Attendance in person is expected. Team members calling or video-conferencing into the meeting should be the exception, not the norm. In-person attendance offers better opportunities for meaningful exchanges, reduces multi-tasking that detract from attending to the meeting content, and provides the opportunity for the team to work together and enhance team operations. ○ **Psychiatric Care Provider:** A psychiatric care provider should be present to participate in the daily team meeting at least twice a week. The expectation is full attendance rather than only attending a portion of the meeting. ○ **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 4x10-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.
Exclusion Criteria
Do not include administrative or treatment planning meetings for this item. If a team reports holding daily team meetings 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.
Rating Guidelines
The team leader interview is the primary data source. Corroborate with observation of the daily team meeting.

	1	**2**	**3**	**4**	**5**
OS3 Daily Team Meeting (Frequency & Attendance)	Team meets fewer than 2 days a week.	Team meets 2 days a week.	Team meets 3 days a week with or without full attendance OR team meets 4 days a week, but without full attendance.	Team meets 4 days a week with full attendance OR team meets 5 days a week, but without full attendance.	Team meets 5 days a week with full attendance.

OS4. Daily Team Meeting (Quality)

Definition: The team uses its daily team meeting to:
(1) Conduct a brief, but clinically-relevant review of all clients & contacts in the past 24 hours AND
(2) Record the status of all clients.

The team develops a daily staff schedule for the day's contacts based on:
(3) Weekly/monthly client schedules,
(4) Emerging needs,
(5) Need for proactive contacts to prevent future crises;
(6) Staff are held accountable for follow-through.

Rationale: Daily team meetings allow ACT staff to systematically update information, briefly discuss clients' status over the past 24 hours, problem-solve approaches to address current or prevent future crises, and discuss planned treatment and rehabilitation contacts, ensuring that all clients receive the best possible services.

DATA SOURCES (* denotes primary data source)

Daily Team Meeting* - Observation Form (p. 189-192)

Refer to Table 2 below for guidance on what to attend to during the daily team meeting.

Team Leader Interview*

(Note**:** Ask daily team meeting questions after observing a daily team meeting. With each question, reference specific observations on how the meeting was conducted.)

Was the daily team meeting we observed today typical of your daily team meetings, and if not how was it different?

How long is a typical daily team meeting? [Ask follow-up questions if there is a discrepancy between what was observed and what is typical]

Can you summarize for us the roles of various team members in facilitating the daily team meeting? *Who was writing/ entering information into the daily client log? Who was leading the roll call of clients? Who, if anyone, was managing today's schedule? Did anyone have out yesterday's schedule for review?*

What directions do team members receive on what to share during the roll call? [Further inquire about how lengthier conversations may be managed, the level of information-sharing that is expected, and whether team members are doing their own documentation into the log prior to the daily team meeting and how that may impact the report out during the meeting.]

How do you determine what needs to happen with each client each day? ***Do you use Individual Treatment Teams (ITTs, and how do you create ITTs)?*** ***Is a staff schedule created daily?*** [If yes:] ***Using what information?*** [Prompt for the extent to which they use the weekly/monthly client schedules to develop their daily staff schedule and how the client schedule itself is created and updated. Pay attention to the extent to which geographic location grids are used to schedule contacts for the day, and whether additional practice standards (e.g., productivity) drive scheduling. Also listen for efforts to schedule out more specific interventions.] ***What is your approach to addressing clients' emerging needs identified during the daily team meeting*** *(e.g., crisis contacts or unplanned contacts based on new information shared during the daily team meeting)**?*** [Refer to specific examples observed during the daily team meeting.] ***When you have a client who isn't currently in crisis, but you see signs or have concerns that they may go into crisis soon, how is that handled during the daily team meeting?*** *Can you give me an example?* [Refer to specific examples observed during the daily team meeting.] ***Do you have any way of monitoring to ensure staff follow-up on scheduled contacts and interventions?*** [If yes:] *Can you describe to me what that is? How do you identify and address a client with a sequence of missed contacts or attempts?* [Reference specific observations from team meeting, if relevant; determine whether staff are accountable for contacts only, or delivery of assigned interventions.]	

Weekly/Monthly Client Schedules* and Chart Review (Treatment Plans)* - Chart Review Log Part II (p. 197-198)

Weekly/Monthly Client Schedules are created for each client, derived from the treatment plan, and regularly updated. These schedules display planned services (i.e., regular contacts and scheduled appointments) either weekly or monthly to meet objectives and goals listed in clients' treatment plans (See example in Table 1).

- Cross-reference client schedules with the treatment plans and services documented in the progress notes for the same clients whose charts are reviewed. Is there an appreciable tie between plans, schedules, and services to suggest that client schedules are optimally used to bridge plans and daily scheduling?
- Examine the level of detail regarding services specified in the client schedule.

Daily Staff Schedule*

Typical daily staff schedules (or "daily team schedule") include all the pre-planned staff contacts with each client for that day (as driven by each weekly/monthly client schedule), as well as newly scheduled contacts based on clients' emerging needs or the need to proactively engage clients to prevent future crises. Daily staff or team schedules may also include planned indirect time, such as clinical supervision and documentation.

If the team leader confirms that the team uses client schedules to develop daily staff (team) schedules, examine the following:

- Level of detail regarding services scheduled to be delivered that day and approximate time of delivery
- Scope of services provided (e.g., is a single client receiving a range of services?)
- Number of clients scheduled out to be seen by individual team members (e.g., if a single team member is scheduled to see eight people in one day, this suggests more limited contacts and less robust treatment interventions)
- The extent to which the schedule appears to follow from a treatment plan (ideally, via client schedules) and demonstrates responsiveness to emerging issues.

Ensuring Staff Accountability*

The intent of this function is not to micromanage staff activities, but to assure that clients are receiving the level and type of services that they need. **If the team leader confirms that they have a mechanism to ensure staff accountability, ask to see it.**

ITEM RESPONSE CODING

Rating Guidelines

Use Table 2 Guidelines to evaluate the extent to which the daily team meeting fully serves all six functions.

Table 1. Sample Weekly Client Schedule

Name: Joe Smith | **ITT:** Jeff, Employment Specialist; Jan, Peer Specialist; Sandra, Care Coordinator

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday/Sunday
AM	9:30-11 Med management/education; Career Profile—Jeff, Emp Specialist		10:30 – 11:00 Psych and med evaluation—Dr. Klein (3rd week of every month only) 11:00 – 12pm WMR Group—Jan, Peer Specialist		9:30-10:30 Med management; activities of daily livings (ADL) assistance and skills training (house cleaning) - Sandra, care coordinator	
PM						2-4 Social skills training in community—Weekend Staff on Rotation (2nd and 4th Saturday)

Consumer Log: Joe Smith			
Feb, 2017	**Contact**	**Type**	**Staff**
1			
2M			
3	Meds. Eating ▲froz veg; scouted employers in neigh. Gd mood	F2F	JC
4			
5	Grocery; selected 2 fruits to try. Engaging /friendly. IMR	F2F	FA/JB
6			
7	Library; coached library card and check-out. Quiet	F2F	MM
8			
9M			
10	Not home	A	JC
11			
12	Reviewed cupboard nutrition; IM – quiet. IMR, but no partic	F2F	FA
13			
14	Library; soc skills – practiced introductions. Quiet. ?Par?	A	MM
15			
16M			
17	Meds. Refused to leave home. More guarded.	F2F	JC
18	Check-in –conversational, slightly guarded	F2F	MM
19	Not answering door/phone	A	FA
20			
21	Park; did not want to practice soc exchanges. ▲Paranoia	F2F	MM
22	Call to Joe – reported feeling ok, mildly conversational and open	Ph	MM
23M			
24	Meds. Increased suspiciousness. No meds ~3 days. Took dose	F2F	Dr. X
25	Assessment; refused voc walk. Reported taking meds	F2F	JC
26	Assment – not eating much. ?meds. Called sister	F2F/P	FA
27	Sister –crisis call – facilitated vol hosp.	PH	
28	Hospital visit. Spoke with SW and Joe -- guarded	F2F	JB

Table 2. Daily Team Meeting (Quality)			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #1: Conduct a brief, but clinically-relevant review of all clients and contacts in the past 24 hours.	• Team does not review all clients (this includes when the report is organized by each staff member taking turns reporting out on who they saw, skipping over those not seen, whether scheduled to be seen or not); or • Only one or two team members simply read through the previous day's recorded contacts for all clients (rather than each team member reporting on their own contacts to the team, which is then recorded).	The team reviews all clients, but the content of the report is either: • Too brief to give enough information to the team about status and possible next steps; or • Too lengthy to provide enough time to review all clients in an efficient manner (i.e., excessive time is spent on several clients, which results in rushed reports on other clients); or • Too extensive in that they repeatedly review clients who were seen more than 24 hours prior to the meeting. Partial credit may be warranted if the meeting was unfocused and/or generally poorly attended to by staff (e.g., many side conversations ensued).	If the client was scheduled and seen the previous day/weekend, team member describes mental status, relevant behaviors, & staff interaction with client. If client was scheduled and not seen, team may note barriers to contact (e.g., timing of day) or concerns about missed appointment. If the client was not scheduled, no report is typically given. Ideally, this meeting is focused, but also incorporates some dynamic staff interaction that facilitates ongoing clinical assessment and planning. A small team serving 50 should be able to complete their daily meeting within 45 minutes to an hour; a larger team serving 100 should be able to complete it within an hour to 75 minutes. Significant departures from these timeframes may be due to this function not being fully carried out.
Function #2: Record status of all clients.	• No such recording occurs; or • Information is inconsistently recorded across time	Client status is regularly recorded, but information logged varies in detail, undercutting its utility as an assessment snapshot (e.g., stability, availability, response to service); or	Client status (mental status/relevant behaviors & staff interaction with client) is recorded daily in some form of a log. The log should serve as a useful clinical snapshot of each individual in a given month. Ideally, the log is predated by

Table 2. Daily Team Meeting (Quality)			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
	and/or does not facilitate quick, clinically useful assessment of client's status (stability, availability, response to service).	team members independently enter their own updates into the log after services have been rendered, but before the daily team meeting, making this process inefficient and likely missing the aim of providing a succinct snapshot that allows one to quickly check status across time/staff, etc.	month for each person, showing services provided, services not provided, and missed contacts. The log is available to team members so that staff can go back and review each client's brief status report if necessary.

Function #3: Daily staff schedule is based on person-centered plan-informed client schedules.[1]	• There are no client weekly/monthly client schedules; or
	• There is no evident relationship between client schedules with either daily staff schedules OR with person-centered plans; or
	• There is not enough detail in the client schedule regarding at least two of the following:
	  • the specific intervention,
	  • who is delivering it, and/or
	  • when it is delivered.
		Client weekly/monthly schedules exist, however:
		• Daily staff (team) schedules and client schedules are misaligned, and/or are narrow in their focus on (e.g., medications and group attendance); or
		• Client schedules are weakly informed by person-centered plans; or
		• The team excessively uses location or geographic grids to determine who delivers services vs. who is the best fit for delivering that service; or
		• There is not enough detail in client schedule regarding one of the following:
		  • the specific intervention,
		  • who is delivering it, and/or
		  • when it is delivered.
			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.

Function #4: Daily staff schedule is based on clients' emerging needs.	Team members talk about clients' emerging needs, but do not specify a plan for contacts to address those needs.	The team talks about clients' emerging needs in the daily team meeting, but is inconsistent about the extent to which they specify a plan for contacts to address those needs.	The daily staff schedule is also based on clients' emerging needs identified during staff report during the daily team meeting. Emerging needs are defined as any client needs identified during the daily team meeting that were not already scheduled to be addressed for that day based on that client's weekly /monthly schedule. Examples include: medical, dental, or other appointments not regularly scheduled based on the clients' treatment plan; and crisis response contacts and hospitalization.

[1] Use Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate the percentage of weekly client schedules that match up with each client's treatment plan.

Table 2. Daily Team Meeting (Quality)			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #5: Daily staff schedule is based on the need for <u>proactive contacts</u> to prevent future crises.	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.	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.	Team members consistently plan to see clients who need proactive contacts. "Proactive contacts" are preventive contacts aimed at heading off future crises. Example proactive contacts include the following: • Contact with a client before or during the anniversary of a significant event (e.g., a death of a significant other); or • Recognizing early warning signs and promptly scheduling a contact with them. <u>Note</u>: Since proactive contacts may be low frequency events, an example may not be observed in the daily team meeting during the fidelity evaluation. Thus, automatically give credit to teams for proactive contacts unless there is evidence that it is not happening (e.g., team discusses concerns without developing a plan to be proactive).
Function #6: Staff are held accountable for follow-up	There is no formal or informal mechanism for ensuring staff accountability in place.	There is a mechanism in place, but there is evidence that it is not typically followed or is not enforced when team members do not follow-up with planned contacts. Accountability may be more focused on contacts alone, not whether planned interventions were carried out.	A mechanism is in place to ensure that staff successfully complete or attempt to complete their assigned contacts each day, which ultimately holds the entire team accountable to follow-up on interventions delineated in the weekly/monthly client schedules, and those recently assigned to address emerging needs. Example mechanisms include the following: • Team leader compares the previous day's staff schedule to staff reports of previous day's contacts during daily team meeting; • Staff checks off or initials daily log or daily staff schedule after they have completed the day's assigned contacts; and • Staff communicates (e.g., email, phone) with team leader and/or team to let them know the outcome of their planned contacts that day.

	1	**2**	**3**	**4**	**5**
OS4 Daily Team Meeting (Quality)	The daily team meeting serves no more than 3 functions.	4 functions are performed at least PARTIALLY (2 are absent).	5 functions are performed at least PARTIALLY (1 is absent) OR ALL 6 functions are performed with 4 or more PARTIALLY performed.	ALL 6 functions are performed, with up to 3 PARTIALLY performed.	ALL 6 daily team meeting functions are FULLY performed.

OS5. Program Size

Definition: The team is of a sufficient size to consistently provide for necessary staffing diversity and coverage.

NOTE: This item includes separate parameters for minimal coverage for smaller teams to allow for enough staff to be available 24 hours a day, seven days a week.

Rationale: The ACT team provides an integrated approach to mental health services, through which the range of treatment issues are addressed from a variety of perspectives; it is critical to maintain adequate staff size and disciplinary background to provide comprehensive, individualized service to each client.

DATA SOURCES (* denotes primary data source)

Team Survey

See team responses to item #1 regarding the number of ACT staff _____ and item #7b regarding the number of clients the team is equipped to serve at capacity _____.

Team Leader Interview*

Briefly review and confirm data regarding staffing as reported in item #1 on the Team Survey. Also clarify current capacity, which may be intentionally staggered given team development plans.	

ITEM RESPONSE CODING

Inclusion Criteria

- Count all direct service staff who meet the criteria to be included in the count for OS1[2] and psychiatric care provider staff following inclusion criteria listed below.
- For teams with more than one psychiatric care provider, each provider must be assigned to work with the team at least 0.20 FTE (i.e., 8 hours/week).
- Psychiatric Residents may also count toward the team staffing if they are assigned to the team at least 0.20 FTE (i.e., 8 hours/week) and are assigned to the team for one year.

Exclusion Criteria

- Do not count the program assistant or any other administrative staff/managers who oversee team.

Rating Guidelines and Formula

Teams that have a caseload size cap at or slightly above or below a 100-client team or 50-client team should simply use the FTE staffing level in ratings 1-5 below to determine rating.

Teams with different caseload size caps should use the grid below. Find the caseload size cap for the team being evaluated, or the next higher caseload cap shown. The criteria (i.e., ranges of required direct clinical staff FTE for each rating) are listed along that row to the right.

[2] Similar to the calculation for OS1, in order to count part time or temporary staff, they must work exclusively with the ACT team for at least 16 hours a week (0.4 FTE) and attend the daily team meeting at least two times a week.

Supplemental Grid for Teams with a Caseload Cap Different than 50 or 100 Clients					
Caseload Cap Size	**Rating**				
	1	**2**	**3**	**4**	**5**
125	Fewer than 5.5 FTE	5.5 - 7.4 FTE	7.5 - 9.4 FTE	9.5 - 11.4 FTE	At least 11.5 FTE
120	Fewer than 5.5 FTE	5.5 - 7.3 FTE	7.4 - 9.2 FTE	9.3 - 11.1 FTE	At least 11.2 FTE
115	Fewer than 5.5 FTE	5.5 - 7.2 FTE	7.3 - 9.0 FTE	9.1 - 10.8 FTE	At least 10.9 FTE
110	Fewer than 5.5 FTE	5.5 - 7.1 FTE	7.2 - 8.8 FTE	8.9 - 10.5 FTE	At least 10.6 FTE
105	Fewer than 5.5 FTE	5.5 - 7.0 FTE	7.1 - 8.6 FTE	8.7 - 10.2 FTE	At least 10.3 FTE
100	Fewer than 5.5 FTE	5.5 - 6.9 FTE	7.0 - 8.4 FTE	8.5 - 9.9 FTE	At least 10.0 FTE
95	Fewer than 5.5 FTE	5.5 - 6.8 FTE	6.9 - 8.2 FTE	8.3 - 9.6 FTE	At least 9.7 FTE
90	Fewer than 5.5 FTE	5.5 - 6.7 FTE	6.8 - 8.0 FTE	8.1 - 9.3 FTE	At least 9.4 FTE
85	Fewer than 5.5 FTE	5.5 - 6.6 FTE	6.7 - 7.8 FTE	7.9 - 9.0 FTE	At least 9.1 FTE
80	Fewer than 5.5 FTE	5.5 - 6.5 FTE	6.6 - 7.6 FTE	7.7 - 8.7 FTE	At least 8.8 FTE
75	Fewer than 5.5 FTE	5.5 - 6.4 FTE	6.5 - 7.4 FTE	7.5 - 8.4 FTE	At least 8.5 FTE
70	Fewer than 5.5 FTE	5.5 - 6.3 FTE	6.4 - 7.2 FTE	7.3 - 8.1 FTE	At least 8.2 FTE
65	Fewer than 5.5 FTE	5.5 - 6.2 FTE	6.3 - 7.0 FTE	7.1 - 7.8 FTE	At least 7.9 FTE
60	Fewer than 5.5 FTE	5.5 - 6.1 FTE	6.2 - 6.8 FTE	6.9 - 7.5 FTE	At least 7.6 FTE
55	Fewer than 5.5 FTE	5.5 - 6.0 FTE	6.1 - 6.6 FTE	6.7 - 7.2 FTE	At least 7.3 FTE
50	Fewer than 5.5 FTE	5.5 - 5.9 FTE	6.0 - 6.4 FTE	6.5 - 6.9 FTE	At least 7.0 FTE
45	Fewer than 5.5 FTE	5.5 - 5.8 FTE	5.9 - 6.2 FTE	6.3 - 6.6 FTE	At least 6.7 FTE
40	Fewer than 5.5 FTE	5.5 - 5.7 FTE	5.8 - 6.0 FTE	6.1 - 6.3 FTE	At least 6.4 FTE
35	Fewer than 5.5 FTE	5.5 - 5.6 FTE	5.7 - 5.8 FTE	5.9 - 6.0 FTE	At least 6.1 FTE
30	Fewer than 5.5 FTE	5.5 FTE	5.6 FTE	5.7 FTE	At least 5.8 FTE

	1	**2**	**3**	**4**	**5**
OS5 Program Size	100-Client Team: Includes fewer than 5.5 FTE direct clinical staff.	5.5 - 6.9 FTE	7.0 - 8.4 FTE	8.5 - 9.9 FTE	100-Client Team: Includes at least 10.0 FTE direct clinical staff.
	50-Client Team: Includes fewer than 5.5 FTE direct clinical staff.	5.5 - 5.9 FTE	6.0 - 6.4 FTE	6.5 - 6.9 FTE	50-Client Team: Includes at least 7.0 FTE direct clinical staff.

OS6. Priority Service Population

Definition: ACT teams serve a specific, high service-need population of adults with serious mental illness and are able to make decisions about who is served by the team.

(1) The team has specific admission criteria, inclusive of schizophrenia & other psychotic disorders or bipolar I disorder, significant functional impairments, and continuous high service needs, and exclusive of a sole or primary diagnosis of a substance use disorder, intellectual development disorder, brain injury or personality disorders.

(2) The team/agency has the authority to be the gatekeeper on admissions to the team (including screening out inappropriate referrals) and discharges from the team.

Rationale: ACT is an evidence-based practice for people with serious mental illness, primarily those diagnosed with schizophrenia spectrum disorders, other psychosis, and bipolar I disorder. Further, given that ACT is a relatively expensive and scarce service resource, it should be available to persons whose needs for this level of intensity are greatest and who meet these diagnostic criteria. Since teams are working with clients in greatest need and who typically require tremendous staffing resources, it is imperative that there is some mechanism by which the team is involved in the decision to both admit and discharge clients from the team.

DATA SOURCES (* denotes primary data source)

Team Survey

See team responses to the following items:
#8: Does the team currently serve any clients who do NOT meet ACT admission criteria and/or are inappropriate for ACT? _____#9: Number of clients estimated to NOT meet ACT admission criteria:_____

Chart Review* - Chart Review Log Part II (p. 197-198)

Specify psychiatric diagnoses from client charts reviewed. In addition to excluding clients with diagnoses inconsistent with the definition for criterion #1 (please see above), consider excluding those who have not otherwise specified (NOS) diagnoses when the prevalence of such diagnoses appears to be high. If, after conducting the chart review, several individuals have diagnoses that are questionably appropriate for ACT, consider requesting a complete list of all clients' psychiatric diagnoses to guide rating for this item.

Team Leader Interview*

Based on your response to the Team Survey, you indicated that approximately ____ people do <u>not</u> meet ACT admission criteria or are inappropriate for ACT. ***Please tell me more about these individuals*** (if reported to be "0," inquire as to how it is none)***.*** [Prompt for any clients who have a sole or primary diagnosis of a substance use disorder, intellectual development disorder, brain injury, or personality disorder. If chart review data indicate a higher number of clients with diagnostic profiles questionably appropriate for ACT, then ask the team leader if they can generate a report on all clients' diagnoses so that criterion #1 can be rated using a full sample]	

What is the current process for screening referrals? Can you walk us through the "life of a referral"? ***What happens if you think a referred client is inappropriate for ACT?*** ***Do you generally feel like you have control over admissions? Why or why not?*** ***Is there a way to discharge clients you think are inappropriate for ACT once you've admitted them to the team?*** [If yes] *Can you describe this process?*	
Clinician Interview	
Are there current ACT clients you feel do not meet the admission criteria? [If yes:] *Why do you think they are inappropriate?* [Differentiate between those who had been inappropriate throughout vs. those who became inappropriate due to some recovery.]	
Psychiatric Care Provider Interview	
Who are the most appropriate clients for ACT? ***Can you give us examples of clients who would not be appropriate for ACT?*** [You are not necessarily seeking specific client examples, but example client symptoms, behaviors, functioning, scenarios that may reflect someone needing a less intensive or even more intensive service than ACT.] ***What is your role in making sure the team is serving those who most need ACT services?***	

ITEM RESPONSE CODING
Rating Guidelines
Cross-reference team leader interview and chart review (primary data sources) with the clinician interview. Rate criterion #1 based on chart review data, unless team can report on diagnostic data across clients. Please refer to Table 3 below to determine credit.

Table 3. Priority Service Population

Criteria	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: The team has specific admission criteria, inclusive of schizophrenia, other psychotic disorders, bipolar disorder I, significant functional impairments, continuous high service needs, exclusive of a sole or primary diagnosis of a substance use disorder, intellectual development disorder, brain injury, or personality disorders.[3]	**Chart review client sample**: More than 20% of clients do not meet diagnostic admission criteria. OR **All clients:** More than 10% of clients do not meet diagnostic admission criteria.	**Chart review client sample**: 80-89% of clients selected for chart review meet diagnostic admission criteria. OR **All clients:** 90-94% of clients meet diagnostic admission criteria.	**Chart review client sample**: 90% or more of chart sample meet diagnostic admission criteria. OR **All clients:** 95% or more meet diagnostic admission criteria.
Criterion #2: The team/agency has the authority to be the gatekeeper on admissions to the team (including screening out inappropriate referrals) and discharges from the team.	The team is not the gatekeeper for admission and discharges and may be compelled to admit clients who are not appropriate for ACT (i.e., there are few options for appealing or rejecting referrals to the team).	The team reports that they are the gatekeeper for admissions and discharges, yet there appear to be some exceptions (e.g., they report instances when they felt like they were "forced" to admit an inappropriate client). Alternatively, team may have less gatekeeper authority, but have an appeal process that bolsters their position to have a final say on who it is they serve.	The team indicates that they generally provide the final say in admissions to, and discharges from, the team, and there is typically minimal external pressure to admit or keep clients on their caseload.

	1	2	3	4	5
OS6 Priority Service Population	The team at least PARTIALLY meets criterion #2 only OR does not meet either criterion.	The team PARTIALLY meets criterion #1 only.	The team PARTIALLY meets criterion #1, and at least PARTIALLY meets criterion #2.	The team FULLY meets criterion #1, and PARTIALLY meets criterion #2.	The team FULLY meets both criteria.

[3] Use Chart Review Tally Sheet I or TMACT Calculation Workbook to calculate the percentage of clients who did not appear to be appropriate for ACT given their diagnostic profile.

OS7. Active Recruitment

Definition:
(1) The team (or its organizational representative) actively recruits new clients who could benefit from ACT, including assertive outreach to referral sites for regular screening and planning for new admissions to the team.
(2) The team is primarily comprised of clients from referral sources and sites outside of usual community mental health settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach).
(3) The team works to fill open slots when they are not at full capacity and/or the client-to-staff ratio is well below 10:1 on more mature teams.

Rationale: ACT is best suited for clients who do not effectively use less intensive mental health services. Reliance on passive approaches to client recruitment using typical mental health organizational intake systems or internal referrals does not typically ensure that the most suitable persons are served. Teams typically need to actively recruit in community settings outside of a parent agency to ensure that ACT services are offered to persons in their region who are most suited to using them. Since ACT is also a scarce resource, it is important for teams to work at full capacity.

DATA SOURCES (* denotes primary data source)

Team Survey*

Item #7a: Number of clients currently enrolled on the team: _____

Item #7b: Number of clients the team is equipped to serve at capacity (Clarify current capacity, which may be intentionally staggered given team development plans): _____

Item #10: Current number of clients who had been "stepped up" from less intensive services within the agency when they were referred to ACT: _____

Team Leader Interview*

Who makes referrals to the team?	
What recruitment procedures do you use to find clients for the ACT team, especially those <u>most</u> in need of this service? *In what ways does the team conduct outreach and engagement for recruiting new clients or collaborate closely with separate outreach programs? What venues are visited for outreach (prompt for a range of places, including shelters, jails, other homeless outreach programs)?* (If the team is at capacity, and therefore is hesitant to actively seek out individuals who may need ACT but who would end up waitlisted, is there evidence that the team works to maintain relationships and warm contacts at potential referral sites [e.g., can they name warm contacts at various sites, do they have an advisory board or steering committee with representatives from potential referrals sites, etc.])?	
How many open slots are there on your team?	

ITEM RESPONSE CODING
Rating Guidelines
Use the team leader interview and survey as primary data sources for rating. Please refer to Table 4 to determine if criteria are met at all, partially, or fully. NOTE: If the ACT team shares outreach and recruitment services within a parent agency or there is another mechanism by which referrals occur (e.g., a managed care organization), evaluate these collective efforts.

Table 4. Active Recruitment

Criteria	Examples/Guideline		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: The team (or its organizational representative) actively recruits new clients who could benefit from ACT, including assertive outreach to referral sites for regular screening and planning for new admissions to the team.	The team does not build relationships with relevant referral sources; existing relationships are only happenstance and not actively maintained.	**The team is not at capacity**, and the team is sporadic with their recruitment activities (e.g., focusing solely on one or two single sources, not fully canvassing their area for relevant referral sources). **The team is at capacity**, and there is weak evidence for the team's persistence in maintaining warm relationships with relevant referral sources, and/or the team has no organized mechanism for prioritizing admissions to the team.	**The team is not at capacity**, and the team regularly visits specific referral sources for outreach and relationship-building, to include community inpatient units, emergency and crisis programs, jails, shelters, and, where available, system-wide community meetings where various referral sources meet regularly. The team conducts regular screening and planning for new admissions. Non-ACT staff (e.g., local government entity, or agency administration) may perform these outreach functions on behalf of the team; however, the team must still actively build and maintain relationships with common and/or anticipated referral sources. **The team is at capacity**, and there is a mechanism for prioritizing admissions to the team (e.g., waiting list) to ensure that new clients can be admitted to the team once there is an open slot. Also, if at full capacity, there may be less of a need to conduct community outreach for the purpose of identifying potential ACT clients, but there is clear evidence that the team has developed and actively maintains positive relationships with referral sites (e.g., can name "warm contacts" at various referral sites, such as local shelters, jail, hospitals, other non-profit organizations, etc.).
Criterion #2: The team is primarily comprised of clients from common referral sources and sites outside of usual community mental health	Less than 50% of clients were referred from outside agencies/referral sources or a more	50 - 74% of clients served by the team were referred from outside	The team caseload is comprised of at least 75% of clients from outside agencies/referral sources or from within more restrictive programs administered by the parent agency (e.g., mobile crisis

Table 4. Active Recruitment			
Criteria	**Examples/Guideline**		
	No Credit	**Partial Credit**	**Full Credit**
settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach) or more restrictive agency programs.[4]	restrictive program within the parent agency vs. less restrictive programs within the parent agency.	agencies/referral sources or more restrictive programs within the parent agency.	team, critical time intervention) vs. less restrictive programs administered by the parent agency (e.g., adult case management program).
Criterion #3: The teams work to fill open slots when they are not at full capacity and/or the client-to-staff ratio is well below 10:1 on more mature teams.	The team has fewer than 90% of slots filled.	The team has 90-94% of slots are filled.	At least 95% of slots are filled. If the team is at least two years old, the client-to-staff ratio is no less than 6:1. **Note**: It is important to clarify with team what their current, not ultimate, caseload cap is.

	1	**2**	**3**	**4**	**5**
OS7 Active Recruitment	The team PARTIALLY meets 1 criterion or less.	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).	2 criteria are FULLY met (1 is absent) OR ALL 3 criteria are met, with 2 or 3 PARTIALLY met.	ALL 3 criteria are met, with 2 FULLY and 1 PARTIALLY met.	ALL 3 criteria are FULLY met.

[4] See the Team Survey response #10 to calculate the percentage of clients referred from less restrictive programs within the agency.

OS8. Gradual Admission Rate

Definition: The team admits new clients at a low rate to maintain a stable service environment.

Rationale: To provide consistent, individualized, and comprehensive services to clients, a low intake rate is necessary. Taking on too many new clients at once can be disruptive to the services that current clients receive and contribute to staff stress and burnout.

DATA SOURCES (* denotes primary data source)

Team Survey

See item #11: Highest number of admissions per month in the past 6 months: _____

Team Leader Interview*

Briefly review and confirm number of admissions reported in the Team Survey item #11.	

Excel spreadsheet (Second column)

Cross-check the number of clients the team indicated as having enrolled in the team within the past 90 days with their reported highest enrollment in a single month in the past six months (i.e., no more than 12 individuals should be noted as recent enrollees if team did not exceed four per month; inquire about apparent discrepancies).

ITEM RESPONSE CODING

Rating Guidelines

If the highest monthly intake rate during the last six months was no greater than four clients, the item is rated as a "5."

NOTE: A team may receive some pressure to enroll a higher number of people in a short amount of time, such as when a new team is building to a capacity, or is absorbing another team's caseload. Although this information may guide feedback in the report, it should not alter the rating itself.

Notes:

	1	2	3	4	5
OS8 Gradual Admission Rate	Highest monthly admission rate in the last 6 months is greater than 15 clients per month.	12 -15	8 - 11	5 - 7	Highest monthly admission rate in the last 6 months no greater than 4 clients per month.

OS9. Transition to Less Intensive Services

Definition:

(1) The team conducts a regular assessment of the need for ACT services;
(2) The team uses explicit criteria or markers to assesses need to transfer to less intensive service option;
(3) Transition is gradual & individualized, with assured continuity of care;
(4) Status is monitored following transition, per individual need; and
(5) The team expedites re-admission to the team if necessary.

Rationale: Although some individuals may experience an increase in symptoms and greater functional impairments without ACT, therefore requiring longer-term ACT services, many individuals also get better over time and are able to graduate from ACT to a less restrictive community program. As supported by research, programs should have an explicit process for assessing the appropriateness of graduation and for making the transition for those ready to graduate.

DATA SOURCES (* denotes primary data source)

Team Survey

Refer to response to item #12. Note whether the team has transitioned any clients to less intensive services in the past year: _____

Team Leader Interview*

[If there were no transitions to less intensive services in the past year, then ask the following and then continue with remaining questions]: ***I see you didn't have any transitions to less intensive services over the past year. Why do you think that is? How many transitions did you have the prior year?***

[If there were transitions, inquire about those clients when asking below questions.]

How do you assess clients in their readiness to graduate from ACT because they are doing better? *On what basis do you determine ongoing need for ACT services? Can you summarize any established criteria that help you to determine whether someone is ready for transition to less intensive services? How often do you conduct these assessments?*

What process do you follow to transfer clients to less intensive services? [Prompt for whether they gradually transition clients, how much contact they have with the transition program, whether they continue to follow clients after transition from ACT and if so, for how long.]

Can you describe a typical transition plan? [Prompt for gradually decreasing number of visits, more office-based contacts, seeing fewer team members, picking up medications at the pharmacy.] ***To what services do clients transition? Under what circumstance would the team maintain contact with clients and/or the new service provider following transition? For how long?*** [Probe for whether contacts with clients were team or client initiated; probe for how it is determined which clients get more extensive follow-up.] ***If a previously graduated client needs to return to the team, what would that process entail? When would the team commence services?*** [Prompt for the following: *Are they put back on the waitlist first or quickly re-admitted? Can the team begin serving the participant without immediate assurance of payment?*] ***In the past two years, can you think of a client whose transition process best reflected the work of the team, and summarize the team's work with us?***	
Clinician Interview	
When do you start discussing transition from ACT with clients? ***What markers or indicators for transition are you assessing and considering?***	

If clients have transitioned from your team to less intensive services, how was that decision made? [Probe for assessment criteria used and whether there were any external initiatives or pressures that played a role in the decision to transition specific clients.] ***To what services did they transition? Under what circumstance would the team maintain contact with clients and/or the new service provider following transition? For how long?*** [Probe for whether contacts with clients were team or client initiated; probe for how it is determined which clients get more extensive follow-up.]	

ITEM RESPONSE CODING

Rating Guidelines

See Table 5 to determine if criteria were met at all, partially, or fully. Use the team leader interview as the primary data source. Cross-reference with information from the chart review and clinician interview.

Rating guidelines for teams that do not identify any clients who have transitioned to less intensive services over the past two years: If the team has not transitioned anyone in the past two years, it may be due to their current stage of development (newly implemented teams) or due to their not meeting criterion #1 and/or #2. If no recent examples of transition to less intensive services are available, assess criteria #3-5 based on the team leader's response to what the team plans to do when they transition clients from the team to less intensive services. Do they have a specific protocol or policies on how to handle these transitions, including gradual transition, continued follow-up, and re-admission to the team, if needed? For established teams that have not transitioned anyone, there should be compelling data speaking to intentions if considering ratings higher than partial rating criteria.

Table 5. Transition to Less Intensive Services

Criteria	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: The team conducts regular assessment of need for ACT services.	The team does not assess for transition readiness. Recent transitions did not result from the team's proactive assessment efforts.	The team does assess for the clients' need for ACT services, but this practice is not systematic and/or formalized (e.g., or no documentation is made or not tied to established processes around planning and authorizations).	Team members regularly assess for client readiness for transition to less intensive services, including improvement across areas of clinical and role functioning, as indicated in client charts. To further support "full credit" practice, one or more of the following are noted: • The team includes a discussion about clients' readiness for transition from ACT as part of their regular treatment plan reviews. This is supported by documentation in the charts; and/or

Table 5. Transition to Less Intensive Services			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
			• The team may use a level of care system to categorize client readiness for transition and regularly review as a team or in each ITT;
Criterion #2: The team uses explicit criteria or markers for need to transfer to less intensive service option.	The team is not able to present relevant and explicit criteria or markers indicating a need to transfer to less intensive services.	Transition readiness criteria do not appear to be explicit (e.g., inconsistent reports across team members). OR, the criteria themselves have questionable utility (e.g., narrowly focusing on medication adherence and hospitalizations only). They may complete a standardized assessment tool, but it isn't <u>used</u> to guide routine review.	Criteria need to be well-specified so that all team members would be able to objectively identify when a client is ready for transition to less intensive services. Ideally, a standardized assessment tool is used to guide routine review. Markers or criteria may include the following: • Use of fewer or less intensive services such as hospitals or emergency rooms; AND • More independent functioning and/or improvement in major domains (e.g., housing, treatment participation, psychiatric medication use, psychiatric hospitalization/crisis management, forensic involvement, substance use, high-risk behaviors, ADL, community integration).
Criterion #3: Transition is gradual & individualized, with assured continuity of care.	Transitions appear abrupt and there is little effort to promote continuity of care.	There is little time between identifying client as ready for transition and actual transition, and/or efforts to prepare client and lay road for service continuity are lacking (e.g., there is limited contact with the transition service provider before the client is discharged). The process itself is not individualized; there is a one size fits all approach. Also, transitions may appear unnecessarily long for most clients.	Period between identification of transition readiness and actual transition should be individualized, considering the need for time to prepare for the transition (e.g., three to six months), while also not unnecessarily prolonging transition. Examples of gradual individualized transitions include: • Gradual transition may begin with a "Transition Group" within the ACT team, comprised of other ACT clients who are getting ready for transition from ACT to less intensive services. • Client may try out services in another program for brief periods of time (e.g., a few hours or one day) while still receiving ACT services. • Team should have some mechanism for communicating with transition service provider to ensure continuity of care.
Criterion #4: Status is monitored following transition, per individual need.	The team does not monitor client status following transition. Communications with the team appear to be initiated primarily by the client	Monitoring of clients' status following transition appears to be inconsistent (e.g., examples are limited, and/or primarily reflect clients' initiating contact with the team). OR	The need for post-discharge monitoring will vary across clients. However, it is assumed that at least some will clearly benefit from such follow-up. • Team continues to communicate with transition service provider regarding client's status (e.g., up to three months). <u>Note</u>: These do not have to be formal meetings, but there needs to be at least some form of checking in on the client's status.

Table 5. Transition to Less Intensive Services			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
	and/or transition provider.	Teams take a one size fits all approach to follow-up (e.g., every client is followed for up to three months regardless of need)	• If needed, team members visit client to assess status in less intensive services after transition from ACT.
Criterion #5: The team expedites re-admission to the team if necessary.	Once discharged, previously served ACT clients are not able to re-enroll; OR they must follow typical enrollment procedures. Enrollment is not expedited; OR the team is precluded from re-admitting the client because of larger system barriers (e.g., the client no longer meets admission criteria even though returning back to the team, even for a brief period, would be helpful to him or her).	Policies and procedures are in place to expedite re-enrollment, however there still appears to be considerable lag time (e.g., these clients are moved to the front of the waitlist, but can remain waitlisted for months); OR Clients who transition to less intensive services have the option to return to the team, depending on whether the team is at full capacity at the time.	Re-enrollment of formerly transitioned clients should be expedited. The team may reserve one-to-two slots for re-enrollment of clients who transition from the program for a limited period (e.g., three months post-discharge from ACT); and/or • Former ACT clients who need to be re-admitted do not have to be placed on a waiting list (e.g., the team is able to exceed capacity to accommodate a client who needs to be re-admitted). • Where ACT eligibility criteria are listed, recently transitioned clients may return to ACT even if not meeting listed entrance criteria.

	1	**2**	**3**	**4**	**5**
OS9 Transition to Less Intensive Services	Up to 1 criterion is met OR 2 criteria are met, with 1 or 2 PARTIALLY met.	2 criteria are FULLY met (3 are absent) OR 3 criteria are met, with 1 to 3 PARTIALLY (2 are absent).	3 criteria are FULLY met (2 are absent) OR 4 criteria are met, at least PARTIALLY (1 is absent).	4 criteria are FULLY met (1 is absent or only partially met).	ALL 5 criteria are FULLY met.

OS10. Retention Rate

Definition: The team retains a high percentage of clients given that they enroll clients appropriate for ACT, utilize appropriate engagement techniques, and deliver individualized services. Referral to a more restrictive setting/program would normally be considered an adverse outcome.

Rationale: Teams that admit the intended population for ACT and are serving them well (i.e., engagement, building rapport, meeting service needs) should be able to retain the vast majority of their caseload within a year's time. Discharges to other institutional settings (e.g., hospitals, nursing homes, group homes) may be warranted in some cases, but may also reflect poor selection, engagement, and service provision. A low retention rate can also reflect broader systemic issues beyond the control of the team, such as an external authority insisting the team serve individuals who may not be appropriate for ACT or a managed care company denying authorization for ACT services for clients who clearly need ACT.

DATA SOURCES (* denotes primary data source)

Team Survey*

Refer to responses on the following survey items, and transfer to Table 6 below:

#7a: Number of clients currently enrolled: _____
#7c: Number of clients enrolled one year ago: _____
#12: Number of clients discharged from the ACT team for listed reasons: _____

Team Leader Interview*

Tell me more about those clients listed who were transferred to more restrictive settings due to medical, health, or safety reasons. What was the team's role in that process? [Note: The default is to include all clients within the numerator count (i.e., 'drop-outs'), however evaluator may judge to not count select cases if it is very clear that the clients' transfers were due to legitimate clinical/health reasons that exceeded the team's ability to appropriately care for their needs.]	
Please tell me more about any others listed on the survey who were discharged (not due to death or graduation). What was the team's role in that process? [If anyone is listed as discharged due to an authorization denial, clarify if team went through an appeals process]	
Were any of the individuals listed as being discharged later re-admitted to the team (e.g., re-enrolled following release from jail)? [Exclude from the final drop-out count anyone who has since been re-admitted to the team.]	

ITEM RESPONSE CODING			
Inclusion and Exclusion Criteria (Refer to Table 6, cross-walking and confirming Team Survey data):			
Table 6. Retention Rate Calculation: Who Constitutes a "Drop Out"?			
Reason for Discharge/Disenrollment in the Past Year:	**Considered a "Drop Out"?**	**Transferred Team Survey Item #12**	**Final "Drop Out" Count**
Unable to locate client	YES		
Incarcerated	YES (exclude if person is since re-enrolled to team)		
Discharged as a result of not receiving authorization from managed care organization	YES. Exception is up to one client may be excluded as a "drop out" if there is convincing evidence that the team put forth significant effort to appeal the authorization denial.		
Transferred to a more restrictive service setting (e.g., hospital, nursing home, residential treatment center)[2]	YES. Exception is if there is convincing evidence that the client had significant medical needs and/or safety concerns that went beyond the team's *reasonable* ability to address.		
Refused services and/or requested discharge	YES		
Moved out of service area	YES. Exception is if the team had knowledge of the move and assisted with the service transfer.		
Other (specify):			
Transitioned to less intensive services/graduated	NO	n/a	n/a
Deceased	NO	n/a	n/a
Formula	$1 - \left[\frac{\text{\# client "Drop-Outs" in the past year}}{(\text{\# clients currently enrolled} + \text{\# clients enrolled 1 year ago}) / 2} \right] \times 100$		
Rating Guidelines			
	Refer to data provided in the Team Survey (items 7a, 7c, and 12). Reference these numbers when asking the team leader for a description of each client who left the team. Then determine who constitutes a drop out by using Table 6 and the formula above.		

	1	2	3	4	5
OS10 Retention Rate	Less than 65% of the caseload is retained over a 12-month period.	65 - 76%	77 – 86%	87 - 94%	95% or more of caseload is retained over a 12-month period.

OS11. Involvement in Psychiatric Hospitalization Decisions

Definition: The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the client (e.g., activating a crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary and involuntary admissions), contact with the client during their hospital stay, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge medications and community disposition (e.g., housing, service planning).

Rationale: To ensure more appropriate use of psychiatric hospitalization and continuity of care, it is essential for the ACT team to be involved in hospitalization decisions and processes, which includes efforts to help the client avoid hospitalization by accessing other less restrictive alternatives and facilitating appropriate admissions. Ongoing ACT team participation during a client's hospitalization and discharge planning allows the team to help maintain community supports (e.g., housing) and continuity of service in the community.

DATA SOURCES (*denotes primary data source)

Team Survey*

Refer to item #14 and extract the last ten psychiatric hospitalization events. An "event' is defined as either an admissions or discharge from a psychiatric hospital.

Team Leader Interview*

Tell me more about the team's involvement in the last ten hospitalization events.

[Go through each of the most recent client psychiatric hospitalization events reported in the Team Survey and determine what role the team played in each by using Table 7 for guidance on whether to give credit for team involvement in each admission or discharge. Use below Table 7 to record the last ten events (e.g., #5 Admission; #5 Discharge; #7 Admission; #8 Admission; #8 Discharge) and then note if credit was granted or not given description.]

Table 7. Examples of Team Involvement with Psychiatric Hospitalization Decisions		**Client ID & Event Type**	**Credited**	**Not credited**
Hospital Admissions	• Activating a crisis plan to employ alternative strategies before resorting to hospitalization • Assessing need for hospitalization • Actual facilitation of hospitalization (voluntary or involuntary) • Coordinating with natural supports or other providers to determine need for hospitalization, which was then facilitated by others • Consulting with hospital staff at time client presents for admission • Providing on-site evaluation of the client at the time of presentation to the ER • Prompt contact with hospital staff upon learning that the client had been hospitalized (within 24 hours of admission) to help coordinate care			
Hospital Discharges	• Involvement in the coordination of care/visiting the client during his or her stay • Assessing readiness for discharge • Coordinating dispositional placement (i.e., housing), discharge medications/services • Actual facilitation of discharge, including transportation from the hospital			

ITEM RESPONSE CODING
Inclusion Criteria
Include all psychiatric hospital admission and discharge events in this count. An "event" is defined as either an admission or a discharge from the hospital.
Rating Guidelines
Use the team leader interview and your review of the ten most recent psychiatric hospitalization events reported in the Team Survey as the primary data sources for rating this item. Please refer to Table 7 to judge whether the team's report of involvement in each hospitalization event is counted in this rating. If team involvement does not reflect a range of efforts to coordinate and/or facilitate psychiatric hospitalization admissions (e.g., primarily just being responsive within 24 hours of client admission) or discharges (e.g., only providing transportation home from the hospital), with no other examples, rate down by one score. 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).

	1	2	3	4	5
OS11. Involvement in Psychiatric Hospitalization Decisions	The team is involved in fewer than 15% of admissions & discharges.	The team is involved in 15% - 44% of admissions & discharges.	The team is involved in 45 - 69% of admissions & discharges.	The team is involved in 70% - 89% of admissions & discharges.	The team is involved in 90% or more admissions & discharges.

OS12. Dedicated Office-Based Program Assistance

Definition: The team has 1.0 FTE of office-based program assistance available to facilitate the day's operations in a supportive manner for the team, clients, natural supports, and other ancillary service providers (e.g., landlords, social security). Primary functions include the following:

(1) Providing direct support to staff, including monitoring & coordinating daily team schedules and supporting staff both in the office and field;
(2) Serving as a liaison between clients and staff, such as attending to the needs of office walk-ins and calls from clients/natural supports; and
(3) Actively participating in the daily team meeting.

Rationale: ACT services are primarily community-based and team activities may change based on emerging client service needs. As a result, it is important for there to be a staff function to include centralized, office-based communication and coordination across team members and clients to promote continuity of care.

DATA SOURCES (* denotes primary data source)

Team Survey

Refer to item #1 before interviewing team leader, noting whether the team currently has 1.0 FTE program assistant assigned.

Team Leader Interview* or Program Assistant

[Clarify how many people share this role, especially if it appears to be shared across staff in a given day. Also clarify the extent to which the person dedicated to this role has other responsibilities, especially those that are non-ACT program activities and/or involve community-based work.] ***Is someone available in the office during the day, such as a program assistant and/or shift manager?*** [If yes]: ***What is their role on the team?*** *To what extent does this person act as a liaison between team members and clients/their natural supports? What about among team members—does this role help them to stay in touch throughout the day?* ***If (team member) is out in the field assigned to see a client who really needs to be seen, but that client is not home at the time, what steps, if any, would the team member take next?*** [Listen for the extent to which the team member relies on the office-based person to help with rescheduling that contact, such as with another team member who is in that area later in the day.]	

How many hours a day/days a week, is someone available to serve in this capacity? [This may be a straightforward FTE if an office-based program assistant dedicated to the team. If the team uses a shift manager, it is important to determine the estimated FTE for this role.] ***Does this person participate in the daily team meeting*****?** [If yes]: ***How often and what role do they serve at the meeting?*** *[Can you give me examples of where the program assistant also provided updates during the meeting, such as phone calls received, encounters with clients or natural supports, etc.?]* [If no]: ***Do you ever give the program assistant important clinical updates based on reports in the daily team meeting?*** [Seek examples]	

Direct Observation

During the process of conducting the fidelity review, it is likely that there will be many opportunities to observe the role of the program assistant and to directly interact with them. Pay attention to the extent to which the program assistant fulfills all specified roles over the course of the review

ITEM RESPONSE CODING

Rating Guidelines

Use Table 8 to determine whether the criteria for this item are met fully or partially.

- The team has 1.0 FTE office-based program assistance. More than one staff person may fulfill the function; however, no more than two staff are appointed to fill this role each day (i.e., the role should not be divided among several staff over the course of one day).
- If two people fill this role, assess based on the extent to which an adequate communication mechanism is in place between these two people to ensure continuity of coordination and care. Note that the minimal team inclusion expectations described in OS1 may not apply here.
- The designated program assistant should be *office-based* so that both functions are adequately fulfilled.
- Meeting these functions is the primary responsibility for the designated program assistant, not secondary to other administrative responsibilities.
- Do not count if the program assistant is technically employed by the team but has been on extended leave for three months or more.

Table 8. Dedicated Office-Based Program Assistance			
Functions	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #1: Provides direct support to staff, including monitoring & coordinating daily team schedules and supporting staff in the office and field.	There is no team member providing program assistance or their role is primarily administrative or clerical.	Team member(s) providing program assistance sometimes provide direct support to staff, but are less consistent in this role. Some administrative or clerical duties may take priority; fulfilling this function is secondary to administrative and clerical tasks.	This office-based team member has a role in developing and/or managing the daily staff schedule and updating it based on reports in the daily team meeting as well as staff vacations/leave. They take responsibility for assisting team members with various clients' appointments and case management tasks, such as arranging clients' medical and housing appointments and working with landlords. They also assist and support field-based staff (e.g., rescheduling another staff to see a client who is absent during contact; looking up address for a client doctor's appointment). Meeting this function is the primary responsibility for the designated program assistant, not secondary to other administrative or clerical responsibilities.
Function #2: Serves as a liaison between clients and staff, such as attending to the needs of office walk-ins and calls from clients/natural supports.	There is no team member providing program assistance or their role is primarily administrative or clerical.	Team member(s) providing program assistance sometimes work with clients and supports by phone and in-person, but are less consistent in this role. Some administrative or clerical duties may take priority; fulfilling this function is secondary to administrative and clerical tasks.	This office-based program assistant actively works directly with clients and natural supports by phone and in-person. The team relies on program assistant to be in the office to attend to emerging needs throughout the day. Examples include the following: • Responding to walk-ins, including figuring out medication refills with the team nurses and disbursement of funding; • Handling calls from clients' family members and natural supports; or • Contacting other team members when needed to assist with response to walk-ins and/or phone calls or to update them.
Function #3: Actively participates in the daily team meeting.	Team member(s) providing program assistance do not regularly attend the daily team meeting. Rating cannot be higher than a "3" on this item.	Team member(s) providing program assistance on the team regularly attend the daily team meeting, but do not take an active role (e.g., sits to the side taking notes or documenting in the log, but not reporting on contacts with clients).	Team member(s) providing program assistance on the team are engaged and contribute to the daily team meeting on a regular basis. They report on recent contacts with clients and natural supports in that meeting. They may also play a role in updating the log, daily staff schedule, or other tools/paperwork related to planning program contacts.

	1	**2**	**3**	**4**	**5**
OS12. Dedicated Office-Based Program Assistance	Less than 0.50 FTE program assistance is available to the team OR 0.50 - 1.0 FTE program assistance is available, but not meeting rating "2" performance.	0.50 - 0.99 FTE program assistance is available, at least PARTIALLY performing 2 functions OR 1.0 FTE program assistance is available and performing 1 function ONLY.	0.50 - 0.99 FTE program assistance is available, at least PARTIALLY performing ALL functions OR 1.0 FTE program assistance is available, at least PARTIALLY performing 2 functions.	1.0 FTE program assistance is available, at least PARTIALLY performing ALL functions.	1.0 FTE program assistance is available, FULLY performing ALL functions.

CT1. Team Leader on Team

Definition: The team has 1.0 full-time (i.e., works 40 hours a week) team leader with full clinical, administrative, and supervisory responsibility to the team. The team leader has no responsibility to any other programs during the 40-hour workweek. The team leader must have at least a master's degree in social work, psychology, psychiatric rehabilitation, or a related clinical field, a license in their respective field, and at least three years of experience in working with adults with severe mental illness. Team leader cannot fill more than one role on the team.

Rationale: This key position on the team requires 100% devotion to the ACT program without responsibility to other service programs. To effectively lead the team in providing high quality clinical care, the team leader is expected to be a trained clinician. More advanced clinical training typically occurs during graduate-level education. State licensure and/or certification in one's clinical field helps to ensure that a minimal standard of training and knowledge of practice and ethics has been met and is being maintained with license renewals.

DATA SOURCES (* denotes primary data source)

Team Survey*

Refer to responses on item #1 related to the team leader's educational degree, licensure status, level of training, and experience in working with this population.

Team Leader Interview

Do you have any agency responsibilities outside of the ACT team (e.g., screening potential agency enrollees across programs, triaging with hospital staff for all agency clients, providing therapy to non-ACT clients)? *If so, please estimate how much of your time is spent in those activities in a given week.* [Clarify the extent to which these non-ACT activities detract from ACT responsibilities, and adjust FTE accordingly, as opposed to non-ACT activities conducted in addition to ACT responsibilities, resulting in a 40+ hour work week with no clear indications that ACT responsibilities are negatively affected.]	
Do you currently fulfill another position or role on the team (e.g., filling in for another staff vacancy)?	

ITEM RESPONSE CODING
Rating Guidelines
The team leader position is assumed by only one person. Minimal qualifications: Master's degree in social work, psychology, psychiatric rehabilitation, or a related field. At least three years of experience working with individuals with severe mental illness. To rate a "5," the team leader must also be licensed within their respective clinical field (note that provisional licenses do not count as meeting minimal qualifications). Full-time commitment to the team: One individual assigned to work full-time (40 hours a week) with the team, with virtually no commitments to agency endeavors/services unrelated to ACT (e.g., less than two hours a week). Estimate actual FTE committed to the team given other non-ACT agency responsibilities. If the team leader's time is split between team leader and another team member's roles (e.g., nursing activities, integrated treatment for COD) due to staff shortages, estimate FTE time given actual commitments to those other non-team leader roles. Reduce FTE to rate this item and credit appropriately in another item (e.g., ST5. Role of Employment Specialist in Services), if applicable. Note that some specialty functions, such as integrated treatment for COD, may be an appropriate use of direct clinical time and should not count against team leader's FTE. ***Special case:*** Do not count if they are technically employed by the team but have been on extended leave for three months or more.

	1	2	3	4	5
CT1. Team Leader on Team	Less than 0.25 FTE team leader OR less than 0.75 FTE team leader with inadequate qualifications.	0.25 - 0.74 FTE team leader who meets at least minimal qualifications.	0.75 - 1.0 FTE team leader who does not meet minimal qualifications for education and experience	0.75 – 0.99 FTE team leader who meets at least minimal qualifications OR 1.0 full-time team leader who meets all qualifications except having a clinical license.	1.0 FTE team leader who meets at least minimal qualifications, including licensure, and has full assigned responsibility to the team.

CT2. Team Leader is Practicing Clinician

Definition: In addition to providing administrative oversight to the team, the team leader performs the following functions:

(1) Directly providing services as a clinician on the team; and
(2) Delivering consistent clinical supervision to ACT staff.

Rationale: Research has shown that a practicing team leader is strongly related to better client outcomes. Clinical supervision has also been found to be a critical element of successful uptake and sustainability of evidence-based practice (EBP). Team leaders who also have direct clinical contact are better able to model appropriate clinical interventions and provide quality supervision, as well as remain in touch with the clients served by the team.

DATA SOURCES (* denotes primary data source)

Team Survey

Refer to the response to #5 and note how many hours per week team leader spends providing direct services:_____

Refer to the response to #6 and note how often the team leader provides clinical supervision to the two staff most in need, and seek to confirm if meeting with those two team members: _____

Productivity Records*

Some agencies require staff to keep track of direct service time. Ask if this applies at this agency, and ask to see the information for the last calendar month (or some similar unit of time). Make sure that the chosen period is typical (e.g., exclude a week in which the center was undergoing JCAHO or CARF accreditation).

Supervision Records*

Examine documentation of supervision provided by the team leader, including supervision records and previous sign-up sheets that staff use to specify their need for supervision.

Team Leader Interview

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 five hours), inquire why it is so low.]	
Are you assigned as the "primary" care provider or coordinator for any of the clients, or serve on ITTs?	
[If yes]: ***For how many? How was it decided that you would serve as the primary for these clients (e.g., individuals who needed more psychotherapy), or on their ITTs?*** [This additional information provides context for the number of direct hours reported in Team Survey.]	

Tell me about your approach to clinical supervision. *How often do you provide it? How long is it typically provided each time? What tends to be the focus of supervision?* [Parse out the time spent during brief, drop-in supervision vs. scheduled time and impromptu supervision that is at least 20 minutes in length.] [Refer to the staff names on the Team Survey reported to receive the most supervision.] ***What does supervision look like for [insert name]?*** *Where does it take place? Is it scheduled? How often does it occur? Does it occur in a group or individually?* [Prompt for how well targeted the team leader's overall plan for supervision is, including titrating effort and attention according to need and capacity, how they ensure that supervision needs are met within the team (in a group or individually), and whether supervision is always directly undertaken by the team leader.] ***What areas of education or training do you think would be helpful for you to do an even better job in your role?***	
Clinician Interview	
Tell me about the type of clinical supervision you typically receive from the team leader.	

COD/Employment Specialist/Peer Specialist Interviews	
Tell me about the type of clinical supervision you typically receive from the team leader.	

ITEM RESPONSE CODING

Inclusion Criteria

Rating for Direct Services:

Give more weight to the actual records than the verbal report, unless records are unavailable.
If there is a discrepancy, then ask the team leader to help you understand it.

Direct service hours may include the following:

- Face-to-face contacts with clients and/or natural supports, whether alone or with other staff;
- Phone contacts with clients and/or natural supports;
- Team leader participation in treatment planning meetings in which a client and/or natural support is present; and
- Team leader participation in initial and comprehensive assessments.

Note: An excessively high number of direct service hours (e.g., 16+ hours per week) does not necessarily reflect best practice, as it indicates that the team leader is employed more as a direct care staff than a team leader, administrator, and supervisor. If a high number of hours are reported, inquire for the reason and provide qualitative feedback in the report. An excessive amount of time spent directly providing services will likely be reflected in lower ratings on other items, including this one (e.g., decreased supervision time).

Rating for Supervision:

Base rating on how much and what type of supervision the team leader provides to the two staff to whom they consistently see for supervision. The team leader gets full credit for weekly supervision if they are either providing group and/or individual supervision to these two staff on a weekly basis.

- The team leader is expected to provide some type of supervision every week, regardless of format and coverage (e.g., group or individual).
- All team members should be receiving regular direct supervision.
- Please note that if the team has an Assistant Team Leader, supervisory responsibilities should not be completely delegated to the Assistant Team Leader and counted toward the credit for this item.

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 EBPs, negotiating ethical quandaries, managing transference and counter transference) and maintaining and facilitating the supervisee's competence and capability to best serve clients in an effective manner. Examples include the following:

- Meeting as a group (separately from the daily team meeting) or individually to discuss specific clinical cases;
- Field mentoring (e.g., helping staff by going out in the field with them to teach, role model skills, and providing feedback on skills);
- Reviewing and giving feedback on the specific tools (e.g., the quality of assessments, treatment plans, progress notes) to better capture and document clinical content;
- Didactic teaching and/or training;
- Formal in-office individual supervision (includes both impromptu meetings at least 20 minutes in length as well as scheduled); and
- A daily team meeting; however, if this is the only mechanism for supervision, rate at no higher than a "3" for this item and only credit for a daily team meeting if evaluators observe appreciable evidence of the team leader providing clinical supervision during the meeting.

Exclusion Criteria

Supervision needs are expected to vary across staff given experience and training; however, the fidelity evaluator should not count the following toward supervision:

- Brief, informal, unscheduled consultations (e.g., "Can I quickly touch base with you about a situation?" or "Hey, I need a minute of your time."). Although these are invaluable, they are difficult to reliably measure and we expect, at a minimum, this is occurring anyway. This item is focused on assessing more formal supervision offered by the team leader; whether scheduled or impromptu, it should be substantive.
- Estimations of weekly "drop-in" supervision.

Table 9. Categorization of Team Leader Services: Clinical Supervision and Direct Service Frequency

	Direct Clinical Services (see definition)	**Clinical Supervision (see definition)**
High level	At least 8 hours a week	Group and/or individual supervision provided every week to the two staff who consistently receive the most supervision.
Moderate level	4.0 – 7.9 hours per week	Group and/or individual supervision provided every two to three weeks to the two staff who consistently receive the most supervision.
Low level	0.5 – 3.9 hours per week	Group and/or individual supervision are provided, but less frequently than every three weeks to the two staff who consistently receive the most supervision.

	1	**2**	**3**	**4**	**5**
CT2. Team Leader as Practicing Clinician	Neither direct clinical services nor clinical supervision is provided at a frequency meeting low level standard.	A low level of frequency for both direct clinical services and clinical supervision OR one practice is not provided.	Both practices are provided at a moderate level of frequency OR one practice is provided at a high or moderate level, and one at a low level of frequency.	One practice is provided at a moderate level, and one practice is at a high level of frequency.	A high level of frequency for both direct clinical services and clinical supervision.

CT3. Psychiatric Care Provider on Team

Definition: The team has at least 0.80 FTE psychiatric care provider time to directly work with a 100-client team. Minimal qualifications include the following:

(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.

Rationale: Each team needs enough psychiatric care provider time to fulfill all required functions within the team (see CT4 and CT5). For 100-client teams, this requires a minimum of 32 hours per week. For 50-client teams, this requires a minimum of 16 hours per week.

DATA SOURCES (*denotes primary data sources)

Team Survey*

Review the team's response to item #1 to guide the questions below. Note whether the team has more than one psychiatric care provider, the FTE devoted by each, and the qualifications of each psychiatric care provider (i.e., do they have a psychiatrist, a physician extender, or both?).

Team Leader Interview*

I see based on your response to the Team Survey that you have ____ hours of psychiatric care provider time. Does the [psychiatric care provider] ever see clients who are NOT on the ACT team? *[If yes:] Is that included in this FTE estimate? What is the actual schedule of the psychiatric care provider?* [Determine if hours are relatively stable from week to week, or changes significantly week to week. If very long or weekend shifts are reported, explore how that time is being spent.] If there is <u>more than one</u> psychiatric care provider on the team: ***Does each*** *[psychiatric care provider]* ***work with their own caseload or do they typically share responsibility for seeing the same clients?*** [Check on how assignments are made, which should also be reflected on column C of Excel spreadsheet.] ***How do the psychiatric care providers know what is happening with each client psychiatrically since they share the role?*** *What is their communication process (i.e., format, quality, frequency)?*	

If the psychiatric care provider is a nurse practitioner or physician assistant: ***Approximately what percent of the*** *(nurse practitioner's or physician assistant's)* ***time is devoted to providing more traditional nursing services?*** *[If applicable:] Is that percentage included in the FTE estimate in the survey?*	
Psychiatric Care Provider Interview	
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 the level of time commitment and integration to the team itself (e.g., they are scheduled for blocks of time with the team throughout the week) as well as what is reported in Team Survey.] [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?*** [If psychiatrist] ***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?***	
ITEM RESPONSE CODING	
Rating Guidelines	
• Do not count if they are technically employed by the team but have been on extended leave for three months or more. • 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 toward 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 on-site 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.
- If the provider is a nurse practitioner: Allow for 20% of nurse practitioner FTE toward more traditional nursing responsibilities (e.g., intramuscular (IM) shots, medication management). If it is more than 20% and due to compensating for nursing practice rather than prioritizing integrated healthcare as a team, then deduct the FTE percentage accordingly. Similar criteria may be applied to Physician Assistants.
- Adequate communication standard when there are multiple providers: Teams with multiple providers (each at least 8 hours with the team) must demonstrate that there is adequate communication and collaboration between/among providers (i.e., there is a reliable process for sharing client information, consulting with one another about specific client needs and concerns, etc.) in order to aggregate the combined FTE. Sufficient communication between/among providers is particularly critical if sharing responsibility for treating the same caseload (rather than splitting the caseload). Poor communication between psychiatric care providers can also result in a resource drain on the team, who is then responsible for repeating information across providers. Teams who have multiple minimal part-time (8 - 12 hours/week) psychiatric providers are less likely to meet this adequate communication standard, and are also less likely to rate as well on CT4 and CT5 given more fragmented performance and less overall team integration.

Note: The denominator in this item is based on the number of clients currently served (not the number intended to serve when the team is at full capacity). If information across sources is inconsistent, the evaluator should ask for clarification during the team leader interview or make follow-up contact with the program. Similar to all scale items, the rating should be based on the most credible evidence available to the evaluator (e.g., even if the psychiatric care provider is reported as 0.80 FTE to a 100-person ACT team, if the clients and clinicians consistently report that they are unavailable for consultation, or the actual work time is questionably at the reported FTE level, an adjusted FTE and lower score may be appropriate).

Formula

FTE value x 100
# of clients currently served = FTE per 100 clients

Please refer to the TMACT Calculation Workbook to enter and compute these data.

Examples

West has 0.15 FTE of psychiatric care provider time for a 48-client program. South has 0.50 FTE for a 104-client program. Both meet qualifications.

WEST: [(.15 * 100) / 48] = 0.31 FTE psychiatric care provider → item coded as a "2"
SOUTH: [(.50 * 100) /104] = 0.48 FTE psychiatric care provider → item coded as a "3"

	1	2	3	4	5
CT3. Psychiatric Care Provider on Team	Less than 0.20 FTE psychiatric care provider(s) per 100 clients.	0.20- 0.39 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients OR criteria for a "3" rating met, except communication standard if two or more providers, OR at least 0.20 FTE with inadequate qualifications cited.	0.40- 0.59 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients with demonstrated communication and collaboration if two providers. OR criteria for a "4" rating met, except communication standard if two or more providers.	0.60- 0.79 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients with demonstrated communication and collaboration if multiple providers. OR criteria for a "5" rating met, except communication standard if two or more providers.	At least 0.80 FTE psychiatric care provider meeting at least minimal qualifications per 100 clients. Two or more providers must demonstrate a mechanism for adequate communication & collaboration between/among providers.

CT4. Role of Psychiatric Care Provider in Treatment

Definition: In addition to providing psychopharmacologic treatment, the psychiatric care provider performs the following functions in treatment:

(1) *Typically* provides at least monthly assessment and treatment of clients' symptoms and response to the medications, including side effects;
(2) Provides brief therapy;
(3) Provides diagnostic and medication education to clients, with medication decisions based in a shared decision-making paradigm;
(4) Monitors clients' non-psychiatric medical conditions and non-psychiatric medications;
(5) If clients are hospitalized, communicates directly with clients' inpatient psychiatric care provider to ensure continuity of care; and
(6) Conducts home and community visits.

Rationale: The psychiatric care provider serves as medical director for the team, taking the lead in all psychiatric treatment and monitoring all other health conditions and medications.

DATA SOURCES (*denotes primary data source)

Excel spreadsheet (columns V and W)

Refer to team's practices around medications, especially the use of antipsychotic injections.

Chart Review (Log I)

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. Also examine frequency of visits.

Psychiatric Care Provider Interview*

We'd like to ask you some questions about your direct work with clients. Although no day may be truly typical, can you describe a typical day for you as it relates to the services you're providing to ACT clients? [Prompt with questions below depending on how much information they provide with this initial question. Ask of each provider, if there are two or more.] ***How often do you typically see clients? Who determines your schedule?*** ***Can you provide (additional) examples** of **brief therapy that you are providing**?* [Seek specific examples and try to understand how often brief therapy is provided and what does it tend to look like, what therapeutic techniques are being used]	

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.* ***Can you tell us more about your role regarding clients' non-psychiatric medical conditions and non-psychiatric medications?*** [Prompt for the extent to which they actively monitor non-psychiatric medical conditions and medications, and if there are any circumstances where they more directly treat. Also prompt for more preventive measures taken around wellness management. Refer to specific clients in the Excel spreadsheet, asking more specifically how the psychiatric care provider is delivering care to those with specific health conditions indicated.] ***If you haven't yet shared, can you provide a good example of your direct involvement in the assessment and/or treatment of a client's non-psychiatric condition?***	

Can you tell us (more) about your role when clients are hospitalized for psychiatric reasons? [Prompt for how actively psychiatric care providers are involved in coordinating care with inpatient staff—are they ever the first point of contact and when, do they ever visit a person in the hospital in person, and what is a recent example.] ***Where do you typically see clients?*** [Prompt for whether they typically see clients in the community on their own, or in the company of other team members—and reasons for this.] ***About what percentage of your time is spent in the office vs. in the community?***	

Nurse Interview*	
What is the psychiatric care provider's role in providing treatment? Describe the range of services they provide. [Prompt for each of the role areas described in the definition, specifically, prompt for their interpersonal style and use of shared decision-making, attention to broader health concerns, and communication with other providers.] ***How would you describe their approach in discussing medications with clients, particularly if the client is not wanting to take certain medications?*** ***In what ways does the psychiatric care provider work or communicate with inpatient psychiatric staff when clients are hospitalized?*** [Prompt for whether they are proactive, rather than relying more on nurses and other team members to coordinate care. If there are two or more providers, assess the role areas for each.]	

Clinician Interview	
What is your sense of the psychiatric care provider's role in providing treatment? Aside from prescribing medications, what other services are they providing? [Query for both providers separately if there are two; specifically, prompt for their interpersonal style with clients and use of shared decision-making, attention to broader health concerns, and communication with other providers.] ***How often do you see them getting out of the office to see clients? Are they willing to see clients independently, or do they prefer that another team member accompany them on visits?*** [If psychiatric care provider has someone accompany him or her into the field, try to understand the rationale for this.]	
Client Interview	
Do you meet with *(name psychiatric care provider)?* ***Please tell me how they help you. What do you like about working with them?*** [If there are more than one provider sharing responsibility in seeing everyone, inquire how well that is working for the client] ***Is there anything you'd like to be different in how you work with (name) and the services you receive?***	

ITEM RESPONSE CODING
Rating Guidelines
If <u>two or more</u> psychiatric care providers share this role <u>at different FTEs</u>: Base this rating on the extent to which the psychiatric care provider with the highest FTE meets the six treatment functions. **If <u>two or more</u> psychiatric care providers share this role <u>at equal FTEs</u>**, assess based on whether their caseload is split or shared: **If the caseload is <u>split</u>:** Base this rating on the psychiatric care provider who fulfills the <u>fewest</u> number of functions within the team. For example, if one provider performs all six treatment functions, but the second provider only fulfills functions #1 through #3, then the highest rating they can achieve is a "2" based on the second provider's performance. **If the caseload is <u>shared</u>:** Base this rating on a collective appraisal of providers' performances. Please use Table 10 to assist with rating each function and making your overall rating.

Table 10. Role of Psychiatric Care Provider in Treatment			
Functions	**No Credit**	**Partial Credit**	**Full Credit**
Function #1: Typically provides at least monthly assessment and treatment of clients' symptoms and response to the medications, including side effects.[5]	Less than 40% of clients are seen by a psychiatric care provider approximately monthly (i.e., every 1 – 6 weeks) AND/OR Clients are seen less frequently than every three months <u>without a good rationale.</u>	About 40-64% of clients are seen by a psychiatric care provider approximately monthly (i.e., every one to six weeks); OR At least 65% seen approximately monthly, but several clients are seen less frequently than every three months <u>with good rationale</u> (e.g., less frequent follow-up is part of a transition plan; attempted contacts are documented).	At least 65% of clients are seen by a psychiatric care provider approximately monthly (i.e., every one to six weeks), AND No clients are seen less frequently than every three months (an exception or two with good rationale may be permissible). <u>Note</u>: Frequency of service provision should be titrated depending on client need and treatment plan specifications. Although it may not be feasible to provide such frequent assessment to institutionalized clients, the provider does make an effort to have face-to-face and collateral contact to assess status.
Function #2: Provides brief therapy.	Does not, or very rarely provides brief therapy. No examples were provided reflecting the use of empirically-supported	Some brief therapy appears to be provided, but limited in number of clients receiving and/or more limited presence across data sources (e.g., reports of such are provided, but see no evidence in chart review).	Brief therapy is provided and follows principles in alignment with known empirically-supported therapies (e.g., motivational interviewing (MI), CBT). Examples include the following: • Clarification of clients' beliefs and feelings about their symptoms, mental illness, medication, and issues of "chemical control" • Cognitive restructuring • Problem-solving • Role-playing

[5] Use the Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate the percentage of clients seen at least every six weeks and no less frequently than every three months.

Table 10. Role of Psychiatric Care Provider in Treatment			
Functions	**No Credit**	**Partial Credit**	**Full Credit**
	therapies within contacts, or examples were extremely limited in quality or quantity.		• Examining pros and cons • Relaxation training • Activity and pleasant event scheduling Evidence of brief therapy should be present across multiple client contacts and data sources, such as interviews and chart reviews.
Function #3: Provides diagnostic and medication education to clients, with medication decisions based in a shared decision-making paradigm.	Does not provide diagnostic or medication education to clients; shared decision-making model is not used.	Provides diagnostic and medication education to clients, but there is some report by clients or other team members that it is inconsistently provided, that it is provided using medical jargon, and/or there are notable instances where a shared decision-making model is not used.	Psychiatric care provider provides information to the client about their psychiatric diagnosis and answers any questions or concerns that arise about that diagnosis and related symptoms/behaviors. Psychiatric care provider meets with each client to discuss the medications they are prescribing, where this discussion may include: • Anticipated benefits; • Possible side effects; • **Clients' past experiences, values, and preferences;** • Administration details, and • Areas of needed collaboration in taking the medication. A variety of medications and administration modes (orals vs. IM injections) corroborates report of a shared decision-making approach. The psychiatric provider uses non-judgmental and non-medical language that is understandable to the client and engages in shared decision-making whenever possible. Psychiatric care providers who typically have short, infrequent visits are often less likely or able to use a shared decision-making model.
Function #4: Monitors clients' non-psychiatric medical conditions and non-psychiatric medications.	Although the provider may be aware of non-psychiatric medical conditions and medications, there is no monitoring.	Monitors non-psychiatric medical conditions and medications, but there is evidence of inconsistent work in this area (e.g., screening and monitoring, but not coordinating with primary care providers).	The psychiatric care provider, in collaboration with nursing, oversees the overall medical care of clients on the team, including: • Regular screening for medical conditions (e.g., ordering lab work, requesting that nurses conduct screening for metabolic syndrome for clients taking atypical antipsychotics); • Consistent monitoring of existing medical conditions (monitoring blood-glucose levels for those with diabetes); • Assessing wellness/health management skills and collaboratively working with the team on developing a wellness management plan or strategy (nicotine replacement therapy; nutrition); and • Checking in with clients and coordinating with primary care/medical doctors regarding medical conditions that require treatment outside the ACT team, as well as non-psychiatric medications.

Table 10. Role of Psychiatric Care Provider in Treatment			
Functions	**No Credit**	**Partial Credit**	**Full Credit**
Function #5: If clients are hospitalized, communicates directly with clients' inpatient psychiatric care provider to ensure continuity of care.	Psychiatric care provider does not communicate with inpatient psychiatric care provider when clients are hospitalized.	There is some contact with inpatient providers when clients are hospitalized, but this does not occur on a regular basis, and/or provider relies heavily on nursing and other staff to communicate with inpatient staff.	When clients are hospitalized, the psychiatric care provider contacts the inpatient psychiatric provider and/or team to discuss the circumstances surrounding the client's hospitalization, medication and symptom history, most recent medications and response to those medications, and overall treatment planning to best support the client during inpatient hospitalization and promote a healthy return to the community. Recent examples (past six months) are provided where the psychiatric care provider has visited a client in the hospital.
Function #6: Conducts home and community visits.	Does not conduct home and community visits, or community contacts are dictated by efficiency rather than clinical need. E.g., provider goes into the community to a residential setting to see ACT clients who reside at that one residence, but does not see other ACT clients in the community.	Psychiatric care providers on new teams spend less than 50% of their time in the community, but do get out of the office for many contacts, per clients' clinical needs. Providers on more established teams spend less than 30% of their time in the community, but do get out of the office for many contacts, per clients' clinical needs; AND/OR psychiatric care providers rely heavily on other staff to accompany him or her out in the community when seeing clients.	The value of community-based contacts may be balanced with efficiency of time. Psychiatric care providers of established teams are expected to have at least 30% of the client contacts in the community, and all or nearly all clients have been met in the community at least one time. Psychiatric care providers of newer teams (operating less than year) are encouraged to spend more time in the community (at least 50%) as there is more work to engage clients, and help serve to model community-based work to the team. It is expected that psychiatric care providers conduct outreach independently, not requiring the company of other staff members beyond practices common for all (e.g., doubling up for safety concerns for a particular client; providing field supervision).

	1	**2**	**3**	**4**	**5**
CT4. Role of Psychiatric Care Provider in Treatment	The psychiatric care provider performs 2 or fewer functions total.	4 functions PARTIALLY performed (2 are absent) OR 3 functions are performed (3 are absent).	4 functions are performed (2 are absent), but up to 3 are only PARTIALLY performed OR 5 functions are performed (1 is absent) OR ALL 6 functions are performed, but more than 2 are PARTIALLY performed.	ALL 6 functions are performed, but up to 2 functions are only PARTIALLY performed.	ALL 6 treatment functions FULLY performed.

CT5. Role of Psychiatric Care Provider within Team

Definition: The psychiatric care provider performs the following functions within the team:

(1) Collaborates with the team leader in sharing overall clinical responsibility for monitoring client treatment and team member service delivery;
(2) Educates non-medical staff on psychiatric and non-psychiatric medications, their side effects, and health-related conditions;
(3) Attends the majority of treatment planning meetings;
(4) Attends daily team meetings in proportion to the minimum time expected for caseload size;
(5) Actively collaborates with nurses; and
(6) Provides psychiatric back-up to the program after-hours and weekends (Note: may be on a rotating basis as long as other psychiatric care providers who share on-call have access to clients' current status and medical records/current medications).

Rationale: In addition to being the medical director of the team, the psychiatric care provider is a fully integrated member of the team, actively collaborating and communicating with other team members and regularly attending all necessary meetings to guide treatment.

DATA SOURCES: (* denotes primary data sources)

Team Leader Interview*

Aside from the clinical services they provide, what is the psychiatric care provider's role within the team? For example, how much do they participate in daily team meetings or treatment planning meetings? [If there are two or more psychiatric care providers, prompt for specific roles identified above for each provider.]	
Can you describe your professional relationship with the psychiatric care provider? How do your roles compliment and/or conflict with one another? [Prompt for how they share team clinical leadership and oversight responsibilities. If there are two or more providers, prompt for specific roles for each.]	

Psychiatric Care Provider Interview*	
Now we'd like to ask you questions as relates to other ACT team staff. How do you see your role within the team—as a team member, separate from the services you provide? [Depending on their response, you may want to ask some of the specific questions listed below. Ask this of each provider if there are two or more.]	
Can you describe your work and relationship with the team leader? *Is it a collaborative relationship? Are there conflicts?* [If more than one psychiatric care provider, further query for how psychiatric care providers work together with team leader.]	
Can you give (additional) examples for how you provide information to other team members regarding medications or clients' health conditions?	
How often do you attend any treatment planning meetings? [A treatment planning meeting is where staff come together with a client to review goals, progress, and develop/update the plan itself. This is different than a clinical treatment team meeting where team members, with or without client and other stakeholders, do some needed problem-solving.] ***For which clients do you attend planning meetings, and how often are such meetings held?***	
How often do you attend daily team meetings? How long do you stay?	

In what ways do you work together with the nurses on the team? Do you have any set aside meeting time with the nurses? [If yes] *What are those meetings focused on?* ***Who provides psychiatric back-up to the team during weekends and after-hours?*** [If there is more than one psychiatric care provider:] ***How do you ensure that clinical information is communicated between you and the other psychiatric care provider(s) on the team?*** ***Is there any part of your role that you find to be challenging to fulfill or carry out day-to-day?*** [Prompt for details] ***Are there areas of education or training you think would be helpful for you to do an even better job delivering ACT services?***	
Clinician Interview	
Who would you say provides clinical leadership to the team? ***How do the team leader and psychiatric provider(s) work together in sharing their leadership responsibilities within the team?*** *What are their respective roles? Are they complementary? Conflicting?* [Ask the following regarding all providers if there are two or more.] ***How often does the psychiatric care provider attend your daily team meeting?***	

How often do they attend treatment planning meetings, especially ones where the client is present and the focus is on plan development? ***Can you provide examples in how they talk with you about clients' medications and related medication needs? How often does this occur?*** ***Are they readily accessible****? What is the typical approach to getting in touch with the psychiatric care provider when they are needed? Are they ever on-call for emergencies with clients?*	

ITEM RESPONSE CODING

Rating Guidelines

Use the team leader and psychiatric care provider interviews as primary data source. Use data from clinician interviews to back-up conclusions. If the psychiatric provider fulfills all six functions within the team, rate this item as a "5."

Treatment Planning Meeting Attendance: To receive credit, an ACT psychiatric care provider must be attending the planning meetings for at least 50% of the caseload if planning meetings are held at least every six months; and/or attend all client planning meetings if held annually. No credit if such planning meetings are not held at least annually.

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 four days per week. If a team this size, however, had a psychiatrist at 16 hours and attending two days a week, they would not meet this standard (of four 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 four daily team meetings per week, regardless if they share in this responsibility equally (e.g., both attends two meetings per week) or not (e.g., one attends once a week, and the other three times per week).

CT5. Role of Psychiatric Care Provider within Team	**1**	**2**	**3**	**4**	**5**
	The psychiatric care provider performs no more than 2 team functions total.	3 team functions are performed.	4 team functions are performed.	5 team functions are performed.	ALL 6 team functions are performed.

CT6. Nurses on Team

Definition: The team has at least 2.85 FTE registered nurses (RNs) assigned to work within a 100-client team. At least one full-time RN on the team has a minimum of one year of experience working with adults with severe mental illness. NOTE: This item is rated based on 2.85 FTE (vs. 3.0 FTE) since there is more likelihood for the team to get penalized on this item if the census goes even slightly above the 100-client team.

Rationale: Nurses have been found to be a critical ingredient in successful ACT programs. According to research studies, the presence of a nurse on an ACT team is associated with improved client outcomes.

DATA SOURCES: (* denotes primary data source)

Team Survey*

Please refer to the item #1 response by noting FTEs and qualifications.

Nursing Interview*

Review and confirm hours with team, degree, and qualifications. ***Approximately what percent of your workweek involves nursing-related activities as opposed to being called upon to engage in activities that clearly do not include a nursing function?*** (Use this estimate to gauge the extent to which they are functioning within the critical roles -- e.g., if they endorse activities representing all six critical roles, but then report that only 40% of their time is engaged in nursing activities, then follow-up questions and referencing other data sources is key to determining true nature of their role within team). ***Are you assigned as the "primary" team member or care coordinator for any clients, or serve on ITTs? If so, how many and why do you think you were assigned to work with those particular clients (i.e., did they have more specialized health-related needs the nurses were best equipped to address)?*** [This additional information provides context for how the nurses may be employed within the team.]	

ITEM RESPONSE CODING

Rating Guidelines

- Inquire about whether nurses have responsibilities outside of the ACT team and adjust FTE time accordingly.
- A nurse practitioner serving as the team psychiatric care provider does not count toward the nursing FTE total unless the break-out of time is clear and supported by multiple data sources.
- 1.0 FTE licensed professional nurse (LPN) or certified medical assistant (CMA) may count toward FTE total, but at 75% of the FTE time and only if team has at least 1.0 FTE RN also on team (0.5 LPN or CMA may count toward FTE total, but at 0.38 of the FTE time). For example, if a 100-client team has 2.0 FTE RNs and 1.0 FTE LPN, then the team is rated based on 2.75 FTE nursing time, which results in a rating of "4").
- Refer to OS1 staffing inclusion criteria. Do not count as part of the team if actual time dedicated to ACT is less than 16 hours per week and/or the nurse does not attend at least two daily team meetings per week. Do not count both FTE of permanent staff on leave and interim temp staff.

Note: The denominator in this item is based on the number of clients currently served. If inconsistent, then the assessor should reconcile information across sources and score accordingly.

Formula

Prorate FTE per 100 clients:

___total FTE value x 100___

# of clients currently served = FTE per 100 clients

Please refer to the TMACT Calculation Workbook to enter and compute these data.

	1	2	3	4	5
CT6. Nurses on Team	Less than 0.50 FTE RNs per 100 clients.	0.50 – 1.40 FTE RNs per 100 clients.	1.41 – 2.10 FTE RNs per 100 clients OR Criteria for "4" or "5" rating met, however no full-time RNs have a minimum of 1 year experience working with adults with severe mental illness.	2.11 - 2.84 FTE RNs per 100 clients.	At least 2.85 FTE Registered Nurses (RNs) per 100-client team; at least 1 full-time nurse must have at least 1 year experience working with adults with SMI. If not, rate no higher than a "3".

CT7. Role of Nurses

Definition: The team nurses perform the following critical roles (in collaboration with the psychiatric care provider):

(1) Manage the medication system, administer and document medication treatment;
(2) Screen and monitor clients for medical problems/side effects;
(3) Communicate and coordinate services with the other medical providers;
(4) Engage in health promotion, prevention, and education activities (i.e., assess for risky behaviors and attempt behavior change);
(5) Educate other team members to help them monitor psychiatric symptoms and medication side effects; and
(6) When clients are in agreement, develop strategies to maximize the taking of medications as prescribed (e.g., behavioral tailoring, development of individual cues and reminders).

Rationale: As described previously, nurses have been found to be a critical ingredient in successful ACT programs. The reason for this is that they play a key role in both direct service and staff education, broadly defined to include not only medication management, but also screening for health problems, health promotion and education, coordination of services with health providers, and cross-training to other ACT staff.

DATA SOURCES (* Denotes primary data source)

Excel spreadsheet (column N, V and W)

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): _____

Chart Review (Log I)

Review charts for the extent to which team is providing health/lifestyle interventions.

Team Leader Interview*

What role do the nurses play on the ACT team? [Prompt for roles above.] ***Do the nurses ever have responsibilities (or serve clients) outside the ACT team?***	

Psychiatric Care Provider Interview	
Please describe how the nurses manage the medication system for ACT clients. [Prompt for the quality of work, such as timely refills, accuracy in preparing medication packets for distribution, and accuracy in maintaining medication administration records (MAR) and updated lists of prescribed medications.]	
Nurse Interview*	
Describe your role on the ACT team. What does your day-to-day work look like? [Follow-up with specific questions below, depending on whether they provide enough information regarding the six roles listed above. Use reflections and summaries to verify what you have so far heard in this opening question as it relates to below topics.] ***Can you tell us more about your specific role within the team regarding medications****?* [Refer to column V on Excel spreadsheet—how many oral medications are directly managed by the ACT team and ACT nursing staff? Gather information on medication check-in, storage, and delivery to clients, including the rates at which clients have medications delivered by team.] [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.] ***Can you tell us more about what you do regarding clients' health conditions****? How are lab work and basic health status indicators (e.g., blood pressure, weight, blood-glucose levels) monitored for non-psychiatric conditions? Are these health data tracked in any way? What kind of nursing assessments do you use* [Prompt for abnormal involuntary movement scale (AIMS) assessment]*? How often do you conduct them?*	

In what ways do you help with communication between the team and non-ACT healthcare providers as it relates to client care? [Prompt for whether communication sheets are used, the reliability of this exchange, and how this information is maintained within the team. Ask for a copy of a health communication form.] ***Do you accompany participants to healthcare appointments? How do you decide who accompanies them?*** [Seek examples] ***Please tell us more about any work you do on prevention or health promotion with clients.*** *Tell us about the health and lifestyle interventions you are using with clients.* [Refer to column N on Excel spreadsheet and Full Credit column under Function #4.] ***What is your role regarding training other team members on clients' medications and/or their health conditions?*** [Prompt for examples as needed—is this more informal 1:1 or in daily team meeting, is it with any prepared and shared educational materials?] ***Please describe any specific strategies you use to help people take their medications as prescribed on their own*** [If needed, prompt for examples of individuals who are not opposed to taking medications, but do not do so consistently due to confusion, memory, or cognitive or behavioral impairments.]	

Is there any part of your role that you find to be challenging to fulfill or carry out day-to-day? [Prompt for details] ***What are the areas of education or training you think would be helpful for you to do an even better job in your role?***	
Clinician Interview	
Do the nurses on the team ever talk with you about how to monitor psychiatric symptoms, medication side effects, or other health-related issues? [Ask for specific examples, and **gauge frequency** with which this occurs]	
ITEM RESPONSE CODING	
Rating Guidelines	
Use Table 11 to determine full and partial credit for each function to determine your overall rating. Use the nurse and team leader interviews as primary data sources; use chart reviews to back-up conclusions. If the nurses fulfill all six functions within the team, rate this item as a "5."	

Table 11. Role of Nurses

Function	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Function #1: Manage the medication system, administer and document medication treatment	Nurses do not or rarely manage the medication system, administer and document medication treatment. Greater than 66% of clients are 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.	Nurses are inconsistent in fulfillment of this particular role. Anywhere from 34% - 66% of clients are 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.	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 MAR and all other documentation related to medications is accurate and up-to-date. One-third (33%) 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. Although ACT helps individuals have more independence and responsibility with medications, there are many reasons why a priority clinical population for ACT benefits from medications routed through the team, including: being positioned to modify and tailor medication supports as needs change; assessing and detecting medication errors and changes; and being able to prescribe and monitor controlled substances.

Table 11. Role of Nurses			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #2: Screen and monitor clients for medical problems/side effects	Nurses do not or rarely screen and/or monitor clients for medical problems/side effects.	Nurses screen and monitor clients for medical problems and side effects, but there is indication that this is less consistently conducted or the quality is variable (e.g., not using available standardized assessments).	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 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 #3: Communicate and coordinate services with the other medical providers	Nurses do not or rarely communicate and coordinate services with the other medical providers.	Nurses contact inpatient and outpatient medical and psychiatric care providers who are treating ACT clients, but there is evidence that this is less consistently done or that this communication is often difficult (e.g., difficulty with inpatient providers calling them back or following-up on the ACT team's recommendations for medication changes). Health communication forms may be used, but not reliably.	Nurses assume a lead role (ideally, in collaboration with psychiatric care provider, see CT4) in coordinating care with other medical providers, including primary care, specialists, and dentists. Evidence that all or most of these functions are fulfilled: • Regularly contact inpatient and outpatient medical and psychiatric care providers who are treating ACT clients, which may occur when a client is hospitalized or when they have an outpatient medical appointment; • Accompany clients to appointments; • Use health communication forms to relay and receive information from non-ACT health providers.
Function #4: Engage in health promotion, prevention, and education activities	Nurses do not or rarely engage in health promotion, prevention, and/or education activities.	Nurses provide some health promotion, prevention, and/or education activities, but do so inconsistently or their scope is limited.	Per interview and chart data, nurses consistently engage in health promotion, prevention and education activities, such as the following: • Working on behavior change strategies related to identified health risk behaviors (e.g., education regarding the importance of safe sex practices, provision of condoms);

Table 11. Role of Nurses			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
			• Intervening on health/medical risk factors or conditions (e.g., providing education and teaching self-management skills to clients with diabetes, obesity, hypertension, high cholesterol); Engaging in strategies to reduce tobacco use (e.g., providing education about and/or access to nicotine replacement therapy, facilitation of smoking cessation counseling or groups like Learning About Healthy Living [LAHL]).
Function #5: Educate other team members to help them monitor psychiatric symptoms and medication side effects	Nurses do not or rarely provide education to other team members to help them monitor psychiatric symptoms and medication side effects, but do so inconsistently.	Nurses provide some education to other team members to help them monitor psychiatric symptoms and medication side effects, but do so inconsistently and/or passively.	Nurses provide regular education to other team members, either formally (e.g., cross-training) or informally (in the daily team meeting) to help them monitor psychiatric symptoms and medication side effects. Education efforts are intentionally inserted into work rather than reflect passive responses to team questions.
Function #6: When clients are in agreement, develop strategies to maximize the taking of medications as prescribed	Nurses do not or rarely develop strategies to maximize the taking of medications as prescribed.	Nurses play some role in assisting with improving medication adherence, but this role is limited in scope or inconsistently provided.	Nurses work with the psychiatric care provider and team to develop ways to improve medication adherence, such as the following: • Behavioral tailoring (e.g., tying med box to toothbrush as a reminder to take medications, putting medications near coffee pot); • Using cues and reminders (post-it notes, prompts from the team, setting up a cell phone or computer reminder), and pill organizers; and • Simplifying or moving dosing, such as reducing to a one time a day medication, considering IM injection because it is preferred by the client.

	1	**2**	**3**	**4**	**5**
CT7. Role of Nurses	Nurses perform 2 or fewer functions total.	4 functions PARTIALLY performed (2 are absent) OR 3 functions are performed (3 are absent).	4 functions are performed (2 are absent), but up to 3 are only PARTIALLY performed OR 5 functions are performed (1 is absent) OR ALL 6 functions are performed, but more than 3 are PARTIALLY performed.	ALL 6 functions, with up to 3 functions are PARTIALLY performed.	ALL 6 functions are FULLY performed.

ST1. Co-Occurring Disorders (COD) Specialist on Team

Definition: The team has at least one 1.0 FTE team member designated as a co-occurring disorders (COD) specialist who has at least a bachelor's degree and meets local standards for certification as a co-occurring specialist. Preferably this specialist has training or experience in integrated treatment for COD.

Rationale: Co-occurring disorders are common in persons with severe mental illness. Appropriate assessment and intervention strategies delivered by competent staff are critical. As a result, it is essential to include a dedicated position to lead these strategies.

DATA SOURCES (* denotes primary data source)

Team Survey

Refer to item #1, noting FTE and qualifications.

Excel spreadsheet (column B)

How many clients are reported to be receiving integrated treatment for COD directly from the ACT team? _____

Chart Review

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 COD specialist have some notation of integrated treatment for COD, 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).

Co-Occurring Disorders Specialist Interview*

Please tell us about your training and experience in delivering integrated treatment for co-occurring disorders (COD).	
If you were to think of a typical week, approximately what percent of client contacts involve some type of integrated treatment for co-occurring disorders service, which include outreach and engagement?	
Are you assigned as the primary care provider or coordinator for any clients? If so, how many and, of those, who have a co-occurring substance use disorder? If your team uses ITTs, how many client's ITTs are you a part of? [This additional information provides context for how the specialist(s) may be employed within the team.]	

ITEM RESPONSE CODING

Inclusion Criteria

If two specialists are on the team: It is acceptable and encouraged to consider the cumulative percent of time devoted to specialty services for up to two individuals serving in this specialty role. Please see the note in the rating guidelines section regarding inclusion of team members who may not be formally designated as a specialist, but have assumed more specialty service responsibilities.

Exclusion Criteria

Refer to OS1 for general inclusion and exclusion criteria (e.g., at least 16 hours of week with team, attending at least two daily team meetings per week).

Rating Guidelines and Formula

Several criteria are considered when determining the rating for ST1. These criteria include the following:

1. Reported time in position (i.e., full-time equivalency (FTE));
2. Actual time devoted to specialty-related activities[1] while in the position; and
3. Qualifications of the specialist(s).

NOTE: Up to two team members may be considered in this rating. Even if the team formally has one team member designated as the COD specialist, evaluators are encouraged to prompt the team leader prior to the fidelity review to determine whether there is any other team member who assumes responsibility for delivering integrated treatment for COD (please see the fidelity review orientation letter in Appendix A). Even if this secondary "COD specialist" does not meet minimal qualifications, they may positively contribute to this rating, which is in the spirit of the team sharing responsibility for services. However, be sure to simultaneously deduct from other staff FTE item, as relevant (e.g., a full-time peer specialist cannot be both credited for serving in peer specialist role full-time (at least 80% of time representing peer functions) and also be credited for 50% time toward COD specialist role).

To rate ST1, input data obtained from pre-fidelity survey and interviews into Table 12.
Then use these data to complete Steps 1 – 3 below.

Table 12. Summary of Data Used to Rate COD Specialist on Team.		**COD Specialist**	
Criteria		**Primary Specialist**	**Secondary Specialist (if applicable)**
A	FTE with ACT team (see pre-fidelity survey and interview data; (FTE = # of hours employed with ACT per week / 40))		
B	Time devoted to specialty-related activities[1]: estimated % of client contacts that involve integrated treatment for COD service (based on interview responses, cross-checked with other data sources[2]).		
C	Meets minimal qualifications, which entails meeting local standards for certification or licensure as a COD specialist and has at least a bachelor's degree. (see under Step #3 below)		

Step 1. Determine Provisional Rating Given the Adjusted FTE (criteria A and B in Table 12)

***Please refer to the TMACT Calculation Workbook to enter and compute these data.

a. **If *80% or more* of client contacts involve specialist-related activities** (criterion B), per specialist report and other sources[2]), **give full credit for the reported FTE on the team** (criterion A). Refer to Table 13 to determine provisional rating (Note: it remains "provisional" because we have yet to examine impact of qualifications).

Example a: Specialist is 1.00 FTE (i.e., 40 hours/week) and reports that 90% of contacts involve COD specialty and other sources support that estimate, then 1.00 FTE (i.e., actual FTE) is used, which provisionally rates a "5" based on Table 13.

b. **If less than 80% of client contacts involve specialist-related activities** (criterion B), per specialist reports and/or other sources[2]), **calculate an adjusted FTE**, which is then used to determine the provisional rating based on Table 13.

Table 13. Provisional Ratings Following Step 1.

FTE	Rating
1.00 +	5
0.75 – 0.99	4
0.50 – 0.74	3
0.25 – 0.49	2
0.00 – 0.24	1

Calculating the Adjusted FTE =

Full-Time

- **If specialist is full-time with the team** (i.e., 1.0 for criterion A in Table 12)**:** Add 10 to the estimated percent of time dedicated to specialist role (criterion B in Table 12), and divide by 100.

Example b1: A full-time COD specialist reported, and other data sources corroborated, that 50% of her time was spent providing specialty services. Her adjusted FTE would be 50 + 10 = 60 / 100 = 0.60 Adjusted FTE, which provisionally rates a "3" based on Table 13. (Note: it remains "provisional" because we have yet to examine impact of qualifications)

Part-Time

- **If specialist is part-time with the team** (i.e., less than 1.0 FTE reported for criterion A in Table 12)**,** use the following formula to calculate the adjusted FTE:
((FTE on team, which is criterion A in Table 12) * (percent of client contacts involving specialty-related activities[1], which is criterion B in Table 12)) +.05.

Example b2: A COD specialist was employed with the team for 24 hours a week, or 0.60 FTE. She estimated that 50% of her time was spent providing specialty services. **(0.60** (which is FTE on team, or criterion A) **0.50** (representing 50%, or criterion B)**) + 0.05 = 0.35 Adjusted FTE**, which provisionally rates a "2" based on Table 13.

Step 2. Complete if there are two specialists; otherwise skip to Step 3

Aggregating FTE for Two Specialists: If there are two specialists in position, go through Step 1 above for each specialist and add together total adjusted FTE and determine provisional rating based on Table 13.

Example c: A team has a designated COD specialist who is full-time (1.0 FTE) with the team. He reported that at least 75% of his client contacts involve integrated treatment for co-occurring disorder services; the evaluators could not find data that supported such a high estimate (e.g., only 35% of his chart note entries reflected any specialty services) and agreed that 60% was more accurate.

A second team member was interviewed, as this person has a master's degree and has co-led integrated treatment for co-occurring disorder groups, as well as delivered some individual COD counseling. She works with the team four days a week at 0.80 FTE. She estimated that, of all the clients she meets with in a typical week, approximately 35% involve integrated treatment for COD intervention. The evaluators found other evidence to support that estimate.

COD specialist 1 (full-time): (**60** (reflecting the 60% estimated time in role) **+ 10** (formula instructions to add "10")) **/ 100 = 0.70 Adjusted FTE**.

COD specialist 2 (part-time): (0.80 (reflecting her FTE on the team) *** 0.35** (reflecting 35% time in specialty role)**) + 0.05** = **0.33 Adjusted FTE**

Aggregate Adjusted FTE = 0.70 + 0.33 = 1.03 Total Adjusted FTE (Provisional "5" rating based on Table 13 – recall, it remains "provisional" as we have yet to determine impact of qualifications standard)

Step 3. Qualifications Determination for Final Rating (Criteria C in Table 12).

a. One specialist on team (see Step 1 examples above):

- **Provisional rating becomes final rating if the following qualifications are met:** Meets local standards for certification or licensure as a COD specialist and has at least a bachelor's degree.
- **Provisional rating is *adjusted down* to next lowest rating if above minimal qualifications are not met** (i.e., If the specialist in example a did not meet minimal qualifications, her provisional rating of a "5" becomes a "4;" if specialist in example b1 above did not meet minimal qualifications, her provisional "3" rating is reduced to a "2" rating.).

b. Two specialists on team (see Step 2 examples above):

- **Two unqualified staff:** Provisional rating is adjusted down to next lowest rating if *both* specialists do not meet above minimal qualifications.
- **One qualified and one unqualified staff:** If one specialist meets qualifications, but the other does not, the final rating is the higher of the following two options: a) final rating is based solely on the one qualified staff or, b) final rating based on two unqualified staff (i.e., in example c described above, assume that Specialist 1 (adjusted FTE of 0.70) met qualifications, but Specialist 2 (adjusted FTE of 0.33 FTE) did not. Their aggregate FTE is 1.03 FTE (provisional "5" rating), and would be reduced to a "4" as one specialist does not meet qualifications (option b). Alternatively, we could rate based only on the one qualified staff, Specialist 1 (option a). However, her adjusted FTE of 0.70 only earns a "3" rating on its own. Thus, in this example, the option b should be used as the aggregate FTE of 1.03 that provisionally rates a "5," but then reduced one rating to a "4" results in the higher rating of the two options.

[1] **Specialist-related activities**: Estimated percent of client contacts that involve any activity associated with the specialty area. Qualifying client contacts include those where engagement practices are delivered while providing other case management services, as well as more obvious specialty-related interventions or assessments. To get full credit (i.e., to be rated according to actual FTE with the team), *at least 80%* of client contacts should involve a specialty-related activity.

[2] **Supporting specialists' estimations:** Evaluators are encouraged to consider other data sources to gauge the approximate amount of time spent in specialist activities. Evaluators should first consider the specialist's estimation, then cross-check that estimation with other data sources, such as activities reported in the daily team meeting, noted in the client log, and progress notes. If a significant discrepancy occurs, evaluators should adjust this percentage, discussing with specialist if possible to agree on a more accurate percentage of time devoted to specialist activities. Otherwise, evaluators should adjust reported percentage, keeping in mind the following heuristic guidelines:

- For a specialist who provides a *high degree* of integrated treatment for COD services (e.g., 80% or more), it is assumed that such a high level of practice will be evident across multiple data sources—e.g., chart review (majority of notes (at least 60%) written by this specialist indicates some integrated treatment for COD services,

inclusive of engagement and MI), observation of daily team meeting (i.e., reported contacts involving integrated treatment for COD services, and scheduled contacts to address integrated treatment for COD needs), and a relatively large breadth of integrated treatment for COD being provided.

- For a specialist who provides a *moderate degree* of integrated treatment for COD services (e.g., 40% - 60%), it is assumed that a moderate level of practice will be evident across several data sources—e.g., chart review (some notes (e.g., 20% - 60%) written by this specialist indicates integrated treatment for COD service, inclusive of engagement and MI), observation of daily team meeting (i.e., reported contacts involving integrated treatment for COD services, and scheduled contacts to address integrated treatment for COD needs), the breadth of integrated treatment for COD being provided may vary.
- For a specialist who provides a *low degree* of integrated treatment for COD services (e.g., 10% - 30%), it is assumed that there will be little evidence of such practice when reviewing multiple data sources—e.g., chart review (very few notes (< 20%) written by this specialist indicates some integrated treatment for COD service), observation of daily team meeting (i.e., very minimal mention of integrated treatment for COD contacts, if at all), and integrated treatment for COD services themselves may be lacking or very limited (e.g., group work only, or focused only on COD counseling for those in more active treatment stage—no work with those in earlier stages of change readiness).

	1	2	3	4	5
ST1. Co-Occurring Disorders (COD) Specialist on Team	Less than 0.25 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE COD specialist with at least minimal qualifications.

NOTE: If there is no COD specialist on the team, rate this item as a "1," but do not rate ST2 and ST3 if COD specialist vacancy has been less than 6 months. Also, rate COD specialists hired within past two months on this item, which will likely be a low rating as they likely are not yet operating fully within their specialty role, but do not rate on ST2 and ST3. If hired more than two months before review, rate new specialist on ST2 and ST3.

ST2. Role of Co-Occurring Disorders (COD) Specialist in Treatment

Definition: The co-occurring disorders (COD) specialist provides integrated treatment for COD to ACT clients who have a substance use problem. Core services include the following:
(1) Conducting ongoing comprehensive substance use assessments that consider the relationship between substance use and mental health;
(2) Assessing and tracking clients' stages of change readiness and stages of treatment;
(3) Using outreach and motivational interviewing (MI) techniques;
(4) Using cognitive behavioral approaches and relapse prevention; and
(5) Applying treatment approaches consistent with clients' stage of change readiness.

Rationale: Individuals with concurrent severe mental illness and substance use problems will most benefit from non-confrontational stage-wise treatment that focuses on the interplay of substance use and mental illness. Yet, it is also important to address the needs of clients who are in later stages of change readiness and treat them appropriately with the recommended techniques.

DATA SOURCES (* Denotes primary data source)

Team Survey

Examine the schedule of all groups provided by the ACT team and determine which ones are targeting individuals with substance use problems (i.e., groups targeting those in earlier stages of change readiness may be more inconspicuous, such as wellness groups).

Excel spreadsheet (columns A and B)

Examine how many clients with a COD are in early vs. late stages of change readiness. How many clients are reported to be receiving individual vs. group integrated treatment for COD directly from the ACT team? Use this information to guide interview questions below.

Team Leader Interview

How are clients who need integrated treatment for COD identified? [If the team reported that less than 40% of the caseload have a co-occurring disorder, inquire for reasons for this.]	
What services are offered, and can you describe the role of the COD specialist in providing such services to clients with COD? [Listen for services offered through the team, and those the team is referring individuals to receive outside of the team.]	

Co-Occurring Disorders Specialist Interview*	
How do you come to identify who has a co-occurring substance use disorder? Can you describe the initial and ongoing assessment process? What type of assessment do you use (and should we see these in the charts)? [Ask follow-up questions, as appropriate, to determine how assessment data is being used to guide treatment strategies. Cross-reference with review of screening and assessment forms as noted in chart review above, as well as copies received from the team.] ***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?] ***What do you think is the goal for clients as it relates to their substance use?*** [Prompt for whether they focus on abstinence or harm reduction. If they use harm reduction, ask for specific examples.]	

Let's say you're working with a client who doesn't acknowledge that they have a substance use problem. What would be your typical approach to working with him? [Prompt to hear about specific examples of clients with whom the specialist is currently working.] ***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.*** ***In what ways do you use confrontation with clients regarding their use?*** ***Are drug/alcohol urine/blood screens ever used?*** *If so, with whom and for what purpose?* ***Let's say you are working with someone who says 'yes, I want to change' and voices commitment to quit or reduce his use. What interventions and/or services would you offer?*** [Prompt to hear about specific examples of clients with whom the specialist is currently working.]	

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.] ***Are there circumstances where you would <u>not</u> provide a particular service given active substance use?*** [If examples are needed, offer: such as assisting to the grocery store, helping fill out a job application; permitting group attendance.] [If yet not clear if the specialist understands and practices stage-wise treatment, ask the following:] ***Are you familiar with stages of change readiness and treatment?*** [If yes] *How is this information collected and used? Reference Excel spreadsheet and prompt for examples of how they work with participants in different stages of change readiness.* [If the team offers groups, ask]: ***What is the focus of this group and who is invited to attend?*** [Is the group tailored to those in earlier or later stages of change? Prompt for to what extent mental illness is addressed in this group —is there effort to truly integrate mental health and COD within the group?]	

What resources (e.g., manuals, workbooks, SAMHSA IDDT Toolkit) do you use in individual and group treatment?	
Do you ever assist clients to self-help meetings? Please tell me more about that.	
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.]	

ITEM RESPONSE CODING

Rating Guidelines

Please see Table 14 for a brief overview of appropriate services given the client's stage of change.

The COD specialist is the primary data source. Rely on chart review to corroborate the description of services provided by the COD specialist and the quality and timeliness of assessments. Use documented clients' stages of change readiness to approximate whether services are stage-wise and appropriate.

Please refer to Table 15 to determine if criteria are met at all, partially, or fully. To achieve a rating of "5" on this item, the COD specialist systematically screens ACT clients for substance use and conducts ongoing comprehensive assessments at least annually and assesses and ideally track client's stage of change readiness for each substance of choice every three to 6 months. Assessment forms are conducive to this task and are maintained in the client's chart. There is clear evidence that a broad range of stage-wise services are provided (in individual and/or group services), and are appropriate given the client's stage of change readiness.

Note: Penetration (i.e., percent of clients receiving the services) is not considered when rating this item as this item is focused on the quality and range of services provided; however, lower rates of penetration may suggest less consistent practice, resulting in less than "full credit" designations.

"N/A" Criteria: If no person is hired into the COD specialist position at the time of the review and the position has been open for less than six months (thereby receiving a "1" rating on ST1), or a recently hired staff person has been in the position for less than two months, then do not rate this item and exclude from ST subscale and Total Score calculations. If a person is hired into position, but still scores a "1" due to not meeting specified criteria, then assess and rate this role item.

Table 14. Examples of Stage-Wise Integrated Treatment for Co-Occurring Disorder Interventions				
	Early Stages of Change Readiness and Treatment		**Later Stages of Change Readiness and Treatment**	
Stage of Change Readiness	**Pre-Contemplation**	**Contemplation and Preparation**	**Action**	**Maintenance**
	The client does not recognize that they have a problem with substance use or has no interest in modifying use at this time.	The client recognizes that substance use is causing some problems and is considering a change. In the contemplation stage, the client is more aware about the pros & cons, but ambivalent about change; whereas in the preparation stage, the client is planning for change.	The client is committed to reducing or discontinuing substance use. Behaviors are being modified to support change.	The client has abstained from substance use for at least 6 months.
Stage of Treatment	**Engagement**	**Motivation**	**Active Treatment**	**Relapse Prevention**
	Focus of treatment: Outreach, **assessment**, **engagement**, and **building a working alliance**. Services are provided regardless of ongoing use, and include harm reduction strategies.	**Focus of treatment: Education** about substances, mental illness, and their interactions, and ongoing use of harm reduction strategies. There is a focus on **identifying pros & cons of use**. **MI** techniques are essential and include the following: • Express empathy • Offer reflective listening • Assist with goal-setting • Develop discrepancy between goals and substance use • Conduct decision balance (pros & cons) • Roll with ambivalence to change • Emphasize personal choice	**Focus of treatment**: **Helping to make change & sustaining it, with continued attention to harm reduction. Specific techniques include the following:** • MI • CBT, to include: • Managing social environments • Identifying & managing triggers and cravings • Relaxation/coping skills • $ management to avoid using • Problem-solving to reduce stress •Relapse-prevention planning	**Focus of treatment**: Maintaining abstinence. Specific techniques include the following: • Develop a relapse prevention plan • Help client attend self-help groups • Help build and maintain social supports for sobriety • Maintain awareness of vulnerability to relapse • MI • Help expand recovery to other areas of life (parent group, vocational supports)

Table 15. Role of Co-Occurring Disorders Specialist in Treatment			
Service	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Service #1: Conducting com-prehensive substance use assessments that consider the relationship between substance use and mental health.[6]	No COD assessments are conducted, are only completed minimally at intake, or are not completed by the COD Specialist.	Assessments are conducted for all clients, but are minimally focused on the interplay of mental health and substance use, and/or lack useful information. Assessments are inconsistently conducted across clients/time, which includes not consistently by the COD specialist. Partial credit is warranted if assessments are comprehensive (e.g., include a functional analysis and payoff matrix), but are only completed at intake (i.e., no follow-up assessments are completed).	COD Specialist completes COD assessments, which are documented in client charts, and these assessments gather information pertinent to the interplay of substance use and mental health (e.g., negative and positive effects of substance use activity on mental health symptoms; timeline of critical life events and stressors with substance use activity). All clients should have received a brief COD assessment at intake (when new to the team, many clients are not willing to discuss their use), while those identified as likely having COD are routinely followed up with additional comprehensive substance use assessments, ideally at least annually.
Service #2: Assessing clients' stages of change readiness and stages of treatment.[6]	There is a lack of understanding and/or documentation of stages of change readiness and treatment.	There is some understanding of the stages of change readiness and treatment, but stages are not accurately assessed and/or systematically documented. This may include documentation of stage of change or stage of treatment in other locations besides the client's medical record.	The clients' stages of change readiness and related stage of treatment are routinely and accurately assessed and documented. Ideally, this information is used to closely track progress and set-backs to identify coinciding events, mood states, etc.
Service #3: Using outreach and MI techniques.	Very little outreach is conducted and specialist does not employ MI techniques.	The specialist has a cursory understanding of MI, loosely applying techniques. Outreach may be more limited, with most of the efforts going toward those in more advanced stages of change readiness.	There is clear evidence that outreach strategies are employed to engage active users who are in earlier stages of change readiness. The specialist is adept at using MI techniques to work with clients who may be contemplating change, or needing assistance in sustaining focus on change.
Service #4: Using CBT approaches and relapse prevention.	There is limited understanding and application of CBT approaches and relapse prevention. There is very little COD counseling offered to those in later stages of change readiness.	There appears to be some understanding and application of CBT and relapse prevention, but it is more limited —clearly more individuals would benefit from advanced COD counseling.	There is clear evidence that the specialist understands and employs cognitive behavioral principles when providing COD counseling and teaching relapse prevention. Examples include attention to triggers for use, emotional reactions to triggers, learning effective coping skills, especially for how to wait out cravings.

[6] Use Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate the percentage of clients in chart review sample for whom stage of change readiness or stage of treatment is document.

Table 15. Role of Co-Occurring Disorders Specialist in Treatment			
Service	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Service #5: Applying treatment approaches consistent with clients' stage of change readiness.	In review of all data sources, many examples were noted where there is an inconsistency between stage of change readiness and treatment approach (e.g., treatment was lacking all together, and or inconsistent with the stage of change readiness for many individuals).	Mixed evidence: most clients are receiving a treatment approach consistent with stage of change readiness, but a few clear exceptions were observed where treatment was not appropriate given the stage of change readiness (e.g., treatment was lacking all together, and or inconsistent with the stage of change readiness for some individuals).	Data sources indicate consistency between clients' stage of change readiness and treatment. To receive full credit, the following was observed: • No examples were noted where a client in an earlier stage of change readiness was being presented with a more advanced treatment approach, such as pushing them to attend a COD counseling class or attend AA meetings (exceptions may be when specialist intervenes more assertively due to significant safety risks); • Clients in an early stage of change readiness were receiving harm reduction interventions, and, where appropriate, MI; Later stages of change readiness clients (e.g., have voiced desire to quit and are working on it) are receiving active COD counseling and relapse prevention.

	1	**2**	**3**	**4**	**5**
ST2. Role of Co-Occurring Disorders (COD) Specialist in Treatment	The COD specialist provides 1 or fewer integrated treatment for co-occurring disorder services.	2 integrated treatment for COD services are provided (3 are absent).	3-4 integrated treatment for COD services are provided, (1 or 2 are absent) OR ALL 5 services are provided, with 3 or more services PARTIALLY provided.	ALL 5 integrated treatment for COD services are provided, but up to 2 services are only PARTIALLY provided.	ALL 5 integrated treatment for COD services are FULLY provided.

ST3. Role of Co-Occurring Disorders Specialist within Team

Definition: The co-occurring disorders (COD) specialist is a key team member in the service planning for clients with COD. The COD specialist performs the following functions WITHIN THE TEAM:
(1) Modeling skills and consultation;
(2) Cross-training to other staff on the team to help them develop co-occurring disorder assessment and treatment skills;
(3) Attending all daily team meetings; and
(4) Attending the majority of treatment planning meetings for clients with COD.

Rationale: The COD specialist appropriately influences fellow team members' practices with co-occurring disordered clients so that clients receive optimal integrated treatment for COD across the team.

DATA SOURCES (* Denotes primary data source)

Daily Team Meeting

Observe whether and how the COD specialist contributes to discussions related to COD during the daily team meeting. Do they appear to be referred to within the team?

Co-Occurring Disorders Specialist Interview*

How often do you attend the daily team meetings? What do you see as your role in that meeting?	
How often do you attend treatment planning meetings? *How do you select the ones you attend?* ***What do you see as your role in that meeting?*** [Prompt for examples]	
Have you provided more formal trainings to the team related to your area of specialty? *When, how often, what was the topic?*	
Do you ever provide more individual consultation with team members? [If yes:] *How often? Can you give me* an example?	
Is there any part of your role that you find to be challenging to fulfill or carry out day-to-day?	
Are there areas of education or training you think would be helpful for you to do an even better job in your role?	

Clinician Interview	
Now we want to better understand how fellow team members may impact your practice. ***How has your work with clients with co-occurring substance use disorders been influenced by the COD specialist?*** *Do they help you in your work with clients with COD? In what ways do you see them as a resource to you?*	

ITEM RESPONSE CODING

General Frequency Guidelines

- **Modeling and Consultation**: Modeling includes demonstration of behaviors and attitudes consistent with the integrated treatment for COD in meetings or in the field. To receive credit, they are not expected to be full-fledged experts in integrated treatment for COD, but are gaining expertise and are viewed as more expert in integrated treatment for COD than other team members. Consultation includes informal and ad hoc assistance with specific clinical cases (i.e., case-based consultation) and/or education specific to the specialist's content area provided frequently, such as at least monthly within the past 6 months.
- **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 four 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 three days a week, then do not credit for this function. Similarly, credit if the specialist works 4x10-hour shifts each week and attends four days per week.
- **Treatment Planning Meetings:** Attends the majority of treatment planning meetings for clients with COD. To receive credit, the specialist(s) attends planning meetings for at least 50% of those with COD, where such meetings are held every 6 months. If held less often than 6 months, no credit for this function is to be given.

Rating Guidelines

Use the interview with the COD specialist as primary data source. Cross-reference with the interview with the clinician. Reconcile any discrepancies with follow-up interview questions with the team leader. To receive full credit, the COD specialist provides all of four these services within the team.

"N/A" Criteria: If no person is hired into the COD specialist position at the time of the review (thereby receiving a "1" rating on ST1), or a recently hired staff person has been in the position for less than two months, then do not rate this item and exclude from ST subscale and Total Score calculations. If a person is hired into position, but still scores a "1" due to not meeting specified criteria, then assess and rate this role item.

ST3. Role of Co-Occurring Disorders (COD) Specialist within Team	1	2	3	4	5
	The COD specialist does not perform any of the 4 functions within the team.	1 function is performed within the team.	2 functions are performed within the team.	3 functions are performed within the team.	ALL 4 functions are performed within the team.

ST4. Employment Specialist on Team

Definition: The team has at least 1.0 FTE team member designated as an employment specialist, with at least one year of experience providing employment services (e.g., job development, job coaching, supported employment). Ideally, the ACT employment specialist is a part of a larger supported employment & education (SEE) program within the agency.

Rationale: ACT teams emphasize skill development and support in natural settings. Fully integrated ACT teams include employment and educational services that enable clients to find and keep jobs in integrated work settings. As a result, it is essential to include a dedicated position to lead these strategies.

DATA SOURCES (* Denotes primary data source)

Team Survey

Refer to response to item #1, noting FTE and qualifications.

Excel spreadsheet (column E)

How many clients are reported to be receiving employment and educational services directly from the ACT team?

Chart Review

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 employment specialist have some notation of employment and education services, 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).

Employment Specialist Interview*

Please tell us about your training and experience in delivering employment and educational services.	
Are you connected to a larger employment program within your agency? [If yes, inquire as to how the agency supported employment and education (SEE) program and ACT team are situated within the agency, and the employment specialist's role with both programs. This additional information provides helpful context for the evaluation of the vocational program. Ideally, the employment specialist is a part of a larger SEE program, but is fully integrated on to the ACT team.]	
Do you provide services to non-ACT clients? [If yes:] *Approximately how much of your time is devoted to non-ACT clients?*	

If you were to think of a typical week, what percentage of your time involves some type of employment and educational service, including outreach, engagement, and job development? ***Are you assigned as the primary care provider or coordinator for any clients? If so, how many are individuals who have expressed employment and educational service needs?*** [This additional information provides context for how the specialist(s) may be employed within the team. As needed, further inquire about how caseload assignments are made (as primary, and/or as part of ITTs).] **Note:** Specialists can use opportunities to conduct case management type interventions to engage clients around specialty. Cause for concern is when the specialist has to fill another need on the team, which prevents him or her from providing specialty interventions.	

ITEM RESPONSE CODING

Inclusion Criteria

If two specialists are on the team: It is acceptable and encouraged to consider the cumulative percent of time devoted to specialty services for up to two individuals serving in this specialty role. Please see the note in the rating guidelines section regarding inclusion of team members who may not be formally designated as a specialist, but have assumed more specialty service responsibilities.

Exclusion Criteria

Refer to OS1 for general inclusion and exclusion criteria (e.g., at least 16 hours of week with team, attending at least two daily team meetings per week).

Rating Guidelines and Formula

Several criteria are considered when determining the rating for ST4. These criteria include the following:

1. Reported time in position (i.e., FTE);
2. Actual time devoted to specialty-related activities[1] while in the position; and
3. Qualifications of the specialist(s).

NOTE: Up to two team members may be considered in this rating. Even if the team formally has one team member designated as the employment specialist, evaluators are encouraged to prompt the team leader prior to the fidelity review to determine whether there is any other team member who assumes greater responsibility for delivering employment and educational services (see fidelity review orientation letter in Appendix A). Even if this secondary "employment specialist" does not meet minimal qualifications, they may positively contribute to this rating, which is in the spirit of the team sharing responsibility for services.

To Rate ST4, input data obtained from pre-fidelity survey and interviews into Table 16. Then use these data to complete Steps 1 – 3 below. If only one specialist on team, skip Step 2.

Table 16. Summary of Data Used to Rate Employment Specialist on Team		Employment Specialist	
	Criteria	**Primary Specialist**	**Secondary Specialist (if applicable)**
A	FTE with ACT team (see pre-fidelity survey and interview data; (FTE = # of hours employed with ACT per week / 40))		
B	Time devoted to specialty-related activities[1]: estimated % of client contacts that involve an employment and educational service (interview data, cross-checked with other data sources[2])		
C	Meets minimal qualifications, which entails meeting local standards for certification or licensure as an employment specialist and has at least one year experience providing employment services and/or has advanced education that involved field training in employment and educational services (see under Step #3 below)		

Step 1. Determine Provisional Rating Given the Adjusted FTE (Criteria A and B in Table 16)

***Please refer to the TMACT Calculation Workbook to enter and compute these data.

a. **If *80% or more* of client contacts involve specialist-related activities** (criterion B), per specialist report and other sources[2], **give full credit for the reported FTE on the team** (criterion A). Refer to Table 17 to determine provisional rating (Note: it remains "provisional" because we have yet to examine the impact of qualifications).
Example a1: Specialist is 1.00 FTE (i.e., 40 hrs/wk) and reports that 90% of contacts involve employment specialty and other sources support that estimate, then 1.00 FTE (i.e., actual FTE) is used, which provisionally rates a "5" based on Table 17.

b. **If less than 80% of client contacts involve specialist-related activities** (criterion B), per specialist reports and/or other sources[2], calculate an adjusted FTE, which is then used to determine the provisional rating based on Table 17.

Table 17. Provisional Ratings Following Step 1.

FTE	Rating
1.00 +	5
0.75 – 0.99	4
0.50 – 0.74	3
0.25 – 0.49	2
0.00 – 0.24	1

Calculating the Adjusted FTE =

Full-Time

- **If the specialist is full-time with the team** (i.e., 1.0 for criterion A in Table 16)**:** Add 10 to the estimated percent of time dedicated to specialist role (criterion B in Table 16), and divide by 100.
Example b1: A full-time employment specialist reported, and other data sources corroborated, that 50% of her time was spent providing specialty services. Her adjusted FTE would then be 50 + 10 = 60 / 100 = 0.60 Adjusted FTE, provisionally rating a "3" based on Table 17. (Note: it remains "provisional" because we have yet to examine impact of qualifications)

- **If the specialist is part-time with the team** (i.e., less than 1.0 FTE reported for criterion A in Table 16)**,** use the following formula to calculate the adjusted FTE:

Part-Time

(FTE on team, which is criterion A in Table 16) * (percent of client contacts involving specialty-related activities[1] which is criterion B in Table 16)) +.05.

Example b2: An employment specialist was employed with the team for 24 hours a week, or 0.60 FTE. She estimated that 50% of her time was spent providing specialty services. (0.60 (FTE on team, or criterion A) * 0.50 (representing 50%, or criterion B)) + 0.05 = 0.35 Adjusted FTE, which provisionally rates a "2" based on Table 16.

Step 2. (Only complete if there are two specialists; otherwise skip to Step 3)

Aggregating FTE for Two Specialists: If two specialists are present, then go through Step 1 above for each specialist and add together the total adjusted FTE time and determine provisional rating based on Table 17.

Example c: A team has a designated employment specialist who is full-time (1.0 FTE) with the team. He reported that at least 75% of his client contacts involve employment and educational services; the evaluators could not find data that supported such a high estimate (e.g., only 25% of his chart note entries reflected any specialty services) and agreed that 50% was more accurate.

A second team member was interviewed; this person has been a longtime champion of competitive work and provides various supports for working clients. She works with the team four days a week at 0.80 FTE. She estimated that, of all the clients she meets with in a typical week, approximately 35% involve an employment and educational service. The evaluators found other evidence to support estimate.

Employment specialist 1 (full-time): **(50** (reflecting the 50% estimated time in role) **+ 10** (formula instructions to add "10")**) / 100 = 0.60** Adjusted FTE.

Employment specialist 2 (part-time): (0.80 (reflecting her FTE on the team) *** 0.35** (reflecting 35% time in specialty role)**) + 0.05** = **0.33** Adjusted FTE.

Aggregate Adjusted FTE = 0.60 + 0.33 = 0.93 Total Adjusted FTE (Provisional "4" rating based on Table 17—recall, it remains "provisional" as we have yet to determine impact of qualifications standard).

Step 3. Qualifications Determination for Final Rating (criterion C in Table 16)

a. One specialist on team (see Step 1 examples above):

- **The provisional rating becomes final rating if the following qualifications are met:** Has at least one year experience providing employment services and/or has advanced education that involved field training in employment and educational services. Experience may include time spent in the current position only if specialist is at least 0.50 FTE and at least 65% of client contacts involve specialist-related activities. Preferably the specialist has training or experience in individual placement and support model (i.e., specific form of SEE that emphasized individual preferences and prompt placement in competitive employment).
- **The provisional rating is *adjusted down* to next lowest rating if above minimal qualifications are not met** (i.e., If the specialist in example a did not meet minimal qualifications, then her provisional "5" rating is reduced to a "4" rating; if specialist in example b1 did not meet minimal qualifications, her provisional "3" rating is reduced to a "2" rating).

b. Two Specialists on team (see Step 2 examples above):

- **Two unqualified staff:** The provisional rating is adjusted down to next lowest rating if *both* specialists do not meet above minimal qualifications.
- **One qualified and one unqualified staff:** If one specialist meets qualifications, but the other does not, then the final rating is the higher of the following two options: a) final rating is based solely on the one qualified staff or, b) final rating based on two unqualified staff (i.e., in example c described above, assume that Specialist 1 (adjusted

FTE of.60) met qualifications, but Specialist 2 (adjusted FTE of.33) did not. Their aggregate FTE is 0.93 FTE (provisional "4" rating), and would be reduced to a "3" as one specialist does not meet qualifications (option b). Alternatively, we could rate based only on the one qualified staff, Specialist 1 (option a). However, her adjusted FTE of 0.60 only earns a "3" rating on its own. Thus, in this example, both options result in a "3" rating.

[1] **Specialist-related activities**: Estimated percent of client contacts that involve any activity associated with the specialty area. Qualifying client contacts include those where engagement practices are delivered while providing other case management services, as well as more obvious specialty-related interventions or assessments. To get full credit (i.e., to be rated according to actual FTE with the team), *at least 80%* of client contacts should involve a specialty-related activity.

[2] **Supporting specialists' estimations:** Evaluators are encouraged to consider other data sources to gauge the approximate amount of time spent in specialist activities. Evaluators should first consider the specialist's estimation, then cross-check that estimation with other data sources, such as activities reported in the daily team meeting, noted in the client log, and progress notes. If a significant discrepancy occurs, then evaluators should adjust this percentage, discussing with the specialist if possible to agree on a more accurate percentage of time devoted to specialist activities. Otherwise, evaluators should adjust reported percentage, keeping in mind the following heuristic guidelines:

- For a specialist who provides a *high degree* of employment and educational services (e.g., 80% or more), it is assumed that such a high level of practice will be evident across multiple data sources—e.g., chart review (majority of notes (at least 60%) written by this specialist indicates some employment and educational service), observation of daily team meeting (i.e., reported contacts involving employment and educational services, and scheduled contacts to address client's vocational needs), and a large breadth of employment and educational services are provided.
- For a specialist who provides a *moderate degree* of employment and educational services (e.g., 40% - 60%), it is assumed that a moderate level of practice will be evident across several data sources—e.g., chart review (some notes (e.g., 20% - 60%) written by this specialist indicates employment and educational service), observation of daily team meeting (i.e., reported contacts involving employment and educational services, and scheduled contacts to address client's vocational needs), the breadth of employment and educational services being provided may vary.
- For a specialist who provides a *low degree* of employment and educational services (e.g., 10% - 30%), it is assumed that there will be little evidence of such practice across multiple data sources—e.g., chart review (very few notes (< 20%) written by this specialist indicates some employment and educational service), observation of daily team meeting (i.e., very minimal mention of employment and educational services, if at all), and employment and educational services themselves may be lacking or very limited (e.g., majority of employment and educational services consists of helping clients prepare for job searches, such as resume development and assessment).

	1	2	3	4	5
ST4. Employment Specialist on Team	Less than 0.25 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE employment specialist with at least minimal qualifications.

NOTE: If there is no employment specialist on the team, then rate this item a "1," but do not rate ST5 and ST6 if employment specialist vacancy has been less than 6 months. Also, rate employment specialists hired within past two months on this item, which will likely be a low rating, but do not rate on ST5 and ST6. If hired more than two months before review, rate new specialist on ST5 and ST6.

ST5. Role of Employment Specialist in Services

Definition: The employment specialist provides supported employment & education services. Core services include the following:
(1) Engagement;
(2) Vocational assessment;
(3) Job development;
(4) Job placement (including going back to school, classes);
(5) Job coaching & follow-along supports (including supports in academic settings); and
(6) Benefits counseling.

In addition to the idea of client choice as sole criterion and limited prevocational assessment, there are no requirements for demonstrating "work readiness," (e.g. demonstrating punctuality, participation in work crews).

Rationale: Work is integral to the recovery process for many clients and research has shown that following the core principles of Supported Employment & Education (SEE) lead to better work outcomes for adults with severe mental illness.

The core employment and educational services, which reflect the key principles of the evidence-based SEE model, assessed in this item are included in the table below:

DATA SOURCES (* Denotes primary data source)

Excel spreadsheet (columns E-I, and L)

Examine how many clients are working, where they are working, the type of position, how they got the position, and the number of clients receiving employment and educational services to guide interview questions. Note how many clients may be receiving other services (e.g., clubhouse) and the extent to which they're receiving them in lieu of what the employment specialist and ACT team provides.

Team Leader Interview

Describe the variety of services provided by the employment specialist [Prompt for roles described above.]	
Can you think of any agency policies that get in the way of providing supported employment & education services (e.g., cannot assist when someone is actively abusing drugs)?	

Employment Specialist Interview*	
Can you describe the range of employment and educational services that you provide? [Use their responses to guide whether you ask the questions listed below, and use reflections and summaries as it pertains to below questions as you receive information here.]:	
How do you motivate clients to consider competitive work? [Seek examples of how employment specialist may bring up the subject of work with clients. Also ask if they have received any training in motivational interviewing, and if so, how that is used in engagement.]	
Can you describe the vocational assessment process? *What forms are used? What information is collected?* [Specifically ask if they are using the Career Profile.]	
How is it determined who is assessed and when assessments are completed?	
How is the information that is gathered in the assessment used? [Listen for language pertaining to job search and ongoing supports and ask for examples in who has an assessment and how it has been used. Also ask to see a completed assessment if you do not see one in the chart review.]	

Think about a recent person you helped to get a job or go back to school. What was the timeframe between their voicing interest and subsequent steps (e.g., completing assessment, reaching out to employers, and getting the job)? [Refer to Excel spreadsheet for specific examples of clients the team reported the team assisted in getting a job.] ***Do you do any job development?*** [If a description is needed, job development entails reaching out to local employers and businesses to develop relationships and discover potential right-fit job matches.] [If yes, ask for examples of businesses the specialist has visited for job development, whether a tracking sheet listing dates of contact is maintained that includes person contacted, summary and plan.] [If yes to job development] ***Can you share with me what you say when your approach employers for job development?*** ***What kind of follow-along supports do you provide?*** ***Could you give an example of the last time you did job coaching —when was that?*** *What about follow-along supports or coaching for those clients who are going back to school?* ***What is your understanding of how work may impact benefits, and work incentive programs. Do you provide benefits counseling?*** Ask for examples.	

How many clients are currently working in a competitive setting? (Cross-reference with *Excel spreadsheet*). ***What about clients working in noncompetitive settings (e.g., volunteer, transitional employment, work crews)—what are those settings?***	
How do you help match clients to jobs or placements? (Look for language suggesting that this is a client-driven process; present an ambitious "dream job" scenario to understand the follow-up questions and responses.)	
Of all the businesses employing clients, which one employs the highest number—what number is that? (Response provides some information about job preferences -- e.g., if 50% are employed at the same business, then it is doubtful that they all wanted a similar job.)	
Do you ever help clients go back to school or access courses if they haven't ever been in school? Ask for examples.	
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.]	

Client Interview	
Is there anyone here who is currently working or has worked in past year? Have any of you recently gone back to school? Tell me about your work/school. Did the team help you get and keep that job or stay in school? [Look for examples of how the employment specialist assists clients around employment or school goals and whether there appears to be a focus on competitive employment. Attend to whether there is clear interest in working that is not being addressed by team, esp. employment specialist.]	

ITEM RESPONSE CODING

Rating Guidelines

Primarily rely on information provided by employment specialist (s), but consider all information gathered across sources and investigate discrepancies. Review progress notes of clients who are receiving employment and educational services; these notes may be weekly summary notes. Refer to Table 18 below to determine if criteria are met at all, partially, or fully. If all six services are provided by the employment specialist (s), rate as a "5."

"N/A" Criteria: If no person is hired into the employment specialist position at the time of the review (thereby receiving a "1" rating on ST4), or a recently hired staff person has been in the position for less than two months, then do not rate this item and exclude from ST subscale and Total Score calculations. If a person is hired into position, but still scores a "1" due to not meeting specified criteria, then assess and rate this role item.

Table 18. Role of Employment Specialist in Services

Service	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Service #1: Engage-ment	There is very limited evidence of engagement activities when reviewing multiple data sources (e.g., progress notes, client log, client interviews).	There is some evidence of engagement, but this does not appear to be a result of a planned strategy (e.g., work is conveniently discussed while taking a client shopping). OR There is evidence that *who* is targeted for engagement is based on inconsequential attributes (e.g., sobriety, medication adherence, symptom stability).	The specialist increases clients' interests in the prospect of work and educates them about their opportunities and the benefits of working. There is concerted effort to be scheduled to meet with clients for engagement, even if within the context of delivering another service. Ideally, the specialist is skilled at MI, using such techniques to address ambivalence about working. It is not uncommon for the whole team to assume a larger role in engagement strategies; however, it should not be at the exclusion of the specialist typically taking the lead in most cases.

Table 18. Role of Employment Specialist in Services			
Service	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Service #2: Vocational assess-ment[7]	No vocational assessment is conducted and documented, OR The vocational assessment process is needlessly lengthy and stalls the actual job placement, where more useful assessment data may be collected.	The prevocational assessment is limited in its utility given the information that is gathered, and/or is inconsistently conducted and documented. There is little evidence of attending to client preferences. There is limited appreciation for collecting assessment data while the client is employed. Partial credit is also warranted if the initial assessment is comprehensive but there are no updated assessments.	The specialist conducts assessments to gather information about work history, strengths, and interests, as well as the extent to which symptoms may have interfered with previous jobs. Employment specialist assesses for clients' preferences, especially regarding disclosure of mental illness and degree of employment specialist's involvement. The assessment itself (or Career Profile) serves a living document, guiding both job searches abut also how to provide ongoing supports. Completion of a prevocational assessment should not delay efforts to focus on job placement itself. More useful assessment information is gathered once client has been placed in a job. To receive full credit, vocational assessment data are complete, updated, and reflecting most or all of the information described above.
Service #3: Job develop-ment	Job development is focused on employment that is not competitive. Or job development is not provided, or provided very minimally (e.g., only one or two examples were provided, dating back to previous year).	Some recent examples of job development are provided, but this important task is clearly not prioritized, is not driven by client preferences and/or has artificial parameters (e.g., specialist only conducts job development in limited areas -- geographical, vocational area/employer). Job development is conducted less often than the equivalent of one day a week per 50 clients.	Specialist develops relationships with local businesses through systematic job development and educates them about the services that the employment specialist provides, collects information about positions, and, ideally, determines potential for job carving options (e.g., whether the duties of one part-time position could be broken into two part-time positions). The equivalent of at least one day a week per 50 clients is devoted to job development.
Service #4: Job placement (including going back to school, classes)	Job placement is not customized to meet clients' preferences (e.g., specialist relies on a couple of go-to employers). If specialist considers behaviors or symptoms they believe reflect "work readiness," beyond mere expression of one's desire to work or return to school, such as substance use, medication adherence, and symptom stability, then rate as no credit if "work readiness" criteria appear to significantly impact job placement activities.	Job placement is somewhat customized (i.e., there is attention to preferences, but a reliance on select employers) and/or placement itself is not "rapid" (i.e., there is considerable delay between voiced interest in work and contact with employers). If specialist considers behaviors or symptoms they believe reflect "work readiness" beyond mere expression of one's desire to work or return to school, such as substance use, medication adherence, and symptom stability, then rate partial if "work readiness" criteria appear to minimally impact job placement activities.	Specialist assists clients in locating jobs that meet their preferences, and does so in a rapid manner. There is a relatively short amount of time (fewer than 30 days) between when the client voices interest in working and initial contact with an employer. Specialist assists with completing applications, resumes, and role-playing interviews. This could also include assistance with going back to school or accessing coursework.

[7] Use the Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate the percentage of charts that included a vocational assessment in line with supported employment & education principles.

Table 18. Role of Employment Specialist in Services			
Service	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Service #5: Job coaching & follow-along supports (including supports in academic settings)	Follow-along support is not provided, or on very rare occasion.	Some evidence of follow-along supports was observed, but this activity was clearly limited (e.g., examples reflected phone support with clients, with no examples of face-to-face on/off site job coaching).	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 on-site 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.
Service #6: Benefits counseling	Benefits counseling is not provided by the specialist, or is extremely limited in content and application. Specialist rarely assists clients in obtaining this information from another source.	Specialist's benefits knowledge is limited (e.g., specialist is aware of how benefits are impacted by work, but unaware of programs that may maximize on clients' return, such as PASS), and/or benefits counseling is not widely provided.	Every step of the way, specialist is providing counseling to the client regarding their benefits and how they are affected by varying levels of employment, providing 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 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.

	1	**2**	**3**	**4**	**5**
ST5. Role of Employment Specialist In Services	The employment specialist provides 2 or fewer employment services.	3 employment services are provided (3 are absent) OR 4 services are PARTALLY provided (2 are absent).	4 employment services are provided (2 are absent), but up to 3 services are only PARTIALLY provided OR 5 employment services are provided (1 is absent) OR ALL 6 services are provided, with 4 or more PARTIALLY provided.	ALL 6 employment services are provided, but up to 3 services are only PARTIALLY provided.	ALL 6 employment services are FULLY provided.

ST6. Role of Employment Specialist within Team

Definition: The employment specialist is a key team member in the service planning for clients who want to work or are currently working. The employment specialist performs the following functions WITHIN THE TEAM:
(1) Modeling skills and consultation;
(2) Cross-training to other staff on the team to help them to develop supported employment & education approaches with clients in the team;
(3) Attending all daily team meetings; and
(4) Attending all treatment planning meetings for clients with employment goals.

Rationale: The employment specialist influences fellow team members' practices with clients by motivating team members to discuss work more often with clients, conduct preliminary assessments, and provide ongoing supports.

DATA SOURCES (* Denotes primary data source)

Daily Team Meeting

Observe whether and how the employment specialist contributes to discussions related to employment and/or school during the daily team meeting. Do they appear to be referred to within the team?

Employment Specialist Interview*

How often do you attend the daily team meetings? What do you see as your role in that meeting?	
Do you attend treatment planning meetings for the clients who have employment or education goals? *How do you select the ones you attend?* ***What do you see as your role in that meeting?*** [Prompt for examples.]	
Have you provided more formal trainings to the team related to your area of specialty? [Prompt for details - *when, how often, what was the topic?]*	
Do you ever provide more individual consultation with team members? [If yes:] *How often? Can you give me* an example?	
What parts of your role do you find to be challenging to fulfill or carry out day-to-day?	
What areas of education or training do you think would be helpful for you to do an even better job in your role?	

Clinician Interview	
How has your work with clients been influenced by the employment specialist? *Do they help you in any way to better work with clients who have employment goals? In what ways do you view the employment specialist as a resource to you?*	

ITEM RESPONSE CODING

General Frequency Guidelines

- **Modeling and Consultation**: Modeling includes demonstration of behaviors and attitudes consistent with evidence-based SEE in meetings or in the field. To receive credit, they are not expected to be full-fledged experts in SEE, but are gaining expertise and are viewed as more expert in SEE than other team members. Consultation includes informal and ad hoc assistance with specific clinical cases (i.e., case-based consultation) and/or education specific to the specialist's content area provided frequently, such as at least monthly within the past 6 months.
- **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 four 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 three days a week, then do not credit for this function. Similarly, credit if the specialist works 4x10 hour shifts each week and attends four days per week.
- **Treatment Planning Meetings:** Attends the majority of treatment planning meetings for clients with employment or education goals (long-term or short-term goals/objectives). To receive credit, the specialist attends planning meetings for at least 50% of those with employment or education goals, where such meetings are held every 6 months. If planning meetings are held less often than 6 months, no credit for this function is to be given.

Rating Guidelines

Use the interview with the employment specialist as primary data source. Cross-reference with interview with clinician. Reconcile any discrepancies with follow-up interview questions with the team leader. To receive full credit, the employment specialist provides all four functions within the team.

"N/A" Criteria: If no person is hired into the employment specialist position at the time of the review (thereby receiving a "1" rating on ST4) or a recently hired staff person has been in the position for less than two months, then do not rate this item and exclude from ST subscale and Total Score calculations. If a person is hired into position, but still scores a "1" due to not meeting specified criteria, then assess and rate this role item.

	1	2	3	4	5
ST6. Role of Employment Specialist Within Team	The employment specialist does not perform any of the 4 functions within the team.	1 function is performed within the team.	2 functions are performed within the team.	3 functions are performed within the team.	ALL 4 functions are performed within the team.

ST7. Peer Specialist on Team

Definition: The team has at least 1.0 FTE team member designated as a peer specialist who meets local standards for certification as a peer specialist. If peer certification is unavailable locally, minimal qualifications include the following:
(1) Self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services;
(2) Is in the process of their own recovery; and
(3) Has successfully completed training in wellness management and recovery (WMR) interventions.

Rationale: Peer specialists play an important role within ACT, delivering a range of practices across the service continuum, including WMR services. Some research has concluded that including clients as staff on case management teams improves the practice culture, making it more attuned to client perspectives and person-centered approaches to care.

DATA SOURCES (***** Denotes primary data source)

Team Survey*

Refer to item #1, noting FTE and qualifications. Is there more than one peer specialist on the team?
If there is more than one specialist, then separate out qualified and unqualified FTE time.

Excel spreadsheet (column K)

How many clients are reported to be receiving formal and/or manualized WMR services directly from the team? This may help gauge the percent of time dedicated to specialist role (I.e., whether an adjusted FTE should be calculated), although it is possible that only informal WMR strategies are being used. _____

Chart Review

Cross-walk what peer specialist reports 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 peer specialist have some notation of WMR services, inclusive of assessment and engagement, and both formal and informal WMR?)

Peer Specialist Interview*

Have you completed any formal training in wellness management and recovery interventions? (e.g., peer counselor training, Wellness Recovery Action Plans (WRAP), IMR; note that the peer specialist does not need to have received training in these example interventions to meet criterion #3.)	
What experiences make you qualified to be the team's peer support specialist? [Listen for whether minimal qualifications have been met, and follow-up with additional questions, as needed.]	

Are you assigned as the primary care provider or coordinator for any clients? If so, how many? How did you come to be assigned to be the primary for those clients? [This additional information provides context for how the specialist(s) may be employed within the team.] ***Approximately what percentage of your time is spent providing services specific to your specialty (e.g., WMR services, client advocacy)? In other words, if you were to think of a typical week, what percentage of client contacts involve some type of peer specialist services, including outreach and engagement?*** [Further probe for how much of their time is spent doing basic case management and/or paraprofessional tasks— e.g., medication deliveries, wellness check-ins, and transportation. Although peer-related services can be paired with case management services, they should not be exclusively delivered within the context these services.]	

ITEM RESPONSE CODING

Inclusion Criteria

If two specialists are on the team: It is acceptable and encouraged to consider the cumulative percent of time devoted to specialty services for up to two individuals serving in this specialty role. Please see the note in the rating guidelines section regarding inclusion of team members who may not be formally designated as a specialist, but have assumed more specialty service responsibilities.

Exclusion Criteria

Refer to OS1 for general inclusion and exclusion criteria (e.g., at least 16 hours of week with team, attending at least two daily team meetings per week).

Rating Guidelines

Several criteria are considered when determining the rating for ST7. These criteria include the following:

1. Reported time in position (i.e., FTE);
2. Actual time devoted to specialty-related activities[1] while in the position; and
3. Qualifications of the specialist(s). *See notes following Step 3.*

NOTE: Up to two team members may be considered in this rating. Even if the team formally has one team member designated as the peer specialist, evaluators are encouraged to prompt the team leader prior to the fidelity review to determine whether any other team member who assumes greater responsibility for delivering peer support services (see fidelity review orientation letter in Appendix A). Even if this secondary "peer specialist" does not meet minimal qualifications, they may positively contribute to this rating, which is in the spirit of the team sharing responsibility for services.

To rate ST7, input data obtained from pre-fidelity survey and interviews into Table 19. Then use these data to complete Steps 1 – 3 below.

Table 19. Summary of Data Used to Rate Peer Specialist on Team		Peer Specialist	
	Criteria	**Primary Specialist**	**Secondary Specialist (if applicable)**
A	FTE with ACT Team (see pre-fidelity survey and interview data; (FTE = # of hours employed with ACT per week / 40))		
B	Time devoted to specialty-related activities[†]: estimated % of client contacts that involve a peer support service (interview data, cross-checked with other data sources[‡])		
C	Meets minimal qualifications, which entails meeting local standards for certification as a peer specialist. If peer certification is unavailable locally, minimum qualifications include the following: (1) self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services; (2) is in the process of their own recovery; and (3) has successfully completed training in WMR interventions (see under Step #3 below).		

Step 1. Determine Provisional Rating Given the Adjusted FTE (Criteria A and B in Table 19)

***Please refer to TMACT Calculation Workbook to enter and compute these data.

a. If *80% or more* of client contacts involve specialist-related activities (criterion B, per specialist report and other sources[‡]), **give full credit for the reported FTE on the team (criterion A).** Refer to Table 20 for provisional rating. (Note: it remains "provisional" because we have yet to examine impact of qualifications).

Example a: The specialist is 0.80 FTE (i.e. 32 hrs/wk) and reports that 90% of contacts involve peer specialty and other sources support that estimate, then 0.80 FTE is used (i.e., actual FTE), which provisionally rates a "4" based on Table 20).

b. If less than 80% of client contacts involve specialist-related activities (criterion B), per specialist reports and/or other sources[‡]) calculate an adjusted FTE, which is used to determine the provisional rating based on Table 20.

Table 20. Provisional Ratings Following Step 1.

FTE	Rating
1.00 +	5
0.75 – 0.99	4
0.50 – 0.74	3
0.25 – 0.49	2
0.00 – 0.24	1

Calculating the Adjusted FTE =

- **If the specialist is full-time with the team** (i.e., 1.0 for criterion A in Table 19)**:** Add 10 to the estimated percent of time dedicated to specialist role (criterion B in Table 19), and divide by 100.

  Example b1: A full-time peer support specialist reported, and other data sources corroborated, that 50% of her time was spent providing specialty services. Her adjusted FTE would then be 50 + 10 = 60 / 100 = 0.60 Adjusted FTE, provisionally rating a "3" based on Table 20. (Note: it remains "provisional" because we have yet to examine impact of qualifications)

- **If the specialist is part-time with the team** (i.e., less than 1.0 FTE reported for criterion A in Table 19), use the following formula to calculate the adjusted FTE:

  ((FTE on team, which is criterion A in Table 19) * (percent of client contacts involving specialty-related activities[1], which is criterion B in Table 19)) + 0.05.

  Example b2: A peer support specialist was employed with the team for 24 hours a week, or 0.60 FTE She estimated that 50% of her time was spent providing specialty services.

  (0.60 (FTE on team, or criterion A) *** 0.50** (representing 50%, or criterion B**)) + 0.05 = 0.35** Adjusted FTE, which provisionally rates a "2" based on Table 20.

Step 2. (Only complete if there are two specialists; otherwise skip to Step 3)

Aggregating FTE for Two Specialists: If there are two specialists in position, go through Step 1 for each specialist and add together total adjusted FTE time. Determine provisional rating, Table 20.

Example c: A team has a designated peer support specialist who is full-time (1.0 FTE) with the team. He reported that at least 75% of his client contacts involve peer support services; the evaluators could not find data that supported such a high estimate (e.g., only 25% of his chart note entries reflected any specialty services) and agreed that 50% was more accurate.

A second team member was interviewed; this person has been a recipient of mental health services in the past and has been open about this with clients, as well as assuming some responsibility for leading a WRAP group. She works with the team four days a week at 0.80 FTE. She estimated that, of all the clients she meets with in a typical week, approximately 25% involve a peer support service. The evaluators found other evidence to support that estimate.

Peer Support specialist 1 (full-time): **(50** (reflecting the 50% estimated time in role) **+ 10** (formula instructions to add "10")**) / 100** = **60 / 100 = 0.60** Adjusted FTE.

Peer Support specialist 2 (part-time): (0.80 (reflecting her FTE on the team) *** 0.20** (reflecting 25% time in specialty role)**) + 0.05 = 0.33** Adjusted FTE.

Aggregate Adjusted FTE = 0.60 + 0.33 = 0.93 Total Adjusted FTE (Provisional "4" rating, Table 20 – recall, it remains "provisional" as we have yet to determine impact of qualifications standard)

Step 3. Qualifications Determination for Final Rating (criterion C in Table 19).

One specialist on team (see Step 1 examples above):

- **Provisional rating becomes final rating if the following qualifications are met:** Meets local standards for certification or licensure as a peer specialist. If peer certification is unavailable locally, minimum qualifications include the following: (1) self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services; (2) is in the process of their own recovery; and (3) has successfully completed training in WMR interventions. Although not required, it is preferred that the peer has had similar experiences as ACT clients, such as having recovered from a psychiatric illness common of ACT clients), having been a recipient of public mental health services, and/or has experienced complications typical of living with a serious mental illness, such as hospitalization, stress within the family, and psychotropic medication side effects).
- **Provisional rating is adjusted down to next lowest rating if above minimal qualifications are not met** (i.e., If the specialist in example a did not meet minimal qualifications, her provisional rating of a "4" becomes a "3;" if specialist in example b1 above did not meet minimal qualifications, her provisional "3" rating is reduced to a "2" rating.).

Two Specialists on Team (see Step 2 examples above):

- **Two unqualified staff:** The provisional rating is adjusted down to the next lowest rating if *both* specialists do not meet above minimal qualifications.
- **One qualified and one unqualified staff:** If one specialist meets qualifications, but the other does not, the final rating is the higher of the following two options: a) final rating is based solely on the one qualified staff or, b) final rating based on two unqualified staff (i.e., in example c described above, assume that Specialist 1 (adjusted FTE of 0.60) met qualifications, but Specialist 2 (adjusted FTE of 0.33 FTE) did not. Their aggregate FTE is 0.93 FTE (provisional "4" rating), and would be reduced to a "3" as one specialist does not meet qualifications (option b). Alternatively, we could rate based only on the one qualified staff, Specialist 1 (option a). However, her adjusted FTE of 0.60 only earns a "3" rating on its own. Thus, in this example, both options would result in a "3" rating.

† **Specialist-related activities**: Estimated percent of client contacts that involve any activity associated with the specialty area. Qualifying client contacts include those where engagement practices are delivered while providing other case management

services, as well as more obvious specialty-related interventions or assessments. To get full credit (i.e., to be rated according to actual FTE with the team), *at least 80%* of client contacts should involve a specialty-related activity.

‡**Supporting specialists' estimations:** Evaluators are encouraged to consider other data sources to gauge the approximate amount of time spent in specialist activities. Evaluators should first consider the specialist's estimation, then cross-check that estimation with other data sources, such as activities reported in the daily team meeting, noted in the client log, and progress notes. If a significant discrepancy occurs, evaluators should adjust this percentage, discussing with specialist if possible to agree on a more accurate percentage of time devoted to specialist activities. Otherwise, evaluators should adjust reported percentage, keeping in mind the following heuristic guidelines:

- For a specialist who provides a *high degree* of peer support services (e.g., 80% or more), it is assumed that such a high level of practice will be evident across multiple data sources, reflecting both formal (e.g., WRAP or IMR) and informal wellness interventions—e.g., chart review (majority of notes (at least 60%) written by this specialist indicates some peer support service), observation of daily team meeting (i.e., reported contacts involving WMR and peer support services, and scheduled contacts to address client's WMR needs), and a large breadth of peer support and WMR services being provided. Although informal WMR services can be easily bundled with many case management tasks, including medication deliveries, the expectation is that there are many strategic opportunities for WMR services not attached to such activities.
- For a specialist who provides a *moderate degree* of peer support services (e.g., 40% - 60%), it is assumed that a moderate level of practice will be evident across several data sources—e.g., chart review (some notes (e.g., 20% - 60%) written by this specialist indicates peer support service), observation of daily team meeting (i.e., reported contacts involving peer support services, and scheduled contacts to address client's WMR needs), the breadth of peer support and WMR services being provided may vary.
- For a specialist who provides a *low degree* of peer support services (e.g., 10% - 30%), it is assumed that there will be little evidence of such practice when reviewing multiple data sources—e.g., chart review (very few notes (< 20%) written by this specialist indicates some peer support service), observation of daily team meeting (i.e., very minimal mention of peer support and WMR services, if at all), and peer support services themselves may be lacking or very limited (e.g., majority of peer support services consists of discussions about symptom management). Peer Specialists used primarily to do wellness or symptom checks, medication deliveries, and/or transportation are not to be credited highly if this is the only time they are reporting any WMR interventions.

	1	2	3	4	5
ST7. Peer Specialist on Team	Less than 0.25 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	At least 1.0 (actual or adjusted) FTE peer specialist with at least minimal qualifications.

NOTE: If there is no peer specialist on the team, rate this item as a "1," but do not rate ST8 as long as peer specialist vacancy has been less than 6 months. Also, rate peer support specialists hired within past two months on this item, which will likely be a low rating, but do not rate on ST8. If hired more than two months before review, rate new specialist on ST8 as well.

ST8. Role of Peer Specialist

Definition: The peer specialist performs the following functions:
(1) Coaching and consultation to clients to promote recovery and self-direction (e.g., preparation for role in treatment planning meetings);
(2) Facilitating wellness management and recovery strategies (e.g., Wellness Recovery Action Plans (WRAP), Illness Management and Recovery (IMR), or other deliberate wellness strategies);
(3) Participating in all team activities (e.g., treatment planning, chart notes) equivalent to fellow team members;
(4) Modeling skills for and providing consultation to fellow team members; and
(5) Providing cross-training to other team members in recovery principles and strategies.

Rationale: Some research has concluded that including clients as staff on case management teams improves the practice culture, making it more attuned to client perspectives.

DATA SOURCES (* Denotes primary data source)

Team Survey

Review team's response to item #13 regarding whether the peer specialist facilitates any groups.

Excel spreadsheet (column K)

Examine whether and how many clients receive manualized WMR services directly from the ACT team, and the type of service(s) provided. Use this information to guide interview questions below.

Daily Team Meeting

Observe whether and how the peer specialist contributes to discussions related to WMR services and principles during the daily team meeting. Do they appear to be referred to within the team for guidance and/or consultation?

Team Leader Interview

Are there activities or services the peer specialist is not allowed to do that most other team members are engaging in? *Can they access client records, contribute to treatment planning and assessment, document contacts in progress notes?* [Query for whether the peer specialist can serve as the primary care coordinator for clients —if not, is the reason applicable to qualifications that apply to other non-peer staff (e.g., minimal educational qualifications)?]	
Describe the variety of services provided by the peer specialist. [Prompt for roles described above.]	

Peer Specialist Interview*	
How would you describe your relationship with the individuals served by the ACT team—how do you view them and how do you think they view you?	
What kind of services do you provide to clients? [Use their response to guide whether/how to ask any of the following questions. Refer to Functions #1 and #2 (esp. informal WMR) in Table 21. Also note whether any specific groups facilitated by the peer specialist are listed in the team's response to item #13 in the Team Survey.]	
Can you tell us more about any wellness management and recovery services you provide to clients *[prompt for WRAP, IMR, or any other manualized approach]****? In what ways do you use*** [insert whatever formal, manualized, WMR they reported using]***? How often do you provide these services?***	
Are you familiar with what a psychiatric advanced directive is? Have you assisted clients in completing a psychiatric advanced directive? [Prompt for examples.]	
What do you think is the most important function of your role as the peer specialist? [Prompt for whether and how a recovery philosophy is steering the peer specialist's practice in how they work with clients.]	
To what extent have you helped clients understand their own role in their treatment or prepare for their treatment planning meetings?	

Have you worked with someone who was not interested in taking some or all of their medications? Can you describe for me the types of conversations you've had with them about these decisions [or what types of conversations you imagine having if you have not yet such clients]**?** ***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.] ***What parts of your role do you find to be challenging to fulfill or carry out day-to-day?*** ***What areas of education or training do you think would be helpful for you to do an even better job in your role?***	

Clinician Interview	
How has your work with clients been influenced by the peer specialist? Do you view the peer specialist as a resource? ***Has the peer specialist shared any aspects of their own personal recovery story?***	
Client Interview	
Do you know who the team peer specialist is—*[Insert the name of the peer specialist if no one knows]****? How often do you see the team peer specialist?*** ***What kinds of things do you talk about with the peer specialist? How have they helped you?*** ***Do you have a relapse prevention plan? Did anyone help you create this plan?***	

ITEM RESPONSE CODING:

General Frequency Guidelines

- **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.
- **Modeling and Consultation**: Modeling includes demonstration of behaviors and attitudes consistent with a recovery-oriented, wellness management approach to service delivery. Such modeling may occur meetings or in the field. Consultation includes informal and ad hoc assistance with specific clinical cases (i.e., case-based consultation). To receive credit for Modeling and Consultation, the peer specialist must clearly embrace and model a recovery philosophy.

Rating Guidelines

Use Table 21 below to guide ratings. Use peer specialist interview as primary data source, with client interviews and chart reviews to back-up conclusions. If the peer specialist fulfills all four functions within the team, rate as a "5." Cross-training should be provided within the past 6 months.

"N/A" Criteria: If no person is hired into the peer support specialist position at the time of the review (thereby receiving a "1" rating on ST7) or a recently hired staff person has been in the position for less than two months, then do not rate this item and exclude from ST subscale and Total Score calculations. If a person is hired into position, but still scores a "1" due to not meeting specified criteria, then assess and rate this role item.

Table 21. Role of Peer Specialist			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #1: Coaching and consultation to clients to promote recovery, self-direction, and independence	There is no evidence that the peer specialist provides any coaching or consultation to clients to promote recovery and self-direction.	The peer specialist provides some coaching and consultation to clients to promote recovery and self-direction, but it is less consistently provided.	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., ADLs), safety planning, transportation planning/navigation skill-building, money management).
Function #2: Facilitating WMR strategies	There is no evidence that the peer specialist is facilitating any specific wellness management strategies with clients served on the team.	The peer specialist provides some WMR services, but it is limited (e.g., they are only working with a few clients on WRAP or IMR or provide fewer informal WMR 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 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.

Table 21. Role of Peer Specialist			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #3: Participating in all team activities equivalent to fellow team members	There is evidence that the peer specialist does not fully participate in all team activities as is consistent with other team members. There may be one or more limitations and the peer specialist does not appear to be treated as an equal among other staff.	There is one limitation in the role of the peer specialist as compared to other team members, but the peer specialist appears to be treated as an equal among other professionals, per observations and interviews.	The peer specialist is treated just like other team members and fully and actively participates in all team activities such as: • Daily team meetings; • Treatment planning meetings; • Documentation within clients' charts; • Community-based contacts with clients; • Assignment as a "primary" for various interventions indicated within the treatment plan given that applicable qualifications are met to assume such a role; In some states or agencies, peer specialists do not provide crisis coverage, which would be an acceptable exception. Further, any exclusion from team activities is due to qualifications that go beyond the peer status alone.
Function #4: Modeling skills for and providing consultation to fellow team members	The peer specialist does not provide modeling or consultation to other team members.	The peer specialist provides modeling and consultation to other team members but it is either inconsistently provided or inconsistently reported by other team members OR The peer specialist provides either modeling or consultation, but not both.	The peer specialist regularly provides modeling and consultation, as consistently reported by other team members as well as the peer specialist. Modeling and consultation must reflect a recovery philosophy. **Modeling** includes demonstration of behaviors and attitudes consistent with recovery-oriented and WMR services in the daily team meeting and other meetings or in the field. To get full credit, other team members are influenced by the peer's words and actions. **Consultation** includes informal and ad hoc assistance with specific clinical cases (i.e., case-based consultation) provided at least monthly within the past six months. To get full credit, others see the peer as a helpful resource and seek the peer out for information and guidance.
Function #5: Providing cross-training to other team members in recovery principles and strategies	Peer specialist does not provide cross-training or has not within the past six months.	Peer specialist has provided some cross-training, but it has only been to a few team members or less than 20 minutes in duration in the past six months.	Peer specialist consistently provides cross-training in recovery principles and strategies. **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.

	1	**2**	**3**	**4**	**5**
ST8. Role of Peer Specialist	The peer specialist performs 1 or fewer functions on the team.	2 functions are FULLY performed (3 are absent) OR 2 to 3 functions performed, 1 to 2 PARTIALLY.	3 functions are FULLY performed (2 are absent or PARTIAL) OR 4 to 5 functions PARTIALLY.	4 functions are FULLY performed (1 is absent or PARTIAL).	ALL 5 functions are FULLY performed.

CP1. Community-Based Services

Definition: The team works to monitor status and develop skills in the community, rather than in-office. The team is oriented to bringing services to the client, who, for various reasons, has not effectively been served by office-based treatment.

Rationale: Contacts in natural settings (i.e., where clients live, work, and interact with other people) are thought to be more effective than when they occur in hospital or office settings, as skills may not transfer well to natural settings. Furthermore, the clinician can conduct a more accurate assessment of his or her community setting as the clinician can make direct observations rather than relying on self-report. Medication delivery, crisis intervention, and networking are more easily accomplished through home visits.

DATA SOURCES (* Denotes primary data source)

Chart Review* - Chart Review Log Part I (p. 195-196) and Chart Review Tally Sheet Part I (p.197-198)

Calculate the ratio of face-to-face community-based contacts to the total number of face-to-face contacts across the randomly selected charts reviewed. Then determine the median proportion of community-based contacts across the sample (e.g., in a 10-chart sample, this would be the average of the 5th and 6th values when the percentage of contacts in the community are rank-ordered). Remember to use the most complete and up-to-date time period from the chart within a four-week (i.e., 28-day) calendar period. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation.

ITEM RESPONSE CODING

Rating Guidelines

Exclude charts with no contacts in that four-week period from the final tally. In scoring this item, only count face-to-face contacts with clients. Do not count phone calls and do not count contacts with collaterals or family members. Use chart review as the primary data source. Evaluator may judge whether select contacts should be included given the meaningfulness of contacts; e.g., a team leader documents a contact that appears to be an unplanned run-in at the agency, with no apparent purpose. If the information from different sources is inconsistent, ask the team leader to help you understand the discrepancy. If at least 75% of total service time occurs in the community, the item is coded as a "5."

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).

Exclude charts with no contacts in that four-week period from the final tally

Formula

Use the Chart Review Tally Sheet or TMACT Calculation Workbook to enter and compute these data.

	1	2	3	4	5
CP1. Community-Based Services	Less than 40% of face-to-face contacts in community.	40 - 54%	55 - 64%	65 - 74%	At least 75% of total face-to-face contacts in community.

CP2. Assertive Engagement Mechanisms

Definition: The team uses an array of techniques to engage difficult-to-treat clients. These techniques include the following:
(1) Collaborative, motivational interventions to engage clients and build intrinsic motivation for receiving services from the team, and, where necessary; and
(2) Therapeutic limit-setting interventions to create extrinsic motivation for receiving services deemed necessary to prevent harm to client or others.

When therapeutic limit-setting interventions are used, there is a focus on instilling autonomy as quickly as possible. In addition to being proficient in a range of engagement interventions, (3) the team has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of chosen techniques, and modifying approach when indicated.

Rationale: Unlike some community-based programs, ACT clients are not discharged from the program due to failure to keep appointments or not participating in treatment, even if present. Retention of clients is a high priority for ACT teams. Persistent, caring attempts to engage clients in treatment helps foster a trusting relationship between the client and the ACT team. Therapeutic limit-setting interventions may be necessary during initial engagement if collaborative interventions fail and risks are too high. When used, therapeutic limit-setting interventions are eventually titrated down to more collaborative interventions to promote empowerment and autonomy.

DATA SOURCES (* Denotes primary data source)

Excel spreadsheet (columns R, S, T, and U)

Examine whether any clients have housing leases specifying that treatment participation is a condition of their housing. How many clients are on involuntary outpatient commitment and/or conditional release? How many clients have a representative payee? How many of those payeeships are held by the team/agency, and to what extent is money managed? How many clients have a guardian? Use this information, which primarily reflects potential therapeutic limit-setting, to guide interview questions below.

Team Leader Interview*

For this item, it is particularly useful to have reviewed charts and observed practice before interviewing staff about the use of assertive engagement. Interview questions listed below are a general guide to getting at some of the information needed to rate this item. However, interview questions are ideally directed by specific examples of clients noted to have received (or not, but clearly needed) assertive engagement practices. Therefore, we recommend readdressing this question with team leader, and other staff, near the end of the evaluation.

How does the team try to keep clients involved in ACT when it is clear that they need ACT services, but are either actively or passively refusing these services? [The focus of interview questions should remain on the team's work with clients who clearly needed ACT, but with whom the team has or had difficulty either physically accessing or interpersonally engaging. Do not focus on clients who are challenging to work with, but are electing to participate in services.]	

Think of 2-3 clients [Or offer examples, as identified through the course of the evaluation] ***who have been hard to engage in the past 6 months. Describe the team's engagement efforts with each of these clients.*** [Engagement refers to the process of having access to a client to determine service needs and wants, and develop a relationship that will encourage service delivery. It includes clients who do not make themselves physically available for contacts, as well as those who are physically available, but unwilling to participate in meaningful service activities.] ***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 to keep them in ACT services?*** [Cross-reference with responses to column S in the Excel spreadsheet regarding the number of clients on involuntary outpatient commitment or conditional release. Prompt if there are discrepancies.]	

Do you have a method for identifying and tracking clients in a tenuous engagement phase —how is this done? What do you do with such information? ***How do you identify clients in need of a different engagement tactic than the one the team has been using?*** [Attend to the extent to which the team has a reliable process in place that allows for timely modification of the assertive engagement strategy—e.g., changing up to a new motivational strategy when previous one is failing; moving from a motivational strategy to a more therapeutic limit-setting strategy when risks are increasing; moving from a therapeutic limit-setting to a less restrictive, more motivational approach to help preserve client autonomy.]	
Clinician Interview	
How has your team successfully and/or attempted to engage individuals who clearly needed ACT, but were not wanting ACT services? ***What considerations did the team have when working with these clients?*** *How has the team attempted to engage the client into services to better assure positive outcomes and reduce the chance of harmful effects of lack of treatment? What techniques does the team use to reach out to clients? Can you think of a person the team debated as to how to best engage them in service—and what ideas were put forth by the team?* [Look for language that suggests MI or therapeutic limit-setting techniques and follow-up with additional questions as needed. Try to anchor conversation in specific examples. It is important to give them an opportunity to offer a range of techniques.]	

[If no therapeutic limit-setting techniques are offered on their 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 our increasing? What then is the team willing to do to engage such clients?***	
Daily Team Meeting	
Listen for clients reported on who appear to be difficult to engage. Does the team set aside time to plan for how to work with these clients, either very briefly during the meeting or by scheduling a follow-up meeting with other team members? Does the team tend to automatically fall back on controlling methods (e.g., outpatient commitment, payee arrangements) in planning how to engage clients? Is there a spirit of creativity and planning around clients who appear to be disengaged?	

ITEM RESPONSE CODING
Rating Guidelines
(1) **Motivational interventions:** A collaborative and non-confrontational approach is the hallmark of MI interventions used to engage clients. The aim is to enhance clients' intrinsic motivation for accessing services from the team. The focus of these interventions is figuring out what is important to the client, what it is that they need/want, and offer assistance in meeting those needs/wants. By getting a foot in the door, so to speak, the ACT team can then work on building rapport and using more MI interventions, such as acknowledging a client's ambivalence around receiving services and expressing empathy and developing discrepancy between a client's expressed goals and current behavior. As motivational interventions should seek to tap something individual about that client, they are often creative. For the sake of rating teams on this item, creative use of inducements (behavioral modification using a reward system) may qualify as a motivational intervention. (2) **Therapeutic limit-setting:** Therapeutic limit-setting interventions are influencing tactics used to ensure that treatment needs are met in the least restrictive setting and while risk of harm to self or others is minimized. These interventions, which aim to create extrinsic motivation to access services, may limit or threaten to limit a client's self-determination in various life areas (e.g., interpersonal pressures may be used to increase medication adherence, access to money or housing may be leveraged against treatment participation, involuntary commitment to treatment may be sought if client meets local judicial criteria). When motivational interventions have not worked and/or safety concerns do not permit extensive trials of motivational interventions, therapeutic limit-setting interventions may need to be employed. (3) **Thoughtful application and withdrawal of engagement practices:** The team has a process for detecting when they may need to try a different approach due to client's poor response to engagement tactics. This process may be most evident in the daily team meeting where services are tracked. One intent of this item is to determine *how* the team identifies *when* their engagement strategies are not effective and therefore in need of revision (e.g., if a team continues to attempt to meet with a client at his home for two weeks without success, at what point does the team revise their approach given the lack of success?). Credit for this practice is needed to rate a "5." Use the team leader interview as the <u>primary</u> data source. Corroborate with observations made during the daily team meeting, chart reviews, and other identified data sources. Refer to Table 22 below to determine if no, partial, or full credit is met for each criterion. If the team is skilled at employing motivational and collaborative interventions to engage clients, but uses therapeutic limit-setting interventions where necessary, AND is thoughtful about when to apply and withdraw these techniques, the item is coded as a "5." <u>Exclusive use of Motivational (Practice #1) or Therapeutic limit-setting (Practice #2) interventions (Rating of "2").</u> Teams that employ therapeutic limit-setting interventions with difficult-to-engage clients (meeting either Full or Partial criteria) with few clear and convincing examples of motivational interventions will likely leave the impression of a highly custodial, paternalistic, and/or coercive team. Although their practices are driven by concern for the client, they tend to heavily rely on strategies that force the client to accept services and prefer to avoid perceived risks that may accompany the use of motivational interventions. Alternatively, teams that employ only motivational interventions (Full or Partial criteria) with no to very few clear and convincing examples of therapeutic limit-setting strategies may leave the impression of a clinically negligent team. The team's concern for undermining client's autonomy and risking damage to the therapeutic relationship consistently overrides the decision to use leverages to help the client avoid further harm. Because teams who are exceptionally skillful in their use of motivational interventions (clear full credit for #1) also may have less need for therapeutic limit-setting; be sure to fully explore what the team is prepared to do in their use of therapeutic limit-setting (i.e., thereby rating higher on this item).

Table 22. Assertive Engagement Mechanisms			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Practice #1: motivational interventions	Motivational interventions are very rarely or not used to engage clients. Examples were few, lacking detail and/or creativity, and situations that would likely benefit from such interventions were observed in the data.	Team uses motivational interventions with the aim of engaging clients who need ACT services, but are passively or actively refusing services, in a limited manner. One or two strategies or techniques were provided (e.g., taking clients out to coffee or lunch, and changing up who saw the client), and/or missed opportunities for such engagement were observed.	Team clearly uses an array of motivational interventions to work with clients who are difficult to engage. There are several robust examples reflecting collaborative and creative approaches to engage client in maintaining contact with the team to receive services. Examples must represent more than two strategies or techniques and go beyond less creative efforts, such as changing up staff who attempt to meet with the client. The following are some descriptive examples of motivational interventions used to engage clients: • persistent, patient efforts to meet with a paranoid and socially anxious woman who refused to speak face-to-face with staff. This included showing up at her apartment at regular times several days a week to offer services, such as running needed errands, and offering to take her out to a local knitting circle since she previously indicated that she liked to knit; • assisting a recently evicted man to find and move to a new residence, while using the increased contact time to discuss how his not taking medications may have created some of the problems leading to eviction; • to develop trust and assess for safety, bringing food to a recently enrolled woman who is staying at the shelter and continuing to prostitute for drugs.
Practice #2: therapeutic limit-setting	Therapeutic limit-setting interventions are very rarely or not used to engage clients. Examples were few, lacking detail and/or creativity, and situations that would likely benefit from such interventions were observed in the data.	Team uses therapeutic limit-setting with the aim of engaging clients who need ACT services, but are passively or actively refusing services, in a limited manner. One or two strategies or techniques (e.g., using representative payee role to leverage treatment participation) were provided, and/or missed opportunities for such engagement were observed. *Note: A team may be extremely adept at using more motivational interventions to engage clients and very rarely need to resort to therapeutic limit-setting, therefore	Team clearly uses an array of therapeutic limit-setting interventions to work with clients who are difficult to engage, or is willing to use an array of techniques if skillful at Practice #1. Evaluators observed robust examples of the team maximizing clients' extrinsic motivation to maintain contact with the team to receive services. Examples must represent more than two strategies or techniques. The following are some descriptive examples of therapeutic limit-setting interventions used to engage clients: • coordinating closely with a disengaged and decompensating client's representative payee to associate timing of more frequent disbursements with team contact for the purpose of increased contact; • working closely with a client's probation officer to arrange for a supervised living residence with stipulations around abstinence and medication adherence; • petitioning for involuntary inpatient commitment of a female client who, after months of living in a shelter and prostituting for drugs during an emerging manic episode, increasingly puts her

Table 22. Assertive Engagement Mechanisms			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
		having few examples to provide. Such a team may get full credit as long as data suggest that the team is willing and able to employ these more restrictive tactics, when needed.	safety at risk and is unresponsive to team's engagement efforts to offer to move to more stable housing—upon hospital discharge, team assisted in her moving into a temporary supervised apartment while she remained on a conditional release.
Practice #3: thoughtful application and withdrawal of engagement practices (Relevant for differen-tiating "4" and "5" ratings)	There is no clear and systematic process being used for tracking the need for and success of team's engagement efforts, ultimately steering team's engagement efforts. Teams who are negligent of this identification process and/or who are not proficient in engagement tactics, may have a higher drop out rate (see item OS10).	No partial credit option.	Team leader was able to clearly articulate a process for tracking the team's engagement efforts, such as by periodically reviewing the daily log and meeting as an ITT to review strategies, response, and plan for new engagement approaches. For example, team leader provided a specific example of how this process resulted in a modification of the team's approach to working with a woman residing in a shelter who was not responding to motivational interventions and required a more deliberate and forceful approach to ensure safety. *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.

	1	**2**	**3**	**4**	**5**
CP2. Assertive Engagement Mechanisms	Very little assertive engagement is evident (#1 and #2 are largely absent).	Team primarily relies on #1 OR #2, not both (1 approach is FULLY or PARTIALLY used and 1 is not used at all (No Credit)).	A more limited array of assertive engagement strategies is used (PARTIAL #1 and #2).	Team uses #1 and #2 (at least 1 approach is FULLY used). Thoughtful application/ withdrawal of engagement strategies is significantly lacking or absent (#3 is absent).	Team is proficient in assertive engagement strategies, including thoughtful application/ withdrawal of engagement strategies, applying all 3 practices.

CP3. Intensity of Service

Definition: The team delivers a high amount of face-to-face service time as needed.

Rationale: To help clients with severe and persistent symptoms maintain and improve their functioning within the community, addressing a broad range of life goals and providing extensive therapeutic and rehabilitative interventions, a high service intensity is often required.

DATA SOURCES (* Denotes primary data source)

Chart Review* - Chart Review Log Part I (p. 195-196) and Chart Review Tally Sheet Part I (p.197-198)

Use the same charts as used for Item CP1. Calculate the mean amount of service hours per client, per week, over a month-long period. (If applicable, the charts should proportionately represent the number of clients who have "stepped down" in program intensity. Teams are queried whether they have their own scaling system used internally, which can guide random chart selection) From the mean values over a four-week period, determine the median number of service hours across the sample (e.g., in a one chart sample, this would be the average of the 5th and 6th values when the mean service hours per week are rank-ordered). Remember to use the most complete and up-to-date time period from the chart during a recent four-week (i.e., 28 day) time frame. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation. See TMACT Part I for guidance in how to use a complete client population data from an electronic medical record query.

ITEM RESPONSE CODING

Rating Guidelines

- In scoring this item, only count face-to-face contacts with clients. Do not count phone calls and do not count contacts with collaterals or family members.
- The evaluator may judge whether select contacts should be included at all in the chart tally given the quality of contacts (e.g., a team leader documents a contact that appears to be an unplanned run-in at the agency, with no apparent purpose).
- As this rating can be inflated by overuse of practices that deviate from more person-centered care (e.g., high use of office-based recreational groups), rate according to the data and consider providing qualitative feedback.
- 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.

Use chart review as the primary data source. If the information from various sources is inconsistent, ask the team leader to help you understand the discrepancy.

Formula

Use the Chart Review Tally Sheet or TMACT Calculation Workbook to enter and compute these data.

	1	2	3	4	5
CP3. Intensity of Service	Average of less than 15 min/week or less of face-to-face contact per client.	15 - 49 minutes/week.	50 - 84 minutes/week.	85 - 119 minutes/week.	Average of 2 hours/week or more of face-to-face contact per client.

CP4. Frequency of Contact

Definition: The team delivers a high number of face-to-face service contacts, as needed.

Rationale: ACT clients require more intensive follow-up and ACT teams are to be the sole provider of a range of biopsychosocial services. ACT teams are highly invested and maintain frequent contact to provide ongoing, responsive support as needed. Frequent contacts are associated with improved client outcomes.

DATA SOURCES (* Denotes primary data source)

Chart Review* - Chart Review Log Part I (p. 195-196) and Chart Review Tally Sheet Part I (p.197-198)

Use the same charts as used for Item CP3. Calculate the mean number of face-to-face client-ACT service contacts, per week, over a month-long period. From the calculated mean values, determine the median number of service contacts across the sample (e.g., in a 10-chart sample, this would be the average of the 5th and 6th values when the mean service contacts per week are rank-ordered). Remember to use the most complete and up-to-date period during a recent 4-week time frame. Ask the team leader, clinicians, or an administrative person for the most recent and complete period of documentation.

Team Leader Interview

How many clients are scheduled to be seen four or more times a week?	
What are some of the reasons for such high number of visits?	
Who is seen least often, per the schedule? [Further query for the number of clients who are scheduled to be seen less than once per week and the reasons for this level of care. This information can help provide context for what is observed in the chart review, especially as to the flexibility of services in general and the reason for the level of care provided. Such information may be used in qualitative feedback.]	

ITEM RESPONSE CODING
Rating Guidelines
• Only count face-to-face contacts with clients. Do not count phone calls or contacts with collaterals or family members. • If a client receives several consecutive contacts across staff, judge whether these contacts are meaningfully differentiated. If they are not, count a series of consecutive contacts in one day with multiple staff as one contact for that day. • The evaluator may judge whether select contacts should be included at all in the chart tally given the quality of contacts (e.g., a team leader documents a contact that appears to be an unplanned run-in at the agency, with no apparent purpose). • Attend to high frequency contacts that detract from person-centered, recovery-oriented services (e.g., clients receiving frequent contacts centered solely on medication and money management services). Although we do not recommend adjusting the rating and continuing to rate given the data, we do recommend providing qualitative feedback. Use chart review as the primary data source. If the information from different sources is inconsistent, ask the team leader to help you understand the discrepancy.
Formula
Use the Chart Review Tally Sheet or TMACT Calculation Workbook to enter and compute these data.

	1	2	3	4	5
CP4. Frequency of Contact	Average of less than 0.5 face-to-face contact / week or fewer per client.	0.6 - 1.3 / week.	1.4 - 2.1 / week.	2.2 - 2.9 / week.	Average of 3 or more face-to-face contacts / week per client.

CP5. Frequency of Contact with Natural Supports

Definition: The team has access to clients' natural supports. These supports either already existed, and/or resulted from the team's efforts to help clients develop natural supports. Natural supports include people in the client's life who are NOT paid service providers (e.g., family, friends, landlord, employer, clergy).

Rationale: Developing and maintaining community support further enhances client's community integration and Many studies have found that other evidence-based practices are enhanced when the family and other natural supports are involved in treatment.

DATA SOURCES (* Denotes primary data source)

Excel spreadsheet (column X)*

Review for number of contacts with clients' natural supports.

Team Leader Interview

Refer to Excel spreadsheet (column X): ***In looking at your team's contact with clients' natural supports, I just need to confirm that these do NOT include contacts with paid service providers*** (e.g., primary care physicians, parole officers, and employed payees). Some discretion may be used here, such as a primary care physician may be truly operating as a natural support to the client.	

ITEM RESPONSE CODING

Rating Guidelines

Use Excel spreadsheet as primary data source. Include **all contacts** (i.e., face-to-face, telephone, and email) with family, friends, landlord, and employer; exclude persons who are paid to provide assistance to the client, such as Social Security Disability or Department of Human Services representatives. Tabulate the percent of clients who the team reports at least once a month contact with natural support system. If the reported number is high (at least 76%), seek corroboration from other sources, including some evidence in chart documentation.

	1	2	3	4	5
CP5. Frequency of Contact with Natural Supports	For less than 25% of clients, the natural support system is contacted by team at least 1 time per month.	26% - 50%	51% - 75%	76% -89%	For at least 90% of clients, the natural support system is contacted by team at least 1 time per month.

CP6. Responsibility for Crisis Services

Definition: The team has 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria: (1) The team is available to clients in crisis 24 hours a day, seven days a week; (2) The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging); (3) The team accesses practical, individualized crisis plans to help them address crises for each client; and (4) The team is able and willing to respond to crises in person, when needed.

Rationale: An immediate response can help minimize distress when persons with severe mental illness are faced with crisis. When the ACT team provides crisis intervention, which should be informed by previous crisis planning with ACT clients, continuity of care is maintained.

DATA SOURCES (* denotes primary data source)

Chart Review - Chart Review Log Part II (p. 197-198) and Chart Review Tally Sheet Part II (p.201-202)

A crisis plan is considered "practical" if it is individualized (i.e., reflecting the client's unique circumstances and preferences) and provides the necessary information to guide how to best respond to the client when they are in a crisis.

Team Leader Interview*

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?	

Client Interview	
If you find yourself experiencing a crisis, what would you do and who would you reach out to? [Prompt for whether they would access the team, specifically the crisis on-call—do they know the crisis hotline number?] ***What has been your experience with getting help from the team when you were in a crisis?*** [Did the client find the team to be helpful and accessible?] ***Do you recall creating a plan with the team for how to best help you when you are experiencing a crisis?*** [If yes:] ***Do you feel like that plan has been helpful?***	

ITEM RESPONSE CODING

Rating Guidelines

Refer to Table 23 to determine if no, partial, or full credit was met for each criterion. Of note, a team that shares responsibility for crisis services across other programs within the agency should be rated lower (e.g., criterion #1 is no credit as there are times non-ACT staff are the on-call; and criterion #2 is likely a no or partial credit as there are times when non-ACT staff are not directly receiving calls, if at all).

Table 23. Responsibility for Crisis Services

Criteria	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: The team is available to clients in crisis 24 hours a day, seven days a week	The team is unavailable to clients in crisis at all times (i.e. the team maintains a more limited crisis on-call schedule, such as between four and midnight, or may share this responsibility across other agency programs leaving blocks of time with no ACT team staff as on-call). The team may solely use a third party for receiving all crisis calls.	No partial credit option.	The team is available to clients in crisis at all times, 24 hours a day, seven days a week.

Criterion #2: The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging)	The team is not the first-line crisis evaluator and responder. A third party receives all calls and handles the majority of them. There may be some cases where the team intervenes, but that is more the exception.	A third party (whether internal or external to provider agency) receives all crisis calls and conducts assessment beyond identifying client as an ACT service recipient. The result is that while the ACT team does receive many crisis calls, some do not get patched through to the ACT crisis on-call during after-hours.	When a client calls the crisis line, they either immediately reach the ACT team or are promptly patched through to the ACT team with nearly no screening. Because the ACT team has more assessment and treatment information regarding each client and it is available at all times, it is critical that the team is primarily responsible for determining whether a situation is an actual emergency or not.
Criterion #3: The team accesses practical, individualized crisis plans[8]	Clients do not have practical crisis plans, OR clients do have practical crisis plans, but this information is not accessible to on-call staff person.	Crisis plans existed and were accessible to staff, but lacked the level of information needed to make them useful (e.g., crisis triggers or warning signs, effective coping mechanisms, less restrictive crisis respite options); OR Practical crisis plans existed, but: • Were located in less than 65% of reviewed charts; AND • Crisis plan information was accessible to the on-call staff person.	Crisis plans: • A practical crisis plan (e.g., reflected useful information to address crises for each client) was identified in at least 65% if the reviewed charts; AND • Crisis plan information was accessible to the on-call staff person. *Note that WRAP, IMR, and psychiatric advance directives may lend to the development of practical crisis plans, which would count here.
Criterion #4: The team is able and willing to respond to crises in person, when needed	The team is unable or unwilling to respond to crises in person. No or very few examples are provided.	The team reports being willing to respond to a crisis call in person during after-hours, but with hesitation. The team provides some examples, but it appears that face-to-face contact is used as an absolute last resort.	In addition to the team responding to client crises via phone, the team assesses the need for whether an in-person contact is needed to either conduct further assessment to determine safety and need for hospitalization or address crisis. In such instances, depending on the situation, the team ideally has a protocol to assure that staff safety is also attended to when in-person response is needed.

	1	2	3	4	5
CP6. Responsibility for Crisis Services	Team has no responsibility for directly handling crises after-hours.	Team meets up to 2 criteria at least PARTIALLY OR criterion #1 is not met.	Team meets criterion #1 and at least PARTIALLY meets 2 to 3 criteria.	Team meets 3 criteria FULLY and 1 PARTIALLY.	Team FULLY meets all 4 criteria.

[8] Use the Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate the percentage of charts that include a practical crisis plan

CP7. Full Responsibility for Psychiatric Services

Definition: The team assumes responsibility for providing psychiatric services to clients, where there is little need for clients to have to access such services outside of the team. The psychiatric care provider assumes most of the responsibility for psychiatric services. However, the team's role in medication administration and monitoring are also considered in this assessment, especially when evaluating psychiatric services provided to clients residing in supervised settings where non-ACT staff also manage medications; the expectation is that ACT staff play an active role in monitoring medication management even when a client is in a residential setting.

CP8. Full Responsibility for Psychiatric Rehabilitation Services

Definition: These services focus on targeted skills training in the areas of community living, which includes skills needed to maintain independent living (e.g., shopping, cooking, cleaning, budgeting, and transportation) and socialization (e.g., enhancing social and/or romantic relationships, recreational and leisure pursuits that contribute to community integration). Psychiatric rehabilitation should address functional deficits, environment, as well as the lack of necessary resources, all of which are identified through the assessment process. As such, deliberate and consistent skills training which typically includes staff demonstration, client practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings. Psychiatric rehabilitation services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, and weekly client schedules).

Rationale for CP7 and CP8: The ACT team is ideally equipped to provide quality services across a range of treatment domains so that clients with relevant needs are well-served and do not have to access these services externally. Creating a one-stop service team should theoretically eliminate communication problems and lead to a more seamless service system working to meet clients' goals. Clients should have the option to receive select services elsewhere, but it is expected that the percentage of clients doing so would be low given that the team is adequately providing the service themselves and meeting clients' needs. Team limitations (e.g., lack of staff to provide service, lack of skills, and lack of time) are not a good reason for clients receiving services externally. The Full Responsibility for Service items (CP7 – CP8) assess the percentage of clients who are receiving a needed service and the extent to which the ACT team is assuming responsibility for delivering this service.

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)

ITEM RESPONSE CODING: Scoring of items CP7 and CP8 is based on the percent of individuals with a given need who are receiving services in that particular service domain from the team. The following equation is calculated for each of the Full Responsibility for Service items (further direction in gathering data for the numerator and denominator will follow):

$$\frac{\textbf{\% of clients receiving service directly from team}}{\textbf{\% of clients needing and/or wanting service (see base rates listed below)}}$$

Calculating the Numerator:

% of clients receiving service directly from team

To determine the numerator, only consider the number of clients receiving services directly from the team. Attend to the definition of the service, as provided to the team in the Excel spreadsheet, the number of clients reported by the team as receiving this service from the team, and other considerations and data sources.

Full Responsibility for Psychiatric Services (CP7) Excel spreadsheet Definition and Instructions:

The team assumes responsibility for providing psychiatric services to clients, where there is little need for clients to have to access such services outside of the team. Core psychiatric services include psychopharmacologic treatment and regular assessment of clients' symptoms & response to medications, including side effects, provided by the team's psychiatric care provider; and medication monitoring and supports provided by other ACT team members. The team's role in medication administration and monitoring are also considered in this assessment, especially when evaluating psychiatric services provided to clients residing in supervised settings where non-ACT staff also manage medications; the expectation is that ACT staff play an active role in monitoring medication management even when a client is in a residential setting.

Worksheet 1. **Calculating the number of clients receiving psychiatric services (CP7) from the team (numerator).**	**Number/ Percent of clients**	
	Team Hope example	**Data Input**
A. How many clients were reported (**Excel spreadsheet, column C**) to be directly receiving psychiatric services from the team? • Engagement-related psychiatric services may also be counted (e.g., if a client is refusing medications, but provider continues to offer other services), but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • Clients who are hospitalized and currently under the care of inpatient psychiatric providers can still count toward the numerator if ACT team psychiatric care provider is following client's care and in contact with hospital, and intends continuing treatment upon discharge.	**(A) Team Reports:** 98 clients, per example of Team Hope, are receiving psychiatric services from the team.	
• Be sure to **only include clients seen by psychiatric care providers who met team inclusion criteria** described in CT3 (if the caseload is shared across providers, clients may be counted if a qualifying psychiatric care provider is seeing these clients). Also include clients with contact with psychiatric residents, although the residents themselves are not qualified for CT3.		
As an example, **Team Hope** is serving 100 clients and reported that 98 were receiving psychiatric care provider services from the team, which includes the 0.60 FTE psychiatrist who is considered part of the team, and the 0.20 FTE psychiatric resident, who is not considered part of the team. Two (2) clients are meeting with non-ACT psychiatrists.		
B. Number of clients who are living in residential settings who are *not* directly receiving medication monitoring from the team, or there is poor communication and collaboration between the residential facility and the team regarding medication monitoring, including missed medications, tolerance of side effects, and overall symptom reduction (Refer to column D, see responses from Nurse Interview below, which asks about staff role in	**(B)** 6 clients are in residences with on-site med monitoring and inadequate	

medication monitoring for those clients noted to be living in residential settings). As an example, **Team Hope** reported in column D that 12 clients are in residential settings with medication monitoring services delivered by residential staff. Of those 12, 6 are in a group home where the team has inadequate communication with residential staff, per staff interviews.	coordination/ communicatio n with team about meds.	
C. Approximate percent of all clients who are seen by the psychiatric care provider <u>less often than every 3 months</u>, per chart review. To determine this approximate percent: • If less than 20% of clients had inadequate follow-up (seen less often than 3 months) AND at least 30% were seen within six weeks, do not make adjustments using Step C. • For those client charts where the team was reported to provide psychiatric care services (column C) <u>and who had not been excluded from the count per Steps A and B above</u>, 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 most recent contact. • **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 consistent 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 not seen within 3 months, but had many attempts in the interim, while remaining clients reviewed seen within 6 weeks). As an example, 20 charts from **Team Hope** were reviewed and 5 charts were of clients not seen within 3 months, but reported to be receiving psychiatric care from the team (column C). One of these 5 charts was for a client deducted per Step B above due to residential living with little team oversight. Thus, 4 of 20 charts, or 20%, is calculated to approximate inadequate follow-up. However, in review of overall practice, at least two charts had documented attempts by psychiatric provider to see these clients more often. Evaluators adjusted the percent likely receiving inadequate follow-up to 15%.	**(C)** 15%	
Total number of clients receiving service (numerator): The final calculation for the numerator is as follows with Team Hope example to follow: **[(Step A – ((Step A – Step B) *Step C))/current caseload] * 100 (this is the final step to translate into a percentage)**. For Team Hope, this is [(98 – ((98 – 6) * 0.15)) / current caseload (100)] *100 [(98 – (92 * 0.15)/100)] * 100 [(98 – 13.8)/100] * 100 = [78.2/100] * 100 = 0.78 * 100 = **78%.** Refer to Table 24 for further guidelines on making adjustments.	Estimated percent of clients receiving psychiatric services from the team **(numerator):** 78%	

Nursing Interview	
If the team reports that clients are receiving medication monitoring from non-ACT providers (column D), ask the following: ***Tell me about what happens when clients receive medication monitoring from other providers. How does the team work with these providers— this includes residential staff? If a client wasn't tolerating a particular medication or missed their medication, how would you know*****?** [Go through each client noted to be living in residential setting with medication monitoring (column D). If team plays minimal role in medication management oversight for clients in residential setting, do not count these clients toward the numerator value, regardless of the ACT team's psychiatric care provider prescribes the medications for these clients.]	

Full Responsibility for Psychiatric Rehabilitation Services (CP8)
Excel spreadsheet Definition and Instructions:

These services focus on targeted skills training in the areas of community living, which includes skills needed to maintain independent living (e.g., shopping, cooking, cleaning, budgeting, and transportation) and socialization (e.g., enhancing social and/or romantic relationships, recreational and leisure pursuits that contribute to community integration). Psychiatric rehabilitation should address functional deficits as well as the lack of necessary resources, all of which are identified through the assessment process. As such, deliberate and consistent skills training which typically includes staff demonstration, client practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings. Psychiatric rehabilitation services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, and weekly client schedules).

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.

Worksheet 2. Method 1. **Calculating the number of clients receiving psychiatric rehabilitation services (CP8) from the team (numerator).**	**Percent of clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving psychiatric rehabilitation from the team? (**Excel spreadsheet, column J**). 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 (or listed in Excel if there is a discrepancy). • Engagement-related rehabilitation 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.	**Team Reports: (A)** 82% are receiving psych rehab services from the team	
Team Hope example. The team reported that 82 of the 100 clients (82%) were receiving psychiatric rehabilitation services from the team.		
B. What percent of all charts reviewed were observed to have any psychiatric rehabilitation service at all (i.e., regardless of it being systematically provided and regardless of quality judged as 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)** 60% found any evidence of psych rehab services	
The results of **Team Hope's** Chart Review found that 12 of 20 (60%) charts were judged to provide some psychiatric rehabilitation, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of psychiatric rehabilitation? (This information may inform how much of an adjustment to make to team's report if there is a discrepancy between their report and chart observation.) • Calculate the percent of charts observed with "high quality" examples of psychiatric rehabilitation (i.e., # of those judged high quality / # judged to have some psychiatric rehab service). • Calculate the percent of charts observed with "systematic delivery" of psychiatric rehabilitation (i.e., # of those judged systematic / # judged to have some psychiatric rehab service). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned psychiatric rehabilitation interventions in person-centered plans and/or client schedules, whether and how clients are using clubhouses and drop-in centers (column L).	**Other Data**: **(C)** 50% "high quality;" 75% "systematic;" and other examples judged to be moderate	
The results of **Team Hope's** Chart Review found that 6 of 12 charts (50%) were judged to be of "high quality," and that 9 of 12 (75%) were systematically delivered. Although planning was lacking in specified interventions and there was limited notation of planned psychiatric rehab interventions in client schedules, several good examples were provided by interviewed staff. Only three clients were accessing local club house or drop-in centers, with no evidence to suggest this was in lieu of the team not providing psychiatric rehabilitation.		
Calculating percent of clients receiving service (numerator): Compare **Steps A (Team Report) with B (Chart Review)**. If there's a significant discrepancy (e.g., a **difference of 20 percentage points or more**) between these two estimates, adjust from the team's report (A) in the direction of data observed (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. <u>Other Tips:</u> • 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 psychiatric rehabilitation 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 highly directive nature to how psychiatric rehabilitation services were being delivered), consider rating a "1" for this item.	Estimated percent of those receiving psych rehab services from Team Hope **(Numerator)**: 71%	
As an example, there was a discrepancy of 22 percentage points between what **Team Hope** reported (82%) and what was observed in the charts (60%), with other data sources overall suggesting a moderate level of practice. Evaluators chose to cut the difference in half, dividing 22 in half (22/2 = 11) and reducing the team's report by 11 percentage points (82-11 = 71%).		

Worksheet 3. Method 2. **Calculating the percent of clients receiving psychiatric rehabilitation services (CP8) from the team (numerator).**	**Percent of Clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving psychiatric rehabilitation from the team? (**Excel spreadsheet, column J**). 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 rehabilitation 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.	**Team Reports: (A)** 82% are receiving psych rehab services from team	
Team Hope example. The team reported that 82 of the 100 clients (82%) were receiving psychiatric rehabilitation services from the team.		
B. What percent of those indicated as receiving psychiatric rehabilitation services from the team (Excel spreadsheet, column J) 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)**: 71% of charts found any psych rehab service	
Team Hope example: In the sample of 20 charts reviewed, 17 clients were reported to be receiving psychiatric rehabilitation from the team, per the Excel spreadsheet (column J). The results of Team Hope's Chart Review found that 12 of 17 (71%) charts were judged to provide some psychiatric rehabilitation, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of psychiatric rehabilitation? (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 psych rehab (i.e., # of those judged high quality / # judged to have some psychiatric rehab service). • Calculate the percent of charts observed with "systematic delivery" of psych rehabilitation (i.e., # of those judged systematic / # judged to have some psych rehab service). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned psychiatric rehabilitation interventions in person-centered plans and/or client schedules, whether and how clients are using clubhouses and drop-in centers (column L).	**Other Data**: **(C)** 50% "high quality;" 75% "systematic;" and other examples judged to be moderate	
Team Hope's Chart Review found that 6 of 12 charts (50%) were judged to be of "high quality," and that 9 of 12 (75%) were systematically delivered. Although planning was lacking in specified interventions and there was limited notation of planned psychiatric rehab interventions in client schedules, several good examples were provided by interviewed staff. Only two clients were accessing local club house or drop-in centers, and it was not clear it was in lieu of the team not providing psychiatric rehabilitation.		
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 moderately to highly favorable (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., 71% + 10 = 81%)		

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, 81% is applied to the team's original report of 82%, which is 0.81 X 0.82 = 0.66 (X 100) = 66% If other data sources are low to moderately favorable (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, 71% is applied to the team's original report of 82%, which is 0.71 X 0.82 = 0.58 (X 100) = 58%. • If other data sources (Step C) are not favorable, 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 71% may be reduced to 61%. The final adjustment then would be 0.61 X 0.82 = 0.50, or 50%. Refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. <u>Other Tips:</u> • 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 psychiatric rehabilitation 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 highly directive nature to how psychiatric rehabilitation services were being delivered), consider rating a "1" for this item.	Estimated percent of those receiving psychiatric services from the team **(Numerator)**: 66%	
For **Team Hope,** 71% of the subsample were found to have documented psychiatric rehabilitation (which his lower than 90% to stay with what team reported in Step A). Other data sources (Step C) were favorable. Evaluators therefore made an adjustment up from 71% to 81%, and applied the 81% to the reported 82% (Step A), resulting an adjusted rate of 66%.		

Clinician Interview	
Does the team use a tool or instrument to assess clients' ADL or "functional" skills? [If yes:] ***Can you tell me more about who completes it and how the information is used?***	

Let's take a look at the Excel spreadsheet and the number of clients who directly receive psychiatric rehabilitation services from the team. Tell me more about what these services include. [Randomly select clients noted as receiving psychiatric rehabilitation services and inquire about what those interventions are, and whether they are likely reflected in the treatment plans; keep in mind the clearly stated definition provided to the team on what counts as rehabilitation interventions. *Note that clients attending clubhouses, drop-in centers, or day treatment programming should also be closely examined when assessing the extent of rehabilitation services offered by the team.] ***If we have not yet heard of it yet, can you share with us an example of your or your team's practice that you think best reflects your team's work in providing psychiatric rehabilitation—where there is a focus on functional skill-building?*** [With this example, try to clarify how far back the example dates.]	

Calculating the Denominator:

% of clients needing and/or wanting service
(see base rates listed below)

To determine the denominator (i.e., those needing/wanting the service), we refer to standardized base rates that are thought to reflect the percentage of ACT clients who would want psychiatric and rehabilitative services, as well as those who may not expressed that they want, but appear to need these services, such as those who would benefit from further engagement in that particular service domain. It is assumed that all ACT clients will need/want psychiatric and rehabilitative services, but a slightly more conservative estimate of 90% is used to calculate need/want to allow for client choice and measurement error.

We estimate ***at least* 90%** of ACT clients will need/want the following services:

- Psychiatric services
- Psychiatric rehabilitation services

Service	Numerator (Method 1)	Numerator (Method 2)	Denominator	Final Calculation (Method 1)	Final Calculation (Method 2)
CP7. Psychiatric services	78%	n/a	90%	87%	n/a
CP8. Psychiatric rehabilitation services	71%	66%	90%	79%	73%

Table 24. A Description of Observed Data Given Actual Service Penetration: A Reference Guide for Evaluators.	
Service penetration level	**Considering the Evidence**
High (75 – 100%) Rating 4 or 5	For a team that provides a high level of service penetration, evidence will be observed across most or all data sources. Of the approximate number of clients expected to want/need that particular service (e.g., 90% of total caseload for psychiatric rehabilitation services), at least 75% of reviewed sampled charts (see Chart Review Tally Sheet - Part I) will have service of interest documented in the progress notes. Service will be commented on during the observation of daily team meeting (i.e., reported contacts involving rehabilitative services, and scheduled contacts to address client's rehabilitation needs). For psychiatric rehabilitation services, a relatively large breadth of rehabilitation services is provided (e.g., social and communication skills training, household management, hygiene skills, safety skills, transportation and navigation skills, and money management). Likewise, it is expected that functional assessments are conducted to help determine impairments. There will be few or no clients participating in other non-ACT psychosocial programs (e.g., clubhouse, day treatment programming). The specification of rehabilitative interventions will likely be very precise and descriptive for a team that has fully embraced this practice.
Moderate (50%) Rating 2 or 3	For a team that provides a moderate level of service penetration, evidence will be observed across several data sources. Of the approximate number of clients expected to want/need that particular service (e.g., 90% of total caseload for psychiatric rehabilitation services), between 40 and 60% of reviewed sampled charts (see Chart Review Tally Sheet - Part I) will have service of interest documented in the progress notes. Service will be commented on during the observation of daily team meeting (i.e., reported contacts involving rehabilitative services, and scheduled contacts to address client's rehabilitation needs), and interview data. The breadth of rehabilitative services provided may be more limited, reflecting a less systematic implementation of psychiatric rehabilitation; functional assessments may not be conducted (i.e., rehabilitation interventions are provided with little systematic assessment of the type and extent of functioning impairment, and related cognitive and psychiatric impairments limiting client's functioning).
Low (20% or less) Rating 1	For a team that provides a low level of service penetration, evidence will be observed across very few data sources—e.g., chart review (no or very few charts have notes that make mention of rehabilitative services), observation of daily team meeting (i.e., no mention of rehabilitative services), and interviews. Rehabilitation services, when observed, lack breadth (e.g., the team mentions assisting a few clients with ADL, such as housekeeping and maintenance). Activities are not systematically delivered or follow from a plan (per the definition provided in Excel spreadsheet).

*Note that these heuristic guidelines are intended to provide examples of observed evidence at three distinct levels of service penetration (high, moderate, and low). For teams providing more intermediate levels (moderate-high or low-moderate), evaluators should take into consideration the overall weight of the evidence, considering the three levels provided here. Data on service penetration summarized in Chart Tally II should be used to support, or adjust (upwards or downwards), the team's reported penetration rate, considering the number of clients assumed to want/need that service; refer to appropriate Worksheet that is included in these rating guidelines.

Example: Calculating Full Responsibility Rates for Psychiatric Services and Psychiatric Rehabilitation Services.		
	CP7.Full Responsibility for Psychiatric Services	**CP8. Full Responsibility for Psychiatric Rehabilitation Services**
Numerator Calculation		
	Team reports on the Excel spreadsheet (column C) that all but 2 of the 88 clients are receiving psychiatric services from the team; two continue to work with a psychiatrist they were with prior to the team. Evaluators considered the 10 clients noted as residing in a supervised setting where medication monitoring is provided (column D of Excel spreadsheet). Information gathered from interviews confirmed that the team plays an active role in coordinating medication monitoring with residential staff (had evidence indicated that the team is relatively unaware of clients' response to medications and adherence with medications, then those clients would be excluded from the count). Evaluators conclude that 86 of the 88 **(98%)** clients are <u>receiving</u> psychiatric care services from team.	Team reports on Excel spreadsheet (column J) that all 75 of 90 **(83%)** clients they serve are receiving psychiatric rehabilitation services from team. Of the 18 charts reviewed, evaluators found that a total of 9 (50%) had any notation of psychiatric rehabilitation interventions, with 6 of these rated as "high quality" and 5 (28% of all charts) noted as being systematically delivered. Clinician examples provided were judged to be of high quality, overall. The team is not conducting functional assessments. Using <u>Method 1</u> (see Worksheet 2), evaluators moderately reduced the 33 percentage point discrepancy (83% reported—50% observed in charts) by 11 (i.e., cutting in thirds) to produce an adjusted percent of **72%** (i.e., 83 – 11) of those served are receiving psychiatric rehabilitation from the team.
Denominator Calculation		
	The **base rate** of **90%** is used to calculate the denominator for both CP7 and CP8**.**	
Formula and Rating	To determine the percentage of clients who were receiving psychiatric services from the team of those who likely needed such services, evaluators calculated the following: **98%** clients estimated receiving / **90%** estimated to need or want psychiatric services = **109%, which rates a "5" on CP7.**	To determine the percentage of clients who were receiving rehabilitative services from the team of those who likely needed such services, evaluators calculated the following: 72% clients estimated receiving / 90% estimated to need or want rehabilitative services = **80%, which rates a "4" on CP8**.

	1	**2**	**3**	**4**	**5**
CP7 Full Responsibility for Psychiatric Services	Less than 20% of clients in need of psychiatric services are receiving them from the team.	20 - 49% of clients in need of psychiatric services are receiving them from the team.	50 - 74% of clients in need of psychiatric services are receiving them from the team.	75 - 89% of clients in need of psychiatric services are receiving them from the team.	90% or more of clients in need of psychiatric services are receiving them from the team.
CP8 Full Responsibility for Psychiatric Rehabilitation Services	Less than 20% of clients in need of psychiatric rehabilitation services are receiving them from the team.	20 - 49% of clients in need of psychiatric rehabilitation services are receiving them from the team.	50 - 74% of clients in need of psychiatric rehabilitation services are receiving them from the team.	75 - 89% of clients in need of psychiatric rehabilitation services are receiving them from the team.	90% or more of clients in need of psychiatric rehabilitation services are receiving them from the team.

EP1. Full Responsibility for Integrated Treatment for Co-Occurring Disorders (COD)

Definition: The team assumes responsibility for providing integrated treatment for co-occurring disorders (COD) services within the larger framework of integrated treatment for COD, where there is little need for clients to have to access such services outside of the team. Core services include systematic and integrated screening and assessment and interventions tailored to those in early stages of change readiness (e.g., outreach, motivational interviewing) and later stages of change readiness (e.g., CBT, relapse prevention). It is expected that the ACT COD specialist will assume the majority of responsibility for delivering integrated treatment for co-occurring disorders, but ideally other team members also provide some integrated treatment for co-occurring disorders services. Integrated treatment for co-occurring disorders reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).

EP2. Full Responsibility for Employment and Educational (EE) Services

Definition: The team assumes responsibility for providing employment and educational (EE) services to clients, where there is little need for clients to have to access such services outside of the team. Core services include engagement, vocational assessment, job development, job placement (including going back to school, classes), and job coaching & follow-along supports (including supports in academic/school settings). It is expected that the ACT Employment Specialist will assume the majority of responsibility for delivering EE services, but ideally other team members also provide some EE services. Employment and educational services reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).

EP3. Full Responsibility for Wellness Management and Recovery (WMR) Services

Definition: The team assumes responsibility for providing wellness management and recovery (WMR) services to clients, where there is little need for clients to have to access such services outside of the team. These services include a formal and/or manualized approach to working with clients to build and apply skills related to their recovery. Examples of such services include the development of Wellness Recovery Action Plans (WRAP) and provision of the Illness Management and Recovery (IMR) curriculum. WMR services reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).

Rationale for EP1, EP2, EP3: The ACT team is ideally equipped to provide quality services across a range of service domains so that clients with relevant needs are well-served and do not have to access these services externally. Creating a one-stop service team should theoretically eliminate communication problems and lead to a more seamless service system working to meet clients' goals. Clients should have the option to receive services elsewhere, but it is expected that the percentage of clients doing so would be low given that the team is adequately providing the service themselves and meeting clients' needs. Team limitations (e.g., lack of staff to provide service, lack of skills, and lack of time) are not a good reason for clients receiving services externally.

The Full Responsibility for Service items assess the percentage of clients who are receiving a needed service and the extent to which the ACT team is assuming responsibility for delivering this service.

Data Sources (* denotes primary data source)

Data Source	EP1. Integrated Treatment for COD	EP2. EE services	EP3. WMR Services
Excel spreadsheet*	columns A and B	columns E, F, and L	column K
Staff interview*	Co-Occurring Disorders Specialist	Employment Specialist	Peer Specialist and Clinician
Chart Data*	Rate at which Integrated Treatment of COD services are documented in charts	Rate at which EE services are documented in charts	Rate at which WMR services are documented in charts

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

ITEM RESPONSE CODING: Scoring of items EP1—EP3 is based on the percentage of individuals with a given need who are receiving adequate services in that particular service domain from the team. Thus, the following equation is calculated for each of the Full Responsibility for Service items (further direction in gathering data for the numerator and denominator will follow):

$$\frac{\text{\% of clients receiving service directly from team}}{\text{\% of clients needing and/or wanting service (see base rates listed below)}}$$

Calculating the Numerator:

$$\frac{\text{\% of clients receiving service directly from team}}{\quad}$$

For the purpose of determining the numerator, only consider the number of clients receiving services directly from the team. Attend to the definition of the service, as provided to the team in the Excel spreadsheet, the number of clients reported by the team as receiving this service from the team, and other considerations and data sources.

To compute the rate at which the service of interest is provided by the team, first start by examining the rate at which the team reports to be delivering this service themselves (Excel spreadsheet). 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 Excel spreadsheet, 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 this service only for those clients the team reported affirmatively in Excel spreadsheet; 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.

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).

Full Responsibility for Integrated Treatment for Co-Occurring Disorders (EP1) Excel spreadsheet Definition and Instructions: *These include services provided by the* COD specialist *as well as other team members well-versed in integrated, stage-wise treatment for COD. Core services include: (1) systematic and integrated screening and assessment and interventions tailored to those in (2) strategies to assist those in early stages of change readiness (e.g., outreach, MI) and (3) and strategies to assist those in later stages of change readiness (e.g., MI, CBT, relapse prevention). Integrated treatment for co-occurring disorder services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, client schedules). NOTE: To be considered a group participant, client attends group at least one time per month. To be counted as an individual integrated treatment for COD participant, the duration and frequency of therapy sessions should be at least 20 minutes per week. Be sure to also include clients whom the team is attempting to actively engage; these attempts should be documented in the client's chart.*

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%	
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%	
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).	**Other Data: (C)** 20% "high quality;" 40% "systematic;" and other examples judged to be weak	

• 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.		
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. <u>Other Tips:</u> • 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%	
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%).		

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%	
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%	
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	
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 moderately to highly favorable (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 moderately favorable (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) are not favorable, 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. <u>Other Tips:</u> • 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."		

Co-Occurring Disorders Specialist Interview:	
Let's take a look at the Excel spreadsheet (column B) and the number of clients who directly receive integrated treatment for COD from the team. Tell me more about what kinds of services you and the team provided to the clients listed in this spreadsheet. [Randomly select clients who were noted as receiving individual and/or group treatment, and ask more specifics about the services they receive. Inquire about a client noted as being in an earlier stage of change (column A) who is also receiving services.]	

Full Responsibility for EE services (EP2) Excel spreadsheet definition and instructions:
These include all services provided by the employment specialist as well as other team members well-versed in SEE services. Core services include: (1) engagement; (2) EE assessment; (3) job development; (4) job placement (including going back to school, classes); & (5) job coaching & follow-along supports (including supports in academic/school settings). Supported education services also should be noted in this column. EE services reported here should be reflected across other data sources (e.g., progress notes, treatments plans).

Worksheet 6. Method 1. **Calculating the number of clients receiving SEE services (EP2) from the team (numerator).**	**Percent of clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving SEE services from the team (**Excel spreadsheet, column E**)? 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 SEE services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • Selectively exclude clients indicated as receiving EE services from a **non-ACT provider (see column E), and/or** are attending clubhouse and/or day treatment programming (column L) when follow-up questioning indicates it is in lieu of team's emphasis of EE services. • Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5.	**Team Reports: (A)** 25%	
Team Hope example. The team reported that 25 of the 100 clients (25%) were receiving SEE services from the team.		
B. What percent of all charts reviewed were observed to have any SEE services (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)** 50%,	
The results of **Team Hope's** Chart Review found that 10 of 20 (50%) charts were judged to provide some SEE services, per review of progress notes alone.		

C. What did other data sources indicate as to the quality and systematic delivering of SEE services? (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 SEE services (i.e., # of those judged high quality / # judged to have some SEE service). • Calculate the percent of charts observed with "systematic delivery" of SEE services (i.e., # of those judged systematic / # judged to have some SEE services). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned SEE services in person-centered plans and/or client schedules, and reliance on other non-ACT SEE services.	**Other Data: (C)** 80% "high quality;" 90% "systematic;" and other examples judged to be strong	
The results of **Team Hope's** Chart Review found that 8 of 10 charts (80%) were judged to be of "high quality," and that 9 of 10 (90%) were systematically delivered. SEE services were included in client schedules, and examples provided were good, clearly reflected a whole team effort, and were generally detailed and reflecting best practices. Also, the team reported assisting the majority of current employed clients in getting those jobs (see column I).		
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. <u>Other Tips:</u> • 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 SEE 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 a clear departure from best practice, such as extensive preparation and reliance on development of "soft skills" before assisting with getting a job, consider rating a "1" for this item.	Estimated percent of those receiving SEE services from the Team (**Numerator)**: 30%	
As an example, there was a discrepancy of 15 percentage points between what **Team Hope** reported (25%) and what was observed in the charts (50%), with other data sources overall suggesting a high level of practice. Evaluators chose to increase the team's reported percent by one-third of the difference (i.e., 15/3 = 5), resulting in 30% (25 + 5).		

Worksheet 7. Method 2. **Calculating the percent of clients receiving SEE (EP2) 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 SEE services from the team (**Excel spreadsheet, column E**)? 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 SEE services may also be counted, but it is recommended that the evaluator request examples of engagement efforts for a selection of clients. • Selectively exclude clients indicated as receiving EE services from a **non-ACT provider (see column E), and/or** are attending clubhouse and/or day treatment programming (column L) when follow-up questioning indicates it is in lieu of team's emphasis of EE services. • Be sure to only include clients seen by staff who meet the team inclusion criteria described in OS1 and OS5.	**Team Reports: (A)** 25%	
Team Hope example. The team reported that 25 of the 100 clients (25%) were receiving SEE services from the team.		
B. Percent of clients in Step A who were noted as receiving SEE service at all (i.e., regardless of it being systematically provided and regardless of quality was judged high or low), per the **Chart Review Tally Sheet Part I** (Please refer to the TMACT Calculation Workbook to enter and compute these data).	**Chart Review Results: (B)** 100%	
In the sample of 20 charts reviewed, 8 charts (40%) were of clients to whom the team had reported to be providing SEE services. The results of **Team Hope's** chart review found that 8 of 8 (100%) charts were judged to provide some SEE services, per review of progress notes alone.		
C. What did other data sources indicate as to the quality and systematic delivering of SEE services? (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 SEE services (i.e., # of those judged high quality / # judged to have some SEE service). • Calculate the percent of charts observed with "systematic delivery" of SEE services (i.e., # of those judged systematic / # judged to have some SEE services). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned SEE services in person-centered plans and/or client schedules, and reliance on other non-ACT SEE services.	**Other Data: (C)** 100% "high quality;" 100% "systematic;" and other examples judged to be strong	
Team Hope's Chart Review found that 8 of 8 charts (100%) were judged to be of "high quality," and that 8 of 8 (100%) were systematically delivered. SEE services were included in client schedules, and examples provided were good, clearly reflected a whole team effort, and were generally detailed and reflecting best practices. Also, the team reported assisting the majority of current employed clients in getting those jobs (see column I).		
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 moderately to highly favorable (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 (i.e., if Step B found 40%, you would add 10 to get 50%). *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 (i.e., if the team had reported 30% in Step A, then you would "apply" 50% by: 0.50 X 0.30 = 0.15 (X 100) = 15% If other data sources are low to moderately favorable (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, 40% is applied to the team's original report of 30%, which is 0.40 X 0.30 = 0.12 (X 100) = 12%. • If other data sources (Step C) are not favorable, 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 40% (from Step B) may be reduced to 30%. The final adjustment then would be 0.30 X 0.30 = 0.09, or 9%. Refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. <u>Other Tips:</u> • 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 SEE 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 a clear departure from best practice, such as extensive preparation and reliance on development of "soft skills" before assisting with getting a job,) consider rating a "1" for this item.	Estimated percent of those receiving SEE services from the team **(Numerator):** 25%	
For **Team Hope,** 100% of the subsample were found to have documented SEE rehabilitation. Other data sources (Step C) were favorable, indicating a high level of systematic delivery and high quality examples of work. Evaluators rated based on the team's original percent as all reported were found to have strong evidence of SEE services. Thus, 25% would be used as the numerator. [Note: Method 2 is less sensitive to detecting team's underreporting of their work, which was the case here for Team Hope.]		

Employment Specialist Interview:	
Let's take a look at the Excel spreadsheet *(column E)* ***and the number of clients who directly receive EE services from the team. Tell me more about what kinds of services you and the team provided to the clients listed in this spreadsheet.*** [Randomly select clients who are noted as receiving services, and inquire about what those services are; select clients noted as being competitively employed (column F), and corroborate how the team may have assisted in obtaining that position (column I).]	

Full Responsibility for WMR Services (EP3)
Excel spreadsheet definition and instructions:

These services include a formal and/or manualized approach to working with clients to build and apply skills related to their recovery. Examples of such services include development of WRAP and provision of the IMR curriculum. These services include a formal and/or manualized approach to working with clients to build and apply skills related to their recovery. WMR services reported here should be reflected across other data sources (e.g., progress notes, treatment plans). ***NOTE: When completing the column for the provision of WMR services, please specify the type of service that the client is receiving (e.g., IMR group, individual WRAP).***

Worksheet 8. Method 1. **Calculating the number of clients receiving manualized WMR services (EP3) from the team (numerator).**	**Percent of clients**	
	Team Hope Example	**Data Input**
A. What percent of clients did the team say is receiving manualized WMR services from the team (**Excel spreadsheet, column K**)? 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.	**Team Reports: (A)** 12%	
• Engagement-related WMR 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.		
Team Hope example. The team reported that 12 of the 100 clients (12%) were receiving WMR services from the team.		

B. Percent of clients noted as receiving manualized WMR service at all (i.e., regardless of it being systematically provided and regardless of quality was judged high or low), per the **Chart Review Tally Sheet Part I** (Please refer to the TMACT Calculation Workbook to enter and compute these data). The results of **Team Hope's** Chart Review found that 2 of 20 (10%) charts were judged to provide some manualized WMR, per review of progress notes alone.	**Chart Review Results: (B)** 10%	
C. What did other data sources indicate as to the quality and systematic delivering of manualized WMR services? (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 WMR services (i.e., # of those judged high quality / # judged to have some WMR service). • Calculate the percent of charts observed with "systematic delivery" of WMR services (i.e., # of those judged systematic / # judged to have some WMR services). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned WMR services in person-centered plans and/or client schedules, whether the WMR manual is actually used in services (e.g., WRAPs are being completed), or mostly referred to as a resource (e.g., there is focus on discussing client's "toolbox" without completing WRAPs). The results of **Team Hope's** Chart Review found that 1 of 2 charts (50%) were judged to be of "high quality," and that 1 of 2 (50%) were systematically delivered. Although planning was lacking in specified interventions and there was limited notation of planned WMR interventions in client schedules. Examples tended to be limited, but having some detail.	**Other Data: (C)** 50% "high quality;" 50% "systematic;" and other examples judged to be strong.	
Calculating percent of clients receiving service (numerator): Compare Steps **A with B**. If there is a significant discrepancy (e.g., a **difference of 10 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 15 points could be divided in thirds (5, 10, 15), 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. <u>Other Tips:</u> • 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 WMR services, if examples cited are clearly a departure from best practices, do not credit for service. As an example, there was a discrepancy of 2 percentage points between what **Team Hope** reported (12%) and what was observed in the charts (10%), with other data sources overall suggesting a moderate level of practice. Evaluators therefore used the team's report of 12%.	Estimated Percent of those receiving WMR services from the Team (**Numerator)**: 12%	

Worksheet 9. Method 2. **Calculating the percent of clients receiving manualized WMR services (CP8) 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 manualized WMR services from the team (**Excel spreadsheet, column K**)? 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 manualized WMR 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. **Team Hope** example. The team reported that 12 of the 100 clients (12%) were receiving manualized WMR services WMR services from the team.	**Team Reports: (A)** 12%	
B. Percent of clients in Step A who were noted as receiving manualized WMR services at all (i.e., regardless of it being systematically provided and regardless of quality was judged high or low), per the **Chart Review Tally Sheet Part I** (Please refer to the TMACT Calculation Workbook to enter and compute these data). In the sample of 20 charts reviewed, 3 charts (15%) were of clients to whom the team had reported to be providing manualized WMR services (this is a highly representative sample). The results of **Team Hope's** Chart Review found that 2 of 3 (67%) charts were judged to provide some manualized WMR services, per review of progress notes alone.	**Chart Review Results: (B)** 67%	
C. What did other data sources indicate as to the quality and systematic delivering of manualized WMR services? (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 WMR services (i.e., # of those judged high quality / # judged to have some WMR service). • Calculate the percent of charts observed with "systematic delivery" of WMR services (i.e., # of those judged systematic / # judged to have some WMR services). • Consider the weight of examples from interviews (quality and quantity of examples), whether there appeared to be planned WMR interventions in person-centered plans and/or client schedules, whether the WMR manual is actually used in services (e.g., WRAPs are being completed), or mostly referred to as a resource (e.g., there is focus on discussing client's "toolbox" without completing WRAPs). **Team Hope's** Chart Review found that 1 of 2 charts (50%) were judged to be of "high quality," and that 1 of 2 (50%) were systematically delivered. Although planning was lacking in specified interventions and there was limited notation of planned manualized WMR services in client schedules, several good examples were provided by interviewed staff.	**Other Data: (C)** 50% "high quality;" 50% "systematic;" and other examples judged to be moderately strong	
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 moderately to highly favorable (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 (i.e., if Step B found 67%, you would add 10 to get 77%). *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 (i.e., if the team had reported 12% in Step A, then you would "apply" 77% by: 0.12 X 0.77 = 0.09 (X 100) = 9% If other data sources are low to moderately favorable (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, 67% is applied to the team's original report of 12%, which is 0.67 X 0.12 = 0.08 (X 100) = 8%. • If other data sources (Step C) are not favorable, overall, the evaluators have discretion to reduce the percentage in Step B down by 10. E.g., 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 67% (from Step B) may be reduced to 57%. The final adjustment then would be 0.57 X 0.12 = 0.07, or 7%. Refer to Table 24 for further guidelines on making such adjustments so that final ratings comport with overall impression of team given data. <u>Other Tips:</u> • 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 WMR services, if examples cited are clearly a departure from best practices, consider rating a "1" for this item.	Estimated Percent of those receiving manualized WMR services from the Team **(Numerator)** 9%	
For **Team Hope,** 65% of the subsample were found to have documented manualized WMR services. Other data sources (Step C) were favorable. Evaluators increased the 65% up to 75% and was applied to the team's report of 12%, resulting in 9% (0.75*0.12).		

Peer Specialist Interview:	
Do you provide any manualized wellness management and recovery (WMR) services? *[If yes:]* ***Let's take a look at the Excel spreadsheet and the number of clients who have received manualized WMR services from the team.*** [Query for quality of services based on what is reported; whether the WMR service is formal and/or manualized.] ***Tell me more about what kinds of services you and the team provided to the clients listed in this spreadsheet*** (randomly select clients marked as receiving specific WMR services and ask for additional information to ascertain that the interventions were indeed manualized).	
Clinician Interview:	
Do you provide any manualized wellness management and recovery (WMR) services? [If yes:] ***Let's take a look at the Excel spreadsheet (column K) and the number of clients who directly receive manualized WMR services from the team.*** [Query for quality of services based on what is reported. Prompt for specific strategies used in IMR or WRAP, as well as gauge whether other deliberate, but less formal, WMR strategies are used.] ***Tell me more about what kinds of services you and the team provided to the clients listed in this spreadsheet*** *(randomly select clients marked as receiving WMR services and ask what is being provided).* ***Do you provide any Wellness Management and Recovery Services like IMR or WRAP?***	

Calculating the Denominator:

% of clients needing and/or wanting service

(see base rates listed below)

To determine the denominator, we refer to standardized base rates that are thought to reflect the percentage of ACT clients who would want these services, as well as those who may not expressed that they want, but appear to need these services and would benefit from further engagement in that particular service domain.

Extrapolating from published research and expert opinion, a conservative base rate is used for estimating the percent of clients who need/want integrated treatment for COD and EE services. It is assumed that *at least* 40% of ACT clients will need/want these services. It is assumed that all ACT clients will need/want WMR services, but a slightly more conservative estimate of 90% is used to calculate need/want to allow for client choice and measurement error.

We estimated that ***at least* 20%** of ACT clients will need/want the following service:

- Manualized WMR Services

We estimated that ***at least 40%*** of ACT clients will need/want the following services:

- Integrated Treatment for COD [1]
- EE Services

[1]If the team's reported rate of COD (see Excel spreadsheet, column A) exceeds 40%, then use their count as the denominator (e.g., it is common for more urban ACT teams to serve a higher rate of individuals with COD). If the team's reported rate is less than 40%, then use the suggested base rate of 40%; it is assumed that poor screening and assessment practices can result in a lower rate. The team may present an argument defending their original estimate, such as cultural and/or regional factors and/or program policies that have resulted in lower rates (e.g., having a separate COD ACT team). Query the team leader, as appropriate.

Service	Numerator (Method 1)	Numerator (Method 2)	Denominator	Final Calculation (Method 1)	Final Calculation (Method 2)
EP1. Integrated Treatment COD	31%	26%	42%	31/42 = 74%	26/42 = 62%
EP2. SEE Services	30%	25%	40%	30/75 = 75%	25/40 = 63%
EP3. Manualized WMR Services	12%	9%	20%	12/20 = 60%	9/20 = 45%

Table 25. A Description of Observed Data Given Actual Service Penetration: A Reference Guide for Evaluators.

Service penetration level	Considering the Evidence
High (75 – 100%) Rating 4 or 5	For a team that provides a high level of service penetration, evidence will be observed across most or all data sources. Of the approximate number of clients expected to want/need that particular service (e.g., 40% of total caseload for EE services), at least 75% of reviewed sampled charts (see Chart Review Tally Sheet Part I) will have service of interest documented in the progress notes. Service will be commented on during the observation of daily team meeting (i.e., reported contacts involving specialty services, and scheduled contacts to address client's specialty service needs), and a relatively large breadth of specialty services being provided. Likewise, there will be few clients who are participating in other non-ACT psychosocial programs (e.g., clubhouse, day treatment programming), which may reflect a lack of EE and/or wellness service activities. The specification of specialty service interventions will likely be very precise for a team that has fully embraced this practice.

Moderate (50%) Rating 2 or 3	For a team that provides a moderate level of service penetration, evidence will be observed across several data sources. Of the approximate number of clients expected to want/need that particular service (e.g., 40% of total caseload for EE services), between 40 and 60% of reviewed sampled charts (see Chart Review Tally Sheet Part I) will have service of interest documented in the progress notes. Service will be commented on during the observation of daily team meeting (i.e., reported contacts involving specialty services, and scheduled contacts to address client's specialty service needs), the breadth of specialty services being provided may be limited and reflect less systematic implementation of the specialty service.
Low (30% or less) Rating 1 or 2	For a team that provides a low level of service penetration, evidence will be observed across very few data sources—e.g., chart review (no or very few charts have notes that make mention of specialty services, and/or statements about the intervention may be vague; one or fewer treatment plans make note of specialty service), observation of daily team meeting (i.e., no mention of specialty services), and specialty services, when observed, lack breadth. Specialty service activities do not appear to be systematically delivered or follow from a plan (per the definition provided in Excel spreadsheet).

*Note that these heuristic guidelines are intended to provide examples of observed evidence at three distinct levels of service penetration (high, moderate, and low). For teams providing more intermediate levels (moderate-high or low-moderate), evaluators should take into consideration the overall weight of the evidence, considering the three levels provided here. Data on service penetration summarized in Chart Tally II should be used to support, or adjust (upwards or downwards), the team's reported penetration rate, considering the number of clients assumed to want/need that service; refer to appropriate Worksheet that is included in these rating guidelines.

	1	2	3	4	5
EP1 Full Responsibility for Integrated Treatment for Co-Occurring Disorders (COD)	Less than 20% of clients in need of integrated treatment for COD are receiving them from the team.	20 - 49% of clients in need of integrated treatment for COD are receiving them from the team.	50 - 74% of clients in need of integrated treatment for COD are receiving them from the team.	75 - 89% of clients in need of integrated treatment for COD are receiving them from the team.	90% or more of clients in need of integrated treatment for COD are receiving them from the team.
EP2 Full Responsibility for Employment and Educational (EE) Services	Less than 20% of clients in need of employment and educational services are receiving them from the team.	20 - 49% of clients in need of EE services are receiving them from the team.	50 - 74% of clients in need of EE services are receiving them from the team.	75 - 89% of clients in need of EE services are receiving them from the team.	90% or more of clients in need of EE services are receiving them from the team.
EP3 Full Responsibility for Wellness Management and Recovery (WMR) Services	Less than 20% of clients in need of WMR services are receiving them from the team.	20 - 49% of clients in need of WMR services are receiving them from the team.	50 - 74% of clients in need of WMR services are receiving them from the team.	75 - 89% of clients in need of WMR services are receiving them from the team.	90% or more of clients in need of WMR services are receiving them from the team.

EP4. Integrated Treatment for Co-Occurring Disorders (COD)

Definition: The TEAM practices from a model aligning with integrated treatment for co-occurring disorders (COD) where the TEAM (1) considers interactions between mental illness and COD; (2) does not have absolute expectations of abstinence and supports harm reduction; (3) understands and applies stages of change readiness in treatment; (4) is skilled in motivational interviewing; and (5) follows cognitive-behavioral principles.

Rationale: The integrated treatment for co-occurring disorders, delivered within the larger integrated treatment for co-occurring disorders that reflects many practices across the TMACT, attends to the concerns of both SMI and co-occurring disorders for maximum opportunity for recovery and symptom management. It is important that the integrated treatment for co-occurring disorders is embraced by all team members.

DATA SOURCES (*Denotes primary data source)

Team Leader Interview

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 <u>stopping their substan</u>ce use, what types of interventions would you use to assist them?*** [Listen for examples of <u>cognitive</u> behavioral techniques.] ***Who would you refer to AA, NA or any other self-help groups? What about detox programs?*** [Seek examples.]	
Psychiatric Care Provider Interview	
Can you tell me a little bit about how you work with clients with comorbid substance use problems?	

What do you consider when prescribing medications and have you used medications to address substance use? [Probe for whether provider is a) willing to prescribe psychiatric medications despite active substance use; b) whether there is greater attention to prescribing addictive substances, such as benzodiazepines; and c) whether the provider has used medications to directly treat substance use (e.g., clozapine to reduce alcohol and drug use in schizophrenia, naltrexone to reduce cravings and intoxicating effects, or acamprosate to reduce intensity and duration of relapses). Responses are pertinent for criteria #1 - #2 in particular. Note, to receive full credit, the psychiatric care provider should voice some awareness that these are treatment options, and have strategically used them to address comorbid substance use.]	
Co-Occurring Disorders Specialist Interview*	
Could you summarize your fellow team members' views of treating clients with comorbid substance use problems? [Probe for whether there is agreement or disagreement among staff in how to work with clients who are actively using. *Do some staff promote more traditional substance use treatment approaches, which may include referring out to other providers to address substance use?*]	
Peer Specialist	
How would you describe your team's approach to supporting people with co-occurring substance use and mental health disorders?	

Clinician 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?***	

ITEM RESPONSE CODING

Rating Guidelines

This item is intended to be an approximate measure of the team's adherence to an evidence-based approach to integrated treatment for COD, both philosophically (i.e., do they embrace these principles within their core belief set) and in practice (i.e., do they apply these principles in their work with clients). Judgment of whether a specific criterion is fully vs. partially met should consider multiple data sources. This item is focused on the practice of the entire team. As it is unlikely that you will be able to interview each team member, use team leader interview as primary data source, but also consider information gathered from COD specialist, other staff, content of progress notes, and discussions observed during daily team meeting.

Refer to Table 26 below to determine if criteria are met at all, partially, or fully. If the program is fully based in integrated treatment for COD principles, the item is coded as a "5."

Table 26. Integrated Treatment for Co-Occurring Disorders (COD)

Criteria for the WHOLE TEAM:	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: considers interactions between mental illness and COD	Most team members' understanding of the interplay between mental illness and substance appears more superficial or believe one is to be addressed before the other.	Evidence is mixed: some team members clearly appreciate the interaction of mental illness and substance use, while others' understanding appears more superficial or believe one is to be addressed before the other.	All or nearly all team members appear to consider the interaction between mental illness and COD, 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 #2: does not have absolute expectations of abstinence and supports harm reduction	All or nearly all team members have absolute expectations of abstinence and do not value the harm reduction model, OR one or two members strongly hold to these values of abstinence over harm reduction and their beliefs have negatively affected the team and work with clients.	Most all team members appear to practice from a harm reduction model, and do not have absolute expectations of abstinence. One or two members appear to have conflicting views, but these deviations appear to have minimal impact on the team and work with clients.	All or nearly all team members appear to practice from a harm reduction model. No one has absolute expectations of abstinence.
Criterion #3: understands and applies stages of change readiness in treatment	Most team members do not understand stages of change readiness theory and therapeutic implications, OR embrace competing theories (e.g., sees substance use as a character flaw, or believes that all clients who use require AA/NA).	There is considerable variation across team members in their understanding and accurate application of stages of change readiness theory, OR most appear to understand the theory, but are less systematic in their application in practice.	All or nearly all team members appear to understand and accurately apply stages of change readiness theory when delivering treatment to those with COD.
Criterion #4: is skilled in MI	Most team members are not skilled in motivational interviewing techniques.	There is considerable variation across team members in their accurate understanding of MI, OR team members' understanding is somewhat superficial and practice is more limited.	All or nearly all team members appear to understand and accurately practice MI techniques when working with clients with COD. 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 use (decisional balance); scaling desires and abilities.
Criterion #5: follows CBT principles	Most team members do not follow CBT principles, possibly due to a lack of understanding of their own OR conflicting treatment philosophies.	There is considerable variation across team members in their accurate understanding of CBT principles, OR team members' understanding is somewhat superficial and practice is more limited.	All or nearly all team members appear to understand and apply CBT principles when working with clients who have comorbid substance use problems. Examples of CBT interventions include: understanding the relationship between thoughts, feelings, behaviors, and consequences; recognizing and replacing irrational thoughts; replacing maladaptive behaviors with competing adaptive behaviors.

	1	2	3	4	5
EP4. Integrated Treatment for Co-Occurring Disorders (COD)	Criteria are not met.	Only 1 - 3 criteria are met.	4 criteria met at least PARTIALLY (1 absent) OR 5 criteria met with 3 or more PARTIALLY met.	Team primarily operates from integrated treatment for COD, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team is fully based in integrated treatment for COD principles, FULLY meeting all 5 criteria.

EP5. Supported Employment & Education (SEE)

Definition: The TEAM practices from a model aligning with evidence-based supported employment and education (SEE) and the TEAM:
(1) Values competitive work as a goal for all clients;
(2) Believes and supports that a client's expressed desire to work is the only eligibility criterion for SEE services;
(3) Believes and supports that on-the-job assessment is more valuable than extensive prevocational assessment;
(4) Believes and supports that placement should be individualized and tailored to a client's preferences; and
(5) Believes that ongoing supports and job coaching should be provided when needed and desired by client, and has provided such supports.

Rationale: SEE is an evidence-based practice for adults with SMI. Successful implementation of SEE will involve full participation of all team members.

DATA SOURCES (* denotes primary data source)

Excel spreadsheet (columns F, G, H & I)

Examine the types of places individuals are working (competitive vs volunteer), whether the settings appear to be varied, and the extent to which the team has helped people obtain employment.

Employment Specialist Interview*

Could you summarize your fellow team members' views of assisting clients in obtaining competitive employment? [Probe for whether there is agreement or disagreement among staff in how to assist clients around their work goals. Do some staff believe in extensive pre-vocational assessment or believe that some clients are not ready for employment, possibly because of substance use or poor personal care?]	

Team Leader Interview	
What is the team's overall approach to employment and educational services within the team? [Prompt for familiarity with SEE including the criteria listed above. Reference Excel spreadsheet for more information on the team's efforts in helping people with competitive employment.]	
Peer Specialist	
How would you describe your team's approach to supporting people who are interested in employment?	
Clinician Interview*	
Now let's talk about employment and education services provided by the team. ***How does the employment specialist come to work with certain clients? How does the team make that decision?*** [Seek information regarding team's active role in engaging interest and referral.] ***What work programs do ACT clients access (e.g., sheltered work programs, work crews, transitional employment)?***	

Are there examples of where the team is providing training to help a person prepare to get a job? [If yes, ask for examples and probe for whether the team is actively doing job search at the same time, how much this preparation may be stalling a job search, and generally if any "work readiness" criteria are being considered.] ***Are you familiar with supported employment & education?*** [If yes:] *What is your understanding of the model?* ***Can you provide examples of how team members encourage and support competitive employment?*** [Select clients who are noted in the Excel spreadsheet to be in competitive employment, cross-reference the ID key to have name available, and ask:] ***Can you describe how the team is providing supports to*** *(insert client name)* ***to help*** *(him or her)* ***keep this job? Do you know if this client has a Career Profile and have you ever seen it?*** [If yes, further inquire how they use information in the Career Profile.]	

If a client says they want to work full-time, but you know they will lose their benefits, what do you typically do?	

ITEM RESPONSE CODING

Rating Guidelines

This item is intended to be an approximate measure of the team's adherence to evidence-based SEE, both philosophically (i.e., do they embrace these principles within their core belief set) and in practice (i.e., do they apply these principles in their work with clients). Judgment of whether a specific criterion is Fully vs. Partially met should consider multiple data sources. This item is focused on the practice of the entire team. As it is unlikely that you will be able to interview each team member, use the team leader interview as primary data source, but also consider information gathered from employment specialist, other clinicians, and discussions observed during daily team meeting.

Refer to Table 27 below to determine if criteria are met at all, partially, or fully. If the program is fully based in SEE principles, the item is coded as a "5."

Table 27. Supported Employment & Education (SEE)

Criteria for the WHOLE TEAM	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: values competitive work as a goal for all clients	Most team members do not appear to embrace the value of competitive employment as an immediate, achievable goal, as reflected by their work with clients.	Evidence appears to be mixed: the value of competitive employment varies considerably across team members, and/or the value is articulated, but with less consistent application in practice.	All or nearly all team members appear to value the importance of competitive work, particularly as an immediate, achievable goal, and these values are reflected in their work with clients.
Criterion #2: believes and supports that a client's expressed desire to work is the only eligibility criterion for SEE services	Most team members appear to value "work readiness" criteria other than client's expressed desire to work. These other "work readiness" criteria may include sobriety, medication adherence, and symptom stability (e.g., no active hallucinations, motivation and follow-through).	Evidence appears to be mixed: some team members appear to hold other less consequential "work readiness" criteria as more important than client's expressed desire to work.	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.

Table 27. Supported Employment & Education (SEE)			
Criteria for the WHOLE TEAM	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #3: believes and supports that on-the-job assessment is more valuable than extensive prevocational assessment	Most team members strongly value extensive prevocational assessment practices (e.g., spending a lot of time completing assessment paperwork, evaluating skills via work groups, expecting clients to complete work trials).	Evidence appears to be mixed: some team members appear to value the practice of extensive prevocational assessment, which may include any trial experience testing soft skills (e.g., punctuality, attention, social skills, grooming) thereby delaying progress toward achieving employment.	All or nearly all team members appear to value the importance of on-the-job assessment and limits extensive prevocational assessment, which can unnecessarily delay progress toward the employment goal. No team member appeared to clearly advocate for extensive work trials and pre-vocational assessments.
Criterion #4: believes and supports that placement should be individualized and tailored to a client's preferences (See Excel spreadsheet columns F, G, H & I)	Most team members appear to minimize the importance of individualized and tailored placements. The team may heavily rely on a few select competitive and noncompetitive employment opportunities known to hire their clients.	Evidence appears to be mixed: some team members appear to minimize the importance of individualized and tailored placements, possibly preferring a few select competitive and noncompetitive employment opportunities known to hire their clients.	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).
Criterion #5: believes that ongoing supports and job coaching should be provided when needed and desired by client	Most team members appear to <u>not</u> view themselves as being responsible for providing ongoing supports and coaching to clients as they engage in educational or work activities.	Evidence appears to be mixed: some team members appear not to value the team's role as providing ongoing supports (e.g., some team members may share stories about when they didn't think job coaching and support was helpful or that it isn't the role of the team or employment specialist to provide).	All or nearly all team members appear to believe that ongoing supports and job coaching should be provided when needed and desired by the client, as evidenced by expressed values and observed practices (e.g., team members consistently report that they think these strategies help and that it is the role of the ACT team to provide, team members may describe when they or others on the team have directly provided such coaching and support).

EP5. Supported Employment & Education (SEE)	**1**	**2**	**3**	**4**	**5**
	Criteria are not met.	Only 1 - 3 criteria are met.	4 criteria met at least PARTIALLY (1 absent) OR 5 criteria met with 3 or more PARTIALLY met.	Team primarily embraces SEE, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team fully embraces SEE and FULLY meets all 5 criteria.

EP6. Engagement & Psychoeducation with Natural Supports

Definition: The FULL TEAM works in partnership with clients' natural supports. As part of their active engagement of natural supports, the team:
(1) Provides education about their loved one's illness;
(2) Teaches problem-solving strategies for difficulties caused by illness; and
(3) Provides &/or connects natural supports with social & support groups.
Rationale: It is the ACT team's role to work collaboratively with clients to help identify natural supports in the community who may be able to provide a role in supporting the client's recovery and furthering community integration. Once these individuals are identified and clients consent to any contact with them, the ACT team should actively engage them by providing them with the information necessary to help them to further support the ACT client and either directly provide or connect them with supports in the community.

DATA SOURCES (* denotes primary data source)

Excel spreadsheet (column X)

Examine responses to contacts with clients' natural supports. While referring to the ID key to access names, randomly select examples to further query about the nature of those contacts.

Daily Team Meeting - Observation Form (p. 189-192)

Listen for whether team members have had contacts with natural supports and the extent to which their contact reflects education, problem-solving and overall support.

Team Leader Interview*

Now I'm going to ask you some questions about how the team works with families and natural supports. ***How does the team typically work with clients' families and natural supports?***	
Can you provide (additional) examples of the team educating natural supports about their loved one's illness? [Prompt for clarification if examples represent proactive or reactive encounters with supports]	
Can you provide (additional) examples of the team working with natural supports and the client to develop better problem-solving skills? [Prompt for clarification if examples represent proactive or reactive encounters with supports]	

In what (other) ways has the team helped connect natural supports to support groups? Randomly select specific clients listed in the Excel spreadsheet with whom the team has had contact with natural supports, reference the ID key to access names, and ask: ***Describe what the team did with this particular client's natural supports.***	
Clinician Interview	
Now I'm going to ask you some questions about how the team works with families and natural supports. ***How does the team typically work with clients' families and natural supports?*** [Note: if the same client examples come up across interviews, prompt for other examples to understand scope of practice.] ***Can you provide (****additional****) examples of the team educating natural supports about their loved one's illness?*** [Prompt for clarification if examples represent proactive or reactive encounters with supports]	

Can you provide (*additional****) examples of the team working with natural supports and the client to develop better problem-solving skills?*** [Prompt for clarification if examples represent proactive or reactive encounters with supports] ***In what (****other****) ways has the team helped connect natural supports to support groups?*** Randomly select specific clients listed in the Excel spreadsheet with whom the team has had contact with natural supports, reference ID key to access names, and ask: ***Describe what the team did with this particular client.***	
Client Interview	
Does the team ever talk to anyone important in your life—such as family, close friends, landlords, church members, or employers? [If yes, probe what the content of those contacts are—do they appear to be quality contacts with the intent of better serving the client?]	

ITEM RESPONSE CODING
Rating Guidelines
Please refer to Table 28 below to determine if services are provided at all, partially, or fully.

Table 28. Engagement & Psychoeducation with Natural Supports			
Service	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
As part of their active engagement of natural supports, team: Service #1: provides education about their loved one's illness;	Team very rarely educates clients' natural supports about their loved one's illness, possibly due to a lack of priority or a lack of understanding of their own.	Examples are provided, but they appear to be isolated and/or reactive/passive to a situation. Team does not appear to prioritize their role as an educator for clients' natural support system.	Team seeks opportunities to educate 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.
Service #2: teaches problem-solving strategies for difficulties caused by illness;	Team very rarely, if at all, works with clients' natural supports to develop effective problem-solving skills.	Examples are provided, but they appear to be isolated and/or reactive/passive to a situation (e.g., a crisis event). Team does not appear to prioritize their role as a point of intervention within the clients' natural support system.	Team embraces their role as an interventionist by proactively addressing problems that exist in the natural support system, including teaching 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.
Service #3: provides &/or connects natural supports with social & support groups.	Team does not appear to attend to the social support needs of clients' natural supports.	Team provides several examples, but this practice is not systemically and routinely provided by the team.	Team directly provides support groups, coordinates with NAMI or other community-based agencies that provide such groups, and/or routinely provides this information to natural supports. The latter could include information in the ACT admission packet and/or group information provided to natural supports when they first meet with them.

	1	**2**	**3**	**4**	**5**
EP6. Engagement & Psychoeducation with Natural Supports	Team does not provide any of the specified services with clients' natural supports.	1 or 2 services are provided.	ALL 3 services are provided, but 2-3 services only PARTIALLY.	ALL 3 services are provided but 1 only PARTIALLY.	ALL 3 services are FULLY provided by team.

EP7. Empirically-Supported Psychotherapy

Definition: The team: (1) deliberately provides individual and/or group psychotherapy, as specified in the treatment plan; (2) uses empirically-supported techniques to address specific symptoms and behaviors; and (3) maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to clients in need of such services. Although all team members can be trained to effectively use therapeutic techniques, such as cognitive behavioral therapy and motivational interviewing, the team also ideally has a licensed therapist.

Rationale: In addition to providing case management/support, psychiatric rehabilitation (e.g., skills training), and wellness and recovery services to clients, core clinical members of the ACT team should be competent in and provide empirically-supported psychotherapy to address the wide range of clinical and behavioral issues for this population (e.g., psychotic symptoms, anxiety, depression, criminal justice involvement, symptoms consistent with borderline personality disorder).

DATA SOURCES (* denotes primary data source)

Excel spreadsheet (column M)*

Examine how many clients are receiving psychotherapy services from the team. Note the specific types of psychotherapeutic techniques reported.

Chart Review

Review the extent to which the team delivers empirically-supported therapies, and how routine are these contacts (e.g., weekly, every other week).

Team Leader Interview

Do clients on your team ever receive psychotherapy from the team? [If yes]: *Tell me more about the kind of psychotherapy services provided. Is it formally or more informally provided? Is there anyone on your team who is a trained therapist? Have other staff received training in specific psychotherapies and/or receive supervision in the use of psychotherapy (e.g., CBT or MI)? Does psychotherapy tend to take place in the context of other services provided (e.g., providing supportive counseling while grocery shopping)?* [Refer to clients noted as seeing <u>non-ACT team therapists in column M</u> of the Excel spreadsheet; select clients and inquire as to why they are seeing a non-ACT therapist.]	

Clinician Interview*	
Note that team members chosen for this clinician interview should ideally include one qualified therapist. ***Do you provide psychotherapy?*** *How would you describe your style in therapy? What kind of therapy do you typically offer? What does it look like? Can you give me examples of specific methods you use with clients who have specific symptoms or concerns?* Give specific examples (e.g., someone with social anxiety; someone with significant trauma history). ***What kind of resources or training materials does your team use to guide delivery of therapy to clients on the team?*** (Prompt for specific worksheets, homework, diary cards/logs. See Table 29 below for examples of manuals.). Refer to responses in column M of the Excel spreadsheet and prompt for: ***About how often is psychotherapy provided—weekly, every other week, monthly, as needed? How long is each session, on average?*** ***Let's talk about this client—tell me about your therapeutic approach in working with them. What about this client?***	

Daily Team Meeting
Listen for how these two clinicians and other team members report on specific psychotherapeutic interventions during their report in the daily team meeting.
ITEM RESPONSE CODING
Rating Guidelines
Note: These services include group or individual therapeutic approaches that are based on established theory and techniques. Therapies are selected and employed to address a specific set of symptoms or behaviors (e.g., relaxation and exposure therapy for anxiety disorders; CBT for schizophrenia or depression; dialectical behavioral therapy for emotional dysregulation). Psychotherapy sessions are deliberate, tied to clients' goals and written into the client's treatment plan. Ideally, psychotherapy is conducted by a trained therapist, but other staff may be equipped to deliver select therapies given appropriate training and supervision. Psychotherapy services reported here should be reflected across other data sources (e.g., progress notes, treatments plans). MI should not be counted for this item and EP1. Full Responsibility for Integrated Treatment for Co-Occurring Disorders unless the client is receiving MI for both COD and for other areas of their life where they may be in an earlier stage of change readiness (e.g., in contemplation about moving from unsafe housing). Both sets of interventions must be documented separately in the treatment plan. Rating is guided by a combination of the clinician report on the extent to which there is a team member providing empirically-supported therapy and the number of clients who receive such formal therapy by the team as identified in the Excel spreadsheet. Use the daily team meeting and chart review (document whether psychotherapy interventions were specified in the charts in the Chart Review Notes) to corroborate other data sources. Use Table 29 below to guide rating for this item.

Formula for Criterion #3	$\frac{\text{\# of clients who receive deliberate, empirically-supported psychotherapy in the past year}}{\text{Total \# of clients served on the ACT team}}$	**x 100**

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.

Table 29. Empirically-Supported Psychotherapy			
Criteria	**Examples/Guidelines**		
	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).
Criterion #3: Team maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to clients in need of such services (See Excel spreadsheet column M)	In the past year, less than 25% of clients have received a deliberate, empirically-supported psychotherapeutic intervention.	In the past year, 25-39% of 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 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)

Table 30. Examples of Empirically-Supported Psychotherapies		
Diagnosis/Symptoms	**Name of Therapy**	**Example Manuals/Handbooks**
Schizophrenia Spectrum Disorders	Cognitive Behavioral Therapy	*Cognitive Behavioral Therapy of Schizophrenia (Kingdon & Turkington, 1994)* *Cognitive-Behavior Therapy for Severe Mental Illness: An Illustrated Guide (Wright, Turkington, Kingdom, & Basco, 2009)* *Cognitive-Behavioral Social Skills Training for Schizophrenia: A Practical Treatment Guide (Granholm, McQuaid, & Holden, 2016)*
	Cognitive Remediation Therapy	*Cognitive Remediation for Psychological Disorders: Therapist Guide (Medalia, Revheim, & Herlands, 2009)* *Cognitive Remediation Therapy for Schizophrenia: Theory & Practice (Wykes & Reeder, 2005)*

Table 30. Examples of Empirically-Supported Psychotherapies		
Diagnosis/Symptoms	**Name of Therapy**	**Example Manuals/Handbooks**
Panic Disorder with or without Agoraphobia; Specific phobias; Social Anxiety Disorder; Generalized Anxiety Disorder	Cognitive Behavioral Therapy	*Mastery of Your Anxiety and Panic (Barlow, Craske, & Meadows, 2005)* *Mastering Your Fears and Phobias (Craske, Antony, & Barlow, 2006)* *The Anxiety and Phobia Workbook, 4th Edition (Bourne, 2005)*
Depressive Disorder	Acceptance and Commitment Therapy (ACT)	*Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change (Hayes, Strosahl, & Wilson, 1999)*
	Cognitive Behavioral Therapy	*Cognitive Therapy: Basics and Beyond (Beck, 1995)* *Cognitive Therapy of Depression (Beck, Rush, Shaw, & Emery, 1979)*
	Interpersonal Therapy	*Comprehensive guide to interpersonal psychotherapy (Weissman, Markowitz, & Klerman, 2000)*
	Problem-Solving Therapy	*Problem-Solving Therapy: A Treatment Manual (Nezu, Nezu, & D'Zurilla, 2012)*
Bipolar Disorder	Cognitive Behavioral Therapy	*Cognitive Behavioral Therapy for Bipolar Disorder (Basco & Rush, 1996)*
	Interpersonal and Social Rhythm Therapy	*Treating Bipolar Disorder: A Clinician's Guide to Interpersonal and Social Rhythm Therapy (Frank, 2007)* *Integrated Family and Individual Therapy for Bipolar Disorder (Miklowitz, Richards, George et al., 2003)*
Borderline Personality Disorder; Chronic suicidality and self-harm	Dialectical Behavior Therapy	*Cognitive-Behavioral Treatment of Borderline Personality Disorder (Linehan, 1993, 2015)* *Skills Training Manual for Treating Borderline Personality Disorder (Linehan, 1993, 2015)*
Post-Traumatic Stress	Exposure Therapy	*Prolonged Exposure Therapy for PTSD (Foa, Hembree, & Rothman, 2007)*
	Trauma Recovery and Empowerment Model (TREM)	*Trauma Recovery & Empowerment: A Clinician's Guide to Working with Women in Groups (Harris, 1998)*
Early stages of change readiness (not specific to treating a co-occurring disorder when rating this item)	Motivational Interviewing	*Motivational Interviewing: Preparing People for Change (Miller & Rollnick, 2002)* *Motivational Interviewing in the Treatment of Psychological Problems (Arkowitz, Miller, Rollnick, & Westra, 2008)*

	1	2	3	4	5
EP7. Empirically-Supported Psychotherapy	Team does not provide psychotherapy to clients. No criteria are met.	1 to 2 criteria are PARTIALLY met.	Criterion #1 is PARTIALLY met and criteria #2 and #3 is at least PARTIALLY met OR Team FULLY meets both criteria #1 and #2, but does not meet criterion #3.	Team FULLY meets criterion #1, PARTIALLY meets criterion #2, and at least PARTIALLY meets criterion #3. OR Team FULLY meets both criteria #1 and #2 and only PARTIALLY meets criterion #3.	Team FULLY meets all 3 criteria.

EP8. Supportive Housing

Definition: The team embraces supportive housing, including: (1) assisting clients in locating housing of their choice (e.g., providing multiple housing options, including integrated housing); (2) respect for clients' privacy within residence; (3) assistance in accessing affordable, safe/decent, and permanent housing; and (4) assured ongoing tenancy rights, regardless of clients' progress or success in ACT services.

Rationale: It is the ACT team's role to work collaboratively with clients to identify and secure safe, affordable, decent housing in the community that provides them with the rights of tenancy under landlord tenant laws. The team provides flexible support and services to help meet clients' needs and preferences in these housing settings. Studies have shown that supportive housing has helped clients progress in recovery and maintain residence in the community.

DATA SOURCES (* denotes primary data source)

Housing Specialist, if available OR Team Leader Interview*

In what kinds of settings are clients living? Do they typically have a choice of where to live or have many options? [As needed, prompt for types of settings and household composition (families; congregate, supervised, independent settings; group, individual) and range of options the team can offer. Review entries on Excel spreadsheet (column O) indicating who lives in settings where more than 25% of units/rooms are designated for tenants with a disability or special need. Use these entries to query Team Leader to further distinguish between who appears to be in more congregate vs. integrated settings. Further query about whether clients who live in congregate setting with others with disabilities actually chose to live in that setting, and what is the team doing to help them move into more independent settings. Exclude those in hospitals or jailed, although this information may be of relevance for other items. Make note of residential settings occupied by a majority of individuals with disability/special needs, although these units/rooms are not specifically designated for these groups; may include in qualitative feedback if reflects a prominent agency behavior that may undermine client choice in housing].	

Review those indicated as being homeless in column O. [Randomly select specific clients listed in the Excel spreadsheet who are living in supervised residential settings, see ID reference to access names, and ask:] ***Describe what the team is doing with this client around their current residential placement (e.g., did the team help them move in and why, is there current action to help this person move out, and what does that look like?).*** ***What is the team doing to help homeless clients access affordable and safe housing?*** ***Does the team have access to clients' residences, such as having a key? If so, for approximately how many clients? Under what conditions does the team access clients' residences?*** [Review entries on Excel spreadsheet (columns P and Q) regarding who is receiving a subsidy, is waitlisted to receive a subsidy, or is paying no more than 30% of income to live in a safe and affordable setting without a subsidy. Make sure that data are accurately entered so that individuals who may be living in affordable, but unsafe, environment are excluded.]	

What types of housing subsidies do these individuals receive? What has been the process for assisting clients in accessing housing subsidies? [Determine whether the team appears to be proactive in assisting clients with accessing subsidies so that they may move into more affordable, and likely safer, independent living residences. Are clients on subsidy waitlists?] ***Do any clients live in housing you consider to not be safe or decent (e.g., relatively clean, not in disrepair, does not pose a threat to the client in some way)? If so, which of the clients listed on the spreadsheet?*** ***Do any clients live in housing that is temporary and/or transitional (i.e., there is a limited timeframe for how long they can live there)? If so, which of the clients listed on the spreadsheet?*** ***Do some clients live in residences where the conditions in the lease go beyond what is typical of a common lease, such as including conditions for treatment participation and/or sobriety?*** [For those with requirements of treatment participation, is it specifically with ACT or any service program? Approximately how many have such contingencies written into the lease? Who was the last client evicted as a result of violating these specific terms of a lease? Query for the team's role in that eviction.]	

Client Interview	
Tell me a little bit about where you live. What do you like and not like about it? [Query for affordability, safety/decency, permanency, whether they live in an integrated or clustered setting, and if there are any requirements of them to remain in treatment or stay sober while living in residence.]	
How did you come to live in your current residence? [Probes: Did you have a choice about where to live? Did the ACT team talk with you about your housing options? Did you have more than one possibility suggested for housing?]	
Do you feel like you have the privacy that you want? [If necessary and appropriate, query for whether staff have access to their home.]	
How long do you get to stay where you currently live? Have you been told you have to move after a certain amount of time?	

Excel spreadsheet*
See Table 31 for specific questions and columns referenced for each criterion.

Chart Review and Daily Team Meeting
Examine charts for information about the nature of clients' residential settings, references to client preferences or other expressions of interests in housing alternatives, and staff access to housing. At the daily team meeting, listen for references to deliberations about housing and residential "placements" and how team members report on or plan for interactions around clients' residential interests.

ITEM RESPONSE CODING
Rating Guidelines
Refer to Table 31 below to determine whether, and to what extent, the team meets these five supportive housing criteria. The assessment of this item is based on the team's approach to assisting clients with housing, regardless of how this approach may be influenced by access to resources and/or policies and procedures external to the ACT team.

Table 31. Estimation of Credit for Four Supportive Housing Practices

Criteria, Definition, and Primary Data Source (marked *):	**No Credit**	**Partial Credit**	**Full Credit**
Criterion #1: Client choice: Clients typically live in housing of their choice (e.g., ideally living in residences typical of the community, without clustering people with disabilities and/or other special needs such as homelessness). **DATA SOURCES:** Excel spreadsheet (column O) and interview questions* While the team may report in the interview that some clients chose to live in congregate or clustered housing, do not adjust percentage, but note it in the qualitative item-level feedback.	Most clients (at least 70%) live in settings where at least 25% of the units/rooms are designated for tenants who meet disability related and/or special needs (e.g., homelessness) eligibility criteria. OR At least 25% of clients live in settings where at least 75% of the units/rooms are designated for tenant who meets disability related and/or homeless eligibility criteria.	Some clients (26% - 69%) live in settings where at least 25% of the units/rooms are designated for tenant who meet disability related and/or special needs (e.g., homelessness) eligibility criteria.	Few clients (25% or less) live in settings where at least 25% of the units/rooms are designated for tenants who meet disability related and/or special needs (e.g. homelessness) eligibility criteria.
Criterion #2: Privacy: Clients have control over whether and when staff enter their residence.	ACT staff has free access to client residences OR At least 40% of ACT clients are residing in supervised residential environments where privacy may be compromised by way of the living environment itself where there is less choice and freedom.	No partial credit.	ACT staff may not enter the client residence unless client invites them OR if the team has reason to believe the client is in crisis and/or has advanced directives for mental health conditions or other high needs (e.g., serious physical conditions) that require them to have extra support to live independently.

Table 31. Estimation of Credit for Four Supportive Housing Practices			
Criteria, Definition, and Primary Data Source (marked *):	**No Credit**	**Partial Credit**	**Full Credit**
Criterion #3: Affordable, safe/decent, and permanent housing: Clients pay a reasonable amount from their income (30% or less) toward their rent or mortgage plus basic utilities, partly as a result of the team's efforts to help them secure housing subsidies and other supports. Exclude individuals who are judged to not be in a safe/decent (e.g., not relatively clean, in disrepair) environment or are in temporary/transitional housing, per the team leader/housing specialist and client interviews. **DATA SOURCES:** Excel spreadsheet (columns P & Q) and client/staff interviews*	Few clients (less than 25%) pay a reasonable amount from their income to live in safe housing.	Some clients (26% - 74%) pay a reasonable amount from their income to live in safe housing.	Most clients (at least 75%) pay a reasonable amount from their income to live in safe housing.
Criterion #4: Tenancy rights: Clients' tenancy is *not* contingent on their progress or success in ACT services. **DATA SOURCES:** Excel spreadsheet (column R) and interview Questions* If "no credit" condition is true for more than one individual, then rate "no credit." To rate full credit, there are no instances where client's lease includes conditions related to successful engagement in ACT services (one or two exceptions may be allowed to still receive full credit). It is not uncommon for access to housing subsidies to require such conditions, resulting in no more than partial credit.	Tenancy is revoked based upon noncompliance with ACT services or failure to participate in other rehabilitative/clinical services (e.g., unwillingness to be seen by staff, and/or lack of progress, such as with substance use reduction or medication adherence). Exclude individuals who elected to live in sober living residences to advance their recovery, where such residences often require treatment participation (and sobriety) to remain in residence.	Clients are required to participate in ACT or other rehabilitative/clinical program, but tenancy is not contingent on progress (e.g., obtaining and maintaining sobriety, or adhering to medications).	Tenancy is not contingent in any way upon clients' participation in ACT or other rehabilitative/clinical service program (i.e., tenancy may be contingent on very basic contact with outreach program for the purpose of very minimal monitoring and engagement opportunities).

	1	2	3	4	5
EP8. Supportive Housing	Team meets no more than 1 criterion.	3 criteria PARTIALLY met OR 2 criteria met, at least PARTIALLY.	4 criteria met, with at least 2 PARTIALLY met OR 3 criteria met, with at least 1 criterion FULLY met.	ALL 4 criteria met, with up to 1 criterion PARTIALLY met (remaining 3 criteria are FULLY met).	ALL 4 criteria FULLY met.

PP1. Strengths Inform Treatment Plan

Definition: (1) The team is oriented toward clients' strengths and resources, and (2) clients' strengths and resources inform treatment plan development.

Rationale: Assessment of strengths alone does not necessarily result in strengths-based approaches to services. To ensure that they are applied within practice, it is important for strengths and resources to be transferred from the assessment and carried out within the treatment plan.

DATA SOURCES (* Denotes primary data source)

Chart Review* - Chart Review Log Part II (p. 197-198) and Chart Review Tally Sheet Part II (p.201-202)

Review treatment plans for three or more meaningful and personal strengths and resources identified in the assessment. Also review plans to determine whether strengths inform the plan itself (i.e., identified strengths are thoughtfully used or leveraged in efforts to move toward personal recovery goals or objectives).

Team Leader Interview*

Does your team routinely assess client strengths and resources? Where would we find these documented? [Acknowledge areas you may have already identified strengths in documentation.]	
How does your team use or apply the strengths and resources that are identified in their work with clients, including how plans are developed?	
[Go to Excel spreadsheet and randomly pick 2-3 clients]: ***Tell us a little bit about this client's strengths/resources and how the team is working with that client, given those particular strengths/ resources.***	

Clinician Interview*	
Do you routinely assess client strengths and resources? ***How do you use or apply the strengths and resources that are identified in your work with clients? Can you give us some examples?*** [If yes:] ***Where would we find that information in the charts?***	

ITEM RESPONSE CODING

Rating Guidelines

Use both the interview data and chart review as the primary data sources in rating this item. Use the Chart Review Log Part II at the end of this protocol to identify strengths and resources within the treatment plan. If strengths and resources are not reflected within the treatment plan goals and action steps, do NOT count that chart toward the percentage of charts that incorporate strengths/resources. Please see Table 32 for further guidelines in how to assess whether each criterion was met.

Table 32. Strengths Inform Treatment Plan

Criteria	Examples/Guidelines		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: The team is oriented toward clients' strengths and resources[9]	The team does not appear to attend to clients' strengths and resources, instead focused on clients' limitations and problems AND/OR	The team variably attends to clients' strengths and resources (evidence was mixed across data sources; limited documentation of strengths/resources	The team is clearly attentive to clients' strengths and resources, with a process in place for more systematic assessment of strengths and resources (i.e., these attributes were consistently documented in assessments/plans) and orientation to those strengths in day-to-day work with clients is evident. Strengths and resources should include those attributes, skills and qualities that are individual and personal to the client, not simply team-generated strengths regarding the client's progress in treatment, such as medication or treatment adherence.

[9] Use Chart Review Tally Sheet II or TMACT Calculation Workbook to calculate percentage of charts in which personal strengths and resources are assessed.

Table 32. Strengths Inform Treatment Plan			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
	nearly all strengths or resources identified were team-generated based on the client's response to treatment (e.g., medication compliance, works well with the team).	was observed) OR some strengths or resources identified were team-generated based on the client's response to treatment (e.g., medication compliance, works well with the team).	Personal strengths may also include ways in which the client has handled difficult situations or persevered despite difficulties in the past. Note: Consider the quality and quality of strengths captured in documentation as well as the perspective and approach of the team, as observed in other data sources (e.g., daily team meetings, team member interviews).
Criterion #2: Clients' strengths and resources inform treatment plan develop-ment[9]	Very few, if any (less than 29%) of the reviewed treatment plans, clients' strengths and resources were not only assessed, but clearly informed the development of goals, objectives, and/or interventions.	For some (i.e., 30 – 64%) of the reviewed treatment plans, clients' strengths and resources were not only assessed, but clearly informed the development of goals, objectives, and/or interventions.	In at least 65% of the reviewed treatment plans, clients' strengths and resources were not only assessed, but clearly informed the development of goals, objectives, and/or interventions. For example: A client's strength was his artistic abilities and interests. In a goal related to his developing healthy relationships, an objective was to join a local art club that met monthly and integrate that goal into provision of individual IMR. A client's strength was her caretaking of others. To help encourage her developing cooking skills, staff collaboratively developed skills training interventions that involved helping her learn how to cook a weekly dinner for herself and a neighbor friend.

	1	**2**	**3**	**4**	**5**
PP1. Strengths Inform Treatment Plan	Strengths are not assessed (no criteria #1).	Team variably attends to clients' strengths and resources and strengths/ resources do not inform planning (Partial #1 only).	Team is clearly attentive to clients' strengths and resources, but clients' strengths and resources do not typically inform plan development (Full #1 and No credit #2) OR Team is variably attentive to strengths and uses this information to inform plans, but less systematically (Partial #1 and Partial #2).	Team is clearly attentive to clients' strengths and resources, which informed plan development for some (Full #1 and Partial #2).	Team is highly attentive to clients' strengths and resources, and gathers such information for the purpose of treatment planning (Full #1 and Full #2).

PP2. Person-Centered Planning

Definition: The team creates treatment plans using a person-centered approach, including:
(1) Development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting) and with the team, preferable the individual treatment team (ITT);
(2) Conducting regularly scheduled treatment planning meetings;
(3) Attendance by *key* staff (i.e., members of the ITT), the client, and anyone else they prefer (e.g., family), tailoring number of participants to fit with the client's preferences;
(4) Provision of guidance and support to promote self-direction and leadership within the meeting, as needed; and
(5) Treatment plan is clearly driven by the client's goals and preferences.

Rationale: Person-centered planning involves rethinking the traditional treatment planning process so that it is maximally responsive to an individual's expressed needs, preferences, and rights to self-determination. By planning a central role in planning their own services and goals, clients are empowered to make positive choices in their own lives, both within and outside the mental health system. Research suggests a linkage between person-centered planning, increased medication adherence, and service engagement.

DATA SOURCES (* Denotes primary data source)

Treatment Planning Meeting* - Observation Form (p. 193) and Chart Review Log Part II (p. 197-198) and Chart Review Tally Sheet Part II Tally (p. 201-202)

Observe at least one treatment planning meeting and note elements of person-centered planning.

Chart Review*

Observe the quality and person-centeredness of Person-Centered Plans. Did they appear to result for a person-centered process?

Team Leader Interview

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.]	

Clinician Interview	
NOTE**:** For all interview questions pertaining to the treatment planning process, try to reserve these questions for after observation of the treatment planning meeting, if possible, and reflect on observations when posing questions. ***How often do treatment planning meetings occur?***	
What is the process of getting the information you need to inform treatment planning meetings with clients?	
Who typically attends these meetings? What percentage of clients attends their treatment planning meetings? [Ask follow-up questions of how commonly the team uses the model described to you.]	
What is the client's role in their treatment planning meetings?	
How do you ensure that clients understand what the treatment planning meeting is and their role within their own treatment and this particular meeting?	

Peer Specialist Interview	
See previous response to this question in ST8.	
Client Interview	
Do you know what your treatment plan (or use the term used by the client or agency) ***is?*** ***Do you ever attend your treatment planning meetings or meetings with the team?*** ***What are those meetings like for you?*** ***Who typically attends those meetings?*** ***Do you feel like what you're saying is being heard by your team when coming up with your plan?***	

ITEM RESPONSE CODING

Rating Guidelines

Observation of the treatment planning meeting should drive the rating on this item with confirmation of observations with staff interviews (i.e., determine whether what was observed reflected typical practice). As described in the introduction, it is important to plan for attendance at this meeting ahead of time when you plan your site review. If attendance in the treatment planning meeting isn't possible, ask team members to describe their treatment planning process during your interviews with them and examine treatment plans in the charts to corroborate what you hear from team members.

Consider whether the team (esp. client's ITT) appears to use their routine contacts to assess clients' needs and wants, and begin formulating a treatment plan prior to the meeting. Are key team members included in the meeting, or is it just the primary case coordinator or, conversely, the entire team? Is there an effort to help the client take some control and responsibility for directing this meeting?

Refer to Table 33 below to determine if criteria are met at all, partially, or fully. If all five elements of ACT person-centered planning are present, rate as a "5."

Table 33. Person-Centered Planning			
Function	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Function #1: Development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting).	The team does not appear to attend to relevant treatment planning data during their routine contacts with clients prior to the treatment planning meeting. During the treatment planning meeting, there is little reference to what staff already know about the client, as relevant to the new treatment plan.	There appears to be some attention to collecting relevant treatment planning data during routine contacts leading up to the treatment plan meeting with the client, but this is done inconsistently, and/or this information is not used to develop a formative treatment plan to be revised during the meeting with client.	The team uses routine contacts to assess clients' needs and wants, and begin formulating a treatment plan prior to the meeting. Pre-treatment plan meetings (i.e., among ITT members) help team members share and synthesize relevant assessment data. There may be multiple pre-treatment plan meetings like this and they can be very informal with only two or three members of the client's treatment team. By the time of the scheduled treatment planning meeting with the client and natural supports, it is clear that the team has collected some or all of the following information, which may then be used to create a formative plan to be revised during the meeting: • Gain feedback on what has worked/not worked as laid out in the treatment plan in the past (if this isn't their initial treatment plan); • Trouble-shoot how to resolve any current concerns with treatment and incorporate them into the treatment plan; and • Get a sense of the client's treatment and recovery goals to develop a formative treatment plan.
Function #2: Conducting regularly scheduled treatment planning meetings.	Treatment planning meetings are typically held more than every six months or not at all.	Treatment planning meetings are held less consistently (sometimes not every six months).	Treatment planning meetings are regularly held, typically at least every six months.
Function #3: Attendance by *key* staff, the client, and anyone else they prefer, tailoring number of participants to fit with the client's preferences.	Treatment planning meetings routinely do not include members of the treatment team, client, or others the client prefers/requests to participate. It may be the case that the "primary" care coordinator assigned to work with the client completes the plan with the client alone.	Treatment planning meetings less consistently include key members of treatment team, clients, and/or others the client prefers/requests to be in the treatment planning meeting; OR The treatment planning meeting includes all participants named above, but it appears to be an overwhelming experience for clients and is not adapted to fit their experience and preferences. In such cases, sometimes clients may opt out of the treatment planning meeting (i.e., "They don't want to come in and meet with all of us.")	Treatment planning meetings consistently include: • Members of the client's ITT; • The client; and • Others the client prefers /requests to be at the meeting (e.g., family, other natural supports). However, if the client prefers to have fewer participants, the number of meeting participants is tailored to those preferences and may include a smaller group.

Table 33. Person-Centered Planning			
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.

	1	**2**	**3**	**4**	**5**
PP2. Person-Centered Planning	No more than 1 function of person-centered planning is performed OR 2 functions are performed, but not fully.	2 functions of person-centered planning are FULLY performed (3 are absent) OR 3 functions are performed at least PARTIALLY (3 are absent).	4 functions of person-centered planning are performed (1 absent) OR 5 functions performed, with 3 or more PARTIALLY performed.	ALL 5 functions of person-centered planning are performed, with up to 2 PARTIALLY performed.	ALL 5 functions of person-centered planning are FULLY performed.

PP3. Interventions Target a Broad Range of Life Domains

Definition: The team attends to a range of life domains (e.g., physical health, employment/education, housing satisfaction, legal problems) when planning and implementing interventions. (1) The team specifies interventions that target a range of life domains in treatment plans and (2) these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs.

Rationale: Pursuit of a range of life goals is essential to recovery and a range of planned interventions are thereby needed to assist clients advance in their recovery. Daily team practices should reflect a breadth of interventions well beyond those typical of basic maintenance and case management (e.g., medication management, money disbursement, and grocery shopping).

DATA SOURCES (* Denotes primary data source)

Daily Team Meeting

Note the services and contacts planned for that day and the extent to which they reflect more than those that are typically clinically-defined (e.g., taking medications, staying out of the hospital, reducing symptoms). Scan Client Daily Log for breadth of services documented as being delivered.

Chart Review* - Chart Review Log Part II (p. 197-198) and Chart Review Tally Sheet Part II (p.201-202)

Review treatment plan goals (in charts) for presence of a diverse range of life areas and respective progress notes to determine if interventions focus on a broad range of life areas.

Weekly Client Schedules*

Review Weekly Client Schedules for planned service contacts and extent to which they focus on a broad range of life goals.

ITEM RESPONSE CODING

Rating Guidelines

Life domains address more than traditional clinical goals, such as medication management, symptom reduction, and staying out of the hospital. They include: Housing, Finances, Physical Health, Social/Relationships, Employment/Education, Independent Living Skills, Legal, Substance Use, and other areas of personal recovery, including targeted psychotherapy. The focus of PP3 is the planning and delivery of *interventions,* which are intended to result in a behavior/symptom change within these life domains; documentation of observations or commentary (e.g., remarking on client's poor self-care) are not considered implemented interventions, nor are case management tasks (distribution of money, per representative payeeship). Refer to Table 34 to determine if criteria are met at all, partially, or fully.

Table 34. Interventions Target A Broad Range of Life Domains			
Criteria	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Criterion #1: Team specifies interventions that target a range of life domains in treatment plans.	Less than 30% of plans reviewed have interventions targeting at least 3 life domains identified above OR less than 65% of plans have interventions targeting at least 2 life domains.	30- 64% of plans reviewed have interventions targeting at least 3 life domains identified above OR at least 65% of plans have interventions targeting at least 2 life domains.	At least 65% of treatment plans reviewed have interventions targeting at least 3 life domains. Life domains address more than traditional clinical goals, such as medication management, symptom reduction, and staying out of the hospital. Note that the focus is on interventions and not *goals.* Interventions addressing a range of life domains may be subsumed under one particular goal—e.g., an intervention to help client address housing maintenance (so environment is more hospitable to company) may follow a social skills training intervention, both subsumed under a Social/ Relationship goal.
Criterion #2: These planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs.	Less than 30% of charts reviewed document interventions targeting at least 3 life domains identified above OR less than 65% of plans have interventions targeting at least 2 life domains.	Approximately half of all clients (30-64%) receive interventions targeting at least 3 life domains identified above OR at least 65% of plans have interventions targeting at least 2 life domains.	Nearly all clients (65% of charts reviewed) receive interventions targeting at least 3 life domains. *Interventions* are intended to result in a behavior/symptom change within these life domains; documentation of observations or commentary (e.g., remarking on client's poor self-care) are not considered implemented interventions, nor are case management tasks (distribution of money per representative payeeship).
Alignment (Relevant for differentiating "4" and "5" ratings)	Less than 60% of the charts having some appreciable continuity between planned interventions (criterion #1) and implemented interventions (criterion #2).	No partial credit option.	Alignment is defined as at least 60% of the charts having some appreciable continuity between planned interventions (criterion #1) and implemented interventions (criterion #2). Refer to "C" of PP3 in the Chart Review Tally Sheet Part II (at the end of this protocol) and gauge extent to which there is alignment, which can impact ratings for anchors "4" and "5."

	1	**2**	**3**	**4**	**5**
PP3. Interventions Target a Broad Range of Life Domains	The team does not plan for and/or deliver interventions that reflect a breadth of life domains.	Team minimally plans for and/or delivers interventions that reflect life domains (PARTIAL credit for one criterion only) OR Team plans for but does not deliver a breadth of services (Full #1 only).	Team plans for and delivers interventions that reflect a breadth of life domains, but less systematically (PARTIAL #1 and PARTIAL #2) OR a larger breadth of services are planned for, but not in turn delivered (FULL #1 and PARTIAL #2).	Team delivers interventions that reflect a range of life domains to all clients (FULL #2), but interventions targeting a breadth of life domains are not systematically specified in treatment plans (PARTIAL #1 OR FULL #1, but lacking Alignment).	Team specifies interventions that target a range of life domains in treatment plans and these interventions are carried out in practice (FULL criteria #1 and #2 with Alignment).

PP4. Client Self-Determination and Independence

Definition: The team promotes clients' independence and self-determination by: (1) helping clients develop greater awareness of meaningful choices available to them; (2) honoring day-to-day choices, as appropriate; and (3) teaching clients the skills required for independent functioning. The team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination.

Rationale: ACT teams serve many individuals who, due to their psychiatric symptoms and cognitive impairments, need greater direction and oversight to help them remain safe in the community. This higher level of involvement in clients' lives may increase the team's potential for engaging in paternalistic and possible coercive interventions. It is important that teams appropriately balance interventions aimed to manage risks against interventions aimed to help clients direct and manage their own lives. Clients' needs for oversight and supervision from the team will vary and it is important that level of services is consistent with functioning and need. Areas of particular risk of excessive supervision include medications and money.

DATA SOURCES (***** Denotes primary data source)

Client Interview

Do you have any examples where a team member has worked with you to learn a new skill that helps you be more independent, such as a cooking skill, cleaning skill, or social skill?	
Do you ever feel like the ACT team tells you what to do—maybe being too directive with you? If yes, ask for examples [possible categories: what to wear, what to eat, whether and when to take medications, when to awake and go to bed, upkeep of residence, how to spend time during the day, where to work].	
Is the team your representative payee? If so, how often do they give you money? Do you feel like it is up to you how to spend your money? *Do they ever tell you how to spend your money?*	

Does the team watch you take your medications? *How often? Do you like how often they do this or do you think it is too often or not often enough?*	
Direct Observation of Services	
Observe the language staff use with the client. Attend to the degree to which staff is directive with client. How respectful our staff with client, especially when in client's natural environment. Do staff take liberties when in client's personal environment (e.g., looking in refrigerator without permission). In general, to what degree do staff oversee the day-to-day activities of clients (e.g., what to wear, eat, do that day, etc.)? Does the level of supervision appear appropriate given client's level of functioning?	
Daily Team Meeting	
Observe the language used about clients in the daily team meeting. Note whether previous or planned contacts are directive in nature. Table 35 provides examples of language that reflects more direction and supervision vs. language that reflects greater promotion of independence and choice.	
Team Leader Interview	
Could you give me an example of how the team has helped a client weigh options to make a more informed choice or decision, even if some options were less desirable from the team's perspective? [Consider the meaningfulness of the choices described in these examples, as well as the team's role in helping client in the decision-making process. Examples of more meaningful choices would include deciding whether to attend a family functioning when there as a history of significant discord, or whether to discontinue taking a particular antipsychotic medication that has helped control many problematic symptoms, but has too many intolerable side effects. An example of a less meaningful choice includes deciding whether to have the team come out to see them in the morning or afternoon for medication supports.]	

Can you think of any examples where the team has intentionally withheld information from a client for the purposes of steering them toward a decision or behavior? [If yes] ***Can you tell me more about those instances?***	
[If 1 or more endorsed as having the agency or team as the representative payee:] ***I see from your report on the Excel spreadsheet*** *(column T)* ***that ___ clients have the agency or team assigned as their representative payee. Describe how clients come to have the team or agency as their representative payee.*** [An excessive number of clients with the team or agency as the payee may reflect a practice driven more by policy or orientation toward supervision of client behaviors rather than client needs. One study of ACT teams found that, on average, teams, or administrating agencies, served in the role of representative payee for 47% of the caseload, which can serve as a guide to judge excessive use of payeeship.] Also note what role the team plays in managing money allocation decisions when an agency external to the team serves as the representative payee for clients.	
Can you give an example of the last client that regained their own payeeship or someone the team has been working with to eventually become their own payee?	

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?	

Excel spreadsheet - (columns S, T, U, V, W)

How many clients are on involuntary commitment or conditional release?

Note the number of clients on payeeship and the extent to which the agency or team is the payee.

How many clients are on guardianship?

Note the number of clients for whom the team directly manages oral medications, as well as the number of an antipsychotic depot injection.

Although some clients make an informed decision to receive depot injections due to greater convenience and improved efficacy, some clients do not. Depot injections can be considered coercive and intrusive by some clients, and historically have been used with clients considered more resistant to taking oral medications. However, it is important to weigh rate information on the use of depot injections with what is learned in CT4 on the use of shared decision-making model.

ITEM RESPONSE CODING

Rating Guidelines

This item is largely impressionistic, although the impressions are informed by several data sources. Refer to Table 36 below to determine if criteria are met at all, partially, or fully. To be rated as a "5" on this item, the team, as a whole, appears to promote client independence and self-determination by helping clients develop greater awareness of meaningful choices available to them, honoring day-to-day choices, as appropriate, and teaching clients the skills required for independent functioning. ACT teams typically serve some clients who are in need of close oversight and more direction given functional/cognitive impairments secondary to their illness, but the team uses good clinical judgment to assure that the **level of direction and oversight is commensurate with the needs of the client and the team works hard to promote client's self-determination.**

Teams score lower on this item if they provide greater supervision and oversight that appear to be disproportionate to client needs. These teams tend to shy away from allowing clients to make their own mistakes or make daily choices that depart from what the team considers best. Also, with teams that do not embrace and prioritize the value of promoting client self-determination and independence, supervisory practices tend to be more universal, rather than individualized given unique needs and functioning impairments, resulting in a higher overall use of these practices. Conversely, teams may score lower on this item if they provide little in terms of proactive interventions intended to further develop clients' self-determination and independence; these teams may be providing very little guidance, both in practical skill-building and in imparting important information to expand clients' choices.

Table 35. Examples of Directive vs. Independence-Promoting Language	
Directive language	**Independence-promoting language**
"Joan was wearing her slippers again when I showed up yesterday. I told her she needed to put on real shoes or else I wouldn't be able to take her to the store."	"Joan was wearing her slippers again yesterday. I reminded her of the shoes she just bought and asked if she'd be willing to try them out as we headed to the store —just so we could see what she likes and doesn't like about them."
"Let's start swinging by Joe's house at 7:30 a.m. for his daily meds. That way, we can make sure he is getting up and not sleeping away his morning."	"Joe's always asleep when we arrive around 10 a.m. Let's ask him if he'd like us to show up earlier to help him start his day, at least two days a week. We should find out why he is staying in bed so late -- drowsiness, depression, no incentives to get out of bed? Maybe a simple coffee maker with a timer would do the trick."

Table 36. Client Self-Determination and Independence			
Practice	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
Practice #1: helping clients develop greater awareness of meaningful choices available to them;	Team does not help clients develop a greater awareness of meaningful options and choices available to them; OR were observed (on several occasions) to purposely withhold information that would allow clients to make more meaningful choices, possibly for the purpose of directing behaviors.	There is *significant* variability across staff and/or clients in the extent to which the team helps clients develop a greater awareness of meaningful choices available to them (e.g., few relevant examples were provided, and/or examples of the team not taking the time to educate clients about options and choices were observed).	Team routinely assists clients in having a better awareness and understanding of their options to facilitate more informed decision-making. Example observations: Team leader easily generates solid examples of the team imparting information to help clients consider options and make choices in their lives: • One such decision was about a client's living circumstances and whether to remain living in a more affordable apartment with an abusive partner or move to less affordable housing without the abusive partner. • Another decision was about a client's plans to continue working with the team in light of an expiring involuntary commitment order. • Evaluators observed example of the team discussing a client whose ongoing substance use was creating financial problems; the team intended to sit down with the client and representative payee to draft three budget options that may or may not entail changes in current behaviors/living arrangements.
Practice #2: honoring day-to-day choices, as appropriate;	Team is largely unaware of the daily lives of most clients, thereby missing opportunity for respectful and therapeutic interventions; OR team tends to micromanage many of clients' day-to-day activities, likely because the team	There is *significant* variability across staff and/or clients in the degree to which day-to-day choices are honored. For example, team was generally observed to be respectful of clients' choices, but have taken an excessively hard stance	Team respects clients' decisions around day-to-day activities, including when to awake and go to sleep, what to eat, what to wear, how household is maintained, and with whom to associate. Maladaptive day-to-day behaviors may be addressed in a very respectful and therapeutic manner (e.g., teaching clients the importance of food safety and ridding refrigerator of spoiled food; selection of

Table 36. Client Self-Determination and Independence			
Practice	**Examples/Guidelines**		
	No Credit	**Partial Credit**	**Full Credit**
	believes such a high level of direction benefits clients.	against clients who smoke cigarettes, often leveraging access to resources against abstinence from nicotine.	clothing that does not put self at risk of unwanted overtures or assault). NOTE: The team is assumed to meet this criterion unless data suggest otherwise—i.e., team appears to be more directive in day-to-day living decisions and behaviors, or largely unaware of such decisions/behaviors.
Practice #3: teaching clients the skills required for independent functioning. Team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination.	Team provides little oversight, direction, and skill-building to promote more independence; OR team tends to "do for" clients and/or supervise behaviors (e.g., management of money, medication adherence, substance use, which includes excessive use of urine drug screens across clients) to avoid deleterious consequences.	There is *significant* variability across staff and/or clients in efforts to help clients develop independent living skills, thereby reducing dependence on the team. Some clients may have been observed as having more excessive oversight with minimal skill-building.	Team strives to help clients learn how to manage their lives by teaching them necessary life skills, thereby limiting the need for the team to supervise various areas of clients' lives.

	1	**2**	**3**	**4**	**5**
PP4. Client Self-Determination & Independence	None of the 3 practices are employed OR only 1 is employed (FULLY or PARTIALLY).	2 practices are employed (FULLY or PARTIALLY), with 1 absent.	3 practices are employed, with 2 to 3 PARTIALLY.	Team generally promotes clients' self-determination and independence. All 3 practices are employed, but 1 PARTIALLY employed.	Team is a strong advocate for clients' self-determination and independence. All 3 practices FULLY employed.

DAILY TEAM MEETING OBSERVATION FORM

ACT Team:	
Team leader:	**Date:**
Reviewer:	

Fidelity Scale Item	**Reviewer Notes**
OS3. Daily Team Meeting: Frequency & Attendance The team meets on a daily basis and all team members scheduled for that shift normally attend to review and plan service contacts with each client.	*Note team members present at observed daily team meeting:*
OS4. Daily Team Meeting (Quality) Team uses its daily team meeting to: (1) Conduct a brief, but clinically-relevant review of all clients & contacts in the past 24 hours AND (2) record status of all clients. Team develops a daily staff schedule for the day's contacts based on: (3) Weekly Client Schedules, (4) emerging needs, AND (5) need for proactive contacts to prevent future crises; (6) team members are held accountable for follow-through.	*Note tools used in daily team meeting and the quality of these tools. Does the team use a weekly client schedule to develop a daily staff schedule that is referred to within the meeting? Is someone documenting clients' status and contacts over the past 24 hours?*

Fidelity Scale Item	Reviewer Notes
OS2. Team Approach ACT staff work as a transdisciplinary team rather than as individual practitioners; ACT staff know and work with all clients. The entire team shares responsibility for each client; each clinician contributes expertise as appropriate.	*Observe how staff are scheduled to visit clients. Ideally, staff assignments will vary naturally as a consequence of scheduling daily services to meet the individual needs of each client; however, the team should also make an effort to diversify the staff scheduling to foster ongoing relationships between each client and several team members.*
CP2. Assertive Engagement Mechanisms The team uses an array of techniques to engage difficult-to-treat clients. These techniques include: (1) collaborative, motivational interventions to engage clients and build intrinsic motivation for receiving services from the team, and, where necessary, (2) therapeutic limit-setting interventions to create extrinsic motivation for receiving services deemed necessary to prevent harm to client or others. When therapeutic limit-setting interventions are used, there is a focus on instilling autonomy as quickly as possible. In addition to being proficient in a range of engagement interventions, (3) the team has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of chosen techniques, and modifying approach when indicated.	*Listen for clients staffed during team meeting who appear to be difficult to engage.* *Does the team set aside time to plan for how to work with these clients, even if this meeting occurs outside the daily team meeting?* *Does the team sound exceptionally heavy-handed in how they engage clients*?

Fidelity Scale Item	Reviewer Notes
EP6. Engagement & Psychoeducation with Natural Supports The FULL TEAM works in partnership with clients' natural supports. As part of their active engagement of natural supports, the team: (1) Provides education about their loved one's illness; (2) Teaches problem-solving strategies for difficulties caused by illness; and (3) Provides &/or connects natural supports with social & support groups.	*Listen for team members reporting on contacts with family and other natural supports. Do they reflect education, problem-solving strategies, and/or general support?*
EP7. Empirically-Supported Psychotherapy The team: (1) deliberately provides individual and/or group psychotherapy, as specified in the treatment plan; (2) uses empirically-supported techniques to address specific symptoms and behaviors; and (3) maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to clients in need of such services. Ideally, psychotherapy is conducted by a trained therapist.	*Note whether team mental health therapists/clinicians identified report on specific psychotherapeutic techniques they are using with clients. Listen for any other team members who report on similar psychotherapy contacts.*
PP3. Interventions Target a Broad Range of Life Domains The team attends to a range of life domains (e.g., physical health, employment/ education, housing satisfaction, legal problems etc.) when planning and implementing interventions. (1) The team specifies interventions that target a range of life domains in person-centered plans, and (2) these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs.	*Note the services and contacts planned for that day and the extent to which they reflect more than those typically clinically-defined (e.g., taking medications).*

Fidelity Scale Item	Reviewer Notes
PP4. Client Self-Determination and Independence The team promotes clients' independence and self-determination by: (1) helping clients develop greater awareness of meaningful choices available to them; (2) honoring day-to-day choices, as appropriate; and (3) teaching clients the skills required for independent functioning. The team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination.	*Observe the language used about clients in the daily team meeting. Note whether previous or planned contacts are directive in nature.*

ACT TREATMENT PLANNING MEETING OBSERVATION FORM

Program:	**Date:**
Reviewer:	

Fidelity Scale Item	**Reviewer Notes**
PP2. Person-Centered Planning The team conducts treatment planning according to the ACT model using a person-centered approach, including: (1) development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting); (2) conducting regularly scheduled treatment planning meetings; (3) attendance by key staff, the client, and anyone else they prefer (e.g., family), tailoring number of participants to fit with the client's preferences; (4) provision of guidance and support to promote self-direction and leadership within the meeting, as needed. For teams that use an ITT, treatment planning meetings should include members from this group. (5) treatment plan is clearly driven by the client's goals and preferences and is structured in a manner to inform person-centered practices.	

Other items to consider:

- How are strengths elicited and used during the development or revision of the treatment plan?
- If natural supports are not present, inquire into the reason behind their absence following the meeting.
- Did the team develop a weekly client schedule with the client during this treatment planning meeting, revise an existing weekly client schedule, or make a plan to meet to develop/revise a weekly client schedule that captures the changes to the treatment plan?
- Based on the assessment and chart information, were appropriate team members present at the meeting?

COMMUNITY VISIT OBSERVATION FORM

Program:	**Date:**
Reviewer:	

Fidelity Scale Item	**Reviewer Notes**
PP4. Client Self-Determination & Independence The team promotes clients' independence and self-determination by: (1) helping clients develop greater awareness of meaningful choices available to them; (2) honoring day-to-day choices, as appropriate; and (3) teaching clients the skills required for independent functioning. The team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination. Observe the language staff use with the client. Attend to the degree to which staff is directive with client. How respectful are staff with client, especially when in client's natural environment? Do staff take liberties when in client's personal environment (e.g., looking in refrigerator without permission)? In general, to what degree do staff oversee the day-to-day activities of clients (e.g., what to wear, eat, do that day, etc.)? Does the level of supervision appear appropriate given client's level of functioning?	

Other areas to look out for:

- Evaluate both the type and quality of services provided.
    - Do they employ psychiatric rehabilitation or case management? Is the type of service appropriate for this/these particular client(s)?
    - How well are they providing other clinical services such as psychotherapy?
    - What is the quality of the integrated treatment for COD, EE, or wellness services delivered?

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.

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): Specialist-related notes (count):	All notes (count): Specialist-related notes (count)	All notes (count): Specialist-related notes (count):

CHART REVIEW LOG (Part II). Partial Sample (i.e., 6 clients). TEAM_____ Client ID_____ Reviewer Name_____

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

Assessments Exist?	**Assessment Quality?**	**Stages of Change Readiness?**	Any **additional observations** regarding substance use assessments reviewed (e.g., timeliness, quality of the assessments) or assessment of stages of change readiness?
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? _____	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	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 treatment strategies being used by the COD specialist? ☐Yes ☐ No ☐Unsure	

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

Assessments Exist?	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**
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? _____			**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?

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 eight 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.

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.

Unique Client ID	OS2: Team Approach	OS6. Priority Service Population	CT4. Psychiatric Provider Contacts (and CP7)	CP1: Community-Based Services	CP3: Intensity of Service	CP4: Frequency of Contact	CT7, CP8, EP1 - EP3 Full Responsibility for Service Items, and EP7					
							For each chart, code the following:					
	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)	Does diagnosis fit w/ ACT criteria? If not, note diagnosis.	How often seen by ACT psychiatric care provider?[1] Code: **1** = within 6 weeks **2** = within 3 months **3** = 3+ months (add * if therapy)	**% 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)	**Mean/ average #** of minutes per week over 4-week period (Total minutes/4)	***Mean/average*** # of face-to-face contacts (office and community) per week over 4-week period	+ = If endorsed 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).			
							Integrated Tx for Co-Occurring Disorders (EP1)	SEE services (EP2)	Psych Rehab Services (CP8)	WMR Services (EP3)	Psycho-therapy (EP7)	Health (CT7)
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Final Calculations	**OS2: Team Approach** 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%.	**OS6: Priority Service Pop.** 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%	**CT4. Psych Care Provider** 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**_____	**CP1: Community-Based** 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%.	**CP3: Intensity** 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.	**CP4: Frequency** 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)			Method 2 (consider subsample of charts endorsed by team as receiving service)		
	(B) % of all charts coded with an H (high quality) OR L (low quality) (H + L) / all charts	(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)	(C) % of charts judged to have service delivered by team at all (H or L) coded with (*) as systematic (*Systematic) / (H + L)	(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)	(C) % of subsample (+) observed to have some service (H or L) that was coded with an H (high quality) only (H) / (H + L subsample)	(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						
EP2. Employment and Educational Services:						
CP8. Psychiatric Rehab Services						
EP3. WMR Services						
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

Please refer to TMACT Calculation Workbook to enter data for final calculations for OS2 and OS6 above.

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)?

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 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:			
	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)