



EVIDENCE-BASED
PRACTICES

KIT

Knowledge Informing Transformation

Evaluating Your Program

MedTEAM



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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Evaluating Your Program

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Evaluating Your Program

Evaluating Your Program shows quality assurance team members how to evaluate the effectiveness of Medication Treatment, Evaluation, and Management (MedTEAM). It includes the following:

- A Readiness Assessment;
- The MedTEAM Organizational Fidelity Scale;
- The MedTEAM Prescriber Fidelity Scale; and
- Outcome measures that are specific to MedTEAM.

You will also find instructions for conducting assessments and tips on how to use the data to improve your MedTEAM initiative.

MedTEAM

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the MedTEAM KIT that includes a DVD, CD-ROM, and seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP

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MedTEAM

Evaluating Your Program

Why Evaluate MedTEAM?

Key stakeholders who implement MedTEAM may find themselves asking two questions:

- **Has MedTEAM been implemented as planned?**
- **Has MedTEAM resulted in the expected outcomes?**

Asking these two questions and using the answers to help improve MedTEAM are critical for ensuring the success of your MedTEAM initiative.

To answer the first question, collect process measures (by using the MedTEAM Fidelity Scales). Process measures capture how services are provided. To answer the second question, collect outcome measures. Outcome measures capture the results or achievements of your initiative.

As you prepare to implement MedTEAM, we strongly recommend that you develop a quality assurance system using both process and outcome measures to monitor and improve the quality of your MedTEAM initiative beginning during the startup phase and continuing thereafter.

Why you should collect process measures

Process measures give you an objective, structured way to determine if you are implementing MedTEAM in the way that research has shown will result in desired outcomes. Process measures allow agencies to understand whether they are providing medication management that is faithful to the evidence-based model. Programs that adhere closely to the model are more effective than those that do not follow the model. Adhering to the model is called *fidelity*.

Collecting process measures is an excellent way to diagnose program weaknesses while helping to clarify program strengths. Once MedTEAM reaches high fidelity, ongoing monitoring allows you to test local innovations while ensuring that your agency does not drift from the core principles of the evidence-based model.

Process measures also give mental health authorities a comparative framework to evaluate the quality of MedTEAM across the state. They allow mental health authorities to identify statewide trends and exceptions to those trends.

Why you should collect outcome measures

While process measures capture how services are provided, outcome measures capture the program's results. Every mental health service intervention has both immediate and long-term consumer goals. In addition, consumers have goals for themselves, which they hope to attain by receiving mental health services. These goals translate into outcomes, and the outcomes translate into specific measures.

Consumer outcomes are the bottom line for mental health services, like profit in business. No successful businessperson would assume that the business was profitable just because employees work hard.

Research Has Shown That You Can Expect These Outcomes

- Improved symptoms
- Improved quality of care
- Increased retention of employment
- Improved satisfaction and adherence to treatment

(Katon et al., 1995; Simon, Von Korff, Rutter, & Wagner, 2000; Wells et al., 2000; Worrall, Angel, Chaulk, Clarke, & Robbins, 1999.)

Why develop a quality assurance system?

In your mental health system, you should develop a quality assurance system that collects not only process measures, such as those on the MedTEAM Fidelity Scales, but also outcome measures, such as those specified above to show the effect of MedTEAM. Developing a quality assurance system will help you do the following:

- Diagnose your program's strengths and weaknesses;
- Formulate action plans for improving your MedTEAM initiative;
- Help consumers achieve their goals for recovery; and
- Deliver medication treatment both efficiently and effectively.

Evaluating Your Program

Conduct a Readiness Assessment

Let's assume that administrators and MedTEAM leaders have read *Building Your Program*. How do you get started with putting MedTEAM into place?

The Readiness Assessment on the next page will help quality assurance team members, advisory group leaders, and

MedTEAM leaders track the processes and administrative tasks required to develop your MedTEAM initiative.

Answering these questions will help you generate an ongoing to-do list (or implementation plan) to guide your steps in implementing MedTEAM.

Readiness Assessment

Check any areas that you feel you do NOT completely understand.

- Who will participate in MedTEAM?
- What are the roles of the MedTEAM leader, prescribers, and other MedTEAM staff?
- Who will supervise MedTEAM staff and direct the program?
- What is the MedTEAM supervisory structure (for example, how often does the MedTEAM leader meet with prescribers and other MedTEAM staff and the agency director)?
- How will MedTEAM staff communicate with one another?
- How will you measure fidelity to the MedTEAM model?
- Who will participate on your MedTEAM advisory committee or the group that will review your fidelity assessment results and develop your implementation plan?
- How will MedTEAM staff relate to your advisory committee?
- Who will lead the process of reviewing and changing documentation?
- Who will lead the process of reviewing and developing procedures related to accessing information from outside agencies?
- Who will lead the process for reviewing and developing treatment guidelines or algorithms including those for consumers with treatment-refractory illnesses?
- Who will lead the process for reviewing and developing procedures for consumer education and participation?
- Who will lead the process for reviewing and developing procedures about scheduling appointments?
- Who will lead the process for reviewing and developing procedures for integrating outcome measures into clinical assessments?
- Who will be responsible for ensuring that outcomes data are also available for the purpose of evaluating MedTEAM?

Note areas where you still are unclear or have questions.

Arrange to speak to an expert consultant or experienced MedTEAM leader.

Evaluating Your Program

Conduct a Process Assessment

In addition to the Readiness Assessment, conduct your first process assessment to determine whether your agency has core components of MedTEAM in place. During the first 2 years of implementing MedTEAM, conduct assessments every 6 months.

After your MedTEAM initiative has matured and achieved high fidelity, you may choose to conduct assessments once a year. Agencies that have successfully implemented MedTEAM indicate that you must continue to evaluate the process to ensure that you do not revert to previous practice patterns.

Once your agency has achieved high fidelity to the evidence-based model, MedTEAM staff may tailor the program to meet individual needs of the community. If you continue to use process evaluations along with outcomes monitoring, you will be able to understand the extent to which your changes result in your agency's departure from model fidelity and whether the changes positively or negatively affect consumers.

How to use process measures

Two tools have been developed to monitor how medication management is provided under the MedTEAM approach:

- The MedTEAM Organizational Fidelity Scale; and
- The MedTEAM Prescriber Fidelity Scale.

You may administer both tools at the same time.

The MedTEAM Organizational Fidelity Scale has 15 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*). The items assess whether MedTEAM is provided as the evidence-based model prescribes.

The MedTEAM Prescriber Fidelity Scale is a second set of process measures that has been developed. In contrast to the Organizational Fidelity Scale that assesses agency's procedures and policies, the Prescriber Fidelity Scale assesses prescriber practices by reviewing documentation. The MedTEAM Prescriber Fidelity Scale has 22 items that may be scored. Each item is rated 0 (meaning *not implemented*) or 1 (meaning *fully implemented*).

For the MedTEAM Fidelity Scales, see Appendices B and D. You can also print these forms from the CD-ROM in the KIT.

About the process measures that are included in the KIT

Quality assurance measures have been developed and are included in all Evidence-Based Practices KITs. The MedTEAM Fidelity Scales were developed by an expert panel. The panel members had expertise in psychopharmacology and in delivering medication services in public mental health settings. The standards used for establishing the anchors for the fully implemented ratings were determined through a variety of expert sources as well as through empirical research.

The scale has undergone numerous drafts and review by many groups. Revisions were made based on feedback from a variety of sources. The scales were field tested in 26 community mental health centers in four states. A psychometric evaluation of the MedTEAM Organizational Fidelity Scale indicated that for the total scale the reliability across all sites was .89 (Howard et al., in press; Taylor et al., 2009). Item-level interrater reliability was generally satisfactory with most intraclass correlations exceeding .80.

A psychometric evaluation of the MedTEAM Prescriber Fidelity Scale indicated that for the total scale the interrater reliability was .87 (Howard et al., in press; Taylor et al., 2009). Item-level interrater reliability was generally satisfactory with all but four items achieving intraclass correlations of .80 or higher. Test-retest reliability for 12 sites for the total scale was .94. Test-retest reliability for individual fidelity items ranged from .15 to .95 with a mean of .77. Further testing is underway.

Who can conduct process assessments?

We recommend enlisting two assessors to conduct your process assessment. Data collected by two assessors simultaneously increases the likelihood that the information will be reliable and valid.

Agencies that have successfully implemented MedTEAM have taken different approaches to identify assessors. Some agencies train MedTEAM Advisory Committee members as assessors and rotate the responsibility of completing assessments. Others have pre-existing quality assurance teams and simply designate members of the team to complete the assessments. In other cases, the mental health authority has designated staff to conduct assessments.

You can conduct assessments either internally through your agency or externally by a review group. External review groups have a distinct advantage because they use assessors who are familiar with the MedTEAM model but, at the same time, are independent. The goal is to select objective and competent assessors.

Although we recommend using external assessors, agencies can also use fidelity scales to rate their own MedTEAM initiative. The validity of these ratings (or any ratings, for that matter) depends on the following:

- The knowledge of the person making the ratings;
- Access to accurate information pertaining to the ratings; and
- The objectivity of the ratings.

If you do conduct your assessments using internal staff, beware of potential biases of raters who are invested in seeing the agency look good or who do not fully understand the MedTEAM model. It is important that ratings are made objectively and that they are based on hard evidence.

Circumstances will dictate decisions in this area, but we encourage agencies to choose a review process that fosters objectivity in ratings, for example, by involving a practitioner who is not centrally involved in the MedTEAM initiative. Only people who have experience and training in interviewing and data collection procedures (including chart reviews) should conduct assessments. Additionally, assessors must understand the nature and critical ingredients of the evidence-based model.

If your agency chooses to use a consultant or trainer to help implement MedTEAM, involving that person in the assessment process will enhance the technical assistance you receive. Whichever approach you choose, we encourage you to make these decisions early in the planning process. For a checklist to help evaluate assessors' training and work performance, see Appendix H.

How to conduct process assessments

A number of activities take place before, during, and after a process assessment. In general, assessments include the following:

- Interviewing administrators, the MedTEAM leader, prescribers, other MedTEAM staff, consumers, and families;
- Interviewing other agency staff (such as intake specialists, appointment schedulers, or medical records staff);
- Observing a treatment team and supervisory meeting; and
- Conducting a chart review.

Collecting information from multiple sources helps assessors more accurately capture how services are provided. A daylong site visit is the best way to learn this information. The following suggestions outline steps in the assessment process.

Before the process assessment

■ ■ ■ Prepare your assessment questions

The Interview and Chart Review Guides in *Appendices C* and *E* provide questions that you may use to collect information during your assessment visit.

The guide helps you understand each item on the MedTEAM Fidelity Scales and the types of information to collect during your assessment. Use the guides to prepare the questions that you will ask during your assessment visit.

While we expect that quality assurance teams will select which outcome measures meet your agency's needs, you should use the MedTEAM Fidelity Scales in full. Collecting data for all the items on these scales will allow your agency to gain a comprehensive understanding of how closely your program resembles the evidence-based approach.

■ ■ ■ Create a timeline for the assessment

List all the necessary activities leading up to and during the visit and create a timeline for completing each task. Carefully coordinating efforts, particularly if you have multiple assessors, will help you complete your assessment in a timely fashion.

■ ■ ■ Establish a contact person

Have one key person arrange your visit and communicate beforehand the purpose and scope of your assessment to people who will participate in interviews. Typically, this contact person will be the MedTEAM leader.

Exercise common courtesy and show respect for competing time demands by scheduling well in advance and making reminder calls to confirm interview dates and times.

■ ■ ■ Establish a shared understanding with the MedTEAM staff

The most successful assessments are those in which assessors and the MedTEAM staff share the goal of understanding how medication treatment is progressing according to evidence-based principles. If administrators or prescribers fear that they will lose funding or look bad if they don't score well, then the accuracy of the data may be compromised. The best agreement is one in which all parties are interested in learning the truth.

■ ■ ■ Indicate what you will need from respondents during your visit

In addition to explaining the purpose of the assessment, briefly describe what information you need, with whom you must speak, and how long each interview will take to complete. The visit will be most efficient if the MedTEAM leader gathers beforehand as much of the following information as possible:

- Roster of MedTEAM staff (roles, full-time equivalents);
- Copies of any rating scales used to document outcomes of medication treatment;
- A copy of the agency's admissions form;
- A copy of the agency's annual update form (if different from the admissions form);
- A copy of the agency's ongoing treatment form; and
- A copy of consumer education materials.

Reassure the MedTEAM leader that you will be able to conduct the assessment, even if all of the information you requested is unavailable.

Tell the contact person that you must observe a treatment team meeting and group supervision meeting during your visit. These are important factors in determining when you should schedule your visit.

■ ■ ■ Alert your contact person that you will need to sample 10 charts

From an efficiency standpoint, it is preferable that the charts be drawn beforehand, using a random selection procedure. A concern may arise that the evaluation may be invalidated if MedTEAM staff members handpick charts or update them before the visit. If you both understand that the goal is to learn how the program is implementing services, this is less likely to occur.

You can further ensure random selection by asking for 20 charts and randomly selecting 10 to review. Other options include asking the MedTEAM leader for a de-identified list of consumers (that is, with names removed) and using the list to choose 10 charts to review.

Since the MedTEAM Prescriber Fidelity Scale was designed for consumers with schizophrenia and adapted for those with major depression and bipolar disorders, limit your chart selection to consumers with those illnesses.

■ ■ ■ Clarify reporting procedures

With the appropriate people (agency administrators, the mental health authority, or the MedTEAM leader), clarify who should receive a report of the assessment results. Recipients may include the following:

- Agency administrators;
- Members of the agency's quality assurance team;

- Members of the MedTEAM advisory committee;
- The MedTEAM leader;
- MedTEAM staff; and
- Consumers and families.

Assessors should also clarify how the agency would like the report to be distributed. For example, assessors may mail or fax the report and follow up to discuss the results in a meeting or by conference call.

■ ■ ■ Organize your assessment materials

Three forms have been created to help you conduct your assessment:

- The first form is a cover sheet for the MedTEAM Fidelity Scales, which is intended to help you organize your process assessment. It captures general descriptive information about the agency and data collection.
- The second and third forms are scoresheets for the two scales. They help you compare assessment ratings from one time period to the next. They may also be useful if you are interested in graphing results to examine your progress over time.

For the MedTEAM Fidelity Scales, cover sheet, and scoresheets, see Appendices A, B, and D. You can also print these forms from the CD-ROM in the KIT.



During your assessment visit

■ ■ ■ Tailor your terminology

To avoid confusion during your interviews, tailor the terminology you use. For example, an agency may use *member* for *consumer* or *clinician* for *practitioner*. Every agency has specific job titles for particular staff roles. By adopting the local terminology, you will improve communication.

■ ■ ■ Conduct your chart review

It is important that your chart review is conducted from a representative sample of charts. When you begin your chart review, note whether your sample includes consumer charts from each prescriber's caseload. If your random sample is not representative in this manner, consider supplementing your sample with selected charts that will increase its representativeness.

While the MedTEAM Prescriber Fidelity Scale was developed specifically for consumers with schizophrenia, items have been adapted for consumers with major depressive and bipolar disorders. Start by limiting your chart review to records of consumers with these diagnoses.

As your MedTEAM initiative evolves, consider adding more charts to your review if you are interested in expanding your review to those with other disorders. In this case, use only those items in the fidelity scales that are not specific to particular diagnoses and medications. This has the obvious disadvantage that important aspects of medication treatment are not measured, but at least it provides a metric of some key aspects of medication treatment that can be used with any chart review for any serious mental illness.

■ ■ ■ If discrepancies between sources occur, query the MedTEAM leader

The most common discrepancy is likely to occur when the MedTEAM leader's interview gives a more idealistic picture of the team's functioning than the chart and observational data indicate. For example, on the MedTEAM Organizational Fidelity Scale, *Consumer Education* (Item 8) assesses whether educational materials are available and the procedures developed for distributing them. Your interviews may indicate that little educational information is distributed, while the MedTEAM leader may relay that prescribers provide educational information.

To understand and resolve this discrepancy, ask the MedTEAM leader about it by saying:

Our interviews indicate that 20 percent of prescribers are involved in consumer education, but your estimate is higher. Would you help us understand the difference?

Often the MedTEAM leader can provide information that will resolve the discrepancy.

■ ■ ■ Before you leave, check for missing data

Fidelity scales should be completed in full, with no missing data on any items. Check in with the MedTEAM leader at the end of the visit to collect any additional information you may need.

After your assessment visit

■ ■ ■ Follow up

It is important to collect any missing data before completing your rating. If necessary, follow up on any missing data (for example, by calling or sending an e-mail). This would include discussing with the MedTEAM leader any discrepancies between data sources that you notice after you've completed the visit.

■ ■ ■ Score your scales

Use the Interview and Chart Review Guides in *Appendices C* and *E* to score MedTEAM. If you assess an agency for the first time to determine which components of MedTEAM the agency already has in place, some items may not apply. If an item cannot be rated, code the item as "1" on the MedTEAM Organizational Fidelity Scale.

For the MedTEAM Prescriber Fidelity Scale, complete one scoresheet for every chart that you review. The scoresheet contains qualifying questions to help you assess whether the item may be scored based on the information in the chart.

For example, if you are reviewing a chart for a consumer who is newly diagnosed, item P11: *Medication Visit Frequency*, which captures whether consumers are contacted after medication changes, will not apply. If an item does not apply, withhold it from scoring.

$$\frac{\text{Total number of points scored}}{\text{Total number of applicable items}}$$

Find an average for each chart reviewed. After you complete your chart review, average all scores.

$$\frac{\text{Sum of scores}}{\text{Number of charts reviewed}}$$

■ ■ ■ Complete scales independently

If you have two assessors, both of you should independently review the data collected and rate the scales. Then compare your ratings, resolve any disagreements, and devise a consensus rating.

■ ■ ■ Complete the scoresheets

Tally the item scores and determine which level of implementation was achieved.



Evaluating Your Program

Monitor Outcomes

Unlike process measures, which must be used in full to comprehensively understand how services are provided, you must decide which outcome measures will be most informative for your MedTEAM program. Initially, your outcomes monitoring system should be simple to use and maintain. Complexity has doomed many well-intended attempts to collect and use outcomes data.

One way to simplify is to limit the number of outcome measures used. Select your outcome measures based on the type of information that will be most useful to your agency.

Based on the research literature, we suggest that you monitor a core set of outcomes such as the following:

- Improved symptoms;
- Improved quality of care;

- Increased retention of employment; and
- Improved satisfaction and adherence to treatment. (Katon et al., 1995; Simon, Von Korff, Rutter, & Wagner, 2000; Wells et al., 2000; Worrall, Angel, Chaulk, Clarke, & Robbins, 1999).

Symptoms targeted by medications are the primary outcome measures used to track direct outcomes of medication treatment. Thus, psychotic symptoms are a measure of antipsychotic medications, anxiety symptoms are a measure of antianxiety medications, and so on.

It is important to measure symptoms for both the purposes of evaluating your MedTEAM program and informing the clinical assessment.

While quantifying symptoms takes more time than recording clinical impressions (for example, “Consumer seems less psychotic”), research has shown that prescribers do a better job of treating symptoms when they have the capacity to track and efficiently and effectively record symptom levels. For more information on measuring psychiatric symptoms, see “Integrating Outcomes into Clinical Assessments” in *Training Frontline Staff* in this KIT.

In addition to targeted symptoms, it is also important to look at global life areas to assess the effectiveness of treatment as a whole. You can use measures of quality of care or outcomes that relate to consumers’ recovery goals, such as employment. For data to be useful, they must be valid. That is,

the data must accurately represent what they were intended to measure. Thus, the outcomes must be few and concrete for MedTEAM staff to focus on key outcomes, to understand them in a similar way, and to make their ratings in a consistent and error-free fashion.

To enhance validity, we recommend using simple ratings initially (such as, Did the consumer hold a competitive job in this quarter?), rather than more detailed ones (such as, How many hours during this quarter did the consumer work competitively?). For a sample Outcomes Report Form that is an example of a simple, paper-based way to collect participation and overall treatment outcomes data regularly, see Appendix F. For instructions for using the Outcomes Report Form, see Appendix G.

What Is the Consumer Outcomes Monitoring Package?

Sponsored in part by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Consumer Outcomes Monitoring Package (COMP) was designed by a team at the School of Social Welfare, University of Kansas. This computer application allows agencies to choose from a pre-established list of outcomes developed for various evidence-based practices. Although not developed specifically for MedTEAM, the outcomes included in COMP represent global life areas that are relevant for assessing overall effects of treatment as a whole. Data may be entered for the chosen outcomes, and reports can be generated quarterly or monthly. The COMP also allows agencies to view their outcomes data using a variety of tables and graphs.

The designers of COMP tried to make the computer application as easy and as flexible to use as possible. You may access COMP through the Web. Agencies can download the computer application and print out *Installation Instructions* and a *User Manual*, which provides definitions and forms.

To download COMP—

- Go to <http://research.socwel.ku.edu/ebp>
- Click the link to the download page;
- Click the links to download the *Installation Instructions* and the *User Manual*; and
- Follow the instructions to install the application.

Develop procedures

Agencies may choose to develop the outcomes portion of their quality assurance system from scratch or use existing outcomes monitoring systems. A number of electronic evaluation programs are available to help you develop comprehensive, integrated, user-friendly outcomes monitoring systems. Examples include the following:

- Publicly available tools such as the Consumer Outcomes Monitoring Package (see the previous page), and Decision Support 2000+ Online (<http://www.ds2kplus.org>); or
- Various commercially available products.

When deciding whether to use an existing outcomes monitoring package or to design your own, it is important to keep your organization's capabilities in mind. The system must not create undue burden for MedTEAM staff, and it must provide information to them that is useful in their jobs.

The system should fit into the workflow of the organization, whether that means making ratings on paper, using the COMP computer application, or developing your own outcomes monitoring package. Start with whatever means are available and expand the system from there. In the beginning, you may collect data with a simple report form and you can report hand-tallied summaries to MedTEAM staff.

Computer software that allows for data entry and manipulation (such as Microsoft Access, Excel, or Lotus) makes tabulating and graphing data easier than if it is done by hand. A computerized system for data entry and report generation presents a clear advantage and may be the goal, but do not wait for it. Feedback does not have to come from a sophisticated computer system to be useful. It is more important that it is meaningful and frequent.

Expanding Your Outcome Measures

Once you have established your core outcomes monitoring system, learned how to routinely collect data, and are accustomed to using it to improve MedTEAM, you will be ready to expand your outcomes measures. Consider asking consumers and families for input on how to improve medication management. Consumers and families are important informants for agencies that are seeking to improve outcomes. Agencies may want to know the following:

- Whether consumers and families are satisfied with their services;
- How services have affected their quality of life; and
- Whether consumers believe the services are helping them achieve their recovery goals.

While collecting data from consumers and families requires more staff time than collecting the information that may be reported quickly by MedTEAM staff, consumers and families give valuable feedback.

We recommend the following surveys for collecting information from consumers and families:

- The Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey at <http://www.mhsip.org>; and
- Recovery measurement instruments such as those described in *Measuring the Promise: A Compendium of Recovery Measures, Volume II*, available from <http://www.tecathsri.org>

It is difficult to obtain a representative sample of consumer and family respondents since mailed surveys are often not returned and interviews may only be done with people who are cooperative and easy to reach. Samples that are not representative may be biased.

Avoid bias in your consumer and family data by using a variety of mechanisms to conduct your assessments. For example, consider combining feedback collected through surveys with that obtained from focus groups. Another option is to hire a consultant to conduct qualitative interviews with a small group of consumers or families.

How often should you collect outcomes data?

Plan to monitor outcomes every 3 months and share the data with your MedTEAM staff. Collecting data at regular and short intervals will enhance the reliability of your outcomes data.

While we recommend that you design a system for collecting outcomes early in the implementation process, agencies should not expect to see the desired results until the MedTEAM approach is fully operational. Depending on the resources available to your agency, this may take anywhere from 6 to 18 months to accomplish.

How should you identify data collectors?

Agency administrators or mental health authorities may assign the responsibility for collecting outcomes data to the following:

- The MedTEAM leader;
- Members of the MedTEAM advisory committee;
- The quality assurance team;
- Independent consultants, including consumers and family members; and
- Other staff.

Unlike collecting process measures, collecting outcome measures does not require a daylong assessment process. Many standard outcome measures, such as symptoms and employment, can be collected by MedTEAM staff from their daily work with consumers. This is especially true if your MedTEAM staff have been trained to integrate outcome measures into their clinical assessments.

It is important to develop a quick, easy, standardized approach to collect outcomes data. For example, create a simple form or computer database that MedTEAM staff can routinely update.



Evaluating Your Program

Use Data To Improve MedTEAM

As you develop a quality assurance system, MedTEAM leaders and staff will weave it into the fabric of their daily routines. Process assessments will give you a window into the demanding work done every day. Outcome reports will give you tangible evidence of the use and value of services, and they will become a basis for decisionmaking and supervision.

At some point, your MedTEAM staff may wonder how they did their jobs without an information system as they come to view it as an essential ingredient of well-implemented evidence-based practices.



■ ■ ■ Create reports from your assessments

For your process data, in addition to completing the MedTEAM Fidelity Scales and scoresheets, assessors should write a report explaining their scores. The report should include the following:

- An interpretation of the results of the assessment;
- Strengths and weaknesses of the agency's approach to medication management; and
- Clear recommendations to help the MedTEAM initiative progress.

The report should be informative, factual, and constructive. Since some process measures assess adherence to the evidence-based model at both the *agency* and *MedTEAM staff levels*, remember to target recommendations to administrators, MedTEAM leaders, and staff.

When summarizing outcomes data, start with simple, easy-to-read reports. Then let experience determine what additional reports you need. You can design your reports to give information about individual consumers, a single prescriber's caseload, or the program as a whole. For example, reports generated for individual consumers may track the consumer's progress using specific outcomes over time. You could enter these reports in consumers' charts and they could be the basis for discussions about consumers' progress.

■ ■ ■ Use tables and graphs to understand your outcomes data

After the first process and outcomes assessments, it is often useful to provide a visual representation of an agency's progress over time. We recommend that you use tables and graphs to report the results.

By graphing your fidelity score, you have a visual representation of how medication management has changed over time. For an example, see Figure 1. For your process data, you may simply graph the results using a spreadsheet and include this in your report.

When your agency shows greater fidelity over time, the graph will display it and reinforce your efforts. Additionally, as you can see in Figure 1, the graph allows you to quickly compare one team to another. In this example, Team A struggled in the first 6 months. Understanding Team A's progress compared to Team B's allowed the teams to partner and share strategies. Consequently, Team A improved dramatically over the next 6-month period.

Another feature of graphing assessment scores is to examine the cutoff score for *fair* (56) or *good* (66) implementation. Your program can use these scores as targets.

■ ■ ■ Share your results

The single factor that will most likely determine the success of an information system is its ability to give useful and timely feedback to key stakeholders. It is fine to worry about what to enter into an information system, but ultimately its worth is in converting data into meaningful information. For example, the data may show that 20 consumers worked in a competitive job during the past quarter, but it is more informative to know that this represents only 10 percent of the consumers in the agency.

For information to influence practice, it must be understandable and meaningful, and it must be delivered in a timely way. In addition, the quality assurance system must tailor the information to suit the needs of various users and to answer their questions.

Sharing results with MedTEAM staff

After each assessment, dedicate time during a supervisory meeting to discuss the results. Numbers that reflect above average or exceptional performance should trigger recognition, compliments, or other rewards. Data that reflect below average performance should provoke a search for underlying reasons and should generate strategies that offer the promise of improvement. By doing this regularly, MedTEAM leaders will create a learning organization characterized by adaptive responses to information that aim to improve consumer outcomes.

Figure 1. Fidelity Over Time



Note: 66-75 = good implementation
56-65 = fair implementation
55 and below = not evidence-based practice

Sharing results with your MedTEAM Advisory Committee or quality assurance team

You may also use this information to keep external stakeholders engaged. Sharing information with vested members of the community, staff from your mental health authority, and consumers and family advocates can be valuable. Through these channels, you may develop support for MedTEAM, increase consumer participation, and raise private funds for your agency.

Sharing results internally

Agencies may distribute reports during all staff and manager-level meetings to keep staff across the agency informed and engaged in the process of implementing MedTEAM. Agencies with successful evidence-based practice programs highlight the importance of developing an understanding and support for the evidence-based model across the agency.

Additionally, integrating consumer-specific reports into clinical charts may help you monitor consumers' progress over time. Reporting consumer-specific outcomes information at the treatment team meetings also helps keep the team focused on consumers' recovery goals.

Sharing results with consumers and families

Agencies may highlight assessment results in consumer and family meetings. Increasing consumers' and families' understanding of MedTEAM may motivate them to participate in the treatment process and build trust in the consumer-practitioner relationship.

Also, sharing results may create hope and enthusiasm for your MedTEAM initiative. Sharing information motivates people and stimulates changes in behavior. Sharing the results of your assessments with a variety of stakeholders is the key to improving medication management in your agency.

Evaluating Your Program

Appendix A: Cover Sheet— MedTEAM Fidelity Scales



Cover Sheet: MedTEAM Fidelity Scales

Assessors' names: _____

Today's date: ____/____/____

Program name (or program code): _____

Agency name: _____

Agency address: _____
Street

City State ZIP code

MedTEAM leader or contact person: _____

Names of the MedTEAM practitioners: _____

Telephone: (____) _____-_____

E-mail: _____

Sources used for assessments:

- | | |
|---|--------------------------|
| <input type="checkbox"/> Chart review | Number reviewed: _____ |
| <input type="checkbox"/> Progress Notes reviewed | Number reviewed: _____ |
| <input type="checkbox"/> MedTEAM curriculum review | |
| <input type="checkbox"/> Brochure review | |
| <input type="checkbox"/> MedTEAM session/group observation | |
| <input type="checkbox"/> MedTEAM director/coordinator interview | |
| <input type="checkbox"/> MedTEAM leader interview | |
| <input type="checkbox"/> MedTEAM practitioner interviews | Number interviewed: ____ |
| <input type="checkbox"/> Consumer interviews | Number interviewed: ____ |
| <input type="checkbox"/> Family member interviews | Number interviewed: ____ |
| <input type="checkbox"/> Other staff interviews | Number interviewed: ____ |
| <input type="checkbox"/> Other _____ | |

Number of MedTEAM practitioners: _____

Number of current MedTEAM consumers: _____

Number of consumers served last year: _____

Funding source: _____

Agency location: Urban
 Rural

Date program was started: ____/____/____



Evaluating Your Program

Appendix B: MedTEAM Organizational Fidelity Scale and Scoresheet



MedTEAM Organizational Fidelity Scale

Criteria	Ratings / Anchors				
	1	2	3	4	5
Staffing					
<p>O1. Standardized Admissions Form</p> <p>Agency has a standardized admissions form covering the following 11 areas:</p> <ul style="list-style-type: none"> ■ Diagnoses ■ Symptoms and severity ■ Illness history (including age of onset, hospitalizations, and suicide attempts) ■ Past medication history (dose, duration, interactions, tolerability, and response) ■ Current medications (dose, duration, interactions, tolerability, and response) ■ Assessment of the effectiveness of current medications and any plans for future medication changes ■ Current medication adherence ■ Current side effects and treatments for them ■ Current consumer functioning ■ Consumer preferences and goals ■ Contact information for previous providers 	Agency has no standardized admissions form	Agency has a standardized admissions form covering fewer than 6 areas	Agency has a standardized admissions form covering 6–7 areas	Agency has a standardized admissions form covering 8–10 areas	Agency has a standardized admissions form covering all 11 areas
<p>O2. Standardized Annual Update Form</p> <p>Agency has a standardized annual update form covering the same 11 areas as the standardized admissions form. (See O1.)</p>	Agency has no standardized annual update form	Agency has a standardized annual update form covering fewer than 6 areas	Agency has a standardized annual update form covering 6–7 areas	Agency has a standardized annual update form covering 8–10 areas	Agency has a standardized annual update form covering all 11 areas
<p>O3. Standardized Ongoing Treatment Form:</p> <p>Agency has a standardized ongoing treatment form covering the following 7 areas:</p> <ul style="list-style-type: none"> ■ Diagnoses ■ Symptoms and severity ■ Current medications (dose, duration, interactions, tolerability, and response) ■ Rationale for any medication changes ■ Current medication adherence ■ Current side effects and treatments for them ■ Current consumer functioning 	Agency has no standardized ongoing treatment form or form is open-ended	Agency has a standardized ongoing treatment form covering 3 or fewer areas	Agency has a standardized ongoing treatment form covering 4–5 areas	Agency has a standardized ongoing treatment form covering 6 areas	Agency has a standardized ongoing treatment form covering all 7 areas

MedTEAM Organizational Fidelity Scale					
Criteria	Ratings / Anchors				
	1	2	3	4	5
<p>04. Prescriber Access to Information at First Medication Visit After Admission (New Consumers Only):</p> <p>Updated charts with all pertinent information are available at the time of consumers' first appointment with the prescriber. (See O1 for list of pertinent information.)</p>	Less than 60% of charts with adequate information available at first medication visit	60–69% of charts with adequate information available at first medication visit	70–79% of charts with adequate information available at first medication visit	80–89% of charts with adequate information available at first medication visit	More than 90% of charts with adequate information available at first medication visit
<p>05. Prescriber Access to Information After Hospital or Emergency Room Visit:</p> <p>Updated charts with all pertinent information are available at the time of consumers' appointment after discharge from hospital or emergency room for a psychiatric emergency.</p>	Less than 60% of charts with adequate information available at first medication visit	60–69% of charts with adequate information available at first medication visit	70–79% of charts with adequate information available at first medication visit	80–89% of charts with adequate information available at first medication visit	More than 90% of charts with adequate information available at first medication visit
<p>06. Prescriber Access to Information at Each Routine Visit:</p> <p>Updated charts with all pertinent information are available at the time of consumers' appointment.</p>	Less than 60% of charts with adequate information available at time of appointment	60–69% of charts with adequate information available at time of appointment	70–79% of charts with adequate information available at time of appointment	80–89% of charts with adequate information available at time of appointment	More than 90% of charts with adequate information available at time of appointment
<p>07. Treatment Refractory:</p> <p>Outcomes are routinely monitored to identify consumers with treatment-refractory conditions (multiple medication failures) and to ensure that they are offered appropriate treatments. The system includes the following:</p> <ul style="list-style-type: none"> ■ Specific operational criteria for treatment refractoriness ■ Regular review (at least every 6 months) ■ Process for informing prescribers 	Agency has no criteria or process to identify consumers whose symptoms have inadequately responded to medication	Agency has a system to identify consumers whose symptoms have inadequately responded to medication, but it falls short on all 3 standards	Agency has a system to identify consumers whose symptoms have inadequately responded to medication, but it fails to satisfy 2 of 3 standards	Agency has a system to identify consumers whose symptoms have inadequately responded to medication, but it fails to fully satisfy 1 of 3 standards (for example, the review process is annual)	Agency fully satisfies the 3 standards to identify consumers whose symptoms have inadequately responded to medication
<p>08. Consumer Education:</p> <p>Agency has educational materials for consumers and families that cover the following topics:</p> <ul style="list-style-type: none"> ■ The purpose of medication treatment ■ Benefits and risks ■ Potential side effects ■ Alternative treatments <p>The agency also has procedures to distribute educational materials and to document prescriber involvement in consumer education.</p>	Agency has no educational materials to distribute	Educational materials are available, but serious deficiencies in content, distribution, and/or prescriber involvement exist	Educational materials have 2 of the following deficiencies: <ul style="list-style-type: none"> 1. 1 or more critical elements missing 2. Distribution is not systematic 3. No agency forms exist to document prescriber involvement 	Educational materials have 1 of the following deficiencies: <ul style="list-style-type: none"> 1. 1 or more critical elements missing 2. Distribution is not systematic 3. No agency forms exist to document prescriber involvement 	Agency has educational materials and procedures to distribute them and document prescriber involvement in consumer education

MedTEAM Organizational Fidelity Scale

Criteria	Ratings / Anchors				
	1	2	3	4	5
<p>09. Agency Medication Guidelines:</p> <p>Agency has written guidelines that include the following:</p> <ul style="list-style-type: none"> ■ Definition of what constitutes an adequate trial for each medication (that is, dose and duration) ■ Recommended medication sequences for inadequate responses ■ Plan to annually update the guidelines 	Agency has no written guidelines	Agency has written guidelines that have not been reviewed in the last 3 years, or the guidelines have major deficiencies	Agency has written guidelines that have not been reviewed in 2–3 years, or the guidelines have major deficiencies	Agency has written guidelines that have not been reviewed in 1–2 years, or the guidelines have minor deficiencies	Agency has written medication guidelines that meet all 3 criteria
<p>010. Scheduling Flexibility for Unscheduled Urgent Visits:</p> <p>Agency has explicit scheduling policies allowing consumers to be seen within 7 days for urgent care.</p>	No explicit policy exists or most consumers are required to wait more than 14 days to be seen	Agency has explicit scheduling policies that are not used or most consumers are seen within 8–14 days	Agency has explicit scheduling policies and 50–79% of consumers are seen within 7 days	Agency has explicit scheduling policies and 80–89% of consumers are seen within 7 days	Agency has explicit scheduling policies allowing > 90% of consumers to be seen within 7 days for urgent care
<p>011. Scheduling Flexibility After Hospital Visits:</p> <p>Agency has and adheres to explicit scheduling policies allowing consumers to be seen within 3 days after discharge from a hospital for psychiatric treatment.</p>	Agency has no explicit policy or consumers are seen after more than 28 days	Agency has explicit scheduling policies that are not used or consumers are seen within 15–28 days	Agency has explicit scheduling policies that are not used or consumers are seen within 8–14 days	Agency has explicit scheduling policies that are not used or consumers are seen within 4–7 days	Agency has explicit scheduling policies allowing consumers to be seen within 3 days after discharge from a hospital for psychiatric treatment
<p>012. Scheduling Flexibility After Emergency Room Visits:</p> <p>Agency has and adheres to explicit scheduling policies allowing consumers to be seen within 3 days after an emergency room visit for a psychiatric emergency.</p>	Agency has no explicit policy or consumers are seen after more than 28 days	Agency has explicit scheduling policies that are not used or consumers are seen within 15–28 days	Agency has explicit scheduling policies that are not used or consumers are seen within 8–14 days	Agency has explicit scheduling policies that are not used or consumers are seen within 4–7 days	Agency has explicit scheduling policies allowing consumers to be seen within 3 days after an emergency room visit for a psychiatric emergency
<p>013. Integration of Services:</p> <p>MedTEAM staff (including prescribers and those who work directly on MedTEAM) are part of a mental health treatment team (for example, case management, nursing, residential services, or employment services). They attend weekly treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.</p>	MedTEAM staff are separate from other treatment team members. No regular, direct contact or only phone or face-to-face contact per month	MedTEAM staff occasionally attend treatment team meetings, but less than monthly	MedTEAM staff have several contacts with treatment team members each month and attend monthly treatment team meetings	MedTEAM staff have several contacts with treatment team members each month and attend biweekly treatment team meetings	MedTEAM staff are part of a mental health treatment team, attend weekly treatment team meetings, and have frequent contact with treatment team members

MedTEAM Organizational Fidelity Scale					
Criteria	Ratings / Anchors				
	1	2	3	4	5
<p>014. Clinical Supervision: MedTEAM staff receive structured, monthly supervision (group or individual format) from an experienced MedTEAM leader. Supervision should be consumer-centered and should explicitly address the MedTEAM model and its application to specific consumer situations.</p>	20% of MedTEAM staff receive supervision	21–40% of MedTEAM staff receive monthly, structured, consumer-centered supervision, or all MedTEAM staff receive informal supervision	41–60% of MedTEAM staff receive monthly, structured, consumer-centered supervision, or all MedTEAM staff receive quarterly supervision	61–80% of MedTEAM staff receive monthly, structured, consumer-centered supervision, or all MedTEAM staff receive bimonthly supervision	More than 80% of MedTEAM staff receive monthly, structured, consumer-centered supervision, focusing on specific consumers, in sessions that explicitly address the MedTEAM model and its application
<p>015. Quality Assurance (QA): Agency has QA committee that comprehensively reviews MedTEAM (using all items on MedTEAM fidelity scales) every 6 months, and assessment information is used to improve the program.</p>	There is no review or committee	QA committee has been formed but no reviews have been completed	Comprehensive QA review occurs less than annually, or QA review is not comprehensive	Comprehensive QA review occurs annually, or QA review is not comprehensive	Agency has QA committee that comprehensively reviews MedTEAM (using all items on MedTEAM fidelity scales) every 6 months, and assessment information is used to improve the program

Organizational Scoresheet: MedTEAM Fidelity Scale

MedTEAM leader: _____

Today's date: ____/____/____

Assessors' names: _____

Site number: _____

		1	2	3	4	5
01	Standardized Admissions Form					
02	Standardized Annual Update Form	<input type="checkbox"/>				
03	Standardized Ongoing Treatment Form	<input type="checkbox"/>				
04	Prescriber Access to Information at First Medication Visit After Admission (New Consumers Only)	<input type="checkbox"/>				
05	Prescriber Access to Information After Hospital or Emergency Room Visit	<input type="checkbox"/>				
06	Prescriber Access to Information at Each Routine Visit	<input type="checkbox"/>				
07	Treatment Refractory	<input type="checkbox"/>				
08	Consumer Education	<input type="checkbox"/>				
09	Agency Medication Guidelines	<input type="checkbox"/>				
010	Scheduling Flexibility for Unscheduled Urgent Visits	<input type="checkbox"/>				
011	Scheduling Flexibility After Hospital Visits	<input type="checkbox"/>				
012	Scheduling Flexibility After Emergency Room Visits	<input type="checkbox"/>				
013	Integration of Services	<input type="checkbox"/>				
014	Clinical Supervision	<input type="checkbox"/>				
015	Quality Assurance	<input type="checkbox"/>				
Total Score						
Items not rated due to insufficient data						



Evaluating Your Program

Appendix C: Interview Guides: MedTEAM Organizational Fidelity Scale



MedTEAM Leader Interview Guide: MedTEAM Organizational Fidelity Scale

Ask the MedTEAM leader (and the agency administrator when necessary) these questions. Collect information that is as detailed as possible. If possible, keep copies of any forms you reviewed.

General Questions

Are your forms electronically accessible or able to be indexed?

- All
- Some
- None

Of your electronic forms, how many prescribers use them?

- All
- Some
- None

01. Standardized Admissions Form

Do you have a standardized admissions form or admission packet?

- Yes. What is the name of this document?

May I see a copy?

- No

To the Interviewer: If you receive the form, examine it for the elements listed below. If any elements are not included, ask the MedTEAM leader if they appear in the chart and if they are recorded systematically.

	On the form	Not on the form or not explicit
Diagnoses	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms and severity	<input type="checkbox"/>	<input type="checkbox"/>
Illness history (including hospitalizations and suicide attempts)	<input type="checkbox"/>	<input type="checkbox"/>
Past medication history (dose, duration, interactions, tolerability, and response)	<input type="checkbox"/>	<input type="checkbox"/>
Current medications (dose, duration, interactions, tolerability, and response)	<input type="checkbox"/>	<input type="checkbox"/>
Assessment of the effectiveness of current medications and any plans for future medication changes	<input type="checkbox"/>	<input type="checkbox"/>
Current medication adherence	<input type="checkbox"/>	<input type="checkbox"/>
Current side effects and treatments for them	<input type="checkbox"/>	<input type="checkbox"/>
Current consumer functioning	<input type="checkbox"/>	<input type="checkbox"/>
Consumer preferences and goals	<input type="checkbox"/>	<input type="checkbox"/>
Contact information for previous providers	<input type="checkbox"/>	<input type="checkbox"/>
Total number present		

Where do I find this form in the chart? (If it is an electronic form, where do you find it?)

02. Standardized Annual Update Form

Do you have a standardized update form?

- Yes
 No

Is this completed annually?

- Yes
 No

To the Interviewer: Examine the form for the elements listed below. Updates can be completed using the Standardized Admissions Form. Updates can also refer to the Initial Admission Form for history that is unchanged.

	On the form	Not on the form or not explicit
Diagnoses	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms and severity	<input type="checkbox"/>	<input type="checkbox"/>
Illness history (including hospitalizations and suicide attempts)	<input type="checkbox"/>	<input type="checkbox"/>
Past medication history (dose, duration, interactions, tolerability, and response)	<input type="checkbox"/>	<input type="checkbox"/>
Current medications (dose, duration, interactions, tolerability, and response)	<input type="checkbox"/>	<input type="checkbox"/>
Assessment of the effectiveness of current medications and any plans for future medication changes	<input type="checkbox"/>	<input type="checkbox"/>
Current medication adherence	<input type="checkbox"/>	<input type="checkbox"/>
Current side effects and treatments for them	<input type="checkbox"/>	<input type="checkbox"/>
Current consumer functioning	<input type="checkbox"/>	<input type="checkbox"/>
Consumer preferences and goals	<input type="checkbox"/>	<input type="checkbox"/>
Contact information for previous providers	<input type="checkbox"/>	<input type="checkbox"/>
Total number present		

03. Standardized Ongoing Treatment Form

Do you have a standardized ongoing treatment form that prescribers complete at every medication visit?

- Yes. What is the name of this form?

May I see a copy?

- No

Where do I find this form in the chart? (If it is an electronic form, where do you find it?)

To the Interviewer: Examine the form for the elements below. The form must be structured, not a free-flowing narrative or open-ended questions. If any elements are missing, ask the MedTEAM leader if they are recorded systematically and located elsewhere in the chart.

	On the form	Not on the form or not explicit
Diagnoses	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms and severity	<input type="checkbox"/>	<input type="checkbox"/>
Current medications (dose, duration, interactions, tolerability, and response)	<input type="checkbox"/>	<input type="checkbox"/>
Rationale for any medication changes	<input type="checkbox"/>	<input type="checkbox"/>
Current medication adherence	<input type="checkbox"/>	<input type="checkbox"/>
Current side effects and treatments for them	<input type="checkbox"/>	<input type="checkbox"/>
Current consumer functioning	<input type="checkbox"/>	<input type="checkbox"/>
Total number present		

O4. Prescriber Access to Information at First Medication Visit After Admission (New Consumers Only)

Who admits consumers?

Do you have an intake specialist?

- Yes
- No

How is the information transmitted or incorporated into the chart?

Do you have procedures for obtaining illness and medication history on admission?

- Yes. What are they?

What information do you obtain?

Do you have policies and procedures for how rapidly admission data are put into charts?

- Yes
- No

Do you monitor them?

- Yes
- No

Are they adequate?

- Yes
- No

- No

Is the chart information always available (from referring institution or previous treatment setting, if it applies)?

- Yes
- No

Is it complete?

- Yes
- No. About how often is it incomplete?

What procedures do you have to ensure completeness?

Can you think of situations in which this information may be delayed (for example, the hospital does not forward information)?



O5. Prescriber Access to Information After Hospital or Emergency Room Visits

What kind of information do prescribers have about consumers after hospital or emergency room visits (for example, lab tests, dictations, item symptom list, etc.)?

Is the chart information always available from the hospital?

- Yes
- No

Is it complete?

- Yes
- No. What percentage of the time is the chart incomplete or unavailable?

_____ percent

What procedures do you have for ensuring that complete chart information is available?

O6. Prescriber Access to Relevant Information at Each Routine Visit

During each routine visit, what kind of information do prescribers have?

Is the chart information always available?

- Yes
- No

Is it complete?

- Yes
- No. What percentage of the time is the chart incomplete or unavailable?

_____ percent

What procedures do you have for ensuring that complete chart information is available?

07. Treatment Refractory

Does your agency have a formal method to identify consumers who have treatment-refractory illnesses?

Yes. *What is your definition of treatment refractory?*
[Probe for operational criteria.]

No

Do you have a current list of consumers who have treatment-refractory illnesses?

Yes. May I see it?

No

What does the agency do when a consumer is identified as having a treatment-refractory illness?

How are outcomes monitored for consumers with treatment-refractory illnesses? How often?

If a monitoring process exists, how are prescribers informed?

To the Interviewer: Are there specific operational criteria for treatment refractory?

Yes

No

Does the agency have a regular review process (at least every 6 months)?

Yes

No

Does the agency have a method for informing prescribers?

Yes

No



08. Consumer Education

Do you have written materials about each medication?

- Yes. May I see samples?
- No. Do you provide consumer education?
 - Yes. What elements are included in your consumer education?
 - No

Do you have procedures to distribute education materials?

- Yes. May I see samples?
- No

Who distributes educational materials?

Is distribution systematic (that is, every time a new medication is prescribed)?

- Yes
- No

How are prescribers involved in consumer education?

Do agency forms document the prescriber involvement? [It doesn't have to be the prescriber who educates as long as he or she acknowledges or reviews it.]

- Yes
- No

To the Interviewer: Probe for the following elements:

	On the form	Not on the form or not explicit
Purpose of medication treatment	<input type="checkbox"/>	<input type="checkbox"/>
Benefits and risks	<input type="checkbox"/>	<input type="checkbox"/>
Potential side effects	<input type="checkbox"/>	<input type="checkbox"/>
Alternative treatments	<input type="checkbox"/>	<input type="checkbox"/>
Procedures to distribute educational materials	<input type="checkbox"/>	<input type="checkbox"/>
Procedures to document prescriber involvement	<input type="checkbox"/>	<input type="checkbox"/>
Total number present		

09. Agency Medication Guidelines

Does your agency have medication guidelines specifying what constitutes an adequate trial for each medication?

- Yes. May I see a copy? Examine the guidelines for the presence of recommendations about—

Dose

- Yes
 No

Duration

- Yes
 No

- No

Do your medication guidelines recommend medication sequences for consumers who are not adequately responding to medication (that is, treatment refractory)?

- Yes
 No

How often are the medication guidelines reviewed or updated?

When was the last update?

_____/_____/_____

[Use this date to rate frequency of updates. For example, if the date is less than a year old, then rate it as annual.]



O10. Scheduling Flexibility for Unscheduled Urgent Visits

To the Interviewer: The intent is to determine the balance between the demands for productivity and the desirability of scheduling flexibility. Some possible probe questions:

Describe your scheduling procedures.

Do you seek to fill completely your prescribers' appointment times?

- Yes
- No

How are unfilled appointment time slots viewed at your agency?

How does your agency handle unscheduled or urgent consumer visits (for example, if consumers experience troublesome side effects that are not life-threatening but would require an evaluation and possible medication change)? [Ask for recent examples and specifics of the manner in which they were handled.]

Do you "hold back" a certain number of time slots in prescribers' schedules for such purposes?

Yes. Number of time slots held back: _____

If held back by prescriber, how many per time period:

_____ per day/week

If held back for agency as a whole, how many per time period:

_____ per day/week

No

How far in the future is a typical appointment date for consumers with an urgent (but not emergency) request to see a doctor?

_____ business days

Do you have an explicit policy about unscheduled or urgent visits?

Yes. Please describe it.

No

Estimated number of days from urgent request to appointment:

_____ days

To the Interviewer: Estimate the percent of consumers who are seen within 7 days.

O11. Scheduling Flexibility After Hospital Visits

When consumers are discharged from the hospital, how long is the wait time before they have a medication visit?

Do you have an explicit policy about visits after discharge from the hospital?

Yes. Please describe.

No

O12. Scheduling Flexibility After Emergency Room Visits

When consumers are seen in the emergency room for a psychiatric emergency, how long is the wait time before they have a medication visit?

Do you have an explicit policy about visits after emergency room visits?

Yes. Please describe.

No



013. Integration of Services

How many treatment teams does your agency have? (Typically, a team comprises a team leader, several case managers, a psychiatrist, and nurses.)

_____ Number of teams

How often does each meet? Do not include administrative meetings. Count only meetings that review individual consumers regarding treatment planning, outcomes, etc.

Team 1 _____

Team 2 _____

Team 3 _____

Team 4 _____

Team 5 _____

Are prescribers and other MedTEAM staff expected to attend these meetings?

Yes. How often? _____

Is it the same for each prescriber?

Yes

No

No

Does a process exist to monitor attendance at these meetings?

Yes. Please describe.

No

Do other ways exist in your agency in which MedTEAM staff have regular contact with other members of the treatment team?

Yes. Please describe.

No

To the Interviewer: The intent of this question is to determine if an equivalent method to ensure regular, consumer-specific treatment planning and coordination exists involving all relevant staff.

_____ Average number of treatment team meetings (or equivalent) attended per week by MedTEAM staff:

_____ Average duration of meetings

O14. Clinical Supervision

Do prescribers and other MedTEAM staff receive clinical supervision?

Yes. How often?

What types of issues are discussed?

No

Who provides clinical supervision?

Is this person experienced in the evidence-based approach to medication management?

Yes

No

O15. Quality Assurance

To the Interviewer: If appropriate, interview the director of quality assurance or quality assurance team members in addition to the MedTEAM leader, asking similar questions, or interview the two together.

Do you have a department or committee responsible for quality assurance of medication management?

Yes. Name of the department or committee:

No

Please describe its composition, function, and procedures.

How often do you conduct reviews?

What specific information is examined in the review?

What corrective actions have been taken?



Prescriber/MedTEAM Staff Interview Guide: MedTEAM Organizational Fidelity Scale

Use these questions for your interviews with prescribers and MedTEAM staff. Collect information that is as detailed as possible. If possible, keep copies of any forms you reviewed. *Note:* Some questions duplicate those asked of the MedTEAM leader; DO NOT share the MedTEAM leader's responses with anyone else on the team. Also, tell the prescriber or MedTEAM staff member that any disclosure will be confidential and in no way will affect his or her relationship with the MedTEAM leader, the staff, or the agency.

01. Standardized Admissions Form

Do you use one standard form or admission packet to summarize illness and medication history?

- Yes. May I see an example from a consumer chart?
Is this information typically fully filled out?
- Yes
- No
- No

02. Standardized Annual Update Form

Do you have a standardized update form?

- Yes. May I see an example from a consumer chart?
- No

How often are updates completed?

03. Standardized Ongoing Treatment Form

Do you complete a standardized ongoing treatment form at every medication visit?

- Yes. May I see an example from a consumer chart?
- No

04. Prescriber Access to Information at First Medication Visit After Admission (New Consumers Only)

What kind of information do you have about consumers at the first medication visit after admission?

Can you think of situations in which this information may be delayed (for example, the hospital does not forward information)?

About what percentage of the time would you estimate that you have all the information you need at the time of first medication visit?

_____ percent

To the Interviewer: Get an estimate of the percentage of all charts with adequate information available at admission. Make fidelity rating based on the prescribers' estimate, but take into account the other information as it informs the credibility of the estimate.

05. Prescriber Access to Information After Hospital or Emergency Room Visits

What kind of information do you have about consumers on visits after hospital discharge?

Is the chart information always available from the hospital?

- Yes
- No. What percentage of time would you say that it is unavailable?

Is it complete? [Use list from Fidelity Item 01 to review the types of information considered to be pertinent.]

- Yes
- No. What percentage of time would you say that it is not complete?

What procedures do you have for ensuring completeness?

To the Interviewer: Get an estimate of the percentage of all charts with adequate information available at appointments after discharge from the hospital. Estimate a percentage of all charts with adequate information available to prescribers at appointments after discharge from the hospital.

06. Prescriber Access to Information at Each Routine Visit

During routine medication visits, do you have access to the consumer's chart?

- Yes
- No

What percentage of time is the chart incomplete or unavailable?

_____ percent

To the Interviewer: Estimate the percent of all charts with adequate information available to prescribers at each routine visit.



07. Treatment Refractory

Does your agency have a formal method to identify consumers who have treatment-refractory illnesses?

- Yes. What is your definition of *treatment refractory*?
[Probe for operational criteria.]
- No

Do you have a current list of consumers who have treatment-refractory illnesses?

- Yes. May I see it?
- No

What do you do when a consumer is identified as having treatment-refractory illness?

Are there specific treatments offered?

- Yes
- No

How are outcomes monitored for consumers with treatment-refractory illnesses?

How often?

Does a clinic-wide monitoring process exist to inform you?

- Yes
- No

To the Interviewer: Are there specific operational criteria for treatment refractory?

- Yes
- No

Does a regular review process exist (at least every 6 months)?

- Yes
- No

Does a method exist for informing prescribers?

- Yes
- No

08. Consumer Education

Do you have written materials about each medication?

- Yes. May I see samples?

How is this information distributed? [Probe for whether the materials are routinely offered or if they are given only when requested.]

- No. Do you provide consumer education?

- Yes. Please describe.
- No

Do agency forms document prescriber involvement? [It doesn't have to be the prescriber that provides education as long as he or she acknowledges or reviews it.]

- Yes
- No

09. Agency Medication Guidelines

Does your agency have medication guidelines specifying what constitutes an adequate trial for each medication?

- Yes. May I see a copy? Examine the guidelines for the presence of recommendations about—

Dose

- Yes

- No

Duration

- Yes

- No

- No

Do your medication guidelines recommend medication sequences for consumers who are not adequately responding to medication (that is, treatment refractory)?

- Yes

- No

How often are the medication guidelines reviewed or updated?

When was the last update?

_____/_____/_____

[Use this date to rate frequency of updates. For example, if the date is less than a year old, then rate it as annual.]

010. Scheduling Flexibility for Unscheduled Urgent Visits

How does your agency handle unscheduled or urgent consumer visits (for example, if consumers experience troublesome side effects that are not life-threatening but would require an evaluation and possible medication adjustment or additional medication)? Are time slots reserved in your schedule?

- Yes

- No

How far into the future is a typical appointment date for consumers with an urgent (but not emergency) request to see you?

_____ business days

Describe the policy for unscheduled or urgent visits.

_____ Number of time slots reserved

_____ Number of days from request to appointment

To the Interviewer: Get an estimate of the percentage of all consumers who are seen within 7 days.

O11. Scheduling Flexibility After Hospital Discharge

When consumers are discharged from the hospital, how long is the wait time before they have a medication visit?

Do you have an explicit policy about scheduling medication appointments after discharge from the hospital?

O12. Scheduling Flexibility After Emergency Room Visits

When consumers are seen in the emergency room for a psychiatric emergency, how long is the wait time before they have a medication visit?

Do you have an explicit policy about scheduling medication appointments after emergency room visits?

O13. Integration of Services

Do you have contact with other members of the treatment team (for example, case managers, residential staff, and vocational staff)?

Yes. Please describe.

No

What is the average duration and frequency of contact?

_____ Duration

_____ Frequency of contact

Do you attend team meetings?

Yes

No

_____ Frequency of team meeting attendance

O14. Supervision

Describe ongoing supervision that prescribers and others who are involved in medication treatment receive about recommended medication practices. Supervision refers to ongoing review of professional development. [There may be a focus on specific consumers or guidelines; it does not include administrative meetings in which no clinical issues are discussed.]

How often does the staff receive medication-specific supervision?

Is it in a group format?

- Yes
- No

How long are these meetings?

Who leads these meetings?

Does a designated person run the meetings?

- Yes
- No

What is the content of the meetings?

What does a typical supervision session look like?

_____ Frequency of supervision

O15. Quality Assurance

Does your agency have a department or committee responsible for quality assurance of medication management?

Yes. Name of the department or committee:

No

How often do they conduct reviews?

Have you seen this information used to improve the way medication management is provided?

Yes. Please describe.

No

Evaluating Your Program

Appendix D: MedTEAM Prescriber Fidelity Scale and Scoresheet



MedTEAM Prescriber Fidelity Scale and Scoresheet

Agency name: _____

Today's date: ____/____/____

Assessors' names: _____

Site number: _____

Note:

		Yes	No	Does not apply
P1. Accessible and Accurate Summary of Illness and Medication History	A. Timeliness of Summary of Illness and Medication History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Illness History			
	Age of onset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Number of hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Most recent hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Summary of course of illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	D. Past Medications			
	History present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Highest daily dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Duration (years taken)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
P2. Current Comprehensive Medication Documentation	A. Timeliness of Current Medication Documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Detailed Prescriber Summary of Current Medications			
	Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Highest daily dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Duration (date started)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rationale and comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Current Side Effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	D. Current Medication Adherence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	E. Consumer Education			
	If standardized form, covered medication risks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If standardized form, covered medication benefits?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If nonstandardized form, covered medication risks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If nonstandardized form, covered medication benefits?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Answers are not scored. These are qualifying questions.

Answers cause the item to be excluded from the scoring.

		Yes	No	Does not apply
P3. Treatment of All Psychiatric Diagnoses and Conditions	Treatment plan updated within last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Diagnosis or condition specified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Intervention specified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Response specified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P4. Treatment Guided by Outcomes	Medication specified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Desired outcome specified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rating method specified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P5. Documentation of Outcomes	Four visits documented?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Visit 1 target system rated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Visit 2 target system rated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Visit 3 target system rated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Visit 4 target system rated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P6. Documentation of Side Effects	Medication side effects documented?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Medication specified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Four side effects monitored?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P7. Treatment of Side Effects	One or more side effects documented?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Intervention specified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P8. Review of Treatment for Side Effects	Side effect treatment reviewed regularly in last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
P9. Simplification of Medication Regimen	More than one medication for a single condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If Yes, is there justification within last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Is each medication administered once or twice daily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If No, is there justification within last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P10. Recommended Dose Range	Four visits documented?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Medication doses documented?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Doses within recommended range?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If No, rationale given?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P11. Medication Visit Frequency	Medication changed within last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If No, has consumer been seen at least 3 times in past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If Yes, was consumer contacted weekly for at least 1 month after the change?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Answers are not scored. These are qualifying questions.

Answers cause the item to be excluded from the scoring.

		Yes	No	Does not apply
P12. Treating Refractory and Persistently Symptomatic Consumers	A. Treatment-Refractory			
	Do consumers with schizophrenia meet the criteria for being treatment-refractory?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	If consumers are treatment-refractory, have they been prescribed or offered clozapine for their condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Persistent Symptoms			
	Are consumers with schizophrenia, major depressive disorder, or bipolar disorder experiencing more than mild symptoms at most recent visit?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	If Yes, have these symptoms persisted over all visits in past 6 months?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	If Yes, has consumer been offered a medication change, or an evidence-based augmentation treatment, or is a convincing rationale for not doing so documented in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P13. Consumer Involvement in Treatment Planning	Consumer Involvement			
	Does documentation exist of consumer goals, preferences, and shared decisionmaking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P14. Consumer Medication Adherence Strategies				
	Regular provision of evidence-based strategies to enhance medication adherence, such as behavioral tailoring and motivational interviewing, documented for all consumers not identified as fully adherent to medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Total number of items scored:		22		
Average score:				

Answers are not scored. These are qualifying questions.

Answers cause the item to be excluded from the scoring.

Evaluating Your Program

Appendix E: Chart Review Guide: MedTEAM Prescriber Fidelity Scale



Chart Review Guide: MedTEAM Prescriber Fidelity Scale

P1. Accessible and Accurate Summary of Illness and Medication History

Before completing the chart review, ask the MedTEAM leader:

Does the agency have a standardized admissions or annual update form that summarizes consumers' psychiatric history?

- Yes
- No

What is the form's name and location in the chart?

An annual update should give complete medication history, although it may refer to other documents (for example, an admissions form). Give the agency credit if it directs you to another location within the chart to find the information.

P1 consists of four separate ratings (A – D). If you cannot find the relevant information in a given chart *within 15 minutes*, then rate item as absent or incomplete.

A. Timeliness of summary of illness and medication history

A comprehensive summary of consumer psychiatric history, updated within the last 12 months, is easily found in every chart. (Use the admission form if consumers are admitted to the agency in the last 12 months.)

___/___/___ Date of last comprehensive summary of consumer psychiatric history

Is the most recent summary within last 12 months?

- Yes
- No

Answer the remaining questions for P1 with respect to **most recent** comprehensive review.

B. Diagnosis

- Yes. Present
- No. Absent

List Current Diagnoses

C. Illness history

Age of onset, number of hospitalizations, most recent hospitalization, and summary of the course of illness EITHER since onset (if onset was less than 5 years ago) OR in last 5 years

Age of onset:

Yes. Specify _____

No

Number of psychiatric hospitalizations (*from Structured Clinical Interview for DSM Disorders (SCID) or best estimate*):

Yes. Specify:

_____ Past year

_____ Past 5 years

_____ Lifetime

No

Most recent hospitalization:

Yes. Specify _____

No

Summary of course of illness:

Yes

No

D. Past medications

Past psychotropic medication treatments are documented including the following:

- Highest daily dose;
- Duration (years taken);
- Response; and
- Comments.

Response is defined as assessing the consumer's degree of medication benefit (includes side effects that the consumer experiences; nonresponse; and inability to adequately gauge response due to polypharmacy, nonadherence, or short duration of medication therapy).

For a chart to be scored *Yes* on this item, it must at least have the list of medications taken and one other category of information shown below, summarized in a single location within the chart. If the chart shows at least one prior psychotropic medication, fill out the table on the next page.

History present:

Yes

No

Does not apply. Go to the next item.

If there is no medication history (consumer has never been on medication before), rate the item as *Does not apply*. Go to next item.

Past Medications

Review medications for at least the past 5 years, listing the most recent medications first.

Medication	Highest Daily Dose	Duration Years Taken	Response	Comments
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			



P2. Current Comprehensive Medication Documentation

Detailed prescriber summary of consumer's current medication status, updated within last 6 months, including the following:

- Medications (name, highest daily dose, duration, response, rationale and comments);
- Current side effects; and
- Medication adherence.

Before completing the review, ask the MedTEAM leader:

Does the agency have a standardized ongoing treatment form or another form that summarizes the consumer's current medication?

- Yes
- No

What is the form's name and location in the chart?

You may use annual update form found in P1 if this form has been completed within the last 6 months and covers the elements of P2. A copy of the prescription in the chart is not sufficient for any item under P2.

P2 consists of five separate ratings (A – E). If you cannot find the relevant information in a given chart *within 15 minutes*, then rate the item as absent or incomplete.

A. Timeliness of current medication documentation

Prescriber summary of current medications completed within last 6 months?

- Yes
- No

Answer remaining questions for P2 with respect to most recent prescriber summary. If no prescriber summary exists within the past 2 years, score the items as *No*, except for those found in any of the last four Progress Notes.

B. Detailed prescriber summary of current medication

Include highest daily dose, duration, response, and rationale and comments.

About rationale and comments, are there medications for conditions that may no longer exist?

- Yes
- No

Current Medications

Review current medications, listing the most recent medications first.

Medication	Total Daily Dose	Duration Date Started	Response	Rationale and Comments
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			



C. Current side effects

Examine the most recent summary (if it was done in last 6 months). If no timely summary was done, examine the Progress Notes in the last 6 months.

The chart must list at least one side effect or it must show “None reported by consumer.” You cannot substitute a Progress Note of a nonprescriber; prescribers must complete the Progress Note.

If chart has the Abnormal Involuntary Movement Scale (AIMS) checklist that is completed by the prescriber or signed by the prescriber, then rate this chart as *Yes* (Present).

- Yes. Present
- No. Absent

List Current Side Effects

D. Current medication adherence

Must be explicitly noted. Any explicit comment on level of adherence would be acceptable, including “*Yes. Mostly.*” Examine the most recent summary (if done in last 6 months) or if no timely summary was done, examine prescriber Progress Notes from the last 6 months.

- Yes. Present
- No. Absent

E. Consumer education

Prescriber discusses therapeutic options and associated risks and benefits with consumer (and with consumer’s family if consent is given).

To the Reviewer: Examine the chart for last 6 months until you find a Progress Note about medication education. If the chart documents consumer education for therapeutic options, medication risks, and medication benefits discussed, rate the item *Yes* (can be standardized medication education checklist covering these elements).

Does evidence exist that medication education was done in the past 6 months?

- Yes
- No

If this is a standardized medication education checklist, does it explicitly mention:

Medication risks?

- Yes
- No

Medication benefits?

- Yes
- No

If no standardized medication education checklist exists covering both elements, does consumer education cover:

Medication risks?

- Yes
- No

Medication benefits?

- Yes
- No

P3. Treatment of All Psychiatric Diagnoses and Conditions

For all identified psychiatric conditions (for example, schizophrenia, schizoaffective disorder, anxiety, depression, insomnia, substance abuse, mood instability, impulsivity) treated with a medication, a specific medication treatment plan is documented and updated within the last 6 months.

For identified psychiatric conditions not treated with medications, the treatment plan specifies a nonmedication intervention or rationale for no intervention.

To the Reviewer: Examine prescriber progress notes for last 6 months.

The underlying question for P3 is: Are conditions not being treated?

Rating this item requires clinical judgment. For example, if depression is noted and antidepressants are prescribed, rate the item as *Yes (satisfactory)* even if no explicit rationale is given. In addition, if the consumer is diagnosed with a schizophrenia-spectrum disorder and is not prescribed an antipsychotic, the chart must give a rationale to be rated *Yes (satisfactory)*. If the consumer is diagnosed with a schizophrenia-spectrum disorder and is not prescribed an antipsychotic, and no rationale is present, rate the item as *No (unsatisfactory)*.

Is there an updated treatment plan within the last 6 months?

- Yes
- No. Go to the next item.

Are psychiatric conditions or diagnoses identified in at least one Progress Note?

- Yes
- No

It does not have to be a formal clinical diagnosis. Include any condition identified as a clinical problem.

Examples of conditions identified
(Check, if present):

Core symptoms:

- Mania
- Depression
- Positive symptoms or psychosis
- Negative symptoms

Other symptoms:

- Irritability
- Mood lability
- Agitation
- Anxiety
- Level of interest
- Appetite
- Energy level
- Insomnia
- Other (specify): _____

An acceptable treatment plan would give the intervention and the response to the intervention.

Condition	Intervention	Response
From above list	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

P4. Treatment Guided by Outcomes

Treatment plan specifies desired outcomes from each medication and a systematic rating method on target outcomes.

For each psychotropic medication identified in P2B, determine if desired outcomes specified. Examples include:

Consumer will be substantially free of psychotic symptoms as measured by the psychosis items in the Brief Psychiatric Rating Scale.

Consumer's depression will be relieved to the point of no longer having suicidal thoughts.

(Must be a quantitative measure. Global Assessment of Functioning (GAF) is not adequate.)

Documentation of desired outcome and rating method must be documented within last 6 months.

Medication	Specifies desired outcome?	Specifies rating method?
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

P5. Documentation of Outcomes

Prescriber makes or reviews ratings of target symptom severity (using any quantitative scale) at every medication visit (for last four visits).

Note: Another member of the treatment team can make the actual rating as long as the prescriber reviews the rating.

Examine the last four medication visits or the last 6 months if fewer than four visits occurred in the last 6 months. Check the box next to each visit if it applies to the consumer.

How are symptoms measured (that is, it must be at least a 3-point scale)? (GAF is not considered adequate measurement of outcomes.)

How many visits were there?

- No visits
- 1 visit
- 2 visits
- 3 visits
- 4 visits

Visit Corresponding to number of visits	Date	Target symptom rated?
<input type="checkbox"/> Visit 1	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Visit 2	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Visit 3	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Visit 4	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Visit 5	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No

P6. Documentation of Side Effects

Prescriber or other MedTEAM staff rates severity of side effects.

Are medication side effects documented in at least one Progress Note or summary in last 6 months?

- Yes. Fill out the table below.
- No. Chart fails on this item. Go to next item.

Medication Class	Type of Side Effect				
Does the consumer take this?					
For Schizophrenia					
Atypical Antipsychotic	Tardive Dyskinesia	Extrapyramidal Symptoms	Blood Glucose	Weight	Other Symptoms
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Typical Antipsychotic					
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
For Major Depressive Disorder					
Antidepressant	Weight	Sexual Dysfunction	Amotivation or Apathy	Other Symptoms	
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Antidepressant Augmenting Agent					
<input type="checkbox"/> Yes					<input type="checkbox"/> Yes
<input type="checkbox"/> No					<input type="checkbox"/> No
For Bipolar Disorder					
Atypical Antipsychotic	Tardive Dyskinesia	Extrapyramidal Symptoms	Blood Glucose	Weight	Other Symptoms
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Typical Antipsychotic					
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Antimanic					
<input type="checkbox"/> Yes				<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No				<input type="checkbox"/> No	<input type="checkbox"/> No
Antidepressant					
<input type="checkbox"/> Yes					<input type="checkbox"/> Yes
<input type="checkbox"/> No					<input type="checkbox"/> No

Note: To get credit for monitoring, prescribers cannot simply say "No side effect complaints." The chart needs to specify.

P7. Treatment of Side Effects

If a consumer has side effects, for each side effect medication or psychosocial intervention is prescribed.

Does the consumer have one or more side effects identified in the last 6 months?

- Yes
 No. Go to the next item.

Has the consumer been prescribed a side effect medication or a psychosocial intervention for each side effect (for example, diet and exercise for weight control)?

- Yes
 No

Since side effects differ by medication, a single rule for what to measure and how often is impossible. Moreover, the likelihood is that some side effects decrease over time (for example, orthostasis), whereas others increase (for example, tardive dyskinesia).

The following chart lists side effects of antipsychotics and their relative potency in causing these side effects. Each consumer chart should specify side effects being monitored (at least four) and how they are being monitored in at least one Progress Note or summary within the last 6 months.

For typical and atypical antipsychotics, tardive dyskinesia, extrapyramidal symptoms, glucose, and weight should be included in the parameters being monitored. Other possible side effects to be monitored could be blood pressure, lipids, or other symptoms specific to the medication.

Examples of prescribed side effect medications for extrapyramidal symptoms are the following:

- Cogentin (benztropine);
- Artane (trihexyphenidyl);
- Amantadine; and
- Benadryl (diphenhydramine).

For Schizophrenia									
Comparative Side Effect Risk of Antipsychotic Agents									
Drug (Trade Name)	Chlorpromazine (Thorazine)	Haloperidol (Haldol)	Aripiprazole (Abilify)*	Clozapine (Clozaril)*	Olanzapine (Zyprexa)*	Paliperidone (Invega)*	Quetiapine (Seroquel)*	Risperidone (Risperdal)*	Ziprasidone (Geodon)*
Anticholinergic	+++	+	+	++++	++	+	+	+	+
Extrapyramidal symptoms	+++	++++	+	0	+	++	+/-	++	+
Orthostasis	++++	+	+	++++	++	++	++	++	+
Hyperprolactinemia	++	+++	0	0	+	+++	0	+++	+
Sedation	++++	+	+	++++	+++	+	+++	+	+
Tardive dyskinesia	+++	++++	?	0	+	+	+/-	+	?
Weight gain	++	+	+/-	++++	+++	++	++	++	+/-
Glucose intolerance	+	+	?	+++	+++	++	++	++	+/-

* indicates atypical antipsychotics

Key

+/-	Negligible	++++	Highest risk of occurrence
+	Minimal risk of occurrence	?	Inadequate data to assess relative risk
++	Low risk of occurrence		
+++	Moderate risk of occurrence		

Common Side Effects for Medications		
Medication		Common Side Effects
For Treating Hypomania and Mania		
Lithium		Tremor, drowsiness, nausea and vomiting, polyuria, muscle weakness, thirst, dry mouth, cognitive impairment
Anticonvulsants	Oxcarbazepine	Dizziness, somnolence, diplopia, fatigue, nausea, vomiting, ataxia, abnormal vision, abdominal pain, tremor, dyspepsia, abnormal gait
	Divalproex sodium	Nausea and vomiting, increased appetite with weight gain, sedation
	Carbamazepine extended-release	Dizziness, somnolence, nausea and vomiting, ataxia, pruritus, dry mouth, blurred vision, speech disorder
Atypical Antipsychotics	Aripiprazole	Anxiety, akathisia, constipation, insomnia, nausea, and vomiting
	Clozapine	Sedation, anticholinergic effects, hypotension, weight gain, hypersalivation, constipation, nausea, vomiting, hyperlipidemia, hyperglycemia
	Olanzapine	Weight gain, sedation, anticholinergic effects, mild extrapyramidal symptoms (EPS), hypotension, potential tardive dyskinesia (TD), hyperlipidemia, hyperglycemia
	Paliperidone/Risperidone	EPS, weight gain, mild sedation, anticholinergic effects, changes in blood pressure, sexual dysfunction, potential TD, hyperprolactinemia, hyperglycemia
	Quetiapine	Sedation, blood pressure, weight gain, hyperlipidemia, hyperglycemia
	Ziprasidone	Nausea and vomiting, constipation, somnolence, EPS, dizziness, akathisia, insomnia
For Treating Bipolar Depression		
SSRIs	Citalopram	Dizziness, dry mouth, insomnia, agitation, nausea, sexual dysfunction, headache, sweating
	Escitalopram	
	Fluoxetine	
	Paroxetine	
	Sertraline	
	Fluvoxamine	
Bupropion SR		Headache, agitation, weight loss, insomnia, nausea, sweating
Bupropion (immediate release)		
Duloxetine		Headache, nausea, dizziness, ataxia, somnolence, rhinitis, rash
Nefazodone		Dizziness, headache, nausea, somnolence, insomnia
Desvenlafaxine		Dizziness, somnolence, insomnia, decreased appetite, anxiety, headache, nausea, sexual dysfunction, sweating
Venlafaxine XR		
Venlafaxine		
Tricyclic antidepressants (TCAs)	Amitriptyline	Sedation, dizziness, dry mouth, nausea, insomnia, anxiety, anticholinergic effects, tremor, constipation, blurred vision, arrhythmias
	Clomipramine	
	Desipramine	
	Imipramine	
	Nortriptyline	
Amoxapine		Sedation, dizziness, dry mouth, nausea, anticholinergic effects, anxiety, insomnia, extrapyramidal reactions, seizures
Mirtazapine		Dizziness, diarrhea, increased appetite, drowsiness, dry mouth
Monoamine oxidase inhibitors (MAOIs)	Phenelzine	Restlessness, dizziness, blurred vision, diarrhea, insomnia, weakness, arrhythmias, headache, sexual dysfunction
	Tranylcypromine	

Common Side Effects for Medications		
Medication		Common Side Effects
For Treating Psychotic Depression		
Atypical Antipsychotics	Aripiprazole	Anxiety, akathisia, constipation, insomnia, nausea, and vomiting
	Clozapine	Sedation, anticholinergic effects, hypotension, weight gain, hypersalivation, constipation, nausea, and vomiting
	Olanzapine	Weight gain, sedation, anticholinergic effects, mild EPS, hypotension, potential TD
	Paliperidone/Risperidone	EPS, weight gain, mild sedation, anticholinergic effects, changes in blood pressure, sexual dysfunction, potential TD
	Quetiapine Ziprasidone	Sedation, blood pressure, weight gain Nausea and vomiting, constipation, somnolence, EPS, dizziness, akathisia, insomnia
For Augmentation Agents		
Lithium		Cognitive impairment, tremor, drowsiness, muscle weakness, nausea and vomiting, thirst, polyuria
Buspirone		Dizziness, nausea and vomiting, insomnia, dry mouth, nervousness
Cytomel		Insomnia, diarrhea, tremor, increased or decreased appetite, headache, heat intolerance, nausea

* For more information about potential side effects, please consult the *Physician's Desk Reference (PDR)* or medication package inserts.

P8. Review of Treatment for Side Effects

Treatments for side effects are reviewed regularly to determine their effectiveness and the need for continuing treatment.

If the consumer has been prescribed a side effect medication, has it been reviewed regularly within the last 6 months to determine its effectiveness and the need for changing or discontinuing treatment?

- Yes
- No. Go to next item.
- Does not apply. Go to next item.

P9. Simplification of Medication Regimen

A single medication prescribed once a day is the simplest regimen. Justification for more complex medication regimens (more than one medication within a class of medication, more than twice a day) should be documented and updated within the last 6 months. Do not include PRN medications (those taken as needed) and anti-anxiety medication in this analysis. Focus on the core symptoms of the illness and the medication used to treat those symptoms.

Does the consumer have more than one medication currently prescribed for any single identified psychiatric condition (for example, two antipsychotics)?

- Yes. Is there a justification within the last 6 months?
 - Yes
 - No
- No

Is each medication in the regimen administered once or twice daily?

- Yes
- No

If no, is there a justification within the last 6 months?

- Yes
- No

An appropriate justification for a more complex regimen documents that a simpler regimen is unacceptable, for example, the consumer has failed on a simpler regimen.

Medication Dose Codes	
Code	Dose
HS	Hour of sleep (before bed)
QD	Daily
BID	2 times a day
TID	3 times a day
QID	4 times a day
QOD	Every other day
RF	Refills
∅	None
T	1 tablet

P10. Recommended Dose Range

Medication doses are within recommended ranges or, when dose falls outside the range (either above or below), prescriber documents rationale for the deviation.

Examine the last four medication visits (that is, the same visits examined in P5).

Has the consumer been prescribed any psychiatric medication?

- Yes
- No
- Does not apply

If the consumer is on two or more antipsychotics, do not score the visit because we do not have evidence-based recommended ranges for combinations of antipsychotics.

Rate the item as *Does not apply* if the consumer has not been prescribed any medication for schizophrenia or bipolar disorder or if the consumer is on two or more antipsychotics.

For Antidepressants		
Antidepressants		
Visit	Dose Documented?	Dose Within Recommended Range?
<input type="checkbox"/> Visit 1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale

For Antidepressant Augmenting Agents		
Antidepressant Augmenting Agents		
Visit	Dose Documented?	Dose Within Recommended Range?
<input type="checkbox"/> Visit 1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale

For Treating Bipolar Disorder		
Medication 1		
<input type="checkbox"/> Antimanic		
<input type="checkbox"/> Antipsychotic		
<input type="checkbox"/> Antidepressant		
Visit	Dose Documented?	Dose Within Recommended Range?
<input type="checkbox"/> Visit 1	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 2	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 3	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 4	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale

For Treating Bipolar Disorder		
Medication 2		
<input type="checkbox"/> Antimanic		
<input type="checkbox"/> Antipsychotic		
<input type="checkbox"/> Antidepressant		
Visit	Dose Documented?	Dose Within Recommended Range?
<input type="checkbox"/> Visit 1	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 2	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 3	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale
<input type="checkbox"/> Visit 4	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> 1. Rationale given <input type="checkbox"/> 2. No rationale



For Depression

Recommended Antidepressant Dosing Used for Acute Phase Treatment of Depression

Type/Class	Medication Brand Name	Initial Target Dose Level	Maximum Dose Level	Recommended Administration Schedule
Selective serotonin reuptake inhibitors (SSRI)	Citalopram (Celexa)	20 mg	60 mg	QAM
	Escitalopram (Lexapro)	10 mg	30 mg	QAM
	Fluoxetine (Prozac)	20 mg	40–80 mg	QAM
	Paroxetine (Paxil)	20–30 mg	40–60 mg	QAM
	Sertraline (Zoloft)	50–100 mg	150–200 mg	QAM
Tricyclic antidepressants (TCA)	Amitriptyline	150–200	300 mg	QHS
	Clomipramine	100–150	250 mg	QHS
	Desipramine	150 mg (> 125ng/ml)	300 mg	QHS
	Imipramine	150 mg (IMI + DMI > 200 ng/ml)	300 mg (200–400ng/ml)	QHS
	Nortriptyline	75–100 mg (50–150 ng/ml)	150 mg (50–150 ng/ml)	QHS
Others	Amoxapine	200–300 mg	400 mg	QHS
	Bupropion SR (Wellbutrin SR)	200–300 mg	400 mg	BID < 200 mg/dose
	Bupropion (Wellbutrin)	225–300 mg	450 mg	TID < 150mg/dose
	Desvenlafaxine	50 mg	400 mg	QD
	Duloxetine (Cymbalta)	40 mg	60 mg	BID
	Mirtazapine (Remeron)	30 mg	60 mg	QHS
	Nefazodone (Serzone)	200–400 mg	600 mg	BID
	Venlafaxine (Effexor)	150–225 mg	375 mg	BID
	Venlafaxine XR(Effexor XR)	75–225 mg	225 mg	QD
Monoamine oxidase inhibitors (MAOIs)	Phenelzine	45–60 mg	90–120 mg	QD–TID
	Tranylcypromine	30–40 mg	60–80 mg	QD–TID

Recommended Doses of Augmenting Agents for Inadequate Response

Type/Class	Medication Brand Name	Initial Target Dose Level	Maximum Dose Level	Recommended Administration Schedule
Recommended Augmentation Agents	Lithium	600–1200 mg (0.4–0.6 mEq/L)	1200–1800 mg (0.8–1.0 mEq/L)	BID
	T3– Cytomel	25–50 micrograms	50 micrograms	QAM
	Bupirone	25–50 mg	45–60 mg	BID-TID
Other Augmenting Agents	Dextroamphetamine	5–30 mg	60 mg	QAM
	Methylphenidate	5–30 mg	40–60 mg	BID

For Mania and Hypomania

Recommended Doses of Medications Used for Acute Phase Treatment of Mania and Hypomania*

Type/Class	Medication Brand Name	Initial Target Dose Level	Maximum Dose Level	Recommended Administration Schedule
	Oxcarbazepine	600-2100	2400	BID or TID
	Divalproex Sodium	(100 ug/mL)	(150 ug/mL)	BID or QHS
	Carbamazepine ER	400-1600	1600	BID
	Aripiprazole	15-30	30	QD
	Clozapine	300	900	QHS
	Olanzapine	10-15	20	BID or QHS
	Paliperidone	3	12	QD
	Risperidone	2	8	BID or QHS
	Quetiapine	200-600	800	BID or QHS
	Ziprasidone	40	160	BID

*Doses used for maintenance treatment may be lower.

For Bipolar Depression

Recommended Doses of Medications Used for Acute Phase Treatment of Bipolar Depression*

Type/Class	Medication Brand Name	Initial Target Dose Level	Maximum Dose Level	Recommended Administration Schedule
Selective Serotonin Reuptake Inhibitors (SSRIs)	Citalopram	20-40	60	QD
	Escitalopram	10-20	20	QD
	Fluoxetine	20	80	QD
	Fluvoxamine	150-250	250	QD
	Paroxetine	20	60	QD
	Sertraline	50	200	QD
Anticonvulsant	Lamotrigine	200**	600	QD
Second Generation Antidepressants	Bupropion SR	300	400 (200/dose max)	BID
	Desvenlafaxine	50	400	QD
	Duloxetine	40-60	60	QD or BID
	Nefazodone	300-600	600	QD
	Venlafaxine XR	75	225	QD

*Doses used for maintenance treatment may be lower.

**Dose titration is necessary to reach this dose to avoid serious side effects.

For Depression

Recommended Dosing of Medications for Treating Associated Symptoms of Depression

Associated Symptoms	Medication	Usual Dose Range mg/day	Schedule
Insomnia	Lorazepam	0.5–2.0 mg	QHS; taper after 7 –10 days or as soon as possible
	Clonazepam	0.5–2.0 mg	
	Temazepam	15–30 mg	
	Zolpidem	5–10 mg	
	Zaleplon	5–20 mg	
	Eszopiclone	2–3 mg	
	Remelteon	8 mg	
	Trazodone	25–100 mg	
Anxiety	Lorazepam ¹	0.5–4.0 mg	Q4–6h prn throughout the day
	Alprazolam	0.75–4.0 mg	
	Clonazepam	1.5–3.0 mg	
Anxiety If history of substance abuse or if benzodiazepines are contraindicated ²	Buspirone	15–60 mg	BID-TID
Severe Agitation	Lorazepam	0.5–2.0 mg	QD
	Clonazepam	0.5–2.0 mg	
	Alprazolam	0.75–4.0 mg	
	Propranolol	10–30 mg	

1 In general, treatment emergent side effects should be addressed first by dose reduction or medication switching, as pharmacological intervention may increase the risk of drug interaction and additional adverse effects, thus decreasing consumer compliance.

2 Benzodiazepines are best avoided in consumers with prior history of substance abuse and dependence or who are at risk for substance abuse. Nonaddicting agents such as zolpidem or buspirone may be preferred.

For Antipsychotic Medications

Recommended Dose Ranges

Drug	Trade Name	Usual Dose Range
Aripiprazole	(Abilify)	10-30 mg/d
Chlorpromazine	(Thorazine)	300-1000mg/d
Clozapine	(Clozaril)	300-900mg/d
Fluphenazine	(Prolixin/Permitil)	5-20mg/d
Fluphenazine Decanoate		6.25-50mgIM/ 2-4weeks
Haloperidol	(Haldol)	2-20mg/d
Haloperidol Decanoate		50-200mg/ 2-4weeks
Loxapine	(Loxitane)	50-150mg/d
Molindone	(Moban)	50-150mg/d
Olanzapine	(Zyprexa)	10-20mg/d
Paliperidone	(Invega)	3-12mg/d
Perphenazine	(Trilafon)	8-32mg/d
Quetiapine	(Seroquel)	300-800mg/d
Risperidone	(Risperdal)	2-8mg/d
Thioridazine	(Mellaril)	300-800mg/d
Thiothixene	(Navane)	15-50mg/d
Trifluoperazine	(Stelazine)	5-40mg/d
Ziprasidone	(Geodon)	40-160mg/d

P11. Medication Visit Frequency

Consumers are seen at least three times every 12 months and more frequently when medications are being changed or when the prescriber requests it.

Examine the chart for last 12 months. Scan for instances where the prescriber has requested additional visits. Rate the item according to the prescriber's intentions.

Has the psychiatric medication changed during last 12 months?

- Yes
- No. Has the consumer been seen at least three times in the past 12 months?
- Yes
- No

If psychiatric medication changed, was the consumer contacted weekly for at least 1 month?

- Yes
- No. How often was the consumer seen when the medications were changed? (Note: You will not need this information to rate P11.) _____

P12. Treating Refractory and Persistently Symptomatic Consumers

All consumers who are identified as having treatment-refractory illnesses are offered state-of-the-art treatment for their treatment-refractory or persistently symptomatic condition.

To the Reviewer: Rating this item requires some clinical judgment and detective work.

First, identify if the consumer has treatment-refractory illness or is persistently symptomatic. If he or she does not meet these definitions, rate the item as *No* and go to next item.

Second, for consumers who have treatment-refractory illnesses or are persistently symptomatic, determine whether they have been offered an evidence-based change in treatment.

A. Treatment refractory

Does the consumer with schizophrenia meet the criteria for having a treatment-refractory illness?

Have the consumer's symptoms failed to respond to monotherapy with two or more antipsychotics during the course of illness?

- Yes
- No. Go to the next item.

If a treatment-refractory illness is identified, has the consumer been offered clozapine at any time?

- Yes
- No. Are there contraindications for clozapine?
 - Yes
 - No

Evidence of response to current antipsychotic:

If treatment-refractory and not offered clozapine and no contraindications for clozapine, is the consumer prescribed another antipsychotic and does he or she have a documented positive response (that is, symptoms are improving or not severe) according to the last two Progress Notes?

- Yes
- No

B. Persistent symptoms

Prescriber systematically identifies consumers who are experiencing persistent symptoms and prescribes or offers a medication change.

Is the consumer currently experiencing more than mild psychotic symptoms at the time of the most recent visit (as documented in Progress Notes, or other documented evidence of elevated symptoms, for example, Positive and Negative Syndrome Scale (PANSS) scores over 60)?

- Yes. Have these symptoms persisted over all visits in past 6 months? (Note: If no visits occurred in the preceding 6 months, go to the last visit before the current one.)
 - Yes. Has the consumer been prescribed or offered a medication change?
 - No. The consumer is not experiencing persistent symptoms. Go to the next item.
- No. The consumer is not experiencing persistent symptoms. Go to the next item.

For schizophrenia:

Has dosing with the current antipsychotic been adjusted upward, as tolerated, or has a switch occurred to a different antipsychotic if dose adjustments have been unsuccessful?

- Yes
- No

For depression:

Has the consumer been treated with two pharmacologically different antidepressants and, if so, has he or she been offered combination therapies with an antidepressant plus an augmenting agent or cognitive behavioral therapy?

- Yes
- No

For bipolar:

Has the consumer failed to respond to optimizing the dose of monotherapy with a mood stabilizer? If so, depending on whether the persistent symptoms are depressive, manic, or mixed, have appropriate combination treatments been tried?

- Yes
- No. Has the prescriber documented a rationale for not prescribing/offering a medication change within the past 6 months?
 - Yes
 - No



P13. Consumer Involvement in Treatment Planning

Consumer involvement is documented for all medication treatment decisions and evidence shows shared decisionmaking between the prescriber and the consumer, or a rationale for deviation is documented. This may include eliciting consumer goals, preferences, and ongoing experience with medication treatment.

To the Reviewer: Examine the last four medication Progress Notes or documentation over the last 6 months, whichever is shorter. Check the box next to each visit if it applies to the consumer.

Rate the item *Yes* if your global impression is that decisionmaking is shared, based on the presence of all or most of the important factors in shared decisionmaking, at least once within last four medication visits.

Visit	Consumer involvement? Or if not, rationale given?
<input type="checkbox"/> Visit 1	<input type="checkbox"/> Yes <input type="checkbox"/> No, but rationale given <input type="checkbox"/> No, no rationale <input type="checkbox"/> Don't know
<input type="checkbox"/> Visit 2	<input type="checkbox"/> Yes <input type="checkbox"/> No, but rationale given <input type="checkbox"/> No, no rationale <input type="checkbox"/> Don't know
<input type="checkbox"/> Visit 3	<input type="checkbox"/> Yes <input type="checkbox"/> No, but rationale given <input type="checkbox"/> No, no rationale <input type="checkbox"/> Don't know
<input type="checkbox"/> Visit 4	<input type="checkbox"/> Yes <input type="checkbox"/> No, but rationale given <input type="checkbox"/> No, no rationale <input type="checkbox"/> Don't know

P14. Consumer Medication Adherence Strategies

Regular provision of evidence-based strategies to enhance medication adherence, such as behavioral tailoring and motivational interviewing, documented for all consumers not identified as fully adherent to medications.

To the Reviewer: Examine the chart for each medication until you find a note about consumer medication adherence strategies, but no longer than 12 months previous to date of chart review. (The note does not have to be from a prescriber. It could be from a case manager, nurse, or anyone else from the treatment team).

If you cannot find the information *within 5 minutes*, rate the item as *No (unsatisfactory)*. If the consumer has been prescribed a long-acting injection medication, this does NOT qualify as a medication adherence strategy. If the documentation shows the consumer is completely adherent, rate the item as *“Does not apply.”*

If evidence shows that the consumer is only partially adherent to medication regimen (or if the chart is unclear whether the consumer is adherent), the chart must document examples of consumer medication adherence strategies. Examples of consumer medication adherence strategies are the following:

- Behavioral tailoring;
- Discussing pros and cons;
- Enlisting support of family members and others in support network;
- Exploring consumer’s reasons for wanting to take and to avoid medications; and
- Relating adherence to consumer’s personal goals.

Rate the item *Yes* if you find at least one example. If evidence shows that the consumer is not adherent and the chart has no documentation of medication adherence strategies, rate the item *No*.

Evaluating Your Program

Appendix F: Outcomes Report Form



Outcomes Report Form

Quarter: January, February, March Year: _____
 April, May, June
 July, August, September
 October, November, December

Reported by: _____
 Agency: _____ Team: _____

About the consumer

Consumer ID: _____ Discharge date: ____/____/____ Date of birth: ____/____/____
 Male Ethnicity: _____
 Female Primary diagnosis: _____

What was the consumer's evidence-based service status on the last day of the quarter?

	Unknown	Not Eligible	Eligible	Enrolled
MedTEAM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integrated Treatment for Co-Occurring Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assertive Community Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illness Management and Recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Psychoeducation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the past 3 months, how often has the consumer...	Number of days	Number of incidents
Been homeless?		
Been incarcerated?		
Been in a state psychiatric hospital?		
Been in a private psychiatric hospital?		
Been hospitalized for substance abuse reasons?		

In the past 3 months, how many days was the consumer competitively employed? (Use 0 if the consumer has not been competitively employed.)

_____ Days

Was the consumer competitively employed on the last day of the reporting period?

- Yes
- No

What was the consumer's stage of substance abuse treatment on the last day of the quarter? Check one.

- Not applicable
- Pre-engagement
- Engagement
- Early persuasion
- Late persuasion
- Early active treatment
- Late active treatment
- Relapse prevention
- In remission or recovery

What was the consumer's living arrangement on the last day of the quarter? Check one.

- Not applicable or unknown
- Psychiatric hospital
- Substance abuse hospitalization
- General hospital psychiatric ward
- Nursing home
- Family care home
- Living with relatives (heavily dependent for personal care)
- Group home
- Boarding house
- Supervised apartment program
- Living with relatives (but is largely independent)
- Living independently
- Homeless
- Emergency shelter
- Other (specify): _____

What was the consumer's educational status on the last day of the quarter? Check one.

- Not applicable or unknown
- No educational participation
- A vocational/educational involvement
- Pre-educational explorations
- Working on GED
- Working on English as a Second Language
- Basic educational skills
- Attending vocational school, vocational program, apprenticeship, or high school
- Attending college: 1 to 6 hours per term
- Attending college: 7 or more hours per term
- Other (specify): _____

What is the consumer's highest level of education? Check one.

- No high school
- High school diploma or General Educational Development (GED) diploma
- Some college
- Associate degree
- Vocational training certificate
- Bachelor of Arts or Bachelor of Science
- Master's degree or Ph.D.

Evaluating Your Program

Appendix G: Instructions for the Outcomes Report Form



Instructions for the Outcomes Report Form

Before you fill out the *Outcomes Report Form*, become familiar with the definitions of the data elements to provide consistency among reporters.

General data

- Quarter:** Check the time frame for the reporting period.
- Year:** Fill in the current year.
- Reported by:** Fill in the name and title of the person who completed the form.
- Agency:** Identify the agency name.
- Team:** Write the team name or number.

About the consumer

- Consumer ID:** Write the consumer ID that is used at your agency, usually a name or an identifying number. This information will be accessible only to the agency providing the service.
- Discharge date:** If the consumer has been discharged during this report period, fill in the discharge date.
- Date of birth:** Fill in the consumer's date of birth (example: 09/22/1950).
- Gender:** Check the appropriate box.
- Ethnicity:** Fill in the consumer's ethnicity.
- Primary diagnosis:** Write the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnosis.

Evidence-based service status

What was the consumer's evidence-based service status on the last day of the quarter? Check the appropriate boxes according to these definitions:

- Eligible:** Does the consumer meet the participation criteria for a specific evidence-based practice (EBP)? Each EBP has criteria for program participation that should be used to determine eligibility.
- Enrolled:** Is the consumer participating in a particular EBP service or has the consumer participated in the EBP in the past period? *Note:* Aggregate data about eligibility and enrollment can be used to determine the percent of eligible consumers who received services.

Incident reporting

For the following outcomes, record the number of days and number of incidents that the consumer spent in each category during the reporting period.

Categories:

- Been homeless:** Number of days that the consumer was homeless and how many times the consumer was homeless during the reporting period. *Homeless* refers to consumers who lack a fixed, regular, and adequate nighttime residence.
- Been incarcerated:** Number of days and incidents that the consumer spent incarcerated in jails or in other criminal justice lockups.
- Been in a state psychiatric hospital:** Number of days and incidents that the consumer spent hospitalized primarily for treatment of psychiatric disorders in a state psychiatric hospital.



Been in a private psychiatric hospital:	Number of days and incidents that the consumer spent hospitalized primarily for treatment of psychiatric disorders in a private psychiatric hospital.
Been hospitalized for substance abuse reasons:	Number of days and incidents that the consumer spent hospitalized primarily for treatment of substance use disorders, including both public and private hospitals whose primary function is treating substance use disorders.

Competitive employment

In the past 3 months, how many days was the consumer competitively employed? *Competitive employment* means working in a paid position (almost always outside the mental health center) that would be open to all community members who wish to apply. Competitive employment excludes consumers working in sheltered workshops, transitional employment positions, or volunteering. It may include consumers who are self-employed but only if the consumer works regularly and is paid for the work.

Stage of substance abuse treatment

What was the consumer's stage of substance abuse treatment on the last day of the quarter? Record the consumer's stage of substance abuse recovery, according to the following nine categories:

- **Not applicable:** No history of substance abuse disorder.
- **Pre-engagement:** No contacts with a case manager, mental health counselor, or substance abuse counselor.
- **Engagement:** Contact with an assigned case manager or counselor, but does not have regular contacts. The lack of regular contact implies lack of a working alliance.
- **Early persuasion:** Regular contacts with a case manager or counselor, but has not reduced substance use for more than a month. Regular contacts imply having a working alliance and a relationship in which substance abuse can be discussed.
- **Late persuasion:** Engaged in a relationship with a case manager or counselor, is discussing substance use or attending a group, and shows evidence of reducing use for at least 1 month (fewer drugs, smaller quantities, or both). External controls (such as Antabuse) may be involved in reduction.
- **Early active treatment:** Engaged in treatment, is discussing substance use or attending a group, has reduced use for at least 1 month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though consumer may still be abusing.
- **Late active treatment:** Engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) but for less than 6 months.
- **Relapse prevention:** Engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least 6 months. Occasional lapses, not days of problematic use, are allowed.
- **In remission or recovery:** No problems related to substance use for more than 1 year and is no longer in any type of substance abuse treatment.

Living arrangement

What was the consumer's living arrangement on the last day of the quarter? These data give your agency an ongoing record of the consumer's residential status.

- **Not applicable or unknown**
- **Psychiatric hospital:** Those hospitals, both public and private, whose primary function is treating mental disorders. This includes state hospitals and other freestanding psychiatric hospitals.
- **Substance use hospitalization:** Those hospitals, both public and private, whose primary function is treating substance use disorders.
- **General hospital psychiatric ward:** Psychiatric wards located in general medical centers that provide short-term, acute crisis care.
- **Nursing home:** Facilities that are responsible for the medical and physical care of consumers and have been licensed as such by the state.
- **Family care home:** Consumers live in single-family dwellings with nonrelatives who provide substantial care. *Substantial care* is determined by the degree to which nonrelatives are responsible for the daily care of consumers. Such things as medication management, transportation, cooking, cleaning, restrictions on leaving the home, and money management are considered. Nonrelatives may have guardianship responsibilities. If consumers are unable to do most daily living tasks without the aid of caretakers, consider caretakers to be providing substantial care.
- **Lives with relatives (heavily dependent for personal care):** Consult consumers and relatives about how much family members are responsible for consumers' daily care. An important distinction between this status and *supervised apartment program* is to ask, "If the family were not involved, would the consumer be living in a more restrictive setting?" In assessing the extent to which family members provide substantial care, consider such things as taking medication, using transportation, cooking, cleaning, having control of leaving the home, and managing money. If consumers are unable to independently perform most daily living functions, consider family members to be providing substantial care.
- **Group home:** A residence that is run by staff who provide many functions (shopping, meal preparation, laundry, etc.) that are essential to living independently.
- **Boarding house:** A facility that provides a place to sleep and meals but is not seen as an extension of a mental health agency, nor is it staffed with mental health personnel. These facilities are largely privately run and consumers have a high degree of autonomy.

- **Supervised apartment program:** Consumers live (fairly independently) in an apartment sponsored by a mental health agency. In determining whether someone fits this category, look at the extent to which mental health staff has control over key aspects of the living arrangements. Example characteristics of control include the following:
 - The mental health agency signs the lease;
 - The mental health agency has keys to the house or apartment;
 - Mental health agency staff provides onsite day or evening coverage; and
 - The mental health agency mandates that consumers participate in certain mental health services—medication clinic, day program, etc., to live in the house or apartment.

Note: Consumers who receive only case management support or financial aid are NOT included in this category; they are considered to be living independently.

- **Lives with relatives (but is largely independent):** An assignment to this category requires having information from consumers and families. The key consideration relates to the degree to which consumers can perform most tasks essential to daily living without being supervised by family members.

- **Living independently:** Consumers who live independently and are capable of self-care, including those who live independently with case management support. This category also includes consumers who are largely independent and choose to live with others for reasons unrelated to mental illness. They may live with friends, a spouse, or other family members. The reasons for shared housing could include personal choice related to culture or financial considerations.
- **Homeless:** Consumers who lack a fixed, regular, and adequate nighttime residence.
- **Emergency shelter:** Temporary arrangements due to a crisis or misfortune that are not specifically related to a recurrence of the consumer's illness. While many emergency shelters provide emotional support, the need for emergency shelter is due to an immediate crisis unrelated to the consumer's mental illness.
- **Other:** Those who complete the form should clearly define this status in the space provided.

Educational status

What was the consumer's educational status on the last day of the quarter? These data give your agency an ongoing record of the consumer's educational status.

- **Not applicable or unknown**
- **No educational participation:** Consumer is not participating in educational activities.
- **Avocational/educational involvement:** Organized classes in which consumers enroll consistently and expect to take part for the purpose of life enrichment, hobbies, recreation, etc. These classes must be community-based, not run by the mental health center. Classes are those in which anyone could participate, not just consumers. If any of these activities involve college enrollment, use the categories below.
- **Pre-educational explorations:** Consumers in this status are engaged in educational activities with the specific purpose of working toward an educational goal. This includes consumers who attend a college orientation class with the goal of enrolling, meet with the financial aid office to apply for scholarships, or apply for admission to enroll. This status also includes consumers who attend a mental health center-sponsored activity focusing on an educational goal (for example, campus visits with a case manager to survey the location of classrooms or meetings with the case manager and college staff to secure entitlements).
- **Working on General Educational Development (GED):** Consumers who are taking classes to earn their GED diploma.
- **Working on English as Second Language:** Consumers who are taking classes in English as a Second Language in a community setting.
- **Basic educational skills:** Consumers who are taking adult educational classes focused on basic skills, such as math and reading.
- **Attending vocational school or apprenticeship, vocational program, or attending high school:** Consumers who are—
 - Participating in community-based vocational schools;
 - Learning skills through an apprenticeship, internship, or in a practicum setting;
 - Involved in on-the-job training to acquire more advanced skills;
 - Participating in correspondence courses which lead to job certification; and
 - Young adults attending high school.
- **Attending college: 1 to 6 hours:** Consumers who attend college for 6 hours or fewer per term. This status continues over breaks, etc., if consumers plan to continue enrollment. This status suggests that consumers regularly attend college and includes correspondence, TV, or video courses for college credit.
- **Attending college: 7 or more hours:** Consumers attend college for 7 or more hours per term. This status continues over breaks, etc., if consumers plan to continue enrollment. Regular attendance with expectations of completing course work is essential for assignment to this status.
- **Other:** Those who complete the form should clearly define this status in the space provided.

Evaluating Your Program

Appendix H: Assessor Training and Work Performance Checklist



Assessor Training and Work Performance Checklist

Assessment date: ____/____/____

Assessor's name _____
First Middle Initial Last Title

Agency visited _____

Agency address _____
Street
City State ZIP code

EBP assessed _____

Assessor qualifications	
Yes	
<input type="checkbox"/>	1a. Data collection and skills: Assessor's skills are evidenced by his or her prior work experience, credentials, or supervisor's observations.
<input type="checkbox"/>	1b. Evidence-based practices (EBP) knowledge: Assessor's knowledge is evidenced by his or her prior work experience, credentials, or passing a knowledge test on a specific EBP.
<input type="checkbox"/>	1c. Training: Assessors receive at least 8 hours of systematic training on chart review, interviewing techniques, and process assessment.
<input type="checkbox"/>	1d. Shadowing: Assessors complete at least one assessment with an experienced assessor before the first official process assessment.
<input type="checkbox"/>	1e. Practice rating: Assessors co-rate as practice before being official assessors and agree exactly with an experienced assessor on ratings for at least 80 percent of items.
____/5	Subtotal



Data collection

Yes

- 2a. **Contact and scheduling:** With contact person, assessors identify a date convenient to visit site, explain purpose of the assessment, identify information to be assembled ahead of time, and develop specific schedule of interviews and assessment activities.
- 2b. **Number of assessors:** Two or more assessors are present during the assessment visit and independently rate all items. If agency is working with a consultant, assessor may join with consultant to conduct assessments.
- 2c. **Time management:** Sufficient time is allotted and all necessary materials reviewed (2 days for two assessors).
- 2d. **Interviewing:** Interview all the sources stipulated in the protocol (for example, interviews with the program leader, team members, and consumers).
- 2e. **Completion of documents:** Complete scoresheet, cover sheet, and any other supplemental documents relating to the agency.
- 2f. **Documentation supporting rating:** Each assessor provides written documentation for evidence supporting the rating for each item (such as marginal notes).
- 2g. **Chart selection and documentation:** Chart selection follows guidelines provided in the protocol (for example, the appropriate type and number of charts). Assessors note discrepancies (such as chart unavailability).
- 2h. **Chart review:** Both assessors review all charts and rate them independently.
- 2i. **Resolution of discrepancies:** When a discrepancy exists between sources (such as charts and MedTEAM team members), assessors follow up with an appropriate informant (typically the MedTEAM leader or relevant staff members).
- 2j. **Independent ratings:** No later than 1 day after the assessment, assessors independently complete scales before discussing ratings.

___/10 Subtotal

Post-assessment visit

Yes

- 3a. **Timely consensus:** Within 5 working days after the assessment, assessors discuss their ratings to determine consensus ratings, identifying any followup information needed. A third assessor (for example, supervisor) may be consulted to resolve difficult ratings.
- 3b. **Interrater reliability:** Raters agree exactly on ratings for at least 80 percent of the items. Sources of unreliability are discussed with supervisor and strategies developed to reduce future unreliability.
- 3c. **Follow up on missing data:** If followup calls are needed to complete an item, information obtained within 3 working days.

___/3 Subtotal

Comprehensive report writing

Yes

- 4a. **Documentation of background information:**
 - List recipients of report in the header (usually the agency director and MedTEAM leader; add others by mutual agreement).
 - Summarize time, place, and method.
 - Provide background about scale.
- 4b. **Site and normative fidelity data:** Provide a table with item-level (consensus) scores, along with normative data (if available). Normative data include both national and state norms. In this table, provide comparative site data from prior assessments. On second and later assessments, provide a graph of global fidelity ratings over time for the site (trend line).
- 4c. **Quantitative summary:** Provide narrative summary of quantitative data. List strengths and weaknesses.
- 4d. **Score interpretations:**
 - Interpret overall score
 - Include other pertinent observations
 - Provide overall summary
 - Provide opportunity for site to comment and clarify
- 4e. **Report editing:** If agency is working with a consultant, consultant may write report. Assessor and supervisor review draft of the report before it is submitted to the agency.

___/5 Subtotal

Report submission and followup

Yes

- 5a. **Timely report:** Report sent to agency director within 2 weeks of visit.
- 5b. **Follow up on report:** If agency is working with a consultant, consultant discusses report with designated agency staff within 1 month of assessment.

___/2 Subtotal

Quality control

Yes

- 6. **Quality control:** Supervisor reviews assessments and gives feedback, as necessary, to assessors. Depending on skill level of assessors, supervisor periodically accompanies assessors on assessment for quality assurance purposes.

___/1 Subtotal

___/27

Total—Add the subtotals.

