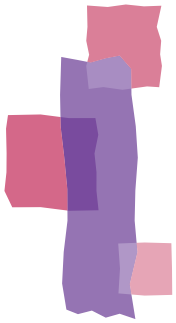

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Building Your Program

MedTEAM

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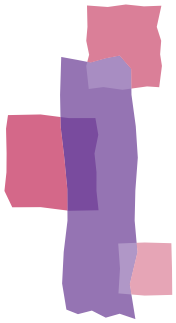

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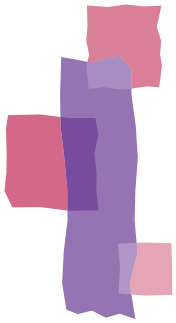


EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

MedTEAM

Building Your Program

Building Your Program is intended to help mental health authorities, agency administrators, and program leaders think through and develop Medication Treatment, Evaluation and Management (MedTEAM). The first part of this booklet gives you background information about the MedTEAM model. Specific information about your role in implementing and sustaining MedTEAM follows. Although you will work closely together to build MedTEAM, for ease, we separated tips into two sections:

- Tips for Mental Health Authorities; and
- Tips for Agency Administrators and MedTEAM Leaders.

In preparing this information, we could think of no one better to advise you than people who have worked successfully with MedTEAM. Therefore, we based the information in this booklet on the experience of veteran MedTEAM leaders and administrators.

For references, see the booklet, *The Evidence.*

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

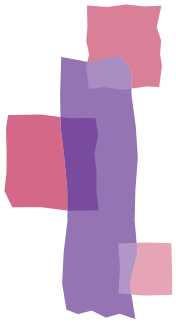
Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP



EVIDENCE-BASED PRACTICES KIT

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MedTEAM

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What Is MedTEAM?

Medication Treatment, Evaluation and Management, or MedTEAM, is an evidence-based approach for offering medication management to people with serious mental illnesses. Four factors are involved in providing evidence-based medication management:

- People who prescribe medications (*prescribers*) must know the best current evidence from systematic research;
- They must integrate that information with their own clinical expertise;
- Prescribers must be aware of consumers' experience and be able to integrate that experience into medication decisions (Parks, 2007; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996); and
- Medication management should be based on active consumer participation, mutual communication, and shared decisionmaking.

Factors involved in evidence-based medication management

- Best evidence from systematic research
- Clinical expertise
- Consumer experience
- Shared decisionmaking

Staying up to date on the research evidence for medication management is a complex endeavor in itself. Research about for whom the medication will be effective, dosing, contraindications, and possible side effects to monitor is continuously evolving.

Similarly, as a result of increasingly reduced time for medication visits, the tasks of collecting and integrating clinical expertise and consumers' experience is more challenging than ever before.

Consequently, studies on medication practices show that providing effective, evidence-based medication management requires a systematic approach (Cabana et al., 1999; Katon et al., 1995; Toprac et al., 2006).

The overriding philosophy of MedTEAM is that informed clinical judgment and shared decisionmaking are at the core of effective prescribing. MedTEAM enhances prescribers' and consumers' ability to effectively select and manage medications; it does not tell prescribers which medications to prescribe or consumers which medications to take.

MedTEAM offers agencies and the systems in which they participate guidance on developing a systematic approach to medication management. The approach includes developing a plan to keep up with the evidence about medications, including using treatment guidelines or algorithms to inform medication decisions.

Access to the most up-to-date scientific evidence and expert consensus on using medications for specific consumers is increased by offering routine training and using a team approach to clinical care. Team members support prescribers by ensuring that they have the information they need to make medication decisions.

MedTEAM also involves developing procedures to facilitate exchanging information between treatment facilities and streamlining documentation so that information is more accessible in the medication record. MedTEAM does not rely solely on prescribers; it requires the entire mental health agency to examine its practices, ranging from appointment scheduling to prescribing practices.

Treatment team collaboration is only one piece of MedTEAM. MedTEAM also emphasizes integrating consumer experience and partnering with consumers to make medication decisions together.

In MedTEAM, medication management is focused on recovery, not just on avoiding harm. Treatment should do more than helping consumers avoid hospitalization, crises, and contacts with the criminal justice system; it should help consumers live meaningful lives and strive to achieve their full potential.

Consumers work closely with all members of the team to share their recovery goals and ensure that their treatment plan helps them achieve those goals. Prescribers and consumers also work together to identify medication-related measures to evaluate their progress. These measures provide important information to consider when deciding whether and how to change medications.

MedTEAM is based on a core set of practice principles. These principles form the foundation of the approach.

Practice Principles of MedTEAM

- The latest scientific evidence guides medication decisions.
- Medication management requires a team approach.
- Systematically assessing medication-related outcomes is key to evaluating clinical progress.
- High-quality documentation provides a record of medication response over consumers' lifetime.
- Consumers and prescribers share in the decisionmaking process.

Principle 1: The latest scientific evidence guides medication decisions

Mental health systems and agencies develop a systematic plan. The plan ensures that the most up-to-date scientific evidence or expert consensus about the types of medications that work best for consumers under specific circumstances guide medication decisions.

For example, plans may include offering routine statewide training or developing procedures for how treatment team members can work together to access information on scientific updates and expert recommendations.

Principle 2: Medication management requires a team approach

Consumer-prescriber visits for medication management are often too short for prescribers to obtain all relevant information. In MedTEAM, consumers and prescribers work together with other practitioners and agency staff to systematically gather the information needed for effective medication management. Prescribers participate in weekly treatment team meetings and communicate regularly with team members.

Principle 3: Systematically assessing medication-related outcomes is key to evaluating clinical progress

Determining whether improvements have been made between visits can be difficult. Routinely using medication-related outcome measures such as brief rating scales help prescribers and consumers evaluate if medications have the desired effect.

Principle 4: High-quality documentation provides a record of medication response over consumers' lifetime

In MedTEAM, mental health systems and agencies evaluate current paperwork requirements and streamline documentation to ensure that prescribers have access to all the information needed to make effective medication decisions about particular consumers.

This process often involves working across agencies and different types of health care facilities. For example, mental health systems and agencies develop systematic plans to improve transferring information after visits to hospitals, emergency rooms, and general medical practitioners and using medications prescribed by other mental health practitioners.

Principle 5: Consumers and prescribers share in the decisionmaking process

Ultimately, consumers decide which medications they will or will not take. Therefore, MedTEAM recognizes the importance of involving consumers in the decisionmaking process about medication prescription. Consumers who understand how medications work, are given choices in medication decisions, and are involved in evaluating their progress are likely to be more satisfied with their treatment and take their medications as prescribed.

How do we know that MedTEAM is effective?

MedTEAM is based on expert consensus that asserts that medication management decisions that integrate treatment guidelines, clinical expertise, and consumer experience lead to improved consumer outcomes. Specifically, the evidence shows the following:

- In four controlled trials, effectively implementing treatment guidelines was associated with improved outcomes such as fewer mental health symptoms, improved quality of care, and increased retention of employment (Katon et al., 1995; Simon, Von Korff, Rutter, & Wagner, 2000; Wells et al., 2000; Worrall, Angel, Chaulk, Clarke, & Robbins, 1999).
- Applying treatment guidelines requires clinical and consumer expertise (Sernyak, Dausey, Desai, & Rosenheck, 2003).
- Consumer education and involvement increases satisfaction with treatment, adherence to treatment regimes, and outcomes (Katon et al., 1995).

Furthermore, prescribers were more likely to integrate treatment guidelines into medication decisions when agencies took a systematic and collaborative approach to medication management. Specifically, the evidence shows the following:

- Interventions that successfully promoted integrating treatment guidelines included educational efforts for prescribers, consumers, and families; system redesign to streamline documentation; and supervision or consultation (Parks, 2007; Bauer, 2002; Weinmann, Koester, & Becker, 2007).
- Prescribers were more likely to implement treatment guidelines when they fully understood them and believed that they would produce the expected outcomes (Cabana et al., 1999).
- Treatment guidelines were more likely to be implemented when consumers understood them and believed that they would help them meet their goals (Cabana et al., 1999; Sernyak et al., 2003).
- Prescribers who specialized in specific disorders (for example, those who saw mostly consumers with schizophrenia) were more likely to integrate treatment guidelines (Young, Mohr, Meterko, Seibert, & McGlynn, 2006).

For more information, see *The Evidence* in this KIT.

Who benefits most from MedTEAM?

Using medications varies by symptomatology, diagnosis, and other clinical circumstances. To simplify presenting information, this KIT focuses many examples on schizophrenia, one of the most serious and impairing psychiatric disorders. However, MedTEAM's general principles apply across the board. Therefore, most suggestions either directly apply to other mental illnesses or can be easily modified when working with consumers who have other mental illnesses. To adapt the KIT for other mental illnesses, you must do the following:

- Identify scientific evidence for medication management of the disorder including recommended dose ranges, side effect profiles, and monitoring recommendations; and
- Select outcome measures such as brief rating scales that are specific to the disorder.

Integrate this new information into your agency's treatment guidelines and MedTEAM fidelity scales.

Where should MedTEAM be provided?

Mental health systems operate under a variety of organizational structures. Commonly, a mental health authority has overall responsibility for multiple agencies or services. The authority may have a designated medical director who supervises medical staff within those agencies.

Agencies usually have their own administrator or medical director. In many systems of care, consumers see different prescribers in different agencies. Also, within each agency, prescribers change over time.

Consequently, it is almost always preferable for each agency within a system to implement MedTEAM in the same way. Many steps to create a systematic approach are best made at the system level, with support from the mental health authority and with all agencies participating, rather than having each agency develop its own way of doing things.

The remaining sections of this booklet include tips targeted specifically to mental health authorities and to agency administrators and MedTEAM leaders to promote a coordinated effort to implement MedTEAM.

EVIDENCE-BASED PRACTICES

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Knowledge Informing Transformation

Building Your Program

Tips for Mental Health Authorities

Successfully implementing evidence-based practices requires the leadership and involvement of mental health authorities. This section discusses why you should be involved in implementing MedTEAM and the types of activities that mental health authorities typically undertake.

Why should you be interested in MedTEAM?

In a variety of states and practice settings, studies of medication practices show frequent problems, both in how medications are used and in how decisions are documented in medical records. For example:

- Doses of antipsychotic medication for those in outpatient settings were found to be outside the recommended range 71 percent of the time (Lehman & Steinwachs, 1998).
- Medication management of consumers with schizophrenia was of poor quality 38 percent of the time (Young, Sullivan, Burnam, & Brook, 1998).
- Documentation of psychotic symptoms and side effects was inadequate 55 and 85 percent of the time, respectively (Cradock, Young, & Sullivan, 2001).

As a result, benefits of medication management are delayed or not realized for consumers, which is costly for both consumers and the mental health system.

Can MedTEAM make a difference?

Whenever new programs come along, administrators have to ask whether reorganization is worthwhile: **Is the new program really going to make a difference?**

When it comes to MedTEAM, research shows that the answer is, "**Yes**." MedTEAM is based on expert consensus that asserts that medication management decisions that integrate treatment guidelines, clinical expertise, and consumer experience lead to improved consumer outcomes.

Research has demonstrated that MedTEAM has a consistent, positive impact on the lives of consumers. The MedTEAM KIT gives public mental health authorities a unique opportunity to improve clinical services for adults with serious mental illnesses. It gives you information and guidance for implementing this evidence-based practice in a comprehensive and easy-to-use format.

Aren't we already doing this?

Medication is a core component of treatment for every mental health system. The question, then, is not whether to adopt the practice of treating mental illnesses with medications. Rather, the question is how effective is medication management in your mental health system?

MedTEAM is a systematic approach to increase the effectiveness of medication management. It is based on the following principles:

- The latest scientific evidence guides medication decisions.
- Medication management requires a team approach.
- Systematically assessing medication-related outcomes is key to evaluating clinical progress.
- High-quality documentation provides a record of medication response over consumers' lifetimes.
- Consumers and prescribers share in the decisionmaking process.

How can mental health authorities support MedTEAM?

As you read about MedTEAM, you may think that it sounds great but unaffordable. We want to challenge that notion because other mental health systems with limited resources are implementing MedTEAM systemwide. These systems have leaders who become convinced of the benefits of providing this evidence-based practice and who have persisted in overcoming challenges to ensure its success.

Implementing MedTEAM must be a consolidated effort by mental health authorities, agency staff, consumers, and families. However, for this initiative to be successful, mental health authorities must lead and be involved in developing MedTEAM in local communities.

Be involved in implementing medteam

Step 1 Create a vision by clearly articulating MedTEAM principles and goals. Designate a staff person to oversee your MedTEAM initiative.

Step 2 Form advisory groups to build support, plan, and provide feedback for your MedTEAM initiative.

Step 3 Establish program standards that support implementation. Make adherence to those standards part of licensing criteria.

Step 4 Develop a training structure tailored to the needs of different stakeholders.

Step 5 Monitor MedTEAM fidelity and outcomes to maintain and sustain program effectiveness.

Create a vision

Agencies commonly set out to implement one program but end up with something entirely different. Sometimes these variations are intentional, but often they occur for the following reasons:

- One administration starts an initiative and another with a different vision and different priorities subsequently assumes leadership;
- The model wasn't clearly understood to begin with; or
- The staff drifted back to doing things in a way that was more familiar and comfortable.

Articulating the vision that medication management should be a systematic, team-oriented approach and consumers should share in the decisionmaking process is essential to successfully implementing MedTEAM.

Place the MedTEAM initiative in the context of the larger recovery paradigm. Medication management has traditionally been viewed from a harm-avoidance perspective. That is, if medications help consumers avoid hospitalization, crisis intervention, and contact with the criminal justice system, then treatment is succeeding.

However, the perspective is different in the recovery model. The question is whether medications are being optimally used to support recovery goals. This means that prescribers must be attuned to consumers' goals. They also must communicate with treatment team members to find out if medication-related issues interfere with movement towards recovery. Communicate this message by explaining how MedTEAM's systematic approach to medication management helps agencies fulfill their mission—assisting consumers in their recovery process.

To ensure that your vision is clearly articulated, designate a staff person to oversee your initiative who has experience with the MedTEAM model, such as your medical director. Some mental health authorities designate an office or staff with whom agencies may consult throughout the process of building and sustaining their EBP programs. Designated staff may also have oversight responsibility for implementing MedTEAM across the state.

Form advisory groups

You can ensure that the MedTEAM model is implemented appropriately if you mandate that stakeholder advisory groups guide the implementation initiative. Your MedTEAM initiative can benefit in many ways from an advisory group. Among other things, an advisory group can help you do the following:

- Build internal and external support;
- Increase program visibility; and
- Obtain input and feedback that contribute to ongoing planning efforts.

Consider forming local and state-level advisory groups. State-level advisory groups may include the following members:

- Representatives from the mental health authority, substance abuse authority, and other state agencies that would be invested in the initiative;
- Representatives from state medical or hospital associations that may be invested in the initiative (for the purposes of improving access to information and coordination of care);
- Representatives of Pharmaceutical and Therapeutics Committees;
- Leadership from implementing agencies; and
- Representatives from consumer and family advocacy organizations.

Local advisory groups can serve as liaisons between the community and agencies that implement MedTEAM. Community stakeholders who have an interest in the success of MedTEAM include the following:

- Agency administrators and the MedTEAM leader;
- MedTEAM staff members;
- Representatives of Pharmaceutical and Therapeutics Committees;
- Local providers (such as representatives of psychiatric and general hospitals or other local providers who may be invested in the initiative); and
- Local consumer and family organizations.

Facilitating your advisory group

From the beginning, you must lead your advisory groups in understanding and articulating what MedTEAM is and how it is going to be developed in your mental health system. For training materials that you can use to help stakeholders develop a basic understanding of the evidence-based practice, see *Using Multimedia to Introduce Your EBP* in this KIT.

Your mental health system may already have components of MedTEAM in place. Use the tools in *Evaluating Your Program* in this KIT to assess which components of MedTEAM are already in place in your mental health system and within each implementing agency.

Use your state and local advisory committees as working groups to help develop your MedTEAM implementation plan based on the results of your readiness assessment. The process can involve the committee working as a whole, or you could break into smaller work groups that will report back to the committee.

Use the results of your readiness assessment to set priorities. You may have a long list of problematic items and a sense that the task is too big. Remember that MedTEAM comprises a number of separate elements that do not all have to be implemented simultaneously.

For purposes of gaining buy-in, it may be best to start with minor changes that have wide support. However, remember, do not sacrifice key elements of MedTEAM for the sake of achieving acceptance. Instead, develop short- and long-term action steps to work on areas that may be harder to address.

It is very important that advisory committee members have a thorough grasp of clinical workflow in the system. The goal is to transform the system, rather than simply adding new components into a system that may be overburdened and operating inefficiently. The operative principles are to be transformative, not additive, while maintaining items that are currently being done well.

Advisory groups should continue to meet well after MedTEAM has been established. We suggest that they meet about once a month for the first year, once every 2 months for the second year, and quarterly for the third year.

By the second and third years, advisory groups may help agencies sustain high fidelity by assisting with fidelity evaluations, outcomes monitoring, or translating evaluation data into steps for continuous quality improvement. For more information on the role of advisory groups, see *Getting Started with Evidence-Based Practices* in this KIT.

Planning your MedTEAM initiative

With a vision firmly in place, the process of unfolding MedTEAM across the service system can begin. Carefully planning this process will help ensure a successful outcome.

Implementing MedTEAM first in pilot or demonstration sites may be useful. Working with pilot sites can help you manage problems as they arise and give constituents the opportunity to see that MedTEAM works.

Multiple pilot sites are preferable to just one. When only one site is used, idiosyncrasies can occur that misrepresent the model. In contrast, when mental health authorities roll the program out systemwide, training all MedTEAM staff members presents a challenge. In that case, system problems that may have been resolved easily on a smaller scale with a few MedTEAM sites can cause havoc.

Establish program standards

Studies of agencies that have tried to replicate evidence-based models have found that if agencies did not achieve positive outcomes, it was often because they failed to implement all of the model's components (Becker et al., 2001; Bond & Salyers, 2004). As a mental health authority, you have the capacity to ensure that the system has incentives to implement MedTEAM. Attention to aligning these incentives in a positive way (such as attaching financial incentives to achieving improved outcomes) is vital to successfully implementing MedTEAM.

States have the authority to adopt regulations that govern services to consumers. These regulations set standards for the quality and adequacy of programs, including criteria that govern these areas:

- Assessment and treatment planning;
- Staffing;
- Service components;
- Consumer medical records;
- Consumer rights; and
- Supervision and program evaluation.

Integrate MedTEAM's systematic approach to medication management at the state level to decrease variability and inefficiencies. Examples of MedTEAM components that you may implement at the state level include the following:

- Standardize documentation so that admissions, annual updates, and ongoing treatment forms include core items that are essential to informing medication management. These core items are outlined in the MedTEAM Organizational Fidelity Scale which you can find in *Evaluating Your Program* in this KIT.
- Collaborate with psychiatric hospitals and emergency rooms to improve access to needed information.
- Mandate that consumers must be seen within 7 days for urgent visits and within 3 days after hospital and emergency room visits for psychiatric treatment.
- Mandate that MedTEAM staff (including prescribers) meet weekly to promote integrating services and support medication management as a team approach.
- Mandate that MedTEAM staff (including prescribers) meet monthly with a supervisor who is experienced in the MedTEAM model for clinical supervision.
- Select or develop medication guidelines or algorithms that specify what constitutes an adequate trial for each medication (for example, dose and duration) and recommended medication sequences for inadequate responses. Develop a plan to update those guidelines annually.

For more information about the components of MedTEAM, see the MedTEAM fidelity scales in *Evaluating Your Program* in this KIT.

Support implementing MedTEAM by explicitly referencing MedTEAM in licensing standards and other program review documents (for example, grant applications, contracts, requests for proposals, and so forth).

You should also review current administrative rules and regulations to identify any barriers to implementing MedTEAM. Work closely with agency administrators to ensure that mental health authority policies support high-fidelity MedTEAM practice.

Develop a training structure

Agencies that implement evidence-based practices are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of MedTEAM.

We encourage you to support agency administrators in their efforts to develop a training structure for implementing MedTEAM. The training plan should include the following:

- Basic training for key stakeholders, including:
  - ❑ Advisory group members;
  - ❑ Staff at all levels across the agency;
  - ❑ Consumers and families; and
  - ❑ Staff from key community organizations.
- Intensive training for staff designated to provide MedTEAM services. Intensive training may include training in the following:
  - ❑ New documentation practices;
  - ❑ Ongoing training on medications; and
  - ❑ Integrating outcome measures into clinical assessments.

For more information, see *Training Frontline Staff* in this KIT.

Choose your trainer

An intensive training plan for prescribers may be designed in several different ways, but you must first decide who will conduct the training. MedTEAM leaders may develop the initial training for prescribers and other MedTEAM staff by using the guidelines in *Training Frontline Staff* in this KIT. Some mental health authorities choose to hire external trainers.

One successful strategy in training MedTEAM staff entails having new staff visit an existing, well-functioning, high-fidelity MedTEAM program to observe how the program works. New staff will benefit most from this visit if they have a basic understanding of the MedTEAM model.

Once trained, MedTEAM leaders and staff will be able to use the tools in *Using Multimedia to Introduce Your EBP* in this KIT to provide basic training to key stakeholders.

Offer ongoing training and consultation

Throughout the first year, we encourage you to offer MedTEAM staff intermittent booster training sessions. After the first year, consider establishing an annual statewide conference on the evidence-based model.

Routine onsite and telephone consultation is also important, particularly for MedTEAM leaders. Supervising MedTEAM staff requires a complex set of administrative and clinical skills. For example, MedTEAM leaders provide direct services and supervision, which may require a shift in thinking about consumers' role in medication decisions and about how colleagues work together.

MedTEAM leaders also may have administrative responsibilities such as hiring, preparing administrative reports, and developing policies and procedures. Perhaps more important, MedTEAM leaders are responsible for ensuring that the program operates with fidelity to the MedTEAM model.

It is very difficult for any MedTEAM leader to grasp everything that has to be learned in a brief time. Also, understanding what must be done and translating that understanding into action are different and equally difficult. Strong daily leadership is essential to ensure that the MedTEAM model is faithfully carried out.

For at least the first year a new program is in operation, MedTEAM leaders need someone who is experienced in MedTEAM to provide ongoing consultation on organizational and clinical issues. Consultation ranges from integrating MedTEAM principles into the agency's policies and procedures to consulting on cases.

Some states develop MedTEAM in a few sites at a time so that the first MedTEAM site can help train those who are in newly developed programs. Generally, it takes about a year for staff to feel confident in using an evidence-based practice approach, but this can vary depending on how much structural change is needed. Agencies that are not already team oriented or staff who are reluctant to accept new models can take longer to change.

It may take 2 to 3 years for an agency to become sufficiently proficient in the MedTEAM model to assume the added responsibility of training other agencies' staff. Agencies that have become evidence-based practice training sites indicate that involving their staff in training staff from new programs reinforces the evidence-based principles and their knowledge of the model.

Other states have established training centers or enhanced existing education and training centers that offer education, training, and ongoing consultation or supervision. A state- or county-wide coordinator who is experienced with the MedTEAM model can also help new MedTEAM sites through ongoing contact, assessment, and troubleshooting.

Monitor fidelity and outcomes

Providing MedTEAM involves incorporating a new approach into the service delivery system. The best way to protect your investment is to make certain that agencies actually provide medication management in a way that positively affects the lives of consumers.

Agencies that adhere more closely to the evidence-based model are more effective than those that do not follow the model. Adhering to the model is called *fidelity*.

The MedTEAM Fidelity Scales measure how well programs follow key elements of the MedTEAM model. Research tells us that the higher an agency scores on a fidelity scale, the greater the likelihood that the agency will achieve favorable outcomes (Bond & Salyers, 2004; Drake, Bond, & Rapp, 2006). For this reason, it is important to monitor both fidelity and outcomes.

As a central part of the initial planning process, you must address how you will monitor fidelity and outcomes for MedTEAM. Too many excellent initiatives had positive beginnings and enthusiastic support but floundered at the end of a year because people did not plan how they would maintain MedTEAM. Monitoring MedTEAM fidelity and outcomes on an ongoing basis is a good way to ensure that MedTEAM is fully implemented and increasing the effectiveness and efficiency of medication management in your system. For more information about monitoring fidelity and outcomes, see *Evaluating Your Program* in this KIT.

Consider developing routine supervision and evaluations for sites that are implementing MedTEAM. If that is impossible, use strategies (for example, rules, contracts, or financial incentives) to support fidelity and outcomes monitoring on the local level or within individual agencies.

The characteristics of an agency that would have a perfect score on the MedTEAM Organizational Fidelity Scale are shown on the next page. For more information about MedTEAM fidelity scales, see *Evaluating Your Program* in this KIT.

Characteristics of an agency that would have a perfect score on the MedTEAM Organizational Fidelity Scale	
Standardized admissions form	Agency has a standardized admissions form including core elements defined in the MedTEAM Organizational Fidelity Scale.
Standardized annual update form	Agency has a standardized annual update form covering the same core elements defined in the standardized admissions form.
Standardized ongoing treatment form	Agency has a standardized ongoing treatment form including core elements defined in the MedTEAM Organizational Fidelity Scale.
Prescriber access to information at first medication visit after admission *(for new consumers only)*	Updated charts with all pertinent information are available for consumers' first appointment with the prescriber.
Prescriber access to information after hospital or emergency room visit	Updated charts with all pertinent information are available for consumers' appointment after discharge from hospital or from emergency room for a psychiatric emergency.
Prescriber access to information at each routine visit	Updated charts with all pertinent information are available for consumers' appointments.
Treatment refractory	Outcomes are routinely monitored to identify consumers with treatment-refractory illnesses (for example, multiple medications were given without achieving the desired outcome) and to ensure that those consumers are offered appropriate treatments for their treatment-refractory condition.
Consumer education	Agency has educational materials for consumers and families. Procedures outline how materials are distributed and how prescribers are involved in consumer education.
Agency medication guidelines	Agency has written guidelines that include a definition of what constitutes an adequate trial for each medication (that is, dose and duration), recommended medication sequences for inadequate responses, and a plan to update the guidelines annually.
Scheduling flexibility for unscheduled urgent visits	Agency adheres to explicit scheduling policies that allow consumers to be seen within 7 days for urgent care.
Scheduling flexibility after hospital visits	Agency adheres to explicit scheduling policies that allow consumers to be seen within 3 days after being discharged from the hospital for psychiatric treatment.
Scheduling flexibility after emergency room visits	Agency adheres to explicit scheduling policies that allow consumers to be seen within 3 days after an emergency room visit for a psychiatric emergency.
Integration of services	MedTEAM staff members are part of a mental health treatment team and attend weekly treatment team meetings (which are not replaced by administrative meetings) and have frequent contact with treatment team members.
Clinical supervision	MedTEAM staff receive structured, monthly supervision (group or individual format) from a program leader experienced in MedTEAM.
Quality assurance	Agency has a committee that comprehensively reviews MedTEAM (using all items on MedTEAM fidelity scales) every 6 months and uses assessment information to improve the program.

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Building Your Program

Tips for Agency Administrators and MedTEAM Leaders

Successfully implementing MedTEAM requires a broad range of activities and collaboration between mental health authorities and agencies. This section assumes that the mental health authority has initiated efforts to implement MedTEAM. It outlines the types of activities in which agency administrators and MedTEAM leaders are often involved.

Recruit your staff

A variety of people are legally empowered to prescribe medications, either independently or under a physician's supervision. For example, in many locations, advanced nurse practitioners do a great deal of prescribing. This KIT uses the term prescriber to encompass all those who can legally authorize prescriptions for consumers.

Traditionally, medication management occurred in one-to-one interactions between prescribers and consumers. As such, it was a highly individualized practice that simply required training prescribers about evidence-based medicine.

But today, medication visits are far too short to rely solely on prescribers to find and record all of the needed information. Moreover, physician time is relatively expensive, so having less expensive personnel gather core information makes good sense. In MedTEAM, medication management is a team approach. MedTEAM leaders, prescribers, and practitioners partner to promote effective medication management.

Choose a MedTEAM leader

It is important to hire or designate a leader to implement MedTEAM in your agency. We suggest that MedTEAM leaders be full-time employees whose time is completely dedicated to MedTEAM.

MedTEAM leaders are often medical directors who have the authority to make or suggest administrative changes within the agency. Successful MedTEAM leaders have both administrative and clinical skills.

As part of their administrative responsibilities, MedTEAM leaders undertake the following tasks:

- Oversee MedTEAM staff;
- Develop MedTEAM policies and procedures;
- Act as a liaison with other agency administrators;
- Monitor the program's fidelity to the MedTEAM model; and
- Oversee various other quality control and financial responsibilities.

As part of their clinical responsibilities, MedTEAM leaders undertake the following:

- Provide medication management;
- Provide monthly individual or group supervision; and
- Give program feedback to the MedTEAM staff.

When hiring or designating staff for this position, choose someone who is a consensus-builder. Your MedTEAM leader should be respected by others and prepared to champion the cause.

Build support for your program

Successfully implementing MedTEAM depends on the support and collaboration of a number of stakeholders. Internally, it is important that your agency director and staff across the agency understand and support implementing MedTEAM. Your agency is more likely to achieve high fidelity in the MedTEAM approach if your agency director is informed and involved in the implementation process from the start.

It is important that your agency director take the lead in promoting the MedTEAM approach and addressing any misconceptions. Articulate internal and public support for MedTEAM by telling key stakeholders that medication management should be a systematic, team-oriented approach and consumers should share in the decisionmaking process.

Place the MedTEAM initiative in the context of the larger recovery paradigm. Medication management has traditionally been viewed from a harm-avoidance perspective. That is, if medications help consumers avoid hospitalization, crisis interventions, and contacts with the criminal justice system, then treatment is succeeding. In the recovery model, however, the perspective is different. The question is whether medications are being optimally used to support recovery goals.

For example, excessive sedation may not be an issue in the harm-avoidance model, but it is very much an issue for consumers with the goals of being employed and having an active social life. This means that prescribers must be attuned to consumers' goals.

They must also communicate with treatment team members to find out if medication-related issues interfere with movement towards recovery. Communicate this message by explaining how MedTEAM's systematic approach to medication management helps your agency fulfill its mission—assisting consumers in their recovery process.

Once your agency director has articulated a clear vision for implementing MedTEAM, continue to bolster internal support for MedTEAM by clearing up misconceptions. Ensure staff that MedTEAM is transformative, not additive. For example, explain that paperwork and procedures will be reevaluated and streamlined to reduce burden, not to increase it.

Give all agency staff basic information about MedTEAM to build support across the agency. For more information, see *Develop a training plan* later in this booklet.

Form advisory committees

Forming a local advisory committee is an effective way to gain key stakeholders' support for MedTEAM. To serve on your committee, identify community stakeholders who have an interest in the success of MedTEAM. Committees often include the following people:

- Agency administrators and the MedTEAM leader;
- MedTEAM staff;
- Representatives of Pharmaceutical and Therapeutics Committees;
- Local providers (such as representatives of psychiatric and general hospitals or other local providers who may be invested in the initiative); and
- Representatives from local consumer and family organizations.

To start, your mental health authority representative or agency director should voice support for the initiative. Next, provide basic training to help advisory group members understand the MedTEAM model. Once established, advisory groups may help implement MedTEAM in a variety of ways. For more information, see Getting Started with EBPs in this KIT.

Sustain support for MedTEAM

Building support for MedTEAM should be an ongoing effort. Find ways to recognize and reward the achievements of MedTEAM staff and consumers. For example, organize meetings with key stakeholders in which consumers share success stories and administrators highlight staff achievements.

Another option is to sponsor a banquet to celebrate the program's accomplishments with consumers, family members, and agency staff members. Banquets are particularly helpful if a wide array of stakeholders (such as physicians, administrators, and key public officials) attend.

Your agency director and MedTEAM leader should meet regularly to review program evaluation data, discuss roadblocks, and plan ways to improve your MedTEAM initiative. Building support from internal staff and key community stakeholders is essential to implementing MedTEAM effectively.

Form collaborative relationships

In many mental health systems, consumers see different prescribers in different agencies. Also, within each agency, prescribers change over time. Without good documentation of consumers' medication history, prescribers rely on consumers' recall, which is likely to be at its worst when they present to a new prescriber with an illness exacerbation.

For this reason, it is important to form collaborative relationships and processes that promote sharing information with key outside organizations such as the following:

- Psychiatric hospitals;
- Emergency rooms in general hospitals;
- General medical providers; and
- Other mental health specialists.

Establish procedures to ensure that prescribers have access to needed information for medication visits. Procedures may range from documenting contact information for primary care providers to providing limited access to core elements within electronic medical records.

Understanding the guidelines and practices of each other's systems will close the gaps that have formed barriers. Collaborations will help create new ways of working together to provide more effective services for consumers.

In summary, building support from internal staff and key community stakeholders for your MedTEAM initiative is essential to effective medication management.

Agency directors can lead this effort

- Articulate clear support for MedTEAM to internal staff and key community stakeholders.
- Attend some MedTEAM trainings and supervision and advisory group meetings.
- Meet monthly with the MedTEAM leader to address roadblocks.
- Facilitate ongoing planning and program improvement efforts.
- Partner with mental health authority representatives and key stakeholders.

Develop effective policies and procedures

Starting a new MedTEAM initiative means developing policies and procedures that support the activities of the MedTEAM model.

What Policies and Procedures Should Cover

- Assessment and treatment planning criteria
- Staffing criteria
- Program organization and communication
- Consumer records requirements
- Consumers' rights
- Program and staff performance evaluation

Develop assessment and treatment planning criteria

The expert consensus panel that developed MedTEAM identified specific types of information that prescribers need to effectively inform medication decisions. If your mental health authority has not already done so, we encourage you to review your documentation to assess which of these areas are already included and identify changes that must be made.

Often existing forms, used for years, capture information that, at one point, the agency, mental health authority, or some other entity deemed important. Some agencies resist changing forms and simply add new forms. This is a mistake that effectively creates more work and inefficiencies. Instead, look critically at the entire information-gathering and recording process and eliminate tasks that have little or no clinical value.

Medication visits fall into three broad categories:

- Initial visit (or admission to the agency);
- Annual update; and
- Routine visits.

The first two categories are occasions for obtaining or updating the complete medication history and consumer issues related to medications. They contain vital historical information that is not recorded at every visit.

MedTEAM has identified 11 core areas that documentation should cover for initial and annual update visits:

- 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; and
- Contact information for previous providers.

Furthermore, MedTEAM recommends documenting the following information during routine medication visits:

- 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; and
- Current consumer functioning.

Sample admissions and annual update and ongoing treatment forms are provided on the next few pages.

Sample Admissions or Annual Update Form

Consumer's name:		Consumer's I.D. number:	
Date completed:	___/___/_____	Appointment time:	
MedTEAM staff or prescriber name:			
Vital signs:	Height _____	Weight _____	
	Blood pressure _____	Pulse _____	
	Temperature _____	Body Mass Index (BMI): $\frac{\text{weight (pounds) } \_\_\_\_ \times 703}{\text{height (inches)}^2} = \text{B.M.I.}$	
Principal Axis I diagnosis:		Age at onset:	
Other Axis I diagnoses:		Age at onset:	
Axis II diagnoses and comments:			
Axis III diagnoses and comments on general medical conditions:			
Discharge date from most recent hospitalization:	___/___/_____	**Number of psychiatric hospitalizations:**	**Past year** _____ **Past 5 years** _____ **Lifetime** _____
		Number of suicide attempts:	**Past year** _____ **Past 5 years** _____ **Lifetime** _____
		Is consumer presently suicidal?	☐ **Yes. Describe:** ☐ **No**

Family History of Psychiatric Disorders

Have any family members had any of the following disorders?

	Parents	Siblings	Children	Aunts or uncles	Grandparents
Depression:	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____
Schizophrenia:	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____
Bipolar disorder:	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____
Alcohol or substance abuse:	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____
Another psychiatric or emotional disorder:	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____	❑ Yes ❑ Treated _____

Information About the Previous Provider

Previous provider:	
Provider's contact information:	

Past Psychiatric Medications *(Consumer Self-Report/Records)*

Medication for at least the past 5 years	Highest daily dose	Number of years taken	Interactions or tolerability	Response Check one:				Comments
List most recent first				Full	Partial	Failure	Unable to assess	
				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	
				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	
				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	
				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	
				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	
				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	

Current Non-Psychiatric Medications, Including Over-the-Counter Medications

(Consumer Self-Report/Records)

Medication for at least the past 5 years		**Highest daily dose**	**Number of years taken**	**Interactions or tolerability**	**Response** Check one:				**Comments**
List most recent first	Prescribed by mental health provider?				**Full**	**Partial**	**Failure**	**Unable to assess**	
	❑ Yes ❑ No				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	
	❑ Yes ❑ No				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	
	❑ Yes ❑ No				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	
	❑ Yes ❑ No				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	
	❑ Yes ❑ No				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	
	❑ Yes ❑ No				❑	❑	❑ Intolerable side effects ❑ No response	❑ Always used in combination ❑ Medication non-adherence ❑ Discontinued by request ❑ Inadequate trial (time/dose)	

Current Psychiatric Medications

Medication	Highest daily dose	Date started	Interactions or tolerability	Current response	Taken as prescribed?	Assessment of medication effectiveness	Plan for future medication change
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		

Mental Status Exam Symptoms and Severity (Functioning)	
Appearance, behavior, speech:	
Mood and affect:	
Sensorium:	
Intellectual functioning:	
Thought processes and content:	

Mental Status Exam. Check all that apply

Appearance

- ❑ Well groomed
- ❑ Disheveled
- ❑ Unkempt
- ❑ Bizarre
- ❑ Eccentric
- ❑ Malodorous
- ❑ Appears older than stated age
- ❑ Appears younger than stated age
- ❑ Appears stated age

Behavior

- ❑ Engaged
- ❑ Guarded
- ❑ Suspicious
- ❑ Friendly
- ❑ Cooperative
- ❑ Hostile
- ❑ Threatening
- ❑ Seductive
- ❑ Disinterested
- ❑ Distracted
- ❑ Self-absorbed
- ❑ Good eye contact
- ❑ Poor eye contact
- ❑ Psychomotor agitation
- ❑ Psychomotor retardation
- ❑ Stereotypy
- ❑ Hand-wringing
- ❑ Pacing
- ❑ Bizarre posturing
- ❑ Use of gestures
- ❑ Tardive dyskinesia
- ❑ Tremor

Speech

- ❑ Mutism
- ❑ Retardation
- ❑ Pressured
- ❑ Poverty of speech
- ❑ Slurred
- ❑ Dysarthria
- ❑ Normal volume
- ❑ Low volume
- ❑ High volume
- ❑ Over-inclusive

Mood

- ❑ Euthymic
- ❑ Depressed
- ❑ Anxious
- ❑ Fearful
- ❑ Suspicious
- ❑ Euphoric
- ❑ Angry
- ❑ Irritable

Affect

Range

- ❑ Normal range
- ❑ Constricted
- ❑ Increased

Intensity

- ❑ Normal
- ❑ Intense
- ❑ Blunted
- ❑ Flat
- ❑ Increased

Stability

- ❑ Stable affect
- ❑ Labile Appropriateness
- ❑ Appropriate
- ❑ Inappropriate

Sensorium

Oriented to

- ❑ Name
- ❑ Place
- ❑ Date
- ❑ Situation

Intelligence

- ❑ Average
- ❑ Below average
- ❑ Above average

Based on:

- ❑ Vocabulary
- ❑ Fund of knowledge

Thought Processes

- ❑ Logical
- ❑ Coherent
- ❑ Goal-directed
- ❑ Perseveration
- ❑ Circumstantiality
- ❑ Distractibility
- ❑ Loose associations
- ❑ Vagueness
- ❑ Blocking
- ❑ Tangentiality
- ❑ Derailment
- ❑ Incoherent
- ❑ Word salad
- ❑ Neologism
- ❑ Clanging
- ❑ Punning
- ❑ Flight of ideas

Thought Content

- ❑ Normal
- ❑ Preoccupation
- ❑ Guilt
- ❑ Ruminations
- ❑ Fantasies
- ❑ Phobias
- ❑ Obsessions
- ❑ Compulsions
- ❑ Delusions
- ❑ Hallucinations
- ❑ Illusions
- ❑ Depersonalization
- ❑ Morbid
- ❑ Suicidal
- ❑ Homicidal
- ❑ Aggressive ideations

Concentration

Serial 7s (or 3s)

- ❑ Pass
- ❑ Fail

Spell world backwards

- ❑ Pass
- ❑ Fail

Digit span

- ❑ Pass
- ❑ Fail

Memory

Remote

- ❑ Intact
- ❑ Impaired

Recent

- ❑ Intact
- ❑ Impaired

Immediate recall

- ❑ Intact
- ❑ Impaired

Abstract Reasoning

- ❑ Intact
- ❑ Impaired
- ❑ Concrete
- ❑ Bizarre

Quality of Delusions

- ❑ Persecutory
- ❑ Grandiose
- ❑ Bizarre
- ❑ Somatic
- ❑ Jealous
- ❑ Nihilistic

Quality of Hallucinations

- ❑ Auditory
- ❑ Visual
- ❑ Tactile
- ❑ Gustatory
- ❑ Olfactory

Insight

- ❑ Intact
- ❑ Impaired

Judgment

- ❑ Intact
- ❑ Impaired

Consumer Global Self-Report (0-10) 0 = No symptoms 5 = moderate 10 = extreme	**Symptom severity:** _____ **Side effects:** _____
Clinical Rating Scales 0 = No symptoms 5 = moderate 10 = extreme	**Positive Symptom Rating Scale (PSRS):** _____ **Brief Negative Symptom Assessment (BNSA):** _____
Side Effect Scales 0 = No symptoms 5 = moderate 10 = extreme	**Abnormal Involuntary Movement Scale (AIMS):** _____ **Simpson-Angus Scale (SAS):** _____
Description of current side effects:	
Recommended psychosocial treatment for side effects: *Note*: List medication-related treatment under current medications above.	
Additional observation notes specific to consumer (for example, specific nature of delusions):	

Consumer Education and Preferences

Consumer education provided:

Check all that apply.

- ❑ Purpose of specific medications provided by:
- ❑ Benefits and risks of specific medications provided by:
- ❑ Potential side effects of specific medications provided by:
- ❑ Alternative treatments provided by:

Consumer preferences and goals:

Include specific examples of consumer input that affected medication decisions.

Latest Laboratory Values

	Tests available from prior records	Tests that were abnormal	When the abnormal results were obtained
Initial Assessment: Which tests are available from prior records? Which were abnormal? When were abnormal results obtained?			
Annual Assessment: Consumers should have a chemistry profile done annually, along with any other measures indicated in monitoring guidelines (such as lipid screening).			

Progress Note

Subjective:			
Objective:			
Assessment:			
Plan:			
Signature:		**Title:**	

Sample Admissions or Annual Update Form: *Instructions*

Caution: This form may not meet local requirements for billing or documentation and should be reviewed for any deficiencies in these areas.

An electronic medical record (EMR) gives you the opportunity to pre-populate many fields with information from the most recent prior assessment, so that MedTEAM staff only need to update items that have changed. Even if you use paper records, it is helpful to record this information electronically for each consumer, such as with Microsoft Word, so that you only have to enter updates.

For the first six items: If you use EMRs, you can program these items to prefill in the document.

- **Consumer's name.** Self-explanatory.
- **Consumer's I.D. number.** Self-explanatory.
- **Date completed.** Self-explanatory.
- **Appointment time.** Self-explanatory.
- **MedTEAM staff or prescriber name.** Enter the name of the MedTEAM staff member or the prescriber seeing consumer for the visit.
- **Vital signs:**

  Height. Enter height in inches (in.). If you use EMRs, you can program this item to prefill when you access the document since it does not change. You can also program it to convert height in feet to inches for ease of use.

  Weight. Enter current weight in pounds (lbs.).

  Blood pressure. Enter current blood pressure (systolic/diastolic).

  Pulse. Enter current pulse rate (beats per minute).

  Temperature. Enter body temperature in degrees Fahrenheit.

  Body Mass Index (BMI). Calculate BMI using the following equation:

$$\frac{\text{weight (lbs.) x 703}}{\text{height (in.)}^2} = \text{B.M.I.}$$

  Example:

  6'2" consumer who weighs 160 lbs. =

$$\frac{160 \times 703}{74^2} = \frac{160 \times 703}{5476} = 0.0292 \times 703 = 20.5$$

  If you have Internet access, you can use a BMI calculator from the National Heart Lung, and Blood Institute Web site:
  http://www.nhlbisupport.com/bmi

- **Principal Axis I diagnosis.** Enter the principal DSM-IV-TR[1] diagnosis for which the consumer is being seen for this visit. You can also include the ICD-10[2] code if you want to capture this information.

  Example: A consumer with schizophrenia may have an appointment focusing on alcohol dependence. The primary Axis I diagnosis would be alcohol dependence. If you use EMRs, you can program this item to have a dropdown menu of all DSM-IV-TR Axis I diagnoses or of all the DSM-IV-TR Axis I diagnoses ever entered for that consumer, with an option to add more. You can also program the ICD-10 codes to prefill when you access the document.

[1] *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision.
[2] *The International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision, Second Edition.

- **Age at onset.** Enter the age of onset for the principal Axis I diagnosis for this visit. If you use EMRs, you can program this item to prefill.
- **Other Axis I diagnoses.** Enter the other active DSM-IV-TR diagnoses for the consumer. If you use EMRs, you can program this item to have a dropdown menu of all DSM-IV-TR Axis I diagnoses or of all the DSM-IV-TR Axis I diagnoses ever entered for that consumer. You can also program the item to prefill.
- **Age at onset.** Enter the age of onset for the other active Axis I diagnoses for this visit. If you use EMRs, you can program this item to prefill.
- **Axis II diagnoses and comments.** List any active Axis II diagnoses and enter any necessary comments about the impact that these diagnoses have on the Axis I diagnoses and any additional pertinent information about the Axis II diagnoses. If you use EMRs, you can program this item to prefill.
- **Axis III diagnoses and comments.** List any active Axis III diagnoses and enter any necessary comments about the impact that these diagnoses have on the Axis I diagnoses and any additional pertinent information about the Axis III diagnoses. If you use EMRs, you can program this item to prefill.
- **Discharge date from most recent hospitalization.** Enter the date of the consumer's most recent psychiatric hospitalization. If it is not in the medical records, ask the consumer. Enter whatever information is available. If the consumer does not know the exact day of the hospitalization, then enter just the month and year. If you use EMRs, you may program this item to prefill from previous forms with the option for the date to be changed if a psychiatric hospitalization has occurred since admission or the last annual review.
- **Number of psychiatric hospitalizations and number of suicide attempts:** Enter the number of the consumer's psychiatric hospitalizations for the past year, past 5 years, and lifetime. Use medical records if possible, but, if they are unavailable, ask the consumer. If you use EMRs, you may program this item to prefill from previous forms with the option for the date to be changed if a psychiatric hospitalization has occurred since admission or the last annual review.
- **Is the consumer presently suicidal?** Check either *Yes* or *No*. If Yes, then supply detailed information about the consumer's response, intent, plan, and means to carry out a given plan.

Family history of psychiatric disorders

Complete the table using information from the consumer. Check *Yes* if a family member has had any of the psychiatric conditions listed.

If *Yes* for any item, ask the consumer if a family member had any treatments for that condition that provided benefit. Check *Treated* and describe it. Be as specific as possible when describing the treatment, such as medication name or type of therapy. Unfortunately, many times consumers may not know the specific medication. In those cases, use general terms, such as "antidepressant," "psychotherapy," "antipsychotic," etc.

If you use EMRs, you can program this item to prefill it with the option to update any information if any family history has changed since admission or last annual review.

Information about the previous provider

Previous provider and provider's contact information
Ask the consumer about previous providers, trying to obtain as much information as possible. Then fill in the blanks by looking the provider up in the phone book, online, board of medicine, etc. You can use the provider contact information to obtain past and current psychiatric and medical records.

Past psychiatric medications

This table consists of multiple data elements.

- **Medication.** Fill in medications taken for at least the past 5 years. You can use the generic or brand name. List the most recent first.
- **Highest daily dose** taken while on the medication.
- **Number of years taken.** Note how long the consumer took the medication. Record this information in years, such as 0.5 years = 6 months.
- **Medication effects.** Under *Interactions and tolerability*, capture how the medications worked for the consumer. Note any medication interactions and assess how well the consumer is able to tolerate the medication. Under *Response*, check the appropriate box. If you check *Failure* or *Unable to Assess*, then also check the box that further explains the answer.

  In the *Comments* column, enter any pertinent information about the medication that you received from the consumer or the medical records, such as serious side effects or consumer opinion about the medication.

If you use EMRs, you have various options to capture each element. You can program *Medication* to have a dropdown menu with medication categories and names. For *Comments*, you can list frequently used comments or simply use the column for free text. For all fields, you can prefill the form from the prior assessment and update it as needed. The most common updates will be medications that were current in the prior assessment but that have been discontinued.

Current nonpsychiatric medications

This item functions the same way as the previous; the only difference is the addition of check boxes in the medication column. Check whether the mental health provider prescribed the non-psychiatric medication to the consumer.

If you use EMRs, you have the same programming opportunities as in the previous table.

Current psychiatric medications

This table has multiple elements.

- **Medication.** Fill in the medication name.
- **Highest daily dose.** For example, you would list ziprasidone 80mg twice daily as 160mg.
- **Date started.** Note when the medication was started or how long the consumer took the medication. Record this information in years, such as 0.5 years = 6 months.
- **Interactions or tolerability.** Assess the consumer's ability to tolerate the medication and medication interactions.

- **Current response.** Asks about medication response over the past month for each medication. Check the most appropriate response criteria based on objective and subjective data.
- **Taken as prescribed?** Check the most appropriate level of adherence to each medication based on consumer report/ pill counts, etc.
- **Assessment of medication effectiveness.** Assess medication effectiveness, that is, has the consumer achieved the desired outcomes?
- **Plan for future medication change.** Indicate a plan for medication change.

You can program this item in many ways in an EMR to ease the burden of having to look up this information from previous records and retyping this data. You could program each element to prefill from previous records.

Mental Status Exam

You can complete the Mental Status Exam either in free text or checklists. Checklists are quicker and have the advantage of collecting uniform data, but do not allow you to record observations that are specific to consumers, such as the nature of their delusion. Therefore, the checklist should also provide space to record this type of information.

- **Consumer Global Self-Report.**

  Symptom severity. This item asks consumers to describe their current symptom severity on a scale from 0 to 10:

  0 = No symptoms

  5 = Moderate symptoms

  10 = Extreme (worst symptoms imaginable)

  If you use EMRs, you can program this item to display the previous score on this item or a graphical representation of all scores recorded for the consumer.

  Side effects. This item asks consumers to describe their current side effects on a scale from 0 to 10:

  0 = No side effects

  5 = Moderate side effects

  10 = Extreme (worst side effects imaginable)

  If you use EMRs, you can program this item to display the previous score on this item or a graphical representation of all scores recorded for the consumer.

- **Clinical Rating Scales.**

  Positive Symptom Rating Scale (PSRS). Enter the total score for the four-item PSRS completed during the interview with the consumer.

  If you use EMRs, you can program this item to display the previous score and the date it was conducted or a graphical representation of all the scores and dates for each scale recorded for the consumer.

  Brief Negative Symptom Assessment (BNSA). Rater enters the total score for the four-item BNSA that was completed during the interview with the consumer.

  If you use EMRs, you can program this item to display the previous score and date it was conducted on this item or a graphical representation of all the scores and dates for each scale recorded for the consumer.

- **Side Effect Scales.**

  Abnormal Involuntary Movement Scale (AIMS). Enter the consumer's score on the AIMS. This item may not be conducted at every visit if the consumer does not show any signs of tardive dyskinesia and may only be conducted every 6 to 12 months. It is recommended that you carry this information over from previous forms, along with the date that the scale was administered.

If you use EMRs, you can program this item to display the previous score and date it was conducted on this item or a graphical representation of all the scores and dates for each scale recorded for the consumer.

Simpson-Angus Scale (SAS). Enter the consumer's score on the SAS. This item may not be conducted at every visit if the consumer does not show any signs of extrapyramidal symptoms and may only be conducted every 6 to 12 months. It is recommended that you carry this information over from previous forms along with the date that the scale was administered.

If you use EMRs, you can program this item to display the previous score and date it was conducted on this item or a graphical representation of all the scores and dates for each scale recorded for the consumer.

Description of current side effects. Enter comments about the consumer's side effects. If the consumer responded *greater than 0* for Consumer Global Self-Report of side effects, the AIMS, or the SAS, there should be some description of side effects, interventions for side effects, and when the side effects and interventions will be reviewed again.

If you use EMRs, you can generate a list of common side effects in a dropdown menu. Then for each side effect chosen, you can choose interventions from a dropdown menu.

Additional information about living situation, life events, physical problems, or other symptoms. In this section, add any pertinent information about what is occurring in the consumer's life, such as changes in housing, employment, health, and family dynamics that can help or hinder their mental health treatment.

If you use EMRs, you can program this section to prefill from previous intake or annual reviews. If any changes occur, you can delete or update the necessary information.

Consumer Education and Preferences

Check all options that apply to the consumer. Enter which MedTEAM staff member provided the educational materials. Document the prescriber's role in the consumer education process. Document consumer preferences and goals including specific examples of how consumer input affected medication decisions.

If you use EMRs, you can program this section to prefill from admissions or annual updates. If any changes occur, you can delete or update the necessary information.

Latest Laboratory Values

Initial Assessment. Indicate which laboratory values were available in the consumer's medical and psychiatric records, which were abnormal, and when these tests were completed.

Annual Assessment. You should have a chemistry profile done annually for each consumer, along with any other tests indicated by the monitoring guidelines (such as lipid screening). Enter which tests were drawn, when they were drawn, and note any abnormal results.

If you use EMRs, you can have the latest laboratory information prefill from results section of EMR.

Chemistry profile results. (*Note:* Reference range was provided by Medline Plus; your laboratory reference range may slightly differ.)

Albumin: 3.9 to 5.0 g/dL

Alkaline phosphatase: 44 to 147 IU/L

ALT (alanine transaminase): 8 to 37 IU/L

AST (aspartate aminotransferase): 10 to 34 IU/L

BUN (blood urea nitrogen): 7 to 20 mg/dL

Calcium – serum: 8.5 to 10.9 mg/dL

Serum chloride: 101 to 111 mmol/L

CO2 (carbon dioxide): 20 to 29 mmol/L

Creatinine: 0.8 to 1.4 mg/dL

Direct bilirubin: 0.0 to 0.3 mg/dL

Gamma-GT (gamma-glutamyl transpeptidase): 0 to 51 IU/L

Glucose test: 64 to 128 mg/dL

LDH (lactate dehydrogenase): 105 to 333 IU/L

Phosphorus – serum: 2.4 to 4.1 mg/dL

Potassium test: 3.7 to 5.2 mEq/L

Serum sodium: 136 to 144 mEq/L

Total bilirubin: 0.2 to 1.9 mg/dL

Total cholesterol: 100 to 240 mg/dL

Total protein: 6.3 to 7.9 g/dL

Uric acid: 4.1 to 8.8 mg/dL

Progress Note

This section is in the form of a standard SOAP (Subjective, Objective, Assessment, and Plan) note. It allows MedTEAM staff to provide specific information about the consumer that may not be captured elsewhere or to expand on information captured earlier in the form.

Sample Ongoing Treatment Form

Consumer's name:		Consumer's I.D. number:	
Date completed:	___/___/_____	Appointment time:	
MedTEAM staff or prescriber name:			
Vital signs:	Height _____	Weight _____	
	Blood pressure _____	Pulse _____	
	Temperature _____	Body Mass Index (BMI): $\frac{\text{weight (pounds) } \_\_\_\_ \times 703}{\text{height (inches)}^2} = \text{B.M.I.}$	
Principal Axis I diagnosis:			
Other Axis I diagnoses:			
Axis II diagnoses:		Comments:	
Axis III diagnoses:		Comments:	

Current Psychiatric Medications

Medication	Highest daily dose	Date started	Interactions or tolerability	Current response	Taken as prescribed?	Assessment of medication effectiveness	Plan for future medication change
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		
				❑ Full ❑ Partial ❑ Minimal ❑ None ❑ Symptoms worsening	❑ Mostly yes. More than 80% of the time ❑ Sometimes. 50-80% of the time ❑ No. Less than 50% of the time		

Mental Status Exam Symptoms and Severity (Functioning)	
Appearance, behavior, speech:	
Mood and affect:	
Sensorium:	
Intellectual functioning:	
Thought processes and content:	

Mental Status Exam. Check all that apply

Appearance

- ❑ Well groomed
- ❑ Disheveled
- ❑ Unkempt
- ❑ Bizarre
- ❑ Eccentric
- ❑ Malodorous
- ❑ Appears older than stated age
- ❑ Appears younger than stated age
- ❑ Appears stated age

Behavior

- ❑ Engaged
- ❑ Guarded
- ❑ Suspicious
- ❑ Friendly
- ❑ Cooperative
- ❑ Hostile
- ❑ Threatening
- ❑ Seductive
- ❑ Disinterested
- ❑ Distracted
- ❑ Self-absorbed
- ❑ Good eye contact
- ❑ Poor eye contact
- ❑ Psychomotor agitation
- ❑ Psychomotor retardation
- ❑ Stereotypy
- ❑ Hand-wringing
- ❑ Pacing
- ❑ Bizarre posturing
- ❑ Use of gestures
- ❑ Tardive dyskinesia
- ❑ Tremor

Speech

- ❑ Mutism
- ❑ Retardation
- ❑ Pressured
- ❑ Poverty of speech
- ❑ Slurred
- ❑ Dysarthria
- ❑ Normal volume
- ❑ Low volume
- ❑ High volume
- ❑ Over-inclusive

Mood

- ❑ Euthymic
- ❑ Depressed
- ❑ Anxious
- ❑ Fearful
- ❑ Suspicious
- ❑ Euphoric
- ❑ Angry
- ❑ Irritable

Affect

Range

- ❑ Normal range
- ❑ Constricted
- ❑ Increased

Intensity

- ❑ Normal
- ❑ Intense
- ❑ Blunted
- ❑ Flat
- ❑ Increased

Stability

- ❑ Stable affect
- ❑ Labile
- ❑ Appropriateness
- ❑ Appropriate
- ❑ Inappropriate

Sensorium

Oriented to

- ❑ Name
- ❑ Place
- ❑ Date
- ❑ Situation

Intelligence

- ❑ Average
- ❑ Below average
- ❑ Above average

Based on:

- ❑ Vocabulary
- ❑ Fund of knowledge

Thought Processes

- ❑ Logical
- ❑ Coherent
- ❑ Goal-directed
- ❑ Perseveration
- ❑ Circumstantiality
- ❑ Distractibility
- ❑ Loose associations
- ❑ Vagueness
- ❑ Blocking
- ❑ Tangentiality
- ❑ Derailment
- ❑ Incoherent
- ❑ Word salad
- ❑ Neologism
- ❑ Clanging
- ❑ Punning
- ❑ Flight of ideas

Thought Content

- ❑ Normal
- ❑ Preoccupation
- ❑ Guilt
- ❑ Ruminations
- ❑ Fantasies
- ❑ Phobias
- ❑ Obsessions
- ❑ Compulsions
- ❑ Delusions
- ❑ Hallucinations
- ❑ Illusions
- ❑ Depersonalization
- ❑ Morbid
- ❑ Suicidal
- ❑ Homicidal
- ❑ Aggressive ideations

Concentration

Serial 7s (or 3s)

- ❑ Pass
- ❑ Fail

Spell world backwards

- ❑ Pass
- ❑ Fail

Digit span

- ❑ Pass
- ❑ Fail

Memory

Remote

- ❑ Intact
- ❑ Impaired

Recent

- ❑ Intact
- ❑ Impaired

Immediate recall

- ❑ Intact
- ❑ Impaired

Abstract Reasoning

- ❑ Intact
- ❑ Impaired
- ❑ Concrete
- ❑ Bizarre

Quality of Delusions

- ❑ Persecutory
- ❑ Grandiose
- ❑ Bizarre
- ❑ Somatic
- ❑ Jealous
- ❑ Nihilistic

Quality of Hallucinations

- ❑ Auditory
- ❑ Visual
- ❑ Tactile
- ❑ Gustatory
- ❑ Olfactory

Insight

- ❑ Intact
- ❑ Impaired

Judgment

- ❑ Intact
- ❑ Impaired

Consumer Global Self-Report (0-10) 0 = No symptoms 5 = moderate 10 = extreme	**Symptom severity:** _____ **Side effects:** _____
Clinical Rating Scales 0 = No symptoms 5 = moderate 10 = extreme	**Positive Symptom Rating Scale (PSRS):** _____ **Brief Negative Symptom Assessment (BNSA):** _____
Side Effect Scales 0 = No symptoms 5 = moderate 10 = extreme	**Abnormal Involuntary Movement Scale (AIMS):** _____ **Simpson-Angus Scale (SAS):** _____
Description of current side effects:	
	Is consumer suicidal? ☐ **Yes. Describe:** ☐ **No**
	Is consumer homicidal? ☐ **Yes. Describe:** ☐ **No**
	Additional information about living situation, life events, physical problems, or other symptoms: ☐ **Yes. Describe:** ☐ **No**
Drug levels: Date and drug level. Enter only if changes have occurred since last medication visit.	
Participation in other treatment or support services: Enter only if changes have occurred since last medication	

Consumer Education and Preferences

Check all that apply.

Enter only if changes have occurred since last medication visit.

- ❑ Purpose of specific medications provided by:
- ❑ Benefits and risks of specific medications provided by:
- ❑ Potential side effects of specific medications provided by:
- ❑ Alternative treatments provided by:

Consumer preferences and goals:

Include specific examples of consumer input that affected medication decisions.

Latest Laboratory Values:

Consumers should have a chemistry profile done annually, along with any other measures indicated in monitoring guidelines (such as lipid screening).

Tests performed	When were they drawn	Abnormal lab values

Progress Note

Subjective:			
Objective:			
Assessment:			
Plan:			
Signature:		**Title:**	

Sample Ongoing Treatment Form: *Instructions*

Caution: This form may not meet local requirements for billing or documentation and should be reviewed for any deficiencies in these areas.

An electronic medical record (EMR) gives you the opportunity to pre-populate many fields with information from the most recent prior assessment, so that MedTEAM staff only need to update items that have changed. Even if you use paper records, it is helpful to record this information electronically for each consumer, such as with Microsoft Word, so that you only have to enter updates.

For the first five items: If you use EMRs, you can program these item to prefill in the document.

- **Consumer's name.** Self-explanatory.
- **Consumer's I.D. number.** Self-explanatory.
- **Date completed.** Self-explanatory.
- **Appointment time.** Self-explanatory.
- **MedTEAM staff or prescriber name.** Enter the name of the MedTEAM staff member or prescriber seeing consumer for the visit.
- **Vital signs:**

  Height. Enter height in inches. If you use EMRs, you can program this item to prefill when you access the document since it does not change. You can also program it to convert height in feet to inches for ease of use.

  Weight. Enter current weight in pounds (lbs.).

  Blood pressure. Enter current blood pressure (systolic/diastolic).

  Pulse. Enter current pulse rate (beats per minute).

  Temperature. Enter body temperature in degrees Fahrenheit.

  Body Mass Index (BMI). Calculate BMI using the following equation:

$$\frac{\text{weight (lbs.)} \times 703}{\text{height (in.)}^2} = \text{B.M.I.}$$

Example:

6'2" consumer who weighs 160 lbs. =

$$\frac{160 \times 703}{74^2} = \frac{160 \times 703}{5476} = 0.0292 \times 703 = 20.5$$

If you have Internet access, you can use a BMI calculator from the National Heart Lung, and Blood Institute Web site:
http://www.nhlbisupport.com/bmi

- **Principal Axis I diagnoses.** Enter the principal DSM-IV-TR diagnosis for which the consumer is being seen for this visit. You can also include the ICD-10 code if you want to capture this information.

  If you use EMRs, you can program this item to have a dropdown menu of all DSM-IV-TR Axis I diagnoses or of all the DSM-IV-TR Axis I diagnoses ever entered for that consumer, with an option to add more. You can also program the ICD-10 codes to prefill when you access the document.

- **Other Axis I diagnoses.** Enter the other active DSM-IV-TR diagnoses for the consumer. If you use EMRs, you can program this item to have a dropdown menu of all DSM-IV-TR Axis I diagnoses or of all the DSM-IV-TR Axis I diagnoses ever entered for that consumer. You can also program the item to prefill.

- **Axis II diagnoses and comments.** List any active Axis II diagnoses and enter any necessary comments about the impact that these diagnoses have on the Axis I diagnoses and any additional pertinent information about the Axis II diagnoses. If you use EMRs, you can program this item to prefill.

- **Axis III diagnoses and comments.** List any active Axis III diagnoses and enter any necessary comments about the impact that these diagnoses have on the Axis I diagnoses and any additional pertinent information about the Axis III diagnoses. If you use EMRs, you can program this item to prefill.

Current psychiatric medications

This table has multiple elements.

- **Medication.** Fill in the medication name.
- **Highest daily dose.** For example, you would list ziprasidone 80mg twice daily as 160mg.
- **Date started.** When the medication was started or how long the consumer took the medication. Record this information in years, such as 0.5 years = 6 months.
- **Interactions or tolerability.** Assess the consumer's ability to tolerate the medication and medication interactions.
- **Current response.** Asks about medication response over the past month for each medication. Check the most appropriate response criteria based on objective and subjective data.
- **Taken as prescribed?** Check the most appropriate level of adherence to each medication based on consumer report or pill counts.
- **Assessment of medication effectiveness.** Assess medication effectiveness, that is, has the medication achieved the desired outcomes?
- **Plan for future medication change.** Indicate a plan for medication change.

You can program this item in many ways in an EMR to ease the burden of having to look up this information from previous records and retyping this data. You could program each element to prefill from previous records.

Mental Status Exam

You can complete the Mental Status Exam either in free text or checklists. Checklists are quicker and have the advantage of collecting uniform data, but do not allow you to record observations that are specific to consumers, such as the nature of their delusion. Therefore, the checklist should also provide space to record this type of information.

- **Consumer Global Self-Report.**

  Symptom severity. This item asks consumers to describe their current symptom severity on a scale from 0 to 10:

  0 = No symptoms

  5 = Moderate symptoms

  10 = Extreme (worst symptoms imaginable)

  If you use EMRs, you can program this item to display the previous score on this item or a graphical representation of all scores recorded for the consumer.

  Side effects. This item asks consumers to describe their current side effects on a scale from 0 to 10:

  0 = No symptoms

  5 = Moderate symptoms

  10 = Extreme (worst symptoms imaginable)

  If you use EMRs, you can program this item to display the previous score on this item or a graphical representation of all scores recorded for the consumer.

- **Clinical Rating Scales.**

  Positive Symptom Rating Scale (PSRS). Enter the total score for the four-item PSRS completed during the interview with the consumer.

  If you use EMRs, you can program this item to display the previous score and the date it was conducted or a graphical representation of all the scores and dates for each scale recorded for the consumer.

  Brief Negative Symptom Assessment (BNSA). Rater enters the total score for the four-item BNSA that was completed during the interview with the consumer.

  If you use EMRs, you can program this item to display the previous score and date it was conducted on this item or a graphical representation of all the scores and dates for each scale recorded for the consumer.

- **Side Effect Scales.**

  Abnormal Involuntary Movement Scale (AIMS). Enter the consumer's score on the AIMS. This item may not be conducted at every visit if the consumer does not show any signs of tardive dyskinesia and may only be conducted every 6 to 12 months. It is recommended that you carry this information over from previous forms, along with the date that the scale was administered.

  If you use EMRs, you can program this item to display the previous score and date it was conducted on this item or a graphical representation of all the scores and dates for each scale recorded for the consumer.

Simpson-Angus Scale (SAS). Enter the consumer's score on the SAS. This item may not be conducted at every visit if the consumer does not show any signs of extrapyramidal symptoms and may only be conducted every 6 to 12 months. It is recommended that you carry this information over from previous forms along with the date that the scale was administered.

If you use EMRs, you can program this item to display the previous score and date it was conducted on this item or a graphical representation of all the scores and dates for each scale recorded for the consumer.

- **Description of current side effects.** Enter comments about the consumer's side effects. If the consumer responded greater than 0 for Consumer Global Self-Report of side effects, the AIMS, or the SAS, there should be some description of side effects, interventions for side effects, and when the side effects and interventions will be reviewed again.

  If you use EMRs, you can generate a list of common side effects in a dropdown menu. Then for each side effect chosen, you can choose interventions from a dropdown menu.

- **Is the consumer suicidal?** Check either Yes or No. If Yes, then give detailed information about the consumer's response, intent, plan, and means to carry out a given plan.

- **Is the consumer homicidal?** Check either *Yes* or *No*. If *Yes*, then give detailed information about the consumer's response, intent, plan, and means to carry out a given plan.

  - ❑ **Additional information about living situation, life events, physical problems, or other symptoms.** In this section, add any pertinent information about what is occurring in the consumer's life, such as, changes in housing, employment, health, family dynamics that can help or hinder their mental health treatment.

    If you use EMRs, you can program this section to prefill from previous intake or annual reviews. If any changes occur, you can delete or update the necessary information.

- **Drug levels.** Date and drug level. Enter the most recent drug levels for any agents that the consumer is taking where drug levels may be used to guide treatment or evaluate response. You only need to update information if changes have occurred since the last medication visit. *Examples*: haloperidol, clozapine, lithium, and valproic acid.

  If you use EMRs, you can program this item to display the previous drug level and date it was drawn or a graphical representation of all the drug levels and dates for each level drawn for the consumer.

- **Participation in other treatment or support services.** Update information about other treatments and services that the consumer is receiving. You only need to update information if changes have occurred since the last medication visit.

  If you use EMRs, you can program this section to prefill from previous intake and annual reviews. If any changes occur, you can delete or update the necessary information.

Consumer Education and Preferences

- **Consumer education provided.** Check all consumer education categories that apply and who provided the educational information.
- **Consumer preferences and goals.** Provide specific examples in which you took consumers' wishes, preferences, and objections into account and incorporated consumers' views into decisions about medication selections.

- **Latest laboratory values.** You should have a chemistry profile done annually for each consumer, along with any other indicated tests and as shown by the monitoring guidelines (such as lipid screening). Indicate which tests were completed, when they were drawn, and note any abnormal results. You need only update information if changes have occurred since the last medication visit. If you use EMRs, you can have the latest laboratory information prefill from laboratory results.

Progress Note

This section is in the form of a standard SOAP (Subjective, Objective, Assessment, Plan) Note. It allows MedTEAM staff to provide specific information about the consumer that may not be captured elsewhere or to expand on information captured earlier in the form.

If your mental health authority has not already adapted these forms, we strongly encourage you to do so and incorporate them into your routine paperwork. For printable copies of the forms, see the CD-ROM for this KIT. For information about documentation practices training for MedTEAM staff, see *Training Frontline Staff* in this KIT.

Establish staffing criteria

Your MedTEAM policies and procedures should specify the staffing criteria for your program. Carefully consider the roles of each MedTEAM staff member. MedTEAM does not change the amount of personnel time available for consumer visits. Instead, it recommends assessing your workflow and making personnel changes to increase the effectiveness of your medication management.

While MedTEAM defines core types of information to collect during each medication visit, decisions about who will do each task must be made at the local level. Consider your local resources and personnel while assessing your current workflow. For example, some agencies pair each prescriber with an experienced practitioner. In these agencies, consumers meet with practitioners before each medication visit. Practitioners support prescribers by collecting and documenting information from consumers about their symptoms, response, and adherence to medications.

Practitioners pass this information on to prescribers at the time of the medication visit. As a result, prescribers have more consumer information to inform medication decisions. This workflow is analogous to what occurs in most primary care settings, where a nurse obtains and records recent medical history, blood pressure, and other information before the doctor sees the patient.

It may help to develop task-specific position descriptions, outline the main task categories, and detail specific duties. For job applicants, a good position description clarifies whether a particular position matches their skills and expectations. Clear job descriptions allow MedTEAM leaders to effectively supervise new employees and also allow employees to focus on the basic elements of their jobs.

Discuss program organization and communication

MedTEAM policies and procedures should include criteria for how MedTEAM is organized and how MedTEAM staff members relate to one another. Criteria should include procedures to ensure that medication management is provided through a team approach.

To be effective, MedTEAM staff must be able to work both independently and collaboratively. Prescribers should also communicate regularly with other members of the treatment team. MedTEAM is most effective in an environment where prescribers are part of a treatment team that meets for at least 1 hour a week. Closely coordinating medication management with other mental health treatment and rehabilitation ensures that everyone involved provides services that support consumers' recovery goals.

Treatment teams are organized differently from one agency to the next. Some teams quickly run through the list of consumers they serve, communicating with team members about clinical issues. Other teams just share information about crisis situations. It is important that treatment team meetings focus on clinical issues, not on administrative ones. It is also important that treatment team members have the time to discuss consumers who are not in crisis and to assess their progress in meeting their recovery goals.

Involve and educate consumers

MedTEAM policies and procedures should encourage and facilitate involving and educating consumers about their medication management. Consumer education should cover the following:

- Purpose of specific medications;
- Benefits and risks of specific medications;
- Potential side effects of specific medications; and
- Alternative treatments.

If your agency offers the evidence-based practice *Illness Management and Recovery (IMR),* (see the IMR KIT in the SAMHSA Evidence-Based Practices KIT series) prescribers can work together with IMR practitioners as they cover similar educational topics in the curriculum. MedTEAM recommends that prescribers be involved in the process of educating consumers. Develop procedures for distributing consumer education materials and for documenting prescriber involvement in consumer education.

MedTEAM policies and procedures should also encourage consumer involvement in medication-related decisions. Document consumer preferences and input in the medical record.

Involve family and other supporters

MedTEAM policies and procedures should encourage and facilitate involving family and other supporters to help consumers increase their natural supports. Instruct MedTEAM staff to ask consumers to identify a family member or other supporter whom they would like to involve in the treatment process.

Involving family or other supporters helps MedTEAM staff to do the following:

- Clarify consumer goals, strengths, and preferences;
- Identify early warning signs and symptoms; and
- Monitor side effects.

With consumers' permission, family or other supporters may attend medication visits, meet or talk with MedTEAM staff alone, or attend treatment team meetings. If your agency offers evidence-based practice *Family Psychoeducation (FPE)* (see the FPE KIT in the SAMHSA Evidence-Based Practices KIT series), MedTEAM members can work together with FPE practitioners to involve families or other supporters in the treatment process.

Involve support staff

MedTEAM policies and procedures should promote scheduling flexibility for consumers who have special circumstances. Involve support staff to ensure that they are aware of the need for flexible scheduling. For example, use open time slots to accommodate providing urgent care within 7 days and visits after hospital and emergency room visits within 3 days.

Describe how to maintain consumer records

In your MedTEAM policies and procedures, describe how you will maintain consumers' records. You must keep records for each consumer and safeguard them against loss, tampering, and unauthorized use. The records should be consistent with The Joint Commission (TJC) (formerly called Joint Commission on Accreditation of Healthcare Organizations) and Centers for Medicaid and Medicare Services (CMS) requirements.

Organize your medical record

Make information easy to find within the record to facilitate efficient and effective care. Having a medical record with the elements of a high fidelity chart does not mean much if it requires hours to find needed information.

The organization of the medical record is a crucial piece for effective medication management. You can accomplish this in many ways. For example, create discrete sections for comprehensive summaries or medication histories instead of requiring MedTEAM staff to search for this information in Progress Notes. These discrete sections can increase the usefulness of your forms. Making the sections as homogeneous as possible allows those who are involved in medication management to quickly know where information is located, instead of filtering through extraneous information.

Another way to organize your charts is to color-code documents within given sections. These standards can also hold true for electronic medical records where information tabs can organize the location of key forms into discrete sections.

Use electronic medical records

A thoughtfully designed electronic medical record system can be enormously helpful in facilitating documentation of medication management and in monitoring quality. The term *electronic medical record* (EMR) describes a wide variety of products.

Some EMRs have the primary purpose of supporting billing processes, but also add other consumer record-type features. Some may focus on personnel performance, which shapes how they are designed. Some products may be electronic, but are not medical records. It is important to understand these differences when considering EMRs for your agency.

To do this, the following resources may be helpful starting points.

- **http://www.capterra.com/mental-health-software:** an extensive list of EMRs and other electronic (scheduling, notes, prescriptions) software vendors;
- **http://www.askesis.com/:** a link to the vendor for the PsychConsult product, developed within and used by Western Psychiatric Institute, among other clients; and
- **Clinical Management Research Information Systems (CMRIS),** a system developed over the past decade by Duke University Department of Psychiatry. It is not only a true EMR, but it also has extensive research and clinical trial capabilities that are being used by top centers in the country and overseas.

You can purchase or develop an EMR locally. Purchased products may have a single format or a menu of features to select from. It may also be programmable to meet local needs. All added features come at a price, and local development requires allocating up front considerable information technology resources. It also requires an ability and commitment to maintain and grow the system.

Migrating old records into the EMR is a major issue that you must consider. The EMR should do the following:

- Be labor-saving;
- Contain prompts;
- Display data over time; and
- Search and aggregate data in any way needed for the purpose of quality improvement.

Some of the features that can be especially labor-saving include the following:

- Electronic forms with checkboxes and dropdown menus;
- Automatic carry-forwards of information that should be recorded at each visit, but often does not change (for example, diagnoses, medications, medical problems);
- Single-click generation of written or electronically transmitted prescriptions;
- Side menus with links to other documents in the record (for example, most recent illness, history summary, medication summary, treatment plan, symptom ratings, hospitalization or emergency room records, laboratory values); and
- Prewritten text with fill-in-the-blank sections for topics that should be covered at each medication visit (for example, side effects and adherence).

The goals are to make data entry simple, to amend rather than re-enter information that is likely not to change, to prompt recording all essential information, and to minimize time spent searching the record for medication-related information.

Prompts in the EMR can promote good practices and reduce errors. Again, you must balance efficient use of user time (too many prompts are wasteful, especially if they require a response.), value of the prompt (How useful is it? What will happen if it is ignored?), and programming time to create the prompt. Consulting with others who have worked with electronic prompts is highly recommended in deciding what to include.

Building displays of data over time into your EMR is very useful. For example, a symptom measure graphed over time can reveal trends that may not otherwise be obvious. See *Evaluating Your Program* in this KIT for more information.

Finally, an EMR can significantly reduce time spent on quality assurance reviews and can make the data more accurate. First, documents may be either missing or misfiled so that reviewers end up looking through the entire chart multiple times, item by item. You can easily search an electronic record. Second, with proper programming, you can automate electronic chart reviews and sort the results as needed (for example, by prescriber). In contrast, reviewers must record paper review results one at a time.

Even in systems that do not use EMRs, it is worthwhile to store the medication history document electronically, so that updating it becomes a matter of editing rather than re-creating a large document. For example, adding dropdown menus for medication names prevents medications from being misspelled or having extraneous information in areas where only the medication name should be placed.

Selecting and designing an EMR system is often an iterative process. You may be unsure of what you need until you try it out. Allow key stakeholders in your agency to have input into selecting and designing your EMR. Consider consulting with other agencies who have successful EMR systems.

Make sure that MedTEAM staff are familiar with your policies and procedures for documenting and maintaining records. MedTEAM recommends offering training on documentation practices. For more information, see *Develop a training plan* later in this booklet.

Discuss how to ensure consumers' rights

In your MedTEAM policies and procedures, discuss how you will ensure that consumers' rights are upheld. MedTEAM staff should do the following:

- Be aware of the state and federal consumer rights requirements;
- Inform consumers of their rights in a meaningful way; and
- Help consumers exercise their rights.

Also, policies and procedures should reflect the model's recovery orientation. Most traditional services were developed with a biomedical approach to mental health treatment. They focus on reducing symptoms and preventing relapse. In contrast, the MedTEAM model is based on the concept of *recovery*. In the recovery framework, the expectation is that consumers can have lives in which mental illnesses are not the driving factors. Recovery means more than maintaining people with mental illnesses in the community. Recovery-oriented services encourage consumers to define and fulfill their personal goals, such as a goal to work or finish college.

MedTEAM members must believe in and be true to the recovery principles within the MedTEAM model. Be careful not to replicate those elements of traditional services that simply emphasize containing symptoms and complying with medication.

The value of consumer choice in medication decisions and service delivery and the importance of consumer perceptions must be infused in how you provide MedTEAM. Most practitioners have never examined their own attitudes and behaviors about consumer recovery and uncritically accept many clinical traditions without paying attention to how disempowering these practices are for consumers.

In recovery-based services, establishing a trusting relationship is critical. Base interactions with consumers on mutuality and respect. Challenge MedTEAM staff to listen to, believe in, and understand consumers' perspectives and take into account consumers' experiences.

MedTEAM staff should also focus on consumer-defined needs and preferences and accept consumers' choices in medication decisions. Providing MedTEAM with a recovery orientation means that you support and empower consumers to achieve their individual goals.

How administrators and MedTEAM leaders can help provide recovery-oriented services

- Clearly explain consumer rights in MedTEAM policies and procedures.
- Offer training on recovery principles and consumer rights.
- Hold community forums using the multimedia tools in this KIT.
- Involve consumers in local advisory groups.

Evaluate program and staff performance

When it is properly implemented, MedTEAM is associated with a variety of positive outcomes. Evaluating the performance of MedTEAM will help you provide high-quality services to consumers and assure stakeholders of the program's effective performance.

Use the guidelines in *Evaluating Your Program* in this KIT to assess which components of MedTEAM your agency has in place and develop an implementation plan. MedTEAM also recommends developing a quality assurance committee that comprehensively reviews MedTEAM (using all items on MedTEAM fidelity scales) every 6 months.

Quality assurance members, advisory group members and MedTEAM staff should work together to ensure that assessment information is used to improve the program. For more information including the two MedTEAM fidelity scales, see *Evaluating Your Program* in this KIT.

Also, develop procedures for how you will supervise and evaluate the performance of your MedTEAM staff. To a large extent, clinical supervision is the process that will determine whether MedTEAM staff understand and consistently apply the evidence-based model or whether further leadership, training, and accountability are required to meet this goal.

MedTEAM leaders who are experienced in the evidence-based model should provide monthly individual or group supervision to MedTEAM staff. Clinical supervision should be consumer-centered and explicitly address MedTEAM and its application to specific consumer situations.

Because MedTEAM leaders dedicate some time to direct services, they will be familiar with all of the parts of providing medication management. MedTEAM leaders will not just review cases that MedTEAM staff present, but will also be able to actively problem-solve using MedTEAM principles and techniques.

MedTEAM leaders may also disseminate the fidelity assessment results during supervisory meetings. A useful form of feedback is to disseminate staff averages (for example, percentage of consumers with psychotic symptoms who are on antipsychotic polypharmacy) along with distributing individual performance data. When possible, compare staff averages with accepted norms or with goals that are based on established and accepted standards. Most MedTEAM staff find it helpful and motivating to see where they stand in relation to their peers.

MedTEAM leaders also provide individual supervision to discuss performance and give feedback. MedTEAM leaders may schedule regular meetings with MedTEAM staff to review specific cases. They should be regularly available to consult with MedTEAM staff, as needed.

If the MedTEAM staff is working with a consultant, the MedTEAM leader should involve the consultant in group supervision and treatment team meetings. Many new evidence-based practice programs have found that feedback from an external consultant is a crucial component for improving staff performance and the quality of their program as a whole.

Develop a training plan

Developing MedTEAM is a complex undertaking. Agencies that have successfully implemented MedTEAM indicate that offering one-time training for prescribers is not enough. Instead, you should assess the knowledge level of key stakeholders (See *Evaluating Your Program* in this KIT) and develop a training plan.

What should your training plan include?

- Basic training for staff at all levels across the agency
- Basic training for key stakeholders, including consumers, families, advisory group members, mental health authorities, and members of key community organizations
- Intensive training for MedTEAM staff including the following:
- New documentation practices
- Ongoing training on medications
- Integrating outcome measures into clinical assessments

Practitioners who implement evidence-based practices are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agencywide staff develop a basic understanding of MedTEAM.

This training will build support for implementing MedTEAM in your agency. Since implementing MedTEAM effectively depends on a collaborative approach, it is important for all practitioners to have a basic understanding of the MedTEAM model.

In addition to these internal basic training activities, consider organizing routine educational meetings for consumers, families, or other key stakeholders in the community where consumers who have received medication management through the MedTEAM approach share their experiences. Events such as these can correct false beliefs before they impede implementing the evidence-based model.

Next, consider how you will offer MedTEAM staff intensive training to allow them to master the evidence-based model. We suggest organizing three types of training:

- New documentation practices;
- Ongoing training on medications; and
- Integrating outcome measures into clinical assessments.

Training on new documentation practices

As described above, MedTEAM recommends collecting information in 11 core areas to inform medication management. MedTEAM also recommends assessing workflow for collecting and documenting this information. These recommendations may result in changes to your agency's documentation practices.

Training Frontline Staff in this KIT describes the rationale for providing training on new documentation practices. The booklet also provides information on the types of topics that you may include in this training.

Ongoing training on medications

Two aspects of serious mental illnesses have led to developing a number of medication guidelines and algorithms that make recommendations for sequencing specific medications for long-term medication treatment.

- First, these illnesses are typically recurrent or chronic.
- Second, the first treatment typically does not work for the duration of the consumer's illness.

Therefore, most consumers will respond inadequately to at least one medication and need either a medication change or addition.

Training Frontline Staff provides information about a number of algorithms and treatment guidelines that are currently available. No algorithm or guideline has been found to be superior to others. However, some generally shared characteristics span many of the currently available guidelines. For example, in treating schizophrenia, the following three tenets are shared across numerous guidelines and algorithms:

- Antipsychotics are the core of medication treatment;
- Clozapine is recommended for those who have a history of inadequate response to two or more other antipsychotics; and
- Combination antipsychotics are a last resort because they lack a strong evidence base.

MedTEAM recommends developing a systematic plan to train MedTEAM staff. Training should include a review of the available guidelines and algorithms for the purpose of adopting one that follows expert consensus based on the latest research.

Written guidelines or algorithms should specify what constitutes an adequate trial for each medication including the dose and duration. MedTEAM also recommends that guidelines include a plan for identifying and treating consumers with treatment-refractory disorders (or those whose symptoms have inadequately responded to medications). The systematic plan should include procedures for updating these guidelines annually and providing ongoing training for MedTEAM staff.

Keeping current in a changing world

The knowledge base about specific medications is growing rapidly. New findings quickly render prior information outdated and even incorrect. Prescribers need to keep up as new drugs are approved and new information emerges about existing ones. Various ways of dealing with the fluidity of knowledge about medication exist.

First, offer routine training for prescribers. Second, consider designating a staff member who may serve as a point person within your agency for medication updates. Have that person routinely update staff during treatment team meetings or other inservice sessions.

Time and effort to access information often compete with time devoted to consumer care. Designated staff can support prescribers with their effort to keep up with scientific updates.

Some agencies may also further specify roles so that one staff member serves as a point person for medications related to schizophrenia and another for mood disorders. Designated staff members may participate in additional training activities.

Routine self training is complex. Many sources of information about medications exist. A few examples include the following:

- Continuing Medical Education (CME) programs;
- Primary research literature;
- Research reviews and meta-analyses;
- Pharmaceutical representatives and programs; and
- Medication-related Web sites and newsletters.

Considerable information is available through the Internet, which also has a plethora of Web sites devoted to specific mental illnesses and psychiatric issues. Unfortunately, the quality of information varies hugely from source to source. Timeliness and reliability of information may be difficult to judge. Provide training to support MedTEAM staff in gaining the skills necessary to undertake these tasks.

For more information about how to design training to support MedTEAM staff members in their effort to keep current on scientific evidence related to medication management, see *Training Frontline Staff* in this KIT.

Integrating outcome measures into clinical assessments

Prescribers collect an enormous amount of information during medication visits that is difficult to record and track simply through handwritten notes. MedTEAM recommends integrating outcome measures, such as brief rating scales, to help assess the effectiveness of current medications, establish a plan for any future medication changes, and document this information in the medical record.

Integrating outcome measures into clinical assessments enhances prescribers' ability to effectively manage medications. Prescribers should also document their rationale for medication decisions, in order to facilitate seamless care when multiple prescribers become involved in the treatment process.

Develop a training plan to help prescribers integrate outcome measures into routine practice. For more information, see *Training Frontline Staff* in this KIT.

Educate and involve consumers

MedTEAM also recommends developing procedures to educate and involve consumers in their medication management. It is important to train MedTEAM staff members on these procedures to ensure that they are properly integrated into the medication management process. For more information, see resources on shared decisionmaking in *The Evidence* in this KIT.

Hire an external consultant and trainer

Establishing processes for providing quality services requires great attention to detail. Consequently, during the first 1 to 2 years of implementing MedTEAM, many agencies have found it helpful to work with an experienced external consultant and trainer.

Consultants and MedTEAM leaders often work together over the first 2 years to ensure that MedTEAM is structured appropriately. They integrate MedTEAM principles into the agency's policies and tailor MedTEAM procedures to meet local needs.

Once the program has been launched, it is important that you do not allow staff to revert to older and more familiar ways of doing things. External consultants and trainers who are experienced in implementing MedTEAM can provide ongoing technical assistance, supervision, and periodic booster training sessions. This type of assistance, along with ongoing evaluation of fidelity and outcomes, has been found to be critical in sustaining an evidence-based approach.

In summary, implementing the MedTEAM approach effectively is a developmental process. We encourage you to periodically revisit the information in this KIT throughout the first year after starting your MedTEAM initiative. We believe that these materials will take on a new meaning as the process of implementing MedTEAM evolves.

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