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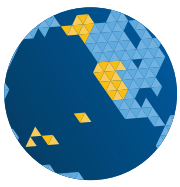
FY25

EVIDENCE-BASED PRACTICES FIDELITY PROJECT

QUALITY IMPROVEMENT REPORT

Submitted to the Montana Behavioral Health and Developmental Disabilities Division

June 2025



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Introduction

The Montana Department of Public Health and Human Services, Behavioral Health and Developmental Disabilities Division (BHDD) prioritizes the utilization of best practices by providers to support individuals with serious mental illness. To this end, BHDD contracts with the Western Interstate Commission for Higher Education Behavioral Health Program (WICHE BHP) to conduct quality service reviews of evidence-based practices (EBPs) for this population. Under this contract, the WICHE BHP reviews provider implementation of Assertive Community Treatment (ACT) as defined by the EBP toolkit established by the Substance Abuse and Mental Health Administration (SAMHSA). Individuals who qualify for ACT services are typically unsuccessful with traditional mental health services and require a community-based approach with more frequent and intensive services. Often, those served by ACT teams experience both serious mental illness and substance use disorders (co-occurring disorders). Integrating treatment services for individuals with co-occurring disorders is an evidence-based approach utilized by effective ACT teams.

In 2020, the BHDD engaged the WICHE BHP to conduct fidelity reviews of providers implementing Assertive Community Treatment.

With consultation from the WICHE BHP, the BHDD authorized a review tool that aligns with the SAMHSA ACT fidelity rating scale while recognizing adaptations required by the rurality of some programs across the state. This new tool, the *Montana Assertive Community Treatment Fidelity and Standards Scale* (MT-ACT Scale) measures how closely Program for Assertive Community Treatment (PACT) and Montana Assertive Community Treatment (MACT) teams deliver Assertive Community Treatment. In Montana, PACT teams operate with up to 18 staff who deliver services to members of a larger census, up to 100 members, and are generally located in urban areas. MACT teams have a smaller member census, often in the mid 30's, and are located in rural areas of the state. MACT programs often operate within a much larger catchment area and employ up to 8 staff who deliver ACT services. MACT and PACT teams are rated on the same items, but rating expectations have been modified for MACT teams to account for their smaller size. Additionally, rating expectations have been modified from the SAMHSA toolkit for MACT and PACT teams in recognition of the rurality that teams face. These adaptations are summarized below.

- PACT and MACT teams that include one (1) Registered Nurse may substitute a Licensed

Practical Nurse for the second nurse, rather than the standard expectation of two Registered Nurses.

- One (1) of the four contacts required per week may be provided via telehealth (i.e., videoconference).
- For teams with a member census of 50 or less, i.e., MACT, the size of the team must be no less than seven (7) direct service staff, rather than ten (10) as indicated for larger teams.
- For teams with a member census of 50 or less, i.e., MACT, the monthly admission of new members shall not exceed three (3).

In 2024, the BHDD created an alternative program model to further accommodate the limitations of service delivery provision for rural teams servicing members in large catchment areas. The new program model is referred to as Montana Community Treatment (MCT). MACT teams have the option of transitioning to the Montana Community Treatment model or into the PACT model. BHDD and the WICHE BHP attended regular meetings to gain feedback from providers to better accommodate their service delivery needs. The WICHE BHP was engaged to develop a new scale to measure the delivery of services to these smaller rural teams. During the development phase, several MACT teams closed their doors due to extenuating circumstances, including those who were scheduled to pilot the new scale. In response, BHDD identified a newly established PACT team to participate in piloting the new tool. MCT programs are scored differently in the areas listed below.

- Two (2) or more MCT team staff meet with members every 30 days, following a team approach to service delivery.
- MCT teams meet at least two (2) days each week to discuss all members. The psychiatric prescriber attends at least one (1) meeting in duration.
- The following staff are fully assigned to the team and do not have outside responsibilities: Team Lead, Registered Nurse, and the Co-Occurring Clinical staff.
- The number of direct service staff assigned to the program must either be 5.375 or 5.5 full time equivalent (FTE). Assignment of the psychiatric prescriber must match 100 members to 1 prescriber ratio. No team shall have a prescriber that is assigned less than .375 FTE.
- Coordination with inpatient psychiatric care teams must be documented in members' medical records to count toward actively participating in discharge planning.
- Service provision occurs in the community 50%, or more, of the time.

- No expectations are identified relating to the duration (intensity) of each service interaction.
- Members receive two (2) or more quality service contacts from the team each week.
    - One (1) of the two (2) contacts may be delivered via telehealth (videoconference).

Project Implementation

In State Fiscal Year 2025 (FY25), July 1, 2024,to June 30, 2025, the WICHE BHP participated in three monthly meetings that involved distinct partners vested in the delivery of assertive community services in Montana. The WICHE BHP staff attended monthly virtual meetings with BHDD staff and leadership from partnering systems. The WICHE BHP staff participated in meetings with the BHDD staff, and PACT and MACT provider leadership and staff. Finally, the BHDD and the WICHE BHP staff met monthly, or more frequently, to discuss provider feedback, BHDD policy, development of the MCT scale, and strategies to improve practices delivered to the beneficiaries of the Montana behavioral health service system. In addition, the WICHE BHP staff were available to meet with BHDD as needed to provide feedback on policy development.

These meetings informed the development of the new MCT Scale and updating of materials, including the fidelity and standards scales, scoring protocols and forms, provider notification and preparation letters, interview guides, record review tool, and fidelity report templates.

The WICHE BHP Fidelity Review Team utilizes the appropriate tool (MT-ACT Scale or, in the future, the new MCT Tool) and the following process to conduct quality service reviews:

- The team issues a notification letter to the provider to initiate the review process, allowing adequate time to prepare for the review. The letter includes:
    - Dates and timelines for the review process
    - Agendas for conducting interviews and meetings
    - Data and documents requested for the review

- A team of two reviewers conduct the review. Each team has a lead reviewer responsible for correspondence, provider scheduling, and drafting the report.

- On the last day of the review, the WICHE BHP review team holds a brief meeting with the provider and BHDD staff. Reviewers share immediate observations of the program's strengths and request feedback on the review process. Programs have an opportunity to ask questions about the review process and application of the EBP.

- Following the completion of the review, each reviewer documents fidelity scores individually. The two reviewers convene to determine final consensus scores.

- The team conducting the fidelity review drafts a report with scoring rationale and recommendations. Members of the larger fidelity review team read and refine the draft to ensure consistent application of EBP standards.

- The WICHE BHP delivers the final report with the fidelity scale score via email to the BHDD, and the provider's point of contact.
    - The report notifies providers that they may respond to the report in writing. They may also opt to participate in a follow-up call with BHDD staff, and the WICHE BHP team to discuss the review findings and answer specific questions regarding the report.

For Fiscal Year 2025, the WICHE BHP conducted five (5) quality service reviews, including four (4) PACT programs and one (1) MACT program. A total of 256 members were being served by the programs that were reviewed. Two MACT teams that were scheduled for review closed services and were removed from the schedule.

PACT Reviews Completed in FY 2025

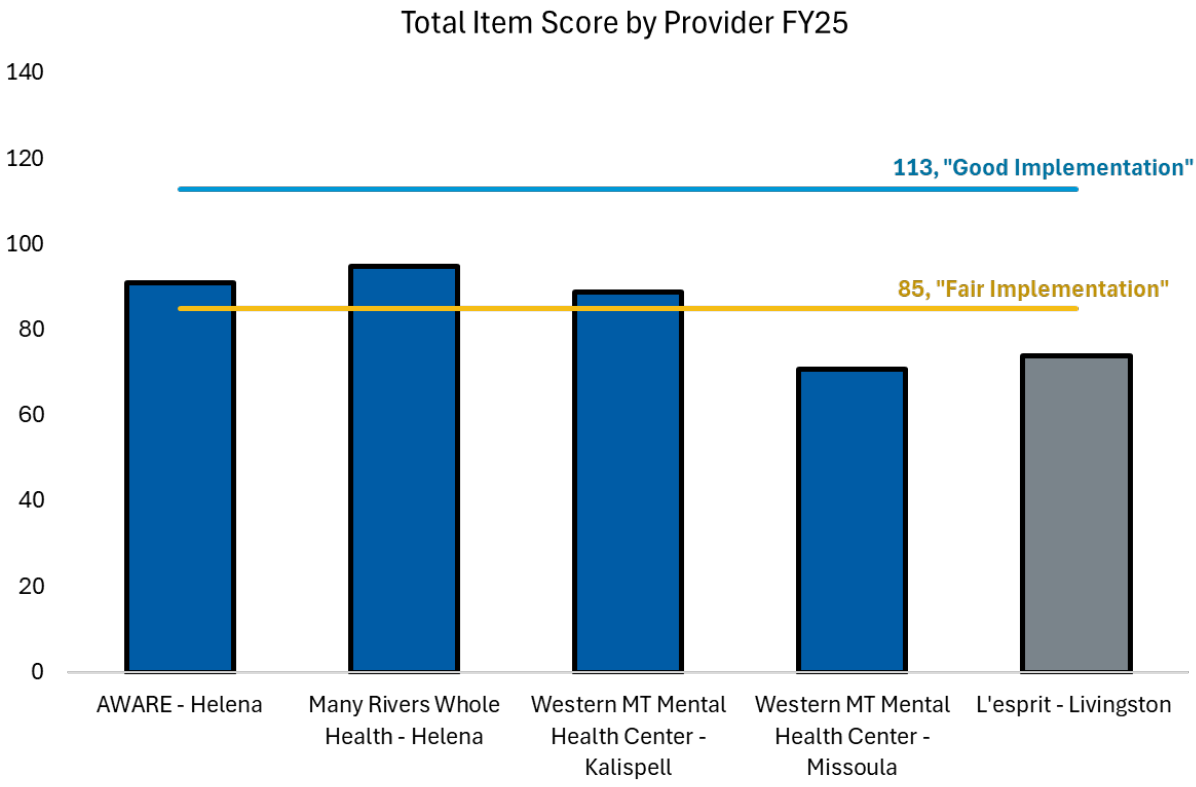
- AWARE - Helena
- Many Rivers Whole Health (formerly Center for Mental Health) – Helena
- Western Montana Mental Health Center – Kalispell
- Western Montana Mental Health Center – Missoula

MACT Reviews Completed in FY 2025

L’ esprit - Livingston

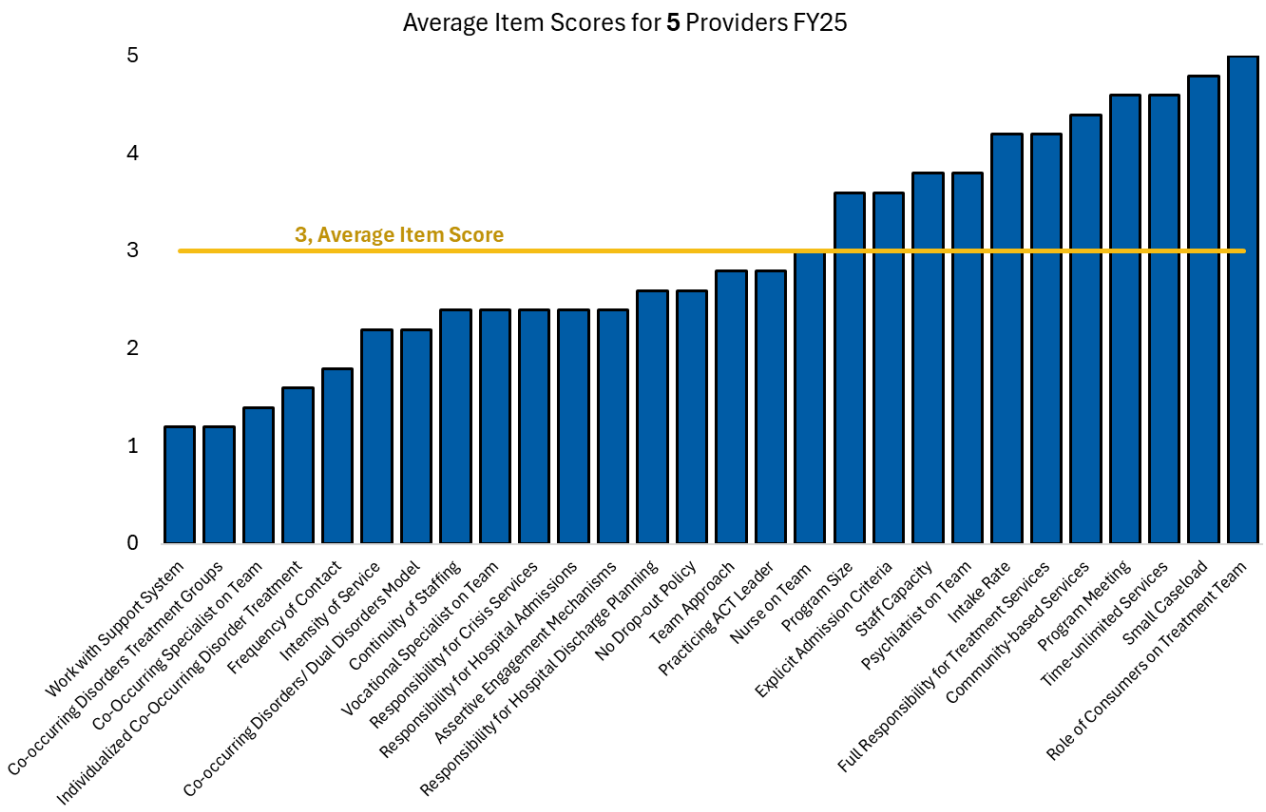
Summary of FY 2025 Fidelity Review Findings

The graph below provides scores for each team reviewed in FY 2025.



- The one (1) MACT provider is highlighted in Grey.
- Three (3) providers achieved a score of 85 or better, indicated by the lower gold line in the graph above, which SAMHSA defines as “fair implementation” on the ACT fidelity rating scale.
- Two (2) providers scored lower than 85, which SAMHSA indicates as “not ACT”.
- No providers exceeded SAMHSA’s rating of 113, shown by the upper blue line in the graph, which indicates “good implementation” of ACT.

The Montana Assertive Community Treatment Fidelity and Standards Scale follows the SAMHSA ACT Toolkit, which includes twenty-eight items on the fidelity review scale. Each item is rated on a 5-point scale ranging from 1 “Not implemented” to 5 “Fully implemented”. The graphs below indicate the average rating for each fidelity item across all PACT and MACT providers reviewed in FY25.



Areas of Success to be Maintained

PACT and MACT providers scored high on a variety of fidelity items in the MT-ACT Scale. Areas of success shared across programs included:

- *Small Caseloads* - Programs maintain appropriate client-to-staff ratios, which promote adequate diversity and intensity of service delivery to members.
- *Program Meeting* – Programs conduct regular team meetings, typically daily. These meetings enable teams to provide updates on member needs and prioritize service delivery by team staff.
- *Intake Rate* – Members are admitted at a rate that allows the delivery of an appropriate intensity of service from the team as the member transitions into services. Program staff are not burdened by a high rate of new admissions.
- *Responsibility for Treatment Services* - Services are provided directly by team staff rather than by others within the agency or from outside providers. This ensures that members experience the benefits of a treatment team approach.
- *Time-Unlimited Services* – Consistent with ACT practice, members transition to a lower level of care when they are ready, rather than at a predetermined time. Teams retain clients until

the member determines a decrease in services is appropriate. Teams then decrease the intensity of services gradually to support the transition, which also allows the team to quickly respond should the members need additional support.

- *Community-Based Services* - Members receive a high proportion of services in their communities and natural environment where they are more likely to experience real-life challenges.

- *Role of Consumers on Treatment Team* – Teams are well-staffed with individuals who have personal lived or living experience in psychiatric care, e.g., certified Peers. Peer staff provide valuable insights to the team about the experience of receiving psychiatric services. Often, teams include non-certified Peer staff who fulfill other specialty roles on the team, but could also be a resource for staff, members, and members' support systems.

An item of success unique to PACT programs included:

- *Program Size* – Providers adequately staff teams to deliver services that meet the intensive needs of members.

Items of success unique to the MACT program included:

- *Practicing ACT Leader* – The MACT leader is highly involved in the direct provision of services to members. The Leader meets with members in their communities, involves natural support systems, and provides services alongside other MACT specialists in a mentoring role.

- *Vocational Specialist on Team* – The team includes staff who are trained and experienced in the delivery of services and support for members interested in seeking employment within their community.

Opportunities for Improvement

Average fidelity scores across PACT and MACT providers are low for several MT-ACT scale items. This section describes common areas across programs that would benefit from focused attention to improve program fidelity and the experience of members as they work on recovery . For each item, a definition of the item is provided followed by a description of current implementation by PACT and MACT providers and recommendations for improvement.

- *Frequency of Contact – Members have a high number of face-to-face service contacts, as needed. ACT teams are highly invested in their consumers and maintain frequent contact to provide ongoing, responsive support as needed. Frequent contacts are associated with improved consumer outcomes.*

    - Teams struggled to engage all members frequently. Some teams had more frequent contact with members than others.

        - Considerations for improvement: Increase the number of times team staff have contact with members. Members, on average, should have direct support from the team four times a week. One of those weekly contacts can be conducted via telehealth.

- *Work with Support System – ACT programs should provide support and skills for members' natural support network. Developing and maintaining community support further enhances members' integration and functioning.*

    - Members' natural support systems are rarely involved in their care, even though team staff reported that a high percentage (56-91%) of members had those supports. Some teams assign specific staff to be responsible for interactions with members' natural support.

        - Considerations for improvement: Include discussions around building a community of support with members when developing and updating service plans. Opportunities may be presented for engaging with members' support systems while meeting with members in their communities. Ensure these natural support systems are aware that the team is there for them as well. Some programs offer support groups for family members/significant others.

Items related to utilizing a Co-Occurring Disorders Model

Generally, programs struggled to provide members with substance use treatment services. Ideally, these services would be delivered utilizing an integrated treatment model approach, an EBP, which treats the serious mental illness, and the substance use disorder at the same time. Several items in the MT-ACT scale and ACT EBP relate to this service delivery, including Co-Occurring Disorders Specialist on the Team, Individualized Co-Occurring Disorders Treatment, Co-Occurring Disorders Treatment Groups, and utilization of a Co-Occurring Disorders Model. For these items, we offer a summary of *considerations for improvement*.

- *Co-Occurring Disorders Specialist on the Team – ACT teams should have at least 2 staff with at least 1 year of training or clinical experience in substance use treatment, per 100-member program. Concurrent substance-use disorders are common in consumers. Appropriate assessment and intervention strategies are critical to their recovery.*

    - One of the four PACT teams had qualified staff on the team at the time of the review who had the capability to provide substance use treatment services to members. When this key position on the team is vacant, members do not receive substance use treatment services, as members were not referred to agency or community providers.

- *Individualized Co-Occurring Disorders Treatment – One or more members of the team should provide direct treatment and substance use treatment for consumers with substance-use*

disorders. Substance-use disorders often occur concurrently in members with serious mental illnesses; these co-occurring disorders require treatment.

- One of the five programs is actively delivering individual substance use and mental health treatment to members of their team. One of the four teams without the ability to provide the services on the team actively provides referrals to agency staff.

- *Co-Occurring Disorders Treatment Groups – Programs should use group modalities as a treatment strategy for people with substance-use disorders. Group treatment has been shown to positively influence recovery for consumers with co-occurring disorders.*

    - *One program provides group substance use treatment.*

- *Co-Occurring Disorders Model – Programs should use a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions between mental illness and substance abuse, and has gradual expectations of abstinence. The co-occurring disorders model attends to the concerns of both SMI and substance abuse for maximum opportunity for recovery and symptom management.*

    - ACT programs are fully based in co-occurring disorders treatment principles with individual and group treatment provided by the team. Teams are versed and knowledgeable about best practices related to supporting members with complex treatment needs.

Considerations for improvement*:* Continue efforts to support programs to provide substance use treatment services in an integrated treatment model approach. Engage programs and leadership in conversations about barriers to delivery of the model. Teams were highly engaged in training provided this past year and requested additional opportunities. Alternative platforms might be considered to garner more interest. Support the teams in developing a team understanding of best practices related to supporting members with co-occurring disorders, including identification of a member's stage of change, appropriate interventions, and recovery-based language to use when addressing substance use with members. Ideally members have the opportunity to attend treatment groups as well as individual sessions with qualified staff, but each staff on the team should have the capacity to speak to members' needs when it surfaces during interactions.

Items for improvement unique to PACT programs included:

- *Vocational Specialist on Team – ACT programs should include at least 2 staff members with at least 1 year of training/experience in vocational rehabilitation and support. ACT teams emphasize skill development and support in natural settings. Fully integrated ACT teams include vocational services that enable members to find and keep jobs in integrated work settings.*

    - Not all PACT programs are appropriately staffed with personnel that have current training and experience supporting individuals to find and keep employment in an integrated setting. One-half of the teams had vacant Vocational/Employment Specialists positions.

        - Considerations for improvement: Maintain consistent conversations about the knowledge that PACT members have the potential to work and that it supports their recovery. Ensure training availability is widely disseminated. Consider seeking feedback from teams on the barriers to filling and keeping these positions.

- *Responsibility for Crisis Services – In the EBP of ACT, programs have 24-hour responsibility for covering psychiatric crises. An immediate response can help minimize distress when consumers are faced with a crisis. When the ACT team provides crisis intervention, continuity of care is maintained.*

    - Some PACT members do not have direct access to their team after-hours, and instead their first contact is with a crisis services staff who may be a stranger to the member. Members of the one team that do have direct access to staff are not normally provided support in the community by the team; rather emergency services are contacted to provide PACT members' community support.

        - Considerations for improvement: Provide members with after-hours crisis support and ensure members have contact information for on-call PACT staff. An immediate response to member needs can minimize distress, maintain continuity of care, and offer opportunities to further build trust in the team and system.

Areas for improvement which are unique to the MACT program include the following:

- *Psychiatrist on Team – ACT is designed for members that are typically unsuccessful with traditional case management and require a higher level of service. Members are scheduled to receive intensive and flexible services, ideally scheduled with the psychiatrist every 30 days or less. Psychiatrists provide valuable oversite of member care and help to direct and prioritize the services the team provides.*

    - Multiple psychiatric prescribers were utilized by the team, and none attended the program meeting. Coordination with prescriber is conducted via an online portal which is cumbersome and delays coordination.

        - Considerations for improvement: Consistent with the EBP of ACT, assign only one prescriber to the team and meet the 1:100 prescriber to member ratio, act as the medical director for the team, meet with members every 30 days or less, and attend a program meeting at a minimum of once a week to obtain updates on members and to provide crucial oversite of service delivery.

- *Nurse on Team – For teams with a roster of 50 members, staffing should include one Nurse ACT. Nurses often engage in non-typical activities associated with the role, such as accompanying members to specialty appointments. ACT Nurses often provide valuable symptomology and medication side effect information to ACT staff and members' support systems.*

    - The 10-month nurse vacancy at the time of review limits the ability of the team to

provide the wraparound support and coordination of medical care crucial to supporting members.

- Considerations for improvement: Continue efforts to support programs using a more flexible staffing expectation related to the Nuse position.

- *Responsibility of Hospital Admissions – Programs are best prepared to assess member needs in the community and provide additional support to potentially prevent hospitalization. When a member is admitted to the hospital, programs model continuity of care by identifying their involvement in the member's treatment and provide immediate coordination of care to begin discharge planning*.

  - Members would benefit from a coordinated effort when requiring psychiatric hospitalization.

    - Considerations for improvement: Support teams to take an active role in coordinating member care with inpatient psychiatric teams. MACT teams should be actively involved in determining discharge plans for members when inpatient psychiatric care is required. Educate members and their support systems about team availability to support members in their communities or, if necessary, to assist with hospital admissions.

- *Responsibility for Hospital Discharge Planning - Program is involved in planning for hospital discharges. Ongoing participation of the ACT team during consumer hospitalization and discharge planning allows the team to help maintain community support.*

  - Members did not experience coordinated care by their behavioral health service providers to appropriately develop discharge plans.

    - Considerations for improvement: Increase efforts to build relationships with inpatient units. An integrated treatment team approach across all providers and systems helps to support members move toward recovery and helps to keep providers aware of the needs of members and services already encountered. Consider enlisting team Nurses to lead the effort to build collaborative relationships with the inpatient treatment teams.

General Recommendations to Strengthen Program Fidelity:

The WICHE BHP recommends the following to strengthen the program fidelity of PACT throughout the provider community.

- Continue support of cross-provider collaborative work sessions. Ideally, providers could share best practices and experiences in areas in which they are succeeding and receive peer consultation regarding challenges in delivering PACT services, including sharing practices that promote staff retention.

- Gather feedback from programs on future collaborative opportunities such as training

topics, or annual work sessions to bring providers together to further collaborate and build a network of support for the delivery of the model, which may include training on PACT.

- Consider offering opportunities for targeted technical assistance to those providers that struggle with the delivery of services that meet model fidelity. Technical assistance could include shadowing a more successful team and learning from best practices and provider leadership styles that champion the delivery of the EBP.

Training Provided in FY 2025

During FY 2025, the WICHE BHP provided training to PACT and MACT teams in the areas listed below.

Assertive Community Treatment -The Role and Relationship in Sustaining Fidelity – Twelve, two-day sessions were offered to providers. A total of 108 staff attended the two-day training, representing all agencies delivering PACT and MACT services in Montana, including: AWARE, Many Rivers Whole Health, Eastern Montana Community Mental Health Center, L' esprit, South Central Regional Mental Health Center, and Western Montana Mental Health Center. The interactive training focused on the 28 items of the ACT model, key factors to successful program implementation, and discussion around barriers and solutions to service delivery.

Co-Occurring Disorders Model - The initiative began by meeting with senior leadership of the provider organizations to receive training and to seek their commitment to the model. Then, three, two-hour sessions were provided to direct service staff from PACT and MACT teams. Participants of the training represented all the agencies providing PACT or MACT services and a total of 74 staff.

Appendix A: FY 2025 Summary Fidelity Review Findings

Assertive Community Treatment	PACT - AWARE - Helena	PACT - Many Rivers Whole Health - Helena	PACT - Western MT Mental Health Center - Kalispell	PACT - Western MT Mental Health Center - Missoula	MACT - L'esprit - Livingston	FY25 All Providers Average
Small Caseload	5	5	5	4	5	4.80
Team Approach	2	5	2	2	3	2.80
Program Meeting	5	5	4	5	4	4.60
Practicing ACT Leader	4	2	3	1	4	2.80
Continuity of Staffing	3	2	3	1	3	2.40
Staff Capacity	4	4	4	4	3	3.80
Psychiatrist on Team	5	5	4	4	1	3.80
Nurse on Team	5	5	3	1	1	3.00
Co-Occurring Specialist on Team	3	1	1	1	1	1.40
Vocational Specialist on Team	1	4	2	1	4	2.40
Program Size	4	5	5	3	1	3.60
Explicit Admission Criteria	3	4	5	3	3	3.60
Intake Rate	3	5	4	5	4	4.20
Full Responsibility for Treatment Services	5	4	4	4	4	4.20
Responsibility for Crisis Services	2	3	3	2	2	2.40
Responsibility for Hospital Admissions	1	4	3	3	1	2.40
Responsibility for Hospital Discharge Planning	3	4	2	3	1	2.60
Time-Unlimited Services	5	4	5	4	5	4.60
Community-Based Services	5	3	5	4	5	4.40
No Drop-Out Policy	1	3	4	2	3	2.60
Assertive Engagement Mechanisms	3	2	3	2	2	2.40
Intensity of Service	3	3	2	1	2	2.20
Frequency of Contact	2	3	2	1	1	1.80
Work With Support System	1	1	2	1	1	1.20
Individualized Co-Occurring Disorders Treatmen	4	1	1	1	1	1.60
Co-Occurring Disorders Treatment Groups	2	1	1	1	1	1.20
Co-Occurring Disorders Model	2	2	2	2	3	2.20
Role of Consumers on Treatment Team	5	5	5	5	5	5.00
FY25 Total Score	91	95	89	71	74	84.00
Total Possible	140	140	140	140	140	140.00
Percent Compliance	65.0%	67.9%	63.6%	50.7%	52.9%	60%
Average Item Score	3.25	3.39	3.18	2.54	2.64	3.00
Roster size	56	40	78	59	32	265