Community Support Team Fidelity Review
Interpretive Guidelines
FY15

This tool summarizes Community Support Team (CST) fidelity review items. The purpose of this tool is to assess the degree to which a CST is performing in a manner consistent with the desires of Illinois Department of Human Services, Division of Mental Health (DHS/DMH) for best practice that incorporates evidence-based interventions and practices while operating within Illinois Rules and contracts.

Sampling

During FY15, all Illinois providers certified to provide CST will receive a fidelity review. Providers with more than one team will have up to three (3) teams reviewed. If a provider has three (3) teams or more, three (3) teams will be reviewed. If a provider has less than three (3) teams, all teams will be reviewed. Ten randomly selected records will be assessed for fidelity for each team selected for review. Each of these reviews will be treated as separate reviews, with an aggregate score for the provider overall.

<u>For providers who have more than three teams:</u>

Providers will be notified 2 weeks prior to the fidelity review that they need to provide the Collaborative Training Coordinator with rosters of all teams. Do not include teams that consist solely of Integrated Care recipients. Rosters must be submitted within three (3) business days of the notification call and include both the consumer name and RIN. Teams and records will then be selected using established sampling techniques. Upon completion of the team and record selection, the provider will receive the formal notification call, one week prior to the review, followed by an encrypted email from the Collaborative identifying teams and records that will be reviewed. Please send rosters via fax to (217) 801-9189 or by encrypted email to: QualityMgmtDept@valueoptions.com.

Reviewers

A team of two Collaborative Regional Liaisons will conduct the review. DHS/DMH Contract Managers will participate in the Exit Conference. For CST providers with multiple teams, additional Collaborative staff may attend the review. Collaborative Liaisons are licensed clinicians. Reviewers have received training on the use of the CST review tool, interviewing and data collection procedures (including chart reviews). In addition, reviewers will have an understanding of the nature and critical ingredients of CST.

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Overview of the Scale

The CST fidelity scale has 21 program items for review in FY15. Seventeen tool items are scored as a "yes" or "no" depending on if there is evidence of the criterion in the individual record. Likewise, four items are scored as a "1", "3" or ""5". The scores on each individual record review will be entered into an Access database. The database is programmed to calculate the percentage of individual reviews that met the fidelity standards on a scale of one to five (1-5).

Methods Used to Ascertain Measurement of Current Practice

CST fidelity monitoring will use a variety of methods to ascertain a measurement of the team's current practice: review of clinical record and semi-structured interviews of staff and persons served are primary methods. Some items may require reports from billing records, staff records and/or administrative records.

Concurrent Documentation

Together, staff and persons served document progress made during treatment. Reviewers will note in the comments section when they see this practice occurring in an agency as it is evidence of person centered treatment.

Plans of Improvements

A Plan of Improvement (POI) will be required if any item scores below the threshold of 4.0. Each item that was below threshold will need to be addressed on the POI. Plans of Improvement are to be submitted to DHS/DMH Regional staff Providers have the option of using the DHS/DMH POI template or their own format for the POI, if it includes all of the specified elements. Plans of Improvement need to be submitted within thirty (30) days from the date on the *DHS/ DMH Community Support Team Fidelity Review* letter. This letter is sent within thirty (30) days of the review by the Collaborative as a support function for DHS/DMH. A revised POI may be requested by DHS/DMH Regional staff, who will monitor progress.

Providers are asked, as a courtesy, to send a copy of the POI to the Illinois Mental Health Collaborative, 400 S. Ninth Street – Suite 201, Springfield, IL 62701, Attn: Training Coordinator.

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Definitions

Natural Settings:
These sites are not licensed, certified or accredited as a treatment setting nor typically identified as treatment sites. A setting where an individual who has not been identified as mentally ill or been diagnosed with a mental illness typically spends time, including home, school, work, churches, community centers, libraries, parks, recreation centers, etc.

Natural Supports:
A person, identified by the person served, who is not paid by the State for providing support to the individual (e.g., family, friends, pastor).

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Reason Codes:

1. **There is a full-time team leader who is at least a QMHP and serves as the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team.**

   The team leader is actively involved in service delivery to persons receiving CST, not just as a substitute or extra person when occasionally needed. The team leader does not have to meet a certain percentage of time spent providing direct care, but you must see that his/her time is 100% dedicated to the team through a combination of administrative and clinical services.

   Rationale: Research has shown this factor was among the five most strongly related to better outcomes. Team leaders who also have direct clinical contact are better able to model appropriate clinical interventions and remain in touch with persons receiving CST.

   Sources of Information:

   Team Leader Interview

   - "Tell me about how you manage your time between administration and being a practicing clinician on the team."

   - "What are your credentials?"

   Chart Review

   - Review progress notes to note the Team Leader's provision of direct care and credentials.

2. At least one member of the team is a person in recovery and this person is a fully integrated CST staff member.

The team is required to include a person in recovery. This staff person is required to be a Certified Recovery Support Specialist (CRSS) or Certified Family Partnership Professional (CFPP)). Full integration would involve this person providing direct care, actively being involved during team meetings, treatment planning, etc.

Rationale: Some research has concluded that including persons in recovery as staff on case management teams improves the practice culture, making it more attuned to the perspectives of persons receiving CST. The idea is that this person shares their experiences and provides hope for recovery which is also useful for engagement of individuals in services.

Sources of Information:

Team Leader Interview

- "How are persons in recovery involved as members of your team? (e.g., employed, volunteer, not at all, etc.)"
- If they are paid employees, are they full time?
- Are they considered full -fledged clinicians? (Alternatively, are they considered aides?)

Clinician Interview

Ask similar questions as for team leader.

Interview of Person Served

- "How are persons in recovery involved as members of your team? (e.g., employed, volunteer, not at all, etc.)"

Chart Review

- Look for progress notes that reflect that the person in recovery is fully integrated on the team.

Item Response Coding: This item refers to individuals who have disclosed that they have received treatment for a psychiatric disorder. If persons in recovery are employed as clinicians with equal status as other case managers, the item is coded as a "5." If persons in recovery work full-time but at reduced responsibility, or part-time, but providing clinical activities (e.g., co-lead a group) code as "3."

3. Team services and supports are available 24 hours per day and 7 days per week.

Rationale: An immediate response can help minimize distress when persons with severe mental illness are faced with crisis. When the CST directly provides crisis intervention, continuity of care is maintained.

Sources of Information:

Notes, Staff Schedules

- Review progress notes to determine if crisis services are being provided by agency staff.
- Review staff schedules to determine if 24 hour coverage is being provided by qualified clinicians.

Team Lead Interview

- Are all services and supports available 24-hours per day, 7 days per week?
- How do you manage the schedule to accomplish this?

Clinician Interview

- Are all services and supports available 24-hours per day, 7 days per week?
- How do you manage the schedule to accomplish this?

Item Response Coding: If the program provides 24-hour coverage directly, the item is coded as a "5." This relates to who handles/responds to the crisis, not who answers the phone. Do not count crises for which the CST program staff was not made aware that they occurred.

4. CST services shall occur during times and at locations that reasonably accommodate the needs of persons receiving CST for services in community locations and other natural settings and at hours that do not interfere with the individual's work, educational and other community activities.

This is about being flexible according to the needs of persons receiving CST, not necessarily only during normal business hours. The team accommodates the person's needs and do not expect the person to work around staff schedules or agency hours. For example, if the individual works in the morning, he/she is able to have appointments in the afternoon.

Sources of Information:

Interview of Person Served

- How often do staff meet with you and schedule appointment times that are convenient for you?

- Do you meet staff at other places besides the office?

Mental Health Assessments (may include consumer preferences)

Item Response Coding: If the program consistently accommodates the needs and preferences for services of persons served, the item is coded as a "5."

5. **A minimum of 60% of all CST contacts must be delivered in natural settings and out of the provider's offices. This requirement will be monitored in the aggregate for a provider for an identified billing period, but will not be required for each person served.**

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

Sources of Information*:*

Data Run

- Data run done by the Collaborative prior to the site visit.
- The data run identifies the percentage of services provided on-site and off-site and is based on claims for a four (4) week period of time, six (6) months prior to the date the run was completed. Assurance that the greatest number of claims can be found in the system (have been submitted and processed) can be achieved by looking at the period of time 6 months prior to the review.

Item Response Coding:

If at least 60% of total service time occurs off-site, the item is coded as a "5."

6. Documentation shall demonstrate a variety of team members providing a variety of services according to the team member's expertise and based on the individual needs of persons receiving CST.

Multiple staff members with differing expertise provide services to each person served. The intent is not that one staff person provides multiple services. The expectation for needing CST is that persons receiving this service need a broader array of services than one individual can provide.

Sources of Information:

Notes and Assessments

- Remember to use the most complete and up-to-date time period from the chart. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation. Data should be taken from the last two full calendar **weeks prior to the fidelity visit (or the most recent two-week period available** in the charts if the records are not current). Count the number of different CST members who have had a face-to-face contact with persons served during this time. Determine the percentage of individuals who have received services from more than one team member in the two-week period.

Item Response Coding: Use chart review as the primary data source. Determine the number of different staff who have provided services for each person served. For example, if > 90% of persons served received services from more than one case manager in a two-week period, the item would receive a "5."

7. Do persons receiving CST know how to access staff after normal business hours?

Persons receiving CST are able to identify crisis numbers and other sources for staff contact after hours.

Sources of Information:

Interview of Person Served

- If you needed help after the agency was closed, how do you contact someone?
- Have you ever had to contact staff in the evenings or on the weekend? How did you do that?

Item Response Coding: If person served is able to clearly identify how to contact provider after hours, score item 5.

8. Staff involves persons receiving CST (and family) in assessment, treatment planning and service delivery

Sources of Information:

Progress Notes and ITP Signatures

Staff Interviews

- "Among individuals with whom you have had at least one contact with their family in the last month, how frequently does the team include them in assessment, treatment planning and service delivery?"
- "How involved are persons served in the assessment and treatment planning process?"
- "Do you often include family members in counseling/therapy, skills building and case management activities?"

Item Response Coding: When individuals and family are consistently shown to have active participation, item is scored a 5. When only occasional quotes are used and sporadic family involvement is demonstrated, score a 3. There is no requirement to involve family if the person doesn't want them involved.

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9. Persons receiving CST (and family) feel they are involved in assessment, treatment planning and service delivery

Persons receiving CST are able to describe how they and their family are actively involved with services. Individuals are not solely signing treatment plan as involvement.

Sources of Information:
Progress Notes

Interview of Person Served

- "Describe how staff involves you and your family (if preferred) in assessment, treatment planning and service delivery."
- "Have you or your family helped to develop your treatment plan?"
- "Does staff ask you your opinion on how your services are progressing, what you want to accomplish or how you feel about the services you receive?"
- "Does your family ever have sessions with you?"
- "Does your family ever speak with staff?"

Item Response Coding: Persons receiving CST can provide consistent and multiple examples of involvement in services and planning, along with family members (if they prefer) are coded as 5. Individuals who can provide a few examples of participating in assessment, treatment planning and service delivery, along with their family (if they prefer) is coded as a 3. There is no requirement to involve family if the individual doesn't want them involved.

10. There is evidence that the Crisis Plan is used and modified as needed.

There is a Crisis Plan in place and modifications to it are evident as changes occur. Changes may include the development of new skills, change in symptoms, changing preferences, of persons receiving CST.

Sources of Information:
Crisis Plans and Progress Notes

Crisis Plans may be titled different things at different providers. Ask providers how they document the crisis plan

Item Response Coding: A review of documentation demonstrates Crisis Plans have been modified as symptoms change, needs evolve or skills have been learned and generalized. Consistent evidence of modification would result in score of 5. In the event that the team is doing a good job and few, or no individuals end up in crisis and Crisis Plans do not get used due to lack of need, mark a "5".

11. In the past year treatment planning and services were individualized and appropriate to the person's level of need.

Sources of Information:

Assessments, Progress Notes and Treatment Plans

Item Response Coding: A review of documentation demonstrates that the needs of persons receiving CST which were addressed in the assessment process have been authorized by ITP and involved in service delivery. Individual needs are clearly identified and being addressed.

12. Does the Treatment Plan include goals/objectives to help the person build and make use of natural supports?

Examples:

- "Individual will work to identify and utilize food pantries in his/her area".
  Then see notes that they are going to food pantries.

- "Staff will help individual to identify 12-step meetings in his/her area that are easily accessible with public transportation".

Sources of Information:
Treatment Plan and Progress Notes

Item Response Coding: A review of documentation demonstrates consistency in addressing natural supports in ITP/ITP Reviews and would result in score of 5.

13. The service consists of therapeutic interventions delivered by a team that facilitates:

- Illness Self-Management
- Skill Building
- Identification and Use of Natural Supports
- Use of Community Resources

Sources of Information:
Progress Notes

Item Response Coding: A review of documentation demonstrates all four types of therapeutic interventions are provided in service delivery by various members of the team. This would result in score of 5.

14. Does the discharge/transition plan change as symptoms change?

A discharge/transition plan is more than an objective.

Sources of Information:
Discharge and Transition Plan, Crisis Plans, Progress Notes

The Discharge/Transition Plan may be located on the Treatment Plan rather than being a separate document. It may not be titled "Discharge/Transition Plan". Ask staff where this information is maintained.

Item Response Coding: Documentation that demonstrates that revisions to Plans occurred as symptoms occurred would result in score of 5. If the records reviewed reflect that that there has not been a change in symptoms and therefore there wasn't a need to change the Discharge Plan, score as a "5".

15. Records support the specified LOCUS Score category "Risk of Harm".

While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for oneself, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner.

Other factors may be considered in determining the likelihood of such behavior such as; past history of dangerous behaviors, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past.

Sources of Information:
LOCUS Tool, Progress Notes, Assessments and Treatment Plans

Item Response Coding: A review of documentation demonstrates consistency across scores, assessments and treatment plans and would result in score of 5.

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16. Records support the specified LOCUS Score category "Functional Status".

This dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care**.**

Sources of Information:
LOCUS Tool, Progress Notes, Assessments and Treatment Plans

Item Response Coding: A review of documentation demonstrates consistency across scores, assessments and treatment plans and would result in score of 5.

17. Records support the specified LOCUS Score category "Co-Morbidity".

This dimension measures potential complications in the course of illness related to co-existing medical illness, substance use disorder, or psychiatric disorder in addition to the condition first identified or most readily apparent.

Sources of Information:
LOCUS Tool, Progress Notes, Assessments and Treatment Plans

Item Response Coding: A review of documentation demonstrates consistency across scores, assessments and treatment plans and would result in score of 5.

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18. Records support the specified LOCUS Score category "Recovery Environment – Stress".

This dimension considers factors in the environment that might be a factor in the onset of or impact the recovery of mental illness. Multiple stressors may be seen and could include such things as relationship difficulties, loss of work, loss of health, death of a loved one, financial difficulties, inability to find work, and could also include "happy" stressors such as marriage, obtaining a job, getting a pet, receiving financial resources, moving into a new home, etc.

Sources of Information:
LOCUS Tool, Progress Notes, Assessments and Treatment Plans

Item Response Coding: A review of documentation demonstrates consistency across scores, assessments and treatment plans and would result in score of 5.

19. Records support the specified LOCUS Score category "Recovery Environment – Support".

This dimension considers factors in the environment that may support a person's efforts to achieve or maintain mental health and role functioning despite potential stressful situations that may be occurring. Types of supports can include such things as having positive relationships with family, community members, friends, etc. and can also include having resources to basic needs.

Sources of Information:
LOCUS Tool, Progress Notes, Assessments and Treatment Plans

Item Response Coding: A review of documentation demonstrates consistency across scores, assessments and treatment plans and would result in score of 5.

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20. Records support the specified LOCUS Score category "Treatment and Recovery History".

This dimension of the assessment recognizes that a person's past experience provides some indication of how that person is likely to respond to similar circumstances in the future. While it is not possible to codify or predict how an individual person may respond to any given situation, this scale uses past trends in responsiveness to treatment exposure and past experience in managing recovery as its primary indicators.

Sources of Information:
LOCUS Tool, Progress Notes, Assessments and Treatment Plans

Item Response Coding: A review of documentation demonstrates consistency across scores, assessments and treatment plans and would result in score of 5.

21. Records support the specified LOCUS Score category "Engagement and Recovery Status."

This dimension of the assessment considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process. Factors such as acceptance of illness, stage in the change process, ability to trust others and accept assistance, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in defining the measures for this dimension.

Sources of Information:
LOCUS Tool, Progress Notes, Assessments and Treatment Plans

Item Response Coding: A review of documentation demonstrates consistency across scores, assessments and treatment plans and would result in score of 5.