# Community Support Team

Fidelity Scale Instructions

Purpose: to Shape Mental Health Services Toward Recovery

Revised: 4/16/08

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The purpose of this tool is to assess the degree to which a Community Support Team is performing in a manner consistent with the desires of DHS/DMH for best practice that incorporates evidence-based interventions and practices while operating within Illinois Rules and contracts.

CST Fidelity monitoring will use a variety of methods to ascertain a measurement of the Team's current practice: clinical records reviews, staff interviews, and interviews with consumers (and sometimes family members) are primary methods. This tool will focus in three main areas: Rule 132 requirements, Contract Attachment B requirements, and Practice Improvement areas. For FY 2008, only one Practice Improvement area is measured: Consumer (and Family as applicable) Participation.  Additional practice improvement areas will be incorporated in future years.

The Fidelity Review will result in a score for each CST in Illinois. Each team can then incorporate the results into their own practice improvement methodology. The aggregate reviews for all CST's will be used by DHS/DMH and the Collaborative to inform technical assistance and training needs. Each CST will participate in a Fidelity Review at least annually.

Each Fidelity Review is expected to look at a random selection of 20 records or 20% which ever is the lowest. These consumer records will be selected for services in a 60-day period and include and interview with staff members of the CST, the Team Leader, and consumers who are members of the CST as appropriate. Family members may also be interviewed. Some items may require reports from billing records. (Sources of information are in small print following the description of the criterion.

Training instructions include:

- Overview of CST services
- Overview of the Scale
- What is rated
- analysis
- How rating is done using the review tool
- Who does the rating
- Missing data

- Before the site visit
- During the site visit
- After the site visit
- CST Review tool

## <u>Overview of  Community Support Team Services</u>

Community Support Team is recovery and resiliency oriented, intensive, community-based rehabilitation and outreach.  It is team-based and consists of mental health rehabilitation interventions and supports necessary to assist the recipient in achieving and maintaining rehabilitative, resiliency and recovery goals. Community Support Team is designed to meet the educational, vocational, residential, mental health, co-occurring disorders (MH/SA, MH/DD, MH/Medical), financial, social and other treatment support needs of the recipient. Interventions are provided primarily in natural settings, and are delivered face to face, by telephone, or by video conference with individual recipients and their family/significant others to the primary well-being and benefit of the recipient. Community Support Team assists in the development of optimal developmentally appropriate community living skills, and in setting and attaining recipient (and family in the case of children) defined recovery/resiliency goals.  It is available 24 hours per day, 7 days per week.  A team-based approach to services must be documented in the clinical record, including the ITP.

In addition, agency policy, staff training and program structure will:

1. Promote the individual's active participation in decision making and self advocacy in all aspects of services and recovery.
2. Support recovery and resilience activities, including assisting the individual to identify strengths, which may assist in recovery/resiliency and how to use them; and identification of barriers to recovery/resiliency and how to overcome them.
3. Assist in developing strategies and supportive interventions for achieving placement in the least restrictive setting.
4. Assist in building and maximizing family/significant other support skills.  Such assistance must primarily be for the well-being and benefit of the individual.
5. Encouraging the identification of existing natural supports and the development and eventual succession of natural supports in all aspects of life.  Assisting the individual to build a natural support team for treatment and recovery.
6. Educate, train and assist in the development of the individual's strengths, resources, preferences, and choices including such examples as the development of crisis contingency and Wellness Recovery and Action Plans (WRAP plans) .
7. In conjunction with the individual, family / significant other (if applicable) identify risk factors related to relapse in mental health and/or co-occurring disorders, and develop strategies and plans to prevent relapse.
8. Assist in the development of interpersonal, family and community coping, and functional skills (including adaptation to home, school, family and work environments) when the acquisition of those skills is impacted negatively by the individual's mental illness.

The goal of Community Support Team services is to

- Serve as a step down for individuals transitioning from more intensive or restrictive levels of care, or for those with psychiatric hospitalizations/repeated detoxification incidence in the past 18 months who are at risk of out of home placement.
- Provide support to recipients to decrease hospitalizations and crisis episodes and increase community tenure/independent functioning.
- Increase time working, in school or with social contacts; and personal satisfaction and autonomy.
- Serve as a step up from less intensive levels of care when those interventions have not succeeded in meeting the individual's clinical and rehabilitative needs through clinical interventions and supports based on identified, individualized needs.
- Assist the recipient to reside in independent, semi-independent, or family living arrangements and be engaged in the recovery/treatment process.
- Provide specific, measurable, and individualized mental health rehabilitation interventions to each person served through the reduction and management of symptoms and the development of stability and independence.

## Overview of the Scale

The CST fidelity scale has 17 program items for review in FY08. The scale has been developed to measure the adequacy of CST program implementation. Each item for individual records is scored as a "yes" or "no" depending on if there is evidence of the criterion in the individual record. The aggregated data is then rated on a scale ranging from 1 (not implemented) to 5 (fully implemented). The standards used to rate the fully implemented items were derived from Rule 132 service definitions, stake holder workgroups that included consumer and provider participation.

## What is Rated

The scale ratings are based on current behavior and activities, not on planned or intended behaviors. For example on item A2, if the staffing to consumer ratio exceeds 18:1 and the plan is increase the number of teams, this would be a "no", on the individual record score tool and be rated as a 1 on the aggregated data analysis. If the ratio of consumer to staff is at 18:1 this would be a "yes" on the individual record score sheet and a rated as a 5 on the aggregated data analysis.

## Analysis

The scale measures fidelity at the team and agency level depending on the item. In this first year of CST services, it is important to identify a baseline for future reviews and shaping of services that reflect the organizational structure and vision along with the individual team contribution to services provided.

## How rating is done using the review tool

To be valid, a fidelity assessment should be done in person, i.e., through a site visit. The fidelity assessment requires a minimum of 6 hours to complete, although a longer period of assessment will offer more opportunity to collect information; hence, it should result in a more valid assessment. The data collection procedures include chart review, team meeting observation, information about home visits, and semi-structured interview with the team leader. Clinicians who work on the CST teams are also valuable sources of data. Data may be obtained through other sources (e.g., supervisors, consumers) as appropriate.

Some items require calculation of either the mean or the median value of service data (e.g., median number of community-based contacts); specific administration instructions are given as needed for individual items (see below).

For some items that require chart review, the intent is to use charts selected at random. Some processes for random selection are suggested below; assessors should feel free to use whatever method is most convenient or practical for the particular visit.

- Prior to site visit, request the team leader to provide list of consumer charts from these charts, reviewer selects 20 or 20% which ever is less at random.
- Center provides a de-identified list of clients (i.e., ID numbers) and the assessors use random selection to choose
- It is important to select the most representative sample of charts; if a team assigns clients to different levels of service intensity, the sample should reflect this (e.g., a team with 30% of its clients on Level 1, 60% of clients on Level 2, and 10% on Level 3, 30% of reviewed charts should come from Level 1 clients, 60% of reviewed charts from Level 2, and so on).

## Who Does the Ratings

The Collaborative staff will administer the individual scores based on the fidelity review tool for each record selected. It is important for the ratings to be made objectively, based on hard evidence, rather than made to "look good." In this first baseline review some agencies will be chosen to self review and to assure that objectivity in ratings. This can be done by having a staff person who is not centrally involved in providing the service designated as the reviewer. With regard to external reviews, there is a distinct advantage in using assessors who are familiar with the program, but at the same time are independent. The goal in this process is the selection of objective and competent and trained reviewers.

The Collaborative staff designated to conduct this fidelity review will have through and intense training on the use of the review tool, training in interviewing and data collection procedures (including chart reviews). In addition, reviewers will have an understanding of the nature and critical ingredients of CST. Fidelity assessments will be conducted by at least two reviewers in order to increase reliability of the findings. The scores on each individual review will be entered into an access data base. The data base is programmed to calculate the percentage of individual reviews that met the fidelity standards on a scale of one to five (1-5).

## Missing Data

The score sheets are designed to be filled out completely, with no missing data on any items. It is essential that reviewers obtain the required information for every item. It is critical that raters record detailed notes of responses given by the interviewees. If information cannot be obtained at the time of the site visit, it will be important for the reviewers to collect it at a later date.

## Before the Fidelity

## Site Visit

**A cover sheet** will identify where the specific reviews will be completed, along with general descriptive information about the site. The sheets may need to be tailored for the individual agencies.

**A timeline for the fidelity review** with coordination of efforts and communication between reviewers and agencies will be established. All of the necessary activities and information will be identified leading up to and during the visit. Reminder calls can included as part of the site visit preparation.

**A contact person at the program will be identified**. This person will arrange and assist the Collaborative team to communicate beforehand the purpose and scope of the review, to the program staff. Typically this will be the CST team leader. Scheduling will occur in advance, respecting the competing time demands on clinicians, etc.

**The team will develop a shared understanding of the fidelity assessment.** The fidelity review team will communicate to each program site the goals of the fidelity assessment; assessors will inform the program site about who will see the report, whether the program site will receive this information, and exactly what information will be provided. The most successful fidelity reviews are those in which there is a shared goal among the reviewers and the program site to understand how the program is progressing according to evidence-based/best practice principles.

**The Collaborative will indicate what is needed from respondents during the fidelity visit**. In addition to the purpose of the assessment, there will be a brief description of what is needed, who the assessor will need to speak with, and how long each interview or visit will take to complete. The fidelity visit will be most efficient if the team leader gathers in advance as much as possible of the following information:

- Roster of CST staff – (roles, full-time equivalents (FTEs))
- Staff vacancies each month for last 6 months (or as long as program has existed, if less than 6 months)
- Number of staff who have left the team over the last six months (or since program

started if less than 6 mos old)

- A written description of the team's admission criteria
- Roster of CST clients
- Number of clients with dual disorders
- Number of clients admitted to CST program, per month, for last six months
- How many clients have terminated from the program in the last 6 mos, broken down in these categories:
    - Graduated (left because of significant improvement)
    - Left town
    - Closed because they refused services or team cannot find them (documented intense efforts to locate)
    - Deceased
    - Other (explain)
- List of all clients so that 20 records or 20% can be randomly selected for review. Of this number, an equal amount

    will be selected based on:
    - last clients admitted to psychiatric hospital
    - last clients discharged from psychiatric hospital
- Number of clients living in supervised group homes
- Number of clients for whom the CST team contacts their informal support network (e.g., family member, landlord, etc.) at least once. (Helpful for team leader to have a list of names at the time of interview.)

The fidelity review can be conducted, even if not all of the above information is available. Some information is more critical (e.g., staffing and number of active clients).

**The reviewer will need to observe at least one team meeting during the visit and/or review the team meeting minutes of the prior months minutes ( up to the past 3 months if CST was in place).**
This is an important factor in scheduling the assessment visit to the program.

**There will need to be a sample of 20 charts or 20% for review the assessor.**
 It is preferable from a time efficiency standpoint that the charts be drawn beforehand, using a
random selection procedure. The goal is to have a shared understanding of what the assessor is
needing in order to understand how a program is implementing services.

### During the Fidelity Site Visit

Use the same terminology as the agency during the interview process. For example, if the site uses the term "member" for consumer, use that term. If "practitioners" are referred to as

clinicians, use that terminology. Every agency has specific job titles for particular staff roles. By adopting the local terminology, the assessor will improve communication.

During the interview, record the names of all relevant programs, the total number of consumers, and the total number of clinicians.

Obtain a random sample of charts:
- Obtain a list of consumers. From this list, randomly select 20 records or 20%, which ever is lower. One appropriate method is to examine the roster of client names. Divide the number of clients by 10 and round down. Suppose there are 65 clients, then the number would be 6. Starting at an arbitrary name, select every 6th name on the roster.
- If the caseload is known to be stratified, for example if the team uses a level of care system in which every client is classified, and if this level of care is related to intensity of services, then a preferred sampling method is to stratify the sample according the level of care. Example: Suppose the team has 50 Level 1, 30 Level 2, and 20 Level 3 clients. Then select 5 Level 1, 3 level 2 and 2 level 3 clients, using a random sampling strategy.
- In some cases, there may be a lag between when a service is rendered and when it is documented in the client's chart. When sampling chart data, try to gather data from the most recent time period where documentation is completed in full to get the most accurate representation of services rendered. The most up-to-date time period might be ascertained by asking the team leader, clinicians, or administrative staff. The point is to avoid getting an inaccurate sampling of data where office-based services (e.g., nurse's visits or weekly groups) might be charted more quickly than services rendered in the field (e.g., Case manager progress notes).

If discrepancies between sources occur, query the team leader to get a better sense of the program's performance in a particular area. The most common discrepancy is likely to occur when the Team leader interview gives a more idealistic picture of the team's functioning than do the chart and observational data. The chart review may show that client contact takes place largely in the office; however, the team leader may state that the clinicians spend the majority of their time working in the community. To understand and resolve this discrepancy, the reviewer may say something like, "Our chart review shows xx% of client contact is office-based, but you estimate the contact at yy%. What is your interpretation of this difference?"

Before you leave, check for missing data. It is a good idea to check in with the program leader at the end of the visit to review and resolve any discrepancies if possible.

**After Your Fidelity Site Visit**

At the end of the second day of reviews, a brief summary of findings will be verbally shared with the program lead. This is not intended to be a complete discussion of the findings but rather a highlight of significant ratings with an emphasis on the strengths of the program.

If necessary, follow up on any missing data (e.g., by phone calls or email to the program site). This would include a discussion with the team leader about any discrepancies between data sources that arise after the visit has been completed.

Assuming there are two reviewers, *both* should independently rate the fidelity scale. The reviewers should then compare their ratings and resolve any disagreements. Come up with a consensus rating.
 Tally the item scores and determine which level of implementation was achieved (See Score

Sheet).

A follow up letter will be sent to the site. In most cases, this letter will include a fidelity report, explaining to the program their scores on the fidelity scale and providing some interpretation of the assessment, highlighting both strengths and weaknesses. The report should be informative, factual, and constructive. The recipients of this report will vary according to the purposes, but would typically include the key administrators involved in the assessment.

 If the future it may be possible to provide a visual representation of a program's progress over time by graphing the total fidelity
scale using an EXCEL spreadsheet, for example. This graph may be included in the fidelity report.