FACT Staff Training Guide

Understanding the Florida Assertive Community Treatment Model

and Recovery-Oriented Service Delivery

January 2026

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Purpose and Intent

This training guide equips all Mental Health Resource Center (MHRC) FACT team members—regardless of role or discipline—with the knowledge, skills, and philosophical foundation necessary to deliver Florida Assertive Community Treatment (FACT) services with fidelity to the evidence-based ACT model. It serves as both an orientation resource for new staff and a reference tool for experienced team members seeking to deepen their understanding of FACT principles and practices.

The intent of this guide is to ensure every FACT staff member understands:

- **What makes FACT unique:** How FACT differs fundamentally from traditional case management and outpatient mental health services through its team-based, community-centered, assertive engagement approach
- **The "can-do" philosophy: Why** recovery-oriented, strengths-based, problem-solving attitudes are essential to FACT's effectiveness and participant outcomes
- **Fidelity requirements:** How daily operations, documentation, team structure, and service delivery must align with ACT/FACT fidelity standards to meet contractual obligations and achieve positive outcomes
- **Regulatory alignment**: How FACT integrates with DCF Guidance 16, AHCA Medicaid Covered Services Policy, TJC accreditation standards, and CCBHC certification requirements
- **Your role in the team:** How each discipline contributes to the shared caseload model and transdisciplinary integration that defines FACT

Understanding these distinctions is not merely academic—it directly impacts decision-making, participant recovery, housing stability, employment success, hospitalization rates, and MHRC's compliance with Florida contractual obligations.

This guide empowers you to deliver the highest quality FACT services that transform lives and strengthen communities.

Section 1: What Is a FACT Program?

1.1 Definition and Purpose

Florida Assertive Community Treatment (FACT) is a self-contained, team-based mental health service delivery model designed to provide comprehensive, community-based treatment to adults (18+) with serious mental illness who are at high risk for hospitalization, incarceration, or housing instability despite availability of traditional community services.

FACT is NOT a traditional outpatient clinic. FACT is an intensive, assertive, recovery-oriented program where a multidisciplinary team functions as a fixed point of accountability for directly providing the majority of an individual's treatment, rehabilitation, and support services.

Core Program Goals

1. Implement with fidelity to the Assertive Community Treatment (ACT) model
2. Promote and incorporate recovery principles in all service delivery
3. Eliminate or reduce symptoms of serious mental illness and co-occurring substance use
4. Meet basic needs and enhance quality of life
5. Improve socialization and develop natural supports
6. Support competitive employment
7. Reduce hospitalization and unnecessary crisis episodes
8. Increase days lived in the community
9. Divert from or minimize criminal justice involvement
10. Strengthen parenting skills and family relationships
11. Reduce dependence on family members for care provision

1.2 Key Distinctions: FACT vs. Traditional Community Mental Health Services

FACT differs from traditional outpatient mental health services in fundamental ways:

Characteristic	FACT	Traditional Case Management
Service Location	75%+ in community (home, street, natural settings)	Office-based or clinic referrals
Team Composition	Multidisciplinary team provides integrated services directly	Individual case manager coordinates referrals
Continuity Model	Shared caseload; whole team knows each participant	Individual case manager with limited team backup
Service Intensity	Flexible; ranges weekly to multiple daily contacts matched to need	Typically predetermined frequency or service limits
Hours of Operation	24/7/365 availability (12 hrs weekdays, 8 hrs weekends minimum; 24/7 on-call)	Standard business hours or limited after-hours
Duration	Services scaled to changing needs; not lifelong but individualized	Often time-limited or episodic
Responsibility	Entire FACT team is fixed point of accountability	Case manager primarily responsible for linkage
Approach	Assertive, proactive, "can-do" outreach and engagement	Typically responsive to consumer initiative
Service Array	Direct provision of psychiatric, nursing, peer support, vocational, substance abuse, rehabilitation services	Brokerage model; coordination of services from other agencies

1.3 FACT Staffing and Team Composition

MHRC operates FACT teams with minimum staffing ratios of 10:1 participant-to-direct-service-staff. Each FACT team includes:

Required Roles

- **Team Leader (1.0 FTE)** -- Clinical, administrative, supervisory responsibility; licensed clinician providing services 50%+ of time
- **Psychiatrist or Psychiatric APRN** -- Minimum 0.32 hours per participant per week; medication management, psychiatric consultation, medical monitoring
- **Registered Nurse (minimum 1.0 FTE)** -- Medication system management, health monitoring, coordination with medical providers
- **Peer Specialist (1.0 FTE, certified)** -- Lived experience expertise; integrated team member promoting self-determination
- **Substance Abuse Specialist (1.0 FTE)** -- Integrated co-occurring disorder treatment
- **Vocational Specialist (1.0 FTE)** -- Supported employment services per IPS model
- **Case Manager (minimum 1.0 FTE)** -- Rehabilitation, support functions, skills training, ongoing assessment
- **Administrative Assistant (1.0 FTE)** -- Non-clinical operations, scheduling, participant support

Key Feature: Unlike traditional programs where a single case manager holds individual responsibility, FACT operates with shared caseload responsibility. While each participant has a designated primary case manager for coordination, all team members maintain responsibility for engagement, service delivery, and continuity of care.

Section 2: The ACT Fidelity Model and Florida Compliance

2.1 What Is ACT Fidelity?

Assertive Community Treatment (ACT) is an evidence-based, recovery-oriented model developed in the 1970s specifically for individuals with the most serious mental illnesses. ACT fidelity refers to adherence to the core principles and operational standards that make ACT effective.

FACT is Florida's adaptation of the ACT model, designed to:

- Maintain ACT's evidence-based elements and rigor
- Add structured flexibility for upscaling and downscaling services
- Serve a broader range of individuals with serious mental illness (not just the most severely impaired)
- Support transition to less intensive services when appropriate

Florida Guidance 16 and AHCA FACT Medicaid Covered Services Policy require MHRC to operate FACT with fidelity to these core ACT elements.

2.2 Core ACT Fidelity Elements

1. Team Approach

- Transdisciplinary team model where staff from multiple disciplines (psychiatry, nursing, social work, peer support, vocational rehabilitation, substance abuse treatment) function as an integrated unit
- Shared caseload: All team members are responsible for all participants; services are not divided by individual staff member assignments
- Daily organizational meetings to review participants, coordinate contacts, and adjust service plans
- Regular treatment planning meetings where all staff contribute to holistic care coordination

2. Fixed Point of Accountability

- The FACT team (as a unit) is the primary provider and fixed point of accountability for planning, coordinating, delivering, and documenting services
- Avoids fragmentation of care across multiple providers
- Maintains clear responsibility for continuity even during staff transitions
- Coordinates with external providers while retaining clinical leadership

3. Community-Based Service Delivery

- Minimum 75% of all services and supports delivered in community settings (participants' homes, streets, workplaces, natural community locations)
- Services follow participants to where they naturally spend time
- In vivo service delivery (services provided where problems occur) supports skill development and real-world application
- Office-based contacts limited to necessary coordination activities or participant preference

4. Assertive Engagement and Outreach

- Assertive outreach to recruit from high-risk settings (hospitals, correctional facilities, shelters, crisis units)
- Ongoing assertive engagement for participants showing signs of disengagement
- Services are voluntary but assertively offered; engagement emphasis rather than service refusal
- Proactive contact; does not wait for participant-initiated requests

2.3 The Florida FACT Model: Upscaling and Downscaling

Key Difference Between ACT and FACT:

Traditional ACT requires individuals to transition out of the program once they achieve a certain level of functioning. FACT introduces structured flexibility through upscaling and downscaling:

- **Downscaling:** As participants stabilize and gain independence, the team reduces service intensity and frequency, moving toward transition to less intensive services
- **Upscaling:** If a participant experiences decompensation, housing instability, or crisis risk, the team rapidly increases contacts and intensity
- **Same team throughout:** Unlike traditional ACT, the same multidisciplinary team provides both intensive and less intensive services, allowing continuity without provider transitions

Section 3: The "Can-Do" Approach and Recovery-Oriented Service Delivery

3.1 Understanding the "Can-Do" Approach

Defining the "Can-Do" Approach

The "can-do" approach is an explicit, core characteristic of FACT service delivery identified in Florida Guidance 16. It represents a fundamental mindset and operational philosophy that distinguishes FACT from traditional case management.

The can-do approach means:

1. Assertive Problem-Solving Orientation

- Staff approach challenges with the assumption that problems can be solved or mitigated
- Focus on "how can we make this work?" rather than "this won't work"
- Creative, flexible responses to barriers
- Proactive identification of solutions before crises emerge

2. Strengths-Based and Recovery-Focused

- Emphasis on participant strengths, abilities, and aspirations—not just deficits or symptoms
- Recovery is the primary goal, not just symptom management or maintenance
- Recognition that people with serious mental illness can work, live independently, have relationships, pursue education, and contribute meaningfully to their communities
- Expectations for progress and improvement, not resignation to chronic disability

3. Flexible, Individualized Responses

- Service type, frequency, and location determined by individual need, not preset limits
- Willingness to provide services in unconventional settings or times if clinically necessary
- Adaptation of evidence-based practices to individual circumstances, preferences, and culture
- No predetermined caps on number of contacts or duration of treatment

4. Assertive Outreach and Persistence

- Staff initiate contact rather than wait for participant requests
- Multiple attempts to engage disengaged participants without giving up
- Persistence through setbacks, relapses, or temporary non-engagement
- Meeting participants where they are (literally and figuratively)

5. Relationship-Centered Engagement

- Recognition that therapeutic relationships are built over time through repeated, positive interactions
- Trust-building emphasis; acceptance of small steps toward engagement
- Willingness to "meet alongside" participants in their communities and activities
- Valuing connection and presence as core interventions

Practical Examples of "Can-Do" Thinking

Scenario 1: Housing Support

Traditional Case Management Approach:

- Referral to housing agency or landlord hotline
- Case manager provides phone number
- If participant doesn't follow up, discharge from program
- "Housing barriers are not our responsibility; we've given them the resource"

FACT "Can-Do" Approach:

- Team member accompanies participant to view apartments
- Assist with application process, negotiate with landlords, address credit issues
- Provide move-in assistance, support landlord relationship
- Monitor housing stability; intervene proactively at first signs of problems
- Continue support indefinitely as needed

Scenario 2: Employment Support

Traditional Case Management Approach:

- Referral to vocational rehabilitation program
- Case manager documents referral
- If participant doesn't engage with VR, case management responsibility completed
- "Participant not motivated for employment; discharge not ready"

FACT "Can-Do" Approach:

- Vocational specialist conducts in-depth vocational assessment in community settings
- Identifies specific job interests and matches to actual employer opportunities
- Develops relationships with local employers
- Intensive job coaching, often staying on job site with participant
- Sustained follow-along support indefinitely; adjustments as needed
- Continues engagement even if participant cycles through multiple jobs

3.2 Philosophical Underpinnings: Recovery Principles

The "can-do" approach is grounded in recovery principles that guide all MHRC FACT work:

- **Hope and Possibility** -- Belief that recovery and positive change are possible, even after serious psychiatric crises
- **Personal Responsibility** -- Participants are active agents in their recovery, not passive recipients
- **Meaningful Roles** -- Connection to work, education, family, spirituality, and community participation
- **Community Involvement** -- Recovery happens in natural community settings with natural supports, not in clinical environments
- **Peer Support** -- Lived experience and peer relationships are healing and empowering
- **Cultural Competence** -- Respect for individual and cultural differences in how recovery is defined and pursued
- **Self-Determination** -- Participants' choices and preferences are paramount; shared decision-making is expected

3.3 "Can-Do" Approach in Daily FACT Practice

In Daily Team Meetings

Team members arrive at morning meeting with this orientation:

- "What do we need to accomplish for this person today?"
- "What barriers might emerge, and how can we address them proactively?"
- "What strengths or resources hasn't this person accessed yet?"
- "How can we increase community integration this week?"

In Treatment Planning

The team asks:

- "What does recovery look like from this person's perspective?"
- "What goals matter most to them?"
- "What would enable them to move toward those goals?"
- "What supports and services do we directly provide vs. coordinate?"

In Engagement

Staff demonstrate can-do approach through:

- Showing up reliably, even when participants are disengaged or resistant
- Reframing setbacks as learning opportunities, not failures
- Celebrating small wins and progress
- Modeling belief in possibility

In Service Delivery

Teams exhibit can-do approach by:

- Adapting services to individual preferences and circumstances
- Providing services at times and locations convenient to participants
- Problem-solving barriers to participation
- Finding creative solutions within resource constraints

Section 4: Why FACT Is NOT Case Management

4.1 Fundamental Philosophical Differences

Case Management and FACT are often confused because both involve coordination of care. However, they are distinct service models with different philosophies, structures, and outcomes.

4.2 Case Management: Definition and Function

Case Management is a coordination and brokerage model where an individual case manager:

- Assesses client needs across life domains
- Plans by identifying needed services and resources
- Coordinates by connecting clients to external providers
- Monitors to ensure services are delivered and adjusted
- Advocates for client access to services and supports

4.3 FACT: Integrated Service Delivery Model

FACT is fundamentally different:

- Team-based provision of comprehensive services, not coordination of external referrals
- Direct delivery by multidisciplinary staff for majority of services
- Shared caseload responsibility rather than individual assignment
- Intensive engagement based on relationship, not service coordination
- Flexibility in service type, frequency, location, and duration based on individualized need
- Assertive outreach and engagement, not waiting for client request
- Community-based delivery (75%+), not office-centered
- No service limits or predetermined time frames

4.4 Structural Comparison

Structural Element	Case Management	FACT
Staff Ratio	1 case manager to 50-100+ clients	1 direct service staff to 10 participants
Service Location	Office, phone, external provider offices	Community (75%+)
Service Provision	Referral/coordination to external providers	Direct provision by team members
Engagement Model	Primarily response to client request	Assertive outreach and proactive engagement
Caseload Structure	Individual assignment	Shared team responsibility
Service Intensity	Limited by case manager availability; predetermined contacts	Flexible; matched to individual need
Backup/Coverage	Limited; depends on case manager availability	Full team coverage; multiple staff relationships
Time Frame	Often time-limited or episodic	Continuous, individualized; transition-oriented

4.5 FACT's "Case Management" Role vs. Traditional Case Management

Important Note: FACT does include a Case Manager position (1.0 FTE minimum per team). However, the FACT Case Manager's role is fundamentally different from traditional case management.

FACT Case Manager Responsibilities

- Primary coordination contact for individual participants
- Rehabilitation and support functions (skills training, ADL coaching, community living support)
- Ongoing assessment and reformulation of problems
- Service coordination within the team (ensuring all needed services are provided)
- Advocacy and natural supports development

Section 5: FACT Fidelity and Florida Contractual Requirements

5.1 Regulatory and Contractual Framework

MHRC operates FACT in compliance with:

1. DCF Guidance 16: Florida Assertive Community Treatment (FACT) Handbook -- Establishes clinical, operational, and administrative standards for FACT service delivery
2. AHCA FACT Medicaid Covered Services Policy -- Defines reimbursable FACT services and coverage criteria
3. Managing Entity Contracts -- Central Florida Cares Health System, Lutheran Services of Florida Health Systems, and Central Florida Behavioral Health Network contractual requirements
4. TJC Accreditation Standards -- Quality, safety, and compliance standards for behavioral health organizations
5. CCBHC Certification Requirements -- Comprehensive Community Behavioral Health Center standards
6. Florida Medicaid Managed Care (SMMC 3.0) -- Statewide managed care requirements effective February 1, 2025

5.2 Why Fidelity Matters: Contractual and Compliance Perspective

MHRC's failure to operate with fidelity to FACT/ACT creates risk in multiple areas:

Financial Risk

- Non-compliant service delivery may result in claim denials or recoupment by Medicaid
- Managing Entity monitoring may identify fidelity gaps, triggering corrective action or contract violations
- Failure to document services with required standards may result in audit findings

Compliance Risk

- TJC accreditation reviews FACT fidelity; deficiencies may impact accreditation status
- CCBHC certification requires demonstration of ACT model compliance; loss of certification impacts funding
- Managing Entity monitoring includes specific FACT fidelity review processes
- Department of Children and Families (DCF) oversight of state-contracted behavioral health services

Clinical and Outcome Risk

- Departure from ACT model reduces program effectiveness
- Lower fidelity correlates with worse participant outcomes (more hospitalizations, less employment, housing instability)
- Non-fidelity compromises evidence-based practice, potentially exposing MHRC to liability
- Inconsistent service delivery damages engagement and therapeutic relationships

5.3 FACT Fidelity Assessment and Monitoring

DCF and Managing Entities monitor FACT fidelity through:

1. Service Delivery Documentation Review

- Are 75%+ of services in community settings?
- Are contacts documented with location, modality, purpose, and clinical linkage?

- Are daily team meetings documented?
- Are treatment plans recovery-oriented and participant-centered?

2. Staffing and Team Organization

- Does team meet minimum composition and FTE requirements?
- Are staff roles aligned with position descriptions and fidelity standards?
- Is psychiatric availability at minimum 0.32 hours per participant per week?
- Do ratio standards meet 10:1 participant-to-direct-service-staff?

3. Contact Frequency and Intensity

- Does each participant receive minimum 1 contact per week?
- Is the team meeting average 3 contacts per week across caseload?
- Is intensity matched to individual need and risk?
- Are contacts escalated for participants showing decompensation signs?

4. Community-Based Service Delivery

- Are participants engaged in employment/education/community roles?
- Are assessments complete and recovery plans person-centered?
- Is transition planning integrated throughout?
- Are natural supports being developed?

5. Crisis and Hospital Coordination

- Is 24/7 crisis response available?
- Are team members maintaining engagement during hospitalizations?
- Are discharge planning processes documented?
- Is follow-up intensity appropriate post-discharge?

MHRC's compliance depends on every staff member understanding these standards and implementing them consistently in daily practice.

Section 6: Best Practices for Delivering FACT with Fidelity

6.1 Daily Operations Aligned with FACT/ACT Principles

Daily Team Meetings: The Foundation of FACT

Daily organizational team meetings are non-negotiable FACT practice. These meetings serve to:

Clinical Functions:

- Review each participant's status from past 24 hours
- Identify participants needing same-day outreach or crisis response
- Assess for early warning signs of decompensation
- Discuss hospitalization, emergency use, legal involvement, housing changes
- Problem-solve barriers to engagement or treatment progress

Operational Functions:

- Maintain centralized participant census and assignment tracking
- Create daily staff assignment schedule based on weekly plans and emerging needs
- Track which contacts are completed and which need follow-up
- Assign responsibilities for administrative and coordination tasks
- Adjust schedules as clinically indicated

Quality and Fidelity Functions:

- Ensure shared team knowledge of all participants
- Maintain accountability for contact completion
- Coordinate across disciplines (psychiatric, nursing, vocational, substance abuse)
- Identify and address staff gaps or coverage needs
- Document organizational processes per fidelity standards

6.2 Person-Centered Recovery Planning

Effective FACT recovery planning:

1. Begins with participant strengths, goals, and preferences

- "What matters most to you?"
- "What are your strengths and abilities?"
- "What does recovery look like from your perspective?"
- Avoid leading questions or predetermined goals

2. Includes participant and natural supports

- Active participation, not passive attendance
- Family/significant others involved with consent
- Participant decision-making capacity respected
- Preferences and choices documented and honored

6.3 Transdisciplinary Team Integration

Transdisciplinary means staff from multiple disciplines work as a single unit, not as separate specialists:

- **Shared knowledge** -- All staff understand all participants' needs across domains
- **Integrated planning** -- Each discipline contributes to holistic planning, not siloed treatment
- **Cross-training** -- Staff learn from each other; psychiatrist teaches symptom management, vocational specialist teaches work readiness, etc.
- **Flexible service provision** -- Services are provided by whoever is best positioned to help, not only by specialists
- **Unified decision-making** -- The team decides collaboratively; no discipline dominates

6.4 Coordination with External Systems

FACT maintains team integrity while coordinating effectively with external providers:

Internal Coordination (across MHRC programs)

- Liaison with inpatient units for discharge planning
- Coordination with crisis services
- Access to outpatient psychiatric services
- Connection to medical services
- Housing resources
- Administrative and pharmacy support

External Coordination (without diminishing team responsibility)

- **Hospitals and emergency departments** -- Maintain engagement during hospitalizations; participate in discharge planning
- **Medical providers** -- Support access; coordinate care; monitor medication interactions
- **Housing providers and landlords** -- Advocate for participant rights; problem-solve housing issues
- **Employers** -- Support job placement and maintenance
- **Educational institutions** -- Support enrollment and engagement
- **Correctional facilities and legal system** -- Participate in reentry planning; advocacy
- **Medicaid managed care plans** -- Coordinate ancillary services (medical, pharmacy) while retaining behavioral health leadership

Section 7: Key Performance Expectations for FACT Staff

7.1 Essential Competencies for All FACT Staff

All FACT team members are expected to demonstrate:

Recovery-Oriented Practice

- Genuine belief in recovery possibilities
- Strength-based language and approach
- Participant choice and self-determination support
- Hope-fostering interactions

Assertive Engagement and Relationship-Building

- Comfort with community-based, in vivo service delivery
- Ability to engage persistently, even with resistant participants
- Skill in building trust and therapeutic relationships
- Comfort with flexibility and unconventional approaches

Transdisciplinary Collaboration

- Respect for other disciplines' expertise
- Willingness to learn from colleagues
- Contribution to team decision-making
- Shared responsibility for all participants, not just assigned caseload

Culturally Competent and Trauma-Informed Practice

- Understanding of cultural differences in mental health, recovery, and family roles
- Sensitivity to histories of trauma
- Bias awareness and mitigation
- Linguistic competence or access to interpretation

Documentation and Clinical Accuracy

- Complete, timely documentation of services
- Clear linkage of services to recovery plan goals
- Accurate location, modality, and time documentation for fidelity compliance
- Adherence to medical record standards and confidentiality

Flexibility and Problem-Solving

- Creative responses to barriers and challenges
- Willingness to adapt evidence-based practices to individual circumstances
- "Can-do" mindset; seeking solutions rather than barriers
- Comfort with ambiguity and evolving situations

7.2 Team Leader Responsibilities

Team Leaders carry primary responsibility for fidelity and quality:

- **Daily team meeting facilitation** -- Ensuring all required components are addressed
- **Contact completion monitoring** -- Tracking which contacts are completed; addressing delays or missed contacts
- **Coaching and feedback** -- Real-time feedback to staff on fidelity, documentation, engagement

- **Problem-solving** -- Addressing barriers to fidelity or service delivery
- **Staff supervision and development** -- Supporting staff skill development in assertive engagement, person-centered planning, integrated treatment
- **Psychiatric coordination** -- Working with psychiatrist on medication issues, treatment planning, participant outcomes
- **Documentation review** -- Ensuring documentation meets standards and supports fidelity
- **Participant assessment** -- Ongoing evaluation of individual progress, risk, and need for service intensity adjustment
- **Performance data monitoring** -- Tracking team metrics (contact frequency, community-based %, hospitalization, employment, housing) and identifying improvement areas
- **Managing Entity liaison** -- Responding to monitoring requests, corrective action plans, performance data requirements

Section 8: Common Fidelity Challenges and Solutions

8.1 Challenge: Drifting Toward Office-Based Service Delivery

Problem: Over time, teams may gradually shift toward office-based services due to scheduling ease, weather, or perceived efficiency, drifting from the 75% community-based requirement.

Why It Matters: Office-based services reduce engagement, skill application in real settings, and community integration. This is a frequent monitoring finding.

Solutions:

- **Track service location data** -- Graph location of services monthly; identify trends
- **Team leader monitoring** -- Daily review of assigned locations in team meeting
- **Intentional scheduling** -- Schedule community-based contacts first; office contacts fill remaining time
- **Transportation support** -- Ensure transportation is not a barrier to community-based service
- **Creative community locations** -- Identify natural settings where participants spend time; use those as service locations
- **Participant preference documentation** -- Document any office-based contacts with clinical justification

8.2 Challenge: Insufficient Contact Frequency

Problem: Teams miss minimum 1-contact-per-week standards or the 3-contact-per-week team average, often due to staffing issues, competing priorities, or documentation lags.

Why It Matters: Contact frequency is a core FACT fidelity element. Low frequency correlates with hospital readmission and poor outcomes.

Solutions:

- **Daily team meeting accountability** -- Explicitly review contact completion by participant
- **Contact frequency targets** -- Set individualized contact goals at treatment planning
- **Flexible service delivery** -- Use phone/telehealth when appropriate to supplement in-person contacts
- **Staffing coverage** -- Ensure adequate coverage for vacations, illness, training
- **Documentation timeliness** -- Don't let documentation lag; document contacts same day when possible
- **Intensity matching** -- Ensure contacts are matched to need; a high-functioning participant might intentionally receive 1 contact/week, while a high-risk participant receives daily contacts

8.3 Challenge: Loss of Shared Caseload Model

Problem: Teams drift toward individual responsibility, where one staff member becomes "the" provider for a participant and other team members are unaware of status or needs.

Why It Matters: Shared caseload is foundational to FACT. Loss of shared responsibility creates vulnerability (staff turnover, sick leave impacts participant), reduces service quality, and compromises fidelity.

Solutions:

- **Structured daily meetings** -- Deliberate review of each participant; all staff contribute knowledge

- **Cross-coverage expectations** -- All staff trained and prepared to serve any participant, not just "assigned" cases
- **Flexible service assignments** -- Deliberately assign services to different team members to prevent solo responsibility
- **Peer mentor relationships** -- Newer staff paired with experienced staff for shared learning
- **Documentation accessibility** -- Ensure all staff can quickly access participant information
- **Coverage planning** -- Proactively plan for staff leave; ensure other staff are prepared

8.4 Challenge: Symptom Focus vs. Recovery Focus

Problem: Teams focus planning and services on "managing symptoms" or "preventing decompensation," inadvertently adopting a maintenance rather than recovery mindset.

Why It Matters: The "can-do" approach requires genuine belief in recovery—not just symptom management. This fundamental shift in mindset affects every team interaction.

Solutions:

- **Language awareness** -- Audit team language; shift from "managing mental illness" to "pursuing recovery goals"
- **Goal-setting practices** -- Ensure recovery plans include goals beyond symptom management (employment, relationships, education, community involvement)
- **Participant aspiration discussion** -- Regularly ask "What would success look like for you?" not just "What symptoms are bothering you?"
- **Training and development** -- Regular discussions on recovery principles, lived experience perspectives, what recovery means
- **Celebrating progress** -- Highlight employment wins, housing stability, community participation, relationship improvements, not just absence of symptoms

8.5 Challenge: Assertive Engagement vs. Respecting Autonomy

Problem: Staff may avoid assertive outreach because they worry about being "pushy" or disrespecting participant autonomy. Conversely, some staff may become too controlling or directive.

Why It Matters: Assertive engagement and respect for autonomy are not opposites; they're complementary. FACT requires both: staff persistently offer services while honoring participant choices.

Solutions:

- **Motivational interviewing training** -- Staff development in how to invite engagement without coercion
- **Transparent about boundaries** -- Clear communication about what FACT can and cannot do
- **"Meeting alongside" practice** -- Engaging in activities the participant values, even if they don't directly relate to treatment
- **Shared decision-making** -- Participants have real choice in treatment goals and methods
- **Cultural humility** -- Recognizing staff's own values/biases; adjusting approach to participant's perspective
- **Persistence without pressure** -- Multiple outreach attempts accepted as normal; "no" today doesn't mean "never"

Section 9: Integrating CCBHC Standards and TJC Requirements

9.1 CCBHC Comprehensive Services Requirements

As a CCBHC, MHRC commits to providing or accessing comprehensive services including:

- 24/7 crisis services (crisis intervention, mobile crisis, crisis stabilization)
- Intensive care coordination and case management
- Psychiatric services and medication management
- Peer support services
- Family and caregiver support
- Co-occurring disorder treatment (mental health + substance use)
- Employment and education support
- Trauma-informed care
- Care coordination for medical and behavioral health

FACT teams contribute to CCBHC comprehensiveness by directly providing many of these services (case management, psychiatric services, peer support, co-occurring disorder treatment, employment support). FACT is positioned within the broader CCBHC to ensure intensive support for the most complex individuals.

9.2 TJC Standards in FACT Context

TJC accreditation focuses on:

- **Governance and leadership** -- Clear organizational structure, accountability, quality oversight
- **Clinical competence** -- Staff qualifications, training, supervision; evidence-based practice
- **Patient safety** -- Protocols for medication management, crisis response, suicide prevention, infection control
- **Quality and performance** -- Data monitoring, outcome measurement, improvement activities
- **Communication and coordination** -- Documentation, discharge planning, continuity
- **Rights and responsibilities** -- Informed consent, confidentiality, grievance processes

FACT compliance with TJC standards includes:

- Clear FACT policy and procedure manual (MHRC maintains comprehensive FACT Manual, Sections 2100.0-2115.0)
- Staff competency demonstration (credentialing, training, supervision documentation)
- Clinical documentation meeting standards (assessment, treatment planning, progress notes, discharge documentation)
- Performance data tracking (contact frequency, community-based %, outcomes, fidelity metrics)
- Monitoring and quality improvement activities (Advisory Committee review, fidelity assessment, staff feedback, performance coaching)
- Risk management and incident reporting (medication errors, adverse events, grievances)

FACT Policy Manual (Sections 2100.0-2115.0)

Comprehensive operational standards addressing:

- 2100.0 -- FACT Program Description and Model Overview
- 2101.0 -- FACT Staffing, Service Coverage, Psychiatric Availability
- 2102.0 -- FACT Team Role Expectations and Staffing Compliance Monitoring
- 2103.0 -- FACT Program Organization
- 2104.0 -- FACT Eligibility Admission Determination
- 2105.0 -- FACT Referral, Access, Pre-Enrollment Engagement
- 2106.0 -- FACT Enrollment Admission Procedures
- 2107.0 -- FACT Transition Discharge Planning
- 2108.0 -- FACT Discharge, Transfer, Re-Enrollment Procedures
- 2109.0 -- FACT Assessments Clinical Evaluation
- 2110.0 -- FACT Recovery Planning Integration with Team Services
- 2111.0 -- FACT Scope Provision of Services
- 2112.0 -- FACT Advisory Committee
- 2113.0 -- FACT Outcome Measures
- 2114.0 -- FACT Reporting Requirements
- 2115.0 -- FACT Fidelity Review and Quality Improvement