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Mental Health Program

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WYOMING

FY 2015-16 (Year 2)

Evidence Based Practices

Fidelity Project

Quality Improvement Report

Submitted to Mercy Maricopa Integrated Care

June 2016

Introduction

In January 2014, a key part of the *Arnold vs. Sarn* settlement agreement was a stipulation that the Arizona Department of Health Services (ADHS) would provide training to providers throughout Maricopa County on the four evidence-based practices of Assertive Community Treatment (ACT), Supported Employment (SE), Consumer Operated Services (COS), and Permanent Supportive Housing (PSH), in order to improve services by more closely adhering to fidelity protocols established by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). ADHS and the Western Interstate Commission for Higher Education – Mental Health Program (WICHE) contracted consultant David Lynde, a national expert in the four SAMHSA evidence-based practices, to provide training, implementation support, and overall guidance for the project.

As an official kick-off for the two-year project in Maricopa County, David Lynde presented a three-day training in early February, 2014, for ADHS staff, Regional Behavioral Health Authority (RBHA) representatives, local service providers, and community members. This training provided a broad overview of the four EBP models and the respective fidelity tools that would be used to measure implementation and adherence to the models. David also explained the fidelity review process that began in July, 2014. Following the initial training, early efforts focused on analyzing the project scope. A review of the final provider census was key in determining staffing requirements and developing a project timeline to achieve deliverables. The overarching goal was to assemble a qualified fidelity review team that was prepared to begin fidelity reviews in July, 2014, within SAMHSA protocol guidelines. Fortunately, the composition of the fidelity review team has remained unchanged during year two (2). The team continues to consist of four staff based in Arizona, supervised by the WICHE project manager Mimi Windemuller of Colorado, with travel as needed to provide on-site assistance. ADHS (transferred in 2016 to the Arizona Health Care Cost Containment System – AHCCCS) Project Manager Kelli Donley continues to provide oversight as needed.

The review team developed strong working relationships early on, which contributes to the efficiency and success of their work. Bi-weekly team conference calls occur with the ADHS/AHCCCS and WICHE project managers, as well as other training calls with EBP expert consultants as necessary. A true team dynamic has evolved with all of the staff.

Project Implementation

Project management worked with ADHS to develop an oversight and approval process for conducting the fidelity reviews that was acceptable to the plaintiff's attorneys from the *Arnold* suit. Plaintiffs required that third-party consultants sign off on fidelity reviews for the first year of the project; however, this was not a requirement during this second year. However, WICHE continued to contract with the same consultants used during year one: David Lynde is lead consultant and primary contact for ACT; Ann Denton from Advocates for Human Potential (AHP) is main contact for PSH, and Laurie

Curtis from AHP is contact for COS. During Year 2, Pat Tucker of AHP was brought in by WICHE to provide some consultation to the SE providers. Each consultant has extensive experience with SAMHSA and the respective EBP fidelity toolkits.

All EBP materials developed for year one of the project, including fidelity scales, review interview guides, scoring protocols and forms, fidelity report templates, provider notification and preparation letters, etc. continued to be used during year two. Applicable documentation was consolidated from the SAMHSA toolkits and reorganized for specific use with the fidelity review team.

The entire fidelity review process continues to accommodate the project scope and timeline, with guidance from the SAMHSA toolkit protocols:

- The team prepares all provider correspondence with necessary data collection tools to accurately conduct reviews across 4 EBPs, while allowing adequate time for both providers and reviewers to prepare. Preparation letters are the first point of contact between the review team and providers.
- Reviews are conducted in two teams of two reviewers. Each team has a lead reviewer in charge of preparation correspondence, provider scheduling, and writing the report. The lead alternates for each review.
- Following the one-to-three day reviews, each team member completes individual scores, and the team then consolidates final consensus scores.
- A detailed fidelity report with scoring rationale and recommendations is drafted by the team. Following discussion and any needed input from respective expert consultant, the report with the fidelity scale score sheet is delivered to providers.
- A follow-up call with providers and RBHA is scheduled to discuss the review findings and answer questions regarding the report.

During training and preparation for fidelity reviews of each EBP, the team discovered that to adequately conduct reviews some adjustments were needed based on how the Arizona system is structured. For example, in the SE and PSH reviews, staff from the Provider Network Organization (PNO) clinics were included to collect appropriate information at the primary referral source for services. Also, it was determined that a representative from the RBHA be included in PSH reviews due to their role in maintaining the housing referral list. These practices continued during year two.

It was noted during year one regarding overall service provision, that the system appears to offer services to members based on what is available versus the members' preferences, which is a distinct difference from the intent of evidence-based practices. Going forward, members receiving services will benefit more if system structure and service options are embraced and prioritized instead of simply "adding on" these new EBPs to current offerings. Systemic efforts were initiated in year two to begin addressing this issue.

Administrative Simplification

In January 2015, Governor Ducey's budget was passed by the Arizona legislature. Within the budget, the Division of Behavioral Health Services was administratively simplified. As of July 1, 2016, all behavioral health services in Arizona, including the exit agreement and provisions of Arnold v. Sarn, were transferred to the Arizona Health Care Cost Containment System (AHCCCS).

FY 2016 Fidelity Review Schedule

The training schedule for year two was initially developed in May and finalized in June 2015. This included the elimination of the SE review of DK Advocates Supported Employment, due to contract termination, as well as the PSH reviews for Helping Hearts and Arizona Mentor, due to their house models not aligning with the evidence-based practice. Also, following the transition of the Circle the City ACT team to the Terros Dunlap clinic, the PSH review for Circle the City was canceled in May. The schedule was front-loaded with all reviews wrapping up by mid-May 2016 in order to allow adequate time for the fidelity review reports to be completed as well as the year two report by the end of the fiscal year, June 30, 2016. Due to the compression of review, the Interim Report included findings from the reviews conducted July – November 2015, and this final report includes all of the remaining fidelity review findings. The tables delineate the reviews completed before and after the Interim Report by a double line column separation. Reasonable efforts were made to conduct the reviews approximately 10 - 12 months after the initial review, to allow adequate time for performance improvement efforts to be implemented.

The provider census for FY 2016 included a total of 42 service providers and 48 reviews (some providers offer more than one EBP):

- 19 ACT
- 6 SE; and
- 6 COS
- 17 PSH.

As of 11/30/15, half of the provider reviews (24) were completed: 12 ACT, 4 SE, 3 COS, and 5 PSH. The remaining 24 reviews were completed from December 2015 through mid-May 2016.

Training and Technical Assistance

The three-pronged quality improvement approach initiated during FY 2015 continued during FY 2016. The three components of this approach include:

- Education;
- Training; and
- Technical assistance.

A meeting was held with MMIC EBP leadership and staff from EBP providers on September 11, 2015. This Annual Summary of SAMHSA Fidelity Reviews meeting was well attended by providers. During the meeting, fidelity review findings for each of the four EBPs were addressed. Providers were able to

see areas of strength as well as fidelity challenges, including how their agency compared with other agencies. Opportunities were available to educate the providers about the intent and expectations of the fidelity items. Additionally, providers were able to learn from each other about some specific practices they have in place that contribute to higher fidelity to the EBP models.

The fidelity staff continue to facilitate conference calls with providers to provide an overview of the fidelity findings and clarify any questions that arise. This process continues to be well-received by the providers and offers an opportunity for timely feedback and explanation of the basis for the findings.

On February 3, 2016, Laurie Curtis of Advocates for Human Potential (AHP) provided telephonic technical assistance and support to the Consumer Operated Services providers. Providers continue to do well with implementing these services and achieving good fidelity to the model.

Permanent Supportive Housing technical assistance was provided on February 24, 2016 by Ann Denton and Adam Kirkman of AHP. Challenges associated with choice of housing, documentation, incentive programs, eviction prevention and other topics were discussed. Participants agreed to initiate periodic meetings to improve collaboration and begin problem solving some common challenges.

David Lynde provided telephonic technical assistance to the ACT providers on February 25 and March 24, 2016. Discussions during these meetings included topics such as co-occurring disorders treatment; staffing retention; substance abuse and vocational specialists; clinical coordinators achieving 50% of their time providing direct services; clarification about the frequency of contacts; and the intensity of services.

Supported Employment technical assistance was provided by Pat Tucker of Advocates for Human Potential (AHP) telephonically on February 3, 2016, and in-person training occurred March 2 and June 9, 2016 with supported employment job developers. The trainings focused on sales/marketing techniques with participants role-playing with other staff, effective and efficient administrative paperwork management, and additional training to support fidelity to the model.

Additionally, the fidelity review team received technical assistance (TA) and support from the consultants on June 9, 2016. This TA was used to clarify discrepancies in how the models are interpreted, data collection and calculation techniques, and improvements to fidelity report recommendations.

Summary of Findings from the Fidelity Reviews

The data below indicate the findings from the FY 2016 fidelity reviews, of which 48 were completed for all identified current providers. The yellow and orange highlights indicate the opportunities for improvement, with orange being the greater opportunity. Areas of opportunity that are common across programs help identify potential systemic issues, technical assistance opportunities, including

areas in which program fidelity clarity may benefit multiple providers. Areas that are challenges for specific providers are also clearly identified in the tables and indicate opportunities for site-specific, fidelity-focused quality improvement interventions. These opportunities are identified for each of the evidence-based practices below following the data tables. For the providers that received fidelity reviews during FY 2015, the year-one summary data are provided at the end of each table. The full data tables for FY 2015 are included at the end of this report.

During the year, several provider changes occurred. Those changes and resulting clinical team transitions are noted below:

- Choices ceased operations July 31, 2015.
 - The Enclave, Townley, and West McDowell clinics transitioned to Terros.
 - The South Central clinic transitioned to Lifewell Behavioral Wellness.
- People of Color Network ceased operations September 30, 2015.
 - The FACT team at Comunidad clinic moved location and transitioned to Community Bridges Inc.
 - The Centro Esperanza clinic transitioned to Chicanos Por La Causa (CPLC).
 - Comunidad and Capitol clinics transitioned to La Frontera-EMPACT.
 - The Capitol ACT team moved to the Comunidad clinic.
- Circle the City ACT team transitioned to the Terros Dunlap clinic.
- Partners in Recovery (PIR) - Medical ACT (M-ACT) moved from Arrowhead to West Indian School.
- Mountain Health and Wellness merged with another agency to form Horizon Health and Wellness.
- Recovery Innovations Arizona rebranded as RI International.
- Southwest Behavioral Health rebranded as Southwest Behavioral & Health Services (SBHS).

Assertive Community Treatment (ACT) Fidelity Reviews Completed and Findings

Reviews completed July – November 2015

- ✓ Terros Enclave (previously Choices - Enclave)
- ✓ Southwest Network - Osborn Adult Clinic (SWN Osborn)
- ✓ Lifewell South Central (previously Choices South Central)
- ✓ Partners in Recovery (PIR) West Valley Adult Clinic
- ✓ Community Bridges, Inc. (CBI) Forensic (FACT)
- ✓ Chicanos Por La Causa (CPLC) Centro Esperanza (previously People of Color Network)
- ✓ Partners in Recovery (PIR) Metro Center Varsity

- ✓ Partners in Recovery (PIR) Metro Center Omega
- ✓ Southwest Network -- Hampton Clinic (SWN Hampton)
- ✓ Terros West McDowell (Terros W McD) (previously Choices)
- ✓ Southwest Network – San Tan (SWN San Tan)
- ✓ Southwest Network – Saguaro (SWN Saguaro)

Reviews completed December 2015 – May 2016

- ✓ Southwest Network – Bethany Village (SWN BV)
- ✓ La Frontera-EMPACT Comunidad (La FC) (previously People of Color Network (PCN))
- ✓ Terros Townley (previously Choices – Townley Center)
- ✓ Community Bridges, Inc. (CBI) Comunidad Forensic (FACT) (previously People of Color Network)
- ✓ Partners in Recovery (PIR) Arrowhead Medical Specialty ACT (M-ACT)
- ✓ La Frontera-EMPACT Capitol Center (La FCC) (previously People of Color Network)
- ✓ Circle the City

Assertive Community Treatment

ACT	Terros Enclave	SWN Osborn	Lifewell South Central	PIR West Valley	CBI FACT	Terros W McD	PIR Metro Varsity	PIR Metro Omega	SWN Hampton	CPLC Centro Esperanza	SWN San Tan	SWN Saguario	SWN BV	La FC	Terros Townley	CBI Com. FACT	PIR [M-ACT]	La FCC	Cir. the City
Human Resources																			
Small Caseload	4	4	5	5	5	5	5	5	4	4	5	5	4	4	5	5	5	5	4
Team Approach	3	3	5	5	4	5	3	3	5	2	4	3	5	3	5	5	5	3	2
Program Meeting	5	5	5	5	4	5	4	5	5	5	5	5	5	5	5	4	5	5	5
Practicing ACT Leader	3	3	2	3	3	3	2	3	3	2	3	1	3	2	2	3	3	3	4
Continuity of Staffing	3	3	2	3	4	3	3	4	4	2	4	4	3	3	2	1	4	2	1
Staff Capacity	5	4	4	4	4	4	4	4	3	3	3	3	4	5	4	5	3	3	3
Psychiatrist on Team	4	4	5	4	5	5	5	4	3	4	4	4	4	4	5	4	5	5	5
Nurse on Team	3	4	3	5	5	5	3	5	4	3	4	4	5	3	5	5	5	3	4
Substance Abuse Specialist on Team	3	3	5	5	4	5	4	5	1	5	1	3	3	3	5	3	2	4	1
Vocational Specialist on Team	5	1	2	5	4	5	3	4	3	3	2	4	3	4	5	2	3	3	1
Program Size	5	4	5	5	5	5	5	5	4	4	5	5	5	5	5	5	5	5	3
Organizational Boundaries																			
Explicit Admission Criteria	4	5	5	5	5	4	5	5	4	5	4	4	5	4	4	5	5	5	5
Intake Rate	5	5	5	5	4	5	5	5	5	5	5	1	5	1	5	4	5	5	5
Full Responsibility for Treatment Services	4	3	3	3	4	3	3	4	3	2	2	2	4	2	4	4	3	3	4
Responsibility for Crisis Services	5	5	5	5	5	5	5	5	5	4	4	4	5	4	5	5	5	5	5
Responsibility for Hospital Admissions	3	4	4	3	3	4	4	3	4	4	4	4	3	3	5	4	4	4	5
Responsibility for Hospital Discharge Planning	4	5	4	5	5	5	5	5	5	5	5	4	4	4	5	5	4	5	5
Time-unlimited Services	5	5	4	3	5	4	5	4	5	4	4	4	5	4	4	5	4	4	5

ACT	Terros Enclave	SWN Osborn	Lifewell South Central	PIR West Valley	CBI FACT	Terros W McD	PIR Metro Varsity	PIR Metro Omega	SWN Hampton	PCN Centro Esperanza	SWN San Tan	SWN Saguario	SWN BV	La FC	Terros Townley	CBI Com. FACT	PIR [M-ACT]	La FCC	Cir. the City
Nature of Services																			
Community-based Services	4	2	4	4	4	3	2	5	2	3	3	3	2	1	2	5	2	3	5
No Drop-out Policy	5	4	5	5	5	5	5	5	5	5	5	4	5	5	5	4	5	5	5
Assertive Engagement Mechanisms	5	5	5	5	5	5	4	5	5	5	5	4	5	4	5	4	5	4	5
Intensity of Service	2	2	2	4	3	2	2	2	4	2	3	3	2	3	2	5	5	2	2
Frequency of Contact	2	2	3	4	3	3	2	2	3	2	3	2	3	2	2	5	5	2	1
Work with Support System	2	2	3	3	3	3	2	3	2	2	3	2	4	1	2	2	3	2	2
Individualized Substance Abuse Treatment	2	1	3	2	4	3	1	4	2	3	2	2	4	2	2	4	3	3	4
Co-occurring Disorders Treatment Groups	3	2	2	3	3	2	2	2	2	2	2	2	2	2	3	2	1	2	3
Co-occurring Disorders/ Dual Disorders Model	2	2	3	2	4	3	2	4	3	3	2	2	4	2	3	4	4	3	4
Role of Consumers on Treatment Team	1	5	1	5	5	5	5	5	1	5	5	5	5	5	5	5	5	5	1
Year 2 Total Score	101	97	104	115	117	114	100	115	99	98	101	93	111	90	111	114	113	103	99
Total Possible (5 point Likert scale -all items)	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140
Percentage	72.1	69.3	74.3	82.1	83.6	81.4	71.4	82.1	70.7	70	72.1	66.4	79.3	64.3	79.3	81.4	80.7	73.6	70.7
Average	3.6	3.46	3.71	4.11	4.18	4.07	3.57	4.1	3.54	3.50	3.61	3.32	3.92	3.21	3.96	4.07	4.04	3.68	3.54
Year 1 Total Score	97	103	112	109	NA	112	111	98	114	90	110	NA	97	114	109	111	NA	81	NA
Total Possible (5 point Likert scale -all items)	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140
Percentage	69.3	73.6	80	77.9	NA	80	79.3	70	81.4	64.3	80	NA	69.3	81.4	77.9	79.3	NA	57.9	NA
Average	3.46	3.68	4	3.89	NA	4	3.96	3.5	4.07	3.21	3.93	NA	3.46	4.07	3.89	3.96	NA	2.89	NA

The fidelity team has noted the following:

- Less referrals are being made to outside providers, and there appears to be more awareness and focus on the integrated team approach with full responsibility of services.
- Staff are moving more toward an integrated co-occurring treatment approach.
- Staff contacts with members should be focused on meaningful clinical interactions, with the majority of contacts occurring in the community. Some staff focus on the frequency of contact, often resulting in brief interactions or contact with multiple staff when members are in the clinic setting, but less frequent contact with members in their communities.
- Specialists need ongoing training and guidance to work as experts in their areas of specialization, to enable them to cross train one another so the team can continue to provide the full spectrum of services if a specialist leaves the team or is unavailable. At least 90% of each service type should be provided by the team, with a focus on individualized treatment versus hosting groups at the clinics.
- Services delivered by the Clinical Coordinator (i.e., Team Leader) can be difficult to determine. Some agencies do not have tracking mechanisms to determine actual service time versus billable time documented to provide a service, or reports do not differentiate between face-to-face services with members and other activities (e.g., team staffing note).
- Some teams have adapted elements of co-occurring treatment to support members who experience substance use challenges. However, it is not clear if all staff on the teams are familiar with an integrated treatment approach, some seek outside resources or make up their own materials to use in group treatment, and there are staff who are unable to identify when medical detoxification is indicated.
- The transition of teams to different providers due to agencies ceasing operations or terminated contracts appears to affect continuity of care, and results in high staff turnover on those teams.

Assertive Community Treatment Quality Improvement Opportunities

The overall ratings for ACT fidelity reviews ranged from 64.3 to 83.6 with an average of 75.1 percent during Year 2, compared with 57.9 to 81.4 with an average of 74.8 percent during Year 1. Interestingly, some providers' fidelity scores showed increases of up to 15.7 percentage points, while others showed decreases of as much as 17.1 percentage points. It is notable that there has been an increase of 8.4 percentage points when comparing the lowest-rated providers from Year 1 to Year 2. Therefore, although a few providers have shown improved fidelity the aggregate ratings across all of the providers show negligible improvement.

ACT Fidelity Scores	Year 1	Year 2
Lowest Rating	57.9	64.3
Highest Rating	81.4	83.6
Overall Average	74.8	75.1

In the Human Resources domain, challenges remain in the areas of a Practicing Team Leader and Continuity of Staffing, followed by Substance Abuse and Vocational Specialists on Teams. There has been some improvement in the Substance Abuse Specialist being assigned to teams, however this continues to be problematic for a just over half of the providers.

Within the domain of Organizational Boundaries, two providers are not approaching fidelity in the area of Intake Rate, while the others received ratings representing full compliance with this, and four providers are not meeting fidelity in the area of Full Responsibility for Treatment Services.

The Nature of Services domain continues to be the most challenging for providers, and significant efforts are needed to address this. The areas that present the greatest opportunities for quality improvement across multiple sites include: provision of Community based Services, Work with Support Systems, Intensity of Services, Frequency of Contact, and availability of substance use related treatment and supports. Efforts to improve the fidelity of these areas will require the engagement of both leadership staff and the ACT team through focused practice changes as well as ongoing training and technical assistance. Deviations from these fidelity items jeopardize the treatment outcomes of the members served.

MMIC may want to develop processes and procedures that outline expectations of providers if ACT teams change provider agencies. For example, to provide guidance to providers on preferred thresholds for staff retention, and to update agency websites to reflect changes, primary contacts, where members can direct questions, etc.

Training focus to support continued quality improvement should include:

- Greater understanding of the components of the Nature of Services domain.
- Ongoing staff training in specific areas of specialization (Substance Abuse Specialists, Vocational Specialists, etc.)
- Additional training and ongoing supervision to support all ACT staff as they transition to an integrated treatment approach to work with members with co-occurring challenges, align appropriate interventions, and distinguish a stage-wise approach with stages of change.

Consumer Operated Services (COS) Fidelity Reviews Completed and Findings

Reviews completed July – November 2015

- ✓ Recovery Empowerment Network (REN)
- ✓ Center for Health Empowerment, Education, Employment and Recovery Services (CHEEERS)
- ✓ Stand Together and Recover Centers, Inc. (S.T.A.R.) - Central location

Reviews completed December 2015 – May 2016

- ✓ Stand Together and Recover Centers, Inc. (S.T.A.R.) - East location
- ✓ Stand Together and Recover Centers, Inc. (S.T.A.R.) - West location
- ✓ Vive La Esperanza – Hope Lives (Hope Lives)

Consumer Operated Services

COS	Likert Scale	REN	CHEERS	STAR Central	STAR East	STAR West	Hope Lives
Structure							
Board Participation	1-5	4	4	4	4	4	4
Consumer Staff	1-5	5	5	5	5	5	5
Hiring Decisions	1-4	4	4	4	4	4	4
Budget Control	1-4	3	4	4	4	4	3
Volunteer Opportunities	1-5	3	5	5	5	5	5
Planning Input	1-5	5	5	4	5	5	5
Satisfaction/Grievance Response	1-5	4	5	5	5	5	4
Linkage with Traditional MH Services	1-5	5	4	4	4	4	4
Linkage with other COS Programs	1-5	2	5	4	4	4	3
Linkage with other Services Agencies	1-5	5	5	3	5	5	5
Environment							
Local Proximity	1-4	4	4	4	3	3	3
Access	1-5	5	5	5	5	3	4
Hours	1-5	5	5	5	5	4	3
Cost	1-5	5	5	5	5	5	5
Reasonable Accommodation	1-4	3	4	4	3	3	3
Lack of Coerciveness	1-5	5	5	4	5	4	4
Program Rules	1-5	5	5	3	5	5	5
Physical Environment	1-4	4	4	4	3	3	2
Social Environment	1-5	5	4	4	5	5	5
Sense of Community	1-4	4	4	4	4	4	4
Timeframes	1-4	4	4	3	4	4	4
Belief Systems							
Peer Principle	1-4	4	4	3	4	3	4
Helper's Principle	1-4	4	4	4	4	4	4
Personal Empowerment	1-5	5	5	5	5	5	5
Personal Accountability	1-5	5	5	5	5	5	5
Group Empowerment	1-4	4	4	3	4	4	4
Choice	1-5	4	4	4	5	5	4
Recovery	1-4	4	4	4	4	3	4
Spiritual Growth	1-4	4	4	2	4	4	3

COS	Likert Scale	REN	CHEERS	STAR Central	STAR East	STAR West	Hope Lives
Peer Support							
Formal Peer Support	1-5	5	5	5	5	5	5
Informal Peer Support	1-4	4	4	4	4	4	4
Telling Our Story	1-5	5	5	3	4	4	4
Artistic Expression	1-5	4	5	4	5	4	4
Consciousness Raising	1-4	4	4	3	3	3	4
Formal Crisis Prevention	1-4	4	4	4	4	4	4
Informal; Crisis Prevention	1-4	4	4	3	4	4	4
Peer Mentoring and Teaching	1-4	4	4	4	4	4	4
Education							
Formally Structured Activities	1-5	4	5	3	5	5	5
Receiving Informal Support	1-5	5	5	5	5	4	5
Providing Informal Support	1-5	5	5	4	5	5	5
Formal Skills Practice	1-5	5	5	5	5	5	3
Job Readiness Activities	1-5	3	5	2	4	3	4
Advocacy							
Formal Self Advocacy	1-5	4	5	4	5	5	5
Peer Advocacy	1-5	5	5	4	5	5	5
Outreach to Participants	1-5	5	5	3	3	3	4
Year 2 Total Score		193	204	177	197	188	186
Total Possible		208	208	208	208	208	208
Percentage Score		92.8	98.1	85.1	94.7	90.4	89.4
Year 1 Total Score	208	199	187	166	179	166	187
Total Possible		208	208	208	208	208	208
Percentage Score		95.7	89.9	79.8	86.1	79.8	89.9

The fidelity team has noted the following:

- Centers are expanding their approach to Spirituality.
- As Consumer-Operated Services grow and expansion into more clinical/professional services is explored, it will be critical to ensure that the core philosophy for COS is not lost. That is, “All services are provided by and for members.”
- Members should be engaged by their programs to advocate in the broader community in addition to activities in the behavioral health treatment community.

Consumer Operated Services Quality Improvement Opportunities

The overall scores for the Consumer Operated Services sites that were reviewed were very good, with percentage scores ranging from 85.1 to 98.1 with an average of 91.7 percent in Year 2, compared with 79.8 to 95.7 with an average of 86.9 percent in Year 1, a difference of 4.8 percentage points.

COS Fidelity Scores	Year 1	Year 2
Lowest Rating	79.8	85.1
Highest Rating	95.7	98.1
Overall Average	86.9	91.7

Although staff of COSPs collaborate on occasion, it is not clear if collaboration is consistent or always reciprocated. A ‘community of practice’ approach would be beneficial in providing support to all of the providers. This collaborative approach would allow for staff to learn from each other’s practices and provide an avenue for shared problem solving for areas that are challenging for multiple agencies. Moreover, this approach could be facilitated through periodic conference calls with COS staff from each of the programs and an identified MMIC staff lead and WICHE staff to help clarify fidelity expectations and practices, while promoting some collaboration across sites. If indicated, it may be helpful for periodic conference calls to be attended by Laurie Curtis, a national expert in Consumer Operated Services, as occurred during Year 2.

Few programs have avenues for members to share information through their program websites, utilize social media, or have other targeted methods to engage sub-groups in the community (e.g., young adults). Engagement in these or similar efforts would enhance the current programs.

Supported Employment (SE) Fidelity Reviews Completed and Findings

Reviews completed July – November 2015

- ✓ Marc Community Resource’s Supported Employment (Marc CR)
- ✓ Focus Employment Services (Focus)
- ✓ Lifewell Behavioral Wellness Supported Employment (Lifewell)
- ✓ VALLEYLIFE Supported Employment (VALLEYLIFE)

Reviews completed December 2015 – May 2016

- ✓ Wedco Employment Center (WEDCO)
- ✓ Beacon Supported Employment (Beacon)

Note: DK Advocates Supported Employment (DK Advocates) was not a contracted provider in Year 2.

Supported Employment

SE 1-5 Likert Scale	Marc CR	Focus	Lifewell	VALLEYLIFE	WEDCO	Beacon
Staffing						
Caseload	5	5	5	5	5	5
Vocational Services Staff	5	4	5	5	5	5
Vocational Generalists	4	4	5	5	4	5
Organization						
Integration of rehabilitation with MH treatment	3	3	3	3	1	2
Vocational Unit	3	3	3	5	3	3
Zero-exclusion criteria	2	2	3	3	3	3
Services						
Ongoing work-based assessment	5	5	5	5	4	5
Rapid search for competitive jobs	5	4	4	4	4	4
Individual job search	5	3	4	4	5	4
Diversity of jobs developed	4	4	3	4	3	3
Permanence of jobs developed	5	3	5	4	4	4
Jobs as transitions	5	5	5	5	5	5
Follow-along supports	5	4	5	4	5	5
Community-based services	2	2	2	4	5	4
Assertive engagement and outreach	5	4	4	5	5	3
Year 2 Total Points	63	55	61	65	61	60
Total Possible	75	75	75	75	75	75
Percentages	84%	73.3%	81.3%	86.7%	81.3%	80%
Averages	4.2	3.7	4.1	4.3	4.07	4
Year 1 Total Points	41	58	57	51	47	51
Total Possible	75	75	75	75	75	75
Percentages	54.6%	77.3%	76%	68%	62.6%	68%
Averages	2.73	3.87	3.8	3.29	3.13	3.29

The fidelity team has noted the following:

- Clinics with co-located staff are more educated and supportive of the SE model, which provides faster processes and access to services for members.
- Clinics with co-located staff have improved communication with the clinical teams, moving toward better integration.
- Agencies are using the vocational profiles, and clinical staff are incorporating similar forms.
- Staff have reported positive feedback on useful training on the model.
- Some Employment Specialists do not provide the majority of services in the community, primarily submitting internet applications during employment searches.
- There are Employment Specialists who seem to rely on job fairs (some geared toward individuals with disabilities) or other narrow job search activities, impacting the diversity of jobs that are pursued and obtained.
- To prevent screening of members, or streaming of members to other avenues (e.g., work adjustment training) there should be continued collaboration with Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR) to support SE services, delivered in a timely fashion, focusing on goals identified by members on their service plans and vocational profiles.
- Though SE provider and clinic staff at co-located locations report a high level of coordination, SE providers often cite confidentiality concerns (i.e., HIPPA restrictions) that prevent full integration with clinic teams. As a result, Employment Specialists often do not attend full team meetings, only a portion of the meeting where members served or pending referral are discussed, potentially resulting in missed opportunities to suggest employment for other members served by clinic teams.
- Some Employment Specialists appear to address disclosure when they first work with members to develop the Vocational Profile, and it is not clear if the benefits of disclosure are fully vetted or revisited at subsequent contacts. As a result, follow along supports are often in the office, not on the job, or through phone contact, and few employers receive support through SE agencies.
- Vocational Profiles are filled out, but often contain limited information and do not appear to be updated as changes occur, status changes, etc. If goals change, addenda are completed, but other elements of the Vocational Profile may not be addressed or revised. It is not clear if all Employment Specialists refer back to the Vocational Profile during job searches.

Supported Employment Quality Improvement Opportunities

Opportunities to improve the fidelity of the Supported Employment programs continue across all sites; however, significant improvement is notable from Year 1 to Year 2. The overall ratings for the sites reviewed range from 73.3 to 86.7 percent in Year 2 compared with 50.6 to 77.3

percent in Year 1. The average percentage scores across sites for Year 2 was 81.2 percent compared with 67.8 percent for Year 1.

SE Fidelity Scores	Year 1	Year 2 Interim
Lowest Rating	50.6*	73.3
Highest Rating	77.3	86.7
Overall Average	67.8	81.2

* DK Advocates, which was not a program reviewed during Year 2.

Integration of rehabilitation with mental health treatment showed significant improvement across all sites. Zero exclusion continues to be an area for improvement across all sites. Readiness activities should not delay members from competitive, permanent employment in community integrated settings. A key part of evidence-based Supported Employment is collaboration among the agency, clinical teams and vocational rehabilitation, which is an opportunity to reduce exclusion from employment opportunities.

It is important that the majority of the services provided are in the community rather than in an office or clinic. For some reviews it was difficult to ascertain whether other member contacts occurred in the community or in the office. Additionally, documentation did not always clearly indicate whether employer contacts were made by phone or in person in the community. Ensuring documentation accurately reflects the services provided may improve some of the fidelity scores.

Given the improvements noted across all three fidelity domains of Staffing, Organization and Services, it appears that providers have a better understanding of the program model and have implemented structural or policy practices to improve fidelity. Additional training and technical assistance for service providers and clinical partners will be valuable in continuing to improve adherence to the Supported Employment model.

Training focus to support continued quality improvement should include:

- Continued training with clinic/treatment team staff to achieve full integration, and clarify HIPPA regulations so that services can be provided through integrated teams.
- Specific job development training for Employment Specialists and their supervisors is recommended, including: sales/marketing techniques, role-playing with other staff and supervisors, and shadowing other successful job developers in the field.
- Few supervisors report they carry caseloads. Further training with supervisors to clarify their role and expectations in providing SE services will be beneficial.
- Additional training is needed on the true purpose of the Vocational Profile, including recommended strategies from national experts. Most providers are completing the form

as a process but not effectively using it to assist with an individualized, strengths-based job search.

- Further consultation and training focusing on working with members to discuss disclosure so that Employment Specialists can offer a wider variety of follow along supports (e.g., on the job, support to employers).

Permanent Supportive Housing (PSH) Fidelity Reviews Completed and Findings

Reviews completed July – November 2015

- ✓ PSA Behavioral Health Agency (PSA)
- ✓ Terros Behavioral Health Agency (Terros)
- ✓ Arizona Health Care Contract Management Services, Inc. (AHCCMS)
- ✓ La Fontera – EMPACT (La F)- ACT teams (previously People of Color Network)
- ✓ Chicanos Por La Causa (CPLC) ACT team (previously People of Color Network)

Reviews completed December 2015 – May 2016

- ✓ Lifewell Behavioral Wellness (Lifewell)
- ✓ RI International (RI)
- ✓ Partners in Recovery (PIR) ACT teams
- ✓ Community Bridges Inc. (CBI)
- ✓ Community Bridges Inc. (CBI) ACT teams
- ✓ Southwest Behavioral & Health Services (SBHS) [previously Southwest Behavioral Health (SBH)]
- ✓ Lifewell Behavioral Wellness ACT team (previously Choices South Central)
- ✓ Southwest Network (SWN) ACT teams
- ✓ Child and Family Support Services, Inc. (CFSS)
- ✓ Terros ACT teams (previously Choices)
- ✓ Marc Community Resources (MARC)
- ✓ Horizon Health and Wellness (HHW) [previously Mountain Health and Wellness (MHW) and Superstition Mountain Mental Health Center (SMMHC)]

Permanent Supportive Housing

PSH	Scale	PSA	Terros	AHC-CMS	La F ACT	CPLC ACT	Life-well	RI	PIR ACT	CBI	CBI ACT	SBHS	Life-well ACT	SWN ACT	CFSS	Terros ACT	MA RC	HHW
Choice of Housing																		
Tenants have choice of type of housing	1,2.5 4	1	1	1	2.5	2.5	1	2.5	2.5	4	4	2.5	2.5	2.5	1	1	2.5	1
Real choice of housing unit	1,4	4	1	1	1	1	1	4	4	4	4	4	1	1	1	1	4	1
Tenant can wait without losing their place in line	1-4	4	3	3	3	3	3	4	3	4	4	3	4	4	3	3	4	3
Tenants have control over composition of household	1,2.5 4	4	2.5	2.5	2.5	2.5	2.5	4	4	4	4	4	2.5	2.5	2.5	2.5	4	2.5
Average Score for Dimension		3.25	1.88	1.88	2.25	2.25	1.88	3.63	3.38	4	4	3.38	2.5	2.5	1.88	1.88	3.63	1.88
Functional Separation of Housing and Services																		
Extent to which housing management providers do not have any authority or formal role in providing social services	1,2.5 4	4	4	4	2.5	2.5	2.5	4	2.5	4	4	4	2.5	4	4	4	4	2.5
Extent to which service providers do not have any responsibility for housing management functions	1,2.5 4	4	4	4	2.5	4	4	4	2.5	4	4	4	2.5	2.5	2.5	2.5	4	2.5
Extent to which social and clinical service providers are based off site (not at housing units)	1-4	4	2	4	3	3	4	4	4	4	3	4	4	3	1	3	4	4
Average Score for Dimension		4	3.33	4	2.67	3.17	3.5	4	3	4	3.67	4	3	3.17	2.5	3.2	4	3
Decent, Safe and Affordable Housing																		
Extent to which tenants pay a reasonable amount of their income for housing	1-4	1	2	2	1	1	4	4	1	3	2	2	3	2	1	3	1	2

PSH		Scale	PSA	Terros	AHC-CMS	La F ACT	CPLC ACT	Life-well	RI	PIR ACT	CBI	CBI ACT	SBHS	Life-well ACT	SWN ACT	CFSS	Terros ACT	MA RC	HHW	
Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1	2.5	1	1	1	1	4	4	1	2.5	1	1	1	1	4	1	1	2.5	
Average Score for Dimension		1	2.25	1.5	1	1	1	4	4	1	2.75	1.5	1.5	2	1.5	2.5	2	1	2.25	
Housing Integration																				
Extent to which housing units are integrated	1-4	4	1	4	3	3	3	1	4	3	4	3	4	2	3	1	2	4	1	
Average Score for Dimension		4	1	4	3	3	3	1	4	3	4	3	4	2	3	1	2	4	1	
Rights of Tenancy																				
Extent to which tenants have legal rights to the housing unit	1,4	1	1	1	1	1	1	4	4	1	1	1	1	1	1	4	4	1	4	
Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4	2.5	4	2.5	1	1	4	2.5	2.5	4	2.5	4	2.5	2.5	2.5	2.5	2.5	2.5	
Average Score for Dimension		2.5	1.75	2.5	1.75	1	1	4	3.25	1.75	2.5	1.75	2.5	1.75	1.75	3.25	3.25	1.75	3.25	
Access to Housing																				
Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	2	1	1	2	3	3	2	1	4	4	4	3	3	3	3	3	2	2	
Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	2.5	2.5	1	2.5	2.5	2.5	2.5	2.5	4	2.5	2.5	2.5	2.5	2.5	2.5	2.5	4	2.5	
Extent to which tenants control staff entry into the unit	1-4	4	2	4	2	4	4	4	4	3	4	3	4	3	3	2	2	3	2	
Average Score for Dimension		2.83	1.83	2	2.17	3.17	3.17	2.83	2.5	3.67	3.5	3.17	3.17	2.83	2.83	2.5	2.5	3	2.17	

PSH	Scale	PSA	Terros	AHC-CMS	La F ACT	CPLC ACT	Life-well	RI	PIR ACT	CBI	CBI ACT	SBHS	Life-well ACT	SWN ACT	CFSS	Terros ACT	MA RC	HHW
Flexible, Voluntary Services																		
Extent to which tenants choose the type of services they want at program entry	1,4	1	1	1	4	1	1	4	4	1	4	4	1	1	1	1	4	4
Extent to which tenants have the opportunity to modify services selection	1,4	4	4	1	4	4	4	4	4	4	4	4	4	1	4	1	4	4
Extent to which tenants are able to choose the services they receive	1-4	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Extent to which services can be changed to meet the tenants changing needs and preferences	1-4	4	2	4	3	3	4	4	3	4	4	3	3	3	4	1	3	3
Extent to which services are consumer driven	1-4	2	2	2	2	2	1	3	2	3	3	2	1	2	3	2	2	2
Extent to which services are provided with optimum caseload sizes	1-4	4	4	4	4	3	4	4	4	4	4	4	4	4	4	4	3	3
Behavioral health services are team based	1-4	2	2	2	4	2	2	2	4	2	3	2	3	4	3	4	2	3
Extent to which services are provided 24 hours, 7 days per week	1-4	3	3	3	4	4	4	4	4	3	4	4	4	4	4	4	2	1
Average Score for Dimension		2.87	2.63	2.5	3.5	3	2.88	3.5	3.5	3	3.63	3.25	2.88	2.75	3.25	2.5	2.86	2.88
Year 2 Total Score		20.5	14.7	18.4	16.3	16.3	20.1	24.9	19.3	23.8	20.7	21.8	16.9	17.5	16.9	17.3	20.2	16.4
Highest Possible Dimension Score		28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28
Percentage Score		73%	52.4%	65.5%	58.4%	58.4%	71.8%	88.9%	69%	85%	74%	78%	60.4%	62.5%	60.3%	61.8%	72.3%	59.7%

PSH	Scale	PSA	Terros	AHC-CMS	La F	CPLC	Life-well	RI	PIR ACT	CBI	CBI ACT	SBH	Life-well ACT	SWN	CFSS	Terros ACT	MA RC	HHW
Year 1 Total Score		12.3	13.7	13.1	15.1	15.1	15.8	20.7	16.0	NA	NA	13.9	15.8	14.8	13.3	15.8	19.2	14
Highest Possible Score		28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28
Percentage Score		43.9	48.8	46.7	53.9	53.9	56.4	74.1	57.0	67.1	49.6	49.6	56.4	52.9	47.5	52.9	68.6	50

The fidelity team has noted the following:

- Clinics appear to be doing less screening for housing readiness.
- Clinic staff are much more aware of housing options available, which supports member choice.
- Many staff report the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) is required when housing applications are submitted to MMIC, and they appear to be using it more often to prioritize those with the most challenges to housing. However, direct service staff are unable to provide detail regarding how MMIC manages waitlists to prioritize those members with more significant housing challenges.
- Housing service providers should attempt to obtain housing documentation (e.g., leases, HQS, rental information) so they can support tenancy by confirming members have rights as tenants, reside in settings that meet set standards, and ensure housing costs are affordable.
- Many agencies need to develop avenues for member control of services, including design and provision. Member input should be solicited on types of services and actual program development, such as member involvement in advisory councils that can direct services, participation in committees, or member involvement in quality assurance activities. Some agencies utilize member surveys, but multiple methods to track member satisfaction should be available.
- Housing service providers and clinical staff (other involved providers, if applicable) should hold regular meetings to coordinate services through an integrated team approach, not just ad hoc meetings when members are struggling.
- Referrals from some clinics are based on team screening, pre-assessment, level of care recommendations, based on availability (i.e., what option staff believe has the shortest waitlist). Tenants of some types of Regional Behavioral Health Authority (RBHA) affiliated housing don't have choice of units, choice of roommates and some must follow program rules to maintain their housing.
- If members are in RBHA affiliated housing they must maintain connection to the RBHA to maintain tenancy. Direct care service staff and tenants do not appear to be aware of provisions or processes that assist members with retention of their home (from a financial perspective) if they dis-enroll from MMIC.
- Some providers have worked to develop relationships with landlords and apartment management to increase housing options they can offer members, other programs have not cultivated these relationships or rely on half-way-houses or other unlicensed board and care homes as temporary residences.

Permanent Supportive Housing Quality Improvement Opportunities

The fidelity percentage scores ranged from 52.4 to 88.9 with an average of 67.7 percent compared with 43.2 to 74.1 with an average of 54 percent in Year 1. There has been significant improvement in these fidelity scores, and it is notable that the average from Year 1 to Year 2 has increased by 13.7 percentage points. In an effort to better identify areas for improvement, for this Year 2 report items receiving a 2.5 rating are highlighted. These items were not highlighted in the Year 1 tables in an effort to avoid overwhelming providers and to offer them some time to gain a better understanding of the fidelity expectations.

PSH Fidelity Scores	Year 1	Year 2 Interim
Lowest Rating	43.2*	52.4
Highest Rating	74.1	88.9
Overall Average	54.0	67.7

* This provider was not reviewed during Year 2.

Significant systemic issues continue to impede fidelity to the PSH model; however, MMIC began engaging in a housing redesign effort during FY 2016 to begin identifying and developing a plan to address some of these issues. Beyond redesign efforts, opportunities exist to improve the fidelity of the Permanent Supportive Housing programs across all sites. These opportunities include education for leadership staff to gain a better understanding of the program model and to explore any structural or policy practices that may inhibit better fidelity to the model.

Additional quality improvement opportunities include:

- Increased transparency on housing support waitlist management, member prioritization, waiting timeframes, etc. so referring service staff can provide the information to members if requested.
- System development of transitional living opportunities. For example, opportunities may exist for the development of member run respite housing support services.

Also, continued training and technical assistance for service providers and community partners will be beneficial in improving adherence to the PSH model and identifying specific quality improvement opportunities. Specific education and training for direct care clinic staff will also be beneficial. Additional training opportunities include:

- More training and implementation assistance for stakeholders on the philosophy of PSH and Housing First principles in place of readiness and level of care assessments.
- Training clinic staff to build relationships and interact with community property managers in order to provide more options for members without subsidies. System development of housing resources in a clearinghouse or database for agencies to refer members seeking housing.
- Providing specific guidance regarding housing members who do not have RBHA vouchers (i.e., a broader approach to housing than just vouchers).

Recommended Quality Improvement Structure for Evidence-Based Practices

Since FY 2015, two provider networks disbanded, which caused transition issues for staff, members served, and data/record maintenance. This has also presented an additional need for new team and agency training in both working with individuals with serious mental illnesses and the evidence-based practices.

Program expansion has resulted in additional access to ACT teams, increased competitive employment and increased scattered-site housing. There has also been a *gradual* shift toward less screening of member readiness for work and housing. However, there still needs to be more training for clinical staff/case managers regarding the intensive supports needed in both SE and PSH, including evidence that positive outcomes are possible. It has also been noted that terminology and language used by the providers should be aligned to be more consistent with the EBPs, including job titles, roles, service elements, etc. along with continued training and technical assistance on best practices to support continued quality improvement.

Given the findings of the fidelity reviews for the two years of the identified evidence-based practices conducted July 2014 through May 2016, the continuation of the three-pronged quality improvement approach is recommended. As noted previously, the three components of this approach include:

- Education;
- Training; and
- Technical assistance.

Education will continue to include a review of the key opportunities for improved fidelity scores based on the findings from the Year 1 and the Year 2 reviews. This effort will target leadership staff from the agencies providing the evidence-based practices and will also include community partners that play key roles in the implementation of the practices. Similar to the September 11, 2015 Annual Summary of SAMHSA Fidelity Reviews, this occurred again in June 2016. The focus of this education included an overview of the four practices with an emphasis on the key fidelity markers for the organization, staffing, resources and role of community partners. This component included the progress and ongoing challenges from Year 1 to Year 2, and was enhanced by a discussion of agency structural and cultural issues that impede system change.

Training for each of the four evidence-based practices will target direct service providers, supervisors, key community partners, and Mercy Maricopa Integrated Care (MMIC) fidelity and training staff, as appropriate. These communities of practice/collaborative learning communities (dialogues with the experts) will continue to be available using telecommunications and will be facilitated by experts in the implementation of the fidelity tools, as well as experience in the implementation of best practices. This training will address fidelity items that continue to be challenging for providers based on the findings from the reviews that have been completed. Efforts to encourage cross provider collaboration will be

encouraged. As appropriate, there will be formal presentations followed by dialogues with the participants to enhance their learning opportunity and to promote the engagement and collaboration across provider sites. MMIC staff will participate to support ongoing fidelity quality improvement opportunities and to support the sustainability of the fidelity efforts in future years.

Individualized technical assistance will build off of the training component and allow the providers to interact with experts for each of the four evidence-based practices to discuss site-specific ways to enhance fidelity, recognize obstacles, begin problem solving concerns and identify any additional technical assistance needs.

Year 1 (FY 2015) Fidelity Review Findings

Assertive Community Treatment Year 1 – FY 2015

ACT	Choices Enclave	SWN Osborn	Choices South Central	PIR West Valley	SWN Hampton	PCN Centro Esperanza	PIR Metro Varsity	PIR Metro Omega	SWN San Tan	Choices WM	SWN BV	Choices Townley	PCN Comunidad	PCN Comunidad [FACT]	PCN CC
Human Resources	1-5 Likert Scale														
Small Caseload	5	5	5	5	5	4	5	5	4	5	5	4	5	5	4
Team Approach	4	5	5	3	5	3	5	4	5	5	3	5	5	5	4
Program Meeting	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Practicing ACT Leader	2	1	2	2	2	2	3	2	1	3	2	3	3	3	1
Continuity of Staffing	3	3	3	5	4	3	3	4	4	3	3	2	5	4	3
Staff Capacity	4	3	4	5	4	1	5	4	3	4	5	4	5	4	4
Psychiatrist on Team	5	4	5	4	5	5	5	4	5	5	5	4	5	4	3
Nurse on Team	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Substance Abuse Specialist on Team	1	5	5	3	3	1	1	1	3	5	3	4	5	3	2
Vocational Specialist on Team	1	1	5	5	3	4	5	2	5	3	1	3	4	5	3
Program Size	5	5	5	5	5	4	5	5	4	5	5	5	5	5	3
Organizational Boundaries	1-5 Likert Scale														
Explicit Admission Criteria	5	4	4	5	4	3	5	4	5	5	4	5	5	4	3
Intake Rate	4	5	4	4	5	5	5	5	5	5	5	5	5	5	5
Full Responsibility for Treatment Services	4	3	4	4	4	3	4	3	4	3	3	3	2	3	2
Responsibility for Crisis Services	5	5	5	5	5	5	5	5	5	5	5	5	4	5	4
Responsibility for Hospital Admissions	4	4	4	5	4	3	3	4	5	4	4	5	4	3	3
Responsibility for Hospital Discharge Planning	5	5	5	5	5	4	5	5	5	4	5	5	5	4	4
Time-unlimited Services	5	4	4	5	5	5	4	4	5	5	5	5	5	5	4

ACT	Choices Enclave	SWN Osborn	Choices South Central	PIR West Valley	SWN Hampton	PCN Centro Esperanza	PIR Metro Varsity	PIR Metro Omega	SWN San Tan	Choices WM	SWN BV	Choices Townley	PCN Comunidad	PCN Comunidad (FACT)	PCN CC
Nature of Services	1-5 Likert Scale														
Community-based Services	3	3	4	2	5	2	5	2	3	3	2	4	3	5	3
No Drop-out Policy	4	5	4	4	5	5	5	5	5	5	5	5	5	4	4
Assertive Engagement Mechanisms	5	5	5	5	5	4	5	5	5	5	5	5	5	5	4
Intensity of Service	2	4	3	2	3	3	2	3	2	2	2	3	5	5	2
Frequency of Contact	2	5	5	2	4	2	4	3	3	3	2	2	5	4	2
Work with Support System	1	1	2	4	1	2	3	1	2	2	3	3	1	3	1
Individualized Substance Abuse Treatment	1	1	2	1	3	1	1	1	3	3	2	2	2	2	1
Co-occurring Disorders Treatment Groups	2	2	2	4	3	1	2	2	4	3	2	2	1	1	1
Co-occurring Disorders/Dual Disorders Model	2	2	3	2	4	2	3	2	2	4	2	3	2	2	2
Role of Consumers on Treatment Team	5	5	5	5	5	5	5	5	5	5	1	5	5	5	1
TOTAL SCORE	97	103	112	109	114	90	111	98	110	112	97	109	114	111	81
Total Possible (5 point Likert scale -all items)	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140
Percentage	69.3	73.6	80	77.9	81.4	64.3	79.3	70	80	80	69.3	77.9	81.4	79.3	57.9
Averages	3.46	3.68	4	3.89	4.07	3.21	3.96	3.5	3.93	4	3.46	3.89	4.07	3.96	2.89

Consumer Operated Services Year 1 – FY 2015

COS	Likert Scale	CHEEERS	REN	STAR Central	STAR East	STAR West	Vive la Esp.
Structure							
Board Participation	1-5	5	4	5	4	4	4
Consumer Staff	1-5	5	5	5	5	5	4
Hiring Decisions	1-4	4	4	4	4	4	4
Budget Control	1-4	3	3	4	4	4	3
Volunteer Opportunities	1-5	5	3	4	5	5	5
Planning Input	1-5	5	5	3	5	5	5
Satisfaction/Grievance Response	1-5	5	5	5	5	5	4
Linkage with Traditional MH Services	1-5	3	5	4	4	4	5
Linkage with other COS Programs	1-5	5	5	5	5	5	4
Linkage with other Services Agencies	1-5	5	5	3	3	3	5
Environment							
Local Proximity	1-4	4	4	4	3	3	3
Access	1-5	5	5	5	4	3	4
Hours	1-5	5	5	3	4	3	3
Cost	1-5	5	5	5	5	5	5
Reasonable Accommodation	1-4	2	3	3	3	2	3
Lack of Coerciveness	1-5	5	5	4	3	3	4
Program Rules	1-5	5	5	5	3	3	5
Physical Environment	1-4	2	4	4	3	3	2
Social Environment	1-5	4	5	3	4	5	5
Sense of Community	1-4	4	4	4	4	4	4
Timeframes	1-4	4	4	2	3	3	4

COS	Likert Scale	CHEEERS	REN	STAR Central	STAR East	STAR West	Vive la Esp.
Belief Systems							
Peer Principle	1-4	4	4	3	4	4	4
Helper's Principle	1-4	4	4	3	4	2	4
Personal Empowerment	1-5	5	5	5	5	5	5
Personal Accountability	1-5	5	5	5	5	4	5
Group Empowerment	1-4	4	4	3	4	3	4
Choice	1-5	5	5	4	4	4	4
Recovery	1-4	4	4	4	4	4	4
Spiritual Growth	1-4	3	4	3	4	3	2
Peer Support							
Formal Peer Support	1-5	5	5	5	5	5	5
Informal Peer Support	1-4	4	4	3	4	3	4
Telling Our Story	1-5	4	4	4	4	4	5
Artistic Expression	1-5	3	4	4	4	4	4
Consciousness Raising	1-4	3	4	3	3	3	4
Formal Crisis Prevention	1-4	4	4	4	4	4	4
Informal; Crisis Prevention	1-4	3	4	3	4	2	4
Peer Mentoring and Teaching	1-4	4	4	3	4	2	4
Education							
Formally Structured Activities	1-5	4	5	3	4	4	5
Receiving Informal Support	1-5	5	5	4	5	5	5
Providing Informal Support	1-5	4	5	2	3	3	5
Formal Skills Practice	1-5	4	4	3	4	4	3
Job Readiness Activities	1-5	4	4	2	3	3	4
Advocacy							
Formal Self Advocacy	1-5	4	5	3	4	4	5
Peer Advocacy	1-5	4	5	3	4	4	5
Outreach to Participants	1-5	4	5	3	3	2	4

COS	Likert Scale	CHEEERS	REN	STAR Central	STAR East	STAR West	Vive la Esp.
Total Score	208	187	199	166	179	166	187
Total Possible		208	208	208	208	208	208
Percent Score		89.9	95.7	79.8	86.1	79.8	89.9

Supported Employment Year 1 – FY 2015

SE 1-5 Likert Scale	Marc CR	DK Advocates	Focus	Lifewell	VALLEYLIFE	WEDCO	Beacon
Staffing							
Caseload	5	5	5	5	5	5	5
Vocational Services Staff	3	4	4	4	5	5	3
Vocational Generalists	4	4	5	4	4	3	3
Organization							
Integration of rehabilitation with MH treatment	1	1	1	1	1	1	1
Vocational Unit	5	4	3	5	4	3	2
Zero-exclusion criteria	1	4	2	4	4	2	2
Services							
Ongoing work-based assessment	1	4	5	5	3	3	5
Rapid search for competitive jobs	1	1	4	4	2	3	3
Individual job search	1	1	5	4	2	2	3
Diversity of jobs developed	2	1	5	3	2	3	3
Permanence of jobs developed	1	2	4	4	3	3	5
Jobs as transitions	5	1	5	4	5	2	5
Follow-along supports	4	1	4	4	4	4	5
Community-based services	2	3	2	2	3	5	3
Assertive engagement and outreach	5	4	4	4	4	3	3
Total Points	41	38	58	57	51	47	51
Total Possible	75	75	75	75	75	75	75
Percentages	54.6%	50.6%	77.3%	76%	68%	62.6%	68%
Averages	2.73	2.67	3.87	3.8	3.29	3.13	3.29

Permanent Supportive Housing Year 1 - FY 2015

PSH	Scale	PSA	AHC-CMS	Terros	PCN	RI	Help Hearts	AZ Mentor	Life-well	SBH	PIR	Marc	MH W	Cho-ices	SWN	CF SS
Choice of Housing																
Tenants have choice of type of housing	1,2,5,4	1	1	1	1	2.5	1	1	1	1	1	1	1	1	1	1
Real choice of housing unit	1,4	1	1	1	1	4	1	1	1	1	1	4	1	1	1	1
Tenant can wait without losing their place in line	1-4	2	3	3	3	4	3	3	3	3	3	4	3	3	3	2
Tenants have control over composition of household	1,2,5,4	2.5	2.5	2.5	2.5	4	2.5	2.5	2.5	2.5	2.5	4	2.5	2.5	2.5	2.5
Average Score for Dimension		1.63	1.87	1.88	1.88	3.62	1.88	1.88	1.88	1.88	1.88	3.25	1.88	1.88	1.88	1.63
Functional Separation of Housing and Services																
Extent to which housing management providers do not have any authority or formal role in providing social services	1,2,5,4	2.5	4	1	2.5	4	4	4	2.5	4	2.5	4	1	2.5	2.5	4
Extent to which service providers do not have any responsibility for housing management functions	1,2,5,4	1	2.5	1	2.5	4	2.5	2.5	2.5	2.5	2.5	4	2.5	2.5	2.5	2.5
Extent to which social and clinical service providers are based off site (not at housing units)	1-4	3	2	2	3	4	1	1	4	2	3	4	4	4	3	1
Average Score for Dimension		2.17	2.83	1.33	2.67	4	2.5	2.5	3	2.83	2.67	4	2.5	3	2.67	2.5
Decent, Safe and Affordable Housing																
Extent to which tenants pay a reasonable amount of their income for housing	1-4	4	2	4	3	4	4	3	4	1	2	1	2	2	2	1

PSH	Scale	PSA	AHC-CMS	Terros	PCN	RI	Help Hearts	AZ Mentor	Life-well	SBH	PIR	Marc	MH W	Choices	SWN	CF SS
Whether housing meets HUD's Housing Quality Standards	1,2.5, 4	1	1	4	1	1	4	1	2.5	1	1	1	4	1	1	1
Average Score for Dimension		2.5	1.5	4	2	2.5	4	2	3.25	1	1.5	1	3	1.5	1.5	1
Housing Integration																
Extent to which housing units are integrated	1-4	1	1	1	2	4	1	1	1	1	3	4	1	2	2	1
Average Score for Dimension		1	1	1	2	4	1	1	1	1	3	4	1	2	2	1
Rights of Tenancy																
Extent to which tenants have legal rights to the housing unit	1,4	1	1	1	1	4	1	1	4	1	1	1	4	1	1	1
Extent to which tenancy is contingent on compliance with program provisions	1,2.5, 4	1	2.5	1	1	2.5	1	1	4	2.5	2.5	2.5	2.5	2.5	2.5	2.5
Average Score for Dimension		1	1.75	1	1	3.25	1	1	4	1.75	1.75	1.75	3.25	1.75	1.75	1.75
Access to Housing																
Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	1	1	1	1	2	1	1	1	2	1	2	1	2	2	2
Extent to which tenants with obstacles to housing stability have priority	1,2.5, 4	2.5	2.5	2.5	4	1	2.5	4	4	2.5	4	1	1	4	2.5	2.5
Extent to which tenants control staff entry into the unit	1-4	1	1	2	3	3	1	1	3	2	3	4	1	2	3	2
Average Score for Dimension		1.5	1.5	1.83	2.67	2	1.5	2	2.67	2.17	2.67	2.33	1	2.67	2.5	2.17

PSH	Scale	PSA	AHC-CMS	Terros	PCN	RI	Help Hearts	AZ Mentor	Life-well	SBH	PIR	Marc	MHW	Choices	SWN	CF SS
Flexible, Voluntary Services																
Extent to which tenants choose the type of services they want at program entry	1,4	1	1	1	1	4	1	1	1	4	1	4	1	1	1	1
Extent to which tenants have the opportunity to modify services selection	1,4	4	4	4	4	4	1	1	4	4	1	4	1	4	1	4
Extent to which tenants are able to choose the services they receive	1-4	2	3	2	3	3	1	2	3	3	2	3	2	3	3	3
Extent to which services can be changed to meet the tenants changing needs and preferences	1-4	2	3	2	3	4	2	2	4	3	3	3	2	3	3	4
Extent to which services are consumer driven	1-4	2	2	2	2	3	1	1	2	2	2	2	1	2	2	3
Extent to which services are provided with optimum caseload sizes	1-4	4	4	4	4	3	4	4	4	4	4	3	1	3	4	4
Behavioral health services are team based	1-4	2	2	2	2	2	2	2	2	2	3	2	2	4	2	3
Extent to which services are provided 24 hours, 7 days per week	1-4	3	2	4	4	4	4	4	4	4	4	2	1	4	4	4
Average Score for Dimension		2.5	2.62	2.63	2.88	3.37	2	2.13	3	3.25	2.5	2.87	1.38	3	2.5	3.25
Total Score		12.3	13.1	13.7	15.1	20.7	13.9	12.5	18.8	13.9	16.0	19.2	14.0	15.8	14.8	13.3
Highest Possible Score		28														
Percentage Score		43.9	46.7	48.8	53.9	74.1	49.6	43.2	67.1	49.6	57.0	68.6	50.0	56.4	52.9	47.5