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FY 2016-17 (Year 3)

Evidence Based Practices

Fidelity Project

Quality Improvement Report

Submitted to the

Arizona Health Care Cost Containment System and Mercy Maricopa Integrated Care

June 2017

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 (EBPs) 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 EBP implementation and fidelity review 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.

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).

The composition of the fidelity review team has remained unchanged since July 1, 2014 through Year 3. The team continued to consist of four staff based in Arizona, supervised by the WICHE project manager Mimi Windemuller of Colorado, both remotely and with travel as needed to provide on-site assistance. One fidelity reviewer is not continuing into Year 4 and recruitment efforts are currently underway to fill this position. The new hire will receive training and mentoring on the four EBPs from expert project consultants and the other reviewers. The Arizona Health Care Cost Containment System (AHCCCS) Project Manager Kelli Donley continues to provide leadership and oversight. Bi-weekly team conference calls occur with the AHCCCS and WICHE project managers, as well as other training calls with EBP expert consultants as necessary.

Project Implementation

Project management initially 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 beyond the first year. WICHE continued to contract with the same consultants used during Year 1: David Lynde is lead consultant and primary contact for ACT; Ann Denton from Advocates for Human Potential (AHP) for PSH, Pat Tucker from AHP for SE and Laurie Curtis from AHP is contact for COS, although her engagement was not needed during Year 3. Each consultant has extensive experience with SAMHSA EBP fidelity toolkits and provides consultation as needed.

All EBP materials developed for Year 1 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. 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 formulates 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 for each review. 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 as 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 3.

It was noted during Year 1 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. Members receiving services 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 continue to be initiated to address this issue.

FY 2017 Fidelity Review Schedule

The training schedule for Year 3 was initially developed in May and finalized in June 2016. The schedule was front-loaded with all reviews scheduled to be wrapped up by mid-May 2017 to allow adequate time for the fidelity review reports to be completed, as well as the year three report by the end of the fiscal year, June 30, 2017. Due to the compression of review, the Interim Report included findings from the reviews conducted July – November 2016, and this final report includes all 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 previous review, to allow adequate time for performance improvement efforts to be implemented.

The provider census for FY 2017 includes a total of 39 service providers and 50 reviews (some providers offer more than one EBP):

- 23 ACT
- 6 COS
- 7 SE; and
- 14 PSH.

During the first part of FY 2017, just under half of the provider reviews (24) were completed: 14 ACT, 4 SE, 3 COS, and 3 PSH. The remaining 26 reviews were completed during the remainder of FY 2017.

Training and Technical Assistance

The three-pronged quality improvement approach initiated during FY 2015 continues during FY 2017. The three components of this approach include:

- ☐ Education;
- ☐ Training; and
- ☐ Technical assistance.

David Lynde provided on-site technical assistance with two ACT providers, as well as some ACT training on November 8 - 9, 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 training and technical assistance were provided by Pat Tucker of Advocates for Human Potential (AHP) January 24, 2017 and on site at PNO clinics on March 29-30, 2017. The January training targeted clinical leaders and prescribers and provided an overview of Supported Employment, including the research and outcomes that supports the practice. The March technical assistance included on-site visits of several Supported Employment programs with Mercy Maricopa Integrated Care staff, providing opportunities to observe program activities and identify quality improvement efforts to enhance fidelity to the model. Some of the specific technical assistance/quality improvement suggestions included;

- Hold training focused solely on job development for all the employment staff, MMIC employment staff, and the supervisors of the employment staff;
- Have MMIC employment staff randomly attend the team staffing meetings and give the employment staff recommendations for improvement and then follow-up later to see if there is any improvement;
- Develop a policy or plan that clearly states what the expectations for the employment staff regarding time in the community are and their role at the team staffing meetings. This plan should make clear how much time they should spend talking in person with potential employers
- Role at the team staffing meetings should include reviewing caseload but also educating new staff about Supported Employment and listening to case reviews to identify employment referrals

Permanent Supportive Housing education, training, and technical assistance were provided on-site by Ann Denton of AHP May 9-11, 2017. Clinical leaders and prescribers attended the training, which provided information about the evidence supporting PSH and Housing First. The practice principles were reviewed and strategies to support continued implementation of the model were shared. Additionally, on-site visits of several clinical team meetings attended by housing specialists occurred to observe staff roles and identify opportunities to enhance collaboration and program fidelity.

Provider Changes

During FY 2016, 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).

Provider changes for FY 2017 included the addition of an SE review for Recovery Empowerment Network (REN). Also, this included the elimination of the PSH reviews for:

- Terros Behavioral Health Agency (Terros);
- Child and Family Support Services, Inc. (CFSS); and
- Horizon Health and Wellness (HHW) [previously Mountain Health and Wellness (MHW) and Superstition Mountain Mental Health Center (SMMHC).

Summary of Findings from the Fidelity Reviews

The data that follow indicate the findings from the FY 2017 fidelity reviews. 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, training/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 and/or 2016, the Year 1 and Year 2 summary data are provided at the end of each FY 2017 table. The full data tables for FY 2015 and FY 2016 are included at the end of this report.

Assertive Community Treatment (ACT) Fidelity Reviews Completed and Findings

Reviews Completed July – November 2016

- ✓ Terros Enclave (previously Choices - Enclave)
- ✓ Southwest Network - Osborn Adult Clinic (SWN Osborn)
- ✓ Chicanos Por La Causa Maryvale (CPLC-Maryvale) NEW
- ✓ Lifewell South Central (previously Choices South Central)
- ✓ Partners in Recovery (PIR) West Valley Adult Clinic
- ✓ Community Bridges, Inc. (CBI) Forensic – Team One (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 Mesa Heritage Clinic (SWN Mesa HC) (previously 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 Sag)
- ✓ Southwest Network – Bethany Village (SWN BV)

Reviews Completed December 2016 – May 2017

- ✓ La Frontera-EMPACT Comunidad (La FC) (previously People of Color Network (PCN)
- ✓ Community Bridges, Inc. Avondale ACT (CBI Avondale)
- ✓ Terros Townley (previously Choices – Townley Center)
- ✓ Community Bridges, Inc. (CBI) Forensic – Team Two (CBI FACT #2) (previously People of Color Network)
- ✓ Partners in Recovery (PIR) West Indian School Medical Specialty ACT (M-ACT) (previously located at Arrowhead)
- ✓ La Frontera-EMPACT Tempe (Madison) (LaF Madi-son)
- ✓ La Frontera-EMPACT Capitol Center (La FCC) (previously People of Color Network) Note: The
- ✓ Community Bridges, Inc. (CBI) Forensic – Team Three (CBI FACT #3)
- ✓ Terros Dunlap (Terros Dunlap) (previously Circle the City)

Assertive Community Treatment

Assertive Community Treatment	Terros En-clave	SWN Os-born	CPLC Mary-vale	Lifewell South Central	PIR West Valley	CBI FACT	Terros W McD	PIR Metro Varsity	PIR Metro Omega	SWN Mesa HC	CPLC Centro Esper-anza	SWN San Tan	SWN Sag-uaro	SWN BV	La FC	CBI Avon dale	Terros Town-ley	CBI FACT #2	PIR [M-ACT]	LaF Madi-son	La FCC	CBI FACT #3	Terros Dunlap
Human Resources: 5 Point Likert Scale																							
Small Caseload	5	4	5	5	4	4	5	5	5	4	5	4	5	4	5	5	5	5	5	5	5	5	5
Team Approach	5	3	4	3	4	3	3	3	5	4	5	5	4	3	4	4	4	4	5	5	4	4	4
Program Meeting	5	5	5	4	5	5	5	5	5	5	5	5	4	5	5	5	5	5	5	5	5	5	5
Practicing ACT Leader	3	2	2	3	2	4	3	1	3	3	3	3	2	3	4	3	3	2	3	3	4	4	2
Continuity of Staffing	3	3	2	1	1	4	1	3	3	4	3	4	4	3	3	4	3	3	4	2	3	3	1
Staff Capacity	4	3	2	3	2	5	4	4	4	4	3	4	4	3	5	5	4	4	4	4	4	4	4
Psychiatrist on Team	4	4	5	5	4	5	5	5	5	5	5	5	5	2	5	5	4	4	5	5	5	5	5
Nurse on Team	5	4	4	5	5	5	3	4	3	4	3	5	5	5	5	5	3	3	5	3	5	3	5
Substance Abuse Specialist on Team	3	2	2	3	3	3	3	3	5	2	5	3	3	5	5	4	5	5	5	4	3	4	5
Vocational Specialist on Team	3	1	3	1	3	2	3	3	4	5	3	4	5	4	4	3	4	3	4	4	5	3	3
Program Size	5	5	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Organizational Boundaries: 5 Point Likert Scale																							
Explicit Admission Criteria	4	5	4	5	4	5	5	5	4	5	5	5	5	5	4	5	5	5	5	5	4	5	5
Intake Rate	5	5	2	5	4	5	5	5	5	5	5	5	5	5	5	5	4	5	5	5	5	5	4
Full Responsibility for Treatment Services	5	3	2	3	2	4	3	3	4	4	3	4	4	4	4	4	4	4	4	4	4	4	4
Responsibility for Crisis Services	5	3	4	4	3	5	3	5	5	5	5	5	4	4	5	5	4	5	5	4	5	4	5
Responsibility for Hospital Admissions	4	4	3	2	3	4	3	4	3	3	4	3	1	4	1	4	3	4	5	3	4	2	3
Responsibility for Hospital Discharge Planning	5	5	4	5	4	5	4	4	5	5	5	5	4	5	5	5	5	5	5	4	5	4	5
Time-unlimited Services	5	4	5	5	5	5	5	4	5	5	5	5	4	5	5	5	5	5	5	5	5	5	5

ACT	Terros En-clave	SWN Osborn	CPLC Mary-vale	Lifewell South Central	PIR West Valley	CBI FACT	Terros W McD	PIR Metro Varsity	PIR Metro Omega	SWN Mesa HC	CPLC Centro Esper-anza	SWN San Tan	SWN Sag-uaro	SWN BV	La FC	CBI Avon dale	Terros Town-ley	CBI FACT #2	PIR [M-ACT]	LaF Madi-son	La FCC	CBI FACT #3	Terros Dunlap
Nature of Services: 5 Point Likert Scale																							
Community-based Services	5	3	4	2	3	3	4	3	2	2	4	4	3	2	4	3	3	3	3	4	3	3	4
No Drop-out Policy	5	5	5	5	4	5	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Assertive Engagement Mechanisms	5	3	4	5	4	5	4	5	5	5	5	5	5	5	4	3	5	4	5	4	5	4	5
Intensity of Service	3	2	3	2	2	3	2	2	2	3	2	3	2	3	4	2	2	2	5	3	2	4	4
Frequency of Contact	4	2	3	3	2	2	2	2	2	3	2	3	2	3	4	2	3	3	5	2	2	3	4
Work with Support System	3	2	2	2	1	2	2	2	2	2	2	2	3	3	3	2	2	1	3	1	3	3	1
Individualized Substance Abuse Treatment	3	2	3	1	1	4	3	3	4	3	1	3	2	3	4	4	3	3	5	4	3	4	4
Co-occurring Disorders Treatment Groups	3	3	2	2	3	4	3	2	3	2	1	2	2	3	3	3	3	3	4	3	2	2	3
Co-occurring Disorders/ Dual Disorders Model	3	2	2	2	3	5	3	3	4	3	3	4	2	4	4	3	3	3	4	3	3	3	3
Role of Consumers on Treatment Team	5	1	1	5	5	5	1	5	5	1	4	5	5	5	5	5	5	5	5	5	5	5	5
Year 3 Total Score	**117**	**90**	**91**	**96**	**91**	**116**	**96**	**103**	**112**	**106**	**106**	**115**	**104**	**110**	**119**	**113**	**109**	**108**	**128**	**109**	**113**	**110**	**113**
Total Possible	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140
Percentage	**83.6**	**64.3**	**65.0**	**68.6**	**65.0**	**82.9**	**68.6**	**73.6**	**80.0**	**75.7**	**75.7**	**82.1**	**74.3**	**78.6**	**85.0**	**80.7**	**77.9**	**77.1**	**91.4**	**77.9**	**80.7**	**78.6**	**80.7**
Average	**4.18**	**3.21**	**3.25**	**3.43**	**3.29**	**4.14**	**3.43**	**3.68**	**4.0**	**3.79**	**3.79**	**4.11**	**3.71**	**3.93**	**4.25**	**4.04**	**3.89**	**3.86**	**4.57**	**3.89**	**4.04**	**3.93**	**4.03**
Year 2 Total Score	**101**	**97**	**NA**	**104**	**115**	**117**	**114**	**100**	**115**	**99**	**98**	**101**	**93**	**111**	**90**	**NA**	**111**	**114**	**113**	**NA**	**103**	**NA**	**99**
Total Possible	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140
Percentage	**72.1**	**69.3**	**NA**	**74.3**	**82.1**	**83.6**	**81.4**	**71.4**	**82.1**	**70.7**	**70**	**72.1**	**66.4**	**79.3**	**64.3**	**NA**	**79.3**	**81.4**	**80.7**	**NA**	**73.6**	**NA**	**70.7**
Average	**3.6**	**3.46**	**NA**	**3.71**	**4.11**	**4.18**	**4.07**	**3.57**	**4.1**	**3.54**	**3.50**	**3.61**	**3.32**	**3.92**	**3.21**	**NA**	**3.96**	**4.07**	**4.04**	**NA**	**3.68**	**NA**	**3.54**
Year 1 Total Score	97	103	NA	112	109	NA	112	111	98	114	90	110	NA	97	114	NA	109	111	NA	NA	81	NA	NA
Total Possible	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140	140
Percentage	**69.3**	**73.6**	**NA**	**80**	**77.9**	**NA**	**80**	**79.3**	**70**	**81.4**	**64.3**	**80**	**NA**	**69.3**	**81.4**	**NA**	**77.9**	**79.3**	**NA**	**NA**	**57.9**	**NA**	**NA**
Average	**3.46**	**3.68**	**NA**	**4**	**3.89**	**NA**	**4**	**3.96**	**3.5**	**4.07**	**3.21**	**3.93**	**NA**	**3.46**	**4.07**	**NA**	**3.89**	**3.96**	**NA**	**NA**	**2.89**	**NA**	**NA**

The fidelity team noted the following:

- ACT teams are reporting fewer referrals to outside providers.
- Staff contacts with members should be more focused on meaningful clinical interactions, with most contacts occurring in the community.
- Specialists need ongoing training and guidance to work as experts in their areas of specialization, which will 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. Specifically, the Substance Abuse Specialist (SAS) and Vocational Specialist (VS) should have the required training and/or supervised experience to provide services in their areas of expertise. Both licensed and unlicensed SAS should have specific training in substance abuse treatment. General professional licensure does not meet SAS qualifications for the ACT team. There appears to be improvement here, but agencies should continue to focus on specialist training, which is now built into the Mercy Maricopa Integrated Care quality assurance program and their ACT Manual.
- Some teams have adapted elements of co-occurring treatment to support members who experience substance use challenges. However, it does not appear that 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. It is recommended that a proven co-occurring treatment model (such as IDDT) be implemented across the system, with supporting training and documentation provided to all providers and clinics. More education and training is recommended on stage-wise treatment versus the stages of change model and how these should effectively be implemented.
- Direct member services delivered by the Clinical Coordinator (i.e., Team Leader) are below the recommended 50% threshold. Agencies should identify issues that may be limiting direct service time and ensure that the Team Leader's actual face-to-face service time (versus billable time) is accurately documented.
- Several ACT teams are introducing several new clinic-based groups into their member services. While these may be intended to increase the intensity and frequency of service, agencies should ensure that these do not replace individualized treatment in members' natural settings in the community.
- Staff appear more cautious to comment and provide information in interviews during recent fidelity reviews. Some staff seem to have been coached on their responses, with concern about answering "incorrectly." Also, there appears to be more focus on the fidelity score rather than on improving the practice.

Assertive Community Treatment Quality Improvement Opportunities

The overall ratings for ACT fidelity reviews ranged from 64.3 to 91.4 with an average of 76.9 percent during Year 3, which is almost two percentage points higher than Year 2. It is notable that there was an increase of 7.8 percentage points when comparing the highest-rated providers from Year 2 to Year 3. There was no change from Year 2 to Year 3 for the lowest provider ratings. Also of note, is that after Year 1 the providers no longer selected the sample charts for review and instead this was done randomly by the review team.

ACT Fidelity Scores	Year 1	Year 2	Year 3
Lowest Rating	57.9%	64.3%	64.3%
Highest Rating	81.4%	83.6%	91.4%
Overall Average	74.8%	75.1%	76.9%

In the Human Resources domain, challenges remain in the areas of Practicing Team Leader and Continuity of Staffing, which was also noted in the FY 2015 and 2016 reports. There has been notable improvement in Substance Abuse and Vocational Specialists being assigned to teams.

Within the domain of Organizational Boundaries, only one provider is not approaching fidelity in Intake Rate, while the others received ratings representing full compliance with this, and seven providers are not approaching fidelity in Full Responsibility for Treatment Services with ratings of three or lower. Responsibility for Hospital Admissions was rated three or lower for 13 providers, compared with four providers in Year 1 and six providers in Year 2.

The Nature of Services domain continues to be the most challenging for providers, and continued efforts are needed to address this. The areas that present the greatest opportunities for quality improvement across multiple sites with the average ratings across providers include: provision of Community-based Services (3.2), Work with Support Systems (2.1), Intensity of Services (2.7), Frequency of Contact (2.7), Individualized Substance Abuse Treatment (3.0), Co-occurring Disorders Treatment Groups (2.7) and Co-occurring Disorders/Dual Disorders Model (3.1). Additionally, four of the providers are not approaching fidelity on the Role of Consumers on Treatment Teams. Efforts to improve the fidelity of these areas will require the engagement of both leadership staff and the ACT teams 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:

- Focusing on ACT as a service with multiple key components, which when operationalized in an integrated way, produce desired outcomes. While addressing specific fidelity markers is important to improve adherence to the evidence-based model, a segmented approach versus a comprehensive approach jeopardizes the stability of ACT.
- Continuing emphasis on understanding of the components of the Nature of Services domain.
- Ongoing staff training in specific areas of specialization (Substance Abuse Specialists, Vocational Specialists, etc.).
- 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. More education and training is recommended on stage-wise treatment versus the stages of change model and how these should effectively be implemented.

Consumer Operated Services (COS) Fidelity Reviews Completed and Findings

Reviews completed July – November 2016

- ✓ 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 2016 – May 2017

- ✓ 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	CHEEERS	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	4	4	4	4	4	4
Volunteer Opportunities	1-5	4	5	5	5	5	5
Planning Input	1-5	5	5	5	5	5	5
Satisfaction/Grievance Response	1-5	5	5	5	5	5	5
Linkage with Traditional MH Services	1-5	5	4	4	5	5	4
Linkage with other COS Programs	1-5	3	5	4	5	5	4
Linkage with other Services Agencies	1-5	5	5	5	5	5	5
Environment							
Local Proximity	1-4	4	4	4	3	3	3
Access	1-5	5	5	5	5	5	4
Hours	1-5	3	5	5	4	5	3
Cost	1-5	4	5	5	5	5	5
Reasonable Accommodation	1-4	3	3	3	3	5	3
Lack of Coerciveness	1-5	5	5	4	5	5	4
Program Rules	1-5	5	5	3	5	5	4
Physical Environment	1-4	4	4	4	3	4	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	4	4	4	4
Belief Systems							
Peer Principle	1-4	4	4	4	4	4	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	4	4	4	4
Choice	1-5	5	5	5	4	4	5
Recovery	1-4	4	4	4	4	4	4
Spiritual Growth	1-4	4	4	4	3	3	3

COS	Likert Scale	REN	CHEEERS	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	5	4	4	4
Artistic Expression	1-5	4	5	4	5	3	4
Consciousness Raising	1-4	4	4	3	3	4	4
Formal Crisis Prevention	1-4	4	4	4	4	4	4
Informal; Crisis Prevention	1-4	4	4	4	4	4	4
Peer Mentoring and Teaching	1-4	4	4	4	4	4	4
Education							
Formally Structured Activities	1-5	5	5	5	4	5	5
Receiving Informal Support	1-5	5	5	5	5	5	5
Providing Informal Support	1-5	5	5	5	5	5	5
Formal Skills Practice	1-5	5	5	5	5	5	5
Job Readiness Activities	1-5	5	5	3	3	3	5
Advocacy							
Formal Self Advocacy	1-5	5	5	5	5	5	5
Peer Advocacy	1-5	5	5	4	5	5	5
Outreach to Participants	1-5	4	5	4	3	3	4
Year 3 Total Score		198	204	194	194	196	192
Total Possible	**208**	208	208	208	208	208	208
Percentage Score		**95.2**	**98.1**	**93.3**	**93.3**	**94.2**	**92.3**
Year 2 Total Score		193	204	177	197	188	186
Total Possible	**208**	208	208	208	208	208	208
Percentage Score		**92.8**	**98.1**	**85.1**	**94.7**	**90.4**	**89.4**
Year 1 Total Score		199	187	166	179	166	187
Total Possible	**208**	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:

- Although staff of COS programs (COSPs) collaborate on occasion, overall collaboration among other COSPs, as well as clinics, is still a challenge.
- Members should be engaged by COSPs to advocate in the broader community in addition to activities in the behavioral health treatment community. They appear to be largely observers of advocacy efforts rather than directly delivering advocacy efforts. This could be done via collaboration between the COSPs.

Consumer Operated Services Quality Improvement Opportunities

The overall scores for the Consumer Operated Services sites that were reviewed remain very good, with percentage scores ranging from 92.3 to 98.1 with an average of 94.4 percent in Year 3. The table below illustrates the rating trends during the past three years. The improvement is remarkable and appears to be sustaining over time.

COS Fidelity Scores	Year 1	Year 2	Year 3
Lowest Rating	79.8%	85.1%	92.3%
Highest Rating	95.7%	98.1%	98.1%
Overall Average	86.9%	91.7%	94.4%

As noted in previous reports, although COS staff 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 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.

As noted in previous reports, 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 2016

- ✓ 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 2016 – May 2017

- ✓ Wedco Employment Center (WEDCO)
- ✓ Beacon Supported Employment (Beacon)
- ✓ Recovery Empowerment Network (REN)

Note: DK Advocates Supported Employment (DK Advocates) was not a contracted provider in Year 2 or Year 3.

Supported Employment

SE 1-5 Likert Scale	Marc CR	Focus	Lifewell	VALLEYLIFE	WEDCO	Beacon	REN
Staffing							
Caseload	5	5	4	5	5	4	4
Vocational Services Staff	5	5	3	5	5	5	5
Vocational Generalists	4	5	4	4	4	5	3
Organization							
Integration of rehabilitation with MH treatment	3	3	1	3	2	2	1
Vocational Unit	5	3	3	4	4	5	4
Zero-exclusion criteria	3	4	3	3	4	4	2
Services							
Ongoing work-based assessment	5	5	4	5	4	5	4
Rapid search for competitive jobs	5	4	3	4	3	5	3
Individual job search	5	4	5	4	5	5	3
Diversity of jobs developed	4	4	4	5	3	4	4
Permanence of jobs developed	5	4	5	5	3	5	4
Jobs as transitions	5	4	5	5	5	5	3
Follow-along supports	5	4	3	4	5	5	2
Community-based services	3	3	1	2	5	5	2
Assertive engagement and outreach	4	4	2	5	4	4	2
Year 3 Total Points: Total Possible 75	**66**	**61**	**50**	**63**	**61**	**68**	**46**
Percentage	88%	81.3%	66.6%	84%	81.3%	90.7%	61.3%
Average	4.4	4.1	3.3	4.2	4.2	4.5	3.1
Year 2 Total Points: Total Possible 75	63	55	61	65	61	60	NA
Percentage	84%	73.3%	81.3%	86.7%	81.3%	80%	NA
Average	4.2	3.7	4.1	4.3	4.07	4	NA
Year 1 Total Points: Total Possible 75	41	58	57	51	47	51	NA
Percentage	54.6%	77.3%	76%	68%	62.6%	68%	NA
Average	2.73	3.87	3.8	3.29	3.13	3.29	NA

The fidelity team has noted the following:

- SE programs need additional training on how to conduct job development with employers in the community. Some Employment Specialists do not provide the majority of services in the community, and primarily submit internet applications during employment searches. Also, Employment Specialists 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.
- 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 concerns including bringing in staff who are not co-located into clinical meetings) 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.
- Community-based services are still a challenge. Teams should understand that this is not just based on meeting members at a coffee shop or conveniently-located fast food restaurant but intended to help members become more familiar and comfortable in different work environment.
- When vocational rehabilitation (VR) is the funding source, most communication is between VR and the Employment Specialist, but it is not clear that consistent communication is occurring between Employment Specialists and case managers regarding member needs, presentation, and potential crisis. All parties should make sure that any concerns, especially warning signs of a member approaching crisis, are related to the case manager for appropriate intervention.
- Some SE providers have argued that VR clients should not be included in reviews because, among other things, VR requires different documentation. To the extent possible, efforts should continue to enhance collaboration with VR to streamline paperwork and support job development services.

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, with less change from Year 2 to Year 3. The Year 3 average was reduced due to Lifewell's low rating of 50 out of 75 possible (66.6%) and that of the new Recovery Empowerment Network SE program, which received a rating of 46 out of 75 (61.3%). The table below illustrates the three-year trends to date.

SE Fidelity Scores	Year 1	Year 2	Year 3
Lowest Rating	50.6%*	73.3%	61.3%
Highest Rating	77.3%	86.7%	90.7%
Overall Average	67.8%	81.2%	79.0%

* DK Advocates, which was not a contracted provider during Year 2 or Year 3.

Integration of rehabilitation with mental health treatment shows sustained improvement across all sites over the three years. Zero exclusion shows significant improvement across most 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 be in the community rather than in an office or clinic. For some reviews, it was difficult to ascertain whether 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 ratings.

Given the improvements noted across all three fidelity domains of Staffing, Organization and Services over the three years of review, it appears that most 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. Additionally, a greater focus on community integration and clearer documentation to support these services may improve adherence to the model.

Training focus to support continued quality improvement should include:

- Continued training and coaching on how to conduct job development with employers in the community. Some Employment Specialists do not provide most services in the community, and primarily submit internet applications during employment searches.
- Decreased reliance on job fairs (some geared toward individuals with disabilities) or other narrow job search activities, as this impacts the diversity of jobs that are pursued and obtained.

- Continued training with clinic/treatment team staff to achieve full integration, and clarify HIPPA regulations so that services can be provided through integrated teams.
- Continued job development training for Employment Specialists and their supervisors including: sales/marketing techniques, role-playing with other staff and supervisors, and shadowing other successful job developers in the field.

Permanent Supportive Housing (PSH) Fidelity Reviews Completed and Findings

Reviews completed July – November 2016

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

Reviews completed December 2016 – May 2017

- ✓ Lifewell Behavioral Wellness (Lifewell)
- ✓ La Fontera – EMPACT (La F)- ACT teams (previously People of Color Network)
- ✓ 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
- ✓ Terros ACT teams (previously Choices)
- ✓ Marc Community Resources (MARC)

Note: To better identify areas for improvement for PSH, for the Year 2 and 3 reports, items receiving a 2.5 rating are highlighted. These items were not highlighted in the Year 1 tables to avoid overwhelming providers and to offer them some time to gain a better understanding of the fidelity expectations.

Permanent Supportive Housing

PSH	Scale	PSA	AHC-CMS	CPLC ACT	Life-well	La F ACT	RI	PIR ACT	CBI	CBI ACT	SBHS	Life-well ACT	SWN ACT	Terros ACT	MARC
Choice of Housing															
Tenants have choice of type of housing	1,2.5,4	1	1	4	1	4	2.5	4	4	4	2.5	2.5	2.5	2.5	2.5
Real choice of housing unit	1,4	4	1	4	1	4	4	4	4	4	4	1	1	1	4
Tenant can wait without losing their place in line	1-4	4	4	3	4	4	4	3	4	4	4	2	4	4	4
Tenants have control over composition of household	1,2.5,4	4	4	4	2.5	4	4	4	2.5	2.5	2.5	1	2.5	2.5	2.5
Average Score for Dimension		3.25	2.5	3.75	2.13	4	3.63	3.75	3.63	3.63	3.25	1.63	2.5	2.5	3.25
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	4	4	4	2.5	4	4	4	4	2.5	4	4
Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	4	4	2.5	4	4	4	4	2.5	4	4	2.5	4	4	4
Extent to which social and clinical service providers are based off site (not at housing units)	1-4	4	4	4	4	3	4	4	4	3	4	2	3	3	4
Average Score for Dimension		4	4	3.5	4	3.67	4	3.5	3.5	3.67	4	2.83	3.17	3.67	4
Decent, Safe and Affordable Housing															
Extent to which tenants pay a reasonable amount of their income for housing	1-4	3	3	1	4	3	4	1	4	3	3	1	1	2	4

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

PSH	Scale	PSA	AHC-CMS	CPLC ACT	Life-well	La F ACT	RI	PIR ACT	CBI	CBI ACT	SBHS	Life-well ACT	SWN ACT	Terros ACT	MARC
Flexible, Voluntary Services															
Extent to which tenants choose the type of services they want at program entry	1,4	1	1	4	1	1	1	1	1	1	4	1	1	4	4
Extent to which tenants have the opportunity to modify services selection	1,4	4	1	1	4	1	1	4	1	4	1	1	1	1	1
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
Extent to which services can be changed to meet the tenants changing needs and preferences	1-4	4	3	2	3	2	4	2	4	3	2	2	3	2	2
Extent to which services are consumer driven	1-4	2	2	2	1	1	4	2	3	2	3	2	2	1	3
Extent to which services are provided with optimum caseload sizes	1-4	4	4	4	4	4	3	4	4	4	4	4	4	4	4
Behavioral health services are team based	1-4	2	2	3	2	4	2	3	2	3	2	3	4	4	2
Extent to which services are provided 24 hours, 7 days per week	1-4	2	3	4	2	4	4	4	3	4	4	4	4	3	2
Average Score for Dimension		2.75	2.38	2.88	2.5	2.5	2.75	2.88	2.63	3	2.88	2.5	2.75	2.75	2.63
Year 3 Total Score		**21.7**	**22.1**	**19.71**	**20.46**	**21.84**	**25.88**	**19.38**	**22.26**	**22.22**	**21.8**	**12.46**	**16**	**18**	**22.8**
Highest Possible Dimension Score		28	28	28	28	28	28	28	28	28	28	28	28	28	28
Percentage Score		**77.5%**	**78.9%**	**70.4%**	**73.1%**	**78.0%**	**92.4%**	**69.2%**	**79.5%**	**79.4%**	**77.9%**	**44.5%**	**57.1%**	**64.3%**	**81.4%**

PSH	Scale	PSA	AHC-CMS	CPLC ACT	Life-well	La F ACT	RI	PIR ACT	CBI	CBI ACT	SBHS	Life-well ACT	SWN ACT	Terros ACT	MARC
Year 2 Total Score		**20.5**	**18.4**	**16.3**	**20.1**	**16.3**	**24.9**	**19.3**	**23.8**	**20.7**	**21.8**	**16.9**	**17.5**	**17.3**	**20.2**
Highest Possible Dimension Score		28	28	28	28	28	28	28	28	28	28	28	28	28	28
Percentage Score		**73%**	**65.5%**	**58.4%**	**71.8%**	**58.4%**	**88.9%**	**69%**	**85%**	**74%**	**78%**	**60.4%**	**62.5%**	**61.8%**	**72.3%**
Year 1 Total Score		**12.3**	**13.1**	**15.1**	**15.8**	**15.1**	**20.7**	**16.0**	**NA**	**NA**	**13.9**	**15.8**	**14.8**	**15.8**	**19.2**
Highest Possible Score		28	28	28	28	28	28	28	28	28	28	28	28	28	28
Percentage Score		**43.9**	**46.7**	**53.9**	**56.4**	**53.9**	**74.1**	**57.0**	**67.1**	**49.6**	**49.6**	**56.4**	**52.9**	**52.9**	**68.6**

The fidelity team has noted the following:

- Some staff reported that landlords/property managers are not receiving rent for voucher-based housing in a timely manner, which could be contributing to more managers not accepting vouchers.
- Agencies should be capable of providing *all* aspects of the PSH model, including searching for housing based on member preference, maintaining member housing, and assisting members in re-locating to different housing if needed. Services are not intended to be "a la carte." Some providers do not actually help members with the housing search at all.
- 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. In order to streamline this, it is recommended to include this in MOAs/MOUs with property managers.
- 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.
- Optimally, housing services should be provided by an integrated team. At a minimum, providers, clinical staff and those involved in housing management should proactively coordinate services, not just having ad hoc meetings when members are struggling.
- Referrals from some clinics are based on team screening, pre-assessment, level of care recommendations, and availability (i.e., what option staff believe has the shortest waitlist). Tenants of some types of RBHA affiliated housing don't have choice of units, or choice of roommates and some must follow program rules to maintain their housing. This had improved but seems to have reverted in the past several months, possibly due to a lack of scattered-site vouchers. This necessitates the need for building relationships with private landlords to create more affordable housing options. This appears to have regressed recently, especially with recently-hired clinical staff. Ensure ongoing training is provided on the PSH model.
- Some providers have worked to develop relationships with landlords and apartment management to increase housing options they can offer members, but other programs have not cultivated these relationships or rely on half-way-houses or other unlicensed board and care homes as temporary residences. It may help create a more integrated

approach to PSH services if marketing efforts were implemented at a higher system level to collaborate with community stakeholders.

Permanent Supportive Housing Quality Improvement Opportunities

Of the 14 PSH reviews completed, the lowest was rating was 44.5, which is significantly lower than the lowest rating from last year (52.4). This provider was Lifewell Behavioral Wellness ACT team, which was previously Choices South Central with a rating of 60.4 last year. The highest rating was 3.5 percentage points greater than the highest rating from Year 2, and the overall average was 5.4 percentage points higher than Year 2.

PSH Fidelity Scores	Year 1	Year 2	Year 3
Lowest Rating	43.2%*	52.4%	44.5%
Highest Rating	74.1%	88.9%	92.4%
Overall Average	54.0%	67.7%	73.1%

* This provider was not reviewed during Year 2 or 3.

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.

Training focus to support continued quality improvement should include:

- 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. It would be helpful if all PSH providers used common language, especially when working with community partners. It appears each PSH provider has its own interpretation of PSH. Due to lack of consistent language and terminology about PSH services, clinic staff have difficulty understanding what various providers offer (scattered site vouchers, ILS supports, etc.).

- Additional technical assistance regarding readiness requirements and considering members' preferences and choices would be beneficial. This could involve the use of scenarios and role-playing ways to ensure and support choice, spotting when it is not happening, and operationalizing what happens next.
- Additional housing resources training may be helpful, especially given staff turnover. Ultimately, the housing specialists must become experts on everything that is available, and should make connections in the community.

Recommended Quality Improvement Structure for Evidence-Based Practices

As noted in the beginning of this report, there have been several provider changes resulting in transition issues for staff, members served, and data/record maintenance. This has also presented a 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 g*radual* 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. It has been noted that some providers are implementing better tracking mechanisms to support fidelity items and these efforts should be encouraged.

Given the findings of the fidelity reviews of the identified evidence-based practices conducted July 2014 through June 2017, 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 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, a Connections Conference was held in June 2016. The focus of this educational forum 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. Planning for the next Connections Conference is underway and it is expected to occur during August 2017.

Training for the evidence-based practices will target direct service providers, supervisors, key community partners, and Mercy Maricopa Integrated Care (MMIC) fidelity and training staff, as appropriate. The focus of the training will target the key challenging areas identified through the reviews. When indicated, 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. 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 continue to promote fidelity quality improvement opportunities and to support the sustainability of the fidelity efforts in future years.

Individualized technical assistance will build off the training component and allow the providers to engage with experts when indicated, and discuss system-wide and site-specific ways to enhance fidelity, recognize obstacles, begin problem solving concerns and identify any additional technical assistance needs. Additionally, with guidance from the EBP-specific consultants and the fidelity review team, MMIC staff will also provide regular support and technical assistance to providers.

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 Hamp-ton	PCN Centro Esper-anza	PIR Metro Varsity	PIR Metro Omega	SWN San Tan	Choices WM	SWN BV	Choices Townley	PCN Comun-idad	PCN Comun–idad [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 Hamp-ton	PCN Centro Esper-anza	PIR Metro Varsity	PIR Metro Omega	SWN San Tan	Choices WM	SWN BV	Choices Townley	PCN Comun-idad	PCN Comun–idad (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
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

COS	Likert Scale	CHEEERS	REN	STAR Central	STAR East	STAR West	Vive la Esp.
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
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	MHW	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	Cho-ices	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 Men-tor	Life-well	SBH	PIR	Marc	MHW	Cho-ices	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	28	28	28	28	28	28	28	28	28	28	28	28	28	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**

Year 2 (FY 2016) Fidelity Review Findings

Assertive Community Treatment

ACT	Terros En-clave	SWN Osborn	Lifewell South Central	PIR West Valley	CBI FACT	Terros W McD	PIR Metro Varsity	PIR Metro Omega	SWN Hamp-ton	CPLC Centro Esper-anza	SWN San Tan	SWN Sag-uaro	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 En-clave	SWN Osborn	Lifewell South Central	PIR West Valley	CBI FACT	Terros W McD	PIR Metro Varsity	PIR Metro Omega	SWN Hamp-ton	PCN Centro Esper-anza	SWN San Tan	SWN Sag-uaro	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**

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**

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
Percentage	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
Percentage	54.6%	77.3%	76%	68%	62.6%	68%
Averages	2.73	3.87	3.8	3.29	3.13	3.29

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	Ter-ros 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	Ter-ros ACT	MA RC	HHW
Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1	2.5	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	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	1	4	3	4	3	4	2	3	1	2	4	1
Average Score for Dimension		4	1	4	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	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	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	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	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	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	3	4	3	4	3	3	2	2	3	2
Average Score for Dimension		2.83	1.83	2	2.17	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	Ter-ros 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	Ter-ros 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**