WICHE

Western Interstate Commission for Higher Education

Mental Health Program

ALASKA

ARIZONA

CALIFORNIA

COLORADO

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

HAWAII

IDAHO

MONTANA

NEVADA

NEW MEXICO

NORTH DAKOTA

OREGON

SOUTH DAKOTA

UTAH

WASHINGTON

WYOMING

www.wiche.edu/mentalhealth

FY 2014-15 (Year 1)

Evidence Based Practices

Fidelity Project

Quality Improvement Report

Submitted to Mercy Maricopa Integrated Care

June 2015

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 would begin 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 would be prepared to begin fidelity reviews in July, 2014, within SAMHSA protocol guidelines.

Based on the number of provider reviews to be completed during a fiscal year, staff requirements were revised to meet project deliverables. It was determined that a fidelity review team of four staff would be hired in Arizona, supervised by the WICHE project manager Mimi Windemuller of Colorado, with frequent travel to provide on-site assistance. ADHS Project Manager Kelli Donley would provide daily oversight as needed.

A detailed job description for a "Fidelity Reviewer" was compiled, and recruiting began throughout the health and human services community in the greater Phoenix and surrounding areas. A large number of resumes were submitted by employees of former RBHA Magellan Health Services, as well as nearby universities and the peer community.

Phone screenings, followed by in-person interviews at ADHS resulted in the selection of a team of four candidates with significant experience in the Arizona behavioral health system. All candidates accepted employment offers and began work in early June, 2014. Staff are housed at ADHS Department of Behavioral Health Services.

The new staff started immediately with four days of in-depth classroom training on each of the EBPs led by consultant David Lynde. Training focused on philosophies behind each practice, the respective fidelity scales and how to measure to them, discussion of other market/system successes and failures, and a detailed break-down of the fidelity review process and scoring components. WICHE project management coordinated the training with David and produced all relevant materials, sample forms, agenda, etc. Additional staff training included analysis of the entire SAMHSA toolkit materials

and first-hand shadowing of a full fidelity review for each of the EBPs with consultants David Lynde and Mimi Windemuller.

The new review team developed strong working relationships early on, which contributed to the efficiency and success of the work from the beginning. All were quick studies of the SAMHSA materials, and each brings a unique perspective to the group, including one as a self-identified peer with lived experience. Weekly team conference calls are scheduled with the ADHS 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. This involved several drafts and language revisions to coincide with the settlement stipulation. In addition, plaintiffs required that third-party consultants sign off on fidelity reviews for the first year of the project. After several meetings and a national recruiting effort by WICHE, plaintiffs supported the addition of three subject experts to provide final approval for the reviews. WICHE contracted with the following consultants: 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. Each has extensive experience with SAMHSA and the respective EBP fidelity toolkits. Mimi Windemuller, with assistance from David Lynde as needed, is primary sign-off for SE reviews.

All EBP materials were developed for the project, including fidelity scales, review interview guides, scoring protocols and forms, fidelity report templates, provider notification and preparation letters, etc. Applicable documentation was consolidated from the SAMHSA toolkits and reorganized for specific use with ADHS and the fidelity review team.

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

- Provider correspondence was created with all 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 two-to-four 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 approval from respective expert consultant, the report and 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.

The training schedule for the new review team was very tight before heading into the field to conduct first reviews. The team and outside consultants would have benefitted from additional training and a better understanding of the Arizona behavioral health system before beginning the fidelity reviews. As the reviews began, a considerable amount of time was needed to educate the consultants on the local system structure, which was necessary to develop appropriate procedures to conduct the reviews in an accurate manner. It would have been advantageous to bring in the additional expert consultants for COS and PSH earlier to assist David Lynde with staff training. This would have provided more diversity and background to each of the practices, but early on the project management team was not aware of the heightened oversight that would be required by the plaintiffs.

With regard to overall service provisions, the system appears to offer services to members based on what is available versus the members' preferences, which is a distinct difference from the 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.

FY 2015 Fidelity Review Schedule

An initial calendar of provider reviews was created for the first six (6) months of the project thru December 31, 2014. Once reviews began in July, only minor schedule changes to the calendar were made to meet various provider needs and to conduct the most efficient reviews possible. During the first six months, a schedule was developed for the remainder of the FY 2015 reviews.

The provider census for FY 2015 included a total of 43 service providers: 15 ACT, 7 SE, 6 COS, and 15 PSH. As of 12/31/14, just less than half of the provider reviews have been completed: 8 ACT, 5 SE, 3 COS, and 3 PSH. The remainder of the 43 reviews were completed between January and June of 2015.

Training and Technical Assistance

Based on the findings of the initial fidelity reviews of the identified evidence-based practices conducted July through December of 2014, a three-pronged quality improvement approach was implemented in March 2015. The three components of this approach include:

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

The **education** was intended to target leadership staff from the agencies providing the evidence-based practices, as well as community partners that play key roles in the implementation of the practices. This educational component included system change concepts that are the foundation for embracing evidence based practices. It also included lessons learned from the perspectives of other state leaders (Dave Wanser, Texas and Kevin Huckshorn, Delaware) with exemplary experience in the roll-out of system improvement through the implementation of evidence-based practices and a greater focus on program outcomes. Their experience highlighted structural, organizational and cultural issues while also addressing system changes. Additionally, this educational session 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.

The **training** component specifically targeted Permanent Supportive Housing service providers, supervisors and key community partners. This practice was identified for additional training based on the challenges providers were having in implementing this housing model, evidenced by the fidelity reviews. Ann Denton of Advocates for Human Potential conducted this 1.5 day training, which was well-attended by community providers.

The **structured technical assistance** component allowed the providers to interact with experts for each of the other three evidence-based practices and discuss site-specific ways to enhance fidelity, recognize obstacles, begin problem solving concerns and identify any ongoing technical assistance needs.

Also, in an effort to provide additional clarification and support regarding the EBPs, the best practices experts met with Mercy Maricopa Integrated Care staff overseeing implementation of each practice to discuss common challenges, as well as opportunities in the implementation of these practices.

Summary of Findings from the Initial Fidelity Reviews (June – July 2015)

The data below indicate the findings from the FY 2015 fidelity reviews, of which 43 were completed for all identified current providers. The yellow and orange highlights indicate the opportunities for improvement, with orange being the greater opportunity. A double-line in the data tables identifies the separation of the reviews that occurred during the first half of FY 2015 versus the second half of FY 2015. Areas of opportunity that are common across programs help identify potential technical assistance, or 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.

Assertive Community Treatment (ACT) Fidelity Reviews Completed and Findings

Reviews completed July – December 2014

- ✓ Choices Enclave
- ✓ Southwest Network - Osborn Adult Clinic (SWN Osborn)
- ✓ Choices South Central
- ✓ Partners in Recovery (PIR) West Valley Adult Clinic
- ✓ Southwest Network (SWN Hampton)
- ✓ People of Color Network (PCN) Centro Esperanza
- ✓ Partners in Recovery (PIR) Metro Center Varsity
- ✓ Partners in Recovery (PIR) Metro Omega

Reviews completed January – June 2015

- ✓ Southwest Network – San Tan (SWN San Tan)
- ✓ Choices West McDowell (Choices WM)
- ✓ Southwest Network – Bethany Village (SWN BV)
- ✓ Choices – Townley Center
- ✓ People of Color Network (PCN) Comunidad
- ✓ People of Color Network (PCN) Comunidad Forensic (FACT)
- ✓ People of Color Network Capitol Center (PCN CC)

Assertive Community Treatment

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
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

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
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**

The fidelity team noted the following:

- The staff high-turnover rate appears to affect continuity of care.
- Specialists need to be trained and empowered to work as experts in their areas of specialization and 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.
- Most teams are not operating from an Integrated Dual Diagnosis Treatment (IDDT)/Stages of Change/Harm Reduction approach. Teams need to be able to track how members are moving through the stages of change and what staff are doing to facilitate movement. Staff are not familiar with these approaches, or are able to provide only superficial information when describing treatment models.
- Teams rely very heavily on referring to outside providers for SE and individualized counseling and psychotherapy due to lack of training and education, certification/licensure, and inability to function within areas of specialization. For example, Substance Abuse Specialists are often not trained in the IDDT model and do not have certification and licensure that would allow them to provide individualized counseling and psychotherapy on the team.
- Teams need to align with the ACT staffing model. For example, teams have only one nurse but have an unnecessary position such as transportation specialist, an area in which any case manager should be able to perform. Most teams have only one nurse and should have two.
- Once an ACT team is trained in how an ACT team functions, members should be oriented to understand the role of their team for crisis services, housing support, employment support, peer support, etc.
- Staff at all the PNOs report struggles to complete documentation due to inefficient electronic records systems and also inability to update documentation while in the community. Some staff report that they are unable to complete documentation during scheduled hours, coming in on weekends, days off and after scheduled hours.
- Staff would benefit from training in clinical documentation. Documentation appears rote, lacks structure and is inconsistent. Notes lack documentation of intervention used, member response, and plan for follow up action.

Assertive Community Treatment Fidelity Quality Improvement Opportunities

The overall ratings for ACT fidelity reviews ranged from 57.9 to 81.4 for the 15 reviews conducted, which is relatively good. The areas that present the greatest opportunities for a quality improvement focus across multiple sites include human resources such as the specific staffing on the teams and services available from the frequency and intensity of contacts to the 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 education and training.

Consumer Operated Services (COS) Fidelity Reviews Completed and Findings

Reviews completed July – December 2014

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

Reviews completed January – June 2015

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

Consumer Operated Services

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

COS	Likert Scale	CHEEERS	REN	STAR Central	STAR East	STAR West	Vive la Esp.
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
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**
Average Scores		**4.2**	**4.42**	**3.69**	**3.98**	**3.69**	**4.2**

The fidelity team noted the following:

- Increase internal and external advocacy/action efforts by members. This could take the form of volunteering, speaking in their own voice to community stakeholders, outreach and advocacy via social media and agency websites.
- Partner with SE agencies to support pre-employment/vocational training such as GED, computer training, etc.

Consumer Operated Services Fidelity Quality Improvement Opportunities

The overall scores for the six (6) Consumer Operated Services sites that were reviewed were very good, with percentage scores ranging from 79.8 to 95.7 percent. The average percentages scores across sites for the first half of FY 2015 was 88.5 percent and was 85.5 percent for the second half of the year. While this is a difference of -3 percentage points, the exceptional score from the Recovery Empowerment Network of 95.7 percent during the first six months accounts for this difference. Based on these ratings, some providers could benefit from some site-specific technical assistance with a focus on the Education and Advocacy ingredients. Structural items focusing on Planning Input and Linkage with other Service Agencies could also be helpful. Given the relatively good performance, facilitated conference calls with program leads from each of the programs would help clarify operationalizing the fidelity expectations and practices while promoting some collaboration across sites. It may be helpful for the conference calls to be facilitated by Laurie Curtis, a national expert in Consumer Operated Services.

Supported Employment (SE) Fidelity Reviews Completed and Findings

Reviews completed July – December 2014

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

Reviews completed January – June 2015

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

Supported Employment

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
Organizational							
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

The fidelity team noted the following:

- At the clinic level, teams have not embraced supported employment as an EBP and continue to rely heavily on prevocational and job training activities such as work adjustment and trial work periods. Pre-assessment and steering limits individuals to explore actual competitive employment and options that would support them in competitive and integrated work environments. Clinic staff often think that members are too disabled to work due to substance use or chronic symptoms and anticipate failure. Clinic staff worry about protecting the self-esteem of clients and want to move slowly toward employment goals so that members "build their stamina" or self-confidence.
- Clinical and SE teams and files are poorly integrated. Agency employment specialists do not regularly attend team meetings with the full team; Employment Specialists (ESs) do not function as members of a team but as separate and unique providers. Some agency ES staff appear to have very limited knowledge or insight into members with behavioral health experience.
- Rehabilitation Services Administration /Vocational Rehabilitation (RSA/VR) uses work adjustment training (WAT) as an assessment tool to determine whether or not they will benefit from VR services or ready to work, which does not align with SE as an EBP and negatively impacts fidelity scores.
- Many SE agencies are not effectively using, if using at all, the Vocational Profile. Some SE staff do not understand how to use the tool as a living document that helps guide employment searches or to assist members in documenting their growth and progress in employment.
- The Informed Choice Model is not being applied in a way that aligns with the goal of gaining competitive employment in an integrated setting. It appears to be used as a means of steering members to WAT, trial work, and pre-job skill training assignments. Informed choice was often used to validate placement of members in WAT, or pre-job skill training and allows SE providers to opt out of helping members manage anxiety, self-doubt and lack of experience when considering competitive work.

Supported Employment Fidelity Quality Improvement Opportunities

Substantial opportunities exist to improve the fidelity of the Supported Employment programs across all sites. The overall ratings for the sites reviewed range from 50.6 to 77.3 percent. The average percentages scores across sites for the first half of FY 2015 remained the same for the second half of the year at 65.3 percent. Given the Organizational ratings, education for leadership staff to gain a better understanding of the program model and to explore any

structural or policy practices that hinder better fidelity to the model would continue to be beneficial. Additionally, training and technical assistance for service providers and clinical partners will be valuable in improving adherence to the Supported Employment model, including service expectations and identifying specific quality improvement opportunities. Specific training on the purpose/uses for the Vocational Profile would be beneficial for both the SE and clinical team, especially the clinical Rehabilitation Specialists who are a primary point of contact for the member's referral into an SE program.

Permanent Supportive Housing

Reviews completed July – December 2014

- ✓ PSA Behavioral Health Agency (PSA)
- ✓ Arizona Health Care Contract Management Services, Inc. (AHCCMS)
- ✓ Terros Behavioral Health Agency (Terros)

Reviews completed January – June 2015

- ✓ People of Color Network (PCN)
- ✓ Recovery Innovations (RI)
- ✓ Helping Hearts (Help Hearts)
- ✓ Arizona Mentor
- ✓ Lifewell Behavioral Wellness (Lifewell)
- ✓ Southwest Behavioral Health (SWH)
- ✓ Partners in Recovery (PIR)
- ✓ Marc Community Resources
- ✓ Mountain Health and Wellness (MHW) [formerly Superstition Mountain Mental Health Center] (SMMHC)
- ✓ Choices
- ✓ Southwest Network (SWN)
- ✓ Child and Family Support Services, Inc.(CFSS)

Permanent Supportive Housing

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	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**

The fidelity team noted the following:

- At the clinic level referrals are based on team screening, pre-assessment and level of care recommendations from the team. For example, members who consistently say they want live on their own in their own apartment or house, may be referred for community living placements (CLPs) but end up in the house or apartment models based on availability versus need.
- The system does not support member choice by exploring all available options. Members don't have choice of units, choice of roommates and often 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. There is no provision or process that assists members with retention of their home (from a financial perspective) if they dis-enroll from the RBHA. Some type of partnership with another voucher agency, or extended assistance for a period of time, may be beneficial to sustaining housing.
- Across clinics, much confusion remains as to the referral process and what options are available. Wait lists and their progression are described in various terms by clinic staff.
- Wait lists are managed primarily by the RBHA and appear to prioritize high hospitalization costs over acuity with lower immediate costs (i.e. homelessness).
- With respect to scattered site PSH, positive behavior and functioning appears to be prioritized over acuity, which may be related to the availability of support and resources. Clinic staff refer to members who can or cannot live on their own because of substance use or symptoms.
- Documentation at the provider level suggests that services focus on fostering basic skills rather than long term independence.
- Providers often do not appear to have a process or procedure to obtain copies of leases and Housing Quality Standards (HQS) documents.

Variation exists between ACT teams as to the extent to which level of care designation is used to make housing referrals. Most staff recognized that when operating according to fidelity to the evidence based practice of PSH, service providers do not require members to meet housing readiness standards in order to gain access to the housing of their choice. Furthermore, staff said that members can successfully live independently regardless of symptomology if given the necessary wrap around supports delivered by the ACT team. One staff said, **"When we make the choice, it never goes well."**

Permanent Supportive Housing Fidelity Quality Improvement Opportunities

The fidelity percentages scores ranged from a low of 43.2 percent to a high of 74.1 percent. The average percentages scores across sites for the first half of FY 2015 was 46.5 percent and increased to 52.1 percent for the second half of the year, an improvement of 5.6 percentage points. Significant 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. Additionally, training and technical assistance for service providers and community partners will be beneficial in improving adherence to the Permanent Supportive Housing model and identifying specific quality improvement opportunities. Specific education and training for direct line clinic staff will be beneficial.

Recommended Quality Improvement Structure for Evidence-Based Practices

Given the findings of the fidelity reviews for the first year of the identified evidence-based practices conducted July 2014 through June 2015, 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 include a review of the key opportunities for improved fidelity scores based on the findings from the year-one 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. It is recommended that this serve as a kick-off for the year two fidelity reviews for each of the EBPs. The focus of this education will include 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 could be enhanced by the engagement of a national leader with exemplary experience in the roll-out of system improvement through the implementation of evidence-based practices and a greater focus on program outcomes. This experience could highlight structural, organizational and, cultural issues while also addressing system changes.

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 collaborative learning communities (dialogues with the

experts) will be conducted 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. As appropriate, 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 interact with experts and discuss site-specific ways to enhance fidelity, recognize obstacles, begin problem solving concerns and identify any additional technical assistance needs.