REPORT / FIRST EPISODE PSYCHOSIS

AUGUST 31, 2021

Fidelity Monitoring Plan for Coordinated Specialty Care

The University of Texas at Austin
Texas Institute for Excellence in Mental Health
Steve Hicks School of Social Work

CONTACT

Texas Institute for Excellence in Mental Health
School of Social Work
The University of Texas at Austin
1823 Red River Street
Austin, Texas 78712

Phone: (512) 232-0616 | Fax: (512) 232-0617
Email: txinstitute4mh@austin.utexas.edu
sites.utexas.edu/mental-health-institute

CONTRIBUTORS/PROJECT LEAD

Molly Lopez, Ph.D.
Arnold Amador, M.S.
Sarah Adams, MSW
Deborah Cohen, Ph.D.

ACKNOWLEDGEMENT

This work is funded through a contract with the Texas Health and Human Services Commission. The contents are solely the responsibility of the authors and do not necessarily represent the official views of Texas Health and Human Services Commission.

Recommended Citation: Lopez, M. A., Amador, A., Adams, S., & Cohen, D. A. (2021). Fidelity Monitoring Plan for Coordinated Specialty Care in Texas. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

Contents

Introduction

Coordinated specialty care is an evidence-based approach to supporting the recovery of youth and young adults experiencing an initial onset of psychosis. The intervention incorporates low-dose atypical antipsychotic medication, cognitive behavioral therapy, family psychoeducation, educational and vocational support, and case management within a team-based structure (Heinssen, et al., 2014; Mueser & Cook, 2014). Teams use assertive outreach strategies to engage young people and operate using the values of person-centered care and shared decision-making. Research has shown the CSC model to reduce or prevent the negative sequelae of psychosis (Kane, Robinson, Schooler, Mueser, Penn, et al., 2016; Dixon, Goldman, Bennett, Wang, McNamara, et al., 2015) and support individual recovery and quality of life (Kane, et al. 2016; Dixon, et al., 2015).

Research has demonstrated that fidelity to the CSC model serves as a mediator of treatment effectiveness (Marino, Nossel, Choi, et al., 2015); however, there remains much to learn about the levels of fidelity necessary to achieve positive outcomes and the specific role played by different components of the multi-faceted intervention. Early research has suggested that the involvement of family members in family psychoeducation meetings and the activities of the recovery coach mediated improvements in social functioning (Marino, et al., 2015). While additional research is needed to outline the impact of different intervention components of CSC on program outcomes, as well as the benchmarks of acceptable fidelity for achieving optimal outcomes, the measurement of intervention fidelity across programs remains an important step in ensuring the quality of care provided across a system of programs.

Fidelity Ratings in Texas

In the 2018-2019 fiscal year, the evaluation team at TIEMH began examining fidelity of CSC programs in Texas using the OnTrack fidelity tool. Participation in the fidelity monitoring process was not mandated, and seven of the ten existing programs participated. Fidelity reviews were conducted through in-person site visits and included interviews of staff, interviews of one individual in care and one family member, review of administrative data, and a review of a sample of health care records.

Overall fidelity scores across sites and for each team are presented in Table 1, masked for the site/team name. The median score for the Total of the 100-item FAS across sites was 1.30 (i.e., between “Acceptable” and “Exceptional”), with a range of 1.18 to 1.45. Table 1 also shows the percentage of the 100 items rated at Acceptable levels and above (i.e., ≥ 1.00) and the percentage of items scored Exceptional (i.e., 2.00). Across teams, almost all items (95% of 600 ratings) met OnTrackNY fidelity acceptable standards, and 35% exceeded those standards. The cross-site median Critical Items score was 1.43, with a range of 1.37 to 1.52, 99% of 162 ratings were at acceptable levels and above, and 44% of item ratings were exceptional.

Table 1. *Cross- and Specific-Site Scores on the 100-Item OnTrackNY Fidelity Assessment Scale and Critical Items*

Overall Scores	*Description*	*Items*	*Mean*	*% Acceptable*	*% Exceptional*	*State Median*
Total	Total score of all fidelity items	100		95%	35%	1.30
Team A			1.45	97%	48%	
Team B			1.29	95%	34%	
Team C			1.18	93%	25%	
Team D			1.32	97%	35%	
Team E			1.26	94%	32%	
Team F			1.31	94%	37%	
Critical	Critical fidelity components	27		99%	44%	1.43
Team A			1.48	96%	52%	
Team B			1.37	100%	37%	
Team C			1.41	100%	41%	
Team D			1.44	100%	44%	
Team E			1.52	100%	52%	
Team F			1.37	96%	41%	

The evaluation team planned to conduct fidelity reviews with newly developed CSC programs, following a state expansion, in 2019-2020 but the COVID-19 pandemic impacted the ability of many programs to fully implement CSC, as well as the teams capacity to conduct on-site reviews. As an alternative approach, the team conducted stakeholder interviews with program Team Leads to gather a narrative description of program characteristics, identify facilitators and barriers to implementation, and gather data on early adaptations related to COVID-19. The evaluation team hoped to perform a fidelity review during the current fiscal year, as well, and began planning a review with the hope that in-state travel would be feasible. However, the pandemic continued throughout the fiscal year and hampered capacity for on-site reviews. The team examined opportunities to adapt the fidelity tool to a remote protocol, and these activities are reflected in the current proposed plan. While the team hopes that on-site reviews will be practical in the 2021-2022 fiscal year, the protocol provides for a remote alternative.

Methodology

The current report set out to re-examine a feasible and efficient approach to measuring fidelity to coordinated specialty care in Texas. With the initiation of EPINET data collection on programs and individuals in care, new data sources were available to inform fidelity monitoring, potentially reducing the burden on CSC teams. The team set out to identify a protocol that utilized these data sources whenever possible. Additionally, some elements of the OnTrack fidelity tool that are intended to be available within administrative data sources are not present in the current administrative data collected through EPINET-TX, leaving these elements to only be available through a review of health care records. Additionally, some core aspects of the Texas approach to coordinated specialty care are not currently reflected in the OnTrack fidelity tool.

Team members set out to develop a proposed fidelity monitoring plan through the following key activities:

- Reviewed the OnTrack fidelity tool to determine items that could be measured remotely versus onsite;
- Reviewed the OnTrack fidelity tool to map items to data sources that are available through HHSC (administrative data), through the EPINET Core Assessment Battery (CAB), through the EPINET Program Level Core Assessment Battery (PL-CAB), through health care record reviews, or through interviews of staff, individuals in care or their family members;
- Adapted the OnTrack fidelity tool by removing select items measured by administrative data that was not available in Texas (specific fidelity concepts were still measured through chart review);
- Adapted the OnTrack fidelity tool by adding items that reflected the core concepts of family peer support, strengths-based assessment, and person-centered planning.
- Developed and piloted a Team Lead interview to gather information on fidelity items;
- Developed a proposed fidelity site review protocol; and
- Presented proposed fidelity protocol and new fidelity items to a focus group of CSC staff for feedback; and
- Incorporated program feedback into the current proposed protocol for fidelity monitoring.

Results: Proposed Fidelity Plan

Texas Fidelity Tool. The evaluation team proposes to utilize the OnTrack fidelity tool with minor adaptations to better reflect the core elements of the CSC programs in Texas and the availability of data for fidelity monitoring. While the aim is to maintain the integrity of the initial tool, as additional research is conducted on the relationship between fidelity and outcomes, the tool should be updated to ensure it accurately measures relevant components of treatment quality. The team looks forward to partnering with the Texas Early Psychosis Consortium to conduct this important research over the next few years. The current proposal would make the following changes to the OnTrack fidelity tool:

- Staffing: Adjust this item to reflect staffing vacancies do not exceed 60 days, with less than 30 days identified as “exceptional”. This item was modified as a result of feedback from the focus group and recognizing the variation in the workforce across different regions of the state.
- Supervision: Add an item reflecting that the team leader provides at least bi-weekly supervision to the Family Partner Peer Specialist. This addition mirrors the supervision fidelity benchmark for other CSC team members.
- 24/7 Availability: The proposal would delete this item from the Data Review, as administrative data does not reflect 24/7 access to crisis services, but maintain the same item from the Site Review protocol. The remaining item has been updated to include information on having access to medical back-up during crises.
- Strengths Assessment: The proposal would add an item to the Treatment Plan Site Review protocol on strengths assessment. The item would read: “Team assessment(s) identify and document strengths (e.g., talents/skills, past successes, interests/hobbies, cultural/religious connections) in multiple areas.”
- Person-Centered Planning: The proposal would add an item to the Treatment Plan Site Review protocol on person-centered planning. The item would read: “The recovery plan reflects that the provider worked with the individual (and their identified family when possible) to develop meaningful goals that are in their own words and reflect developmental accomplishments and/or

quality of life changes." While this one element is not a comprehensive measurement of person-centered planning, it brings one core aspect into the fidelity measure.

- Case Management: Two current items reflecting case management would be modified slightly to shift focus from "concrete needs" to "social determinants of health and mental health." This change would emphasize the focus on a variety of experiences that can hamper equitable outcomes in health and mental health, such as exposure to violence/adversity.
- The proposal would delete one item focused on safety planning for individuals at risk of suicide from the Data Review, but maintain a similar item within the Site Review protocol.
- Trauma Interventions: The item was modified to provide sample trauma interventions commonly used in the Texas system, such as Cognitive Processing Therapy and Trauma-Focused Cognitive Behavioral Therapy.
- Family Partner Services: Four items were added to measure the provision of family partner services. These item mirror those items measuring peer services, to the extent it made sense. The proposed items are:
    - 35% of participant family members meet with the family partner at least once per quarter.
    - For all clients who have permitted family involvement, Team has conversations regarding their preferences for working with the Family Partner.
    - Interviews with Primary Clinicians, Family Partners, family members, and review of medical records indicate that families are being offered meetings with the family partner.
    - The Family Partner is engaged with team outreach activities and initial engagement of the client and family.
    - The Family Partner is working with families using their personal stories and providing support to family members on system navigation, advocacy and voice, coping strategies, etc.

The proposed fidelity tool is available in the Appendix. Items removed from the measure are reflected with strikeout text. Items that have been added to the tool are reflected in blue text. Changes to numbering and the shifting of an item from Data Review to Site Review are not marked.

Proposed Protocol. The evaluation team proposes the following protocol for CSC fidelity reviews. The team will provide all CSC sites with materials describing the fidelity review protocol to ease planning. The site visit date will be set three months prior to the site visit, in collaboration with the CSC program. During the preparation phase, the CSC program will receive a site visit checklist outlining materials to prepare and a draft schedule for the day, allowing for flexibility to adjust the schedule as needed. During the preparation phase, the evaluation team will collect data from the PL-CAB, CAB, and CMBHS. Initial ratings of Data Review fidelity items will be scored, and any questions documented in preparation for the on-site review. One month prior to the site visit, the evaluation team will identify a sample of approximately 5-10 charts for review, depending on the number of reviewers. These charts will be stratified to include both adolescents and young adults, and individuals who were enrolled less than six months and those enrolled for more than six months.

The team will return to finalize the review, reach consensus on all ratings, and discuss discrepancies with supervisors. During the first year, fidelity benchmarking scores will be developed for urban and rural regions. Reports will provide benchmarks for the state as a whole, and urban and rural regions, with benchmarks updated each year, reflecting the last three years of data. A final report will be developed within three weeks of the site visit and shared with the CSC team. The site review team will conduct a virtual debriefing meeting with the team to explain the results and answer any questions.

The evaluation team proposes to conduct a fidelity review with each CSC program every three years, reviewing eight programs per year. In the initial year, programs would be recruited to volunteer for the early phase, with additional programs recruited in the subsequent two years. Unless directed by HHSC, sites would not be required to participate in the external fidelity review. Aggregate results will be provided to the state each year in a report, with accompanying recommendations highlighting opportunities for technical assistance to enhance fidelity or identifying and policy barriers that may be impacting fidelity.

Option for Remote Review. The COVID-19 pandemic has been a barrier to conducting fidelity review site visits. If an inability to travel persists into the 2021-2022 fiscal year, the evaluation team proposes to conduct remote fidelity assessments. The team will conduct virtual interviews through Zoom, as well as listen to a team meeting through a phone or video conferencing. The team will work with the CSC program to understand their capacity for remote chart reviews. If possible, the team will review charts directly within the EHR over a secure platform. When this option is not within the local programs policies, the evaluation team will review an electronic copy of the chart, printed from the EHR. The team has experience conducting virtual site visits at some community mental health centers. One study has examined the reliability and feasibility of conducting a remote fidelity assessment, using information from administrative data, health record review, and phone interviews with staff. Interrater reliability was good to excellent across the items (First Episode Psychosis Services Fidelity Scale – Remote; FEPS-FS-R) and it required an average of 10.5 hours of staff time for preparing for and conducting the fidelity review (Addington, Noel, Landers, et al., 2020).

Future Fidelity Opportunities. Depending on team capacity and provider interest, the team would like to move towards offering practice-specific fidelity reviews over time. Fidelity tools currently exist for:

- Individual Placements and Support – Supported Employment and Education (Ellison, Klodnick, Bond, Krzos, Kaiser, et al., 2015).
- Family Psychoeducation (Joa, Johannessen, Helervang, Sviland, Nordin, et al., 2020)
- Cognitive Behavioral Therapy for Psychosis (Rollinson, Smith, Steel, Jolley, Onwumere, et al., 2007).

This would allow for a more thorough review of individual components of coordinated specialty care and further deepen the understanding of program quality, as well as allow for examining the relation between these programs and select outcomes.

References

Addington, D., Noel, V., Landers, M., & Bond, G. R. (2020). Reliability and feasibility of the first-episode psychosis services fidelity scale–revised for remote assessment. *Psychiatric Services, 71(12)*, 1245-1251.

Marino, L., Nossel, I., Choi, J. C., Nuechterlein, K., Wang, Y., Essock, S., et al. (2015). The RAISE connection program for early psychosis: secondary outcomes and mediators and moderators of improvement. *The Journal of Nervous and Mental Disease, 203(5),* 365.

Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., et al., (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry, 173(4),* 362-372.

Dixon, L. B., Goldman, H. H., Bennett, M. E., Wang, Y., McNamara, K. A., et al. (2015). Implementing coordinated specialty care for early psychosis: the RAISE Connection Program. *Psychiatric Services, 66(7),* 691-698.

Heinssen, R. K., Goldstein, A. B., & Azrin, S. T. (2014). Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care. National Institute for Mental Health. Available at https://www.nasmhpd.org/sites/default/files/Summary%20of%20Evidence-BasedTreament%20Components%20for%20FEP_14APR_2014_Final.pdf

Mueser, K. T., & Cook, J. A. (2014). Rising to the challenge of first episode psychosis: The NIMH Recovery After Initial Schizophrenia Episode (RAISE) initiative [Editorial]. *Psychiatric Rehabilitation Journal, 37*(4), 267–269.

Joa, I., Johannessen, J. O., Heiervang, K. S., Sviland, A. A., Nordin, H. A., et al. (2020). The Family Psychoeducation Fidelity scale: psychometric properties. *Administration and Policy in Mental Health and Mental Health Services Research, 47(6),* 894-900.

Ellison, M. L., Klodnick, V. V., Bond, G. R., Krzos, I. M., Kaiser, S. M., et al., (2015). Adapting supported employment for emerging adults with serious mental health conditions. *The Journal of Behavioral Health Services & Research, 42(2),* 206-222.

Rollinson, R., Smith, B., Steel, C., Jolley, S., Onwumere, J., Garety, P., Kuipers, E., Freeman, D., Bebbington, P., Dunn, G., Startup, M., & Fowler, D. (2007). Measuring Adherence in CBT for Psychosis: A Psychometric Analysis of an Adherence Scale. *Behavioural and Cognitive Psychotherapy, 36*, 163 - 178.

Coordinated Specialty Care Fidelity – Texas

(Adapted from OnTrack Fidelity Tool; v1 Aug. 2021)

Definition	Data Source	Unacceptable	Acceptable	Exceptional
I. Staffing: from data				
1. Staffing: No less than 4.0 FTE; 4.0FTE total; each team is staffed with persons meeting at least the minimum credentialing requirements and are fulfilling the following (TL, PC, ORC, SEES, Prescriber, Nurse, and Peer Specialist)	PL-CAB			
2. Staffing: Vacancies do not exceed 60 days (< 30 days for exceptional)	PL-CAB			
II. Staffing: from site visit				
3. Staffing: When meeting with the team determine that there is a TL, ORC, SEES, Peer Specialist, Prescriber, and Nurse *Probing question: What role does each member on the team? For individuals serving more than one role how does this work?*	Site Visit Team Interview			
III. Team Integration: from data				
4. Team-Based Approach: At least 50% of clients meet with 2 or more team members in a given quarter.	CMBHS			
5. Team Meeting: Full team meets at least weekly (expectation is 12 meetings per quarter).	Site Visit Document Review			
6. Team Meeting: Staff Meets as a Team. Each team member attends at least 80% of team meetings.	Site Visit Document Review			
7. Supervision: Team Leader provides clinical supervision to clinicians serving as the Primary Clinician and ORC at least bi-weekly for clinical supervision to review client progress, interventions attempted, and next steps.	Site Visit Document Review, Interview			
8. Supervision: Team Leader provides intensive, outcome-based supervision with respect to meeting clients' goals for education and employment. Team leader conducts at least twice monthly SEES supervision during which each client on the team is reviewed with respect to education and employment outcomes to identify new strategies and ideas to help clients in their school and work lives.	Site Visit Document Review, Interview			

9. Supervision: Team leader provides at least bi-weekly supervision to the Peer Specialist to review engagement strategies for incoming clients and review of work with current clients.	Site Visit Document Review, Interview			
10. Supervision: Team leader provides at least bi-weekly supervision to the Family Partner Peer Specialist to review engagement strategies for family members and review of work with current client families.	Site Visit Document Review, Interview			
IV. Team Integration: from site visit				
11. Supervision: Supervisees report that the TL meets with them on a regular basis to discuss client progress. *Probing question: How often do you meet with the TL to discuss a client's progress?*	Site Visit Document Review, Interview			
12. Staff Meets as Team: Each client's clinical status is reviewed at least briefly at each meeting. *Probing question: Do you review each client's clinical status at each team meeting? How often do you have team meetings to discuss client's status? Ask if there are notes taken at the meetings you can take a look at or if there is a table with each client's status that is regularly updated at the meetings.*	Site Visit, Team Meeting Observation and Interview			
13. Team Communication: Team has developed a system for team communication, as needed, outside of team meetings. *Probing question: How do you communicate within the team, outside of team meetings?*	Site Visit, Team Meeting Observation and Interview			
V. Target Population: Eligibility: from data				
14. Eligibility: Eligibility forms completed and only clients meeting criteria are enrolled.	CAB			
VI. Target Population: Eligibility: from site visit				
15. Eligibility: Client records indicate that participants meet program's eligibility criteria and there is evidence of this in the client's client records. *Probing question: Ask for the client records to make sure the clients have been meeting eligibility criteria. If they use OnTrackNY Evaluation form this information will be clearly documented. If not, ask the Primary Clinician to clarify what is documented on an intake form.*	Site Visit, Chart Review			

VII. Target Population: Community Outreach: from data				
16. ORC conducts outreach to hospitals and other likely settings to provide information and solicit referrals: ORC visits each target hospital at least once each quarter, speaking with inpatient, outpatient and ER clinical staff about CSC program and leaving printed material.	Site Visit, Document Review			
17. ORC conducts outreach to hospitals and other likely settings to provide information and solicit referrals: In addition, each quarter the ORC will make outreach visits to other community settings, leaving printed material.	Site Visit, Document Review			
18. ORC conducts outreach to hospitals and other likely settings to provide information and solicit referrals: In the past 6 months, all settings noted in the Program Components form will receive some type of outreach (face to face, telephone, electronic).	Site Visit, Document Review			
VIII. Target Population: Community Outreach: from the site				
19. Development of Referral Network: ORC routinely builds and maintains relationships within referring community to establish referral network. Probing questions- *Ask for examples about how they approach relationship building and maintaining these relationships in the community. Ask to see their outreach plan and ask for specific examples of how they have worked with community agencies. Review Outreach Work Plan Outreach Tracking document.*	Site Visit, Interview with ORC			
20. Community Education: Community education about early episode psychosis routinely provided in referring communities to key stakeholders. Probing questions- *Might ask to see their materials for providing community education.*	Site Visit, Interview with ORC			
IX. Target Population: Managing Referrals: from data				
21. Prompt Admission: For at least 80% of individuals admitted to the program, the time from eligibility determination to admission is < 1 week.	CAB & CMBHS			
22. Team Acts on Referrals and Engaged Families Throughout the Admission Process: At least 65% of individuals went from screening to initial evaluation within 7 days.	CAB & CMBHS			

23. Team Acts on Referrals and Engaged Families Throughout the Admission Process: At least 85% of individuals deemed eligible enter/enroll in the program.	CAB & CMBHS			
X. Target Population: Managing Referrals: from site visit				
24. Screening window: Participants are screened by phone within 72 hours of contact for eligibility and scheduling of initial evaluation. *Probing question: Ask to see the referral tracking log or other form they might use to track referrals.*	Site Visit, Chart Review, Referral Tracking			
25. Initial Evaluation window: Participants are seen within one week of initial contact for initial eligibility evaluation *Probing question: Ask ORC if they are doing this and how is it going. This information might be available in the referral tracking log.*	Site Visit, Chart Review, Referral Tracking			
26. Meeting with Prescriber: If appropriate for program, participants are scheduled for an intake evaluation with both PC and Prescriber within a week of eligibility determination. *Probing question: Might compare the referral tracking log with the date when they met prescriber. Ask the ORC and Primary Clinician how long it takes to schedule with the prescriber on average*	Site Visit, Chart Review, Referral Tracking			
XI. Caseload: from data				
27. Caseload: Team's caseload does not exceed a 12:1 ratio- based on the last day of any given quarter.	CAB & PL-CAB			
28. Caseload: By the end of the past 6 months, team has at least 25 current clients.	CAB			
XII. Caseload: from site visit				
29. Caseload: Review the team's census on site *Probing question: Ask for the materials where the number of clients the team is working with is being recorded or discuss census with the TL.*	Site Visit, Interview with TL			
XIII. Flexibility of Services: from data				
30. Services in the Community: At least 10% of clients are seen in the community by at least one Team member at least once per quarter (exclude services provided by the Supported Education and Employment Specialist).	CMBHS			

XIV. Flexibility of Services: from site visit				
31. Scheduling: Staff schedule shows the regular availability of office time outside of 9am to 5pm for the scheduling of routine appointments. *Probing question: Ask to see the staff schedule. Is there regular availability of office time outside of 9am to 5pm for routine appointments to be scheduled? Who is usually available outside of these times to schedule routine appointments?*	Site Visit, Interview with TL			
XV. Assertive Outreach: from site visit				
32. Assertive Outreach: Team can explain a concrete strategy to promote client engagement when clients miss appointments or show disinterest in services, which includes reaching out to people various methods (e.g., phone, text, email, and home visits) to promote engagement. *Probing question: What does the team usually do when dealing with client disengagement and disinterest in services? What methods of communication or strategies are being utilized to increase engagement? Ask Primary Clinicians if they go out to the community to meet clients and what creative activities they might offer to increase engagement.*	Site Visit, Team Meeting Observation and Interview			
XVI. Crisis Services: from data				
~~**33. 24/7 Availability:** Team provides 24/7 phone access to clients and families and team has a system in place in accordance with the host agency policy to manage crises, including access to medical back-up.~~				
33. Crisis Services: Team is involved in providing in-person crisis support or coordinating linkages to manage crises on a timely basis.	CMBHS			
XVII. Crisis Services: from site visit				
34. 24/7 Availability: Team provides 24/7 phone access to clients and families and the policy is posted at the site in a location visible to clients/family members and distributed to each client. The team has a system in place in accordance with the host agency to manage crises, including access to medical back-up.	Site Visit, Interviews			

Probing question: What system is in place so that clients and families have 24/7 access to the team? Is there always someone available to answer a call or return a missed call? How quick does it take for a missed phone call to be returned? Where is the policy that the team provides 24/7 access to clients and families posted at the site? Is it easily visible? Do you distribute this policy to each client?				
35. Crisis Services: Team has a system in place in accordance with the host agency policy to manage crises, including access to medical back-up. *Probing question: Ask the team or the primary clinician if there is a system that is in accordance with the host agency policy for dealing with a crisis. Ask if this system includes access to medical back-up. Ask them to describe the system step by step.*	Site Visit, Interviews			
36. Crisis Services: Team is involved in providing in-person crisis support or coordinating linkages to manage crises on a timely basis. *Probing questions: Who on the team is involved in providing in-person crisis support? Who on the team is involved with coordinating linkages to manage crises on a timely basis? How quickly are linkages coordinated to manage crises?*	Site Visit, Interviews			
XVIII. Care Processes: from data				
37. Core Sessions: 70% of clients receive core sessions 1-5 within the first 6 months of working with the team.	CMBHS			
XIX. Care Processes: from site visit				
38. Core Sessions: Clinicians report receiving training on core care processes including recovery, person-centered care, shared-decision making, and cultural competency. *Probing questions: Did you receive training on core care processes including recovery, person-centered care, shared decision making, and cultural competency? Ask them to describe examples of how they have used these concepts with clients*	Site Visit, Interviews			

39. Core Sessions: Clients report that the team is delivering person-centered care, using recovery principles, shared-decision making (e.g., watching the SDM video) and cultural competency. *<u>Probing questions</u>: Do you feel like you are involved in decisions around your care (meds, visits, etc.)? Did you watch the SDM video?*	Site Visit, Client & Family Interviews			
XX. Eligibility Evaluation and Treatment Planning: from site visit				
40. Eligibility Evaluation: Comprehensive clinical assessment. Eligibility evaluation includes: 1. Time course of symptoms, change in functioning and substance use; 2. Recent changes in behavior; 3. Risk assessment risk to self/others; 4. Mental status exam; 5. Psychiatric history; 6. Premorbid functioning; 7. Co-morbid medical illness; 8. Co-morbid substance use; 9. Family history *<u>Probing questions</u>: Does the eligibility evaluation include determining the time course of symptoms, whether there is a change in functioning, and if substance use is present? Does it include determining if there have been any recent changes in behavior and whether they there is a risk to themselves and/or others? Does a mental status exam take place? Is psychiatric history assessed? Do you ask about the client's functioning before they began experiencing symptoms? Do you determine if there is a co-morbid medical exam or co-morbid substance use? Is family history asked about? If available in the client's chart, please verify. If not available, determine if this information is gathered by asking the clinicians to describe their assessment and treatment planning processes.*	Site Visit, Chart Review			
41. Needs Assessment: Psychosocial needs assessed for care plan: assess client and family preference and incorporate into care plan needs related to: 1. Housing; 2. Employment; 3. Education; 4. Social support; 5. Finances; 6. Basic living skills; 7. Primary care access; 8. Social skills; 9. Family support; 10. Past trauma; 11. Legal	Site Visit, Chart Review			

Probing questions: Ask the primary clinician how psychosocial needs are assessed for the care plan? Are the client and family preferences related to housing, employment, education, social support, finances, basic living skills, primary care access, social skills, family support, past trauma, and legal circumstances assessed to be incorporated into the care plans? If available in the client's chart, please verify. If not available, determine if this information is gathered by asking the clinicians to describe their assessment and treatment planning processes.				
42. Treatment Plan: Individualized clinical treatment plan after eligibility evaluation: patients, family and staff develop individualized treatment plan using evidence-supported treatments addressing client needs, goals and preferences (i.e. pharmacotherapy, psychotherapy, addictions, mood problems, suicide prevention, weight management). *Probing questions: Is the clinical treatment plan developed after the eligibility evaluation? How do you ensure the treatment plan is individualized for each client? Give examples. Ask the clinician to describe how the team uses evidence-supported treatments to address client needs, goals and preferences (i.e. pharmacotherapy, psychotherapy, addictions, mood problems, suicide prevention, weight management)? If available in the client's chart, please verify. If not available, determine if this information is gathered by asking the clinicians to describe their assessment and treatment planning processes.*	Site Visit, Chart Review			
43. Strengths Assessment: Team assessments identify and document strengths (e.g., talents/skills, past successes, interests/hobbies, cultural/religious connections) in multiple areas.	Site Visit, Chart Review			
44. Person-Centered Planning: The recovery plan reflects that the provider worked with the individual (and their identified family) to develop meaningful goals that are in their own words and reflect developmental accomplishments and/or quality of life changes.	Site Visit, Chart Review			

XXI. Case Management: from site visit				
45. Case Management: Interviews with Primary Clinicians, clients and review of medical records indicate that Primary Clinicians routinely assess clients' and families' ~~concrete needs~~ social determinants of health and mental health. *Probing questions: How often do you (the Primary Clinicians) assess the clients' and families' concrete needs?. Ask primary clinicians to describe their assessment processes and to give examples of how they have done this. Ask clients how the team has helped them with concrete needs or whether the team has connected them to community resources* Determine *if there is any documentation of this in the medical record.*	Site Visit, Chart Review and Interviews			
46. Case Management: Primary Clinicians provide case management services to help clients and families with ~~concrete needs~~ social determinants of health and mental health. *Probing questions: Ask the Primary Clinicians for examples of how they provide case management services to help clients and families with concrete needs and to show you where these activities are documented.*	Site Visit, Chart Review and Interviews			
~~**XXII. Assessments: from data**~~				
~~**45. Safety Assessment:** The CSSR or equivalent tool is completed with every client at admission and whenever concerns about possible suicide are raised.~~				
~~**46. Safety Assessment:** For those who meet or exceed the specified threshold indicating a risk of suicide, a safety plan is developed the same day of the screening and is included in the chart.~~				
XXII. Assessments: from site visit				
47. Safety Assessment: The C-SSRS or equivalent tool is completed with every client at admission and whenever concerns about possible suicide are raised.	Site Visit, Chart Review and Interviews			
48. Safety Assessment: Interviews with Primary Clinicians, clients and review of medical records indicate safety plan intervention is being delivered. *Probing questions: Do you (Primary Clinician) deliver an intervention for developing a safety plan with the client?*	Site Visit, Chart Review and Interviews			

49. Safety Assessment: Safety plan is available in the medical record for clients who endorse suicidal ideation plan or intent. *<u>Probing questions</u>: Review the medical records to determine if for clients who have endorsed suicidal ideation plan or intent to see if a safety plan is there.*	Site Visit, Chart Review and Interviews			
XXXIII. Medications: from data				
50. Psychotropic Medications: On the last day of the reporting period, antipsychotic medication was prescribed for at least 60% of clients.	CAB			
51. Psychotropic Medications: At least 75% of clients have had at least one trial of an antipsychotic medication prescribed for at least 4 continuous weeks within the recommended dosage range.	CAB (partially)			
52. Psychotropic Medications: Psychiatrist or nurse practitioner records symptoms and side effects for each client prescribed psychotropic medication at least quarterly using standardized assessment scales in a manner that facilitates monitoring changes over time.	CAB			
53. Psychotropic Medications: At least one client is on clozapine.	CAB			
XXIV. Medications: from site visit				
54. Psychotropic Medications: Evidence that antipsychotic medication was prescribed or discussed with clients. *<u>Probing question</u>: Review medical records to determine whether antipsychotic medication was prescribed and any documentation of how this was discuss with clients. Ask the nurse or prescriber how they introduce antipsychotic medications to clients and discuss side effects.*	Site Visit, Chart Review and Interviews			
55. Psychotropic Medications: Evidence in medical record that clients have had at least one trial of antipsychotic medication for at least 4 continuous weeks within the recommended dosage range. *<u>Probing questions</u>: Review medical records to determine if clients have had at least one trial of antipsychotic medication for at least 4 continuous weeks within the recommended dosage range.*	Site Visit, Chart Review and Interviews			
56. Side Effects: Evidence that prescriber or nurse assess for side effects and standardized assessment scales can be found in the medical record.	Site Visit, Chart Review and Interviews			

Probing questions: Review medical records to determine if there are any assessments used to assess medication side effects. How do you (prescriber or nurse) assess for side effects and what methods do you use?				
57. Psychotropic Medications: Prescribers and clients report that client preferences are considered and SDM is used before medications are prescribed. *Probing questions: Do you (prescriber) engage in shared decision making with your client before medications are prescribed? Do you make sure the preferences of the client are considered first? Please, describe. Ask clients if they think their preferences are considered with regards to medications. Might ask them to describe how the team discusses medications with them*	Site Visit, Prescriber and Client Interviews			
XXV. Metabolic Risk Factors: from data				
58. Weight Assessment: For at least 80% of clients prescribed an antipsychotic medication, weight is assessed at least quarterly. (Weight gain of over 1 BMI prompts consideration of a change (in medication, dosage, or behavioral intervention).	CAB (partially)			
59. Monitoring of fasting glucose/HbA1c and lipids: For at least 25% of clients prescribed an antipsychotic, assessment of fasting glucose/HbA1c and lipids conducted at least quarterly.	CAB (partially)			
60. Nurse works with clients to promote wellness: At least 50% of clients meet individually (i.e., not as part of a group) with the nurse within 3 months of their admission date.	CMBHS			
61. Nurse works with clients to promote wellness: At least 80% meet individually with the nurse within 6 months of their admission date.	CMBHS			
XXVI. Metabolic Risk Factors: from site visit				
62. Nurse works with clients to promote wellness: At least 45% of clients have completed a Core Session with the nurse about health and wellness services available within the first 6 months of treatment.	Site Visit, Chart Review			
63. Nurse works with clients to promote wellness: At least 35% of clients meet with the nurse at least once per quarter beyond the core session.	Site Visit, Chart Review			

64. Weight Assessment: Interviews with providers and medical records substantiate that team is performing weight assessments, requesting glucose and lipid levels, and working on wellness strategies with clients. *Probing questions: Review medical records to determine whether the team is regularly performing weight assessments and requesting glucose and lipid levels from the clients. What type of wellness strategies do you work on with the clients?*	Site Visit, Chart Review and Interviews			
XXVII. Psychoeducation: from data				
65. Core Sessions: At least 75% of clients participate in at least five of the ten core sessions with the Primary Clinician.	CMBHS			
XXVIII. Psychoeducation: from site visit				
66. Psychoeducation: Interviews with providers, clients and medical records indicate that Primary Clinicians are using psychoeducation routinely in care. *Probing questions: Review medical records to determine whether the Primary Clinicians are using psychoeducation regularly in care. What are some examples of psychoeducation you (Primary Clinicians) use with your clients? Ask Primary Clinicians how often they use psychoeducation with their clients? Ask clients if their primary clinicians offer sessions focused on psychoeducation (information about psychosis).*	Site Visit, Chart Review and Interviews			
XXIX. Cognitive Behavioral Therapy/Motivational Enhancement-Based Interventions: from data				
67. Primary Clinician provides flexible, motivational interventions: At least 30% of clients participate in at least one of the following skills building interventions with the Primary Clinician: coping skills, social skills, substance use treatment, behavioral activation.	CMBHS			
XXX. Cognitive Behavioral Therapy/Motivational Enhancement-Based Interventions: from site visit				
68. CBT Interventions: Interviews with Primary Clinicians, clients and medical records indicate that Primary Clinicians are using empirically-validated CBT-based interventions to match client problems based on client preferences.	Site Visit, Chart Reviews and Interviews			

<u>Probing questions:</u> Are you trained in CBTp or other CBT intervention? What strategies do you use for helping clients manage persistent positive psychotic symptoms, depression or anxiety? Do you use behavioral experiments with your clients? Do you perform any community-based approaches like behavioral experiments? Ask the clients how their primary clinicians help them come up with ways to manage and cope with symptoms.				
69. Conducting a Variety of Groups: At least one such group (family psychoeducation, substance use, social skills, coping skills, health & wellness) occurs at least monthly (to count as a group, family members of at least 2 clients must attend).	Site Visit, Chart Reviews			
70. Conducting a Variety of Groups: At least once per month, at least one such group occurs outside of normal business hours (outside of 9am-5pm, M-F).	Site Visit, Interviews			
XXXI. Substance Abuse Treatment: from site visit				
71. Substance Use Assessment & Treatment: At least 90% of Admission and Follow-up forms indicate what, if any, substances were used during the quarter and whether this use was seen as problematic by the client and by the team	Site Visit, Chart Reviews			
72. Substance Use Treatment: Of clients whose substance use is seen as problematic by at least one member of the team (including the client), at least 50% of such clients are receiving treatment for substance use by meeting with at least one CSC clinician during the quarter	Site Visit, Chart Reviews			
73. Substance Use Treatment: There is evidence from interviews with Primary Clinicians that they use Motivational Interventions/Shared Decision Making/ Harm Reduction strategies with clients who have substance use issues. *<u>Probing questions:</u> Have you been trained in Motivational Interventions/Shared Decision Making/Harm Reduction strategies? Do you have any examples you can share that depict using any of these strategies with clients who are dealing with substance use? Ask clients if their primary clinician has offered to work with them on issues related to substance abuse.*	Site Visit, Interview with Clinician			

74. Substance Use Treatment: If substance use is a treatment goal, it is documented in the treatment plan and the medical record reflects that this is being worked on collaboratively with clients and the team. *Probing questions: Review medical records to determine if substance abuse treatment is offered to clients and whether this treatment is being delivered.*	Site Visit, Chart Reviews			
XXXII. Trauma-Informed Treatment: from site visit				
75. Trauma Assessment: Interviews with Primary Clinicians, clients and review of medical records indicate that routine assessments of PTSD are being performed with clients. *Probing questions: Ask clinicians what they use to assess PTSD with clients. How often are they assessing for PTSD? Review medical records to determine what assessments are being used, if any.*	Site Visit, Chart Reviews and Interviews			
76. Trauma Intervention: Interventions for trauma, such as CPT and TF-CBT, are delivered based on client preferences. Ask primary clinicians if they are familiar with the evidence-based trauma interventions and whether they have used any with any clients. Ask clients if they were offered trauma treatment and whether their preferences were considered.	Site Visit, Chart Reviews and Interviews			
XXXIII. Working with Families: from data				
77. Family Involvement: For at least 50% of clients, at least one team member met with at least one member of the client's family each quarter.	CMBHS			
XXXIV. Working with Families: from site visit				
78. Family Involvement: For all clients, Team has conversations regarding their preferences for family involvement as part of the admission process.	Site Visit, Interviews			
79. Family Involvement: At least one family member group each month meets outside the hours of 9am-5pm M-F.	Site Visit, Interviews			
80. Family Involvement: Interviews with Primary Clinicians, clients and review of medical records indicate that that Primary Clinicians offer meetings with client's families and for those who agree, family meetings are happening depending on client and family preferences.	Site Visit, Chart Reviews and Interviews			

Probing questions: Review medical records to determine if the Primary Clinicians is offering meetings for families and whether these are happening. Ask the Primary clinician to describe the various ways in which family meetings are arranged and how they determine clients' and families' preferences? Ask clients whether their preferences were respected regarding how the team is working with their family. Ask clients whether their preferences were respected regarding how the team is working with their family. Review Family Needs Assessment if available				
81. Family Involvement: Primary Clinicians report that they are conducting at least one family session outside the hours of 9am-5pm M-F. *Probing question: Are you working with at least one family outside the regular hours of 9am-5pm M-F?*	Site Visit, Interviews			
XXXV. Supported Employment and Education Services: from data				
82. SEES focuses exclusively on supported employment and supported education: SEES primarily provide employment and education services. At least 90% of the SEES's time is devoted to assisting client in working on employment or education goals.	CMBHS			
~~**83. Individualized follow-along supports:** At least 50% of SEES' time is spent in community settings (outside the mental health center), devoted to engagement, employer and educational institution contacts, providing follow-along support, etc.~~				
83. SEES helps clients find competitive jobs and mainstream education: At least 50% of clients were competitively employed, in a competitive internship, or attended school as part of a degree-granting program at least 1 day per quarter.	CAB			
84. SEES helps clients find competitive jobs and mainstream education: On the last day of the quarter, at least 65% of enrolled clients were competitively employed, in a competitive internship, or attended school as part of a degree-granting program. For clients discharged during the quarter, consider their school/employment status on the day of discharge.	CAB			

85. SEES is fully integrated into the team: At least 90% of clients who have a goal of school or work indicated on their Follow-up form (or for newly admitted clients, on their Admission form), to have met with the SEES for help with school or employment.	CAB & CMBHS			
XXXVI. Supported Employment and Education Services: from site visit				
86. For clients who express a desire to work with the SEES, the, SEES completes a standardized assessment detailing client's goals for work/school and of supports needed. At least 40% of clients who have met with the SEES have the Career Profile Form was completed within 2 weeks of first meeting with the SEES.	Site Visit, Chart Reviews			
87. SEES Time: Interviews with SEES and TL and medical records reflect that SEES spends most of their time helping clients find competitive jobs or returning to mainstream education as well as providing follow-along supports. *Probing questions: How much time do you (SEES/TL) spend assisting the clients in finding competitive jobs or returning to obtain an education? How much time is spent providing follow-along supports? Review medical records that contain the activity of the SEES and the services provided to each client to see if there is documentation that reflects how SEES spends time working with the client.*	Site Visit, Chart Reviews and Interviews			
88. Work and School Goals: Medical records reflect work and school goals in the treatment plan and indicate whether clients are enrolled in school or have jobs. *Probing questions: Review medical records to determine if work and school goals are included in the treatment plan. Determine if school enrollment or employment status is being documented in the medical records.*	Site Visit, Chart Reviews			
XXXVII. Peer Specialist Services: from data				
89. Peer Specialist Services: 50% of participants meet with the peer specialist at least once per quarter.	CMBHS			
XXXVIII. Peer Specialist Services: from site visit				
90. Peer Specialist Services: For all clients, Team has conversations regarding their preferences for working with the Peer Specialist.	Site Visit, Interviews			

91. Peer Specialist Services: Interviews with Primary Clinicians, Peer Specialist, clients, and review of medical records indicate that clients and families are being offered meetings with the peer specialist. *Probing questions: Are clients and families being offered opportunities to meet with the peer specialist? How often does the Peer Specialist meet with clients or families? Review medical records to determine if meetings with Peer Specialist are being offered. Ask clients if they are able to meet with the Peer Specialist if this is something they want to do.*	Site Visit, Chart Reviews and Interviews			
92. Peer Specialist Services: Peer Specialist is engaged with team outreach activities and initial client engagement. *Probing questions: Ask the Peer Specialist: What are examples of some of the activities you (peer specialist participated in to help with outreach efforts? What are some in which you worked with the client to promote their engagement with the team initially?*	Interviews with Peer Specialist			
93. Peer Specialist Services: The Peer Specialist is working with clients using their recovery stories and providing support to clients around primary clinician interventions. *Probing questions: What are some of the different ways you use your recovery story to work with clients? Can you provide some examples about how you work to support clients with whom you are working? How have you worked with the primary clinician to help support some of the clinical interventions to clients?*	Site Visit, Chart Reviews and Interviews			
XXXIX. Family Partner Services: from data				
94. Family Partner Services: 35% of participant family members meet with the family partner at least once per quarter.	CMBHS			
XL. Family Partner Services: from site visit				
95. Family Partner Services: For all clients who have permitted family involvement, Team has conversations regarding their preferences for working with the Family Partner.	Site Visit, Interviews			
96. Family Partner Services: Interviews with Primary Clinicians, Family Partners, family members, and review of medical records indicate that families are being offered meetings with the family partner.	Site Visit, Chart Reviews and Interviews			

Probing questions: Are clients and families being offered opportunities to meet with the family partner? How often does the Family Partner meet with families? Review medical records to determine if meetings with Family Partner are being offered. Ask families if they are able to meet with the Family Partner if this is something they want to do.				
97. Family Partner Services: The Family Partner is engaged with team outreach activities and initial engagement of the client and family. *Probing questions: Ask the Family Partner: What are examples of some of the activities you (family partner) participated in to help with outreach efforts? What are some in which you worked with the family members to promote their engagement with the team initially?*	Interviews with Peer Specialist			
98. Family Partner Services: The Family Partner is working with families using their personal stories and providing support to family members on system navigation, advocacy and voice, coping strategies, etc. *Probing questions: What are some of the different ways you use your family's story to work with other families? Can you provide some examples about how you work to support the families with whom you are working? How have you worked with the primary clinician to help support some of the interventions to clients?*	Site Visit, Chart Reviews and Interviews			
XLI. Discharge Planning: from data				
99. Discharge: For at least 80% of clients who are discharged, that discharge occurs after team and client have worked together and established appropriate follow-up mental health services and community supports post discharge (as opposed to leaving precipitously).	CAB			
XLII. Discharge Planning: from site visit				
100. Discharge: Interviews with Primary Clinicians, clients and review of medical records indicate that Primary Clinicians identify and provide linkages to community supports that clients and families may need for a successful transition (e.g., NAMI, social-groups/activities, school supports, and mental health service providers).	Site Visit, Chart Reviews and Interviews			

Probing questions: Review medical records to determine if steps are being taken to help with setting up a successful discharge. Is there any documentation supporting that Primary Clinicians are connecting clients and families community resource? Ask the primary clinician to describe what are some of the most popular links in the community that are being identified and provided to support the clients and families when transitioning from the program? Ask the client, families and primary clinicians to describe transition-planning processes.				
XLIII. Time-Limited Services: from data				
101. Timely Discharges: Individual length of stay for enrolled clients will not exceed 36 months.	CAB			
102. Timely Discharges: At least 80% percent of discharged clients attend their first appointment with a mental health or substance use treatment provider within 30 days of discharge.	CMBHS			
103. Timely Discharges: At least 90% of discharged clients who were prescribed an antipsychotic medication at the time of discharge keep a follow up appointment with a psychiatrist or psychiatric nurse practitioner within 30 days of discharge.	CMBHS			
XLIV. Time-Limited Services: from site visit				
104. Discharge: Participants who are non-responsive to treatment or outreach are referred to appropriate treatment providers and appropriate follow up given for assurance of engagement	Site Visit, Chart Review			
105. Discharge: Interviews with Primary Clinicians, clients and review of medical records indicate that teams are performing planned discharges and have a system for following-up to make sure clients are attending initial appointments with new providers. *Probing questions: Ask the primary clinician: What is the typical planned discharge protocol being carried out regularly at this site? What methods or strategies are being utilized to make sure the clients are attending their initial appointments with new providers? Review discharge plans in the medical records.*	Site Visit, Chart Reviews and Interviews			