

Polk County Mental Health & Disability Services Region
**2025 Forensic Assertive Community
Treatment (FACT)**
Outcomes Evaluation

IOWA | LAW

LAW, HEALTH POLICY & DISABILITY CENTER

Tessa Heeren, Research Manager
Angela Wright, Assistant Research Scientist

University of Iowa College of Law
Iowa City, Iowa 52242

Executive Summary

Participant incarceration history creates barriers across outcome areas.

FACT program participants face challenges to stabilization in the community and growth towards self-sufficiency due to criminal records and financial debts. In addition, participants who experience homelessness and incarceration hinder program achievement in healthy behavior outcomes like **Somatic Care** and **Community Inclusion**.



Criminal records that include serious felonies prevent inclusion in assistance programs and qualification requires agency assistance to access resources like housing support.



Securing employment opportunities is a challenge and despite best efforts to apply for jobs, participants face repeated rejection.



Interest in furthering educational attainment is low amongst participants, with some working towards GEDs. In addition to low motivation to continue education, past loans can prevent participants from enrolling, perpetuating limitations on upward mobility and self-sufficiency.

Program staff report utilizing preventative tactics, proactive support, and community resources to prevent recidivism and mitigate crisis.

The FACT program continues a 5-year trend of *Exceeding Expectations* in **Psychiatric Emergency Room Visits** and **Involvement in the Criminal Justice System**.



Agency staff maintain contact with probation officers, attend court appearances, and work with the jail diversion program. They take on extra responsibilities to support participants and reduce recidivism.



Agency staff monitor participants mental health closely to ensure appropriate medication adherence and stability. When behavioral health is unstable, participants utilize agency crisis phone lines to de-escalate potentially emergent situations.

Internal process improvement ensures high quality, consistent, and thorough documentation compliance.



The FACT program continued a two-year trend of achieving **100% Participant Empowerment** in 2025, an increase of 20% compared to the program's 2022 performance. Agency staff noted implementing strategies (including physical paper checklists and supervisor audits) to support outcome performance.

Table of Contents

Executive Summary2

FACT Evaluation Results Summary4

FACT Outcomes7

 Housing8

 Engagement Toward Employment..... 11

 Working Toward Self-Sufficiency 12

 Education 15

 Access to Somatic Care..... 17

 Community Inclusion.....20

 Participant Empowerment..... 22

 Negative Disenrollment..... 24

 Psychiatric Hospitalizations 26

 Emergency Room Visits..... 28

 Involvement in the Criminal Justice System 30

 Homelessness 32

 Participant Satisfaction 34

 Quality of Life 37

 Summary Table..... i

Appendix A. Program Description..... ii

Appendix B. Participant Interview Script.....iii

Appendix C. Data Sources and Definitions..... **Error! Bookmark not defined.**

Appendix D. Outlier Analysis iv

Appendix E. Satisfaction Surveysviii

FACT Evaluation Results Summary

This is a report on the findings of the independent evaluation of the Polk County Region FACT Program from July 1, 2024, through March 31, 2025. The service agency for the FACT program is Eyerly Ball and served an average of 64 participants a month over FY25.

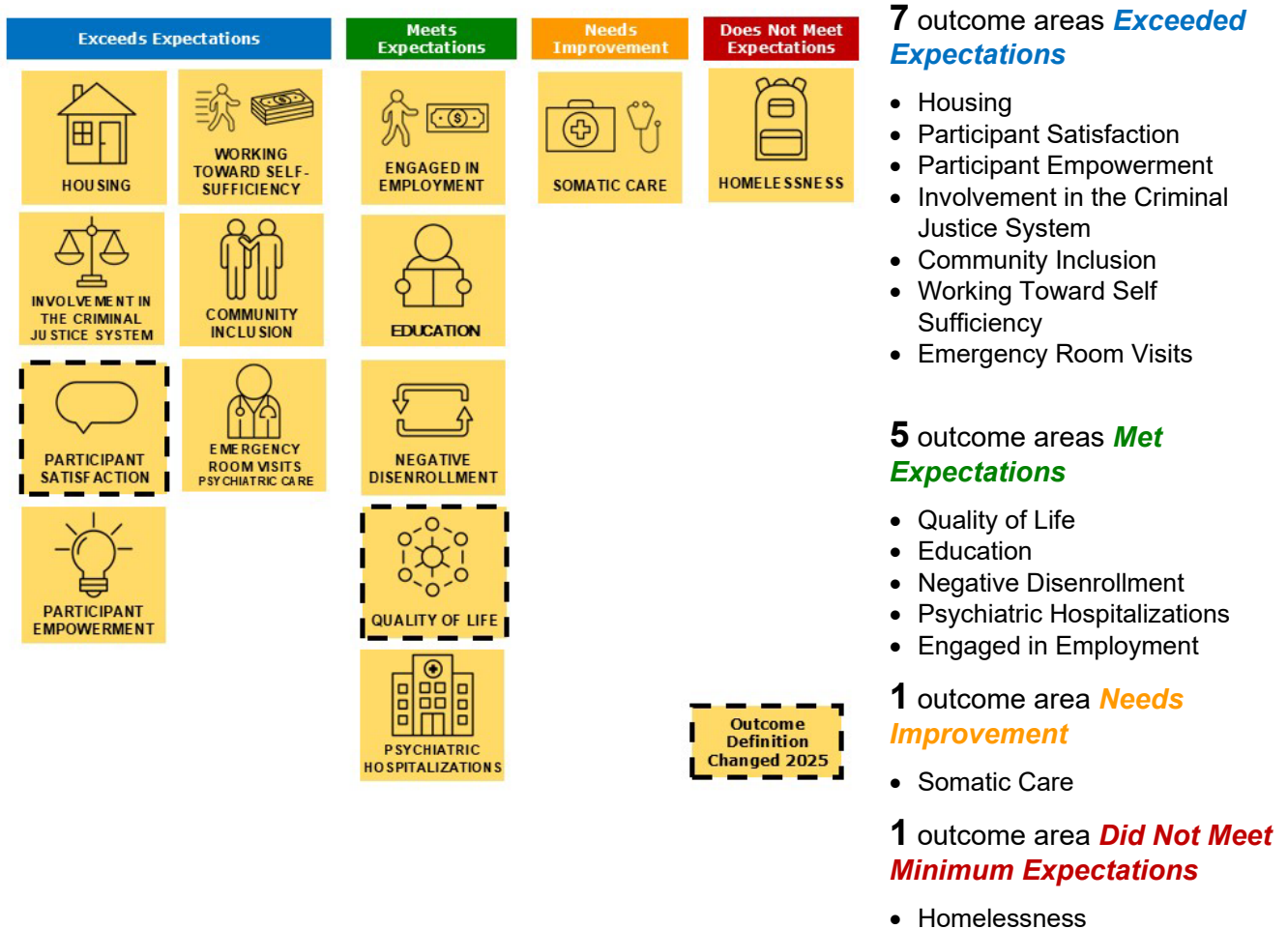
This evaluation report includes results from 3 sources: 1) Community Services Network (CSN) data management system, 2) Polk County MHDS Region Participant survey and 3) Program File Reviews.

In the previous evaluation year, 2024, the FACT program entered outcome data into CSN for the first time following a transition from PolkMIS. As a result, the fiscal year ending June 30, 2024, served as a baseline year, with only five outcome areas scored (Somatic Care, Participant Empowerment, Participant Satisfaction, Quality of Life, and Administrative Outcomes).

In the current evaluation year, 2025, the FACT program was rated across all outcome areas entered into CSN. Survey-based outcomes for Participant Satisfaction and Quality of Life reflect responses to newly piloted survey items. Additionally, the evaluation period was shortened due to statewide changes under HF2637, which restructured behavioral health services into new districts. Data collection ended March 31, 2025, and the File Review covered a six-month period instead of a full year.

In 2025, the FACT System *Met* or *Exceeded Expectations* in 12 of 14 outcome areas. Figure 1 shows each outcome area by performance.

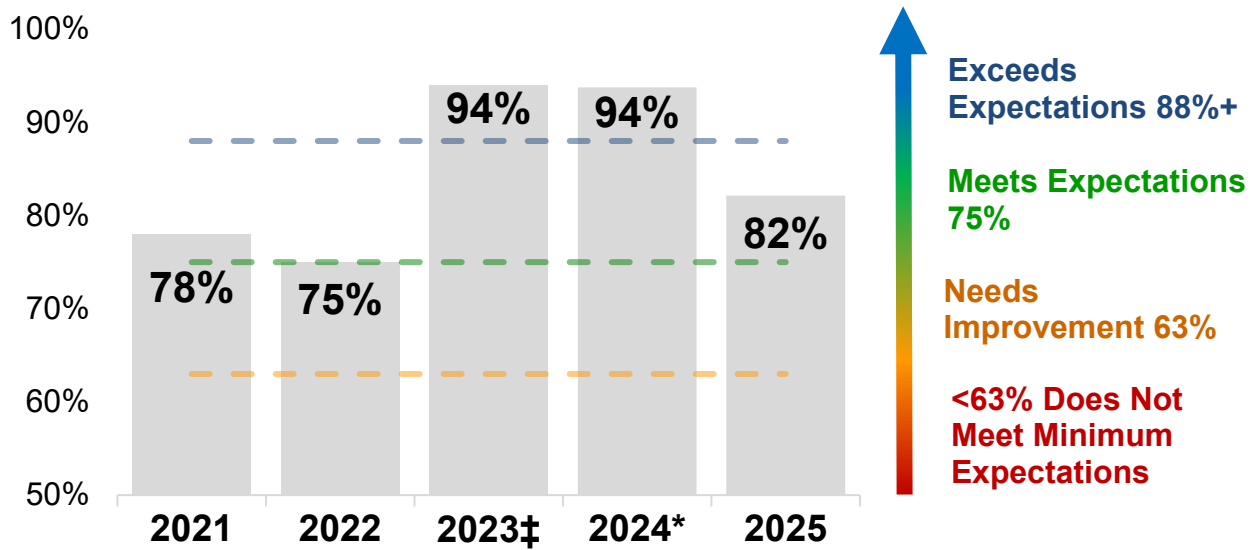
Figure 1. Outcome Areas by 2025 Performance FACT Program Averages



In 2025, the FACT program received a rating of **Meets Expectations** in **Program Overall Performance**, with a performance of 82%.

While the program performance is lower relative to the **Exceeds Expectations** ratings in the two preceding years (2023 and 2024), those scores were based on limited outcome areas, so are not comparable to 2025. Compared to program performance in years with all outcome areas included (2021 and 2022), the FACT program performance increased in 2025.

Figure 2. FACT System Performance 2021-2025



‡ Overall Performance calculation in 2023 based on limited (3) outcome areas

* Overall Performance calculation in 2024 based on limited (4) outcome areas

FACT Outcomes

To evaluate agency performance, the Polk County MHDS Region uses 14 outcome areas to assess service delivery. Each outcome area has thresholds established that determine four performance ratings and corresponding point values, namely *Exceeds Expectations* (4), *Meets Expectations* (3), *Needs Improvement* (2), and *Does Not Meet Minimum Expectations* (1).

The FACT Evaluation includes 14 outcome areas, outlined below

1. Quality Services

1. Participant Satisfaction
2. Quality Of Life
3. Negative Disenrollment
4. Participant Empowerment

2. Community Integration

5. Housing
6. Engagement Toward Employment
7. Working Towards Self-Sufficiency
8. Education
9. Access To Somatic Care
10. Community Inclusion

3. Healthy Days In The Community¹

11. Homelessness
12. Involvement In The Criminal Justice System
13. Psychiatric Hospitalizations
14. Psychiatric Emergency Room Visits

¹ Healthy days reflect when a participant's physical and mental health are stable. Psychiatric hospitalizations, Emergency Room visits, Jail Days, and Homelessness outcome areas contribute to participants' overall health.



HOUSING

Metric	The percentage of individuals living in safe. ² , affordable. ³ , accessible. ⁴ , and acceptable. ⁵ living environments annually.
Intent	Community housing addresses the desires, goals, strengths, abilities, needs, health, safety, and life span issues of the person served regardless of the home in which they live and/or the intensity of support services. When needed, supports are designed to assist the individual achieve success in and satisfaction with community living. The intent is to assist individuals with disabilities in establishing a home that is personally satisfying, meets health and safety expectations, provides a barrier-free environment, and allows the individual to have the resources in order to meaningfully and fully participate in their community.
Rationale	The Polk County Region recognizes with this outcome that individuals with disabilities face challenges to find safe, affordable, accessible, and acceptable housing. “Many people with a serious mental illness live on Supplemental Security Income (SSI), which averages just 18% of the median income and can make finding an affordable home near impossible.” (NAMI)

Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4	3	2	1
	80%+	50% - 79%	40% - 49%	< 40%

² A living environment meets safety expectations if all of the following: the living environment is free of any kind of abuse and neglect, has safety equipment, is kept free of health risks, there is no evidence of illegal activity in the individual's own apartment or living environment, and the individual knows what to do in case of an emergency.

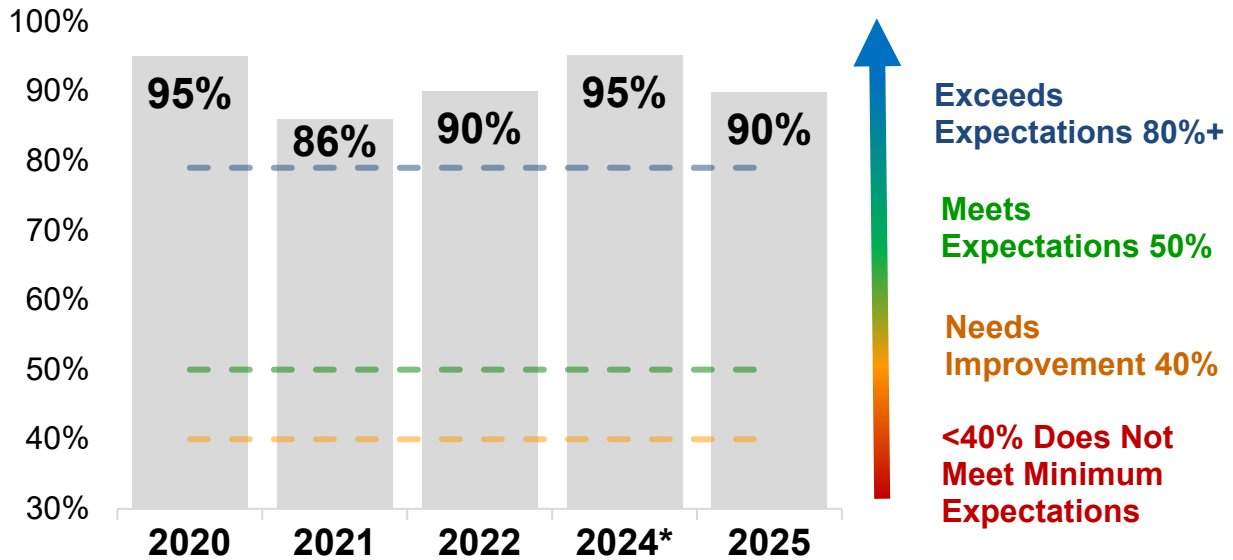
³ A living environment meets affordability expectations if no more than 40% of the individual's income is spent on total housing needs (persons receiving rent subsidy and living in host homes meet criteria; cost of rent and utilities do not exceed 40%).

⁴ When needed, a living environment meets the individual's accessibility expectations [or has 24-hour equivalent] if: the living environment allows for freedom of movement, supports communication, and supports community involvement.

⁵ A living environment meets acceptability expectations if the individual (rather than guardian) chooses where to live and with whom. Individuals with guardians should participate and give input into their living environment to the greatest extent possible.

In 2025, the FACT program maintained a rating of *Exceeds Expectations* in *Housing*, achieving a program performance of 90%. Although this outcome decreased by 5 percentage points compared to 2024, program performance consistently received an *Exceeds Expectations* rating over the past 5 years (ranging from 86%-95%).

Figure 3. Housing FACT Program Average 2020-2025



* 2024 was a baseline year after transition in data management systems; outcome area not measured in 2023

PROVIDER PERSPECTIVES

Housing

- FACT staff emphasized that **housing instability affects every other part of life** for their participants.
- Many clients have **serious felony histories** and are **ineligible for most housing programs** without FACT's support.
- Staff have worked to **build relationships with landlords** and noted that **public housing would not be accessible** without **Polk County funding**.
- There are **ongoing concerns about state redesign**, which may further limit housing options for justice-involved individuals.

Employment

- **Justice involvement remains a major barrier** to employment. Even participants with only **minor charges** face repeated rejection from employers and temp agencies.
- One client has been **unemployed for three years** despite consistent effort and agency support, including multiple job applications and interviews.
- Staff reported that **participants apply for jobs daily** but are often not hired, and the reasons are not always clear.



ENGAGED IN EMPLOYMENT

*Metric	The percentage of individuals working 5 hours or more per week and earning the minimum wage or greater during the specified reporting periods. ⁶
Intent	The number of program participants working toward self-sufficiency during the year will increase. The intent of the outcome is to increase the employment rate of people with disabilities, increase wages, and increase assets.
Rationale	Unemployment is one of the most profound issues facing the disability community. Only 32% of Americans with disabilities aged 18 to 64 are working, but two-thirds of those who are unemployed say they would rather be working [source: The National Organization on Disability (N.O.D.)]. The Polk County MHDS Region recognizes that employment is not only a profound issue for the disability community, but also a key to self-sufficiency. “Most people ... want to work, yet they face significant barriers in finding and keeping jobs, such as a limited number of jobs in communities, discrimination against people with mental illnesses, limited or compromised executive functioning skills among some consumers that hinder one’s ability to perform and attend work, lack of supported employment programs, and inadequate transportation. With support, they can work in competitive jobs or start their own businesses, enabling them to increase their work activity and earnings over time.” (SAMHSA.gov)

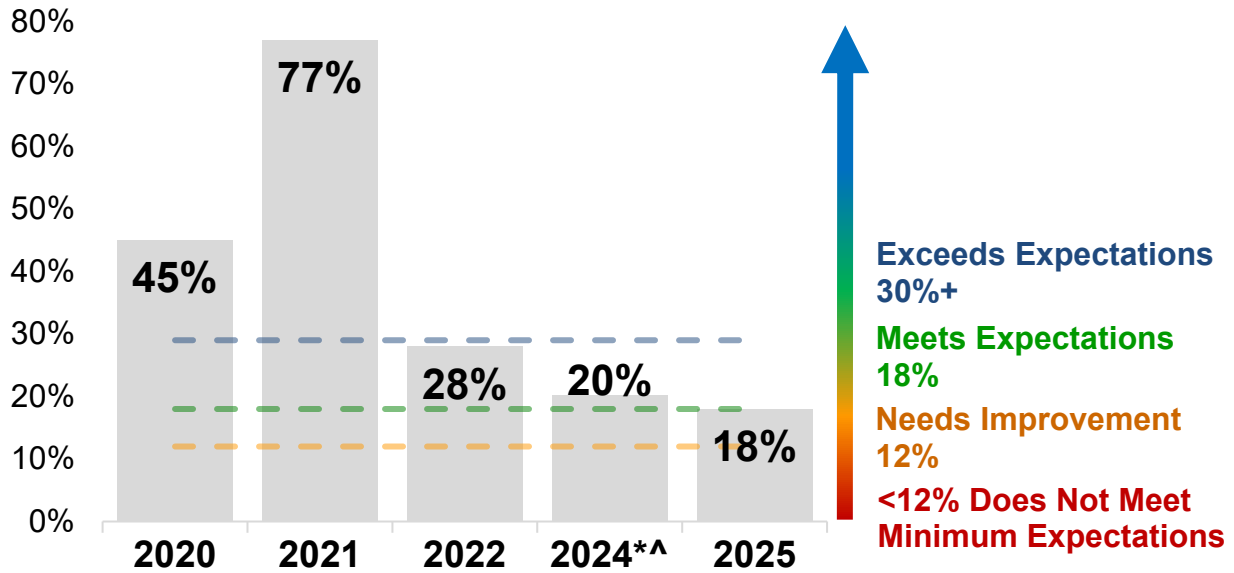
Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4 30%+	3 18% - 29%	2 12% - 17%	1 < 12%

⁶ * Prior to 2024, Polk County reported employment outcomes only for **employment eligible** individuals (defined as individuals under the age of 65 and with a Level of Functioning score below level 5 or 6). In 2024, with the transition to CSN, the definition was changed to be consistent with all MHDS regions in the state, which excluded any Level of Functioning exemption for employment eligibility. Only individuals age 65 and older are exempted from being employment eligible.

Reporting Dates	
Quarter 1	7/14/2024 – 7/27/2024
Quarter 2	10/13/2024 – 10/26/2024
Quarter 3	1/12/2025-1/25/2025
Quarter 4	NA, excluded from data collection

In 2025, the FACT program received a rating of **Meets Expectations** in the **Engaged in Employment** outcome, with a system performance of 18%. Performance in 2025 decreased by two percentage points from 2024 and continues a 3-year trend of relatively lower performance compared to **Exceeding Expectations** in 2020 and 2021.

Figure 4. Engaged in Employment FACT Program Average 2020-2025



* 2024 was a baseline year after transition in data management systems; outcome area not measured in 2023

^ The definition of this outcome area changed in 2024.



WORKING TOWARD SELF-SUFFICIENCY

Metric*	The percentage of individuals working 20 hours or more per week and earning the minimum wage or greater during the specified two-week reporting periods. ⁷
Intent	The number of program participants working at self-sufficiency during the year will increase. The intent is to increase people with disabilities' assets.
Rationale	Unemployment is a notable disparity experienced by many members of the disability community. Only 32% of Americans with disabilities aged 18 to 64 are working, but two-thirds of those unemployed would rather be working [source: The National Organization on Disability (N.O.D.)]. The Polk County MHDS Region recognizes that employment is not only a profound issue for the disability community, but also a key to self-sufficiency. The unemployment rate among individuals with severe mental health conditions is between 80 and 90%. The financial strain of unemployment tends to exacerbate poor mental health. Psychological distress also increases the risk of being unemployed, which impedes perceptions of self-sufficiency. Setting vocational goals for employment can be a key factor in mental health recovery (Hong et al., 2019).

Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4	3	2	1
	8%+	2% - 7%	1% - 1%	< 1%

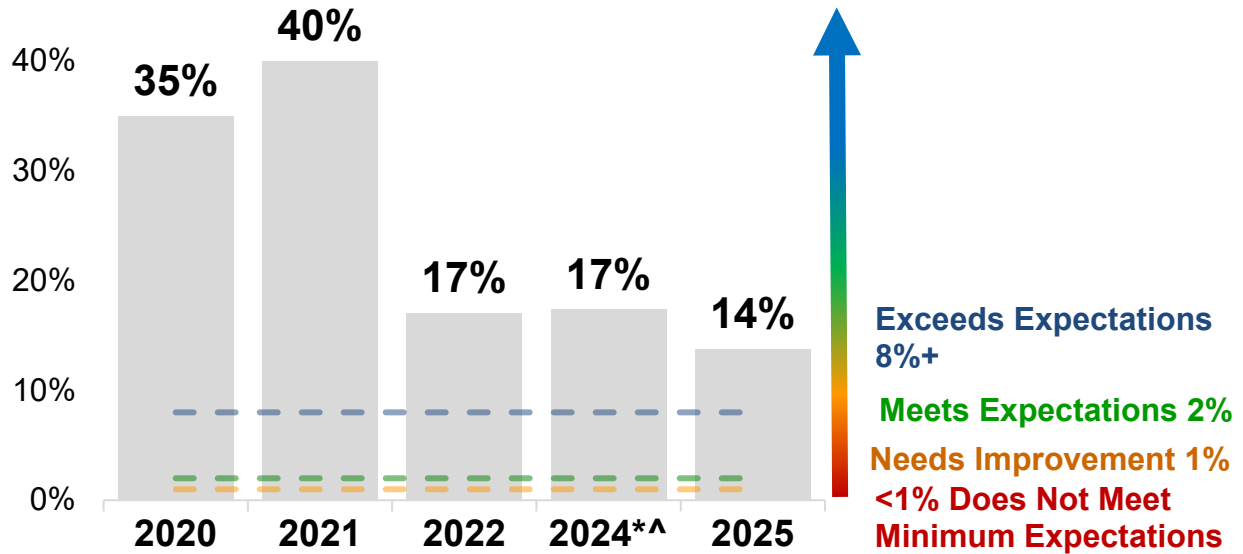
7 * Prior to 2024, Polk County reported employment outcomes only for **employment eligible** individuals (defined as individuals under the age of 65 and with a Level of Functioning score below level 5 or 6). In 2024, with the transition to CSN, the definition was changed to be consistent with all MHDS regions in the state, which excluded any Level of Functioning exemption for employment eligibility. Only individuals age 65 and older are exempted from being employment eligible.

Reporting Dates	
Quarter 1	7/14/2024 – 7/27/2024
Quarter 2	10/13/2024 – 10/26/2024
Quarter 3	1/12/2025-1/25/2025
Quarter 4	NA, excluded from data collection

Figure 5 represents the FACT program trends in *Working Towards Self-Sufficiency* from 2020 to 2025 (ranging from 14%-40%).

The FACT program continues a 5-year trend of *Exceeding Expectations* in 2025, maintaining a performance of 14% (a 3 percentage point decrease from 2022 and 2024) in 2025.

Figure 5. Working Toward Self-Sufficiency FACT Program Average 2020-2025



* 2024 was a baseline year after transition in data management systems; outcome area not measured in 2023

^ The definition of this outcome area changed in 2024.



EDUCATION

Metric*	The percentage of employable individuals involved in training or education during the fiscal year. ⁸
Intent	Increase the number of program participants receiving classes or training provided by an educational institution or a recognized training program. ^{9, 10} The intent for this outcome is to increase skill development.
Rationale	<p>The Polk County Region recognizes with this outcome that education has an important impact on independence, employment, and earnings.</p> <p>Education is the key to independence and future success; it is critical to obtaining work and affects how much money one can earn. Before the passage of the Individuals with Disabilities Education Act (IDEA) in 1975, which granted all children with disabilities a free, appropriate public education, many children with disabilities did not attend school because the buildings or class activities were inaccessible. Even now, 22% of Americans with disabilities fail to graduate high school, compared to 9% of those without disabilities [source: The National Organization on Disability (N.O.D.)].</p> <p>“Disability is a natural part of the human experience and in no way diminishes the right of individuals to participate in or contribute to society. Improving educational results for children with disabilities is an essential element of our national policy of ensuring equality of opportunity, full participation, independent living, and economic self-sufficiency for individuals with disabilities.” (IDEA, Individuals with Disabilities Education Act).</p>

Performance Rating	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4	3	2	1
	20%+	4% - 19%	1% - 3%	< 1%

⁸ Measurement is captured in March and not averaged.

⁹ A recognized training program meets the definition if “yes” is the response to the following questions: (1) Does the training prepare the individual for employment? And (2) Is the class designed to train and test skill obtainment and produce a certificate that will secure, maintain, or advance employment opportunities/be of value to employers?

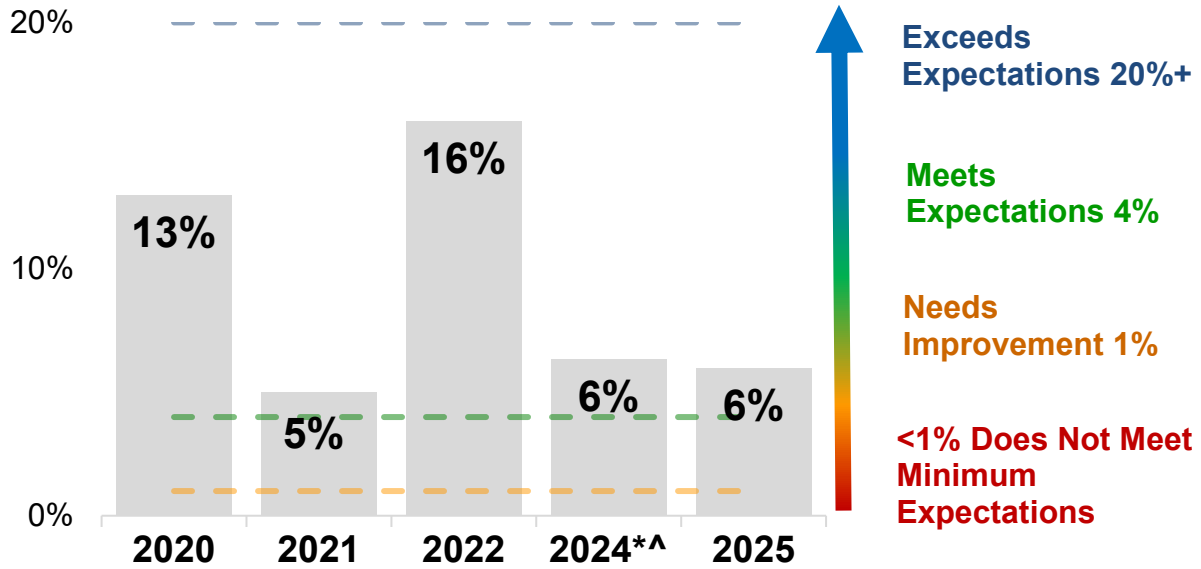
¹⁰ A recognized training program is a program that requires multiple (3 or more) classes in one area to receive a certificate which is recognized by employers to secure, maintain, or advance the program participant’s employment opportunities. The program will have structure through a curriculum with defined start and end dates.

* Prior to 2024, Polk County reported education outcomes only for **employment eligible** individuals (defined as individuals under the age of 65 and with a Level of Functioning score below level 5 or 6). In 2024, with the transition to CSN, the definition was changed to be consistent with all MHDS regions in the state, which excluded any Level of Functioning exemption for education eligibility. Only individuals age 65 and older are exempted from being employment eligible.

Figure 6 represents the FACT program trends in **Education** from 2020 through 2025.

While performance has fluctuated over time (ranging from 5%-16%), the program maintains a five-year trend of **Meeting Expectations** with a performance of 6% in 2025.

Figure 6. Education FACT Program Average 2020-2025



* 2024 was a baseline year after transition in data management systems; outcome area not measured in 2023

^ The definition of this outcome area changed in 2024.



SOMATIC CARE

Metric	The percentage of individuals having documentation supporting somatic care involvement with a physician. ^{11, 12.}
Intent	Program participants will receive somatic care. The intent of this outcome is to ensure that people have accessible and affordable healthcare.

Rationale Americans with disabilities are more than twice as likely to postpone needed health care because they cannot afford it. Furthermore, people with disabilities are four times more likely to have special health care needs that are not covered by their health insurance [source: The National Organization on Disability (N.O.D.)]. True independence requires accessible and affordable health care. The WHO reports a high degree of multi-morbidity between mental disorders and other noncommunicable conditions (cardiovascular disease, diabetes, cancer, and alcohol use disorders and states that co-management in primary care is a logical choice. “Individuals with ... (a brain health) or substance use disorder have higher rates of acute and chronic medical conditions, shorter life expectancies (by an average of 25 years), and worse quality-of-life than the general medical population” (Gerrity, 2014). Expenditures, such as emergency room visits, could be reduced through routine health promotion activities; early identification and intervention; primary care screening, monitoring, and treatment; care coordination strategies; and other outreach programs. (Gerrity, 2014).

Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4	3	2	1
	100%	95% - 99%	90% - 94%	< 90%

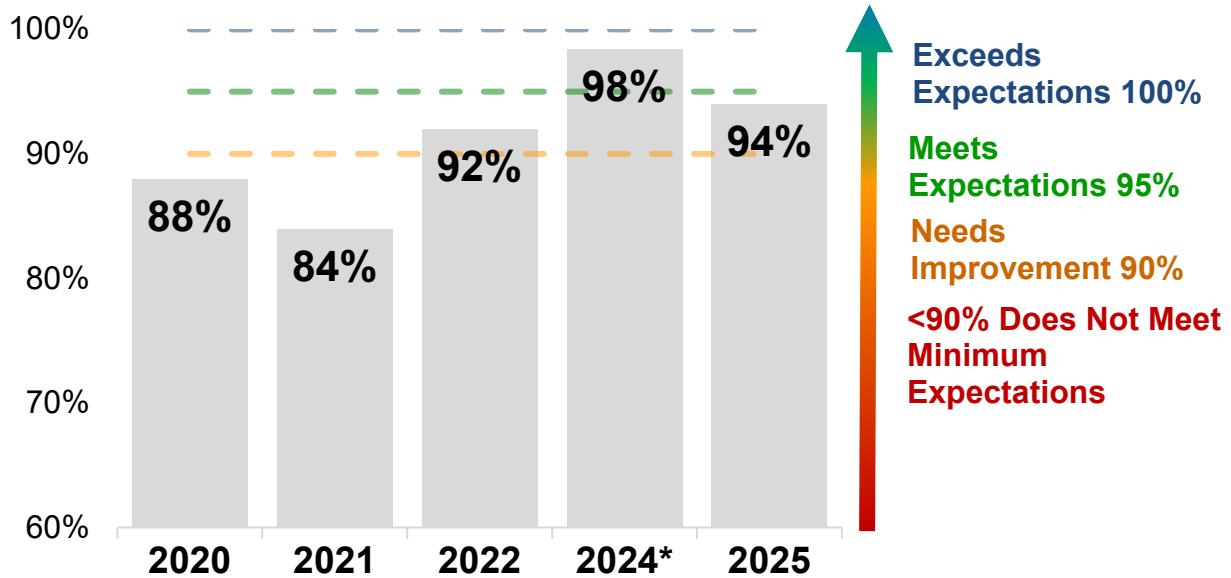
¹¹ Measurement is captured in March and not averaged.

¹² Someone has received somatic care if the person has had an annual physical, if any issues identified in the physical exam needing follow-up are treated, if ongoing or routine care is required, or if symptoms of a physical illness appear since the physical exam and the program participant receives treatment for the illness. Emergency Room visits do not count toward this indicator. Somatic care is more than just stating that there is a physician’s name on record, ongoing documentation of care is needed. This includes but is not limited to the annual physical. The individual’s file must have documentation supporting somatic care. The independent evaluator will also discuss somatic care during program participant and family interviews.

Figure 7 represents the FACT program trends in **Somatic Care** from 2020 through 2025, ranging from 84%-98%.

The FACT program increased steadily by 14% from 2021 to 2024 and then decreased by 4% in 2025. The program performance was 94% and earned a **Needs Improvement** rating in 2025.

Figure 7. Somatic Care 2020-2025



* Outcome area not measured in 2023

PROVIDER PERSPECTIVES

Education

- FACT participants showed **little interest in education**, with only a few working on **GED completion**.
- Many are **blocked from re-enrollment** due to **past student loan debt**, and without employment, they cannot repay those loans—creating a **cycle that prevents progress**.

Somatic Care

- FACT staff prioritize somatic care from the start, asking at intake about routine doctor's visits.
- Staff work as a team to **schedule and follow up on appointments**, especially for participants who are **incarcerated or difficult to locate**.
- Some participants are still being added to the system as qualifying data is uploaded.

Community Inclusion

- FACT staff reported that **some clients are in the routine of completing community inclusion activities** and proactively notify staff for documentation.
- Others, particularly those who are **new or incarcerated**, are not yet engaged.
- Staff noted that **homelessness and incarceration** were key reasons some participants did not complete this outcome.

Participant Empowerment

- FACT uses **physical checklists** and **internal review systems** to ensure documentation of empowerment discussions.
- Staff are expected to **turn in completed forms**, which are reviewed by supervisors to ensure compliance.
- This system is described as **more effective than electronic tracking**, especially for teams with smaller caseloads.



COMMUNITY INCLUSION

Metric	The percentage of program participants accessing and having ongoing involvement in 3 or more different community activities per year. ¹³ .
Intent	The intent of this outcome is to remove barriers to community integration activities so people with disabilities can participate with nondisabled people in community activities of their choice and become a part of the community. The intent is to address these participation gaps and to remove barriers to community integration activities so people with disabilities can participate with non-disabled people in community activities of their choice and become a part of the community. ¹⁴
Rationale	Social isolation is a health risk. Individuals with disabilities spend less time outside the home socializing, going out, and participating in community activities. Differences in involvement in religious services, local politics, cultural events, outdoor activities, and community service organizations are greatest between individuals with and without disabilities. Little to no differences exist with respect to participating in community events related to hobbies, participating in volunteer work, attending special community events such as fairs and parades, and attending recreational activities such as sporting events and movie. (National Organization on Disability)

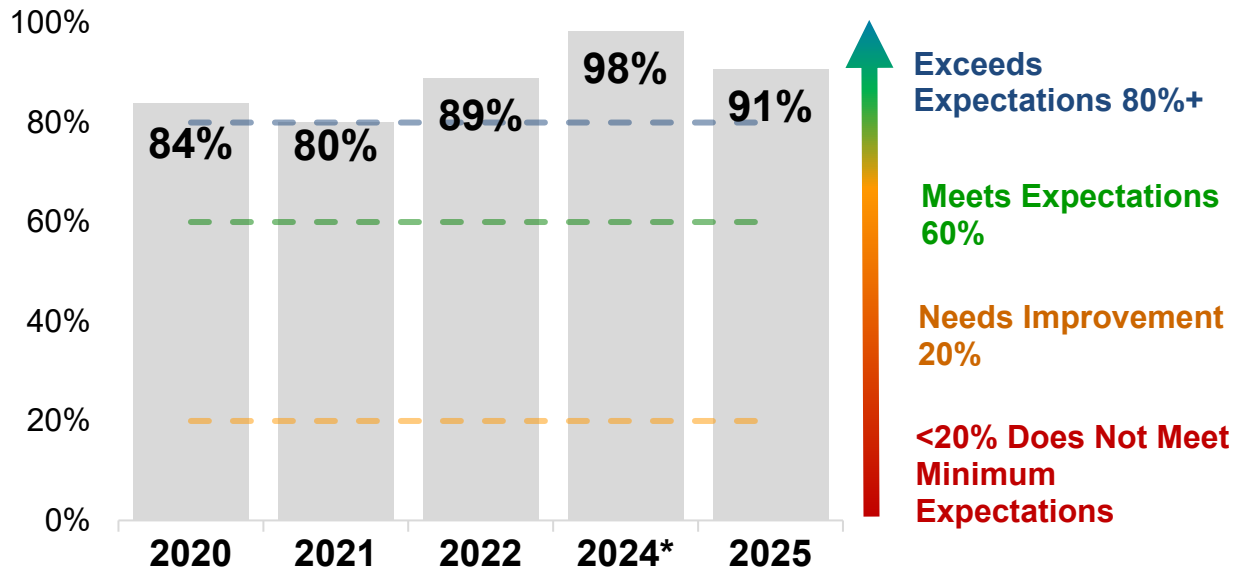
Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4 80%+	3 60% - 79%	2 20% - 59%	1 < 20%

¹³ Measurement is captured in March and not averaged.

¹⁴ Activities are grouped into three main categories: 1) Spiritual, 2) Civic (local politics & volunteerism), and 3) Cultural (community events, clubs, and classes). An activity meets the definition if “yes” is the response to the following three questions: (1) Is the activity community-based and not sponsored by a provider agency? (2) Is the activity person-directed? and (3) Is the activity integrated? Program participants can participate in activities by themselves, with a friend/s, support staff person, or with natural supports. Activities sponsored by or connected with an agency serving people with disabilities and everyday life activities do not count toward activities for the purposes of this outcome area.

The FACT program continued a 2-year trend of *Exceeding Expectations* in the *Community Inclusion* outcome in 2025. While program performance decreased by 7% in 2025 compared to 2024, program performance increased by 18% between 2021 and 2024.

Figure 8. Community Inclusion FACT Program Average 2020-2025



* 2024 was a baseline year after transition in data management systems; outcome area not measured in 2023



PARTICIPANT EMPOWERMENT

Metric

The outcome is the percent of files reviewed that meet the following criteria.

- Whether there was evidence that the participant was involved in setting the goals
- Whether individualized, measurable goals were in place and what services the agency program planned to provide to achieve the goals,
- Whether employment or education or community integration were addressed with the participant¹⁵
- Whether goals were regularly reviewed with respect to expected outcomes and services documented in the file

Intent

Individuals supported will achieve individualized goals resulting in feeling a sense of empowerment with the system. The Polk County Region recognizes with this outcome that individuals should be treated with respect, allowed to make meaningful choices regarding their future, and given the opportunity to succeed and the right to fail. Empowerment is based on the file review.

Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4	3	2	1
	95%+	90% - 94%	85% - 89%	< 85%

Table 1. Participant Empowerment Results by Category

	FACT
Goals in Place and Reviewed Regularly	100%
Consumer Involvement	100%
Quarterly Empowerment Discussions¹⁵	100%
Services Documented	100%
All Goal Components Present	100%

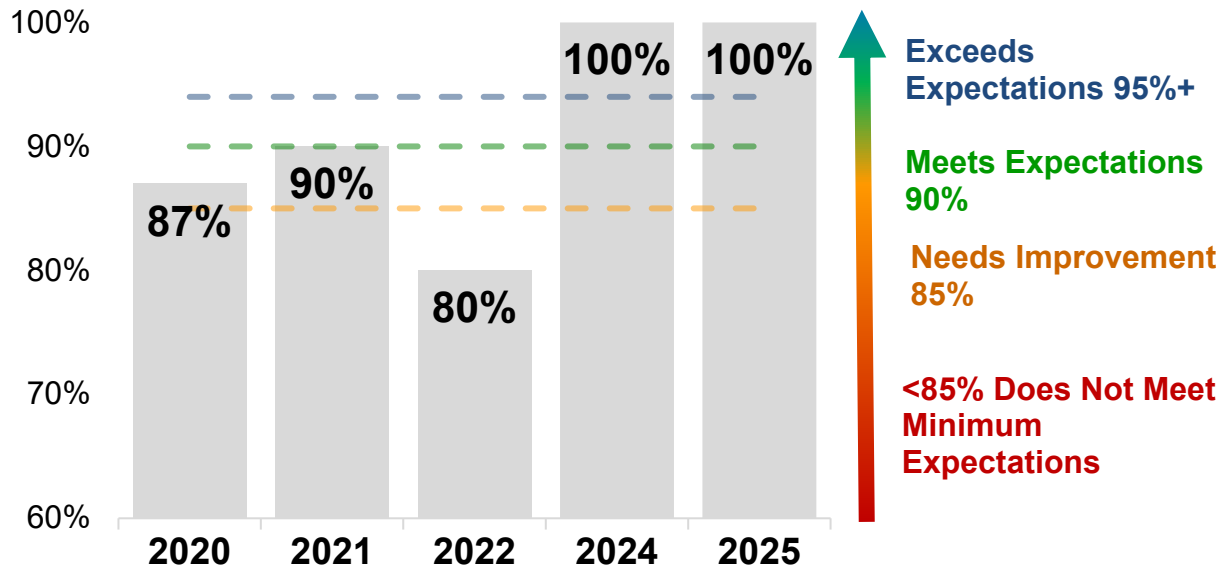
¹⁵ Empowerment Discussion: Expectation that staff routinely (quarterly) discuss and document prompts to engage in Employment, Education and/or Community Integration with participants.

Table 2 displays results including the four criteria which contribute to the overall **Participant Empowerment** outcome. The FACT program received scores of 100% across all criteria.

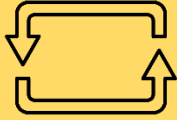
The FACT program **Exceeded Expectations** in 2025, with a 100% performance for the second year.

In 2022, the FACT program received its lowest performance in **Participant Empowerment** over the last five years at 80% (**Not Meeting Minimum Expectations**) and then achieved its highest performances at 100% in 2024 and 2025 (**Exceeding Expectations**).

Figure 9. Participant Empowerment 2020-2025



* Outcome area not measured in 2023



NEGATIVE DISENROLLMENT

Metric	The percentage of program participants negatively disenrolled.
Intent	The organization will not negatively disenroll program participants. The intent of this outcome is for the agencies to develop trusting and meaningful relationships with their participants.
Rationale	Ensure continuity of care and avoid individuals with disabilities encountering barriers to accessing services because they are too difficult or expensive for the agency to assist. Service agencies report needing to provide services or a level of care that is not covered by state Medicaid benefits to address critical needs of clients, especially those with complex needs (NCQA).

Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4 < 5.10%	3 5.10% - 15.00%	2 15.10% - 23.00%	1 23+%

PROVIDER PERSPECTIVES

Negative Disenrollment

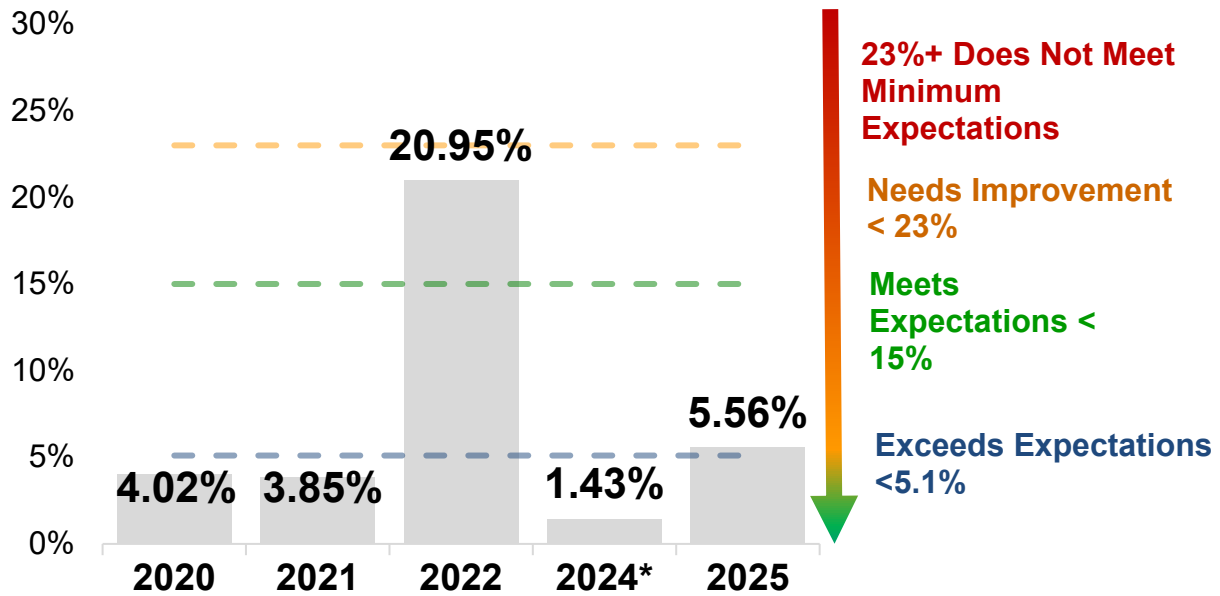
- FACT reported **eight total discharges** this year:
 - Two transitioned to a higher level of care
 - One participant died
 - One went to prison
 - One disengaged and could not be located for three months before being discharged
- Staff expressed that the program performed well in spite of the challenges beyond their control.

¹⁶ Disenrollment is the termination of services due to an individual leaving the program either on a voluntary or involuntary discharge. Negative disenrollments are defined as individual refuses to participate, the individual is displeased with services, the agency initiates discharge, or the individual is discharged to prison for greater than 6 months.

For the **Negative Disenrollment** outcome, the FACT program earned a **Meets Expectations** rating of 5.56% in 2025.

Although program performance declined from the 2024 **Exceeds Expectations** rate of 1.43%, it remains within the **Meets Expectations** range.

Figure 10. Negative Disenrollment Rates 2020-2025



* 2024 was a baseline year after transition in data management systems; outcome area not measured in 2023



PSYCHIATRIC HOSPITALIZATIONS

Metric	The average number of hospital days per program participant per year. ^{17, 18.}
Intent	Psychiatric hospital days will be reduced. The intent is to provide adequate supports in the community so people can receive community-based services.
Rationale	Psychiatric inpatient hospitalizations can be prevented and stabilizations can be achieved by utilizing specialized crisis response services, such as observation units and behavioral health urgent care.

Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4 < 2 days	3 2 – 5.99 days	2 6 – 6.99 days	1 7+ days

PROVIDER PERSPECTIVES

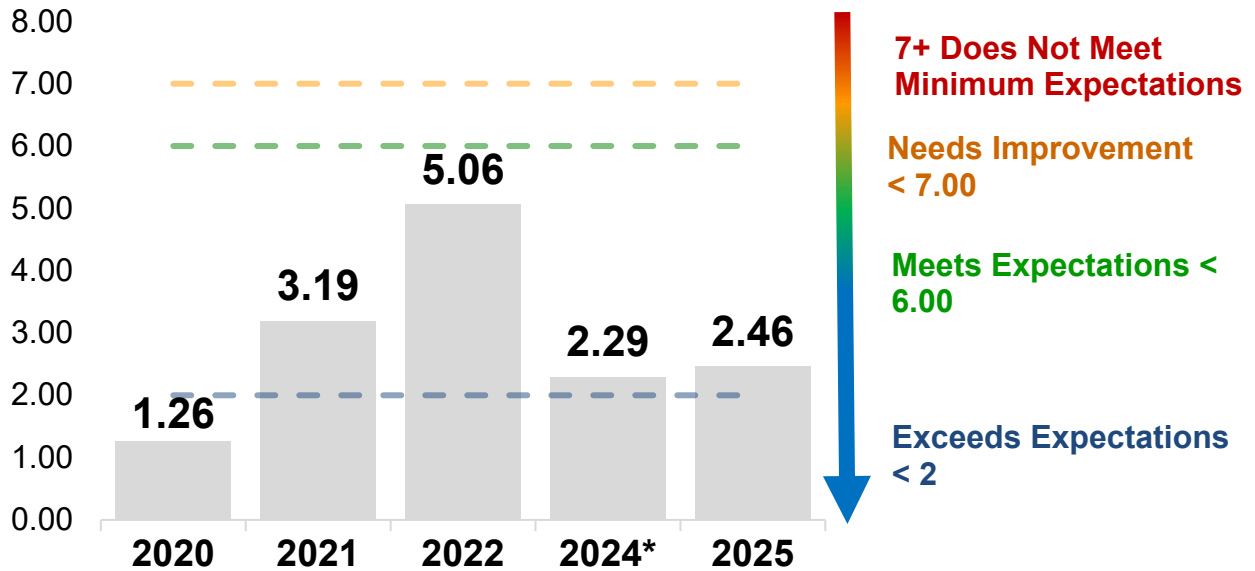
Psychiatric Hospitalizations

- FACT staff noted that **some hospitalizations were necessary and appropriate**, often following committals.
- These hospitalizations were not seen as preventable but rather as the **appropriate level of care** for the severity of symptoms.

¹⁷ A hospital day is measured by the number of nights spent hospitalized.

For the **Psychiatric Hospitalizations** outcome, the FACT program maintained a 4-year trend of **Meets Expectations** ratings, with an average of 2.46 nights in the hospital in 2025.

Figure 11. Psychiatric Hospitalizations 2020-2025



* 2024 was a baseline year after transition in data management systems; outcome area not measured in 2023



EMERGENCY ROOM VISITS FOR PSYCHIATRIC CARE

Metric	The average number of emergency room visits ¹⁹ per program participant per year.
Intent	Emergency room visits for psychiatric visits will be reduced. The intent is to provide adequate supports in the community, so people do not access psychiatric care through the ER.
Rationale	Approximately 4% of emergency room visits are due to mental illness or substance use (NAMI). Between 2006 and 2014, individuals with mental illness or substance abuse experienced a 44% increase in ED visits (Murrell et al., 2019). Most emergency room doctors do not specialize in mental health or addiction and will often treat the medical symptoms rather than the mental and emotional causes of a person’s condition (NAMI).

Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4 < 0.31 visit	3 0.31 - 0.75 visit	2 0.76 – 1.3 visits	1 1.3+ visits

PROVIDER PERSPECTIVES

Emergency Room Visits for Psychiatric Care

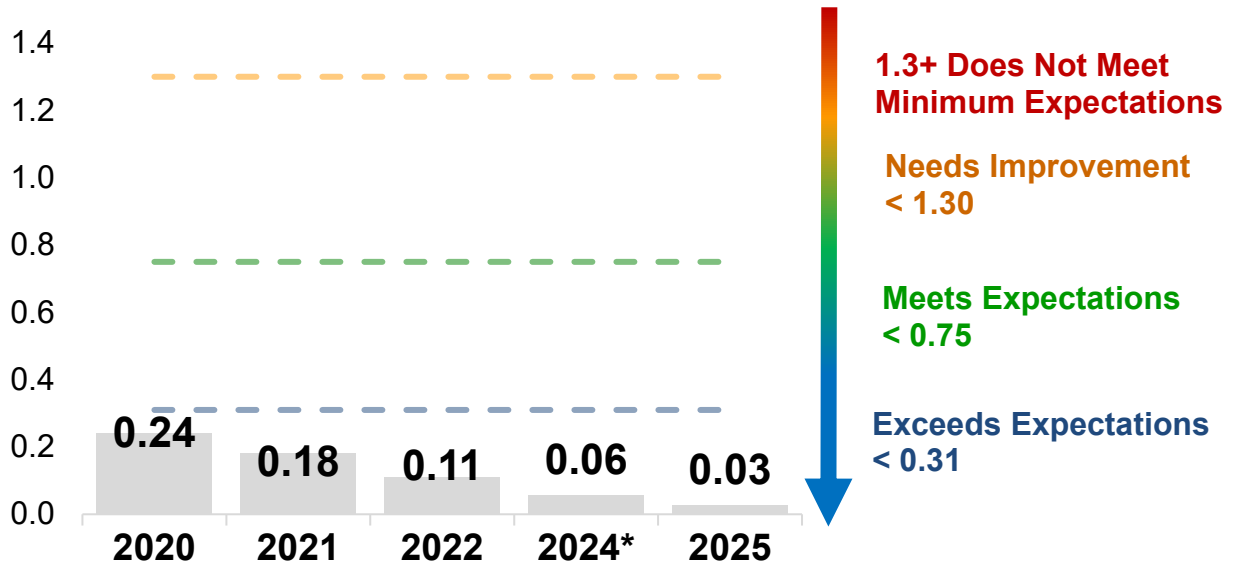
- FACT participants typically **call staff directly** when in crisis, allowing for **real-time support and de-escalation**.
- Staff adjust services in the moment, such as **increasing medication deliveries or home visits**, to prevent ER use.

¹⁹ An emergency room visit is measured by the number of times the individual goes to the emergency room is observed and returned home without being admitted.

For the **Emergency Room Visits for Psychiatric Care** outcome, the FACT program averaged an **Exceeds Expectation** rating, with near-zero ER visits (0.03 visit average).

FACT program performance in the **Emergency Room Visits for Psychiatric Care** outcome continues a consistent trend of decreasing –earning the 5th **Exceeds Expectations** rating over 5 years in 2025.

Figure 12. Psychiatric Emergency Room Visits FACT Program Average 2020-2025



* 2024 was a baseline year after transition in data management systems; outcome area not measured in 2023



INVOLVEMENT IN THE CRIMINAL JUSTICE SYSTEM

Metric	The average number of jail days. ²⁰ utilized per program participant per year.
Intent	The intent of this outcome is to provide adequate supports in the community to prevent offenses or re-offenses and, thus, minimize the number of days spent in jail.
Rationale	Individuals with brain health issues experience extremely high rates of co-occurring disorders, which can increase the risk of involvement in the Criminal Justice system. Criminal Justice involvement can be strongly influenced by societal factors, such as poverty (about 2.5 million people with mental health live in poverty), poor and unstable housing, adverse childhood experiences, racism, and alcohol and drug abuse (NAMI).

Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4 < 25 days	3 25 – 49.99 days	2 50 – 69.99 days	1 70+ days

PROVIDER PERSPECTIVES

Involvement in the Criminal Justice System

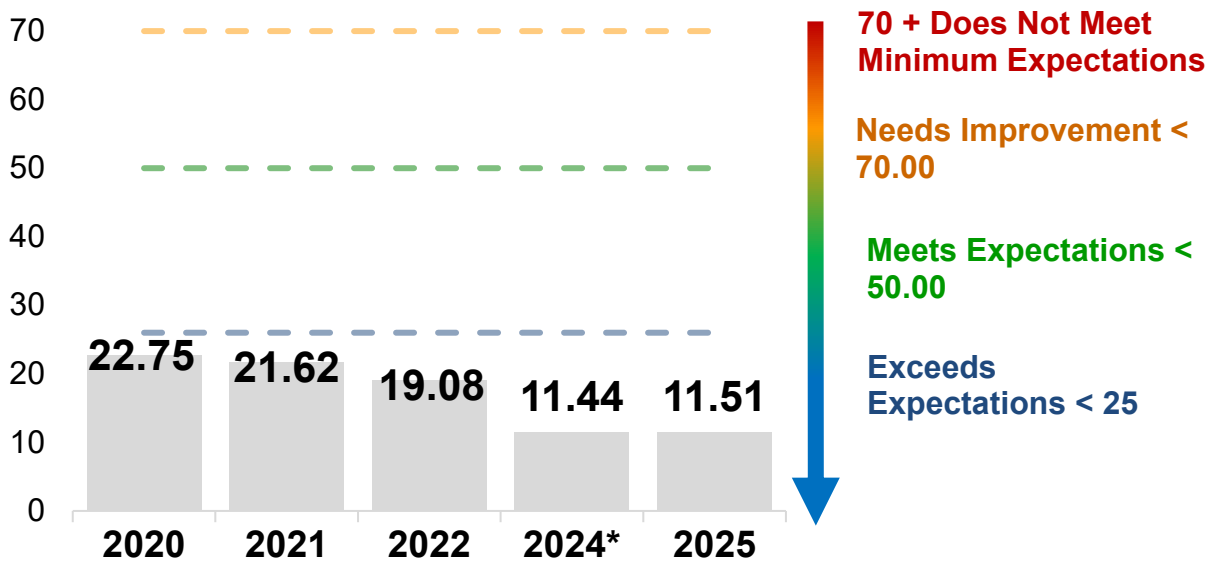
- FACT maintains **strong relationships with probation officers** and attend nearly all **probation visits** and **court appearances**.
- Staff are actively involved in **jail diversion efforts** and try to expedite common systemic delays in legal processes.
- They are **willing to take on extra responsibilities** to help participants avoid or exit incarceration.

²⁰ A jail day is measured by the number of nights spent in jail. Jail time assigned for offenses committed prior to enrollment in the program will not be counted.

For the *Involvement in the Criminal Justice System* outcome, the FACT program received an *Exceeds Expectations* rating, with 11.51 days in jail on average, decreasing by more than 11 days since 2020.

FACT program performance in the *Involvement in the Criminal Justice System* outcome maintains a consistently high performance – earning the 5th *Exceeds Expectations* rating over 5 years in 2025.

Figure 13. Involvement in the Criminal Justice System 2020-2025



* 2024 was a baseline year after transition in data management systems; outcome area not measured in 2023



HOMELESSNESS

Metric	The average number of nights spent in a homeless shelter or on the street per program participant per year.
Intent	<p>Nights spent homeless will be reduced.</p> <p>Individuals with disabilities are challenged to find safe, accessible and affordable housing.</p> <p>The intent is to provide adequate supports in the community and to encourage independence through working to help individuals with disabilities to live in and to view living arrangements as their home.</p>
Rationale	<p>“According to a 2015 assessment by the U.S. Department of Housing and Urban Development, 564,708 people were homeless on a given night in the U.S. At a minimum, 25% of these people were seriously mentally ill, and 45% had any mental illness.” (bbrfoundation.org)</p> <p>“Most researchers agree that the connection between homelessness and mental illness is a complicated, two-way relationship. An individual’s mental illness may lead to cognitive and behavioral problems that make it difficult to earn a stable income or to carry out daily activities in ways that encourage stable housing. Several studies have shown, however, that individuals with mental illnesses often find themselves homeless primarily as the result of poverty and a lack of low-income housing.” (bbrfoundation.org)</p>

Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4 < .41 night	3 0.41 – 1 night	2 1.01 – 2 nights	1 2+ nights

PROVIDER PERSPECTIVES

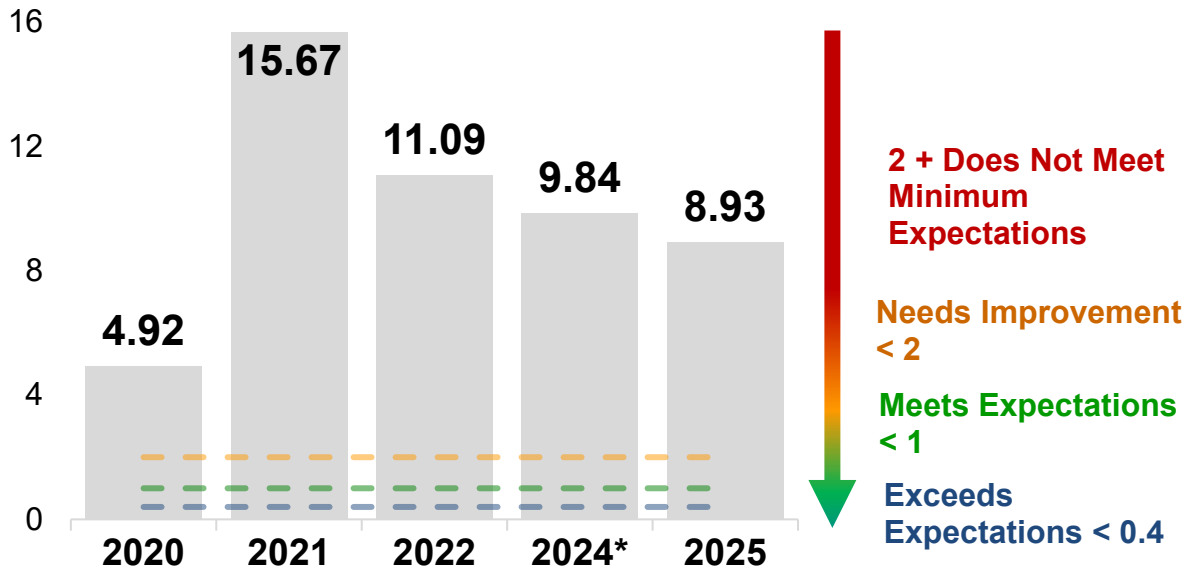
Homelessness

- FACT staff reported that **two clients were chronically homeless and unwilling to engage with support.**
- One participant was **housed through the Anawin program**, but others remained unhoused due to **complex needs and lifestyle choices.**
- Staff described these cases as **outliers** that significantly impacted outcome data.

FACT program performance in the **Homelessness** outcome continued a five-year trend of **Not Meeting Minimum Expectations** in 2025, with an average of 8.93 homeless nights.

The FACT program continues a 4-year trend of **Homelessness** performance improvement, decreasing homeless night by more than 6 nights since 2021.

Figure 14. Homelessness 2020-2025



* 2024 was a baseline year after transition in data management systems; outcome area not measured in 2023



PARTICIPANT SATISFACTION

The FY2025 evaluation marks a shift from the satisfaction survey used in previous evaluations. In response to agency feedback and evidence-based literature, the evaluation paused the existing survey tool and conducted primarily qualitative interviews to inform development of a more meaningful, participant-informed instrument. To maintain some continuity with previous reports, 9 new scored quantitative items were included, consistent with the concepts that were important to agency staff.

Metric

These covered areas such as skill development, service experience, social determinants of health, and safety. The quantitative portion included 4 yes/no questions (scored as 1 point for "yes" and 0 points for "no") and 5 questions using frequency-based responses ("usually," "sometimes," and "rarely"), scored as 1, 0.5, and 0 points respectively. Scores were calculated as percentages after dividing the total points earned by the total points possible, based only on participants who answered each question.

Due to substantial changes in survey content and format, this year's scores are not directly comparable to past results and should only be interpreted as part of an ongoing improvement process.

Intent

Program participants will report satisfaction with the services that they receive. Program participants are the best judge of how services and supports are meeting their needs. Increasing literature finds that involving participants in the delivery or re-design of health care can lead to improved quality of life and enhanced quality and accountability of health services (Bombard et al., 2020).

Rationale

When asked, many people who have struggled with brain health or addiction voice that the most important part of their recovery was finding a support plan that worked with them as an individual and not just as part of a system. Strengths-based programs that are person-centered allow individuals to work toward recovery at their own pace and utilize resources that will help them improve (NAMI).

One key measure of service programs is satisfaction.

Assessing the perceptions of individuals is an essential part of evaluating and planning services and an important component of respect for self-direction and autonomy. (Copeland, Luckasson &Shauger 2014)

Eliciting satisfaction from participants yields beneficial information for service providers. (Copeland, Luckasson &Shauger 2014)

Clients have a wealth of information regarding the functioning of social service programs, and client satisfaction surveys provide the client perspective on those aspects of the service that are important to them. (Spiro, Dekel & Peled, 2009)

Client satisfaction surveys empower clients by giving them a voice in the evaluation and, indirectly, in the management of services. (Spiro, Dekel & Peled, 2009)

	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
Performance Ratings	4	3	2	1
	95%+	90% - 94%	85% - 89%	< 85%

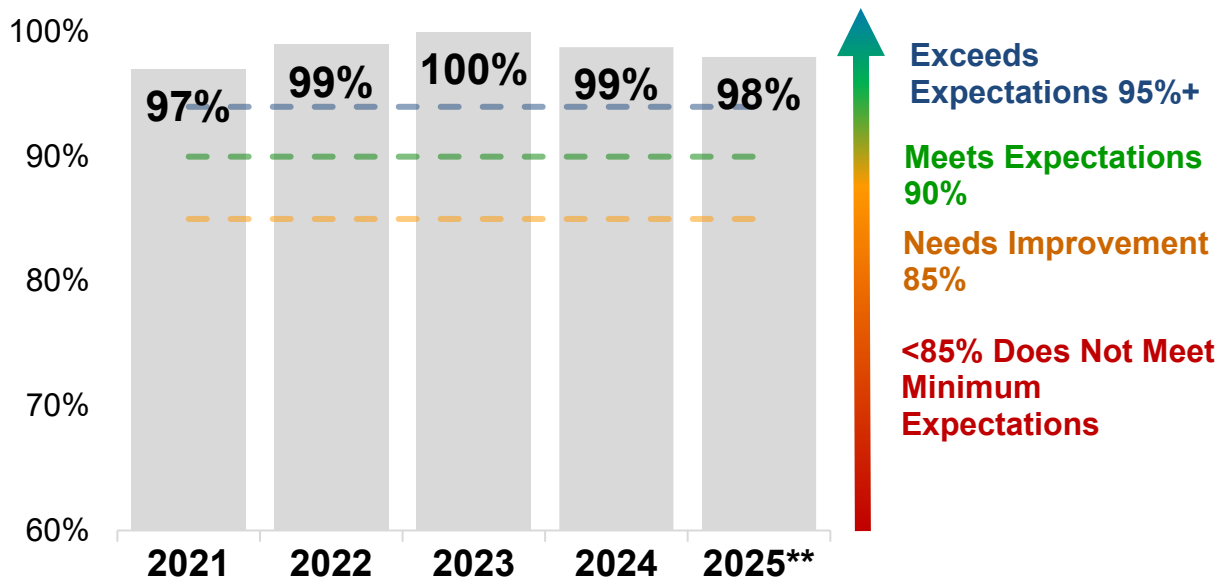
Participant Satisfaction

- FACT participants expressed **high satisfaction with services**, particularly during **in-person events** like “survey day,” which included food and social activities.
- A **new sample of respondents** was selected this year, but scores remained consistent, reinforcing that participants are **generally happy with services**.

For the **Participant Satisfaction** outcome, the system averaged an **Exceeds Expectations** rating of 98%.

The FACT program performance for the **Participant Satisfaction** outcome has maintained a five-year trend in the **Exceeds Expectations** category, ranging from 97% to 100% satisfaction.

Figure 15. Participant Satisfaction 2021-2025 FACT Program Average



**2025 survey results reflect a new survey format. Results are not comparable to previous years

Figure 16 shows rates of agreement by item from the 2025 **Participant Satisfaction** outcome survey. Rates of satisfaction were high overall, ranging from 79% to 100% satisfaction across survey items.

100% of participants surveyed reported:

- They were happy with the way staff treated them.
- Staff see and understand what they need.
- Staff explained their ideas about services so it made sense to them.
- They knew who to call in a physical and mental health emergency.

Agreement was lower among participants regarding:

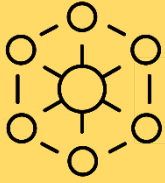
- Staff helping them to take care of their body (79% “usually happy,” 21% “sometimes happy”).

Figure 16. Participant Satisfaction FACT Program Average by item ²¹

N=15



²¹ Full survey items listed in Appendix B



QUALITY OF LIFE

Metric The Quality of Life outcome is based on participant interviews. This year’s survey revised the previous 7-item yes/no format to 5 items using a three-point response scale—“usually” (1 point), “sometimes” (0.5), and “rarely” (0). Scores were calculated as percentages based only on responses from participants who answered each item. As noted earlier, due to changes in survey format and content, results should be interpreted as part of a broader transition process and are not directly comparable to previous years.

Intent Increase participant satisfaction with housing, employment, education, and recreation/leisure activities.

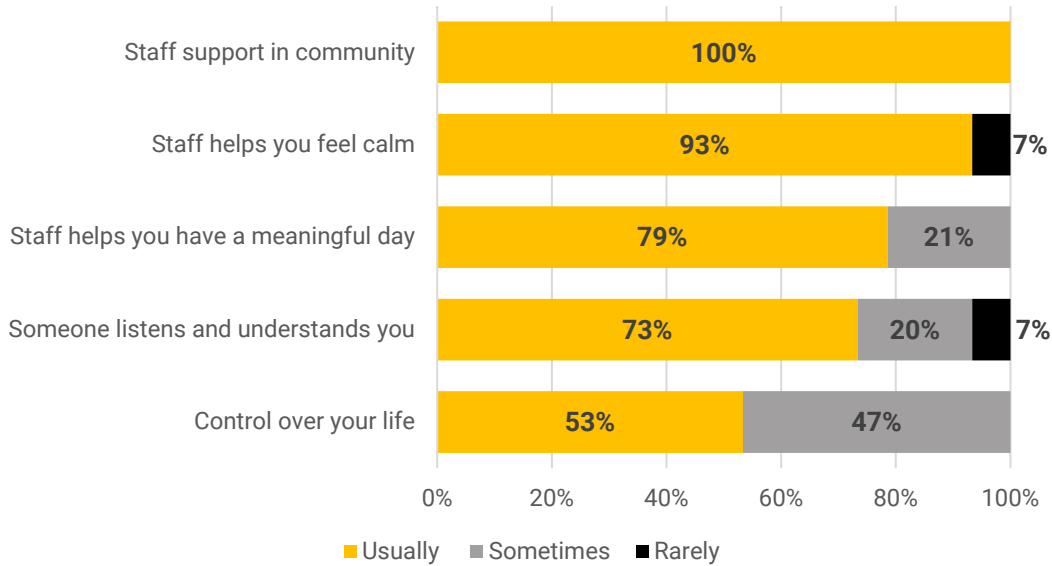
Performance Ratings	Exceeds Expectations	Meets Expectations	Needs Improvement	Does Not Meet Minimum Expectations
	4 95%+	3 85% - 94%	2 80% - 84%	1 < 80%

PROVIDER PERSPECTIVES

Quality of Life

- FACT staff reported that **participants appreciate the support**, even if they are not pursuing employment, education, or community activities.
- Staff are **setting clearer boundaries** and encouraging **greater independence**, while still maintaining strong relationships.
- The agency continues to balance **assertiveness with respect**, which contributes to positive quality of life outcomes.

Figure 17. Quality of Life FACT Program Average by Item 2024



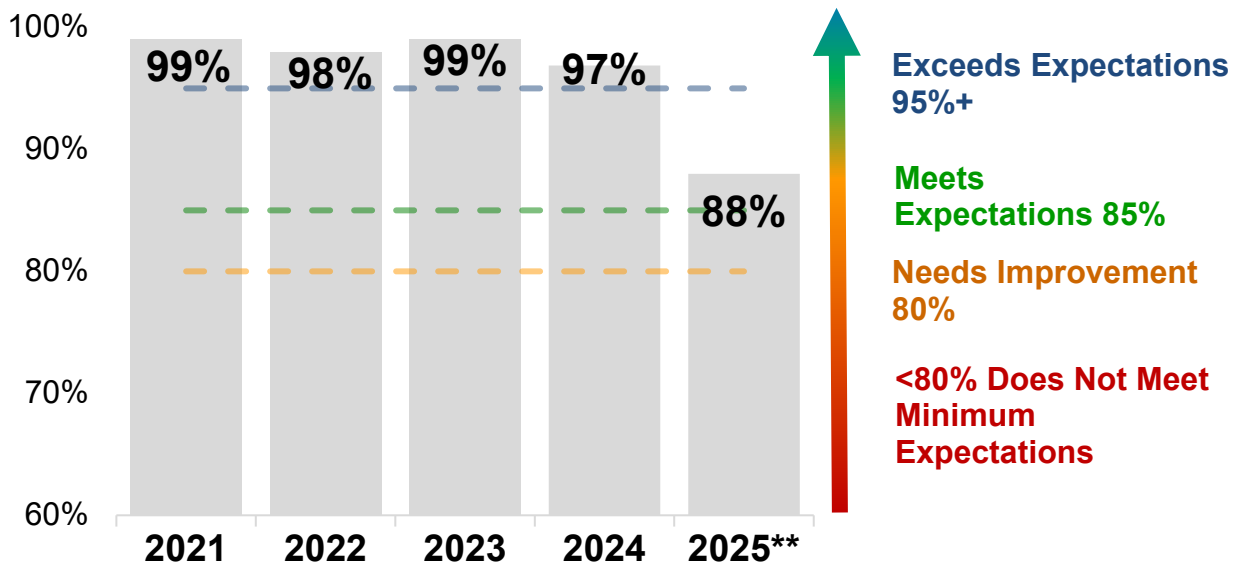
Participant **Quality of Life** measures received ratings ranging from 53% to 100% across items (Figure 17).

- Participants reported high levels of agreement related to:
 - Happiness with *staff helping them get into the community* (100%).
 - Happiness with *staff helping them to feel calm* (93%).
- Participant agreement was lower regarding *staff helping them to have a meaningful day* (79% “usually happy,” 21% “sometimes happy”), *having someone who listens and understands* (73% “usually happy,” 20% “sometimes happy”), and *control over their life* (53% “usually happy,” 47% “sometimes happy”).

Quality of Life averaged an 88% rating in 2025, a performance which is based on a compilation of pilot survey items.

Prior to these pilot items, the program maintained a four-year trend with performance ratings in the *Exceeds Expectations* category. From 2021-2025, performance ratings have ranged from 88% to 99%.

Figure 18. Quality of Life FACT Program Average 2021-2025



**2025 survey results reflect a new survey format. Results are not comparable to previous years

Summary Table

The following table represents a summation of the results in the report, which shows FACT System Outcome Scores and Performance Ratings over the last 5 years.

Table 2. 2020 - 2025 Summary Table FACT Outcome Scores and Performance Ratings

	2020		2021		2022		2023‡		2024*		2025	
	Performance	Score	Performance	Score	Performance	Score	Performance	Score	Performance	Score	Performance	Score
Housing	95%	4	86%	4	90%	4			95%	4	90%	4
Engaged Toward Employment^	45%	4	77%	4	28%	3			20%	3	18%	3
Working Toward Self-Sufficiency^	35%	4	40%	4	17%	4			17%	4	14%	4
Education^	13%	3	5%	3	16%	3			6%	3	6%	3
Somatic Care	88%	1	84%	1	92%	2			98%	3	94%	2
Community Inclusion	84%	4	80%	4	89%	4			98%	4	91%	4
Participant Empowerment	98%	4	87%	2	90%	3			100%	4	100%	4
Negative Disenrollment	4%	4	4%	4	21%	2			1.43%	4	5.56%	3
Hospital Bed Days	1.26	4	3.19	3	5.06	3			2.29	3	2.46**	3
Emergency Room Visits	0.24	4	0.18	4	0.11	4			0.057	4	0.028	4
Involvement in the Criminal Justice System	22.75	4	21.62	4	19.08	4			11.44	4	11.51**	4
Homelessness	4.92	1	15.67	1	11.09	1			9.84	1	8.93	1
Participant Satisfaction^^	100%	4	97%	4	99%	4	100%	4	99%	4	98%	4
Quality of Life^^	98%	4	99%	4	98%	4	99%	4	97%	4	88%	3
Family and Concerned Others Satisfaction	84%	1	80%	1	78%	1	82%	1	-	-	-	-
Program Overall Performance	80%	3	78%	3	75%	3	94%	3	88%	4	82%	3
Adjusted Overall Performance									94%	4		

‡ Overall Performance calculation in 2023 based on limited (3) outcome areas. Data collection for one of the three outcomes, **Family and Concerned Others** outcome area was paused starting in 2024

^ Outcome definition changed in 2024; ^^ Outcome definition changed in 2025

*2024 was a baseline year after transition in data management systems, results are not comparable to prior years

** Denotes an outlier was identified in the dataset. See Appendix D for additional information about the outlier analysis for FY25.

Outcome not included in Overall Performance calculation

Appendix A. Program Description

FACT is a program for adults who are at high risk or have a history of criminal justice involvement. The program began serving individuals as of November 1, 2011.

The FACT program is a subsidiary Integrated Services Program, offering the same flexibility as the Integrated Services Programs but following the evidence-based Assertive Community Treatment (ACT) practice. FACT specifically serves adults who are at high risk or have a history of criminal justice involvement. As Pinal (2014) notes in a recent review article, individuals with mental health issues “who have criminal justice and forensic involvement have an increased risk of significantly fractured care (Hoge et al., 2009) and a high risk of mortality and poor outcomes (Binswanger et al., 2007). ... Their trans institutional existence and characteristics make treatment challenging and far more costly (Swanson et al., 2013). Barriers to uninterrupted care include multiple comorbidities associated with mental health, substance use, and medical illness. These are often treated in disjointed approaches at different community settings, across numerous hospitalizations, and through emergency room visits” (pg. 7).

To combat this fractured care, the FACT program uses the ACT model which combines treatment, rehabilitation, and support services provided by a self-contained team of professionals, including those from psychiatry, nursing, addiction counseling, and vocational rehabilitation (Morrissey, Meyer, & Cuddeback, 2007). The team is available to work with individuals 24 hours, 7 days a week to provide both outreach and assistance for individuals to build independent living and coping skills in real life settings. ACT programs are designed for participants who have severe mental illness or functional impairment and are at high risk for future inpatient hospitalizations. These individuals often have multi-occurring conditions, including substance abuse, other medical conditions, or criminal histories. Reviews of research studies have concluded that ACT programs are more effective than case management in reducing psychiatric hospitalizations and improving housing stability (Bond, Drake, Mueser, & Latimer, 2001; Morrissey, 2013).

The FACT program extends the ACT model, focusing on the subpopulation that is at high risk for or has a recent and significant history of criminal justice involvement (Morrissey & Meyer, 2008; Morrissey et al., 2007). Thus, criminal justice stakeholders are incorporated into the team, including probation, parole, or law enforcement personnel. Where initial studies have suggested that these types of programs may be effective in reducing recidivism, the studies have not reported improved mental health outcomes, although this may be the result of the programs being more forensic and failing to adhere closely to ACT models (Morrissey et al., 2007).

Appendix B. Participant Interview Script

Full Survey item (<i>Participant Satisfaction</i>)	Abbreviated Survey item
How often are you happy with [staff] helping you to take care of your body?	Staff helps you take care of your body
How often are you happy with [staff] working with you as a team to help you?	Staff works with you as a team
How often are you happy with the way [staff] treats you?	Happy with staff treatment
Do you feel like [staff] sees and understands what you're good at?	Staff understands what you need
How often do you feel [staff] is there for you when you need them?	Staff is there for you when needed
Does [staff] explain their ideas about your services so it makes sense to you?	Staff explain services so it makes sense
How often are you happy with how [staff] helps you find the services you need?	Staff help finding services
Do you know who to call in an emergency (for example, in case of a fire or medical emergency)	Know who to call in an emergency
Do you know who to call during times when you feel like you might hurt yourself or someone else, or you feel like you can't care for yourself?	Know who to call in a MH emergency
Full Survey item (<i>Quality of Life</i>)	Abbreviated Survey item
In the last year, how often have you been happy with your ability to control your own life?	Control over your life
How often are you happy with [staff] helping you to feel calm?	Staff helps you feel calm
How often do you have people who listen and understand you when you need to talk?	Someone listens and understands you
In the last year, how often have you felt happy about staff helping you do things out in the community?	Staff support in community
How often are you happy with [staff] helping you to have meaningful days	Staff helps you have a meaningful day

Appendix C. Data Sources and Definitions

Procedures: The following outlines procedures for the FY24 evaluation. Information was obtained from two sources:

1. Meetings with program directors and staff members
2. Interviews with participants
3. File reviews
4. Analysis of outcome data submitted to CSN

Meetings

Zoom consultations were conducted with each of the program directors in to review the file review results. Finally, exit interviews were held with PCMHDS and program staff in September to review the complete report.

Interviews – Participants

Participants were interviewed as part of the evaluation process. A target of fifteen participants were interviewed from each ISA program. Interviews were conducted by phone. The interview questions are included as Appendix B of the report. Agree/disagree responses to the questions make up the statistics used for the **Participant Satisfaction** and **Quality of Life** outcome scores. Comments from the interviews are included in Appendix A. Although direct quotations are used, neither names of respondents nor staff members are included and gendered pronouns (e.g. he, she his, hers) of both respondents and staff members were replaced with they/ them to de-identify comments.

File Reviews

LHPDC randomly selected 15 program participant files from each agency for file review. The File Review Form was used to monitor documentation. The expectation is that reported results will be consistent with information in the file for PCMHDS to have confidence in and rely on the information reported by the programs. **Participant Empowerment** outcome is based solely on the file review. As technical assistance, programs were provided with information from the file review.

Outcome Data

The evaluators were provided with all the data that each of the programs submitted monthly to PCMHDS.

System and Data Source Changes Over Time

Education and Employment Definitions

Three outcome definitions—**Education**, **Engaged in Employment**, and **Working Towards Self-Sufficiency**—were revised in 2024 to align with statewide Mental Health and Disability Services (MHDS) region standards. Prior to 2024, Polk County reported employment outcomes only for individuals considered *employment eligible*, defined as those under age 65 with a Level of Functioning (LOF) score below level 5 or 6. However, individuals who were employed but did not meet the employment-eligible criteria (due to age or higher LOF scores) were still included in reporting as “extra credit,” inflating overall performance metrics.

Beginning in 2024, with the transition to the Community Services Network (CSN), the LOF-based exemption was removed. Under the new standard, only individuals aged 65 or older are excluded from being considered employment eligible. This definitional change resulted in a decrease in employment outcome scores in FY24 and FY25, not due to a decline in performance, but because previously excluded employed individuals are no longer given “extra credit” in outcome calculations.

FY24 Data – A Baseline Year

FY24 served as a **baseline year** for evaluating program performance under the new data infrastructure and definitional standards. It is not directly comparable to previous years due to the following contextual changes:

- Documentation Transition:**
 The Polk County MHDS transitioned from PolkMIS to CSN beginning in FY23. FY24 marks the first full year of required outcome reporting in CSN. Due to this system shift, data entry processes and verification protocols were still stabilizing, limiting the reliability and validity of the data for strict performance assessment.
- Outcome Area Scope:**
 In FY24, only five outcome areas were scored—**Somatic Care**, **Participant Empowerment**, **Participant Satisfaction**, **Quality of Life**, and **Administrative Outcomes**—reflecting a phased implementation of CSN functionality and quality control.
- Data Aggregation Improvements:**
 Unlike previous years, the CSN system allows for the tracking of *unduplicated individual counts*, enhancing the precision of outcome metrics. Given this methodological shift, FY24 outcomes should be considered a reset point for longitudinal comparison.

System Transition: From PolkMIS to CSN

The transition from PolkMIS to the **Community Services Network (CSN)** represents a major shift in data management and accountability infrastructure for MHDS providers in Polk County. Initiated in response to a statewide mandate beginning **July 2022**, all Iowa MHDS Regions were required to adopt CSN, a centralized data system hosted by the Iowa Association of Counties.

Previously, Polk County used a locally controlled system, PolkMIS, in which providers entered outcome data for 16 distinct areas. During the early stages of this transition in FY23, outcome tracking was significantly reduced. Full-scale data entry resumed in FY24, but only five outcome areas were scored

as the region adapted to the new system and worked to ensure data integrity. While data collection resumed in CSN, limitations in training, workflow standardization, and outcome report generation contributed to variation in data quality across agencies.

FY24 represents the first full year of CSN-based outcome reporting in Polk County and serves as a *technical and procedural baseline*, reflecting new workflows, definitions, and reporting practices. As such, comparisons to pre-CSN years should be made with caution.

System Transition: Statewide MHDS Restructuring (HF2637)

In addition to the transition to CSN, Iowa's MHDS system underwent significant structural reform in FY25 as a result of **House File 2637**, which dismantled the regional MHDS framework and replaced it with **state-administered behavioral health districts**, effective **July 1, 2025**. This transition eliminated the region-based governance model that had been in place for over a decade and redefined service coordination and oversight structures statewide.

As a result, the FY25 evaluation period was **shortened**, with data collection concluding on **March 31, 2025**, to accommodate system-wide reorganization. The File Review covered only six months of service delivery. Despite these constraints, all outcome areas were assessed using CSN data, and newly piloted survey instruments were used for **Participant Satisfaction** and **Quality of Life**.

These changes mark a second major disruption to the continuity of data collection and performance assessment. Stakeholders are advised to interpret FY25 results with an understanding of both the **technological transition to CSN** and the **structural shift from regional MHDS to statewide behavioral health districts**.

Appendix D. Outlier Analysis

Outlier analysis was used as a method for looking at the outcome data to find people whose experiences are much different from most others in a program. This analysis focused on identifying outliers in the outcome data across three key performance areas: ***Hospital Bed Days, Involvement in the Criminal Justice System, and Homelessness***. These performance areas are especially sensitive to extreme cases because of the complex relationship between mental health, co-occurring disorders, and the unique challenges individuals face within legal, health care, and housing systems.

Defining an Outlier

An outlier in this outcome data should represent a participant whose experience is outside of the norm compared to everyone else. Most participant outcomes will fall within a typical range, for example, spending a few days in jail, a few nights homeless, or a short stay in the hospital. Some participants might have very different experiences, like spending a year in jail or being homeless almost every night. These extreme cases are outliers.

It's important to understand that outliers are identified relative to the group of participants they are being compared to. High outcome numbers do not automatically indicate an outlier. For a participant to be considered an outlier, their outcomes must be significantly higher than most others in that specific dataset. A number that stands out as extreme for one agency might not be unusual for another, depending on the typical outcomes seen in each agency's population.

Methods

This analysis was conducted using IBM SPSS Statistics (Version 29). Results were based on a combination of methods including:

- **Interquartile Range (IQR):** Data points falling outside 1.5 times the IQR above the third quartile or below the first quartile are flagged as outliers.
- **Visual Inspection:** Box plots and scatter plots visually identify participants who have an unusually high number of days in jail, nights homeless, or hospital bed days.

Results

In the FACT System, there were participants across two of the three outcome areas with unusually high outcomes, which qualified as outliers:

- ***Hospital Bed Days:*** One participant spent 118 days in the hospital.
- ***Involvement in the Criminal Justice System:*** One participant spent 252 days in jail, and another participant spent 191 days in jail.

Appendix E. Satisfaction Surveys

Survey Development and FY25 Data Collection Overview

The FY25 survey marked a transitional year in the development of a new provider and participant-centered feedback tool for individuals receiving disability services. As a step towards designing the finalized survey instrument, the FY25 survey was used to further explore with participants the concepts that agencies indicated were important for evaluation. Development of the FY25 revised instrument was informed by interviews, focus groups, and collaboration with agency staff and other stakeholders.

This temporary version of the survey included primarily qualitative items to explore participant experiences, while retaining some quantitative items for traditional agency scoring and feedback. As such, FY25 data serve a dual purpose: (1) informing ongoing survey redesign efforts and (2) providing actionable feedback to agencies. Because of changes to item wording, structure, and scoring, FY25 results should be interpreted as part of a broader transition and are not directly comparable to scores from previous years.

Methods

Satisfaction Questions

The participant satisfaction section was revised from 11 quantitative questions to 9 for this temporary scoring year. Some existing items were removed due to redundancy or limited utility, while others were rephrased using evidence-based recommendations for surveying individuals with disabilities.

The table below outlines how previous survey items corresponded to FY25 versions:

Previous Abbreviated Item	Revised FY25 Abbreviated Item
Medical care needs met	Staff helps you take care of your body
Satisfaction with services	Happy with staff working as a team
Respectful treatment	Happy with staff treatment
Responsive to needs	Staff sees and understands what you need*
Available as necessary	Staff is there for you when needed
Goals discussed	Staff explain ideas about services so it makes sense*
Deliver necessary services	Helps you find the services you need
Know who to call in an emergency (no context)	Know who to call in an emergency: 1. fire or medical* 2. might hurt yourself or someone else*
Help and support received	<i>Qualitatively measured</i>
Support independence	<i>Qualitatively measured</i>

Previous Abbreviated Item	Revised FY25 Abbreviated Item
Recommend services	<i>Not measured</i>

Of the 9 revised questions, four questions* were structured as yes/no (scored as 1 point for "yes" and 0 for "no") and five used a three-point scale ("usually" = 1 point, "sometimes" = 0.5, "rarely" = 0 points). Satisfaction scores were calculated based on the percentage of points received per valid response.

Quality of Life (QOL) Questions

The QOL section was reduced from 7 questions to 5 quantitative items. Two prior items, relating to problem-solving and housing, were explored qualitatively rather than through structured response options.

Previous Item	Revised FY25 Item
I am better able to control my life	Happy with ability to control own life
I am better able to deal with a crisis	Staff helping you to feel calm
I am getting along better with my family	Have people who listen and understand when you need to talk
I do better in social situations	Staff helps you get out in the community
I do better at school or work	Staff help you have a meaningful day
My housing situation has improved	<i>Qualitatively measured</i>
I deal more effectively with daily problems	<i>Qualitatively measured</i>

Like the revised satisfaction items, QOL items used a three-point scale with scores assigned as follows: "usually" = 1, "sometimes" = 0.5, and "rarely" = 0. Scores were calculated as the percentage of possible points, based only on participants who answered the item.

Next Steps

Findings from the FY25 concept testing interviews will undergo qualitative data analysis to identify themes, common language, and areas of priority. These insights will be combined with:

- Input from agency and interviewer focus groups
- Responses from the FY24 stakeholder Qualtrics survey
- Existing research on validated survey tools in disability services

Together, this information will guide the development of a new, evidence-informed survey instrument. This tool will be designed to reflect participant perspectives, stakeholder priorities, and best practices in the field.