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SERVICE CAPACITY ASSESSMENT PRIORITY MENTAL HEALTH SERVICES 2017

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

JULY 21, 2017

MARSH & McLENNAN COMPANIES

CONTENTS

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Executive Summary

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency, engaged Mercer Government Human Services Consulting (Mercer) to implement a network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI) in Maricopa County. This report represents the fourth in a series of annual service capacity assessments performed by Mercer.

The service capacity assessment included an evaluation of the availability, assessed need and provision of supported housing, supported employment, consumer operated services (peer support services and family support services), and assertive community treatment (ACT). Mercer assessed service capacity of the priority mental health services utilizing the following methods:

- *Key informant surveys, interviews and focus groups:* Surveys and interviews were completed with key informants and focus groups were conducted with members, family members, case managers, and providers.
- *Medical record reviews*: A sample ("Group 1") of members' assessments and ISPs were compared to recipient perceptions regarding the extent to which needs for the priority services were assessed and incorporated into service planning. Recipient perspectives were obtained during interviews conducted by peer specialists employed by two separate consumer operated organizations under contract with Mercer. A second sample of class members ("Group 2") was drawn to support an evaluation of clinical assessments, ISPs, and progress notes to examine the extent to which recipient's needs for the priority services were being assessed and met.
- *Analysis of service utilization data and contracted capacity for each of the priority mental health services*: Analysis was conducted to evaluate the volume of unique users, billing units, and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to estimate "persistence" in treatment. Persistence was evaluated by calculating the proportion of recipients who only received a priority service during a single month. Additional progressive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months, and nine months) to determine the volume of recipients who sustained consistent participation in the selected prioritized services.
- *Analysis of outcomes data:* Analysis of data including homeless prevalence, employment data, and criminal justice information.
- *Benchmark analysis:* Analysis of priority service penetration rates in other states and local systems that represent relevant comparisons for Maricopa County.

Overview of Findings and Recommendations

The most significant findings and recommendations regarding the accessibility and provision of the priority services are summarized below. When applicable and available, comparisons of findings and results from prior year reviews are presented. The review period primarily

targeted calendar year 2016 (CY 2016), though for some units of analysis that rely on service utilization data, the timeframe was extended (i.e., October 2015 – June 30, 2016) to account for potential lags in processing fully adjudicated administrative data.

Service Capacity Assessment Conclusions

Mercer's current service capacity assessment identified that the Maricopa County SMI service delivery system experienced noted expansions for some priority mental health services (e.g., ACT teams), while other priority mental health services sustained recently expanded capacity as established and documented in prior year service capacity assessments. In addition, more members are accessing the priority mental health services at higher numbers and percentages than ever before.

Mercer noted a substantial increase in the number of SMI members who received covered services during the review period. Mercer explored explanations to identify factors that may be influencing increases in the number of SMI members assigned to the Maricopa County RBHA. Changes in Medicaid eligibility criteria and Medicaid expansion may be driving increases in penetration and enrollment. Mercer determined that 81% of the total SMI population that received a covered service during the review period is Medicaid eligible; the highest proportion of SMI Title XIX members in the past four review cycles.

Another possible reason for the increase is attributed to a new navigator program that the Maricopa County RBHA implemented during the review period. Per the Maricopa County RBHA Provider Manual, the SMI Patient Navigator is a position within the direct care SMI clinics to ensure that all members designated as SMI (Title XIX or Non-Title XIX) are assigned to a behavioral health home. The SMI patient navigator staff screen members for service needs and based on the needs identified, conduct an assessment and treatment plan outlining necessary support services, outreach and engagement from the direct care SMI clinics. With a targeted case load size of 1:250, the SMI patient navigator applies a screening tool and health risk assessment to members assigned to the program (at a minimum, the screenings take place at least once per year). If the screening tool indicates a need to initiate or continue navigator services, the member is engaged to complete a basic treatment plan that reflects the level of service needed. If the member requires more intense supports and services, the member can be transitioned to a more appropriate level of case management (i.e., connective, supportive, ACT). The program engages SMI members in services who might otherwise not be actively receiving services. Despite significant increases in the denominator of members served, percentages of priority services received over the review period increased across the board, including the addition of three new ACT teams and almost 400 new ACT team members.

The extent of the assessed need for the services appears to be within the system's contracted capacity to provide each of the prioritized services. For example, ACT team capacity across the 24 available teams was found to be 87% at the time of the service capacity assessment, though some of the teams are new and require appropriate intervals of time to recruit new members. Key informant interviews with multiple supported employment providers reveal that capacity exists in excess of the current demand for supported employment services. Supported housing providers are adding new members into permanent support housing supports and services, but do not appear to be exceeding contracted capacity. One noted exception is the lack of available housing vouchers with extended wait lists reported for some SMI members.

Mercer continues to observe occasional challenges with identifying member service needs and found that when a need is identified, recipients are not consistently able to access the service in a timely manner. In some cases, priority service needs were identified and documented, but the clinical team did not appear to follow up with initiating a referral for the service(s). Issues also persist with outdated assessments and individual service plans and the contracted provider network organizations and administrative entities experience challenges with accurately tracking assigned members who may be in need of an annual assessment update. The Maricopa County RBHA is actively monitoring compliance with these requirements and has reportedly imposed sanctions with some contractors over the review period. However, the RBHA relies heavily on contractor self-reported data to assess compliance with expectations for current assessments and individual service plans[1]. Mercer's experience when trying to obtain member samples to support the service capacity assessment suggests that the provider network organizations and administrative entities do not have an effective process to accurately track when annual assessment updates have been completed. For example, even after confirming with the contractors that a roster of members had completed assessments during the specified review period, several contractors were unable to subsequently generate the member's assessment for a substantial portion (up to 20%) of the pre-reviewed member roster.

There was sufficient evidence to indicate that members of the clinical teams (case managers and clinical supervisors) could benefit from additional training regarding the appropriate application of covered services, including many of the priority mental health services (i.e., supported employment, family support, and peer support). Mercer observed multiple ISPs with identified services that were inappropriate to meet the member's stated needs, goals and objectives. For example, several ISPs in the medical record sample repeatedly listed cognitive rehabilitation to meet members' assessed needs for supported employment services. In another example, family support was identified as an intervention that the family mentor was going to provide to the member once every six months in the absence of any involved or available family members. In another example, peer support services were identified as the intervention to assist the member with abiding by the terms of her lease agreement, paying bills on time and keeping her apartment clean.

Mercer also identified a need for more robust clinical oversight of case management teams and activities. In a subset of cases, individuals appeared capable of taking full advantage of the priority services to achieve a higher level of functioning, but the repeated escalation of psychiatric symptoms disrupted and impeded the member's progress. Within the direct care clinical team service delivery model, the case manager typically has the most contact with members and is best positioned to identify how the member is responding to clinical treatment, detect early signs of worsening psychiatric symptoms, and to alert the clinical team of the need for immediate clinical attention. Because the case manager did not perform these functions in these cases, members were not able to achieve their highest level of functioning as efficiently as they might have had they had access to more immediate clinical support to manage their symptoms.

The Maricopa County RBHA has also implemented a value-based purchasing initiative and is monitoring designated performance measures that tie to improved member outcomes. The purpose of the initiative is to encourage continuous quality improvement and learning, particularly initiatives that target improved health outcomes and cost savings. AHCCCS has led the effort and is leveraging the managed

[1] During an interview with RBHA representatives, it was reported that the RBHA quality management department also monitors the requirements via a medical record review.

care model toward value-based health care with the expectation to improve members' health care experience and population health. Performance measure results reported by the RBHA that are directly relevant to the Maricopa County SMI population and the priority mental health services are summarized below[2].

For ACT team providers, findings include:

- Psychiatric hospitalizations per 1000 members have decreased 8%;
- 62% of the participating ACT teams exceeded a target of a 10% decrease in hospitalizations;
- Emergency department visits per 1000 members have decreased by 6%;
- 48% of the participating ACT teams exceeded a target of a 10% in emergency department visits;
- 45% of the participating ACT teams achieved an increase of 10% or greater in the numbers of members competitively employed. Among those teams, the average increase in employment was 39%; and
- More than half (52%) of the participating ACT teams reduced homelessness by an established target of 10% or more.

For Forensic ACT team providers, findings included:

- A forensic ACT team achieved a 76% reduction in the number of jail bookings;
- A 31% reduction in psychiatric hospital admissions;
- An 18% reduction in emergency department visits; and
- A 19% reduction in the number of homeless members.

For permanent supporting housing providers, findings include:

- A 60% reduction in psychiatric hospital admissions was observed for members affiliated with a participating supported housing service provider;
- A 49% reduction in the number of members who utilized a mobile crisis service; and
- A 10% increase in the number of members who maintained stable housing once secured.

A summary of findings specific to each priority mental health service are presented below.

Consumer Operated Services (Peer Support Services and Family Support Services)

- Service utilization data demonstrates a significant increase in the percentage of members who received at least one unit of peer support services over the review period. During CY 2016, 38% of members received peer support services representing the highest percentage observed since CY 2013. (CY 2013 — 38%; CY 2014 — 31%; CY 2015 — 29%).
- Maricopa County excels in making peer support services available to persons in need. The penetration rate in 2016 is still relatively high. The Omaha area of Nebraska has a slightly higher penetration rate, but Maricopa County also constitutes a "best practice" benchmark in terms of access to peer support.

[2] As reported by the Maricopa County RBHA, correspondence dated May 25, 2017.

- 16% of the assessments identified peer support as a need. When assessed as a need, peer support services were identified on the recipient's ISP 58% of the time. However, 45% of the Group 1 recipients received at least one unit of peer support services during CY 2016 based on a review of service utilization data. It was noted that members tend to access services despite assessed needs and/or services identified on the ISP.
- Service utilization data demonstrates minor differences in the percentage of members who received at least one unit of family support services over the respective review periods (CY 2013 — 2%; CY 2014 — 3%; CY 2015 — 2%; CY 2016).
- As reported by the Maricopa County RBHA, peer support and family support contracted capacity is capable of serving at least 2,215 members.

Supported Employment Services

- Service utilization data demonstrates an increase in the percentage of members who received at least one unit of supported employment during the review period, with 26% of SMI members receiving at least one unit of supported employment services during CY 2016. (CY 2013 – 39%; CY 2014 – 20%; CY 2015 – 17%).
- The review team observed a pattern in one administrative entity of indiscriminately listing services on member's ISPs, including supported employment services. However, clinical team documentation did not consistently support follow up with referrals for these services. It was unclear (based on available documentation) that the services were needed or that the service listed on the ISP was an intervention that the member intended to pursue (e.g., member self-identifies as retired).
- Consistent with patterns noted over the past four years, the service utilization data set demonstrates proportional variation in the volume of encountered service codes for supported employment. For the time period October 1, 2015 through June 30, 2016, H2027 (pre-job training and development) accounts for 87% of the total supported employment services (slight increase from CY 2015 – 84%).
- The Department of Economic Security/Rehabilitation Services Administration (DES/RSA) data secured from the Maricopa County RBHA for Federal Fiscal Year 2017, Quarter 1, included the following:
  - RBHA members referred to RSA/Vocational Rehabilitation (VR) – 2,325 (January 1, 2016 – November 30, 2016)
  - RBHA member enrolled in the VR program – 1,484 (quarter end September 30, 2016)
  - RBHA members in service plan status with VR – 1,052 (quarter end September 30, 2016)
- As reported by the Maricopa County RBHA, supported employment contracted capacity is capable of serving at least 1,070 members.

Supported Housing Services

- Service utilization data demonstrates that 10% of members received at least one unit of supported housing during the review period.
- In nineteen cases, reviewers were able to review progress notes and record the reasons that the person did not access supported housing services after housing-related assistance was identified as a need by the clinical team. The most common reason was that there was a lack of evidence that the clinical team followed up with initiating a referral for the service.
- 46% of the survey respondents felt that supported housing services were difficult to access, up from 38% a year ago. As noted during CY 2014 and CY 2015, none of the respondents indicated that supported housing services were inaccessible, a sustained improvement from CY 2013 when 17% of the key informants felt that the services were inaccessible.

- As reported by the Maricopa County RBHA, permanent supported housing contracted capacity is capable of serving at least 1,872 members.

ACT Team Services

- As a percentage of the total SMI population, 7% of all members are assigned to an ACT team. This is the same finding observed in CY 2015 and slightly higher than the finding derived during CY 2013 and CY 2014 (6%).
- A review of 100 SMI members that represent the highest aggregate behavioral health service costs was conducted. It was determined that 25% of the members were assigned to an ACT team. This compares to 23% when the same analysis was completed during CY 2015, 18% during CY 2014 and 20% during CY 2013.
- An analysis of jail booking data was completed to identify members that have had multiple jail bookings over a defined period (i.e., eleven months—January through November 2016) and determine if the member was subsequently referred and assigned to an ACT team, including one of the three forensic specialty ACT teams. The analysis found:
  - 467 members experienced at least two jail bookings during the period under review (408 for the same time period in CY 2015).
  - Of these 467 members, 119 (25%) were assigned to an ACT team (CY 2015 – 23%) during the review period.
  - Of the 119 members assigned to an ACT team, 26 (22%) were assigned to a forensic specialty ACT team (CY 2015 – 20%).
  - 36 members receiving ACT team services have three or more incarcerations over the review period, but are not assigned to one of the three available forensic specialty ACT teams.
- 2,092 recipients were assigned to 24 ACT teams as of December 1, 2016. An increase of three teams and 399 members since CY 2015.

Additional findings and recommendations for each of the priority services can be found in *Section 5, Findings and Recommendations.*

2

Overview

The Arizona Health Care Cost Containment System (AHCCCS) engaged Mercer Government Human Services Consulting (Mercer) to implement an annual network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI).[3] The service capacity assessment included a need and allocation evaluation of supported housing, supported employment, consumer operated services (peer support services and family support services), and assertive community treatment (ACT).

Goals and Objectives of Analyses

The primary objectives of the service capacity assessment were designed to answer the following questions regarding the prioritized mental health services. For each of the four prioritized services:

1. What is the extent of the assessed need for the service?
2. When a need for the service is identified, are recipients able to timely access the service for the intensity and duration commensurate with the person's clinical needs?
3. What factors (e.g., capacity, quality, system design) most commonly impact the appropriate assessment of need and/or ability to access the service?
4. Identify system strengths and opportunities to improve the appropriate identification of need and access to the prioritized mental health services.

Limitations and Conditions

Mercer did not independently verify the accuracy and completeness of service utilization data, outcomes data, and other primary source information collected. Service utilization data includes encounter submission lag times that are known to impact the completeness of the data set. Mercer performed an analysis of summary level service utilization data related to the four prioritized mental health services and aggregated available functional and clinical outcomes data.

[3] The determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis.

3

Background

During the review period, AHCCCS and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) alternately served as the single State authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health system. AHCCCS and ADHS/DBHS contracted with community-based organizations, known as RBHAs, to administer integrated physical health (to select populations) and behavioral health services throughout the State of Arizona. Effective July 1, 2016, AHCCCS' and DBHS' administrative structure and personnel merged in an effort to eliminate areas of duplication while strengthening the expertise of a single, unified administrative agency. As such, AHCCCS now administers and oversees the full spectrum of services to support integration efforts at the health plan, provider and member levels.

History of *Arnold v. Sarn*

In 1981, a class action lawsuit was filed alleging that the State, through the Department of Health Services and Maricopa County, did not adequately fund a comprehensive mental health system as required by State statute. The lawsuit, *Arnold v. Sarn*, sought to enforce the community mental health residential treatment system on behalf of persons with SMI in Maricopa County. Furthermore, the severe State budget crisis in recent years resulted in significant funding reductions to class members, a temporary stay in enforcement of the lawsuit, and agreement by the parties to renegotiate exit criteria.

On May 17, 2012, as the State's fiscal situation was improving, former Arizona Governor Jan Brewer, State health officials, and plaintiffs' attorneys announced a two-year agreement that included a return of much of the previously reduced funding for a package of recovery-oriented services including supported employment, living skills training, supported housing, case management, and expansion of organizations run by and for people living with SMI. The two-year agreement included activities aimed to assess the quality of services provided, member outcomes, and overall network sufficiency.

On January 8, 2014, a final agreement was reached in the *Arnold v. Sarn* case. The final settlement provides a variety of community-based services and programs agreed upon by the State and plaintiffs, including crisis services; supported employment and housing services; ACT; family and peer support; life skills training; and respite care services. ADHS/DBHS was required to adopt national quality standards outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as annual quality service reviews conducted by an independent contractor and an independent service capacity assessment to ensure the delivery of quality care to the State's SMI population.

SMI Service Delivery System

Beginning July 1, 2016, AHCCCS contracted with RBHAs to deliver integrated physical health (to select populations) and behavioral health services in three geographic service areas (GSAs) across Arizona. Each RBHA must manage a network of providers to deliver all covered

physical health and behavioral health services to Medicaid eligible persons determined to have a serious mental illness. RBHAs contract with behavioral health providers to provide the full array of covered physical health and behavioral health services, including the four prioritized mental health services that are the focus of this assessment.

For persons determined to have a SMI in Maricopa County, the RBHA has contracts with two adult provider network organizations (PNOs) and multiple administrative entities that manage ACT teams and/or operate direct care clinics throughout the county. The PNOs and administrative entities include, Partners in Recovery Network, Southwest Network, Terros, Lifewell Behavioral Wellness, LaFrontera/EMPACT, Chicano Por La Causa, Community Bridges, Inc., Assurance Health and Wellness, Jewish Family and Children's Service and Maricopa Integrated Health System. The table below identifies the adult PNOs and administrative entities and assigned direct care clinics.

Organization	Direct Care Clinics	Organization	Direct Care Clinics
Terros	Enclave	**Southwest Network**	Saguaro
	Townley Center		Highland
	West McDowell		San Tan
			Bethany Village
			Garden Lakes
			Mesa Heritage
			Osborn
Lifewell Behavioral Wellness	Oak	**Chicano Por La Causa**	Centro Esperanza
	Windsor		
	South Mountain		
LaFrontera/EMPACT	Comunidad	**Partners in Recovery Network**	Metro Center Campus
	EMPACT – San Tan		West Valley Campus
			Arrowhead Campus
			East Valley Campus
			Hassayampa Campus
			Gateway Campus

The direct care clinics provide a range of recovery focused services to SMI recipients such as medication services, medical management, case management, transportation, peer support services, family support services, and health and wellness groups. 24 ACT teams are available at different direct care clinics and community provider locations. Access to other covered behavioral health services, including supported employment and supported housing is primarily accessible to SMI recipients through RBHA contracted community-based providers.

Current Service Capacity

The information presented below reflects the contracted capacity for each of the prioritized services during the period under review.[4]

ACT Teams (24 teams serving 2,092 recipients)[5]

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Southwest Network: San Tan		100	98	2%
Southwest Network: Saguaro		100	94	6%
Southwest Network: Mesa Heritage		100	100	0%
Southwest Network: Osborn		100	97	3%
Southwest Network: Bethany Village		100	99	1%
Lifewell Behavioral Wellness: South Mountain		100	97	3%
Terros: Enclave		100	101	N/A
Terros: Townley Center	Primary Care Provider (PCP) Partnership	100	97	3%
Terros: Dunlap		100	79	21%
Terros: West McDowell	PCP Partnership	100	95	5%
Chicanos Por La Causa: Centro Esperanza		100	91	9%
Chicanos Por La Causa: Maryvale		100	58	42%
LaFrontera/EMPACT: Tempe*	PCP Partnership	100	62	38%
LaFrontera/EMPACT: Comunidad		100	99	1%
LaFrontera/EMPACT: Capitol Center		100	96	4%
Partners in Recovery: Metro Center Campus – Omega Team		100	95	5%
Partners in Recovery: Metro Center Campus – Varsity Team		100	93	7%
Partners in Recovery: Indian School	Medical Team	100	92	8%
Partners in Recovery: West Valley Campus	PCP Partnership	100	98	2%
Community Bridges: FACT Team 1	Forensic Team	100	96	4%
Community Bridges: FACT Team 2	Forensic Team	100	84	16%
Community Bridges: FACT Team 3*	Forensic Team	100	69	31%
Community Bridges: Avondale	PCP Partnership	100	73	27%
Maricopa Integrated Health System – Mesa Riverview*	PCP Partnership	100	29	71%
	Totals	**2,400**	**2,092**	**13%****

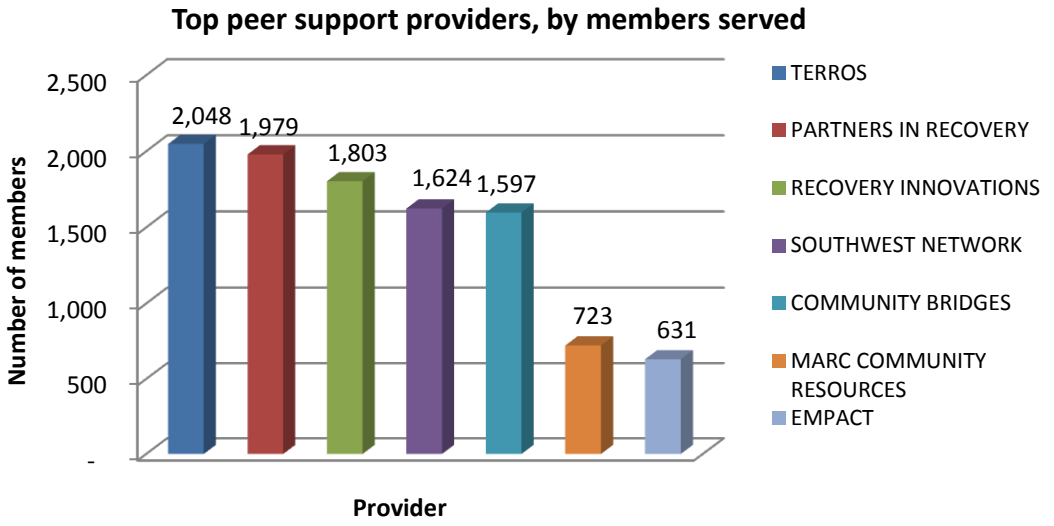
[4] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2017.
[5] As of December 1, 2016.

***** Represent new ACT teams since the last review. The teams are working to build capacity consistent with fidelity to SAMHSA's evidence-based practice model.
**When new teams are excluded, the percent below full capacity is 8%.

A presentation of service utilization data is depicted to identify the volume of units and unique members affiliated with each provider. The review is intended to identify the most prevalent providers of the priority services. The analysis was completed for the following priority mental health services: peer support, family support, supported employment and supported housing.

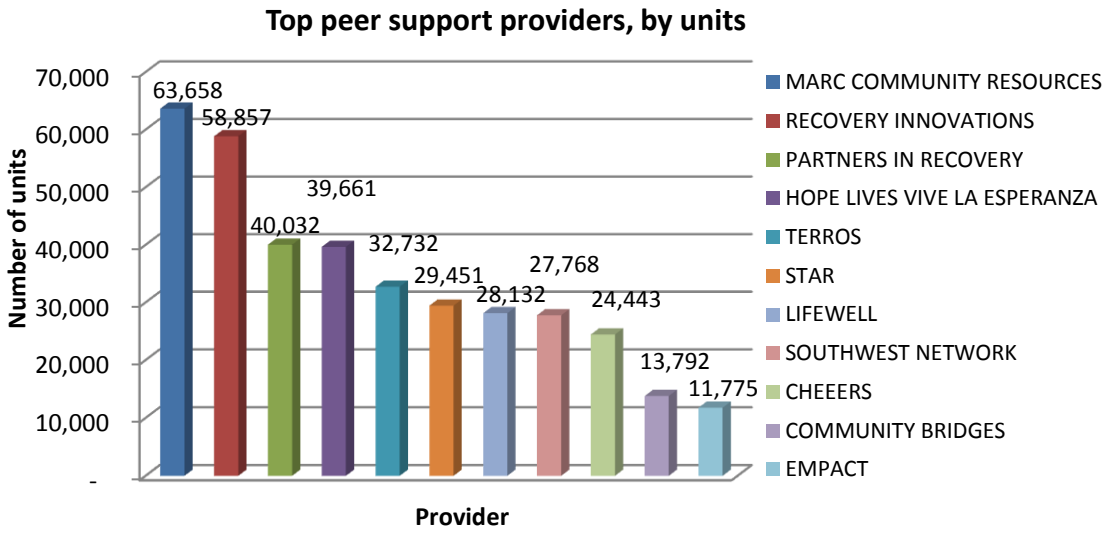
Consumer Operated Services (peer support and family support)[6]

- Assurance Health and Wellness.
- CHEEERS.
- Chicanos Por La Causa (CPLC)
- Community Bridges, Inc.
- Family Involvement Center
- Hope Lives Vive la Esperanza.
- Horizon Health and Wellness.
- La Frontera/EMPACT
- Lifewell Behavioral Wellness.
- Marc Community Resources.
- Maricopa Integrated Health System (MIHS)
- National Council on Alcoholism and Drug Dependence (NCADD).
- NAZCARE.
- Partners in Recovery.
- Phoenix Shanti
- PSA.
- Recovery Empowerment Network (REN).

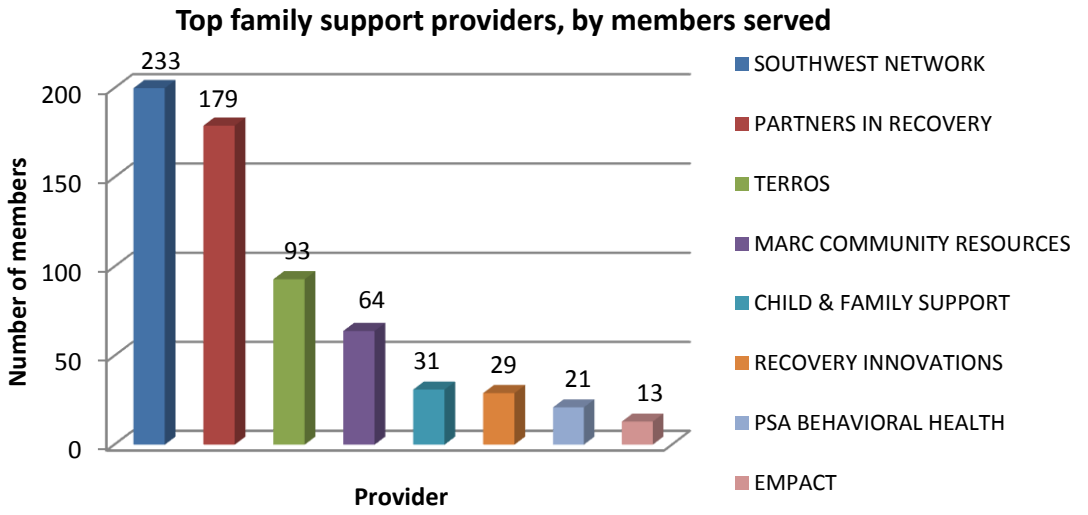


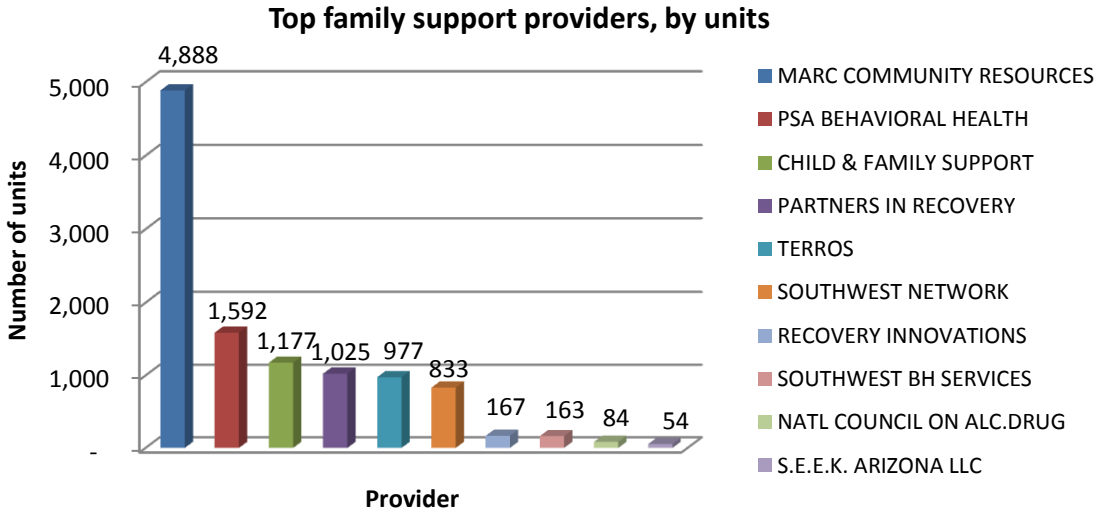
[6] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2017.

- Recovery Innovations of Arizona (RIAZ).
- Southwest Behavioral Health.
- Southwest Network.
- Stand Together and Recover (STAR).
- Terros.
- Valle de Sol



Consumer Operated Services (family support)[7]

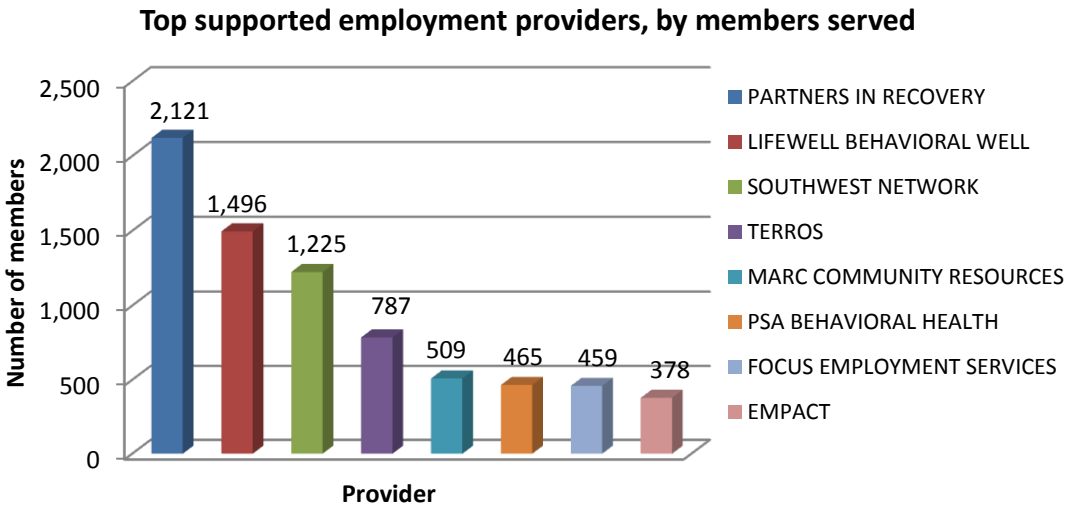


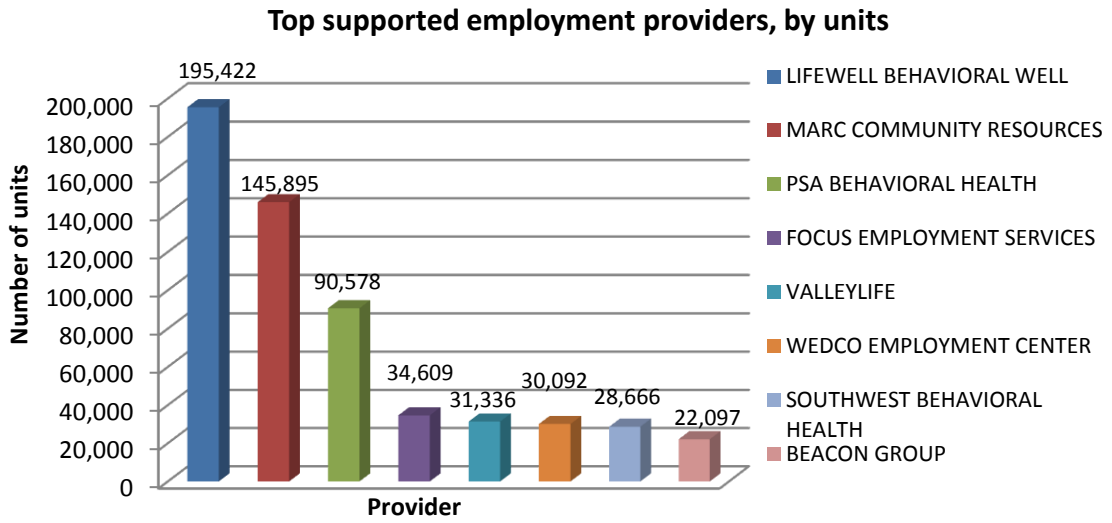


[7] As reported by the Maricopa County RBHA administering the AH

Supported Employment Providers[8]

- Beacon Group.
- Focus Employment Services.
- Lifewell Behavioral Wellness.
- Marc Community Resources.
- Recovery Empowerment Network
- Valleylife.
- Wedco

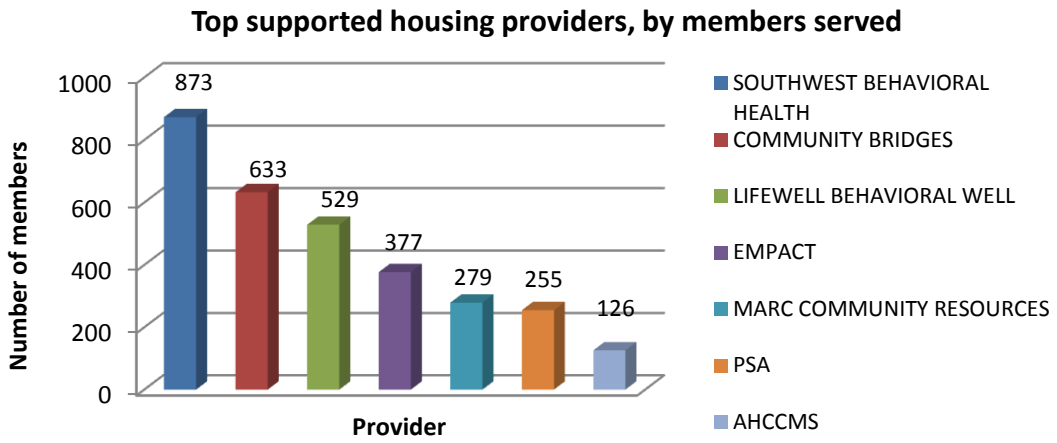


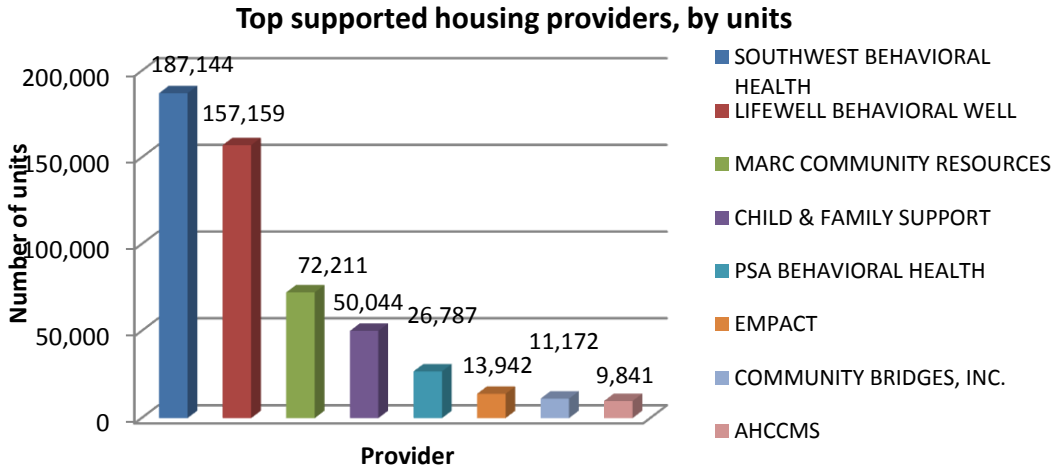


[8] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2017.

Supported Housing Providers[9,10]

- A New Leaf
- Arizona Behavioral Health Corporation.
- Arizona Health Care Contract Management Services (AHCCMS).
- Biltmore Properties.
- Chicano Por La Causa.
- Child and Family Support Services.
- Community Bridges, Inc.
- Florence Crittenton.
- Housing Authority of Maricopa County.
- LaFrontera/Empact.
- Lifewell Behavioral Wellness.
- Marc Community Resources.
- Native American Connections.
- ProMarc.
- PSA Behavioral Health Agency.
- RI International.
- Save the Family.
- Southwest Behavioral Health Services.
- Terros.





[9] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2017.

[10] Mercer broadened the supported housing service utilization data query to include Skills Training and Development (H2014) when the service was rendered by a contracted supported housing provider.

4

Methodology

Mercer performed a service capacity assessment of the priority mental health services to assess unmet needs utilizing the following methods:

- *Key informant surveys, interviews and focus groups:* Surveys and interviews were completed with key informants and focus groups were conducted with members, family members, case managers, and providers.
- *Medical record reviews*: A sample ("Group 1") of members' assessments and ISPs were compared to recipient perceptions regarding the extent to which needs for the priority services were assessed and incorporated into service planning. Recipient perspectives were obtained during interviews conducted by peer specialists employed by two separate consumer operated organizations under contract with Mercer. A second sample of class members ("Group 2") was drawn to support an evaluation of clinical assessments, ISPs, and progress notes to examine the extent to which recipient's needs for the priority services were being assessed and met.
- *Analysis of service utilization data and contracted capacity for each of the priority mental health services*: Analysis was conducted to evaluate the volume of unique users, billing units, and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to estimate "persistence" in treatment. Persistence was evaluated by calculating the proportion of recipients who only received a priority service during a single month. Additional progressive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months, and nine months) to determine the volume of recipients who sustained consistent participation in the selected prioritized services.
- *Analysis of outcomes data:* Analysis of data including homeless prevalence, employment data, and criminal justice information.
- *Benchmark analysis:* Analysis of priority service penetration rates in other states and local systems that represent relevant comparisons for Maricopa County.

A description of the methodology utilized for each evaluation component is presented below.

Focus Groups

As part of the service capacity assessment of the priority behavioral health services in Maricopa County, four focus groups were conducted with key informants. The focus groups were organized and managed to facilitate discussion with participants who have direct experience with the priority mental health services.

Participation in the focus groups was solicited by an invitation created by Mercer, which was reviewed and approved by AHCCCS[11].

[11] See Appendix A: Focus Group Invitation.

Notification of the annual Service Capacity Assessment focus groups was communicated to key stakeholders in the community. This included email communications and electronic invitations sent to the Adult PNOs, administrative entities, providers of the priority mental health services and to family and peer run organizations.

The focus groups included the following participants:

- Providers of supported housing services, supported employment services, ACT team services, and peer and family support services.
- Family members of SMI adults receiving behavioral health services.
- SMI adults receiving behavioral health services.
- Direct care clinic case managers.

A total of 37 stakeholders participated in the four two-hour focus groups conducted on February 22, 2017 and February 24, 2017. All four focus groups were held at the Refuge Cafe. 12 direct care clinic staff, nine providers, nine family members and seven SMI adult recipients participated.

The methodology included the following approach:

- A handout defining each of the priority mental health services was provided to each group of participants at the onset of the focus groups.
- Participants were prompted to discuss experiences related to accessing each of the priority services, including perceived system strengths and barriers.
- Based on findings derived from the prior year's evaluation, participants were asked to share observations regarding any noted system changes, improvements and/or ongoing and emerging concerns regarding the availability and capacity of the priority mental health services.

Key Informant Surveys and Interviews

One objective of the service capacity assessment was to obtain comprehensive stakeholder feedback regarding the availability of each of the priority mental health services. As a result, a key informant survey was created using *Survey Monkey®.* The survey tool included questions with rating assignments related to accessing the priority mental health services, including the ease of access and timeliness of access to the services.[12] It should be noted that the survey distribution process targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

[12] See Appendix B: Key Informant Survey.

The survey was disseminated to key system stakeholders via email with a hyperlink to the online survey. A total of 48 respondents completed the survey tool.

In addition, in-depth interviews were conducted with providers of the targeted services to gather information regarding system strengths and potential barriers to accessing the priority mental health services.

Medical Record Reviews (Group 1 and Group 2)

Mercer obtained two separate samples for the record reviews that were conducted. The first sample ("Group 1") focused on the extent to which the attempts of clinical team members to assess and attend to needs for priority services matched the recipient's perceptions of their need for the services, as determined through direct recipient interviews. In reviewing the records of the second sample ('Group 2"), Mercer evaluated clinical assessments, ISPs, and clinical team progress notes to determine the extent to which needs for priority services were being considered in service planning and met through service provision. Both samples consisted of adults with SMI who were widely distributed across PNOs, direct care clinics, and levels of case management (i.e., assertive, supportive, and connective).

Group 1

The Group 1 sample included 121 randomly selected cases.

The Group 1 medical record review sought to answer the following questions regarding the assessment process and determination that assessed needs were addressed as part of the recipient's ISP:

- Is there evidence that each of the priority mental health services was assessed by the clinical team?
- When assessed as a need, is the priority mental health service(s) identified on the recipient's ISP?
- Is the clinical team's assessment consistent with the recipient's perception regarding the need for one or more of the priority mental health services?

Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient's current annual assessment update or initial assessment and/or a current psychiatric evaluation, and the recipient's current ISP.

Mercer developed an interview guide[13] to support the assessment of the recipient's perception regarding the need for one or more of the priority services. Mercer's review team trained peer reviewers regarding the use of the interview tool to help ensure consistent application of the guide across reviewers.

All 121 Group 1 recipients completed in-person interviews.

[13] See Appendix C: Assessment Verification Interview Tool.

Group 1 medical record documentation for the sample (n=121) was reviewed by Mercer behavioral health professionals and recorded in a data collection tool. Documentation regarding the priority mental health services was analyzed by reviewing assessments and ISPs, the findings from which were recorded in the data collection tool. Findings from the recipient interviews were added to the data collection tool to support a comparative analysis between the medical record documentation findings and the recipient's recorded responses to the interview questions.

Group 2

For Group 2, the final sample included 199 randomly cases, selected using the following criteria:

- The recipient was identified as SMI and received a covered behavioral health service during October 1, 2015 and December 31, 2016.[14]
- The recipient had an assessment date between January 1 and November 15, 2016.[15]

The Group 2 medical record review sought to answer the following questions regarding the assessment and provision of the priority mental health services:

- Is there evidence that the need for each of the priority mental health services was assessed by the clinical team?
- When assessed as a need, was the priority mental health service(s) identified on the recipient's ISP?
- When identified as a need and listed on the recipient's ISP, is there evidence that the recipient accessed the service consistent with the prescribed frequency and duration and within a reasonable time period?
- If the recipient was unable to access the recommended priority service, what were the reasons that the service(s) was not delivered?

Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient's current annual assessment update or initial assessment and/or a current psychiatric evaluation, the recipient's current ISP, and all clinical team progress notes following each recipients' assessment date through December 31, 2016.

Group 2 medical record documentation for the sample (n=199) was reviewed by three licensed clinicians and recorded in a data collection tool.[16] Additional comments were recorded to further clarify findings. Prior to conducting the medical record reviews, inter-rater reliability testing was completed over a two day period with all reviewers using actual cases, resulting in 95% agreement between reviewers across all scoring tool questions.

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[14] The total population of unique SMI recipients who received behavioral health services is 30,440 for the period October 1, 2015 through December 31, 2016.

[15] Cases for Group 2 were selected to ensure that sufficient time had elapsed to reasonably expect the delivery of recommended services following the completion of the recipient's assessment and ISP.

[16] See Appendix D: Group 2 Medical Record Review Tool.

Analysis of Service Utilization Data

Mercer initiated a request to AHCCCS for a comprehensive service utilization data file. The service utilization data file included all adjudicated service encounters for any person designated as SMI and assigned to the Maricopa County GSA.

The specified time frame for the file included dates of service between October 1, 2015 and December 31, 2016. As noted in previous service capacity assessment reports, encounter submission lag times can impact the completeness of the data set.

Specific queries were developed to identify the presence of each prioritized mental health service.[17] Analysis was conducted to evaluate the volume of unique users, billing units, and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to determine "persistence" in treatment. Through the evaluation, proportions of recipients who only received the service in a single month were calculated. Additional progressive consecutive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months, and nine months) to determine the volume of recipients who sustained consistent participation in each of the prioritized services. For ACT team services, a roster of ACT team members was obtained and a corresponding analysis of service utilization was also performed.

The service utilization data file supports the extraction of the Group 1 and Group 2 medical record samples and allows for an analysis of the service utilization profile for each recipient selected, as well as supporting an aggregated view of service utilization for each sample group (total sample size across Group 1 and Group 2 = 320). Group 1 and Group 2 sample characteristics for each year of the service capacity assessment are illustrated in the following tables and are compared to the characteristics of the total population of active users.

[17] ACT team services are one of the identified prioritized mental health services reviewed as part of the service capacity assessment. However, ACT team services are not assigned a unique billing code and; therefore, are not represented in the service utilization data file.

2016 Service Capacity Assessment Time Period – Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Group 1	121	45%	7%	45%	14%	4%
Group 2	199	36%	5%	27%	9%	11%
Service utilization data	30,440	38%	3%	26%	10%[18]	7%[19]

2015 Service Capacity Assessment Time Period – Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Group 1	119	24%	1%	18%	3%	2%
Group 2	201	30%	4%	21%	3%	4%
Service utilization data	24,608	29%	2%	17%	4%	7%

2014 Service Capacity Assessment Time Period – Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Group 1	124	29%	2%	10%	2%	6%
Group 2	197	30%	3%	18%	4%	4%
Service utilization data	24,048	31%	3%	20%	3%	6%

2013 Service Capacity Assessment Time Period – Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Group 1	122	36%	2%	39%	0%	7%
Group 2	198	40%	3%	32%	0%	4%
Service utilization data	23,512	38%	2%	39%	0.02%	6%

[18] Mercer broadened the supported housing service utilization data query to include Skills Training and Development (H2014) when the service was rendered by a contracted supported housing provider.

[19] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 7% of all active SMI recipients are assigned to ACT teams.

Analysis of Outcomes Data

The service capacity assessment utilized an analysis of recipient outcome data in an attempt to correlate receipt of one or more of the priority mental health services with improved functional outcomes. Based on the available data and the desire to compare year-to-year results, the review team selected the following outcome indicators to support the analysis:

- Criminal justice records (i.e., number of arrests);
- Homeless prevalence (i.e., primary residence); and
- Employment status.

The outcome indicators listed above are described as part of the AHCCCS Demographic and Outcomes Data Set User Guide, which provides information for the completion and submission of the demographic data set, a set of data elements that RBHAs are required to collect and submit to AHCCCS. The data is used to:

- Monitor and report on recipients' outcomes;
- Comply with federal, State, and/or grant requirements to ensure continued funding for the behavioral health system;
- Assist with financial-related activities such as budget development and rate setting;
- Support quality management and utilization management activities; and
- Inform stakeholders and community members.

The data fields contained in the demographic data set are mandatory and must be collected and submitted within required timeframes, recorded using valid values, and in compliance with specified definitions.

The outcomes data was provided by AHCCCS as part of the service utilization data file request. For each recipient included in the service utilization file, AHCCCS provided abstracts of the most recent demographic data record.

AHCCCS has established valid values for recording each demographic data element, including the selected functional outcomes. Each indicator is described and valid selections are presented below.

Number of Arrests

The outcome indicator records the number of times that the recipient has been arrested within the last 30 days. A valid entry is the number of times (between 0 and 31).

Primary Residence

The outcome indicator is described as the place where the recipient has spent most of his/her time in the past 30 days prior to the assessment. Valid values include:

- Independent.
- Hotel.
- Boarding home.
- Supervisory care/assisted living.
- Arizona state hospital.
- Jail/prison/detention.
- Homeless/homeless shelter.
- Other.
- Foster home or therapeutic foster home.
- Nursing home.
- Home with family.
- Crisis shelter.
- Level I, II, or III behavioral health treatment setting.
- Transitional housing (Level IV) or Department of Economic Security group homes for children.

Employment Status

The outcome indicator records the recipient's current employment status. Valid values include:

- Unemployed.
- Volunteer.
- Unpaid rehabilitation activities.
- Homemaker.
- Student.
- Retired.
- Disabled.
- Inmate of institution.
- Competitive employment full-time.
- Competitive employment part-time.
- Work adjustment training.
- Transitional employment placement.
- Unknown.

Penetration and Prevalence Analysis

As part of the service capacity assessment, a review of utilization and penetration rates of the priority mental health services (Assertive Community Treatment [ACT], supported employment, supported housing, and peer support[20]) was conducted. Penetration rates were compared to benchmarks, as described below.
The following review process was completed by Mercer:

- Select academic publications were reviewed;
- Mercer consulted with national experts regarding the prioritized services and benchmarks for numbers served; and
- National data from the Substance Abuse and Mental Health Services Administration (SAMHSA) on evidence-based practice (EBP) penetration rates at the state level were reviewed.

The intent in reviewing these sources was to identify average benchmarks for EBP penetration, as well as to look at best practice benchmarks. *Average benchmarks* are drawn from national averages and other sources that do not necessarily represent a best practice level of effort, whereas *best practice benchmarks* are drawn from the highest-performing systems included in the study.

Service Expansions — Comparison of Select States

During the initial year of the service capacity assessment, a comparative analysis was performed with selected states and included a review of negotiated agreements to increase capacity and services to populations of persons identified to have serious and persistent mental illness, as well as interviews with key state staff involved in the implementation of each state's settlement agreements. Each state reviewed has proposed service expansions for one or more of the prioritized services. The review supports a comparison of other states with Maricopa County's agreement to expand service capacity. States reviewed included Delaware, New Hampshire, and North Carolina as each state has recently negotiated settlements that include many of the same priority services for comparable disability populations. For the 2016 Service Capacity Assessment, Mercer researched each state to update and track progress as applicable and available.

[20] Peer support services are not currently reported on the SAMHSA 2014 Mental Health National Outcome Measures (NOMS) report.

5

Findings and Recommendations

Findings and recommendations associated with each of the priority mental health services is summarized for each evaluation component that was applied to support the service capacity assessment. As part of each summary, key findings and recommendations are identified to address how effectively the overall service delivery system is performing to identify and meet recipient needs through the provision of the priority mental health services.

The distinct evaluation components that were applied as part of the service capacity assessment are listed below:

- Penetration and prevalence analysis.
- Service expansions — comparison of select states.
- Multi-evaluation component analysis:
  - Focus groups.
  - Key informant survey data.
  - Medical record reviews Group 1.
  - Medical record reviews Group 2.
  - Service utilization data.
- Outcomes data analysis.

SMI Prevalence and Penetration — Overview of Findings

Penetration is defined as the percentage of individuals who received services among the estimated number of individuals considered eligible for services during a defined time period. As depicted in the table below, a relatively small percentage (22%) of the estimated number of adults with SMI is served through the publicly funded system in Maricopa County. The penetration rate is below the national penetration rate of 38%, and even communities of relatively similar size (Harris County, [Houston] Texas and Bexar County (San Antonio) have higher penetration rates. Within the Maricopa County Medicaid system, the penetration rate exceeds the national average. The overall lower penetration rate for Maricopa County appears to be due to the relatively low penetration rate among people without Medicaid coverage.

The Maricopa County system excels in certain areas of evidence-based practice utilization. For example, supported housing and supported employment are more available in Maricopa County (especially to Medicaid recipients) compared to the national average. Maricopa County also has strong access to peer support services, such that it could be considered to represent a “best practice benchmark.” In addition, Maricopa County has more Assertive Community Treatment (ACT) teams than most comparison communities included in this analysis. Just fewer than 2,100 people received ACT services in CY 2016. Based on a published study by leading ACT researchers nationally, a

benchmark of 4.3% was used to estimate the percentage of adults with SMI who need the ACT level of care.[21] Many other communities do not achieve that level of penetration. With an ACT penetration rate of 7%, Maricopa County exceeds the estimated 4.3% benchmark for access to ACT team services.

Maricopa County now has three Forensic ACT (FACT) teams that attend to the needs of adults with SMI who have historically high utilization of the criminal justice system. This allocation of resources for justice system-involved consumers reflects responsiveness to the stated concerns of many system stakeholders.

[21] Cuddeback, G.S., Morrissey, J.P., & Cusack, K.J. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806.

Service System Penetration Rates for Persons with Serious Mental Illness

Table 1: Penetration Rates

Region	Adult Population (≥18 Years Old)[22]	Estimated Rate of SMI in the Adult Population[23]	Estimated Number of Adults with SMI in the Pop.[24]	Number of Adults with SMI Served[25]	Penetration Rate Among Adults with SMI[26]
US	247,813,910	4.1%	10,036,463	3,848,392	38%
Arizona	5,202,986	4.3%	225,289	43,370	19%
Maricopa County[27]	3,138,464	4.1%	135,895	30,440	22%
Maricopa County — Medicaid	411,959[28]	11.7%	48,199	24,604	51%
Maricopa County Gen. Adult Pop.	2,726,505	3.2%	87,696	5,836	7%
Texas	20,244,737	3.3%	676,174	255,423	38%
Harris County (Houston)	3,312,760	4.6%	152,387	65,000	43%
Bexar County (San Antonio)	1,404,337	4.5%	63,055	27,564	44%

[22] US Census Bureau 2015 population estimates for adults (18 years of age and older).

[23] SAMHSA. (2016). State Estimates of Serious Mental Illness from the 2015 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report. Retrieved from https://www.samhsa.gov/data/us_map?map=1 The estimated rate of SMI statewide for Arizona was used for all Maricopa County adults. Please note that the estimated rate of SMI in the adult population was lower than what we reported in the past. This is due to some changes in the methodology used by the National Survey on Drug Use and Health. See *National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 Population Percentages (50 States and the District of Columbia)*. However, these changes were made nationwide and with all other states.

[24] Calculation: Estimated SMI rate multiplied by adult population.

[25] The state-level proportion of people served with a serious mental illness is reported from SAHMSA (2014) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI.

[26] Number of adults with SMI served within the system (for states, see calculation note above), divided by the estimated number of adults with SMI in the total adult population.

[27] Maricopa County data received through analysis of the service utilization data file.

[28] The adult population for Medicaid is based on a 12-month average (July 2015 – June 2016) of adults enrolled in at least one episode of care. Data was derived from the Maricopa County Eligibility and Enrollment Report generated on September 2, 2016.

Table 1: Penetration Rates					
Region	**Adult Population (≥18 Years Old)[29]**	**Estimated Rate of SMI in the Adult Population[30]**	**Estimated Number of Adults with SMI in the Pop.[31]**	**Number of Adults with SMI Served[32]**	**Penetration Rate Among Adults with SMI[33]**
New York	15,579,288	3.9%	607,592	418,953	69%
New York City[34]	1,404,418	3.9%	54,772	10,894	20%
Colorado	4,201,562	4.3%	179,407	70,004	39%
Denver City-County[35]	541,941	4.3%	23,141	16,085	70%
Nebraska	1,425,935	4.4%	63,169	11,383	18%
California	30,024,075	3.5%	1,059,850	380,652	36%

[29] US Census Bureau 2015 population estimates for adults (18 years of age and older).

[30] SAMHSA. (2016). State Estimates of Serious Mental Illness from the 2015 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report. Retrieved from https://www.samhsa.gov/data/us_map?map=1 The estimated rate of SMI statewide for Arizona was used for all Maricopa County adults. Please note that the estimated rate of SMI in the adult population was lower than what we reported in the past. This is due to some changes in the methodology used by the National Survey on Drug Use and Health. See *National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 Population Percentages (50 States and the District of Columbia)*. However, these changes were made nationwide and with all other states.

[31] Calculation: Estimated SMI rate multiplied by adult population.

[32] The state-level proportion of people served with a serious mental illness is reported from SAHMSA (2014) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI.

[33] Number of adults with SMI served within the system (for states, see calculation note above), divided by the estimated number of adults with SMI in the total adult population.

[34] New York State Office of Mental Health. (2015). (Online Dashboard) Patient Characteristics Survey- Summary Reports: New York County. Retrieved from https://my.omh.ny.gov/webcenter/faces/pcs/planning?wc.contextURL=/spaces/pcs&_adf.ctrl-state=1akxeosyer_4&wc.contextURL=/spaces/pcs&wc.contextURL=%2Fspaces%2Fpcs&wc.originURL=%2Fspaces%2Fpcs&_afrLoop=44553068891870 on April 3, 2017.

[35] Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015, 2016 and 2017.

Region	Adult Population (≥18 Years Old)[36]	Estimated Rate of SMI in the Adult Population[37]	Estimated Number of Adults with SMI in the Pop.[38]	Number of Adults with SMI Served[39]	Penetration Rate Among Adults with SMI[40]
Table 1: Penetration Rates					
Illinois	9,902,196	3.5%	349,548	89,261	26%
Kansas	2,192,466	4.1%	89,453	19,596	22%
Minnesota	4,205,029	4.3%	182,078	107,449	59%
Wisconsin	4,478,558	4.0%	178,694	28,750	16%
Tennessee	5,102,031	4.4%	222,449	149,821	67%
Indiana	5,037,576	4.8%	242,307	80,101	33%
Delaware	741,612	3.8%	27,810	6,718	24%
New Hampshire	1,067,148	5.4%	57,839	11,868	21%
North Carolina	7,753,043	4.7%	362,067	123,904	34%

Overview of Evidence-Based Practice Utilization Benchmark Analyses

Data in the table below depict the penetration rates for Assertive Community Treatment (ACT), Supported Employment, and Supported Housing among those served in the Maricopa County behavioral health system. Maricopa County has an ACT penetration rate of 7%, which is at a best practice level.[41] The County's penetration rate for supported housing services exceeds the national average benchmark but trails

[36] US Census Bureau 2015 population estimates for adults (18 years of age and older).

[37] SAMHSA. (2016). State Estimates of Serious Mental Illness from the 2015 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report. Retrieved from https://www.samhsa.gov/data/us_map?map=1 The estimated rate of SMI statewide for Arizona was used for all Maricopa County adults. Please note that the estimated rate of SMI in the adult population was lower than what we reported in the past. This is due to some changes in the methodology used by the National Survey on Drug Use and Health. See *National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 Population Percentages (50 States and the District of Columbia)*. However, these changes were made nationwide and with all other states.

[38] Calculation: Estimated SMI rate multiplied by adult population.

[39] The state-level proportion of people served with a serious mental illness is reported from SAHMSA (2014) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI.

[40] Number of adults with SMI served within the system (for states, see calculation note above), divided by the estimated number of adults with SMI in the total adult population.

[41] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806.

best practice benchmarks. The penetration rate for supported employment appears to be at a best practice level. However, while the ongoing supported employment penetration rate in Maricopa County exceeds the national average, it is below best practice levels.

Table 2: EBP Utilization Rates Among Persons with SMI Who Were Served in the System[42]

Region	Assertive Community Treatment		Supported Employment		Supported Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
US	61,215	1.6%	62,500	1.6%	71,533	1.9%
Arizona	N/A[43]	N/A	10,208	23.5%	N/A	N/A
Maricopa County	2,093	1.5%	7,930	26.1%	2.983	9.7%
Maricopa County — Medicaid	1,839	7.5%	7,152	29.1%	2,865	11.6%
Maricopa County — Non-Medicaid	254	4.4%	846	14.5%	118	2.0%
Maricopa County (SE ongoing)[44]	*n/a*	*n/a*	*1,547*	*5.1%*	*n/a*	*n/a*
New Hampshire	921	7.8%	1,688	14%	*n/a*	*n/a*
North Carolina	6,866	5.5%	*n/a*	*n/a*	*n/a*	*n/a*
Texas	4,552	1.8%	17,078	6.7%	15,079	5.9%
Harris County (Houston)	99	0.2%	1,238	1.9%	568	0.9%
Bexar County (San Antonio)	119	0.4%	264	1.0%	558	2.0%
New York	6,203	1.5%	1,864	0.4%	22,280	5.3%
New York County (NY City)	1,235	11.3%	*n/a*	*n/a*	*n/a*	*n/a*
Colorado	5,488	7.8%	1,252	1.8%	344	0.5%
Denver City-County (MHCD)[45]	1,300	8.1%	521	3.2%	1,698	10.6%
Nebraska	115	1.0%	605	5.3%	801	7.0%

[42] National and State-level data on the number of people utilizing EBPs are reported from the SAHMSA (2014). *Mental Health NOMS: Central Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. Rates are based on number with SMI served in the system.

[43] Arizona did not report the number of people served with Assertive Community Treatment statewide.

[44] We conducted a second analysis of Supported Employment utilization, including ongoing support to maintain employment but excluding pre-job training and development. Mercer found in its 2013 review of clinical records that the latter services, which accounted for 94% of SE services coded, often indicated brief discussions with clients about employment, outside of the context of a comprehensive, evidence-based supported employment program. The 1,547 people receiving "SE ongoing" services represent a subset of consumers receiving SE.

[45] Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015, 2016, and 2017.

Table 2: EBP Utilization Rates Among Persons with SMI Who Were Served in the System[42]						
Region	**Assertive Community Treatment**		**Supported Employment**		**Supported Housing**	
	Number of Adults with SMI Using EBP	**Percentage of Adults with SMI Using EBP**	**Number of Adults with SMI Using EBP**	**Percentage of Adults with SMI Using EBP**	**Number of Adults with SMI Using EBP**	**Percentage of Adults with SMI Using EBP**
California	6,282	1.7%	516	0.1%	1,260	0.3%
Illinois	1,020	1.1%	2,452	2.8%	N/A	N/A
Kansas	*n/a*	*n/a*	1,315	6.7%	2,968	15.1%
Minnesota	2,009	1.9%	785	0.7%	403	0.4%
Wisconsin	3,049	10.6%	883	3.1%	717	2.5%
Tennessee	423	0.3%	503	0.3%	1,368	0.9%
Indiana	404	0.5%	1,320	1.7%	3,124	3.9%
Delaware	576	8.6%	14	<1%	42	0.6%

Changes in Evidenced-Based Practice (EBP) Utilization from 2013 to 2016

The table on the next page compares utilization of ACT, supported employment, and supported housing in 2013, 2014, 2015 and 2016. Following are some highlights of the findings in comparing utilization/penetration across those four years.

- *Assertive Community Treatment*. There have been increases in the number of adults with SMI who received ACT services. Although the penetration rate had decreased between 2013 and 2014, in 2015 and 2016 it exceeded the 2013 baseline. From 2013 to 2016 there has been a slight increase in the penetration of ACT (from 6.7% to 6.9%), but that is somewhat misleading because the number of people receiving ACT has increased by 54% over that same time period. The penetration rate has increased only slightly because the number of people served in the system has increased dramatically from 2013 to 2016.
- *Supported Emp*loyment. The overall penetration rate for supported employment dropped from 2013 to 2014, and then dropped further in 2015. This may have been due to a decrease in the reported number of people receiving pre-job training and development services, because the number of people receiving ongoing support to maintain employment services (which is more reflective of evidence-based supported employment) actually increased from 2013 to 2014, and again in 2015. In 2016, Maricopa County reported a dramatic increase in Supported Employment, which exceeded its baseline rate in 2013. This finding was consistent with the penetration rate among those receiving on-going supported employment.
- *Supported Housing*. In previous years, the analysis utilized a single supported housing billing code that was not often utilized (H0043). As a result, changes in the supported housing penetration rate could not be calculated between 2013 and 2014. For 2016, an additional code was added (H2014) when utilized by a RBHA contracted supported housing provider. An improvement in supported housing utilization from 2014 to 2015 was evident in the overall *percentage* of adults with SMI using supported housing — the penetration rate increased from 3.3% to 3.7% (using H0043). In 2016, with the addition of the H2014 code (skills training and development), the supported housing penetration increased from 3.7% to 9.7%.

Maricopa County EBP Utilization in 2013, 2014, 2015 and 2016

Table 3: Maricopa County: 2013-2016 EBP Utilization Rates Among People with SMI Served in the System							
Year	Number of Adults with SMI Served	Assertive Community Treatment		Supported Employment		Supported Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[46]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2016)	30,440	2,093	6.9%	7,930	26.1%	1,408	4.6%
SE Ongoing				*1,544*	*5.1%*		
Maricopa County (2015)	24,608	1,693	6.9%	4,230	17.2%	902	3.7%
SE Ongoing				*725*	*3.0%*		
Maricopa County (2014)	23,977	1,526	6.4%	5,634	23.4%	793	3.3%
SE Ongoing				*657*	*2.7%*		
Maricopa County (2013)	20,291	1,361	6.7%	7,366	36.3%	No Data	No Data
SE Ongoing				*515*	*2.5%*		

[46] The number of people with SMI receiving supported employment includes a very high percentage who only received pre-job training and development employment services and no other aspects of the evidence-based supported employment model.

Assertive Community Treatment Benchmarks

Over the past few years, Maricopa County has enhanced its capacity to provide ACT team services to people with SMI. An important 2006 study by Cuddeback, Morrissey, and Meyer reported that an estimated 4.3% of adults with SMI need ACT level of care in any given year. The ACT penetration rate relative to all people with SMI served in the system, as well as relative to the 4.3% estimate provided by Cuddeback, et al. is presented in the table below.

Maricopa County's ACT penetration rate (7%) exceeds the benchmark in the Cuddeback study (4.3%) and its penetration rate compares favorably with other communities nationally, even those performing at a best practice benchmark level.

In addition, it is noteworthy that among the ACT teams in Maricopa County, there are three Forensic ACT teams that aim to meet the treatment and recovery needs of adults with SMI who have a history of criminal justice system involvement. Many communities do not have any FACT teams and these teams represent a vital resource in Maricopa County.

Table 4: Assertive Community Treatment Utilization Relative to Estimated Need Among People with SMI					
				ACT Penetration	
Region	Number of Adults with SMI Served in Public System[47]	Number with SMI Who Need ACT[48]	Number Received ACT[49]	Percent of All People With SMI Who Received ACT	Percent of the Number in Need of Act Who Received ACT
Ideal Benchmark[50]				*4.3%*	*100%*
US	3,848,392	165,481	61,215	1.6%	37%
Arizona	43,370	1,865	n/a	n/a	n/a
Maricopa Co. — RBHA Total	30,440	1,309	*2,093*	6.9%	160%
Maricopa Co. — Medicaid	24,604	1,058	1,839	7.5%	174%
Maricopa Co. — Gen Adult Pop	5,836	251	254	4.4%	101%
New Hampshire	11,868	510	921	7.8%	180%
North Carolina	123,904	5,328	6,866	5.5%	129%
Texas	255,423	10983	4,552	1.8%	41%
Harris County (Houston)	65,000	2,795	99	0.2%	4%
Bexar County (San Antonio)	27,564	1,185	119	0.4%	10%
New York	418,953	18,015	6,203	1.5%	34%
New York County (NY City)	10,894	468	726	6.7%	155%
Colorado	70,004	3,010	5,488	7.8%	182%
Denver County (MHCD)[51]	16,085	692	1,300	8.1%	188%

[47] The state-level proportion of people served with a serious mental illness is reported from SAHMSA (2014) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. We calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI.

[48] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806. This study examined the prevalence of people with serious mental illness who need an ACT level of care and concluded that 4.3% of adults with serious mental illness (SMI) receiving mental health services needed an ACT level of care. The authors stipulated people with SMI needed ACT level of care if they met three criteria: received treatment for at least one year for a qualifying mental health disorder; had been enrolled in SSI or SSDI and in treatment for at least two years, and had three or more psychiatric hospitalizations within a single year.

[49] National and State-level penetration counts for ACT received are reported from SAHMSA. (2014). Mental Health NOMS: Central Mental Health Services Uniform Reporting System. Retrieved from http://www.samhsa.gov/data/us_map?map=1. Arizona was among the states that did not report the number receiving ACT statewide.

[50] See Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006).

[51] Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015, 2016 and 2017.

Table 4: Assertive Community Treatment Utilization Relative to Estimated Need Among People with SMI					
				ACT Penetration	
Region	Number of Adults with SMI Served in Public System[47]	Number with SMI Who Need ACT[48]	Number Received ACT[49]	Percent of All People With SMI Who Received ACT	Percent of the Number in Need of Act Who Received ACT
King County (Seattle, WA)	74,373	3,198	90	<1%	3%
Nebraska	11,383	489	115	1.0%	23%
California	380,652	16,368	6,282	1.7%	38%
Illinois	89,261	3,838	1,020	1.1%	27%
Minnesota	107,449	4,620	2,009	1.9%	43%
Wisconsin	28,750	1,236	3,049	10.6%	247%
Tennessee	149,821	6,442	423	0.3%	7%
Indiana	80,101	3,444	404	0.5%	12%
Delaware	6,718	289	576	8.6%	199%

Supported Employment Benchmarks

Maricopa County meets a high percentage of the estimated need for supported employment services among those receiving services, although there is a smaller percentage of people who appear to be receiving ongoing support employment services. Nearly 8,000 people received pre-job training and development services, but fewer received services associated with obtaining and maintaining a job. This could mean that supported employment services in Maricopa County rarely result in people obtaining jobs, or that the number of people receiving the full array of supported employment services is under-reported. However, based on previous clinical record reviews and interviews with recipients, as well observations of other stakeholders participating in focus groups, it is more likely that a large volume of pre-vocational services is being provided, but fewer people are receiving ongoing support in Maricopa County.

Nevertheless, in 2016, Maricopa County's 11% penetration rate for the more evidence-based "SE-ongoing" services compared fairly well to national benchmarks. It exceeded the US penetration rate of 4% and among all comparison communities — both metropolitan communities and states — only trailed three benchmark states (Texas, New Hampshire and Kansas).

Table 5: Supported Employment Utilization Relative to Estimated Need Among Persons with SMI					
				SE Penetration	
Region	Number of Adults with SMI Served in System[52]	Number of People in Need of SE[53]	Number of People Who Received SE[54]	Percent Served Among People With SMI	Percent Served Among People Who Need SE
Ideal Benchmark				*45%*	*100%*
US	3,848,392	1,731,777	62,500	2%	4%
Arizona	43,370	19,516	10,208	4%	52%
Maricopa Co. (Total served)	30,440	13,698	7,930	26%	58%
Maricopa Co. (SE Ongoing)	30,440	13,698	1,544	5%	11%
Maricopa Co. - Medicaid	24,604	11,072	7,152	29%	65%
Medicaid (SE Ongoing)	24,604	11,072	1,429	*6%*	*13%*
Maricopa Co. — Gen Adult Pop	5,836	2,626	778	13%	30%
Non-Medicaid (SE Ongoing)	5,836	*2,626*	*115*	*2%*	*4%*
New Hampshire	11,868	5,341	1,688	14%	32%
Texas	255,423	114,940	17,078	7%	15%
Harris County (Dallas)	65,000	29,250	1,238	2%	4%
Bexar County (San Antonio)	27,564	12,404	264	1%	2%
New York	418,953	188,529	1,864	<1%	1%
Colorado	70,004	31,502	1,252	2%	4%
Denver County (MHCD)[55]	16,085	7,238	521	3%	7%
Nebraska	11,383	5,122	605	5%	12%
California	380,652	171,293	516	<1%	<1%

[52] The state-level proportion of people served with a serious mental illness is reported from SAHMSA (2014) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. We calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI.

[53] Approximately 90% of consumers with SMI are unemployed. Consumer preference research suggests approximately 50% desires to work. These two proportions are applied to the estimated SMI population to determine the estimated number of consumers who need Supported Employment.

[54] National and State-level penetration supported employment counts are reported from the SAHMSA. (2014). Mental Health NOMS: Central Mental Health Services Uniform Reporting System. Retrieved from http://www.samhsa.gov/data/us_map?map=1.

[55] Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015, 2016, and 2017.

Table 5: Supported Employment Utilization Relative to Estimated Need Among Persons with SMI					
				SE Penetration	
Region	Number of Adults with SMI Served in System[52]	Number of People in Need of SE[53]	Number of People Who Received SE[54]	Percent Served Among People With SMI	Percent Served Among People Who Need SE
Illinois	89,261	40,168	2,452	3%	6%
Kansas	19,596	8,818	1,315	7%	15%
Minnesota	107,449	48,352	785	1%	2%
Wisconsin	28,750	12,938	883	3%	7%
Tennessee	149,821	67,419	503	<1%	1%
Indiana	80,101	36,045	1,320	2%	4%
Delaware	6,718	3,023	14	<1%	<1%

Peer Support Benchmarks

Maricopa County excels in making peer support services available to persons in need. The penetration rate in 2016, which matched 2013, is relatively high. The Omaha area of Nebraska has a slightly higher penetration rate, but Maricopa County also constitutes a “best practice” benchmark in terms of access to peer support.

Table 6: Peer Support Penetration Rates — 2016		
Region	PS Received	PS Penetration Rate
Arizona		
Maricopa County (Total) - 2016	11,629	38%
Maricopa County (Total) - 2015	7,173	29%
Maricopa County (Total) - 2014	7,522	31%
Maricopa County (Total) - 2013	8,385	38%
Texas		
Harris County	3,550	5%
Colorado		
Denver City-County	170	1%

Service Expansions — Comparison of Select States

A comparative analysis was performed with selected states and included a review of negotiated agreements to increase capacity and services to populations of persons identified to have serious and persistent mental illnesses. This analysis consisted of a review of state published reports respective to settlement agreements and to the provision of evidence-based practices. This information provides an informative set of contextual and comparative information concerning the opportunities and challenges each state has experienced with their settlement agreement implementations. Each state reviewed has proposed service expansions for one or more of the prioritized services. The review supports a comparison of other states with Maricopa County's agreement to expand service capacity. States reviewed included Delaware, New Hampshire, and North Carolina. Each of these states has negotiated settlements that included many of the same priority services for comparable populations, as were included in the Arizona settlement.

How does Maricopa County's agreement to expand service capacity compare to other states that have negotiated similar agreements for comparable populations?

ACT Team Services

Maricopa County has met its ACT expansion goals of 23 ACT teams capable of serving 2,300 recipients. At the time of this report, Maricopa County had 24 ACT teams and three FACT teams. Published estimates of the need for ACT indicate that 4.3% of adults with SMI need either ACT or FACT, and Maricopa County has exceeded this figure.[56]

Achieving the milestones for ACT team services appears to be the area in which each of the state's report success. Delaware and North Carolina both met their settlement agreement benchmarks for ACT team services set for 2014 and 2015. New Hampshire achieved the 2014 benchmark for 11 statewide ACT teams. However, New Hampshire has not yet achieved its ACT utilization goal of 1,500 consumers per year; this may be due in part to the fact that their utilization goal of 1,500 served exceeds the fidelity capacity for 11 teams, which would be 1,100.

Supported Housing Services

The agreement calls for Maricopa County to expand supported housing services to reach an additional 1,200 recipients by FY 2016. The increase represented added capacity of 5% when based on the enrolled population at that time. In 2016, Maricopa County served 2,983 consumers with supported housing, exceeding the targeted goal.

[56] Cuddeback, G.S., Morrissey, J.P., & Meyer, P.S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806.

Delaware's agreement called for added capacity of 7.8% (by 2015); North Carolina was to add capacity of 7.5% based on the reported enrolled population (by 2020); and New Hampshire was to add capacity of 4%. Delaware and New Hampshire met their 2016 targets for supported housing and North Carolina met their FY 2015 supported housing goal.

Supported Employment Services

Maricopa County was required to expand supported employment services to 750 additional recipients by FY 2016. At the time the goal was set, it represented an increase in capacity of 3%, based on the then-enrolled population. In 2016, Maricopa County served 7,930 consumers with supported employment services. Of those consumers, 1,547 received ongoing support, which is more consistent with high-fidelity supported employment. This figure of 1,547 significantly exceeded the original goal.

In comparison, Delaware's agreement called for added capacity of 4.8%; North Carolina's agreement will result in increased capacity of 6.2%; and New Hampshire will increase capacity of supported employment services resulting in an overall penetration rate of 18.6%. This service was reported as the one that presented the most challenges for the states. Challenges previously reported included how to allocate funding and ensuring fidelity to the supported employment model. However, at the time of this report, Delaware, New Hampshire and North Carolina each exceeded their supported employment expansion goals.

Peer Support Services and Family Support Services

Maricopa County's' agreement calls for 1,500 members to receive peer and family support services. In 2016, Maricopa County served over 11,000 people through peer and family support services, vastly exceeding the goal.

Delaware committed to serving 1,000 people through peer support. New Hampshire's agreement does not specify how much peer and family support services capacity will be added, and North Carolina does not explicitly identify and include peer and family support services for service expansion. Like Maricopa County, Delaware significantly exceeded their compliance goals for peer and family support services.

Overall Compliance Ratings

Based on the comparative analysis, Maricopa County's plan for expanded services appears to be in many ways similar to the selected states reviewed. The table below provides a summary of each state's levels of compliance with agreements to expand services. The compliance status ratings below are based on the degree to which a state achieved its agreement's most recent service expansion benchmark. When a state met its service expansion goal, it was considered to be "compliant." When a state far exceeded its expansion goal, its status was considered to be "substantially compliant." Conversely, when a state failed to meet service expansion benchmarks, it was considered to be "partially compliant."

State	ACT	Supported Housing	Supported Employment	Peer and Family Support Services
Arizona	Compliant	Compliant	Substantially Compliant	Substantially Compliant
Deleware	Compliant	Compliant	Substantially Compliant	Substantially Compliant
New Hampshire	Partially Compliant	Compliant	Substantially Compliant	Substantially Compliant
North Carolina	Substantially Compliant	Compliant	Substantially Compliant	Not Specified

State	Enrollment	Timelines	ACT	Supported Housing	Supported Employment	Peer and Family Support Services
Arizona						
		FYs 2015-2016 (2014-2016)	8 teams (some specialty)	Services for 1,200 class members	Services for 750 class members	Services for 1,500 class members
2017 Update	30,440		24 ACT teams serve 2,092 consumers, and three F-ACT teams serve 249 consumers.	In 2016, Maricopa County served 2,983 consumers with supported housing.	In 2016, Maricopa County served 7,930 consumers with any degree of supported employment (SE) services. Of those consumers 1,547 received 'on-going' SE, which is more likely to be consistent with high SE fidelity.	In 2016, Maricopa County served 11,629 consumers peer and family support services.
Compliance Status			**Compliant**	**Compliant**	**Substantially Compliant**	**Substantially Compliant**

State	Enrollment	Timelines	ACT	Supported Housing	Supported Employment	Peer & Family Support
Delaware						
		FY 2014	Expand from 9 teams to 10 teams	Vouchers/Subsidies/Bridge Funding to 550 Individuals	Supported Employment Up to Additional 300 Individuals/Year	Provide Family or Peer Support to 750 Additional Individuals/Year
		FY 2015	Expand from 10 teams to 11 teams	Vouchers/Subsidies/Bridge Funding to 650 Individuals	Supported Employment Up to Additional 400 Individuals/Year	Provide Family or Peer Support to 1,000 Additional Individuals/Year
		FY 2016	No FY 2016 Exapnsion Goals	State Will Provide Vouchers/Subsidies/Bridge Funding to **Anyone** in the Target Population in need	No FY 2016 Exapnsion Goals	No FY 2016 Exapnsion Goals
Updated 2017[57]	6,718[58]		In 2016, Deleware had15 ACT teams serving "greater than 1,425" consumers[59]	In 2016, Deleware served 812 consumers with voucher, subsideies, or Bridge Funding; Goal= 650[60]	In 2016, Deleware served 729 consumers with supported empoyment; Goal = 300[61]	In 2016, Deleware served nearly 2,500 consumers with peer support; Goal = 1,000[62]
Compliance Status			**Compliant**	**Compliant**	**Substantially Compliant**	**Substantially Compliant**

[57] U.S. v State of Delaware. Civil Action No: 11-591-LPS (2016). Tenth Report of the Court Monitor on Progress Towards Compliance with the Agreement: U.S. v. State of Delaware U.S. District Court for the District of Delaware. Retrieved from https://www.ada.gov/olmstead/documents/de_10th_report.pdf on 5/6/17.

[58] State-level enrollment is based on the number of adults served within the publically funded system and reported in SAHMSA (2015) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/sites/default/files/Delaware.pdf on 5/6/2017.

[59] See Court Monitor (2016) above, page 36

[60] See Court Monitor (2016) above, page 52

State	Enrollment	Timelines	ACT	Supported Housing	Supported Employment	Peer and Family Support Services
New Hampshire						
		June 2014	Each Mental Health Region has an ACT Team	240 Supported Housing Units	Increase Penetration Rate by 2% over 2012 Penetration Rate of 12.1 to 14.1%	Maintain Family Support Services Consistent with the Agreement. Have a System of Peer Support Services Offered Through Peer Support Centers Open a Minimum of 8 Hours Per Day for 5.5 Days Per Week in Each Mental Health Region of the State

[61] Delaware Health and Social Services. (2016). Fourth Progress Report on Implementation of the Settlement Agreement Between the U.S. Department of Justice and the State of Delaware. *Division of Substance Abuse and Mental Health*. p. 11. Retrieved from http://www.dhss.delaware.gov/dhss/dsamh/files/Fourth_DOJ_DE_Report_062416.pdf on 5/6/2017.

[62] See Court Monitor (2016) above, page 63.

State	Enrollment	Timelines	ACT	Supported Housing	Supported Employment	Peer and Family Support Services
New Hampshire						
		October 2014	All 11 ACT Teams Operate Within the Standards of the Settlement	December 2014 Additional 50 Housing Units Total = 290	All Individuals Receiving ACT will have Access to Supported Employment from Employment Specialist on their ACT Team	
		June 2015	Serve at Least 1,300 of the Target Population	50 Additional for a Total of 340	Increase Penetration to 2% to 16.1%	
		June 2016	Serve Additional 200 People for Capacity to 1,500	Additional 110 Total of 450	Increase 5% to 18.6% Maintain a List of Individuals with SMI who Would Benefit from Supported Employment Services but for Whom it is Not Available	

State	Enrollment	Timelines	ACT	Supported Housing	Supported Employment	Peer and Family Support Services
New Hampshire						
2017 Update[63]	12,259[64]		In 2016, New Hampsire provided 11 ACT teams that served 970 consumers; Goal = 1,500.	In 2016, New Hampsire served 481 consumers who attained a leased housing unit or were approved for bridge subsidy housing; goal = 450.	In 2016, New Hampsire served 3,040 consumers with SE among 13,108 SE eligible consumers, achieving a penetration rate of 23.2%, Goal= 18.1%	In 2016, New Hampsire served 3,265 consumers with peer support services.
Compliance Status			**Partially Compliant**	**Compliant**	**Substantially Compliant**	**Substantially Compliant**

[63] New Hampshire Department of Health and Human Services. (2017). New Hampshire Community Mental Health Agreement Quarterly Data Report. Office of Quality Assurance and Improvement. Retrieved from https://www.dhhs.nh.gov/dcbcs/bbh/documents/cmha-ext-report-jan-mar-17.pdf on 5/24/17.

[64] State-level enrollment is based on the number of adults served within the publically funded system and reported in SAHMSA (2015) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/sites/default/files/NewHampshire.pdf on 5/6/2017.

State	Enrollment	Timelines	ACT	Supported Housing	Supported Employment	Peer and Family Support Services
North Carolina						
		July 2014	Increase to 34 Teams Serving 3,467 Individuals	150 Additional	Provide Supported Employment to Total of 250 Individuals	Peer support serviced were not specified in agreement
		July 2015	Increase to 37 Teams Serving 3,727 Individuals	At Least 708 Individuals	Provide Supported Employment to a Total of 708 Individuals	
		July 2016	Increase to 40 Teams Serving 4,006 Individuals	At Least 1,166 Individuals	Provide Supported Employment to a Total of 1,166 Individuals	
		July 2017-2020	A total of 10 additional teams serving 994 individuals	At least an additonal 1,834 individiuals	Provide to a total of 1,334 additional individuals	
2017 Update[65]	123,930[66]		In FY15, North Carolina's 77 ACT teams served 5,218 consumers[67]	In FY15, North Carolina housed 853 consumers.[68]	Total Served: 1,755 by teams meeting high SE fidelity; and seved 2,089 with any SE fidelity levels.[69]	
Compliance Status			**Substantially Compliant**	**Compliant**	**Substantially Compliant**	

[65] North Carolina Health and Human Services. (2016). North Carolina Transitions to Community Living Initiative Annual Report for State Fiscal Year 2016. Retrieved from https://www2.ncdhhs.gov/tcli/pdf/annual-reports/2015%20Annual%20Report.pdf on 5/6/2017.

[66] State-level enrollment is based on the number of adults served within the publically funded system and reported in SAHMSA (2015) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/sites/default/files/NorthCarolina.pdf on 5/6/2017.

[67] North Carolina Health and Human Services. (2016). Table 2

[68] North Carolina Health and Human Services. (2016). Table 2

[69] North Carolina Health and Human Services. (2016). Table 3

Consumer Operated Services

Multi-Evaluation Component Analysis

Service Descriptions:

Peer support services are delivered in individual and group settings by individuals who have personal experience with mental illness, substance abuse, or dependence, and recovery to help people develop skills to aid in their recovery.

Family support services are delivered in individual and group settings and are designed to teach families skills and strategies for better supporting their family member's treatment and recovery in the community. Supports include training on identifying a crisis and connecting recipients in crisis to services, as well as education about mental illness and about available ongoing community-based services.

Focus Groups

As part of the service capacity assessment of the four priority behavioral health services in Maricopa County, four focus groups were conducted with key system stakeholders. The focus groups were developed to facilitate discussion with participants with direct experience with the four priority mental health services. Key findings derived from the focus groups regarding the delivery system's capacity to deliver peer support and family support services included:

- Participants reported observations that peer support specialists are completing peer-related work such as facilitating Wellness Recovery Action Plan (WRAP) classes, skill-building classes, and health and wellness groups. Likewise, family support specialists are able to provide both individual and group support services to members and involved family members.
- For those members who are unable to receive clinic-based services, peer support specialists are also able to provide 1:1 services (including WRAP) to members in their homes and in the community.
- Arizona State University now offers advanced training to peer support specialists, providing peer support specialists a career path and opportunities for growth.
- Similar to last year, participants reported that not every direct care clinic employs a peer support specialist or family support specialist. Staff turnover remains high and vacancies may not be immediately filled.
- Peer and family support specialists report that they are often overwhelmed by the demands of their work. Per the focus group participants, all peer and family support positions at the direct care clinics are required to be full-time. Participants in all focus groups agreed that peer support specialists, in particular, should be offered supported employment to assist with the transition into full-time work.
- Participants reported that the family mentors who are available at the clinics are able to provide a variety of services to families. However, family mentors are often overwhelmed by caseloads that are perceived to be too high. It was reported that one family mentor serves over 2,000 family members.
- As reported in prior year service capacity assessments, participants in the case manager and adult member focus groups expressed that clinical teams do not consistently demonstrate an understanding of the appropriate role of the peer support specialist, recovery

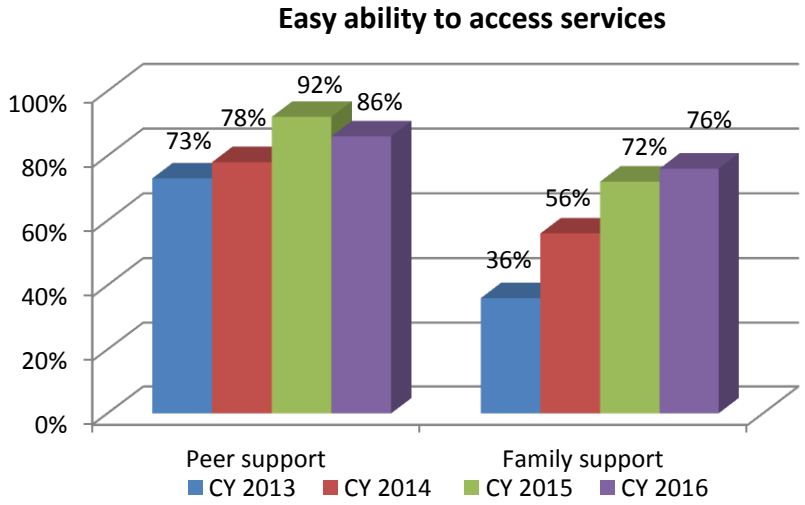
navigator and family support specialists/mentors. One case manager reported that she forgets about these services because they are discussed among the clinical team on such an infrequent basis.

- Focus group participants reported that there has been some progress regarding inclusion and acceptance of peer support specialists on clinical teams. Peer support specialists reported a higher sense of inclusion as team members but case managers agree that clinical teams would benefit from additional training regarding the role of peer support specialists.
- As was reported over the last three years, family members continue to experience issues with restrictive interpretations of the Health Insurance Portability and Accountability Act (HIPAA) by clinical teams. Focus group participants expressed that misinterpretation of information sharing protocols can lead to the exclusion of family members from the ISP process. One family member reported that his son's clinic would not accept proof of power of attorney or the release of information on file for their son who was receiving services.
- Case managers and provider representatives reported that there is an elevated awareness to comply with HIPAA and that little clinical guidance from supervisors is available to navigate interactions with family members when there is no release of information in the member's file. Focus group participants would like to be better equipped to support family members who want to be engaged in services with the member. Case manager focus group participants agree that in-person training on HIPAA would be helpful.
- Similar to last year, family members, individuals receiving services and case managers all agree that family members would benefit from a service delivery system navigational guide and/or a compendium of available supportive resources that are easily accessible.

Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to the priority services, a key informant survey was administered. The survey tool included questions and rating assignments related to the priority mental health services. It should be noted that the survey distribution process targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

Most respondents felt that peer support services were easier or easy to access (86%) as opposed to difficult to access or having no ability to access (14%). Consistent with the last three years, peer support services were perceived as the easiest of all the priority services to access.



24% of survey respondents felt that family support services were difficult to access or were inaccessible while 76% of the respondents indicated that family support services were easier to access or easy to access.

Overall, perceptions regarding the ease of accessing peer support and family support services remained consistent during CY 2016 when compared to CY 2015 results.

Consumer Operated Services

The most common factors identified that negatively impact accessing peer support services were:

- Member declines service.
- Clinical team unable to engage/contact member.
- Transportation barriers.
- Staffing turnover.

The most common factors identified that negatively impact accessing family support services were:

- Clinical team unable to engage/contact member.
- Member declines services.
- Transportation barriers.

In terms of service utilization, 89% of the responses indicated that peer support services were being utilized efficiently or were utilized efficiently most of the time. 11% of respondents indicated that the peer support services were not utilized efficiently.

79% of the responses indicated that family support services were being utilized effectively or were utilized efficiently most of the time. Alternatively, 21% of the responses indicated that family support services were not utilized efficiently.

Regarding the duration of time to access peer support services and family support services after a need has been identified:

- 82% of the survey respondents reported that peer support services could be **accessed within 30 days** of the identification of the service need. This finding compares to 75% during CY 2014 and 78% during CY 2015.
- 79% of the survey respondents reported that family support services could be **accessed within 30 days** of the identification of service need. This finding compares to 33% during CY 2013, 69% during CY 2014, and 74% during CY 2015.
- 13% reported it taking **four to six weeks to access** peer support services following the identification of need (20% – CY 2013; 13% – CY 2014; 15% - CY 2015).
- 13% percent reported it taking **four to six weeks to access** family support services following the identification of need (44% – CY 2013; 8% – CY 2014; 13% - CY 2015).
- 4% of the survey respondents reported that it would take an average **of six weeks or longer to access** peer support services (10% – CY 2013; 13% – CY 2014; 7% - CY 2015).
- 8% of the survey respondents reported that it would take an average **of six weeks or longer to access** family support services (22% – CY 2013; 23% – CY 2014; 13% - CY 2015).

Consumer Operated Services

Medical Record Reviews Group 1

A random sample of 121 recipients was identified to support an analysis of assessment and service planning documentation. The review evaluated the extent to which the clinical teams were identifying needs for peer support services and family support services. When identified as needed service to benefit the recipient, information was reviewed to determine if the need was translated to the recipient's ISP and identified as a specific intervention. The entire sample of recipients was subsequently interviewed to collect information regarding their perceived needs for the same services.

As noted in previous service capacity assessments, medical record documentation revealed that the clinical teams are regularly assessing the recipient's need and desire for social and community integration. This establishes the ability to identify opportunities to apply targeted interventions to address related needs, such as peer support services.

16% of the assessments identified peer support as a need. When assessed as a need, peer support services were identified on the recipient's ISP 58% of the time.

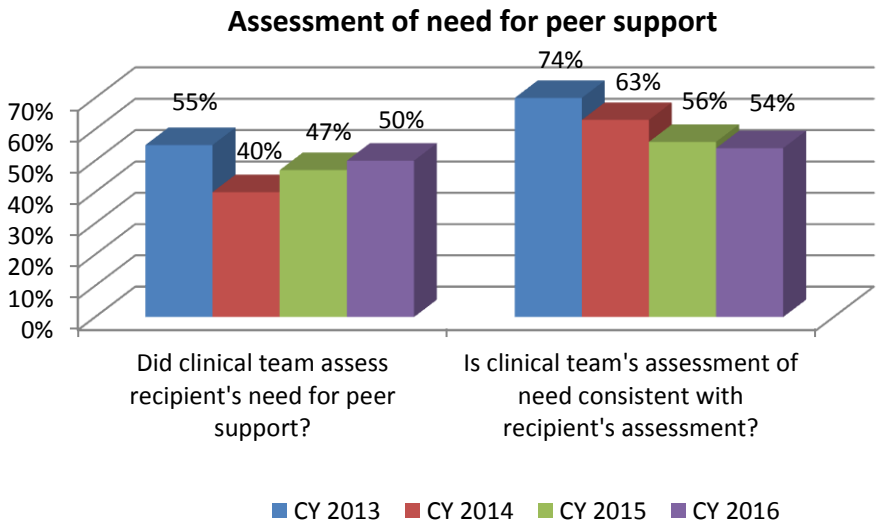
45% of the Group 1 recipients received at least one unit of peer support services during CY 2016 based on a review of service utilization data.

Interviews

All Group 1 recipients participated in an interview regarding the prioritized mental health services.

The interview asked the following:

- Did the clinical team assess the recipient's need for peer support services? 50% of the respondents indicated that the clinical team had discussed peer support service opportunities.
- Is the clinical team's assessment consistent with the recipient's perception regarding the need for one or more of the priority mental health services? In slightly over half of the cases (54%), the clinical team's determination of need matched the recipient's perception of need.



Consumer Operated Services

Family Support Services

The clinical teams usually identify and document natural and family supports that are important to the recipient as part of the initial or annual assessment update process. Most of the records reviewed included evidence that family supports were at least identified by the clinical team. Family support services can be an effective intervention for family members to develop skills to interact and support the person in the home and community. Despite the clinical team's identification of natural and family supports, ISPs rarely included family support services.

Consistent with findings during CY 2013, CY 2014 and CY 2015, opportunities continue to exist to leverage family support services to support family members in working with recipients to achieve their ISP goals.

7% of the assessments reviewed identified a related need for family support services. In these cases, one ISP explicitly identified family support services as an intervention to address the need.

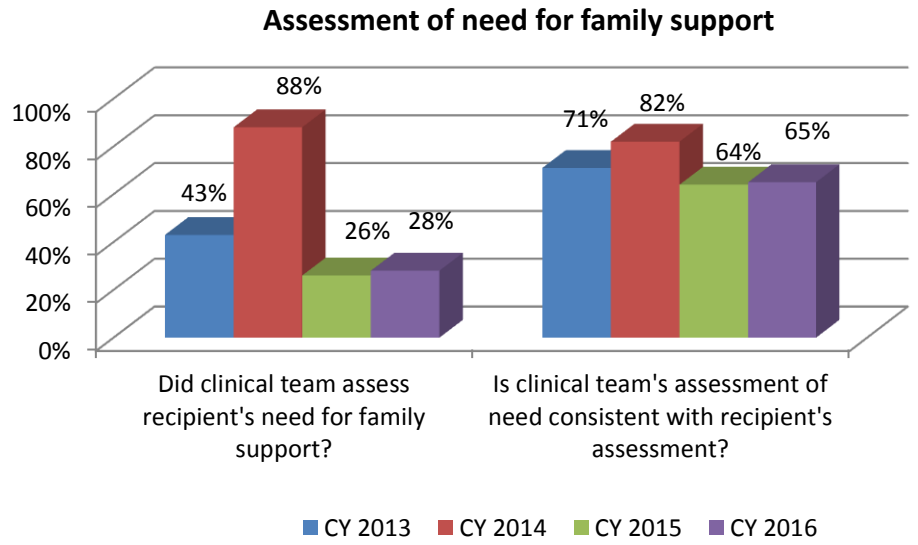
7% of the Group 1 recipients received at least one unit of family support services during CY 2016 based on a review of service utilization data.

Interviews

All Group 1 recipients participated in an interview regarding the prioritized mental health services.

The interview asked the following:

- Did the clinical team assess the recipient's and family's need for family support services? 28% of Group 1 recipients recalled discussing family support services with the clinical team.
- The clinical team's assessment was found to be consistent with the recipient's perception regarding the need for family support services in 65% of the cases.



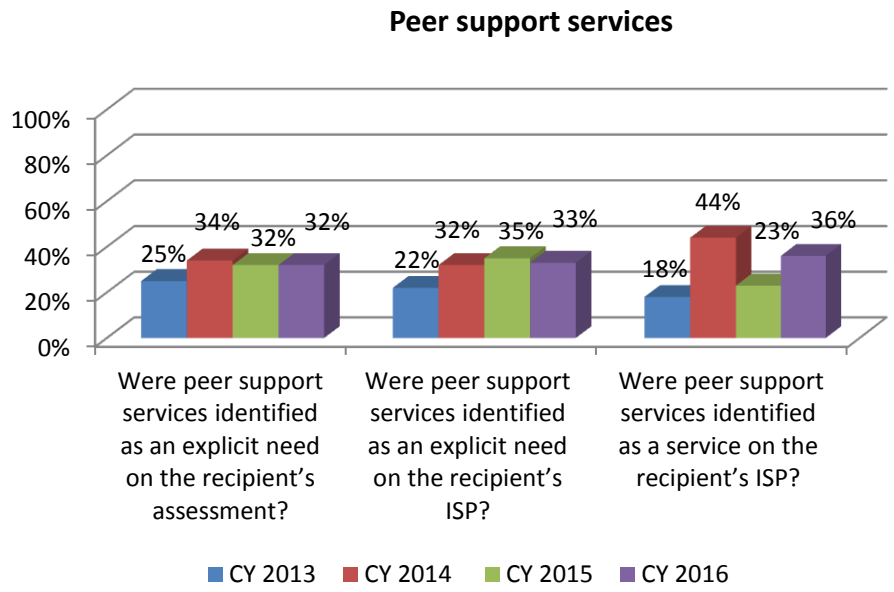
Consumer Operated Services

Medical Record Reviews: Group 2

A random sample of 199 SMI recipients' medical record documentation was reviewed to assess the consistency in which peer support services and family support services were assessed by the clinical team, identified as a needed service to support the recipient, and included as part of the ISP.

36% of the ISPs included peer support services when assessed as a need.

36% of the recipients included in the sample received at least one unit of peer support during CY 2016 based on a review of service utilization data.



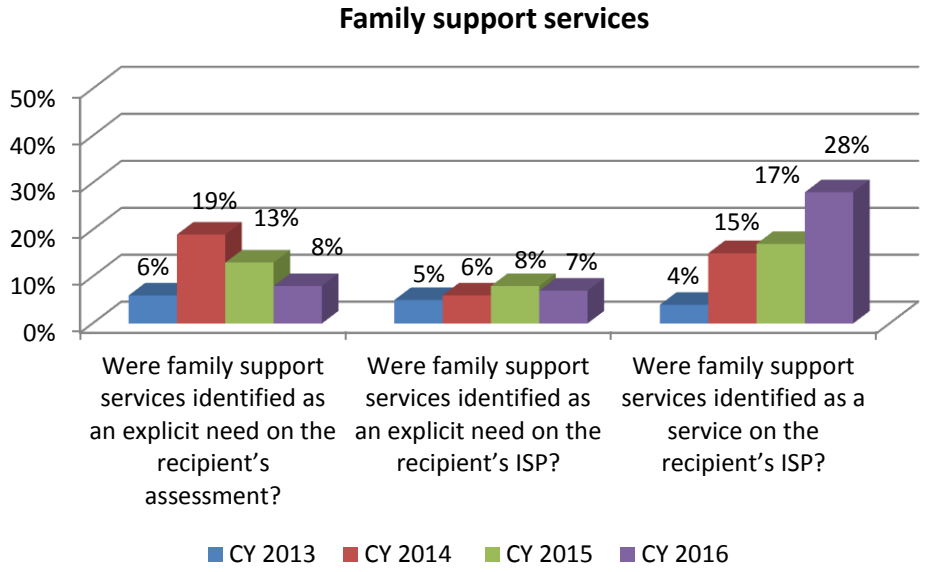
Consumer Operated Services

Reviewers were able to review progress notes and record the documented reasons that the person was unable to access peer support services when recommended by the clinical team. The most common findings included the following:

- The clinical team did not follow up with initiating a referral for the service; and
- The member declined to attend the service.

Family Support Services

As part of the clinical services assessment process, information is routinely collected and documented by the clinical team regarding the natural and family supports available and important to the recipient. Increasingly, this information is being utilized as part of service planning development.



28% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP, an improvement when compared to CY 2015. Examples in which the review team determined that a need for family support services existed included circumstances in which the recipient had explicitly expressed a desire for a family member to be involved in treatment and/or clinical team documentation was present that identified a need for the recipient to seek support and/or engage with involved family members.

5% of the recipients included in the sample received at least one unit of family support during CY 2016 based on a review of service utilization data.

- In 17 cases, the person was unable to access family support services after the service was recommended by the clinical team. Reviewers were able to review progress notes and determined that in 64% of these cases, there was a misunderstanding regarding the appropriate application of the service by the clinical team (e.g., family mentor to provide family support directly to the member without the involvement of the person's family members who resided out-of-state and were not meaningfully involved in the person's life).

Consumer Operated Services

Service Utilization Data

During the time period of October 1, 2015 through June 30, 2016, 29,569 unique users were represented in the service utilization data file. Of those, 81% were Medicaid eligible and 19% were non-Title XIX eligible.

- Overall, 33% of the recipients received at least one unit of peer support services during the time period (29% over a comparable time period last year).

Access to the service was unevenly split between Title XIX (35%) and non-Title XIX groups (28%).

An analysis of the persistence in peer support services was completed by analyzing the sustainability of engagement in the service over consecutive monthly intervals.

- Slightly over half of the members who received at least one unit of peer support during the review period accessed the service during a single month.
- Sixteen percent of members received peer support services for three to four consecutive months during the review period and 3.5% received the service for nine consecutive months.

Persistence in Peer Support Services
October 2015 — June 2016

Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	48.5%	61.7%	50.7%
2	20.0%	18.4%	19.7%
3–4	16.9%	11.1%	15.9%
5–6	7.7%	4.4%	7.2%
7–8	2.7%	2.4%	2.7%
9	3.8%	1.7%	3.5%

Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.

Family support services (i.e., Home Care Training Family) are assigned a unique service code (S5110). The billing unit is 15 minutes in duration.

- Overall, 2.1% of the recipients received at least one unit of family support services during the time period (1.9% over a comparable time period last year).

Access to the service was split between Title XIX (2.3%) and non-Title XIX groups (1.3%).

An analysis of the persistence in family support services was completed by analyzing the sustainability of engagement in the service over consecutive monthly intervals.

Consumer Operated Services

- 77% of the members who received at least one unit of family support during the review period accessed the service during a single month, the same as last year.
- 5.5% of the members received family support services for three to four consecutive months during the review period and 2.1% received the service for seven to eight consecutive months.

Persistence in Family Support Services
October 2015 — June 2016

Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	74.4%	79.7%	75.0%
2	11.6%	10.8%	11.5%
3–4	6.5%	5.4%	6.4%
5–6	2.1%	2.7%	2.2%
7–8	1.6%	0.0%	1.4%
9	3.6%	1.3%	3.3%

Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.

Key Findings and Recommendations

The most significant findings regarding the demand and provision of peer support and family support services are presented below.

Findings: Peer Support

- Service utilization data demonstrates a significant increase in the percentage of members who received at least one unit of peer support services over the review period. During CY 2016, 38% of members received peer support services representing the highest percentage observed since CY 2013. (CY 2013 — 38%; CY 2014 — 31%; CY 2015 — 29%).
- Focus group participants reported that there has been some progress regarding inclusion and acceptance of peer support specialists on clinical teams. Peer support specialists reported a higher sense of inclusion as team members but case managers agree that clinical teams would benefit from additional training regarding the role of peer support specialists.
- Consistent with the last three years, peer support services were perceived as the easiest of all the priority services to access.
- All Group 1 recipients participated in an interview regarding the prioritized mental health services. 50% of the respondents indicated that the clinical team had discussed peer support service opportunities.
- 16% of the assessments identified peer support as a need. When assessed as a need, peer support services were identified on the recipient's ISP 58% of the time. However, 45% of the Group 1 recipients received at least one unit of peer support services during CY 2016 based on a review of service utilization data. It was noted that members tend to access services despite assessed needs and/or services identified on the ISP.
- Maricopa County excels in making peer support services available to persons in need. The penetration rate in 2016 is still relatively high. The Omaha area of Nebraska has a slightly higher penetration rate, but Maricopa County also constitutes a "best practice" benchmark in terms of access to peer support services.
- As reported by the Maricopa County RBHA, peer support and family support contracted capacity is capable of serving at least 2,215 members.

Consumer Operated Services

Findings: Family Support

- Service utilization data demonstrates minor differences in the percentage of members who received at least one unit of family support services over the respective review periods (CY 2013 — 2%; CY 2014 — 3%; CY 2015 — 2%; CY 2016 – 2%).
- 79% of the survey respondents reported that family support services could be accessed within 30 days of the identification of service need. This finding compares to 33% during CY 2013, 69% during CY 2014, and 74% during CY 2015.
- Participants reported that the family mentors who are available at the clinics are able to provide a variety of services to families. However, family mentors are often overwhelmed by caseloads that are perceived to be too high. It was reported that one family mentor serves over 2,000 family members.
- 28% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP, an improvement when compared to CY 2015 (17%).
- Consistent with findings during CY 2013, CY 2014 and CY 2015, opportunities continue to exist to leverage family support services to support recipients in achieving their ISP goals. In 17 cases, the person was unable to access family support services after the service was recommended by the clinical team. Reviewers were able to review progress notes and determined that in 64% of these cases, there was a misunderstanding regarding the appropriate application of the service by the clinical team (e.g., family mentor to provide family support directly to the member without the involvement of the person's family members who resided out-of-state and were not meaningfully involved in the person's life).
- 28% of Group 1 recipients recalled discussing family support services with the clinical team. The clinical team's assessment was found to be consistent with the recipient's perception regarding the need for family support services in 65% of the cases.

Recommendations: Peer Support

- Assess the reported expectation that all peer support positions at the direct care clinics are required to be employed full-time. As indicated and determined to be appropriate, explore opportunities to have peers work in part-time roles.
- Ensure through training and ongoing supervision that direct care clinical team members, including case managers and clinical supervisors, understand the appropriate application of covered behavioral health services, including peer support.
- Provide additional training and supervision to recognize the value of peer support services as effective service plan intervention.

Recommendations: Family Support

- Work with provider network organizations and administrative entities to examine the case load sizes of family mentors and determine an appropriate targeted case load size based on the family mentor's job description and expectations. Once established, monitor the target on an ongoing basis and take appropriate actions when caseload sizes persistently exceed the threshold.
- Ensure the consistent application of privacy practices at the direct care clinics to balance compliance with member confidentiality while providing opportunities for involved family members to participate in the member's care as appropriate and consistent with the member's choice.

- Ensure through training and ongoing supervision that direct care clinical team members, including case managers and clinical supervisors, understand the appropriate application of covered behavioral health services, including family support.
- Provide additional training and supervision to recognize the value of family support services as effective service plan intervention.

Supported Employment

Service Description:

Supported employment services are services through which recipients receive assistance in preparing for, identifying, attaining, and maintaining competitive employment. The services provided include job coaching, transportation, assistive technology, specialized job training and individually tailored supervision.

Focus Groups

Findings collected from focus group participants regarding supported employment services included the following themes:

- Similar to observations from last year, there has been a perceived increase in the number of Vocational Rehabilitation (VR) specialists co-located at the clinics. While there is noted variation in the timely access to VR services, participants expressed that the increased availability of VR specialists has been a positive change.
- Participants in the provider focus group reported that the Maricopa County RBHA implemented a requirement for quarterly trainings for direct care clinic staff by the rehabilitation specialists. The participants credit this training for the positive "philosophical shift" that has resulted in a perceived reduction in clinical teams simply assessing a member's readiness for employment to more substantive engagement with individuals regarding work interests, work history and conveying the inherent value that employment can bear for individuals advancing their personal recovery.
- Focus group participants reported that many direct care clinics now have co-located supported employment specialists that have promoted a greater awareness about the availability and value of supported employment services. However, participants in the case manager group reported that supported employment specialists are sometimes prevented from attending clinical team meetings due to HIPAA concerns. This practice has contributed to supported employment specialists' sense of exclusion from the clinical teams.
- Participants reported that there is high turnover among rehabilitation specialists and some rehabilitation specialists are asked to complete case management duties when there are case manager vacancies.
- Participants in all four focus groups stated that members are continuing to be encouraged to pursue a wider variety of employment opportunities outside of peer support specialist training and employment. Provider organizations are now co-located at the clinics leading to more diverse opportunities for members. Case manager participants also reported that they have observed an increase in the number of employers who are willing to hire individuals SMI diagnoses.
- Case manager participants reported that their clinics are also more willing to accommodate members who are working by offering earlier or later clinical appointments.
- Similar to the last two years, adults and family members reported that access to supported employment services is dependent upon the skillset and knowledge level of the assigned case manager.
- Benefit specialists are now available in most clinics, but they are often overwhelmed by the volume of members needing assistance. It has been noted that some members may elect not to pursue employment due to concerns that health and welfare benefits could be jeopardized with added income. Some participants reported that appointments to meet with benefit specialists are scheduled 2 to 3 months out and the technical knowledge of the benefit specialists can vary.

- Many participants agreed that they would benefit from additional trainings on programs such as “Freedom to Work,” “Ticket to Work” and the availability of “Disability 101” trainings. Case manager participants expressed that members are concerned about the impact employment will have on their benefits and they do not have the knowledge base to work directly with members to evaluate their options.

Key Informant Survey Data

The survey distribution process targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

21% of survey respondents felt that supported employment services were difficult to access, comparable to last year (17%) and significantly less than CY 2013 and CY 2014 (75% – CY 2013; 33% – CY 2014). 79% of respondents indicated that supported employment services were easy to access or easier to access, down slightly from CY 2015 (83%), but higher than CY 2014 (66%).

Factors that negatively impact accessing supported employment services included:

- Clinical team unable to engage/contact member;
- Member declines services; and
- Transportation barriers.

77% of the responses indicated that supported employment services were being utilized efficiently or were utilized efficiently most of the time, down from 83% last year. 23% of respondents indicated that supported employment services were not utilized efficiently.

73% of the survey respondents reported that supported employment services could be **accessed within 30 days** of the identification of the service need. This compares to 70% during CY 2015, 60% during CY 2014, and 22% during CY 2013. 14% of the survey respondents reported that it would take an average of **six weeks or longer** to access supported employment services.

Medical Record Reviews Group 1

The Group 1 medical record review sought to answer the following questions regarding the assessment process and determination that assessed needs were addressed as part of the recipient’s ISP.

- Is there evidence that the need for supported employment services was assessed by the clinical team?

Supported Employment

- When assessed as a need, are supported employment services identified on the recipient's ISP?
- Is the clinical team's assessment consistent with the recipient's perception regarding the need for supported employment services?

Findings specific to supported employment services are presented below.

- 39 of 121 (32%) Group 1 medical records identified an assessed need for supported employment services.
- When assessed as a need, 51% of the ISPs included a supported employment service.
- In 12 cases, the ISP included supported employment services despite an absence of any assessed need for the service.
- Several cases with an assessed need for supported employment services included evidence that the clinical team lacked awareness of the appropriate application of covered behavioral health services when identifying services on a member's ISP. For example, several ISPs in the sample listed cognitive rehabilitation to meet members' assessed needs for supported employment services. Cognitive rehabilitation services are intended to facilitate an individual's recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible[70] and are not typically an appropriate intervention to address a need for supported employment. In addition, the ISPs specified that that the rehabilitation specialist would render cognitive rehabilitation services; despite billing requirements that the service be delivered by an independently licensed behavioral health professional. A review of the service data utilization data set that included 30,440 SMI members revealed that only 8 unique members received a cognitive rehabilitation service over a 15 month period of time. None of the members in the Group 1 sample received cognitive rehabilitation services as revealed by the service utilization data analysis.
- 33% of the Group 1 recipients received at least one unit of supported employment services during CY 2016.

Interviews
The interview revealed the following findings:

- Less than half (45%) of the interview respondents reported that there was an assessment regarding supported employment needs and available services.
- In 62% of the cases, the clinical team's assessment of need for supported employment services was consistent with the recipient's perception of need.

Medical Record Reviews: Group 2

The results of the medical record review for Group 2 showed that supported employment services were identified as a need on either the recipient's assessment and/or ISP in 49% of the cases reviewed. Supported employment services were identified as a service on the recipient's ISP in 53% of the cases reviewed when assessed as a need. (CY 2013 - 13%; CY 2014 - 26%; CY 2015 - 22%).

[70] Excerpt from the AHCCCS Covered Behavioral Health Services Guide, revised February 2017.

The review team observed a pattern in one administrative entity of indiscriminately listing services on member's ISPs, including supported employment services. However, clinical team documentation did not consistently support follow up with referrals for these services. It was unclear (based on available documentation) that the services were needed or that the service listed on the ISP was an intervention that the member intended to pursue (e.g., member self-identifies as retired).

27% of the recipients included in the sample received at least one unit of supported employment during CY 2016 based on a review of the service utilization data.

In 53 cases, reviewers were able to review progress notes and record the reasons that the person did not access supported employment services after a supported employment need was identified by the clinical team. A lack of evidence that the clinical team followed up with initiating a referral for the service was noted in 40% of those cases in which the person did not access the service despite an identified need.

Supported Employment

Service Utilization Data

Three distinct billing codes are available to reflect the provision of supported employment services. Billing code distinctions include:

- Pre-job training and development (H2027).
- Ongoing support to maintain employment:
  - Service duration 15 minutes (H2025).
  - Service duration per diem (H2026).

H2027 — Psychoeducational Services (Pre-Job Training and Development)
Services which prepare a person to engage in meaningful work-related activities may include: career/educational counseling, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, study skills, work activities, professional decorum and dress, time management, and assistance in finding employment.

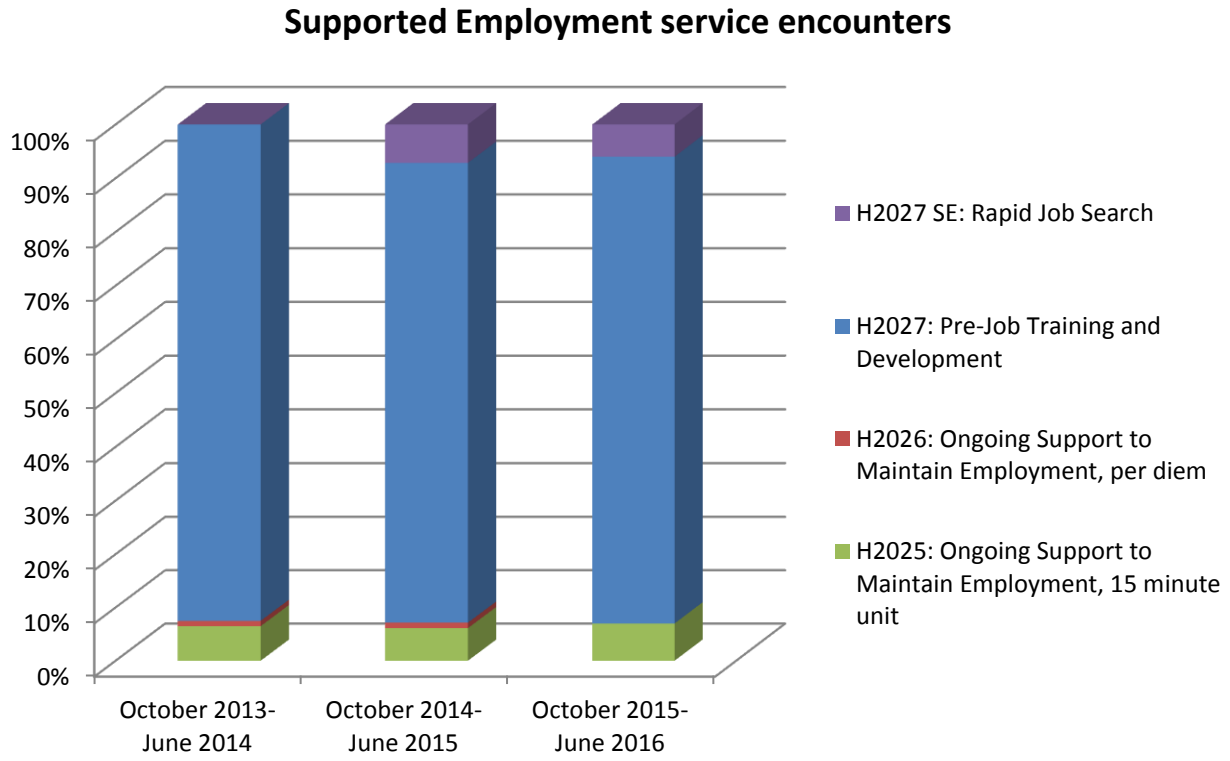
H2025 — Ongoing Support to Maintain Employment Includes support services that enable a person to complete job training or maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, work-adjustment training, and supportive counseling.

H2026 — Ongoing Support to Maintain Employment (per diem)
Includes support services that enable a person to complete job training or maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, work-adjustment training, and supportive counseling.

Supported Employment

For the time period October 1, 2015 through June 30, 2016, H2027 (pre-job training and development) accounts for 87% of the total supported employment services (a decrease from CY 2013 – 93% and CY 2014 – 94%, but an increase from CY 2015 – 84%). H2025 (ongoing support to maintain employment/15 minute billing unit) represents 7% of the supported employment utilization (CY 2013 – 7%; CY 2014 – 6%; CY 2015 – 9%). H2026 (ongoing support to maintain employment/per diem billing unit) accounted for less than 1% of the overall supported employment utilization.

A billing modifier (i.e., SE) is applied in conjunction with billing code H2027 and Mercer analyzed the presence of this code and modifier within the service utilization data file (see graphic below). H2027 SE represents 6% of the overall supported employment utilization. The intended use of the modifier is to track members who are engaged in rapid job search with an expected outcome of securing employment within 45 days of engaging in supported employment services.



Supported Employment

Information was collected during key informant interviews with key system stakeholders, including RBHA contracted supported employment providers. To increase access to supported employment services, supported employment providers, the Maricopa County RBHA and the PNOs/administrative entities have partnered to co-locate supported employment specialists/job developers in many of the direct care clinics. One supported employment provider reported that the employment specialists spend approximately four hours per week at the assigned clinic and the balance of their time in the community supporting members with employment related needs. The clinical teams and the supported employment specialists meet regularly to integrate and coordinate services for members interested in obtaining and/or maintaining employment. The meetings provide a forum for the supported employment specialist to share the current caseload of members engaged in supported employment services, support outreach efforts and to review the member's clinical status, though some clinics reportedly discourage full integration of care with the co-located providers citing HIPAA privacy concerns.

Most supported employment service referrals are initiated by the direct care clinical teams and referrals must be accompanied by a "packet" of information that includes the member's face sheet, current at-risk crisis plan, current assessment and current ISP. One supported employment provider reported that delays in accessing the service can occur if the member's assessment is not current, though the referral process will proceed in "outreach status" until the clinical team can provide updated documentation. One supported employment provider interviewed stated that the current member caseload is significantly short of the contracted capacity and that stimulating interest and referrals for supported employment services within the clinical teams can be challenging. The supported employment provider reported that the capacity for the system was more than sufficient to meet the current demand for supported employment services.

The supported employment specialists coordinate closely with staff employed with the Arizona Department of Economic Security/Rehabilitation Services Administration (DES/RSA). Twenty - seven full – time DES/RSA Vocational Rehabilitation (VR) Counselors are co-located and represented at all the direct care clinic locations. An additional 8 positions are dedicated but vacant (as of September 30, 2016). VR counselors meet regularly with contracted supported employment providers and work in coordination to meet member's supported employment needs.

Most referrals for DES/RSA are initiated by rehabilitation specialists employed by the PNOs/administrative entities and require specified documentation (member diagnosis, face sheet, current assessment, current ISP) to be submitted when referring a candidate for supported employment services. During a telephonic interview with four VR counselors, It was reported that the referral process can proceed in the event that some of the required information is missing or is out of date. The VR counselors noted challenges with high turnover rates within the PNOs/administrative entities and that some teams do not have a rehabilitation specialist assigned and/or available. DES/RSA emphasizes preparation and finding the right fit for members in their employment search so that individuals are more likely to retain employment once a job is secured. DES/RSA data secured from the Maricopa County RBHA for Federal Fiscal Year 2017, Quarter 1, included the following:

- RBHA members referred to RSA/VR – 2,325 (January 1, 2016 – November 30, 2016)

- RBHA member enrolled in the VR program – 1,484 (quarter end September 30, 2016)
- RBHA members in service plan status with VR – 1,052 (quarter end September 30, 2016)

Additional findings from the service utilization data set are as follows:

- Overall, 26% of the recipients received at least one unit of supported employment during the review period.
- Access to the service was unevenly split between Title XIX (29%) and non-Title XIX groups (13%).

Supported Employment

An analysis of the persistence in supported employment services was completed by examining the sustainability of engagement in the service over consecutive monthly intervals.

- Fifty-seven percent of the recipients who received at least one unit of supported employment services during the review period accessed the service during a single month;
- 13% of the recipients received supported employment services for three to four consecutive months during the review period; and
- 5% of the recipients received the service for nine consecutive months.

Persistence in Supported Employment Services October 2015 — June 2016			
Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	56.3%	63.4%	57.1%
2	17.4%	14.0%	17.0%
3–4	13.4%	10.8%	13.1%
5–6	5.3%	5.1%	5.3%
7–8	2.3%	1.2%	2.1%
9	5.0%	5.2%	5.0%

Key Findings and Recommendations

The most significant findings regarding the need and delivery of supported employment services are presented below. Recommendations are included that should be considered as follow up activities to address select findings.

Findings: Supported Employment

- Service utilization data demonstrates an increase in the number and percentage of members who received at least one unit of supported employment during the review period, with 26% of SMI members receiving at least one unit of supported employment services during CY 2016. (CY 2013 – 39%; CY 2014 – 20%; CY 2015 – 17%).
- The results of the medical record review for Group 2 showed that supported employment services were identified as a need on either the recipient's assessment and/or ISP in 49% of the cases reviewed. Supported employment services were identified as a service on the recipient's ISP in 53% of the cases reviewed when assessed as a need. (CY 2013 - 13%; CY 2014 - 26%; CY 2015 - 22%).
- The review team observed a pattern in one administrative entity of indiscriminately listing services on member's ISPs, including supported employment services. However, clinical team documentation did not consistently support follow up with referrals for these services. It was unclear (based on available documentation) that the services were needed or that the service listed on the ISP was an intervention that the member intended to pursue (e.g., member self-identifies as retired).
- Several cases with an assessed need for supported employment services included evidence that the clinical team lacked awareness of the appropriate application of covered behavioral health services. For example, several ISPs affiliated with a single PNO repeatedly listed cognitive rehabilitation to meet members' assessed needs for supported employment services. Cognitive rehabilitation services are intended to facilitate an individual's recovery from cognitive impairments in order to achieve

independence or the highest level of functioning possible[71]. A review of the service data utilization data set that included 30,440 SMI members revealed that only 8 unique members received a cognitive rehabilitation service over a 15 month period of time. None of the members in the Group 1 sample received cognitive rehabilitation services as revealed by the service utilization data analysis.

- Per the focus group participants, benefit specialists are now available in most clinics, but they are often overwhelmed by the volume of members needing assistance. It has been noted that some members may elect not to pursue employment due to concerns that health and welfare benefits could be jeopardized with added income. Some participants reported that appointments to meet with benefit specialists are scheduled 2 to 3 months out and the technical knowledge of the benefit specialists can vary.
- One supported employment provider interviewed stated that the current member caseload is significantly short of the contracted capacity and that stimulating interest and referrals for supported employment services within the clinical teams can be challenging. The supported employment provider reported that the capacity for the system was more than sufficient to meet the current demand for supported employment services.
- Consistent with patterns noted over the past four years, the service utilization data set demonstrates proportional variation in the volume of encountered service codes for supported employment. For the time period October 1, 2015 through June 30, 2016, H2027 (pre-job training and development) accounts for 87% of the total supported employment services (slight increase from CY 2015 – 84%).
- As reported by the Maricopa County RBHA, supported employment contracted capacity is capable of serving at least 1,070 members.

[71] Excerpt from the AHCCCS Covered Behavioral Health Services Guide, revised February 2017.

Supported Employment

Recommendations: Supported Employment

- Through training and supervision, ensure that clinical team members understand the appropriate application of covered services designed to meet a person's objective and goal of securing and/or maintaining employment.
- Establish regular monitoring and performance improvement activities to address instances in which the clinical team identifies supported employment services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services.
- Review information sharing requirements and practices between the direct care clinics and co-located supported employment providers to promote integration and coordination of care consistent with applicable member confidentiality requirements.
- Monitor (and take actions as appropriate) the observed practice of indiscriminately documenting supported employment services on members' individual service plans without evidence of an assessed need for the service.

Supported Housing

Service Description:

Supported housing is permanent housing with tenancy rights and support services that enable recipients to attain and maintain integrated affordable housing. It enables recipients to have the choice to live in their own homes and with whom they wish to live. Support services are flexible and available as needed but not mandated as a condition of maintaining tenancy. Supported housing also includes rental subsidies or vouchers and bridge funding to cover deposits and other household necessities, although these items alone do not constitute supported housing.

Focus Groups

Key themes related to supported housing services included:

- Per focus group participants, the Maricopa County RBHA has implemented a relatively new program titled “Temporary Housing Assistance Program”. This program received positive affirmation from participants in the case manager and provider focus groups as it helps meet the needs of members who need to locate immediate temporary housing.
- Housing providers reportedly collaborate with one another and meet monthly on an independent basis to discuss prevalent program issues. Participants recommended that the Maricopa County RBHA facilitate a regular meeting or method of communication among housing providers and case management staff to facilitate active sharing of current housing options.
- Similar to the last two years, the insufficient capacity of available and affordable housing units, including transitional housing, remains a primary concern of focus group participants. The Maricopa County RBHA did reportedly release approximately 200 vouchers; however, they were exhausted quickly. Case managers and providers expressed ongoing concern about the lack of safe and affordable housing available in Maricopa County. Participants recommended the hiring of housing navigators who can cultivate relationships in the community to increase the availability of housing, particularly for members with multiple evictions and/or felony records. Participants also recommended prioritizing surplus non-title XIX funds (to the extent funding is available) to increase housing capacity.
- Participants expressed a need for additional assisted living housing that will support the needs of aging and elderly members.
- Consistent with the last two years, participants, including case managers, reported that case managers do not have sufficient time and knowledge to assist members in locating safe and affordable housing. The ratio of case managers to members remains too high. Per the focus group participants, clinics need to employ more housing specialists who can directly assist members with housing needs.
- Participants expressed the need for additional training regarding criteria and availability of the various housing programs.
- Focus group participants observed that when members are able to locate housing, they often have outstanding utility bills, need assistance with move-in deposits, and lack the basic necessities to equip a home. All of these issues impact the long-term stability of a member’s housing. Although the Maricopa County RBHA reportedly offers “start-up kits,” most focus group participants were unaware of their availability. Flex funds may also be used for these purposes, but participants reported that flex funds are extremely limited.

- Case manager participants reported that the Maricopa County RBHA no longer considers “couch surfing” to meet the definition of homelessness. The participants stated that couch surfing is an unpredictable and unstable form of housing and the classification increases the likelihood of homelessness for SMI members who are now unable to pursue homeless housing vouchers.
- There is a lack of knowledge and subsequent housing resources to meet the unique needs of transition age youth who may require supported housing when they enter the adult SMI system.
- Family member participants expressed concerns about the loss of housing following a member’s hospitalization for psychiatric treatment. The participants recommended that the Maricopa County RBHA secure the member’s housing and belongings for the hospitalization period to reduce the prevalence of homelessness post-hospitalization and to ensure a safe discharge plan.
- Family member participants reported that administrative rules prevent the inclusion of family members under certain housing vouchers and/or programs. This restriction has resulted in the breaking up of families or the denial of supported housing services for affected members.

Supported Housing

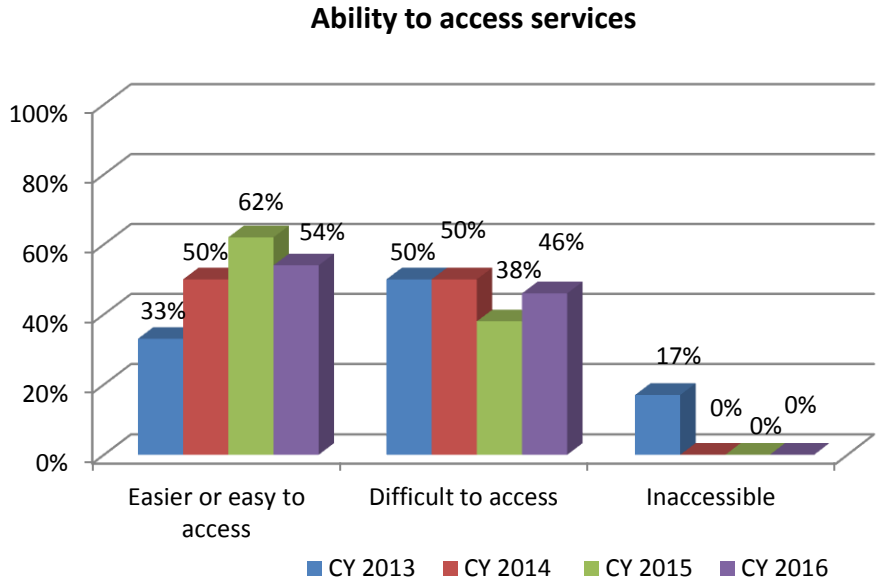
Key Informant Survey Data

The survey distribution process targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

46% of the survey respondents felt that supported housing services were difficult to access, up from 38% a year ago. As noted during CY 2014 and CY 2015, none of the respondents indicated that supported housing services were inaccessible, a sustained improvement from CY 2013 when 17% of the key informants felt that the services were inaccessible.

54% of respondents indicated that supported housing services were easier to access or easy to access. When asked about the factors that negatively impact accessing supported housing services, the responses are as follows:

- 45% of the responses indicated that a wait list exists for the service; (25% during CY 2013; 63% during CY 2014; 59% during CY 2015);
- 37% of the responses were directed to a lack of capacity/no service provider available (31% during CY 2013; 50% during CY 2014; 38% during CY 2015); and
- 20% percent selected admission criteria for services too restrictive (25% during CY 2013; 31% during CY 2014; 26% during CY 2015).



In terms of service utilization:

- 33% of the responses indicated that the services were being utilized efficiently (10% during CY 2013; 25% during CY 2014; 31% during CY 2015);
- 42% responded that the services were utilized efficiently most of the time (30% during CY 2013; 50% during CY 2014; 38% during CY 2015); and
- 24% of the respondents indicated that supported housing services were not utilized efficiently (60% during CY 2013; 25% during CY 2014; 26% during CY 2015).

21% of the survey respondents reported that supported housing services could be accessed within 30 days of the identification of the service need (11% during CY 2013; 0% during CY 2014; 17% during CY 2015). 11% of the respondents indicated that the service could be accessed on average within four to six weeks (22% during CY 2013; 0% during CY 2014; 4% during CY 2015). 68% of the survey respondents reported that it would take an average of six weeks or longer to access supported housing services (67% during CY 2013; 92% during CY 2014; 78% during CY 2015).

Supported Housing

Medical Record Reviews: Group 1

The Group 1 medical record review sought to answer the following questions regarding the assessment and provision of supported housing services:

- Is there evidence that supported housing services were assessed by the clinical team?
- When assessed as a need, are supported housing services identified on the recipient's ISP?
- Is the clinical team's assessment consistent with the recipient's perception regarding the need for supported housing services?

Findings specific to supported housing services are presented below.

- The Group 1 medical record review looked for evidence that the recipients were in need of supported housing services. 17 cases or 14% of the sample demonstrated an assessed need for supported housing.
- When assessed as a need, supported housing related services were identified on the recipient's ISP in 35% of the records (20% during CY 2013; 19% during CY 2014; 50% during CY 2015).

14% of the Group 1 recipients received at least one unit of supported housing services during CY 2016 based on a review of service utilization data[72].

Interviews

All Group 1 recipients participated in an interview regarding the prioritized mental health services.

The interview revealed the following:

- 45% of the recipients interviewed reported that the clinical team did discuss housing related supports and services.
- Disagreement between the clinical team's assessment and the recipient's perception of need was found in 36% of the cases reviewed (down slightly from 44% during CY 2014 and 41% during CY 2015).

[72] Mercer broadened the supported housing service utilization data query to include Skills Training and Development (H2014) when the service was rendered by a contracted supported housing provider.

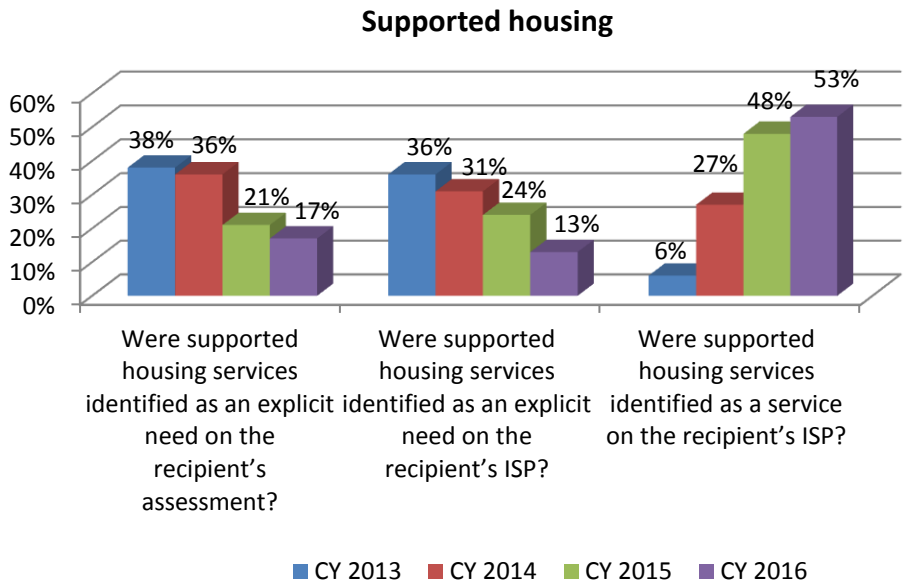
Supported Housing

Medical Record Reviews: Group 2

Consistent with prior year evaluations, the recipient's living situation was assessed and documented in almost all the cases reviewed.

- Supported housing services were identified as a need on either the recipient's assessment and/or recipient's ISP in 20% of the cases reviewed.
- Supported housing was identified as a service on the recipient's ISP in 53% of the cases. (up from last year when 48% of the ISPs included supported housing)

9% of the recipients included in the Group 2 sample received a unit of supported housing during CY 2016.



In nineteen cases, reviewers were able to review progress notes and record the reasons that the person was unable to access supported housing services after housing-related assistance was identified as a need by the clinical team. The most common reason was that there was a lack of evidence that the clinical team followed up with initiating a referral for the service.

Challenges with securing and maintaining stable housing are accentuated when members present with active psychiatric symptoms and/or substance use disorders. In a small percentage of the cases reviewed, it appeared that case managers and other clinical team members struggled with supporting members who exhibited active psychosis and/or addiction disorders and were in need of housing and related supports. In one particular case, a member remained homeless throughout the nine month review period despite intermittent attempts by the clinical team to secure housing for the individual. At different stages, the case manager was not fully aware of the member's housing referral status, questioning several months later if a housing referral had ever been initiated; it appeared that the clinical team was unclear regarding the type of housing that would best meet the member's needs with multiple, simultaneous housing options being independently pursued; and it was evident that more robust clinical oversight was needed and that clinical consultation should have been sought out in an effort to review and identify viable clinical interventions that could have assisted the individual with more effective symptom management and securing a stable living environment. In another case, a woman residing in a temporary shelter and in need of housing and related supports was eventually hospitalized and subsequently

discharged without viable housing or shelter. The clinical team's attempts to support the member were limited to repeated observations and welfare checks while she resided in the temporary shelter. Despite escalating clinical symptoms that necessitated her admission to an inpatient psychiatric facility, the case manager monitoring the member's status did not elevate the concerns to a clinical supervisor or seek clinical consultation to address the member's deteriorating mental status. Even in the absence of active support, the woman was able to eventually secure housing and employment independent of her clinical team.

In this subset of cases, the members were capable of taking full advantage of the priority services to achieve a higher level of functioning, but the repeated breakthrough of psychiatric symptoms disrupted and impeded their progress. Within the direct care clinical team, the case manager typically has the most contact with members and is the staff person best positioned to identify how the member is responding to clinical treatment, early signs of escalating psychiatric symptoms, and to alert the medical team of the need for immediate clinical attention. Because the case manager did not perform these activities in these cases, members were not able to achieve their highest level of functioning as efficiently as they might have had they had more immediate clinical support to manage their symptoms.

Service Utilization Data

Prior service capacity assessments have established that the supported housing billing code (H0043) is rarely utilized. The Maricopa County RBHA is now tracking additional covered services that may be encountered in the context of providing supported housing services. Permanent supported housing utilization includes skills training and development and personal care services to help members obtain and maintain community-based independent living arrangements. In addition to these services, targeted services for contracted permanent supported housing providers can include behavioral health prevention and education, peer support, case management, behavioral health screening and assessment, non-emergency transportation, medication training and support, counseling, personal care and psychoeducational services.

As indicated within the service utilization data file, 2,865 Title XIX eligible (Medicaid) recipients were affiliated with the service during the time period of October 1, 2015 – December 31, 2016 and 118 non-Title XIX recipients received the service from a total population of 30,440 (10%).

Supported Housing

Key Findings and Recommendations

The following information summarizes key findings identified as part of the service capacity assessment of supported housing.

Findings: Supported Housing

- Service utilization data demonstrates that 10% of members received at least one unit of supported housing during the review period.
- Case manager participants reported that the Maricopa County RBHA no longer considers “couch surfing” to meet the definition of homelessness. The term refers to individuals who do not have stable housing, but may temporarily find shelter at friend’s or acquaintance’s dwellings. The participants expressed that couch surfing is an unpredictable and unstable form of housing and the classification increases the likelihood of homelessness for SMI members who are now unable to pursue homeless housing vouchers.
- The Group 1 medical record review looked for evidence that the recipients were in need of supported housing services. 17 cases or 14% of the sample demonstrated an assessed need for supported housing. When assessed as a need, supported housing related services were identified on the recipient’s ISP in 35% of the records (20% during CY 2013; 19% during CY 2014; 50% during CY 2015).
- In nineteen cases, reviewers were able to review progress notes and record the reasons that the person did not access supported housing services after housing-related assistance was identified as a need by the clinical team. The most common reason was that there was a lack of evidence that the clinical team followed up with initiating a referral for the service.
- 46% of the survey respondents felt that supported housing services were difficult to access, up from 38% a year ago. As noted during CY 2014 and CY 2015, none of the respondents indicated that supported housing services were inaccessible, a sustained improvement from CY 2013 when 17% of the key informants felt that the services were inaccessible.
- During key informant interviews with select supported housing service providers, delays in accessing services can occur when the direct care clinical team is unable to produce updated assessments and/or individual service plans.
- Permanent supported housing utilization includes skills training and development and personal care services to help members obtain and maintain community-based independent living arrangements. In addition to these services, targeted services for contracted permanent supported housing providers can include behavioral health prevention and education, peer support, case management, behavioral health screening and assessment, non-emergency transportation, medication training and support, counseling, personal care and psychoeducational services.
- As reported by the Maricopa County RBHA, permanent supported housing contracted capacity is capable of serving at least 1,872 members.

Supported Housing

Recommendations: Supported Housing

- Promote more robust clinical supervision and oversight of case managers and other direct care clinic team members that ensures regular and timely consultation to address the ongoing clinical needs of members.
- Through training and supervision, ensure that clinical team members understand the appropriate application of covered services designed to meet a person's objective and goal of securing and maintaining independent living arrangements.
- Establish regular monitoring and performance improvement activities to address instances in which the clinical team identifies supported housing services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services.
- As part of oversight and monitoring activities, assess the impact of timely access to care when delays occur with obtaining updated ISPs and documentation from the clinics as part of the referral process for each of the priority mental health services, including supported housing services. Initiate appropriate corrective actions to address any identified performance deficiencies.

Assertive Community Treatment Teams

Service Description:

An ACT team is a multi-disciplinary group of professionals including a psychiatrist, a nurse, a social worker, a substance abuse specialist, a vocational rehabilitation specialist, and a peer specialist. Services are customized to a recipient's needs and vary over time as needs change.

Focus Groups

Key findings derived from focus group meetings regarding ACT team services are presented below:

- Adult focus group members who currently utilize or have utilized ACT team services in the past stated that their ACT team was beneficial to them.
- For one of the medical ACT teams, it was reported that members are required to change primary care providers (PCPs) if they are not currently assigned to the PCP on the ACT team. For some members the reassignment of PCPs was reported to disrupt continuity of care.
- Participants in the case manager focus group reported that ACT teams are frequently at capacity. It was reported that the forensic teams may only consider referrals from criminal justice entities such as probation and parole. Participants recommended allowing the mental health courts to make referrals as well, which would allow other members to gain access to this specialized service.
- Contrary to observations collected last year, participants in the case manager focus group reported that criteria for ACT admission are unclear and that reasons for non-acceptance of ACT team services is rarely provided.
- Case managers reported that there is still hesitancy to discharge members from ACT teams. Focus group participants reported that ACT teams prefer to maintain caseloads of individuals who are "easier" to treat and are reluctant to admit members who require more complex care.
- Similar to last year, not all clinics have an ACT team or an ACT team in close proximity to the clinic. Some members who would benefit from ACT team services decline enrollment with an ACT team because they do not want to be served by another clinic or have to move to be closer to an ACT team.
- Family members reported that access to ACT teams can be challenging. One parent reported, "It took six months for me to get my son on an ACT team. We had to change clinics for him to be admitted."
- Similar to last year, participants reported that some ACT team staff members do not seem to have the requisite skill set to adequately serve members on an ACT team. Participants reported that newly hired case managers are still being assigned to ACT teams and may lack the experience required to serve members with complex needs.
- Some ACT teams are fully staffed while others experience higher attrition rates and frequent staff vacancies (particularly for peer support specialist positions). Focus group participants also reported an increase in turnover among ACT team psychiatrists. Case managers report that ACT team psychiatrists are now required to be in the field weekly. This expectation was perceived to be a deterrent for recruiting psychiatrists and has led to higher turnover rates.

- Provider agency and family member participants expressed concerns that individuals on ACT teams are excluded from participating in non-ACT-delivered services such as individual and group peer support and family support services. One family member stated that her son would benefit from peer support services. He did not connect with the peer support specialist on his ACT team ("wrong age, wrong sex") but was prevented from accessing a different peer due to ACT fidelity requirements. Family mentors and peer support specialists reported that other members lose connections to long-standing group activities and relationships once they are assigned to an ACT team.
- Participants observed that ACT teams are required to provide family support services when identified as a need, but ACT teams reportedly do not currently include family mentors. Focus group participants stated that family members may lose access to family mentor services when a member is assigned to an ACT team.
- Focus group participants agreed that strict adherence to ACT fidelity does not always equate to person-centered care that should place the clinical needs of an individual before the requirement to maintain fidelity to the ACT team model. Case manager and provider focus group members recommend a review of fidelity requirements to promote a higher degree of flexibility in the delivery of ACT services. One example offered by the focus group participants included reducing the requirement for four home visits per week for every member. The participants stated that, for some members, this frequency of home contact can be perceived as invasive and can be a barrier to reaching a higher level of independence. It was also reported that other members decline ACT services due to this requirement

Assertive Community Treatment Teams

Key Informant Survey Data

As noted previously, the survey distribution process targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

24% of survey respondents reported that ACT team services were difficult to access (46% during CY 2013; 33% during CY 2014; 23% during CY 2015) and one (2%) of the respondents indicated that the service was inaccessible (18% perceived the services inaccessible during CY 2013). 73% of respondents indicated that ACT team services were easier to access or easy to access (36% during CY 2013; 50% during CY 2014; 77% during CY 2015).

When asked about the factors that negatively impact accessing ACT team services, the responses are as follows:

- 43% indicated that the member declines service (20% – CY 2013; 50% – CY 2014; 41% - CY 2015).
- 41% of the responses identified clinical team unable to engage/contact member (27% during CY 2013; 32% during CY 2014; 45% - CY 2015);
- 35% selected staffing turnover (CY 2014 32%; CY 2015 – 41%).

In terms of the efficiency of service utilization:

- 30% of the responses indicated that the services were being utilized efficiently (CY 2013 – 27%; 19% – CY 2014; 29% - CY 2015);
- 58% responded that the services were utilized efficiently most of the time (CY 2013 – 18%; CY 2014 – 56%; CY 2015 – 63%); and
- 13% of the respondents indicated that ACT team services were not utilized efficiently (55% during CY 2013; 6% during CY 2014; 8% during CY 2015).

75% of the survey respondents reported that ACT team services could be accessed within 30 days of the identification of the service need (CY 2013 – 60%; CY 2014 – 58%; CY 2015 – 77%). 8% indicated that the service could be accessed on average, within four to six weeks (20% – CY 2013; 6% – CY 2014; 5% - CY 2015). The remaining 17% of the survey respondents reported that it would take an average of six weeks or longer to access ACT team services (20% – CY 2013; 33% – CY 2014; 18% - CY 2015).

Medical Record Reviews: Group 1

The Group 1 medical record review sought to answer the following questions regarding the assessment and provision of the priority mental health services:

- Is there evidence that ACT team services were assessed by the clinical team?
- When assessed as a need, are ACT team services identified on the recipient's ISP?

- Is the clinical team's assessment consistent with the recipient's perception regarding the need for ACT team services?
- 99 (82%) of the Group 1 records included evidence that the clinical team assessed and/or documented the level of case management needed by the member, including ACT team services.
- 2% of the Group 1 members had an assessed need for ACT. Of these, one record identified ACT team services on the recipient's ISP.

Assertive Community Treatment Teams

Five of the 121 cases (4%) included recipients assigned to an ACT team.

Interviews
All Group 1 recipients participated in an interview regarding the prioritized mental health services.

The interview disclosed the following:

- 20% of recipients recalled the clinical team discussing ACT team services during the annual assessment and service planning process. The review team observed that ACT team services are usually not documented as part of the annual assessment and treatment planning process.
- 75% of the recipients agreed with the clinical team's assessment regarding the need for ACT team services.

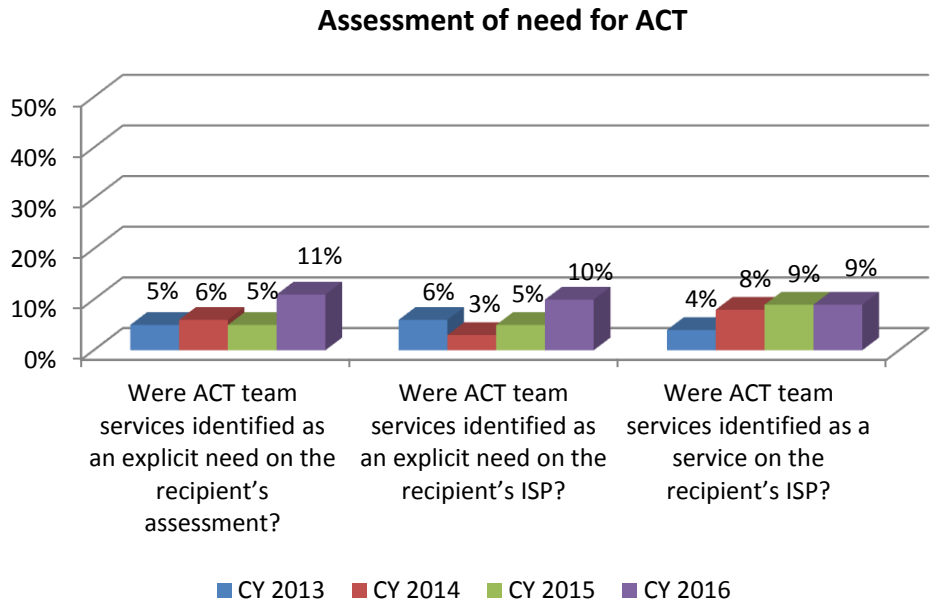
Medical Record Reviews: Group 2

Consistent with the past two years, in most cases reviewed, there was little to no documented evidence that the clinical team was considering or recommending a change in the level of case management, including referring a person to an ACT team or stepping down a recipient assigned to an ACT team to a less intensive level of case management.

In 22 cases, ACT team services were identified as a need on recipients' assessments and/or ISPs. However, only two of these cases explicitly identified ACT team services on the ISP.

In most of the remaining cases, ISPs would identify case management services as the intervention to meet an assessed need for ACT.

11% of the recipients included in the sample were assigned to an ACT team.



Assertive Community Treatment Teams

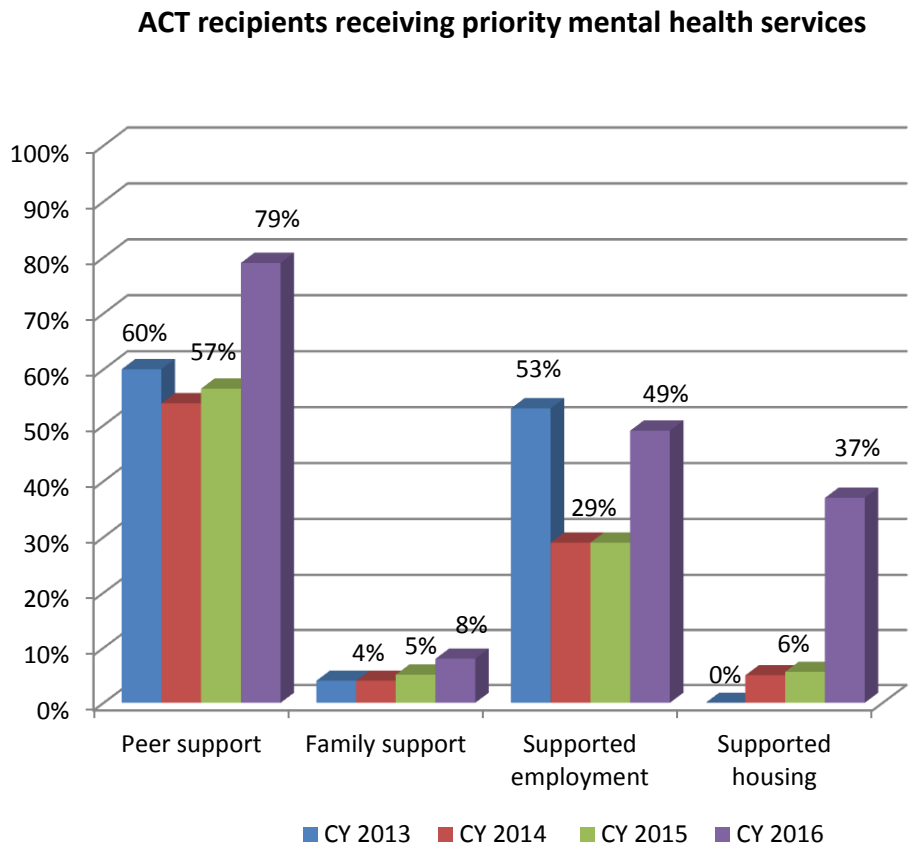
Service Utilization Data

ACT team services are not assigned a specific billing code. Therefore, ACT team services are not uniquely reflected in the service utilization data file.

However, Mercer did complete an analysis of service utilization for recipients that were assigned to an ACT team. CY 2016 service utilization profiles for 1,687 ACT recipients who received a behavioral health service were analyzed.

The analysis sought to identify the utilization of one or more of the priority services (supported employment, supported housing, peer support services, family support services).

The analysis found 79% of the ACT team recipients received peer support services during CY 2016. ACT recipients who received supported employment services was determined to be 49%, an increase from CY 2015 and CY 2014 (29%). Utilization of supported housing services (37%) increased due to an expanded service utilization data query that included additional support service codes when rendered by contracted supported housing providers[73].



[73] Mercer broadened the supported housing service utilization data query to include Skills Training and Development (H2014) when the service was rendered by a contracted supported housing provider.

Assertive Community Treatment Teams

Key Findings and Recommendations

Findings: ACT Team Services

- As a percentage of the total SMI population, 7% of all members are assigned to an ACT team. This is the same percentage found during CY 2015 and slightly higher than the finding derived during CY 2013 and CY 2014 (6%).
- Case managers reported an ongoing hesitancy to discharge members from ACT teams. Focus group participants reported that ACT teams prefer to maintain caseloads of individuals who are "easier" to treat and are reluctant to admit members who require more complex care.
- 24% of survey respondents reported that ACT team services were difficult to access (46% during CY 2013; 33% during CY 2014; 23% during CY 2015) and one (2%) of the respondents indicated that the service was inaccessible (18% perceived the services inaccessible during CY 2013). 73% of respondents indicated that ACT team services were easier to access or easy to access (36% during CY 2013; 50% during CY 2014; 77% during CY 2015).
- 30% of the responses indicated that the services were being utilized efficiently (CY 2013 – 27%; 19% – CY 2014; 29% - CY 2015).
- A review of 100 SMI members that represent the highest aggregate behavioral health service costs during CY 2016 was conducted. It was determined that 25% of the members were assigned to an ACT team. This compares to 20% when the same analysis was completed during CY 2013, 18% during CY 2014 and 23% during CY 2015. Of the 25 members assigned to ACT and included on the list of the top 100 members with the highest behavioral health service costs; 9 (36%) also resided in supervised behavioral health residential settings. During times of transition (admission or discharge from ACT team services), it may be appropriate to temporarily have a member assigned to ACT and placed in a supervised setting, but this should be time-limited due to the duplicative nature of the services. Overall, 34 of the 100 (34%) members resided in a supervised behavioral health residential setting, which may contribute to higher service costs for those members and may discourage clinical teams from considering or referring a member to an ACT team. If members placed in a supervised behavioral health residential setting (and not currently assigned to an ACT team) are excluded from the analysis, then 33% of the highest cost utilizers are assigned to an ACT team.
- An analysis of jail booking data was completed to identify members that have had multiple jail bookings over a defined period (i.e., eleven months—January through November 2016) and determine if the member was subsequently referred and assigned to an ACT team, including one of the three forensic specialty ACT teams. The analysis found:
  - 467 members experienced at least two jail bookings during the period under review (408 for same time period in CY 2015).
  - Of these 467 members, 119 (25%) were assigned to an ACT team (CY 2015 – 23%) during the review period.
  - Of the 119 members assigned to an ACT team, 26 (22%) are assigned to a forensic specialty ACT team (CY 2015 – 20%).
  - 36 members receiving ACT team services have 3 or more incarcerations over the review period, but are not assigned to one of the three available forensic specialty ACT teams.
- 2,092 recipients were assigned to 24 ACT teams as of December 1, 2016. An increase of three teams and 399 members since CY 2015.

Assertive Community Treatment Teams

Recommendations: ACT Team Services

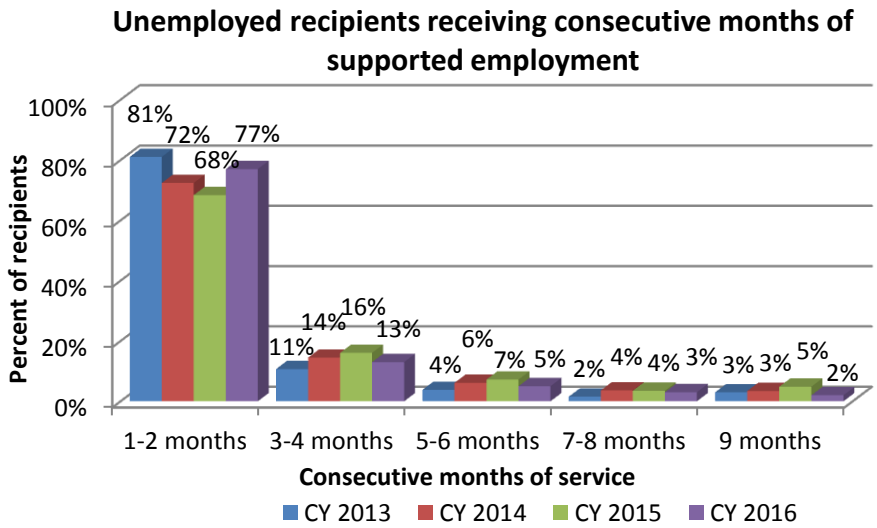
- Continue efforts to actively facilitate the identification of appropriate candidates for ACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns and adverse incidents involving SMI recipients.

Outcomes Data Analysis

The service capacity assessment utilized an analysis of recipient outcome data in an attempt to link receipt of one or more of the priority mental health services with improved functional outcomes. Please note that relationships between outcomes and service utilization trends may be identified, but those relationships do not necessarily reflect causal effects. In other words, observed outcomes may be contingent on a number of variables that are unrelated to receipt of one or more of the priority mental health services. Consistent with prior year's analyses, the review team selected the following outcome indicators:

- Criminal justice records (i.e., number of arrests);
- Homeless prevalence (i.e., primary residence); and
- Employment status.

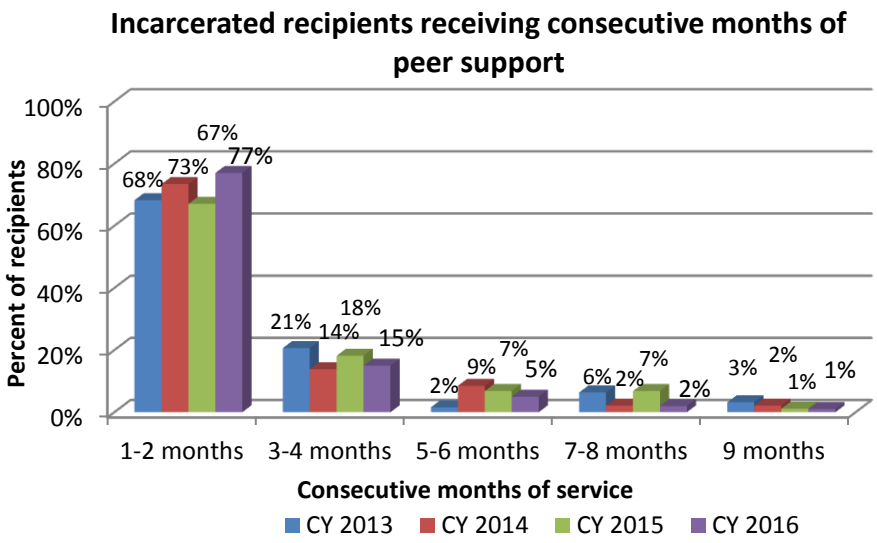
During CY 2016, an analysis was completed that compared recipients' persistence with receiving supported employment services and peer support services for each of the outcome indicators selected. Overall, there are strong relationships between receipt of the priority services and improved outcomes related to incarcerations, living situation and employment status. The relationship is further strengthened when the recipient sustains consistent participation in the priority service over an extended period of time.



The following results were noted when reviewing select outcomes for recipients who had received supported employment services:

- Similar to CY 2013, CY 2014 and CY 2015 results, the percentage of recipients identified as unemployed decreases as the duration with supported employment services increases. For example, 77% of recipients identified as unemployed are associated with two or less consecutive months of supported employment services. Alternatively, recipients who experienced five or more consecutive months of supported employment services constituted only 5% of the total unemployed group.

The following outcomes were noted when reviewing recipients who had received peer support services during the review period:



- Of the group of recipients who were incarcerated during the review period, only 1% received nine consecutive months of peer support services. 77% of recipients who had experienced an incarceration received peer support services during a single month or during two consecutive months during the review period.
- Only 13% of recipients noted to be homeless or residing in a boarding home, crisis shelter, hotel, or behavioral health treatment setting received peer support services during the review period.
- Longer periods of consecutive peer support services are also associated with lower unemployment rates. For example, 68% of the recipients identified as unemployed received one or two months of peer support services; the percentage of unemployed recipients who received peer support services for seven or more consecutive months was determined to be 6%.

The Maricopa County RBHA has also implemented a value-based purchasing initiative and is monitoring designated performance measures that tie to improved member outcomes. The purpose of the initiative is to encourage continuous quality improvement and learning, particularly initiatives that target improved health outcomes and cost savings. AHCCCS has led the effort and is leveraging the managed care model toward value-based health care with the expectation to improve members' health care experience and population health. Performance measure results reported by the RBHA that are directly relevant to the Maricopa County SMI population and the priority mental health services are summarized below[74].

For ACT team providers, findings include:

- Psychiatric hospitalizations per 1000 members have decreased 8%;
- 62% of the participating ACT teams exceeded a target of a 10% decrease in hospitalizations;
- Emergency department visits per 1000 members have decreased by 6%;
- 48% of the participating ACT teams exceeded a target of a 10% in emergency department visits;
- 45% of the participating ACT teams achieved an increase of 10% or greater in the numbers of members competitively employed. Among those teams, the average increase in employment was 39%; and

[74] As reported by the Maricopa County RBHA, correspondence dated May 25, 2017.

- More than half (52%) of the participating ACT teams reduced homelessness by an established target of 10% or more.

For Forensic ACT team providers, findings included:

- A forensic ACT team achieved a 76% reduction in the number of jail bookings;
- A 31% reduction in psychiatric hospital admissions;
- An 18% reduction in emergency department visits; and
- A 19% reduction in the number of homeless members.

For permanent supporting housing providers, findings include:

- A 60% reduction in psychiatric hospital admissions was observed for members affiliated with a participating supported housing service provider;
- A 49% reduction in the number of members who utilized a mobile crisis service; and
- A 10% increase in the number of members who maintained stable housing once secured.

APPENDIX A

Focus Group Invitation

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On behalf of the Arizona Health Care Cost Containment System (AHCCCS), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC is conducting four focus groups in Maricopa County.

This is the fourth year of Mercer's evaluation of adults with serious mental illness (SMI) access to the Priority Mental Health services (PMHS): Assertive Community Treatment (ACT), Supported Housing (SH), Supported Employment (SE) and Peer and Family support services. The evaluation includes a review of system strengths, challenges, barriers and concerns related to the priority behavioral health services. This information will be used to inform strategies to help the adult system of care in Maricopa County move toward a more recovery-oriented service delivery system.

Focus groups will be held at the following location:
The Refuge
4727 N 7th Ave
Phoenix, AZ 85013

Focus Group One Family Members of Adults Receiving SMI Priority Mental Health Services February 22, 2017 6:00 pm–8:00 pm	**Focus Group Two** Direct Care Clinic Case Managers Providing Services to Adults Receiving SMI Priority Mental Health Services February 24, 2017 10:00 am–12:00 pm
Focus Group Three Adults receiving SMI Priority Mental Health Services February 24, 2017 2:00 pm–4:00 pm	**Focus Group Four** Providers of ACT, SH, SE, Peer and Family Support Services to Adults Receiving SMI Priority Mental Health Services February 24, 2017 6:00 pm–8:00 pm

Space is available for 15 participants per focus group based on a confirmed email basis.
Once capacity is reached, interested participants will be placed on a waiting list.
RSVP by Thursday, February 16, 2017 to **Stacia Ortega** at stacia.ortega@mercer.com.
Refreshments will be provided.

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APPENDIX B

Key Informant Survey

* 1. What is your job role/title?

- ○ CEO
- ○ Executive Management
- ○ Clinical Leadership (behavioral health)
- ○ Clinical Leadership (medical)
- ○ Specialty Case Manager
- ○ Direct Services Staff (BHP/BHT)
- ○ Other (please specify)

* 2. From the list below, please select which best describes your organization.

- ○ ACT Team Provider
- ○ Behavioral Health Provider for Adults with a Serious Mental Illness (SMI) Only
- ○ Behavioral Health Provider for Adults with a SMI, Children, General Mental Health/Substance Abuse
- ○ Consumer Operated Agency (peer support services/family support services for adults)
- ○ Crisis Provider
- ○ Hospital
- ○ Provider Network Organization or other Administrative Entity within the Maricopa County Regional Behavioral Health Authority System
- ○ Supported Employment Provider
- ○ Supported Housing Provider
- ○ Other (please specify)

* 3. Please indicate if you provide the following behavioral health services to adults with a SMI.

	Yes	No	N/A
Assertive Community Treatment (ACT)	○	○	○
Family Support Services	○	○	○
Peer Support Services	○	○	○
Supported Employment	○	○	○
Supported Housing	○	○	○

* 4. In providing services for adults with SMI, how would you rate the following services? (1=No Access/Service Not Available, 2=Difficult to Access, 3=Easier to Access, 4=Easy to Access)

	1	2	3	4	N/A
ACT	○	○	○	○	○
Family Support Services	○	○	○	○	○
Peer Support Services	○	○	○	○	○
Supported Employment	○	○	○	○	○
Supported Housing	○	○	○	○	○

* 5. Please select from the list below the factors that you feel negatively impact accessing the following services. (Select all that apply.)

	Member Declines Service	Wait List Exists for Service	Language or Cultural Barrier	Transportation Barrier	Clinical Team Unable to Engage/Contact Member	Lack of Capacity/No Service Provider Available	Admission Criteria for Services too Restrictive	Staffing Turnover	Other
ACT	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family Support Services	☐	☐	☐	☐	☐	☐	☐	☐	☐
Peer Support Services	☐	☐	☐	☐	☐	☐	☐	☐	☐
Supported Employment	☐	☐	☐	☐	☐	☐	☐	☐	☐
Supported Housing	☐	☐	☐	☐	☐	☐	☐	☐	☐

If you checked other above (please specify)

* 6. In terms of service utilization, are the services below being utilized efficiently?

	Yes	Most of the Time	No	N/A
ACT	○	○	○	○
Family Support Services	○	○	○	○
Peer Support Services	○	○	○	○
Supported Employment	○	○	○	○
Supported Housing	○	○	○	○

* 7. On average, after the clinical team, member, and family (as applicable) identify a service need, how long does it take for the member to access the service? (Please complete for each service listed.)

	1-2 Weeks	3-4 Weeks	4-6 Weeks	Longer than 6 weeks	NA
ACT	○	○	○	○	○
Family Support Services	○	○	○	○	○
Peer Support Services	○	○	○	○	○
Supported Employment	○	○	○	○	○
Supported Housing	○	○	○	○	○

* 8. Please rate the degree over the past 12 months, access to each of the following services (1=easier to access, 2=more difficult to access 3=no change)

	1	2	3
ACT	○	○	○
Family Support Services	○	○	○
Peer Support Services	○	○	○
Supported Employment	○	○	○
Supported Housing	○	○	○

* 9. What would you say are the most significant service delivery issues for the persons with a SMI accessing behavioral health services in Maricopa County?

APPENDIX C

Assessment Verification Interview Tool

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ASSESSMENT VERIFICATION INTERVIEW

Recipient Name: _____
Provider Network Organization: _____
Clinic: _____
Date: _____
Interviewer: _____

1. When you met with your clinical team to discuss your treatment plan, did you talk about any of the following types of services to help you? (Describe to member and check all that apply.)

___ *Assertive Community Treatment*	A team with a doctor, nurse, case manager, peer support worker, and employment and housing case managers. You usually see someone from your assertive community treatment team once a day or multiple times during the week. The team assists you with support and services in the community.
___ *Supported Employment*	Supported employment helps you get a job that you are interested in. It can involve helping you think about what job you want, reviewing your job skills and needs for training, finding jobs you might want, preparing for interviewing or applying for a job, and supporting you once you have a job.
___ *Supported Housing*	Supported housing helps you find and maintain a good place to live. It might help you get the help you need to afford a place to live, work with the landlord when necessary, and make sure you have all the skills and support you need to stay in an apartment or other place to live. It might include coaching and help with the rent.
___ *Peer Support Services*	Peer support services are provided by another person who also receives behavioral health services and has similar lived experiences as you. It may include helping you find the right kind of services and talking to you about your recovery.
___ *Family Support Services*	Family support services helps your family be better at understanding and helping you. It may be provided by a family mentor at your clinic.

2. Are any of these services in your most recent individual service plan?

____ Yes ____ No

3. Do you think that you need any of these services?

___Yes

- ___Assertive Community Treatment
- ___ Supported Employment
- ___ Supported Housing
- ___ Peer Support Services
- ___ Family Support Services

___No

APPENDIX D

Group 2 Medical Record Review Tool

Log-in screen [1]

Reviewer Name _____ Client ID _____ DOB ___/___/___

Date _____/_____/_____ Provider Network Organization _____ Direct Care Clinic_____

Date of most recent assessment ___/___/___ Date of most recent ISP___/___/___ Sample period: *January 1, 2015 – December 31, 2015*

Chart review [2]

	Functional Assessment Need (as documented by the clinical team) **[2A]**	ISP Goals Need (as documented by the clinical team) **[2B]**	Is the documented need consistent with other information (e.g., client statements, assessment documentation) **[2C]**	ISP Services (record any relevant service(s) referenced on the ISP **[2D]**	Evidence of Service Delivery Consistent with ISP **[2E]**	Reasons Service was not Delivered Consistent with ISP **[2F]**
ACT						
Supported Employment						
Supported Housing						
Peer Support Services						
Family Support Services						

APPENDIX E

Summary of Recommendations

Service	Recommendations
Peer Support Services (PSS)	PSS1. Assess the reported expectation that all peer support positions at the direct care clinics are required to be employed full-time. As indicated and determined to be appropriate, explore opportunities to have peers work in part-time roles. PSS2.Ensure through training and ongoing supervision that direct care clinical team members, including case managers and clinical supervisors, understand the appropriate application of covered behavioral health services, including peer support. PSS3. Provide additional training and supervision to recognize the value of peer support services as effective service plan intervention.
Family Support Services (FSS)	FSS1. Work with provider network organizations and administrative entities to examine the case load sizes of family mentors and determine an appropriate targeted case load size based on the family mentor's job description and expectations. Once established, monitor the target on an ongoing basis and take appropriate actions when caseload sizes persistently exceed the threshold. FSS2.Ensure the consistent application of privacy practices at the direct care clinics to balance compliance with member confidentiality while providing opportunities for involved family members to participate in the member's care as appropriate and consistent with the member's choice. FSS3.Ensure through training and ongoing supervision that direct care clinical team members, including case managers and clinical supervisors, understand the appropriate application of covered behavioral health services, including family support. FSS4.Provide additional training and supervision to recognize the value of family support services as effective service plan intervention.

Service	Recommendations
Supported Employment Services (SES)	SES1. Through training and supervision, ensure that clinical team members understand the appropriate application of covered services designed to meet a person's objective and goal of securing and/or maintaining employment. SES2. Establish regular monitoring and performance improvement activities to address instances in which the clinical team identifies supported employment services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services. SES3. Review information sharing requirements and practices between the direct care clinics and co-located supported employment providers to promote integration and coordination of care consistent with applicable member confidentiality requirements. SES4. Monitor (and take actions as appropriate) the observed practice of indiscriminately documenting supported employment services on members' individual service plans without evidence of an assessed need for the service.
Supported Housing Services (SHS)	SHS1. Promote more robust clinical supervision and oversight of case managers and other direct care clinic team members that ensures regular and timely consultation to address the ongoing clinical needs of members. SHS2. Through training and supervision, ensure that clinical team members understand the appropriate application of covered services designed to meet a person's objective and goal of securing and maintaining independent living arrangements. SHS3. Establish regular monitoring and performance improvement activities to address instances in which the clinical team identifies supported housing services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services. SHS4. As part of oversight and monitoring activities, assess the impact of timely access to care when delays occur with obtaining updated ISPs and documentation from the clinics as part of the referral process for each of the priority mental health services, including supported housing services. Initiate appropriate corrective actions to address any identified performance deficiencies.

Assertive Community Treatment Teams (ACTT)	ACTT.1 Continue efforts to actively facilitate the identification of appropriate candidates for ACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns and adverse incidents involving SMI recipients.

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