Mercer

Government Human Services Consulting

Priority Mental Health Services 2023

Service Capacity Assessment

Arizona Health Care Cost Containment System

August 31, 2023

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Section 1

Executive Summary

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency (hereafter referred to as Arizona or State), 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, Arizona. This report represents the tenth in a series of annual service capacity assessments performed by Mercer.

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

- *Key informant surveys, interviews, and focus groups*: The analysis includes surveys and interviews with key informants and focus groups with members, family members, case managers, and providers.
- *Medical record reviews:* Mercer identifies a random sample (n=200) of class members to support an evaluation of clinical assessments, individual service plans (ISPs), and progress notes. The record review examines each recipient's assessed needs and the timeliness of accessing the priority mental health services.
- *Analysis of service utilization data and contracted capacity for each of the priority mental health services:* The analysis evaluates the volume of unique users, billing units, and rendering providers for select priority mental health services that can be identified via administrative claims data. In addition to the percentage of recipients who received one or more of the prioritized services, Mercer completes an analysis to estimate "persistence" in treatment. The persistence calculation includes the proportion of recipients who only received a priority service during a single month as well as progressive time intervals (i.e., two to three months, three to four months, five to six months, seven to eight months, and nine months or longer) to determine the volume of recipients who sustained consistent participation in the selected prioritized services during the review period.
- *Analysis of outcomes data:* Mercer performs an analysis of outcome data including employment data and criminal justice involvement.
- *Benchmark analysis*: The analysis evaluates priority service prevalence and penetration rates in other states and local systems that represent relevant comparisons to Maricopa County.

Overview of Findings and Recommendations

See Table 1 for a summary of findings and recommendations regarding the accessibility and provision of the priority services. The current review period primarily targets calendar year (CY) 2022, though for some units of analysis that rely on service utilization data, the timeframe was adjusted (e.g., October 2021–June 30, 2022 and October 2021–December 2022) to account for potential lags in processing administrative claims data.

Service Capacity Assessment Conclusions

Mercer's service capacity assessment found decreases in the percentage of members utilizing the priority mental health services during CY 2022 when compared to CY 2021 and CY 2020 as depicted in the following tables.

Table 1 — Summary of Priority Mental Health Services Utilization, CY[1] 2022, CY 2021, and CY 2020

CY 2022 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	37,107	31%	3%	30%	17%	5.7%[2]

CY 2021 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	36,718	37%	4%	32%	22%	6.2%

[1] Calendar Year (CY) referenced in this context refers to the time period October 1, 2020 through December 31, 2021.

[2] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 5.7% of all active SMI recipients are assigned to ACT teams.

CY 2020 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	35,114	41%	6%	34%	22%	6.6%

Opportunities to improve the identification of need, access to the services, and sufficiency of the system to meet the needs of persons with SMI, as well as system strengths, are noted below.

CY 2022 and the Ongoing Impact of the COVID-19 Pandemic

Residual effects stemming from the COVID-19 pandemic continued to present challenges with accessing the priority mental health services during CY 2022. Workforce challenges among service providers is a significant challenge and has resulted in referral holds being placed on some ACT teams and may be contributing to an overall decrease in utilization across all of the priority mental health services.

Consumer Operated Services (Peer Support and Family Support)

Thirty-one percent of all members with a SMI received at least one unit of peer support during the period of October 1, 2021 through December 31, 2022; a decrease from the prior review period in which 37% of members received peer support services. Peer support specialists are available within the health home clinics, through multi-disciplinary teams providing ACT team services, via participation in an expansive array of clinic-based education and support groups, and/or within the community by attending one of many available consumer operated peer support programs.

Service utilization data demonstrates that 3% of members received at least one unit of family support services during 2022, a reduction of one percentage point when compared to last year. There continues to be a lack of education about the availability and benefit of family support services. Some case managers were able to describe the role of a family support specialist, but half of the adult member focus group participants were unaware of what constitutes family support services.

Supported Employment

Service utilization data demonstrates 30% of members received at least one unit of supported employment during CY 2022, a decrease of 2% from last year and continuing a trend of year-to-year decreases in utilization.

Case managers and provider participants shared positive feedback about co-located employment providers who are active at the clinics. Case managers were pleased that some now attend morning meetings and the providers shared they are working hard to

reconnect with clinical teams following the pandemic.

In a large number of medical records reviewed by Mercer, there were inconsistencies between the functional assessment and the ISP, with the assessment typically including an explicit statement from the member that they did not wish to pursue employment opportunities. Yet, in many of these same cases, the clinical team listed supported employment services on the ISP in the absence of any assessed need. As a result, 66% of the cases lacked evidence that the member received supported employment services despite the service being listed on the ISP. ISPs are not always based on the member's assessed or individualized needs and can include generic language and/or services that fail to differentiate each member's unique circumstances and needs. In other cases, there is evidence that clinical team members do not understand the appropriate application of supported employment services and/or list supported employment service codes (e.g., H2027, H2025) to reflect the health home's policy to have all members meet with a rehabilitation specialist one time per year to complete a vocational activity profile.

Supportive Housing

Service utilization data reveals that 17% of members received at least one unit of supportive housing during the review period, a significant decrease when compared to the last two years (22% in CY 2021 and CY 2022). In addition, over 1,500 less members received supportive housing services during CY 2022 when compared to CY 2021.

Sixty-three percent of the survey respondents reported that it would take an average of six weeks or longer to access supportive housing services. When asked about the factors that negatively impact accessing supportive housing services, 23% of the responses indicated staff turnover.

Housing related challenges include a lack of housing vouchers, ambiguity regarding how homelessness is defined to qualify for services, a lack of affordable housing, a lack of housing accepting subsidies, members struggling with substance abuse disorders, and safety issues with available housing (e.g., one placement recently failed inspections on three different occasions due to safety concerns with the housing unit).

Assertive Community Treatment

As a percentage of the total population with SMI, 5.7% of all members are assigned to an ACT team. Almost 150 less members are utilizing ACT when compared to CY 2021.

Provider workforce challenges have resulted in temporary holds for transitioning new referrals to the ACT teams. Recruiting and retaining nurses on the ACT teams has been particularly challenging with one provider reporting 40% to 50% of ACT team nursing positions as vacant.

One ACT provider participating in the focus group states that their ACT teams recently transitioned to a four-day, 10 hour per day work schedule, hired a dedicated staff person to assist with the transcription of progress notes, and offers staff two hours per day of do-not-disturb time. The provider reports that the changes have improved staff morale, increased productivity levels, and has resulted in reduced staff burnout.

General Findings and Recommendations

Mercer also noted additional findings and recommendations to improve the appropriate identification and, when indicated, the provision of the priority mental health services members who may benefit from the services. Opportunities identified this year include:

- Perform an assessment of the work processes at the health homes that focuses on the timely implementation of members' ISPs, including timely referral to needed services. Consider initiating referrals on the same day that the member's ISP is reviewed/updated.
- Continue efforts to monitor the timely completion of annual member assessments and ISPs. When compiling the sample for medical record reviews, 11% of the cases (from a sample of 200) did not include current assessments/ISPs.
- Consider a one-time review of health home new employee orientation and ongoing training curriculum to ensure that health home clinical team members understand the appropriate application of the priority mental health services and how to assist members with accessing the services when medically necessary.
- Review each contracted health home's electronic medical record templates for documenting assessments and ISPs and ensure that the templates include all minimum data fields. Mercer noted that one provider's ISP template does not include a field to identify the covered services needed to address the member's objectives and needs.

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

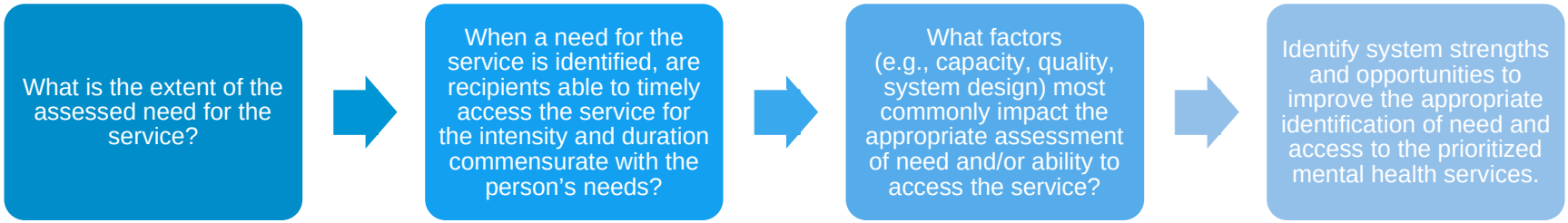
Section 2

Overview

The Arizona Health Care Cost Containment System (AHCCCS) (hereafter referred to as Arizona or State) retained 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 consumer operated services (peer support services and family support services), supported employment, supportive housing, 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 prioritized 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 from AHCCCS. Service utilization data includes encounter submission lag times that are known to impact the completeness of the data set, although some units of analysis were adjusted to accommodate potential claims run-out limitations. Mercer performed an

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

analysis of summary level service utilization data related to the prioritized mental health services and aggregated available functional and clinical outcomes data.

Section 3

Background

AHCCCS serves as the single Arizona authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health system. AHCCCS contracts with managed care organizations to administer integrated physical health and behavioral health services throughout the State. AHCCCS administers and oversees the full spectrum of covered 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 Arizona Department of Health Services and Maricopa County, did not adequately fund a comprehensive mental health system as required by State statute. The lawsuit, referred to as Arnold v. Sarn, sought to enforce the community mental health treatment system on behalf of persons with SMI in Maricopa County.

On May 17, 2012, former Arizona Governor Jan Brewer, State health officials, and plaintiffs' attorneys announced a two-year agreement that included funding for recovery-oriented services including supported employment, living skills training, supportive 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 extends access to community-based services and programs agreed upon by the State and plaintiffs, including crisis services; supported employment and supportive housing services; ACT; family and peer support; life skills training; and respite care services. The State 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 evaluate the delivery of care to persons with SMI.

Serious Mental Illness Service Delivery System

AHCCCS contracts with managed care organizations to deliver integrated physical health and behavioral health services in three geographic service areas (GSAs) across Arizona. Each contractor (also known as a managed care contractor) must manage a network of providers to deliver all covered physical health and behavioral health services to Medicaid eligible persons determined to have an SMI. The managed care organizations contract with behavioral health providers to provide the full array of covered physical health and behavioral health services, including the prioritized mental health services that are the focus of this assessment. In addition to Medicaid eligible members, system

administrators must ensure that all medically necessary covered behavioral health services are available to enrolled adult individuals (i.e., non-Title XIX) who meet established criteria for SMI.

For persons determined to have a SMI in Maricopa County, the designated managed care organization has contracts with multiple administrative entities that manage ACT teams and/or operate health homes throughout the GSA. Table 2 below identifies the administrative entities and assigned health homes.

Table 2 — Maricopa County Health Homes

Organization	Health Home	Organization	Health Home
Alium	Ironwood	Intensive Treatment Systems	West Clinic Access Point
		Lifewell Behavioral Wellness	Desert Cove
Chicano Por La Causa (CPLC)	Centro Esperanza		Oak
Community 43	16th Street		South Mountain
Community Bridges, Inc.	Mesa Heritage		Windsor
Community Partners Integrated Healthcare, Inc. (CPIH)	Osborn		
Copa Health	Arrowhead Campus	Resilient Health	Higley
	East Valley Campus		1st Street
	Gateway Campus	Southwest Behavioral and Health Services	Buckeye Outpatient
	Hassayampa Campus		
	Metro Campus	Southwest Network	Estrella Vista
	West Valley Campus		Northern Star
			Saguaro
			San Tan
Horizon Health and Wellness	Plaza	Spectrum	Anywhere Care

Organization	Health Home	Organization	Health Home
Jewish Family and Children Services	Queen Creek		
	Michael R. Zent Healthcare Clinic	Terros	Priest
	East Valley Health Center		23rd Avenue
La Frontera/EMPACT	Apache Junction		51st Avenue
	Comunidad		
	San Tan		
	Tempe		
Valleywise	First Episode Center	Valle Del Sol	Red Mountain
	Mesa Behavioral Health Specialty Clinic		

Current Service Capacity

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

Table 3 — ACT Teams (24 teams serving 2,117 recipients)[5]

Health Home Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Community Bridges: 99th Avenue	Primary Care Provider (PCP) Partnership	100	70	30%
Community Bridges: Avondale	PCP Partnership	100	82	18%

[4] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2023.

[5] As of December 1, 2022.

Health Home Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Community Bridges: Forensic Assertive Community Treatment (FACT) Team 1	Forensic Team & PCP Partnership	100	69	31%
Community Bridges: FACT Team 2	Forensic Team & PCP Partnership	100	69	31%
Community Bridges: FACT Team 3	Forensic Team & PCP Partnership	100	79	21%
Community Bridges: Mesa Heritage	PCP Partnership	100	88	12%
La Frontera/EMPACT: Tempe	PCP Partnership	100	91	9%
La Frontera/EMPACT: Capitol Center	PCP Partnership	100	80	20%
La Frontera/EMPACT: Comunidad	PCP Partnership	100	91	9%
Lifewell Behavioral Wellness: Desert Cove	PCP Partnership	100	82	18%
Lifewell Behavioral Wellness: South Mountain	PCP Partnership	100	92	8%
Copa Health: Gateway	PCP Partnership	100	97	3%
Copa Health: Metro Campus — Omega Team	PCP Partnership	100	96	4%
Copa Health: Metro Campus — Varsity Team	PCP Partnership	100	96	4%
Copa Health: West Valley	Medical Team	100	89	11%
Copa Health: West Valley Campus	PCP Partnership	100	93	7%
Southwest Network: Northern Star	PCP Partnership	100	95	5%
Southwest Network: Saguaro	PCP Partnership	100	95	5%
Southwest Network: San Tan	PCP Partnership	100	94	6%
Terros: 51st Avenue	PCP Partnership	100	97	3%
Terros: Enclave		100	88	12%

Health Home Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Terros: 23rd Avenue Recovery Center ACT 1 (Formerly Townley 1)	PCP Partnership	100	98	2%
Terros: 23rd Avenue Recovery Center ACT 2 (Formerly Townley 2)		100	96	4%
Valleywise: Mesa Riverview	PCP Partnership	100	90	10%
Totals		**2,400**	**2,117**	**11.8%**

Current Service Utilization

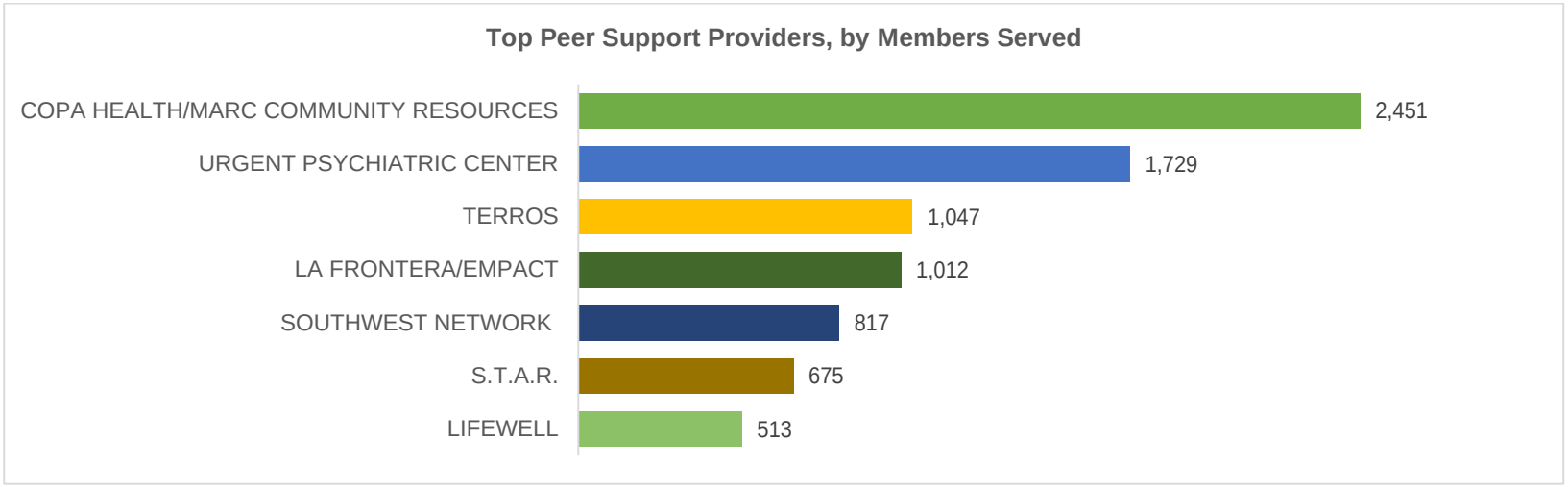
An analysis of service utilization data is presented below to identify the volume of units and unique members affiliated with each priority mental health service provider. The results identify the most prominent providers of the priority mental health services. The analysis was completed for the following priority mental health services: peer support, family support, supported employment, and supportive housing.

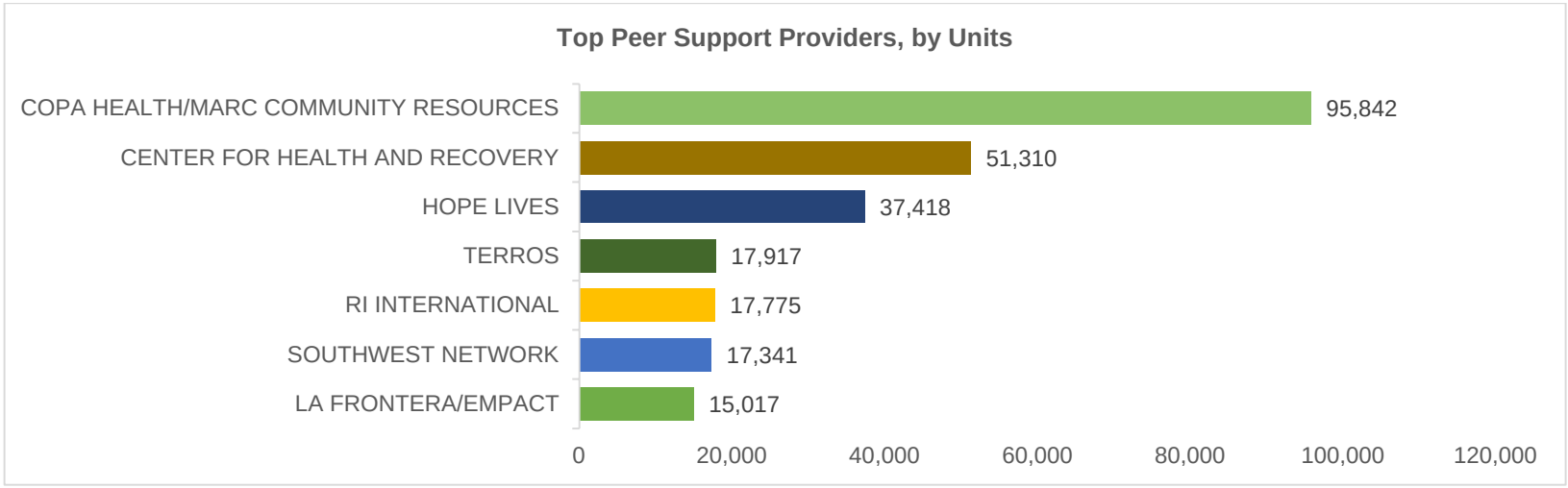
Consumer Operated Services (peer support and family support) Providers[6]

- Arizona Women's Recovery Center
- CHEEERS
- CPLC
- Community Bridges, Inc.
- CPIH
- Copa Health/Marc Community Resources
- Hope Lives — Vive la Esperanza

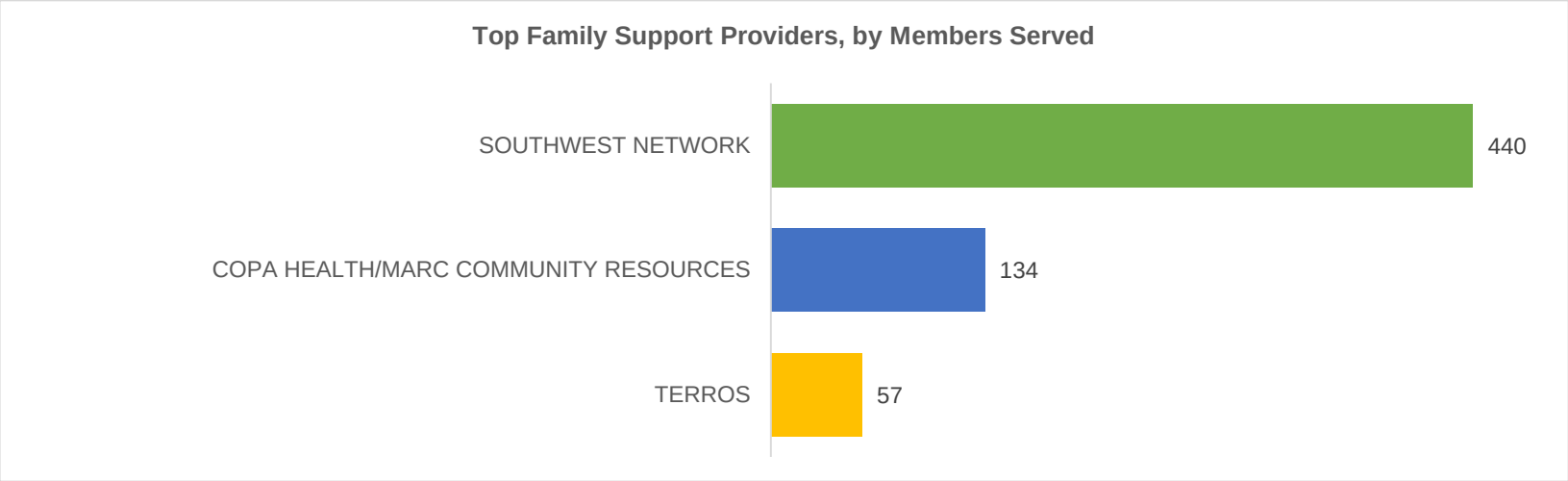
[6] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2023.

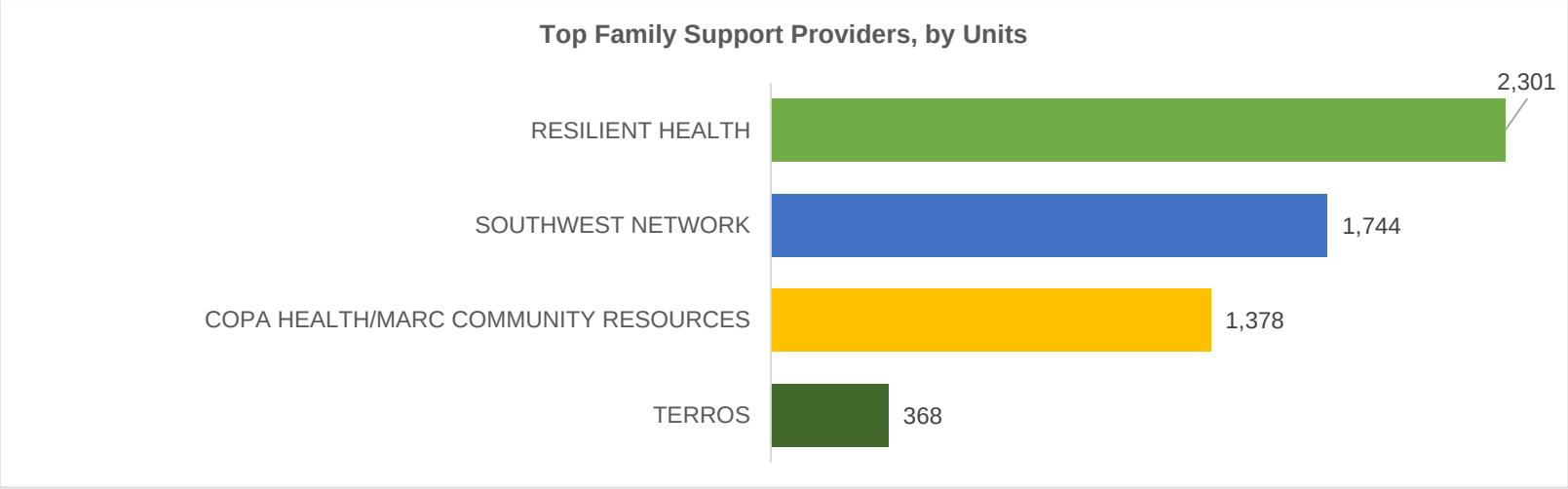
- Horizon Health and Wellness
- La Frontera/EMPACT
- Lifewell Behavioral Wellness
- NAZCARE
- Recovery Empowerment Network
- Recovery Innovations
- Resilient Health
- Southwest Behavioral Health
- Southwest Network
- Stand Together and Recover (S.T.A.R.)
- Terros
- Valle del Sol
- Valleywise Health


Top Peer Support Providers, by Members Served
COPA HEALTH/MARC COMMUNITY RESOURCES
2,451
URGENT PSYCHIATRIC CENTER
1,729
TERROS
1,047
LA FRONTERA/EMPACT
1,012
SOUTHWEST NETWORK
817
S.T.A.R.
675
LIFEWELL
513


Top Peer Support Providers, by Units
COPA HEALTH/MARC COMMUNITY RESOURCES
95,842
CENTER FOR HEALTH AND RECOVERY
51,310
HOPE LIVES
37,418
TERROS
17,917
RI INTERNATIONAL
17,775
SOUTHWEST NETWORK
17,341
LA FRONTERA/EMPACT
15,017
0
20,000
40,000
60,000
80,000
100,000
120,000

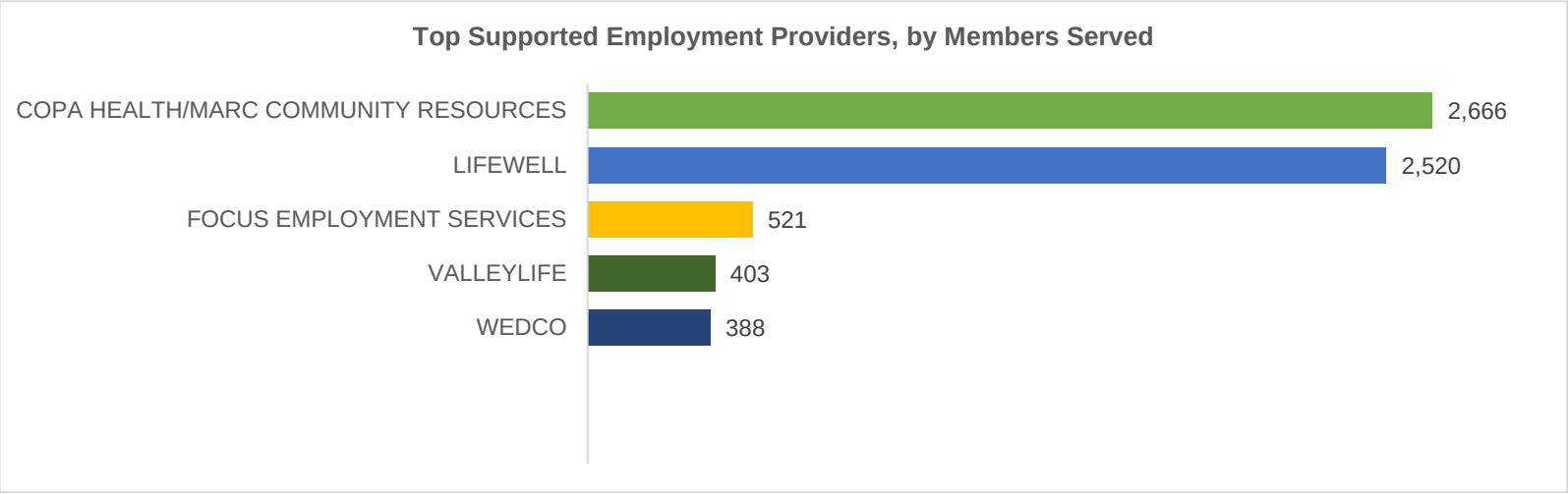
Consumer Operated Services (Family Support)



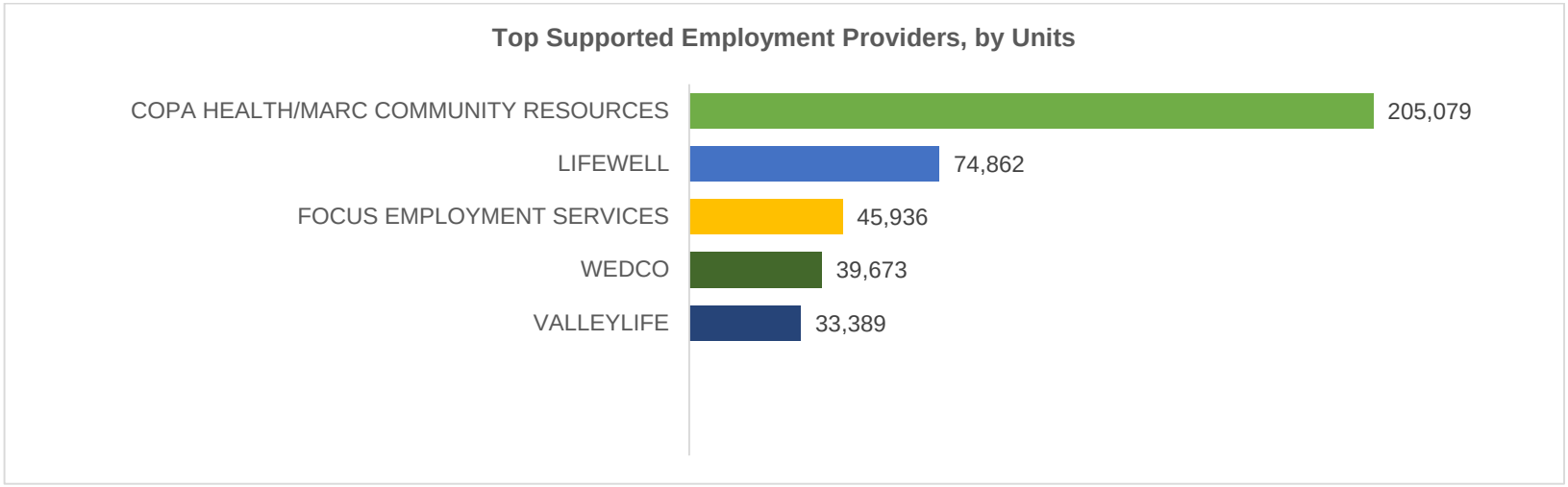


Supported Employment Providers[7]

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



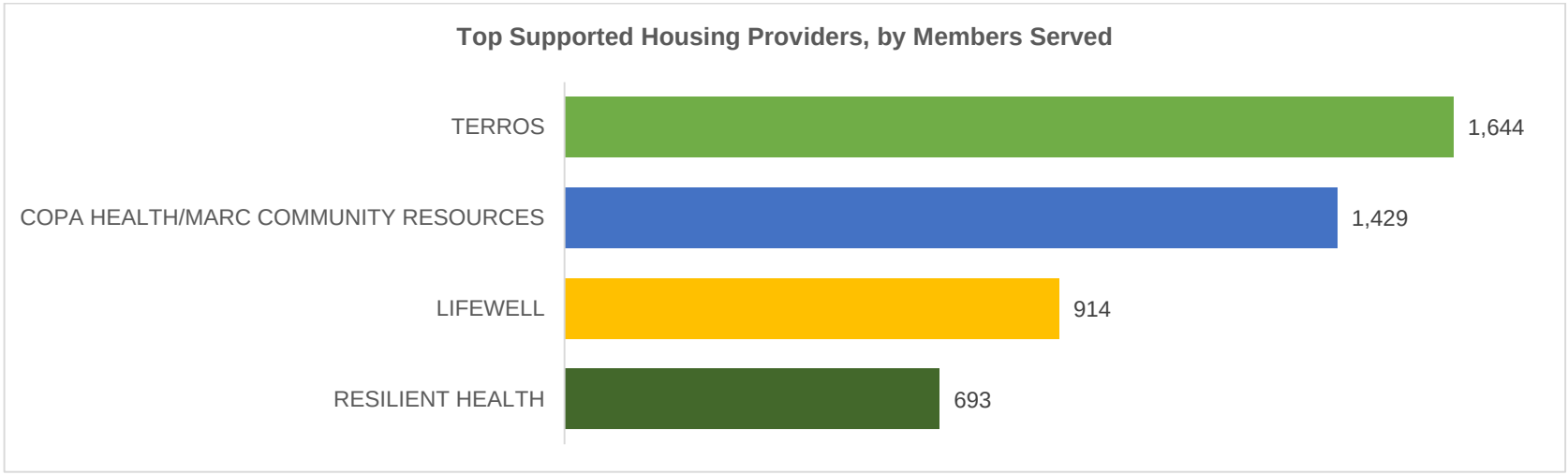
[7] As reported by the Maricopa County RBHAs administering the AHCCCS contract in January 2023.

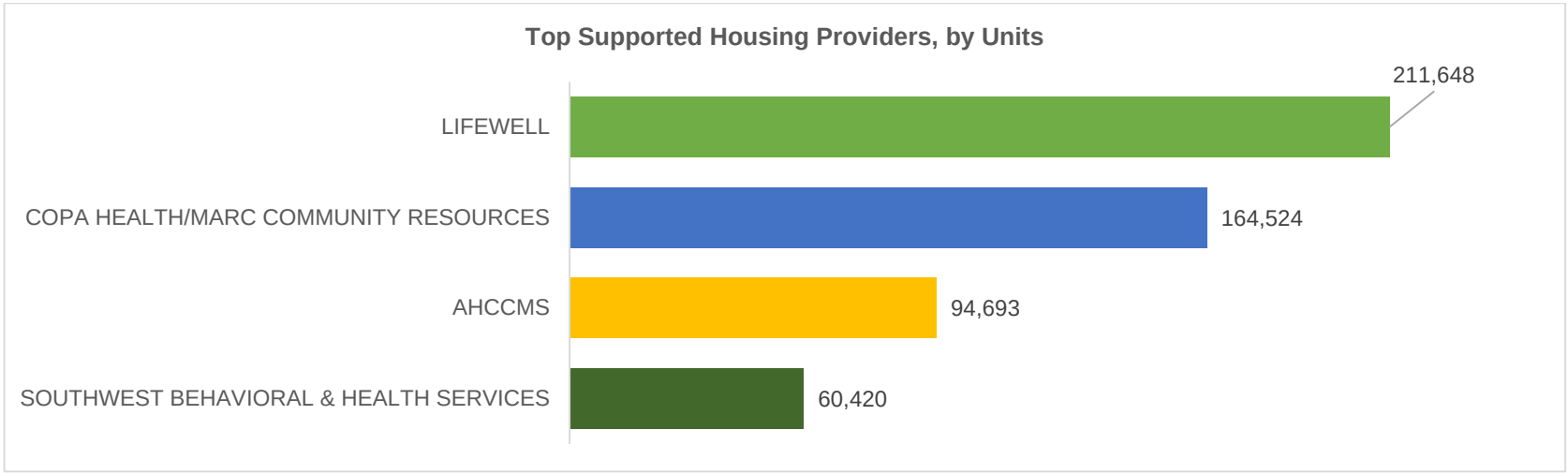

Top Supported Employment Providers, by Units
COPA HEALTH/MARC COMMUNITY RESOURCES
205,079
LIFEWELL
74,862
FOCUS EMPLOYMENT SERVICES
45,936
WEDCO
39,673
VALLEYLIFE
33,389

Supportive Housing Providers[8]

- Arizona Mentor
- AZ Health Care Contract Management Services (AHCCMS)
- Child and Family Support Services
- Community Bridges, Inc.
- Copa Health/Marc Community Resources
- Helping Hearts
- La Frontera/EMPACT
- Lifewell
- Native Connections
- Resilient Health
- RI International
- Southwest Behavioral & Health Services
- Terros

[8] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2023. Supportive housing service providers include the temporary housing assistance program, permanent supportive housing services (scattered site and community-based), and community living program providers.


Top Supported Housing Providers, by Members Served
TERROS
1,644
COPA HEALTH/MARC COMMUNITY RESOURCES
1,429
LIFEWELL
914
RESILIENT HEALTH
693


Top Supported Housing Providers, by Units
LIFEWELL
211,648
COPA HEALTH/MARC COMMUNITY RESOURCES
164,524
AHCCMS
94,693
SOUTHWEST BEHAVIORAL & HEALTH SERVICES
60,420

Section 4

Methodology

Each year, Mercer performs a service capacity assessment of the priority mental health services to assess unmet needs and utilizes the following methods:

- *Key informant surveys, interviews, and focus groups:* Mercer solicits feedback from key informants via interviews and surveys. In addition, members, family members, case managers, and providers participate in focus groups to solicit information about the availability of the priority mental health services.
- *Medical record reviews:* A random sample (n=200) of class members is drawn to support an evaluation of clinical assessments, individual service plans (ISPs), and progress notes. The chart review examines the extent to which recipient's needs for the priority services are assessed and met.
- *Analysis of service utilization data and contracted capacity for each of the priority mental health services:* Mercer evaluates the volume of unique users, billing units, and identifies the most prevalent providers of the priority mental health services. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis is 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. The persistence in treatment analysis includes additional progressive time intervals (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 during the review period.
- *Analysis of outcomes data:* Analysis of data including employment data and criminal justice information.
- *Benchmark analysis:* Analysis of priority service penetration rates in other states and local systems that represent relevant comparisons to 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 discussions 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.[9]

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 administrative entities, providers of the priority mental health services, and to family and peer-run organizations. Mercer distributed the invitation multiple times to each set of key stakeholders to increase participant registration rates.

The focus groups targeted the following participants:

- Providers of supportive housing services, supported employment services, ACT team services, and peer and family support services.
- Family members of adults with SMI and receiving behavioral health services.
- Adults with SMI and receiving behavioral health services.
- Health home clinic case managers.

A total of 35 stakeholders participated in the four two-hour focus groups conducted on January 31, 2023 and February 1, 2023. All four focus groups were held in-person at a central location in the city of Phoenix, Arizona. Invitations to voluntarily participate in the focus groups were distributed to a defined list of stakeholders and the actual number of participants does not represent a statistically significant sample. As such, focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants.

The methodology included the following approach:

- Definitions of each of the priority mental health services were communicated 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, including the perceived ongoing impact of the COVID-19 pandemic.

[9] See Appendix A: Focus Group Invitation.

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. To meet this objective, a key informant survey was created using Qualtrics®. The survey tool includes questions with rating assignments related to accessing the priority mental health services, including the ease of access and timeliness of access to the services.[10] The survey distribution approach 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 not be construed to be representative of the total population of system stakeholders.

The survey was disseminated to key system stakeholders (e.g., service providers, administrators of health homes, etc.) via email with a hyperlink to the online survey. A total of 25 respondents completed the survey tool.

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

Medical Record Reviews

Mercer pulled a random sample of members and 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. The medical record sample consisted of adults with SMI who were widely distributed across administrative entities, health home clinics, and levels of case management (i.e., assertive, supportive, and connective).

The final sample included 200 randomly chosen cases stratified by fund source, administrative entity, and clinic, and selected using the following parameters:

- The recipient was identified with a SMI and received a covered behavioral health service during October 1, 2021 and December 31, 2022.[11]
- The recipient had an assessment and ISP date between January 1, 2022 and November 15, 2022.[12]

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

[10] See Appendix B: Key Informant Survey.

[11] The total population of unique recipients with SMI who received behavioral health services is 37,107 for the period October 1, 2021 through December 31, 2022.

[12] Cases for the sample 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.

- 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?
- 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, 2022. Issues with accessing current assessments and ISPs has been a long-standing challenge in performing the medical record reviews as the audit methodology requires access to an assessment and ISP within the designated review period. During calendar year (CY) 2022, 89% of the initially requested cases included current assessments and ISPs.

To complete the medical record audit, four licensed clinicians review medical record documentation and record results in a data collection tool. As applicable, additional comments may be added to the tool to further clarify scoring and findings. Inter-rater reliability testing prior to the medical record audit as well as documented scoring guidelines helps to ensure that each reviewer consistently applies the 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 includes all adjudicated service encounters for any person designated as SMI and assigned to the Maricopa County GSA with dates of service between October 1, 2021 and December 31, 2022.

Specific queries are run to identify utilization of each prioritized mental health service.[13] The analysis evaluates 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.

[13] 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.

To examine priority mental health service utilization for members assigned to an ACT team, Mercer reviews each ACT team member's service array and aggregates findings by priority service.

The service utilization data file supports the extraction of the medical record review sample 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 the sample group.

Sample characteristics for CY 2019–CY 2022 of the service capacity assessment are illustrated in the following tables and are compared to the characteristics of the total population of active users.

CY 2022 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample Group	200	37%	4%	46%	26%	8%
Service Utilization Data	37,107	31%	3%	30%	17%	5.7%[14]

CY 2021 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample Group	200	35%	5%	32%	22%	7%
Service Utilization Data	36,718	37%	4%	32%	22%	6.2%

CY 2020 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample Group	200	50%	1%	44%	5%	12%

[14] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 5.7% of all active recipients with SMI are assigned to ACT teams.

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	35,114	41%	6%	34%	22%	6.6%

CY 2019 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample Group	200	52%	6%	51%	22%	12%
Service Utilization Data	34,451	35%	5%	31%	15%	6.6%

Analysis of Outcomes Data

The service capacity assessment includes an analysis of member outcome data 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:

- Employment status
- Criminal justice records (i.e., number of arrests)

The outcome indicators listed above are described as part of the AHCCCS DUGless Portal Guide, which provides information for the completion and submission of the demographic data set, a set of data elements that contractors are required to collect and submit to AHCCCS. The data are 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.

- 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 member 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).

Employment Status

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

- 17 — Unpaid Rehabilitation Activity
- 20 — Student
- 24 — Competitively Employed Full-Time
- 25 — Competitively Employed Part-Time
- 28 — Other Employment
- 29 — Inactive in the Community
- 99 — Unknown

Penetration and Prevalence Analysis

As part of the service capacity assessment, a review of utilization and penetration rates of the prioritized mental health services (ACT, supported employment, supportive housing, and peer support[15]) was conducted. Penetration rates were compared to benchmarks, as described below.

The following review process was completed by Mercer:

- Review of select academic publications.
- Consultation with national experts regarding the prioritized services and benchmarks for numbers served.
- Review of data from the Substance Abuse and Mental Health Services Administration on evidence-based practice (EBP) penetration rates at the State and national level.

The intent in reviewing these sources was to identify average and best practice benchmarks for EBP penetration. *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 in a study.

Please note that data for Maricopa County included in this report generally cover CY 2022, whereas some of the comparison states and communities have not updated their publicly available data sets since 2020 because of the public health emergency.

[15] Peer support services are not currently reported on the Substance Abuse and Mental Health Services Administration's National Outcome Measures (NOMS) interview tool.

Section 5

Findings and Recommendations

Findings and recommendations associated with each of the priority mental health services is summarized for each evaluation component that comprise the service capacity assessment. Key findings identify how effectively the overall service delivery system is performing to identify and meet member needs through the provision of the priority mental health services.

The service capacity assessment includes the following distinct evaluation components:

- Penetration and prevalence analysis
- Multi-evaluation component analyses of each priority mental health service:
  - Focus groups
  - Key informant survey data
  - Medical record reviews
  - Service utilization data
- Outcomes data analyses

5.1 Serious Mental Illness Prevalence and Penetration — Overview of Findings

Service system penetration is defined as the percentage of people who received services among the estimated number of people considered eligible for services during a specified period. As detailed in Table 1, 19% of the estimated number of adults with SMI in Maricopa County were served in the publicly funded system in 2022. This penetration rate is lower than the national (publicly funded) penetration rate of 30%; however, it is higher than some statewide rates and is similar to rates of certain communities of a similar size. Within the Maricopa County Medicaid system, the penetration rate (44%) exceeds the national average (30%) and the rates of similarly sized regions in Texas (i.e., Harris County [Houston] and Bexar County [San Antonio], which have penetration rates of 29% and 28%, respectively). Thus, Maricopa County's lower overall penetration rate appears to result from the low penetration rate among people without Medicaid coverage (6%). During the COVID-19 public health emergency, many states (including Arizona) expanded their Medicaid-eligible populations.

The Maricopa County system's utilization rates excel for certain EBPs. For example, supportive housing and supported employment are more available in Maricopa County (especially for Medicaid recipients) than for people with SMI nationally. Maricopa County also provides strong access to peer support services in what could be considered a best practice benchmark. In addition, Maricopa County provides ACT to a greater percentage of the eligible population than most comparison communities that were included in this analysis. In Maricopa County, 2,117 individuals were assigned to ACT teams in 2022. A study by ACT researchers estimated that 4.3% of adults with SMI served in a mental health system need an ACT-level of care.[16] Few of the identified comparison communities provide ACT to 4.3% or more of their adults who have SMI, but 5.7% of adults with SMI residing in Maricopa County received ACT in 2022.

Maricopa County has 24 ACT teams, including specialty ACT teams such as teams that partner with PCPs, medical specialty teams, and forensic teams. Some people in need of ACT-level services also live with chronic (and sometimes acute) physical health conditions. People with co-occurring high physical and mental health needs are best served by a team that works closely with a PCP and, when possible, other medical professionals. Maricopa County has 22 ACT teams that integrate medical professionals (Medical ACT or M-ACT) or partner with PCPs (PCP Partnership ACT Teams). There are three FACT teams that serve adults with SMI who have a history of high utilization of the criminal justice system (the FACT teams include PCP partnerships). This allocation of resources for justice-involved people reflects responsiveness to the stated concerns of many system stakeholders that more needs to be done to address the needs of people who have both SMI and histories of criminal justice system involvement. In addition, each of the three FACT teams includes a PCP partnership. Maricopa County's array of ACT and FACT offerings is very comprehensive in comparison to other large counties, nationally.

[16] Cuddeback, G. S., Morrissey, J. P., Cusack, K. J. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803–1806. The estimate of 4.3% was based on findings from an analysis of data of the services for people with SMI in the Portland, Oregon, area.

Table 1 — Service System Penetration Rates for Individuals with SMI

Penetration Rates					
Region	**Adult Population (≥ 18 Years Old)[17]**	**Estimated Rate of SMI in the Adult Population[18]**	**Estimated Number of Adults with SMI in the Population[19]**	**Number of Adults with SMI Served[20]**	**Penetration Rate Among Adults with SMI[21]**
United States	258,327,312	5.5%	14,336,481	4,308,677	30%
Arizona	5,662,328	5.6%	318,703	126,433	40%
Maricopa County[22]	3,460,218	5.6%	192,868	37,107	19%
Adults with Medicaid	786,775	8.6%	67,663	29,611	44%
Non-Medicaid Adults	2,673,443	4.7%	125,205	7,496	6%
Texas	22,052,508	5.7%	1,252,239	316,774	25%
Harris County (Houston)	3,487,128	3.4%	117,300	33,840	29%
Bexar County (San Antonio)	1,519,807	3.5%	52,769	14,884	28%
New York	15,722,590	4.2%	664,503	544,572	82%

[17] All state-level population estimates are based on the U.S. Census Bureau, Population Division. *Estimates of the total resident population and resident population age 18 years and older for the United States, States, and Puerto Rico: July 1, 2020*.

[18] National and state-level SMI estimates: Substance Abuse and Mental Health Services Administration. (2022). *2019-2020 National Survey on Drug Use and Health: Model-based prevalence estimates (50 states and the District of Columbia)*. Available at: https://www.samhsa.gov/data/report/2019-2020-nsduh-state-prevalence-estimates

County-level SMI estimates: Substance Abuse and Mental Health Services Administration. (2022). *2018-2020 NSDUH substate region estimates – tables.* Available at: https://www.samhsa.gov/data/report/2018-2020-nsduh-substate-region-estimates-tables

[19] The estimated number of adults with SMI is calculated by multiplying the estimated rate of SMI in the adult population by the adult population in the region or state.

[20] The national and state-level percentages of people with SMI served were obtained from Substance Abuse and Mental Health Services Administration. (2022). *2020 Uniform Reporting System (URS) output tables*. Available at: https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables

[21] The penetration rate of people with SMI served among those with SMI in the community is calculated by dividing the number of adults with SMI served within the system (for states, see calculation note above) by the estimated number of adults with SMI in the adult population.

[22] The number of people with SMI served in Maricopa County is based on Arizona Health Care Cost Containment System's 2021 service utilization data file.

Penetration Rates					
Region	**Adult Population (≥ 18 Years Old)[17]**	**Estimated Rate of SMI in the Adult Population[18]**	**Estimated Number of Adults with SMI in the Population[19]**	**Number of Adults with SMI Served[20]**	**Penetration Rate Among Adults with SMI[21]**
New York County (New York City)[23]	1,381,874	4.8%	66,579	91,191	137%
Colorado	4,568,613	6.0%	274,486	78,134	28%
Denver City/County[24]	579,002	5.9%	34,070	19,087	56%
Nebraska	1,480,808	7.6%	113,110	12,304	11%
California	30,465,205	6.1%	1,859,407	403,665	22%
Kansas	2,231,518	6.5%	145,768	12,736	9%
Minnesota	4,389,823	5.5%	240,972	153,994	64%
Wisconsin	4,621,152	6.0%	277,039	29,491	11%
Tennessee	5,434,544	6.5%	352,634	213,937	61%
Indiana	5,218,979	6.0%	313,972	87,227	28%
Delaware	795,090	4.3%	34,188	7,705	23%
New Hampshire	1,132,616	5.2%	58,608	15,367	26%
North Carolina	8,249,659	5.3%	433,263	67,702	16%

[23] Utilization data were obtained by personal communication with Marleen Radigan, Dr.PH, MPH, MS, Research Scientist VI and Director in the Office of Performance Measurement and Evaluation within the New York State Office of Mental Health, May 2019. No update is available since the COVID-19 pandemic began in 2020.

[24] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative director Kim Foust and her staff at the Mental Health Center of Denver, May 26, 2023.

Overview of EBP Utilization Benchmark Analyses

Table 2 shows the utilization rates of ACT, supported employment, and supportive housing among adults with SMI served in the Maricopa County behavioral health system. Maricopa County has an ACT utilization rate of 5.7%, which exceeds researchers' best estimate of the percentage of people with SMI who need ACT (4.3%).[25] The county's utilization rates for supportive housing and supported employment services also exceed the national average benchmarks. Maricopa County's supported employment utilization rate of 30% and ongoing supported employment utilization rate of 6.5% (considered closer to high-fidelity supported employment) are among the highest in this benchmark analysis. For example, the national utilization rate for supported employment is less than 2%. Given that the vast majority of people with SMI served in the public system are unemployed, supported employment is a vital EBP that is under-utilized across the country. The utilization rate for supportive housing (17%) in Maricopa County also is much higher than the national average (2.2%) and the utilization rates of all other regions in the analysis. The availability of supportive housing is important in preventing chronic homelessness among the population of people with SMI.

Table 2 — EBP Utilization Rates among People with SMI Who Were Served in the System[26]

EBP Utilization Rates						
Region	ACT		Supported Employment		Supportive 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
United States	71,933	1.7%	65,963	1.5%	93,371	2.2%
Arizona	Not Available[27]	Not Available	13,333	10.5%	1,006	0.8%
Maricopa Co. (2021)[28,29]	2,117	5.7%	11,011	29.7%	6,412	17.3%

[25] Cuddeback, G. S., Morrissey, J. P., Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803–1806. Note that the 4.3% figure does not include some people who would only be eligible for FACT and not ACT, whereas the Maricopa County analysis includes people receiving ACT and FACT. Maricopa County's penetration rate for ACT excluding FACT (4.99%) is therefore even closer to the ideal figure of 4.3% that was drawn from the empirical work of Cuddeback and colleagues.

[26] National and state-level data on the number of people utilizing EBPs were obtained from Substance Abuse and Mental Health Services Administration. (2022). *2020 Uniform Reporting System (URS) output tables*. Available at: https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables

[27] Arizona's state mental health authority did not report the number of people served with ACT statewide to SAMHSA's mental health services Uniform Reporting System.

[28] Supported employment services in Maricopa County are associated with seven billing codes: H2025, H2025 HQ, H2025 SE, H2026, H2027, H2027 HQ, and H2027 SE. Codes H2025 through H2026 are labeled as ongoing support to maintain employment. H2027, H2027 HQ, and H2027 SE are labeled as psychoeducational services (pre-job training and development). For this analysis, we report both the unduplicated number of people who received any service associated with supported employment and separately those who received "ongoing" supported employment. The ongoing billing codes are most likely to indicate high-fidelity supported employment. We also do not know the extent to which the figures from other regions and states represent actual, evidence-based SE.

[29] The number served in Maricopa County with evidence-based services is based on Arizona Health Care Cost Containment System's 2021 service utilization data file.

EBP Utilization Rates						
Region	ACT		Supported Employment		Supportive 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
Maricopa Co. — Medicaid	1,748	5.9%	9,142	30.9%	5,525	18.7%
Maricopa Co. — non-Medicaid	369	4.9%	1,869	24.9%	887	11.8%
Maricopa County (Supported Employment Ongoing)[30]	*Not Applicable*	*Not Applicable*	*2,423*	*6.5%*	*Not Applicable*	*Not Applicable*
Texas	7,982	2.5%	8,887	2.8%	8,274	2.6%
Harris County (Houston)	1,178	3.5%	3,327	9.8%	1,063	3.1%
Bexar County (San Antonio)	186	1.2%	275	1.8%	1,048	7.0%
New York	8,205	1.5%	848	0.2%	25,208	4.6%
New York County (New York City)[31]	1,218	1.3%	Not Available	Not Available	4,717	5.2%
Colorado	1,586	2.0%	1,101	1.4%	280	0.4%
Denver City/County (MHCD)[32]	581	1.7%	414	1.2%	1,685	4.9%
Nebraska	76	0.6%	661	5.4%	732	5.9%
California	5,220	1.3%	410	0.1%	1,127	0.3%
Kansas	Not available	N/A	855	6.7%	2,027	15.9%

[30] Ongoing supported employment refers to the employment/vocational services associated with obtaining and maintaining employment and excludes people who only received pre-job training and development services.

[31] Utilization data were obtained by with Marleen Radigan, Dr.PH, MPH, MS, Research Scientist VI and Director in the Office of Performance Measurement and Evaluation within the New York State Office of Mental Health, May 2019. No update is available since the COVID-19 pandemic began in 2020.

[32] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative director Kim Foust and her staff at the Mental Health Center of Denver, May 26, 2023.

EBP Utilization Rates						
Region	ACT		Supported Employment		Supportive 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
Minnesota	1,830	1.2%	1,675	1.1%	1,801	1.2%
Tennessee	108	0.1%	866	0.4%	814	0.4%
Indiana	952	1.1%	1,122	1.3%	3,139	3.6%
Delaware	715	9.3%	5	0.1%	94	1.2%
New Hampshire	1,211	7.9%	4,708	30.6%	Not available	Not available
North Carolina	4,416	6.5%	Not available	N/A	Not available	Not available

Changes in EBP Utilization from 2013 through 2022

Table 3 compares the utilization of ACT, supported employment, and supportive housing in Maricopa County from 2013 through 2022. The following are highlighted findings of the analysis comparing utilization/penetration rates across those years.

- *ACT*: Between 2013 and 2020, Maricopa County experienced a steady increase each year in the total number of adults with SMI who received ACT services, consistently achieving penetration rates that ranged from 6.4% to 7.0%, which exceed the benchmark penetration rate for ACT services (4.3%). The ACT penetration rate decreased in 2021 and 2022 to 6.2% and 5.7%, with the 24 ACT teams serving 2,117 people as of December 1, 2022. However, these decreases do not necessarily represent a decrease in the quality of care, as they indicate a penetration rate that is closer to the best estimate that we currently have of the percentage of people with SMI served in a publicly funded system who need ACT.
- *Supported Employment*: From 2021 to 2022, there were decreases in the overall penetration rate for supported employment (32.1% to 29.7%) and ongoing supported employment (7.0% to 6.5%). In 2020, the overall penetration rate for supported employment reached its highest point since 2013. The number of individuals who received *ongoing* supported employment during 2020 exceeded 3,200 unique individuals; this decreased to just over 2,500 people in 2021 and to just over 2,400 in 2022. However, the penetration rate for ongoing supported employment services in 2022 is four percentage points higher than it was in 2013 (6.5% versus 2.5%). Regardless, the penetration rate for SE is well below the level of need for SE, as is true nationally, as well.

- *Supportive Housing*: In the initial years of the penetration rate analysis, supportive housing was informed by a single supportive housing billing code that was infrequently used (H0043). As a result, the supportive housing penetration rate changes could not be accurately calculated between 2013 and 2014. A slight improvement in supportive housing utilization was evident from 2014 to 2015 (3.3% to 3.7% [using H0043]). In recognition that supportive housing services can incorporate myriad interventions and activities, an additional billing code (H2014: Skills Training and Development) was added in 2016 to accurately capture the provision of supportive housing services by contracted supportive housing providers. With the addition of the H2014 code, the supportive housing penetration rate increased from 3.7% in 2015 to 4.6% in 2016 and then to 6.6% in 2017. In 2018, additional service codes were included (T1019 and T1020: Personal Care Services; and H2017: Psychosocial Rehabilitation Services) when contracted supportive housing providers began rendering these services. As a result, the penetration rate for supportive housing more than doubled to 15.1% in 2018, and the total number of people served with supportive housing also increased significantly. The penetration rate for supportive housing increased substantially between 2019 (14.9%) and 2021 (21.8%) but decreased in 2022 to 17.3% (6,412 served).

Table 3 — Maricopa County EBP Utilization Rates: 2013 through 2022

Maricopa County EBP Utilization Rates among People with SMI Served in the System							
Year	Number of Adults with SMI Served	ACT		Supported Employment (SE)		Supportive Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[33]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2022)	37,107	2,117	5.7%	11,011	29.7%	6,412	17.3%
SE Ongoing	-	-	-	2,423	6.5%	-	-
Maricopa County (2021)	36,718	2,265	6.2%	11,790	32.1%	7,988	21.8%
SE Ongoing	-	-	-	2,567	7.0%	-	-

[33] For additional information regarding ongoing supported employment, see footnotes 14 and 16.

Maricopa County EBP Utilization Rates among People with SMI Served in the System							
Year	Number of Adults with SMI Served	ACT		Supported Employment (SE)		Supportive Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[33]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2020)	35,114	2,317	6.6%	11,890	33.8%	7,558	21.5%
SE Ongoing	-	-	-	3,265	9.2%	-	-
Maricopa County (2019)	34,451	2,278	6.6%	10,615	30.8%	5,149	14.9%
SE Ongoing	-	-	-	2,436	7.1%	-	-
Maricopa County (2018)	34,264	2,241	6.5%	9,861	28.8%	5,160	15.1%
SE Ongoing	-	-	-	2,376	6.9%	-	-
Maricopa County (2017)	31,712	2,233	7.0%	8,168	25.8%	2,098	6.6%
SE Ongoing	-	-	-	1,708	5.4%	-	-
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 EBP Utilization Rates among People with SMI Served in the System							
Year	Number of Adults with SMI Served	ACT		Supported Employment (SE)		Supportive Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[33]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
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%	Not Available	Not Available
SE Ongoing	-	-	-	515	2.5%	-	-

Chart 1 — Maricopa County Assertive Community Treatment (ACT) Utilization Rates: 2013 through 2022

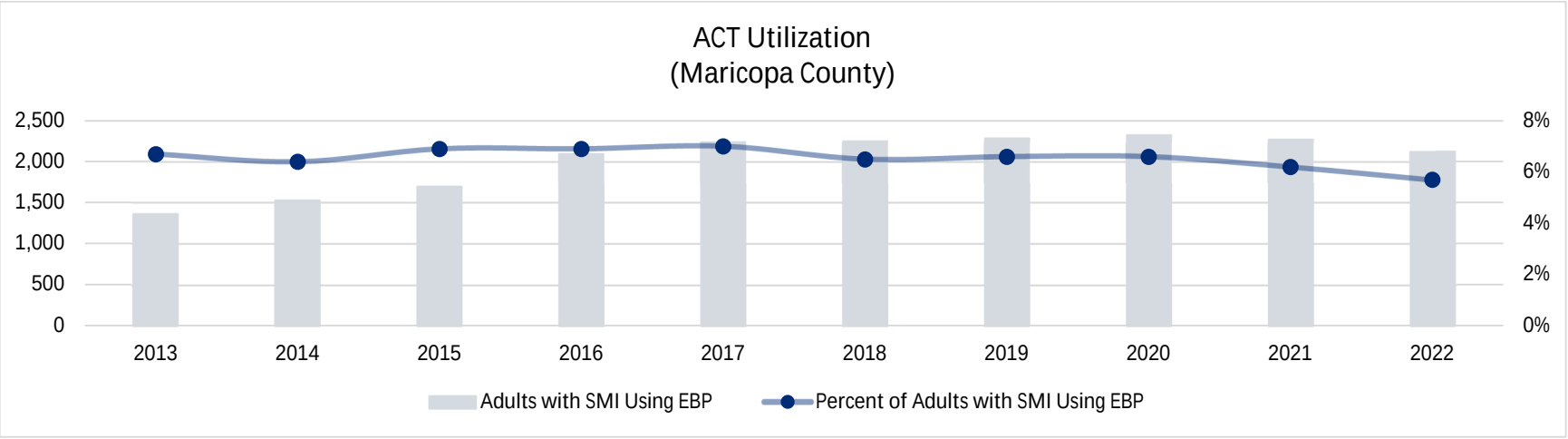


Chart 2 — Maricopa County Supported Employment Utilization Rates: 2013 through 2022

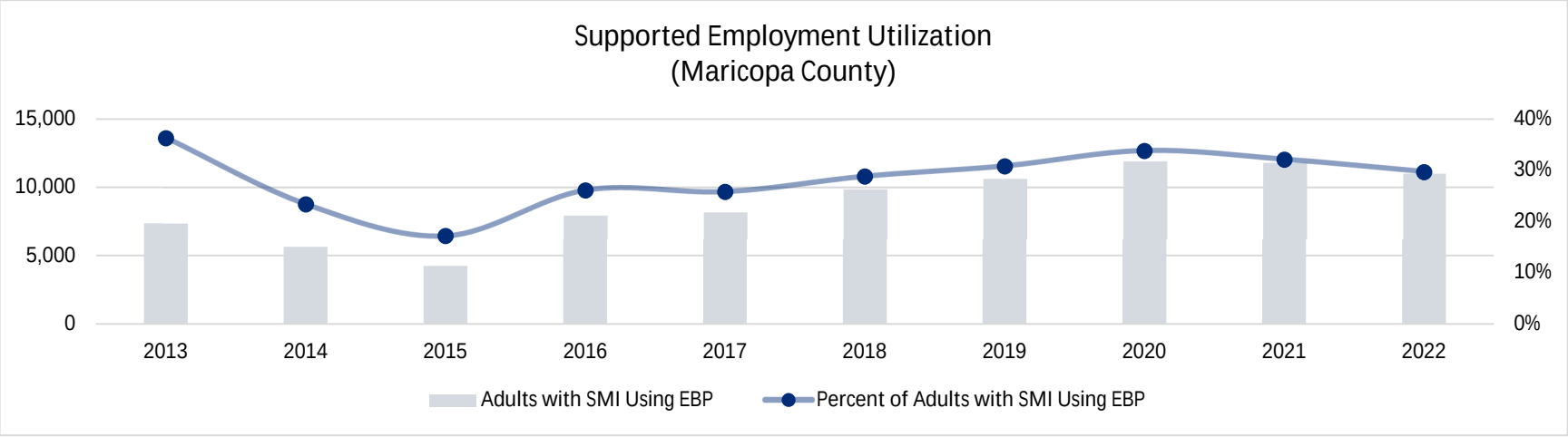


Chart 3 — Maricopa County Ongoing Supported Employment Utilization Rates: 2013 through 2022

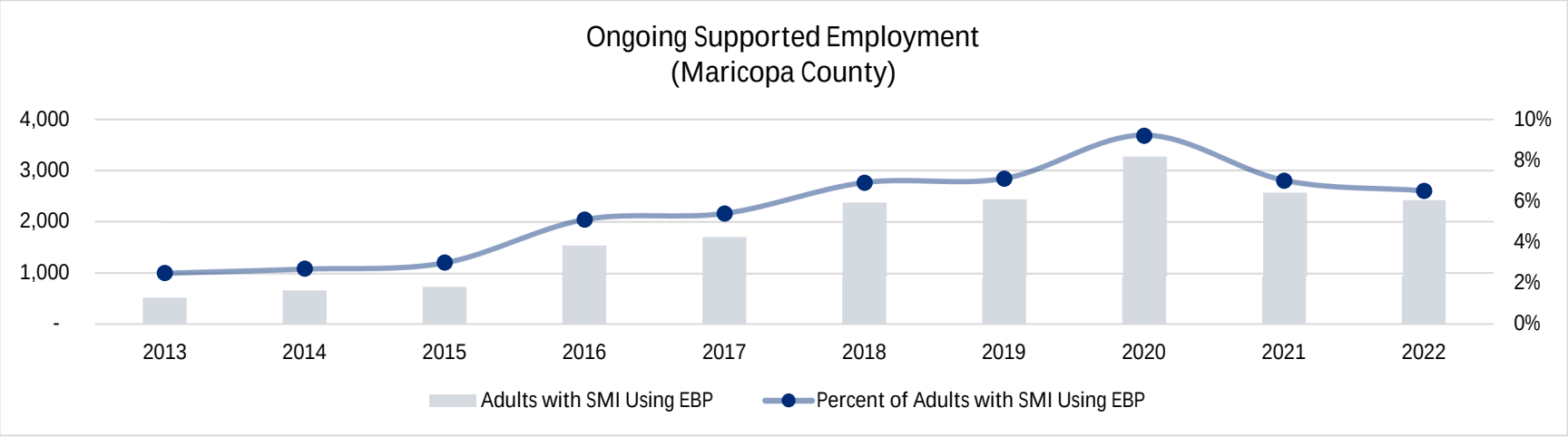
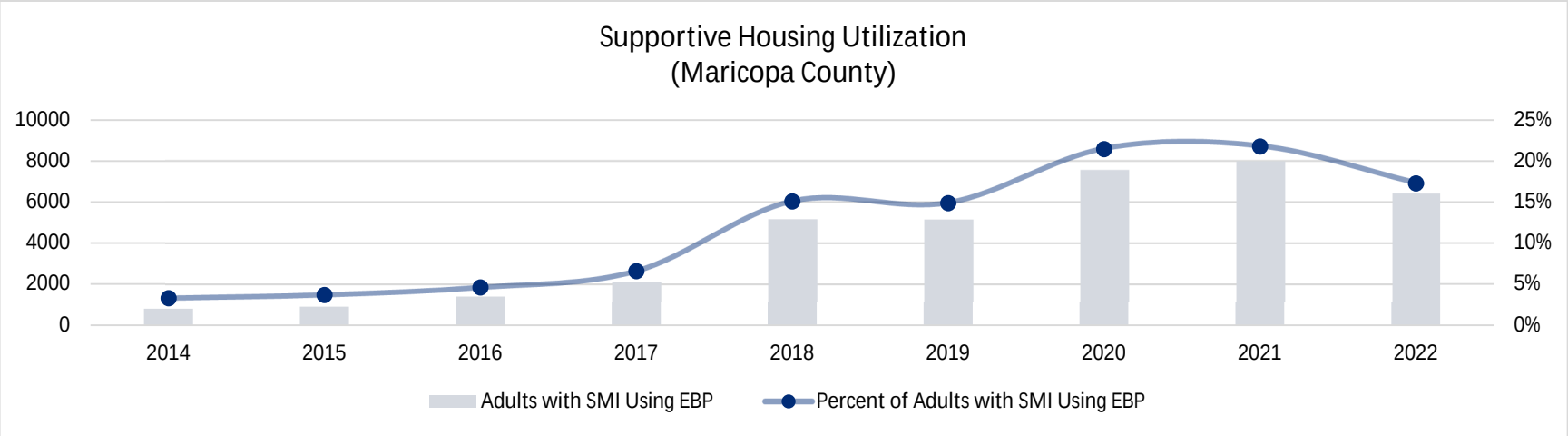


Chart 4 — Maricopa Supportive Housing Utilization Rates: 2014 through 2022



ACT Benchmarks

In an important 2006 study, Cuddeback, Morrissey, and Meyer estimated that over a 12-month period, 4.3% of adults with SMI in an urban mental health system needed an ACT level of care. The Maricopa County ACT penetration rate is presented in Table 4 relative to all people with SMI served in the system (as well as relative to the 4.3% estimate provided by Cuddeback, et al.).[34]

In recent years, Maricopa County has enhanced its capacity to provide ACT services to people with SMI. Its ACT penetration rate (5.7%) exceeds the benchmark in the Cuddeback et al. study (4.3%),[35] compares favorably with other communities nationally, and could be considered a best practice benchmark level, especially given that Maricopa County a) includes FACT teams that respond to the needs of adults with SMI who also have histories of involvement with the criminal justice system, and b) integrates physical health care into most of its teams.

Table 4 — ACT Utilization Relative to Estimated Need among People with SMI

ACT Utilization					
				ACT Penetration	
Region	Number of Adults with SMI Served in Public System[36]	Number of Adults Estimated to Need ACT[37]	Number of Adults Who Received ACT[38]	Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
Ideal Benchmark[39]	-	-	-	*4.3%*	*100%*
United States	4,308,677	185,273	71,933	1.7%	39%

[34] Some readers might conclude from this analysis that Maricopa County provides ACT to too many people with SMI, given that its penetration rate of 5.7% exceeds the estimated percentage of people with SMI in need of ACT (4.3%). However, it is important to note that the 4.3% estimate we use in this analysis was derived from a study conducted in Portland, Oregon almost 15 years ago. That study is the only United States-based study of its kind that we could find, that would be pertinent to Maricopa County, and it did use well-accepted criteria concerning the number of psychiatric hospitalizations that would indicate that a given person needs ACT. However, since the Cuddeback et al. study was conducted, ACT has been extended to people with SMI who have recurring involvement in the criminal justice system and who may or may not have enough hospitalizations to qualify for ACT. Maricopa County has extended ACT to these clients and the overall penetration rate for ACT likely is very close to actual level of need. A more in-depth study would be needed to verify that conclusion, but the overall finding is that Maricopa County is delivering a robust level of ACT as well as varying types of ACT to its clients who need that level of care.

[35] Cuddeback et al. also estimated the need for FACT; their 4.3% figure only includes those who need ACT. FACT is rarely provided, and although we do not have FACT benchmark data from comparison sites, any FACT services provided were included in this analysis.

[36] The national and state-level percentages of people with SMI served were obtained from Substance Abuse and Mental Health Services Administration. (2021). 2020 Uniform Reporting System (URS) output tables. Available at: https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables

[37] Cuddeback, G. S., Morrissey, J. P., Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803–1806. The authors stipulated that people with SMI needed an ACT level of care if they met three criteria: if they 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 one year.

[38] National and state-level penetration counts for ACT services received were obtained from Substance Abuse and Mental Health Services Administration. (2021). *2020 Uniform Reporting System (URS) output tables*. Available at: https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables. Arizona's state mental health authority did not report the number of people receiving ACT statewide to the Uniform Reporting System.

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

ACT Utilization					
Region	Number of Adults with SMI Served in Public System[36]	Number of Adults Estimated to Need ACT[37]	Number of Adults Who Received ACT[38]	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
Arizona	126,433	5,437	Not available	Not available	Not available
Maricopa Co.	37,107	1,596	2,117	5.7%	133%
Maricopa Co. — Medicaid	29,611	1,273	1,748	5.9%	137%
Maricopa Co. — non-Medicaid	7,496	322	369	4.9%	114%
Texas	316,774	13,621	7,982	2.5%	59%
Harris County (Houston)	33,840	1,455	1,178	3.5%	81%
Bexar County (San Antonio)	14,884	640	186	1.2%	29%
New York	544,572	23,417	8,205	1.5%	35%
New York County (New York City)[40]	91,191	3,921	1,218	1.3%	31%
Colorado	78,134	3,360	1,586	2.0%	47%
Denver County (MHCD)[41]	19,087	821	581	3.0%	71%
King County (Seattle, WA)	4,037	174	300	7.4%	173%
Nebraska	12,304	529	76	0.6%	14%
California	403,665	17,358	5,220	1.3%	30%

[40] Utilization data were obtained by with Marleen Radigan, D.Ph., MPH, MS, Research Scientist VI and Director in the Office of Performance Measurement and Evaluation within the New York State Office of Mental Health.

[41] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative director Kim Foust and her staff at the Mental Health Center of Denver, May 26, 2023.

ACT Utilization					
Region	Number of Adults with SMI Served in Public System[36]	Number of Adults Estimated to Need ACT[37]	Number of Adults Who Received ACT[38]	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
Minnesota	153,994	6,622	1,830	1.2%	28%
Tennessee	213,937	9,199	108	0.1%	1%
Indiana	87,227	3,751	952	1.1%	25%
Delaware	7,705	331	715	9.3%	216%
New Hampshire	15,367	661	1,211	7.9%	183%
North Carolina	67,702	2,911	4,416	6.5%	152%

Supported Employment Benchmarks

Maricopa County provides aspects of supported employment to a high percentage of those with estimated need for this EBP: 30% of people with SMI in the public mental health system received at least one vocational assessment or other type of pre-vocational service. However, the best estimate of the percentage of individuals who received high-fidelity supported employment in Maricopa County is based on those who received ongoing support to maintain employment (6.5%).

Table 5 — Supported Employment Utilization Relative to Estimated Need among People with SMI

Supported Employment (SE) Utilization					
Region	Number of Adults with SMI Served in System[42]	Number of Adults in Need of SE[43]	Number of Adults Who Received SE[44]	SE Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
Ideal Benchmark	-	-	-	*45.0%*	*100%*
United States	4,308,677	1,938,905	65,963	1.5%	3%
Arizona[45]	126,433	56,895	13,333	10.5%	23%
Maricopa Co. — Total Served	37,107	16,698	11,011	29.7%	66%
SE Ongoing	37,107	16,698	2,423	**6.5%**	15%
Maricopa Co. — Medicaid	29,611	13,325	1,760	5.9%	13%
SE Ongoing	29,611	13,325	2,078	**7.0%**	16%
Maricopa Co. — non-Medicaid	7,496	3,373	1,869	24.9%	55%
SE Ongoing	7,496	3,373	345	**4.6%**	10%
Texas	316,774	142,548	8,887	2.8%	6%
Harris County (Houston)	33,840	15,228	3,327	9.8%	22%
Bexar County (San Antonio)	14,884	6,698	275	1.8%	4%

[42] The number of people with SMI served at the national and state-level was obtained from Substance Abuse and Mental Health Services Administration. (2021). *2020 Uniform Reporting System (URS) output tables*. Available at: https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables

[43] Approximately 90% of people with SMI are unemployed. Consumer preference research suggests approximately 50% desire to work. These two percentages were applied to the estimated SMI population to determine the estimated number of people who need supported employment.

[44] The number of people who received supported employment at the national and state levels were obtained from Substance Abuse and Mental Health Services Administration. (2021). *2020 Uniform Reporting System (URS) output tables*. Available at: https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables

[45] The penetration rates for Arizona are likely comparable to the "total served" (including pre-vocational and assessment services rates for Maricopa County) and not ongoing supported employment penetration rates.

Supported Employment (SE) Utilization					
Region	Number of Adults with SMI Served in System[42]	Number of Adults in Need of SE[43]	Number of Adults Who Received SE[44]	SE Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
New York	544,572	245,057	848	0.2%	0.3%
Colorado	78,134	35,160	1,101	1.4%	3%
Denver County (MHCD)[46]	19,087	8,589	414	2.2%	5%
Nebraska	12,304	5,537	661	5.4%	12%
California	403,665	181,649	410	0.1%	0.2%
Kansas	12,736	5,731	855	6.7%	15%
Tennessee	213,937	96,272	866	0.4%	1%
Indiana	87,227	39,252	1,122	1.3%	3%
Delaware	7,705	3,467	5	0.1%	0.1%
New Hampshire	15,367	6,915	4,708	30.6%	68%

Peer Support Benchmarks

Maricopa County excels in making peer support services available to people in need. Its penetration rates for 2013–2022 are high and likely represent a best practice benchmark in terms of access to peer support (see Table 6).

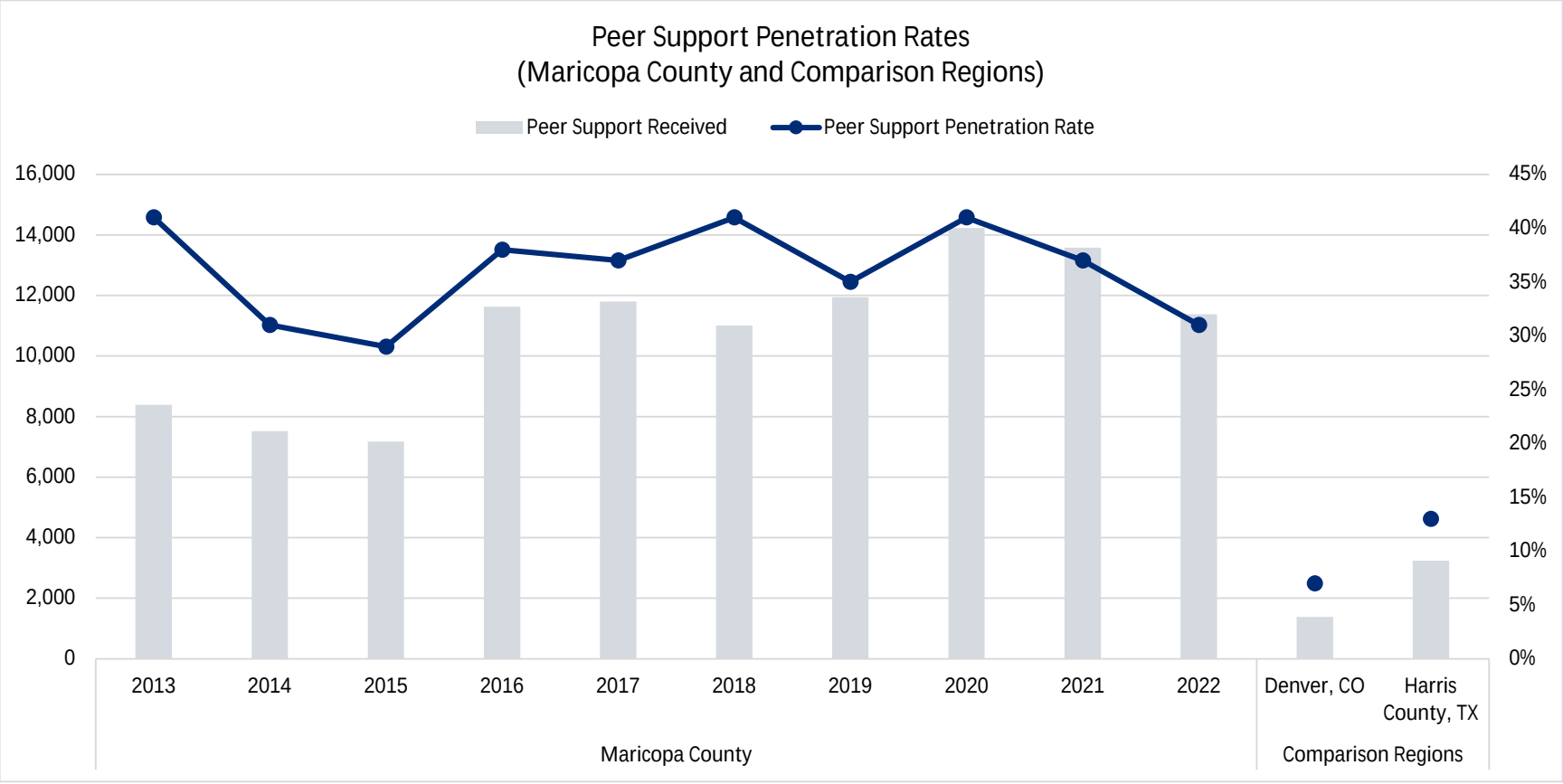
[46] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative director Kim Foust and her staff at the Mental Health Center of Denver, May 26, 2023.

Table 6 — Peer Support Penetration Rates

Peer Support		
Region	**Peer Support Received**	**Peer Support Penetration Rate**
Arizona		
Maricopa County (Total) — 2022	11,374	31%
Maricopa County (Total) — 2021	13,573	37%
Maricopa County (Total) — 2020	14,224	41%
Maricopa County (Total) — 2019	11,943	35%
Maricopa County (Total) — 2018	11,001	41%
Maricopa County (Total) — 2017	11,803	37%
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	41%
Texas		
Harris County	3,238	13%
Colorado		
Denver City/County[47] (2022)	1,381	7%

[47] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative director Kim Foust and her staff at the Mental Health Center of Denver, May 26, 2023. The Mental Health Center of Denver peer support services for adults with SMI using peer mentors and peer specialists. This figure may include some duplication of those served by both a peer mentor and a peer specialist.

Chart 5 — Peer Support Penetration Rates



5.2 Multi-Evaluation Component Analysis — Consumer Operated Services (Peer Support and Family Support)

Service Descriptions[48]

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 convened to facilitate discussion with participants with direct experience with the priority mental health services. Focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants. Key findings derived from the focus groups regarding the delivery system's capacity to deliver peer support and family support services included:

- During the pandemic, peer support services moved to strictly virtual and telephonic delivery for both group and individual sessions. Most health homes and peer-run organizations have moved back to in-person delivery of peer support services, while some continue to offer the option of virtual group sessions. Telephonic individual peer support services also remain an option with one case manager supervisor noting that it would be exceedingly difficult to conduct business without this as a delivery option. In the adult member focus group, there was consensus that having options is important and appreciated.
- The virtual delivery of peer support continued to receive mixed reviews from adult member participants. Some felt that while these options improved accessibility for some members, it created barriers for others. Notably, more vulnerable members, including those without internet or telephone access, may remain without any meaningful support.
- Those who voiced support for a virtual option noted that some members continue to have COVID-19-related fears which deter them from attending in-person. Others indicated a virtual option eliminates the need to organize transportation to a clinic and accommodates for medical

[48] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation* which may not reflect the terminology utilized to currently describe these services.

needs that may prevent a person from attending in-person. One adult member participant shared that when her chronic medical condition flares, she appreciates that she can still connect to others through a virtual option.

- Case manager and provider focus group participants indicated that attendance at in-person group peer support sessions at health homes and peer-run organizations has increased and is almost back to pre-pandemic levels.
- Last year, case manager and provider participants shared conflicting information about if they were still permitted to bill for peer support virtually and telephonically. However, this year, participants expressed a consistent understanding of allowable billing practices for both virtual and telephonic peer support services.
- Participants in all focus groups reported that there are still not enough peer support specialists in the system. One case manager supervisor shared that his clinic has seven teams and only three peer support specialists. Others shared that it is commonplace for peer support specialists to serve multiple teams.
- Participants in the provider and case manager groups indicated they are not seeing sufficient recruitment efforts for additional peer support specialists and likewise, there are not enough applicants for clinic-based positions. Additionally, the onboarding process can be long for peer support specialists. One case manager supervisor indicated that peer support specialists “require a lot of support to be successful in their roles” which contributes to the length of the onboarding process. Alternatively, one peer-run organization indicated that they are seeing an increase in hiring at their organization and feels the quality of applicants is improving.
- Adult member participants suggested that it would be helpful to have more peer support available in the evenings and on weekends. While there is a warm line available, some adult members expressed that it is not welcoming at times and the wait times can be long.
- As reported in prior years, participants indicated that turnover rates remain high among peer support specialists. Primary contributors to staff turnover include; low pay when compared to other staff, rapidly changing technology/IT platforms, the demands/stress of the position (note-taking and billing requirements), exacerbation of their own mental health challenges, and requirements to drive personal vehicles for business purposes.
- Participants agreed that peer support specialists would benefit from more on-the-job support related to the “mechanics” of their role and their own mental health. One case manager supervisor noted that peer support specialists “need to be valued more financially and through clinical support.” However, he noted that due to turnover rates and low staff capacity, it is challenging to provide this type of support to peer support specialists. Another case manager stated that peer support specialists are “the most valuable assets” in a clinic and yet they are not always recognized in this manner.
- Case manager and provider participants shared that peer support specialists “do just as much as the rest of the clinical team and have similar responsibilities to the case managers.” Yet, they do not reap the financial “rewards” of case managers. One adult member who

previously served as a peer support specialist shared that reimbursement rates for peer support specialists need to be evaluated. He stated, "It's a difficult job and it doesn't pay."

- To address turnover, focus group participants suggested offering more accommodations and structured daily and/or weekly support specific to peer support specialists (similar to morning huddles offered to clinical teams and 1:1 clinical supervision). Some health homes reported they offer in-house peer support certifications to enhance the recruitment of peer support specialists and some health homes allow individuals to work in the clinics while pursuing certification.
- Provider and case manager participants reported that peer support specialists are often asked to perform tasks outside of their scope such as case management services, therapy groups, and substance use disorder treatment services. One peer support specialist shared she is being asked to facilitate groups that she is not trained to provide and has not been offered the requisite training. Participants also expressed that high case manager turnover rates have contributed to the practice of peer support specialists being asked to cover case manager roles and responsibilities.
- Participants in the adult member, provider, and case manager groups expressed opinions regarding billing requirements and efficiency standards for peer support specialists. One health home has established an incentive program for all staff; however, the supervisor expressed that it is "impossible" for peer support specialists to meet the minimum productivity standards, let alone the incentive benchmarks. Per the supervisor, peer support specialists may be disciplined and terminated for not meeting productivity requirements. A provider group participant shared that peer support specialists cannot bill for certain job-related activities (e.g., transporting members) and these expectations result in less opportunities to bill for services.
- Focus group participants perceive barriers exist when initiating peer support services for members at community-based peer-run organizations because a referral is preemptively required from the health home. Case manager focus group participants confirmed that members may not self-refer to community providers. However, peer-run organization representatives offered conflicting requirements regarding the need for health home referrals. For example, one peer-run organization will not begin services until a referral has been received from the health home. Other organizations will allow individuals to self-refer and at least one peer-run organization offers a 10-day grace period that allows the person to participate in services until a referral can be obtained. This was presented as a successful alternative to engage individuals not yet enrolled in the behavioral health system and establishes an opportunity for the person to initiate peer support services without delay.
- Adult member and provider participants shared that obtaining referrals and member consent can be barriers to accessing services at peer-run organizations. Barriers can include trying to obtain referrals in a timely manner for members without an assigned case manager, obtaining referrals from "overworked case managers," and securing signed consent forms from legal guardians.
- Participants offered varying responses regarding the length of time it takes for peer support services to be initiated. One adult member reported that it took over a year to receive peer support from the health home, while another reported that it took about a week for the

services to begin. Case manager participants reported that in-house referrals are processed within three days and on average, it takes about a week for the services to begin at a peer-run organization.

- There continues to be a lack of education about the availability and benefit of family support services. Some case managers were able to describe the role of a family support specialist, but half of the adult member focus group participants were unaware of what constitutes family support services. One health home provides an overview of family support services during new employee orientation, while another health home and providers reported that they do not receive any training on this service. Providers report that, in some cases, family support specialists do not receive training about expected roles.
- After focus group facilitators defined family support services, adult member participants stated that they would want to include a family member in their care. One family member stated that she is the legally appointed guardian for her son, but the team does not include her in meetings, notify her of appointments, or involve her in the treatment of her son. Another family member shared that she has never been offered family support services in the many years her daughter has been receiving SMI services.
- Due to frequent case manager turnover, some family members have been encouraged by others at the clinic to call supervisors when there are concerns. However, the family members report rarely receiving a call back from clinic staff. The family members feel the member would "be lost" without assistance, but the clinical team does not always involve the family members when considering significant treatment decisions (e.g., discontinuation of long-term prescribed medications, the need for more intensive services, etc.).
- Focus group participants agree that there are not enough family support specialists in the system. Only one clinic reported having a family support specialist at their clinic and other health homes representatives could not confirm if their clinics had a family support specialist on staff.
- Some focus group attendees recalled when family support was offered at their health homes, but over time, the family support specialists were asked to assume case management duties due to staff coverage issues. One case manager supervisor reported that the family support specialist assigned to the clinical team rarely provided family support services (e.g., about 10% of the family support specialists workload). One provider added, "The one family support specialist on staff is answering crisis calls all day long and doesn't know what her role should be because she is always having to do other tasks due to staff shortages."
- When turnover occurs for family support specialist positions, the health home representatives report electing not to rehire for the position or struggle to find applicants. Most health home representatives reported not observing active recruitment for the vacant family support specialist positions. Focus group participants cited competitive pay as a contributing factor to high turnover rates of family support specialists.
- Case managers that participated in the focus groups report referring family members to the National Alliance on Mental Illness (NAMI) for support and rarely include family support as a service on ISPs.

- Case managers and providers that participated in the focus groups noted that members commonly decline to have family members involved in their treatment. At times, family members do not always understand the member's rights to choose if they want others involved in their treatment. Focus group participants agree that family members would benefit from training on family support services and how it may benefit the member and family.
- Last year, it was reported that some health homes offered monthly group meetings for family members which were facilitated by family support specialists. This year, however, only some ACT teams reported offering family support services in group settings and the groups are facilitated by peer support specialists.

Key Informant Survey Data

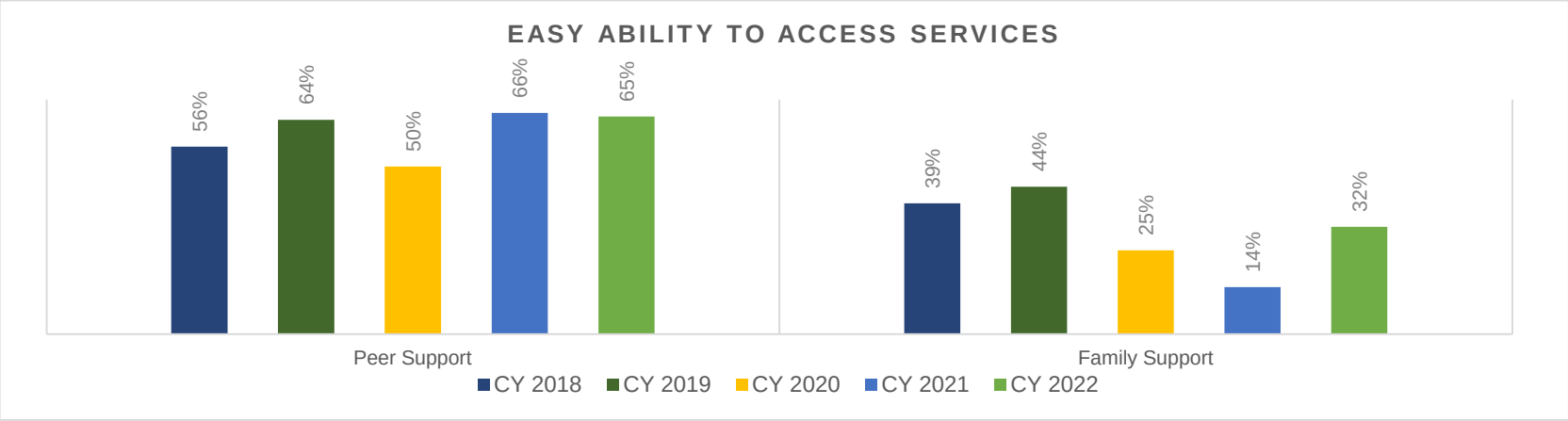
As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to the priority services, a key informant survey was administered. The survey tool included questions and rating assignments related to the priority mental health services. It should 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 not be construed to be representative of the total population of system stakeholders.

Level of Accessibility

Sixty-five percent of the survey respondents felt that peer support services were easy to access, a slight decrease compared to last year's findings (66%). Nine percent of survey respondents indicated that peer support services were difficult to access or believed that the services were inaccessible. Consistent with the last nine years, peer support services were perceived as the easiest of all the priority services to access.

Twenty-one percent of survey respondents felt that family support services were difficult to access while 32% of the respondents indicated that family support services were easy to access. Thirty-seven percent of respondents rated access to family support services as "fair".

Overall, respondents felt that the ability to access peer support services was about the same during CY 2022 when compared to CY 2021. However, family support services are perceived to be easier to access during CY 2022.



Factors that Hinder Access

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

- Staff turnover
- Member declines service

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

- Clinical team unable to engage/contact member
- Member declines service

Efficient Utilization

In terms of service utilization, 95% of the responses indicated that peer support services were being utilized efficiently or were utilized efficiently most of the time. Five percent of respondents indicated that the peer support services were not utilized efficiently.

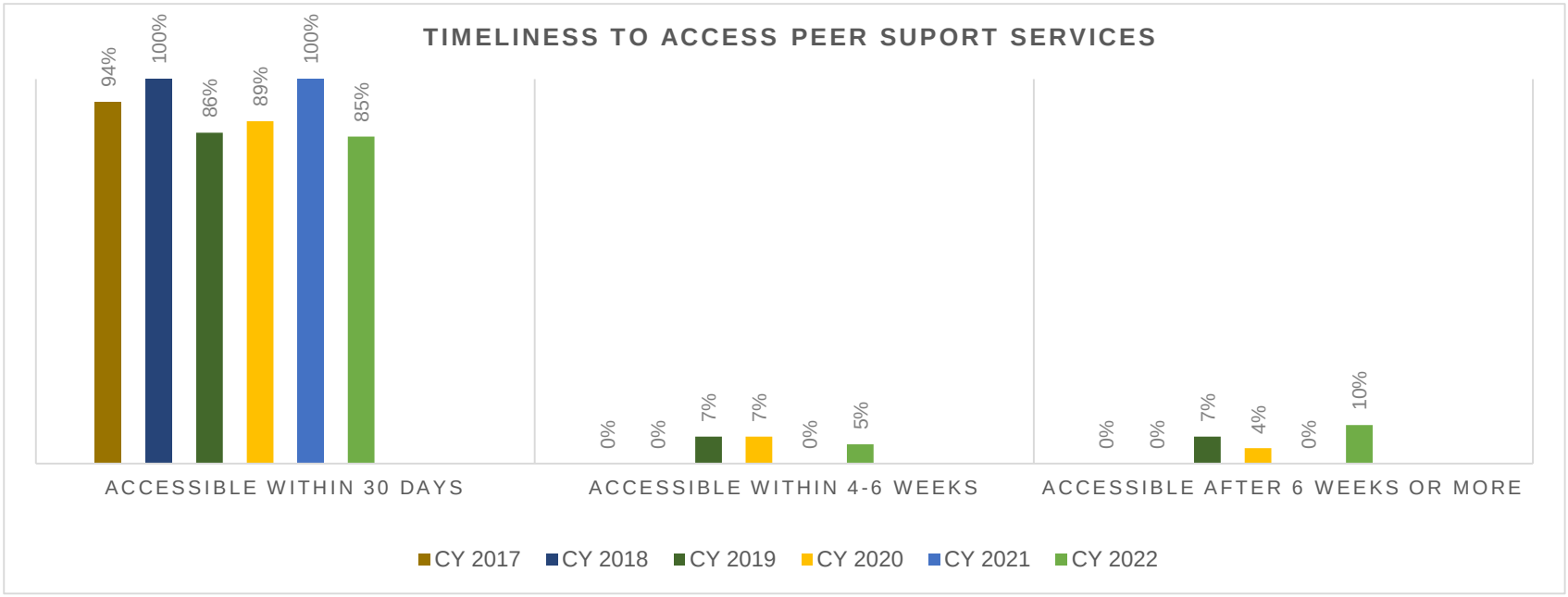
Eighty-two percent of the respondents indicated that family support services were being utilized effectively or were utilized efficiently most of the time.

Eighteen percent of the respondents indicated that family support services were not utilized efficiently.

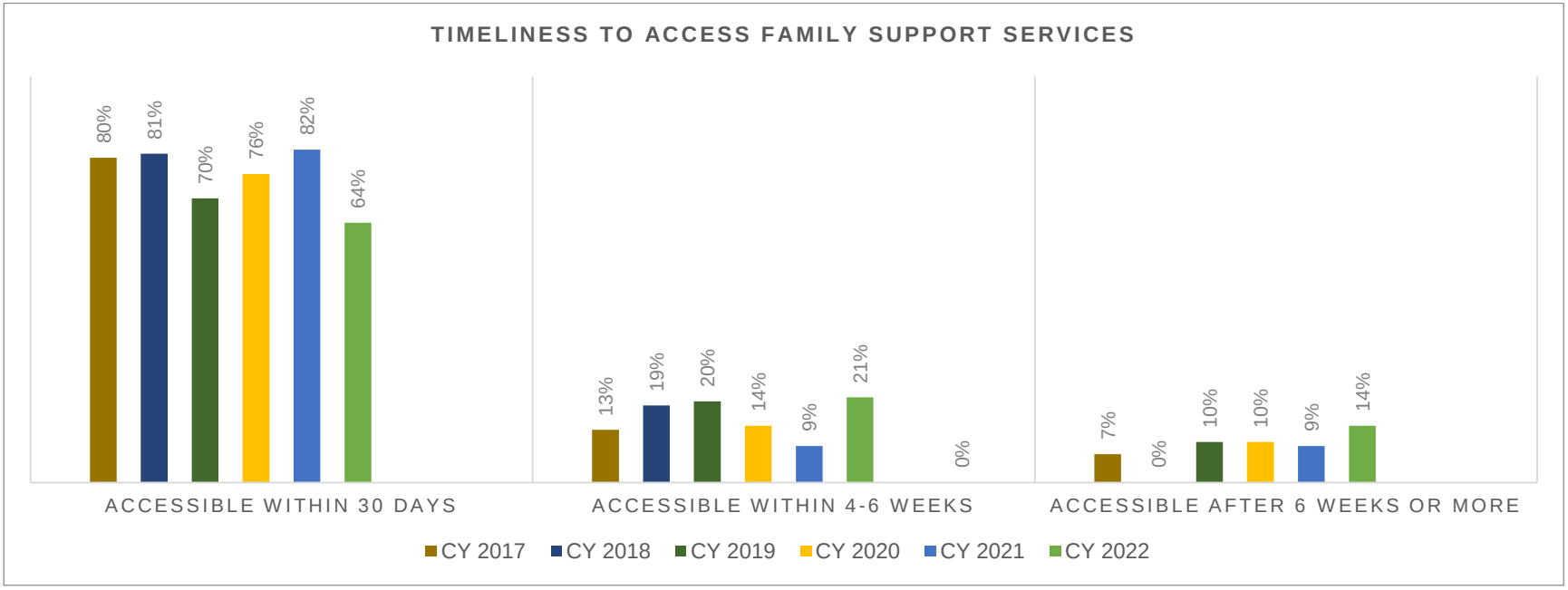
Timeliness

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

- 85% 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 70% during CY 2013, 75% during CY 2014, 78% during CY 2015, 82% during CY 2016, 94% during CY 2017, 100% during CY 2018, 86% during CY 2019, 89% during CY 2020, and 100% during CY 2021.
- 5% reported it taking four to six weeks to access peer support services following the identification of need (compared to: 20% — CY 2013; 13% — CY 2014; 15% — CY 2015; 13% — CY 2016; 0% — CY 2017; 0% — CY 2018; 7% — CY 2019; 7% — CY 2020; and 0% — CY 2021).
- 10% of the survey respondents reported that it would take an average of six weeks or longer to access peer support services (compared to: 10% — CY 2013; 13% — CY 2014; 7% — CY 2015; 4% — CY 2016; 6% — CY 2017; 0% — CY 2018; 7% — CY 2019; 4% — CY 2020; and 0% — CY 2021).



- 64% of the survey respondents reported that family support services could be accessed within 30 days of the identification of a service need. This finding compares to 33% during CY 2013, 69% during CY 2014, 74% during CY 2015, 79% during CY 2016, 80% during CY 2017, 81% during CY 2018, 70% during CY 2019, 76% during CY 2020, 82% during CY 2021.
- 21% percent reported it taking four to six weeks to access family support services following the identification of need (compared to: 44% — CY 2013; 8% — CY 2014; 13% — CY 2015; 13% — CY 2016; 13% — CY 2017; 19% — CY 2018; 20% — CY 2019; 14% — CY 2020; and 9% — CY 2021).
- 14% of the survey respondents reported that it would take an average of six weeks or longer to access family support services (compared to 22% — CY 2013; 23% — CY 2014; 13% — CY 2015; 8% — CY 2016; 7% — CY 2017; 0% — 2018; 10% — CY 2019; 10% — CY 2020; and 9% — CY 2021).



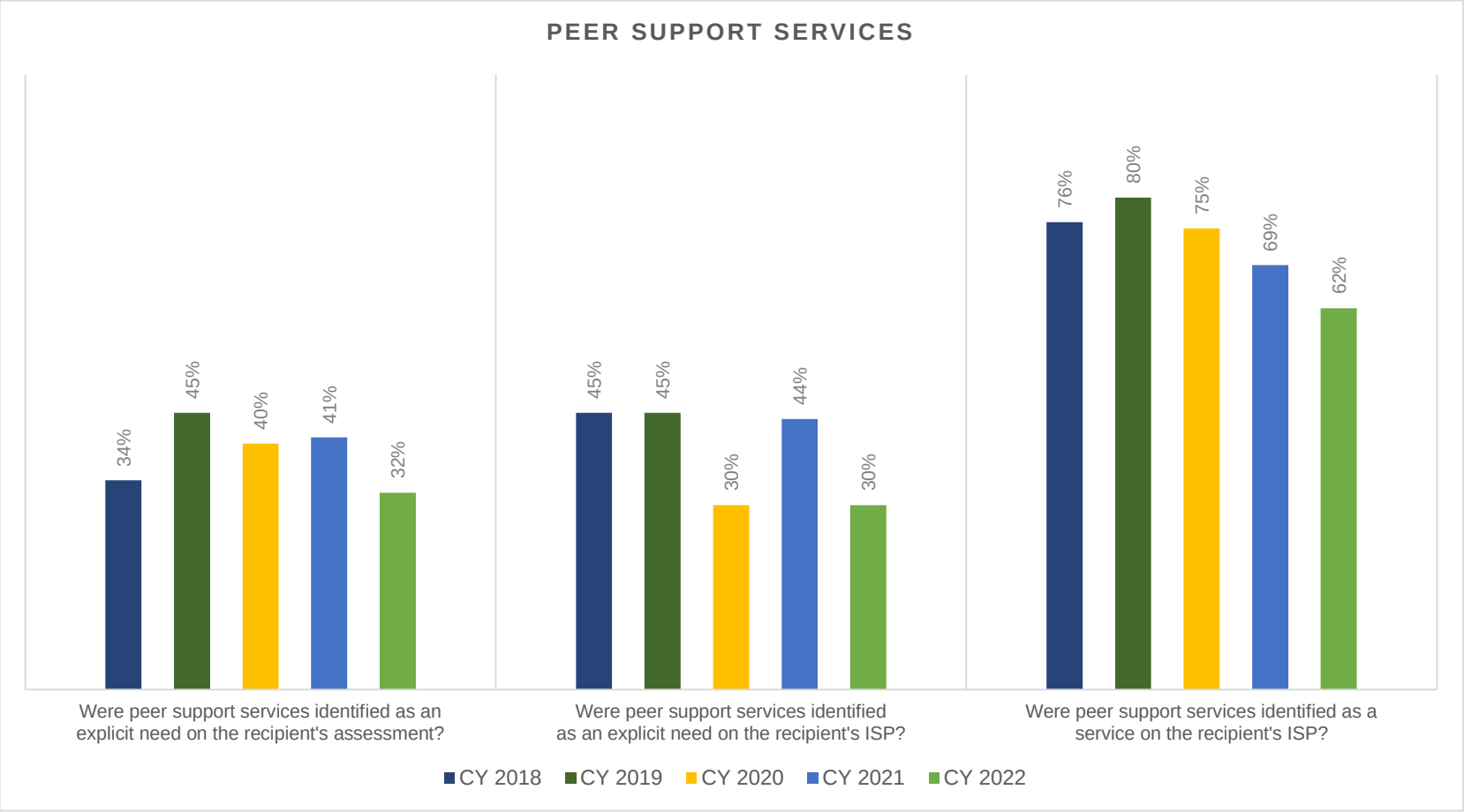
Medical Record Reviews

Mercer reviewed a random sample of 200 recipients' medical record documentation to evaluate 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, included as part of the ISP, and, when applicable, accessed in a timely manner by the member.

Peer Support Services

Sixty-two percent of the ISPs included peer support services when assessed as a need; a decrease when compared to CY 2021 (69%) and CY 2020 (75%).

Thirty-seven percent of the recipients included in the sample received at least one unit of peer support during CY 2022.



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:

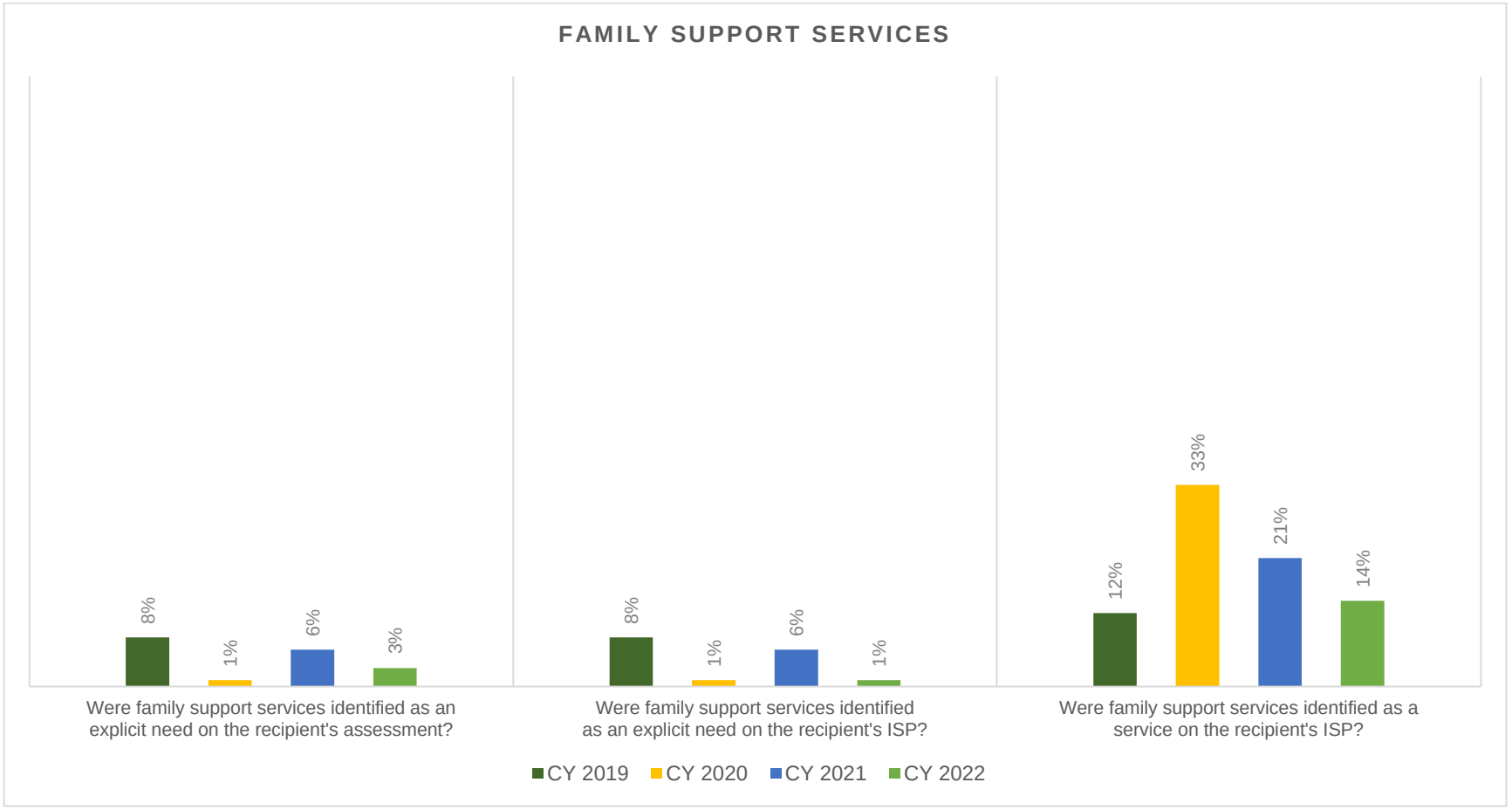
- The clinical team did not follow-up with initiating a referral for the service.
- There was no assessed need for the service, but the service was listed on the ISP.
- There was an assessed need for the service, but no service listed on the ISP.

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. However, clinical teams rarely leverage the opportunity to involve others significant to the person during the service planning process by recommending family support services.

Four percent of the cases included an assessed need for family support services. Of these cases, 14% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP.

Four percent of the recipients included in the sample received at least one unit of family support during CY 2022 based on a review of service utilization data.



Year-over-year, family support services are infrequently identified as a need on the assessment and/or ISP, a trend that continued during CY 2022. For CY 2022, family support services were rarely included as a distinct service on a member's ISP. Of the seven cases in the sample that included an assessed need for family support services, only one ISP included family support services as an intervention to address the need.

Service Utilization Data — Peer Support Services

Peer support services (i.e., self-help/peer services) are designated by two unique billing codes (H0038 — 15 minute billing unit and H2016 — per diem). During the time period of October 1, 2021 through June 30, 2022; 36,018 unique users were represented in the service utilization data file. Of those, 80% were Medicaid eligible (i.e., Title XIX) and 20% were non-Title XIX eligible.

- Overall, 26% of the recipients received at least one unit of peer support services during the period (a decrease from last year when 32% of recipients received peer support over a comparable period).

Access to the service favored Title XIX eligible members (27%) over the non-Title XIX population (23%).

Persistence in Services

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

- Overall, 55% of members who received at least one unit of peer support during the review period accessed the service during a single month, an increase when compared to CY 2021 (52%).
- 73% of all members who received at least one unit of peer support during the review period accessed the service for one or two months. During CY 2021, this result was 70%. Peer support services are widely accessible across the system and members may have multiple opportunities to attend a clinic-based peer support group and/or receive peer support services within or outside their assigned health home. The nature of the service can lend to episodic participation and is less dependent on sustained participation to be an effective support and intervention.

Persistence in Peer Support Services October 2021–June 2022			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
1	54.5%	54.7%	54.5%
2	18.2%	18.6%	18.3%
3–4	15.6%	14.1%	15.3%
5–6	5.2%	5.4%	5.2%
7–8	2.3%	2.5%	2.3%
9+	4.3%	4.8%	4.4%
Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.			

Service Utilization Data — Family Support Services

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, 2.2% of the recipients received at least one unit of family support services during the review period (3.4% over a comparable review period last year). Over the 10 years that the service capacity assessment has been conducted, family support service utilization rates have been consistently at 2% to 5%. Several factors may be influencing these results including the absence of supportive family members, member choice to exclude family members in their treatment, and a lack of understanding by clinical teams regarding the appropriate application and potential benefits of the service.

Access to the service was shared between Title XIX (2.3%) and non-Title XIX groups (1.8%).

Persistence in Services

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

- 73% of the members who received at least one unit of family support during the review period accessed the service during a single month, an increase from last year when 65% of the members accessed the service during a single month.
- 88% of all members who received at least one unit of family support during the review period accessed the service for one or two months. This compares to 80% during CY 2021.

Persistence in Family Support Services October 2021–June 2022			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
1	71.6%	77.3%	72.5%
2	15.9%	12.1%	15.3%
3–4	8.4%	6.8%	8.1%
5–6	3.4%	2.3%	3.2%
7–8	<1.0%	<1.0%	<1.0%
9+	<1.0%	<1.0%	<1.0%
Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.			

Key Findings and Recommendations

Significant findings regarding the demand and provision of peer support and family support services are presented below.

Findings: Peer Support

- Service utilization data reveals the volume of peer support services provided during a defined review period. For the period of October 1, 2021 through December 31, 2022, 31% of all members with an SMI received at least one unit of peer support. During the prior year, 37% of members received peer support services (2013 — 38%; 2014 — 31%; 2015 — 29%; 2016 — 38%; 2017 — 37%; 2018 — 36%; 2019 — 35%; 2020 — 41%; and 2021 – 37%).
- Case manager and provider focus group participants indicated that attendance at in-person group peer support sessions at the health homes and peer-run organizations has increased and is almost back to pre-pandemic levels.
- To address turnover, focus group participants suggested offering more accommodations and structured daily and/or weekly support specific to peer support specialists (similar to morning huddles offered to clinical teams and 1:1 clinical supervision). Some health homes reported they offer in-house peer support certifications to enhance the recruitment of peer support specialists and some health homes allow individuals to work in the clinics while pursuing certification.
- Focus group participants perceive barriers exist when initiating peer support services for members at community-based peer-run organizations because a referral is preemptively required from the health home. Case manager focus group participants confirmed that members may not self-refer to community providers. However, peer-run organization representatives offered conflicting requirements regarding the need for health home referrals. For example, one peer-run organization will not begin services until a referral has been received from the health home. Other organizations will allow individuals to self-refer and at least one peer-run organization offers a 10-day grace period that allows the person to participate in services until a referral can be obtained. This was presented as a successful alternative to engage individuals not yet enrolled in the behavioral health system and establishes an opportunity for the person to initiate peer support services without delay.
- 65% of the survey respondents felt that peer support services were easy to access, a slight decrease compared to last year's findings (66%). Nine percent of survey respondents indicated that peer support services were difficult to access or believed that the services were inaccessible. Consistent with the last nine years, peer support services were perceived as the easiest of all the priority services to access.
- 62% of the ISPs included peer support services when assessed as a need; a decrease when compared to CY 2021 (69%) and CY 2020 (75%).
- 37% of the recipients included in the medical record review sample received at least one unit of peer support during CY 2022.

- 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. Consistent with prior years, the most common finding was that the clinical team did not follow-up with initiating a referral for the service.
- Overall, 55% of members who received at least one unit of peer support during the review period accessed the service during a single month, an increase when compared to CY 2021 (52%).

Findings: Family Support

- Service utilization data demonstrates that 3% of members received at least one unit of family support services during 2022, a reduction of one percentage point when compared to last year (compared to: 2013 — 2%; 2014 — 3%; 2015 — 2%; 2016 — 2%; 2017 — 2%; 2018 — 4%; 2019 — 6%; 2020 — 6%; and 2021 — 4%).
- 4% of the sample of medical records included an assessed need for family support services. Of these cases, only 14% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP.
- 4% of the recipients included in the medical record review sample received at least one unit of family support during CY 2022 based on a review of service utilization data.
- 64% of the survey respondents reported that family support services could be accessed within 30 days of the identification of a service need. This finding compares to 82% during CY 2021.
- There continues to be a lack of education about the availability and benefit of family support services. Some case managers were able to describe the role of a family support specialist, but half of the adult member focus group participants were unaware of what constitutes family support services.
- Case managers and providers that participated in the focus groups noted that members commonly decline to have family members involved in their treatment. At times, family members do not always understand the member's rights to choose if they want others involved in their treatment. Focus group participants agree that family members would benefit from training on family support services and how it may benefit the member and family.

Recommendations: Peer Support

- Consistent with the *AHCCCS Contractor Operations Manual, Policy 407, Workforce Development*[49], examine factors contributing to high turnover and vacancies across peer support specialists operating within the service delivery system and take appropriate actions to improve recruitment and retention *(repeat recommendation from last year).*
- Monitor reductions in the utilization of peer support services and identify the most prominent causal factors contributing to reduced utilization. As appropriate, take corrective actions to improve access and increase utilization.

Recommendations: Family Support

- Provide training and supervision to ensure that health home clinical team members understand the appropriate application of family support services and to recognize the value of family support services as an effective service plan intervention *(repeat recommendation from last year).*

[49] This policy specifies contractor requirements to establish and maintain a Workforce Development Operation (WFDO) to monitor and collect information about the workforce, collaboratively plan workforce development initiatives, and when necessary, provide direct assistance to strengthen provider workforce development programs.

5.3 Multi-Evaluation Component Analysis — Supported Employment

Service Description[50]

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

Focus groups were convened to facilitate discussion with participants with direct experience with the priority mental health services. Focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants. Findings collected from focus group participants regarding supported employment services included the following themes:

- Last year, focus group participants shared that the pandemic had impacted member engagement with supported employment services. However, all focus group participants reported that member interest in employment, volunteerism, and pursuit of daily meaningful activities has continued to increase. Participants noted that while some members continue to have fears about leaving their homes due to COVID-19, this appears to be more prevalent among older populations.
- Adult members shared that assigned case managers bring up employment opportunities at different frequencies. Some case managers broach the subject annually during the annual ISP update process while others bring it up monthly to assess the members' interest. These observations aligned with the case manager focus group where participants reported that employment discussions are usually held during ISP update sessions, while other case managers try to raise the topic on a more frequent basis.
- Adult members felt it would be helpful if supported employment services were "advertised" differently for members so that they could learn more about the service, other than from their case managers. Many adult members did not know about the variety of options to transition into employment or that discussions about "employment" could also include the pursuit of volunteer opportunities or expanding interest/participation in meaningful daily activities.
- Provider focus group participants reported that some members are being "forced" to consider employment due to increasing housing costs.

[50] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation* which may not reflect the terminology utilized to currently describe these services.

- Adult members expressed a need for additional part-time work opportunities. For some members, this tied to worries about losing their benefits if they worked. For others, it was overwhelming to consider working full-time. Several members expressed how difficult it was to find employers who offer part-time options.
- Last year, participants reported that co-located vocational rehabilitation (VR) specialists had moved to virtual services during the pandemic and had not returned to the clinics. This year, VR specialists are now available on a part-time basis at most clinics (1–2 days per week) and some are attending weekly team meetings. VR orientation sessions are offered both virtually and in-person. Provider focus group participants noted that the virtual option for orientations can be a barrier for some members, yet some VR specialists are only offering virtual orientation sessions.
- Per the focus group participants, members engaging with VR services sometimes feel the process takes too long. One family member shared that her daughter's VR counselor recently resigned and, subsequently, the process has been stalled for several months. The initial assessment went well, and the member and family are disappointed that there has been no follow-up or further engagement with the member. However, most adult members and providers reported that the process is generally quick once the referral is received by VR. Delays are typically caused by challenges in obtaining a referral from a case manager.
- Providers and adult members expressed that this same barrier applies to referrals made to employment providers or rehabilitation specialists. One rehabilitation specialist noted it is "very difficult to get ISPs from case managers which are required for referrals to be initiated." An adult member added, "There is a lot of run around when it comes to getting referrals from case managers. But once the referral is made, the process is quick and services are typically easy to access." Case managers shared that due to high turnover, they frequently get behind on completing ISPs and referrals.
- Adult members expressed positive feedback regarding the supported employment services they have received, noting that they are very helpful. One member explained that he has a visual impairment and the services were "extremely helpful". He is eager to work and stated, "I want to have purpose and feel like I contribute." Another member shared that the supported employment specialist at the peer-run organization helped her to develop a resume and she was pleased with this assistance. And yet another member shared that their community-based supported employment provider is helping her with job leads so she can work from home.
- Case managers and provider participants shared positive feedback about co-located employment providers who are active at the clinics. Case managers were pleased that some now attend morning meetings and the providers shared they are working hard to reconnect with clinical teams following the pandemic.
- As reported the last two years, case managers, providers, and adult members convey that members remain fearful of the impact of working on maintaining eligibility for public assistance programs and services (e.g., housing vouchers, Medicaid eligibility, social security disability insurance [SSDI], etc.).

- Providers, case managers, and adult members participating in the focus groups report awareness of Disability 101 (DB101), an online resource that helps determine the impact of employment income on public assistance benefits. However, case managers shared that they do not receive training on how to use DB101 and typically only the rehabilitation specialists receive this training. Some adult members found the DB101 resource to be helpful, but others expressed confusion regarding how to determine the impact of work on their benefits. Providers shared they are trying to provide more education on DB101 and "Ticket to Work" programs through trainings and flyers for members and clinical teams.
- Adult members, providers, and case managers all agree that there are not enough rehabilitation specialists at the clinics and turnover is high for these positions. One rehabilitation specialist shared that she is the only one at her clinic and she serves five clinical teams. A case manager supervisor noted that their clinic had four rehabilitation specialists, but three resigned at the same time. High workloads and productivity requirements were the leading causes of turnover.
- In prior years, focus group participants discussed the unavailability of clinic-based benefit specialists. This year, case manager and provider participants shared that benefit specialists are only available on a part-time basis at designated clinics. The benefit specialists reportedly no longer provide eligibility determination guidance for Supplemental Security Income (SSI) and SSDI benefits and primarily focus on identifying community-based resources to assist members.
- Provider participants expressed concerns about planned reductions in reimbursement rates for certain supported employment services (i.e., job coaching and job placement services), particularly impacting the non-Title XIX SMI population. Focus group participants expressed concern that the rate reductions may serve as a disincentive for employment providers to give equal focus to non-Title XIX members.

Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding the availability, quality, and access to the priority mental health services, a key informant survey was administered. 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 not be construed to be representative of the total population of system stakeholders.

Level of Accessibility

Thirteen percent of survey respondents felt that supported employment services were difficult to access, less than last year (17%). One respondent (4%) indicated that the service was not available. Eighty-three percent of respondents indicated that supported employment services were easy to access or having "fair" access, the same finding as CY 2021.

Factors that Hinder Access

Factors that negatively impact accessing supported employment services include:

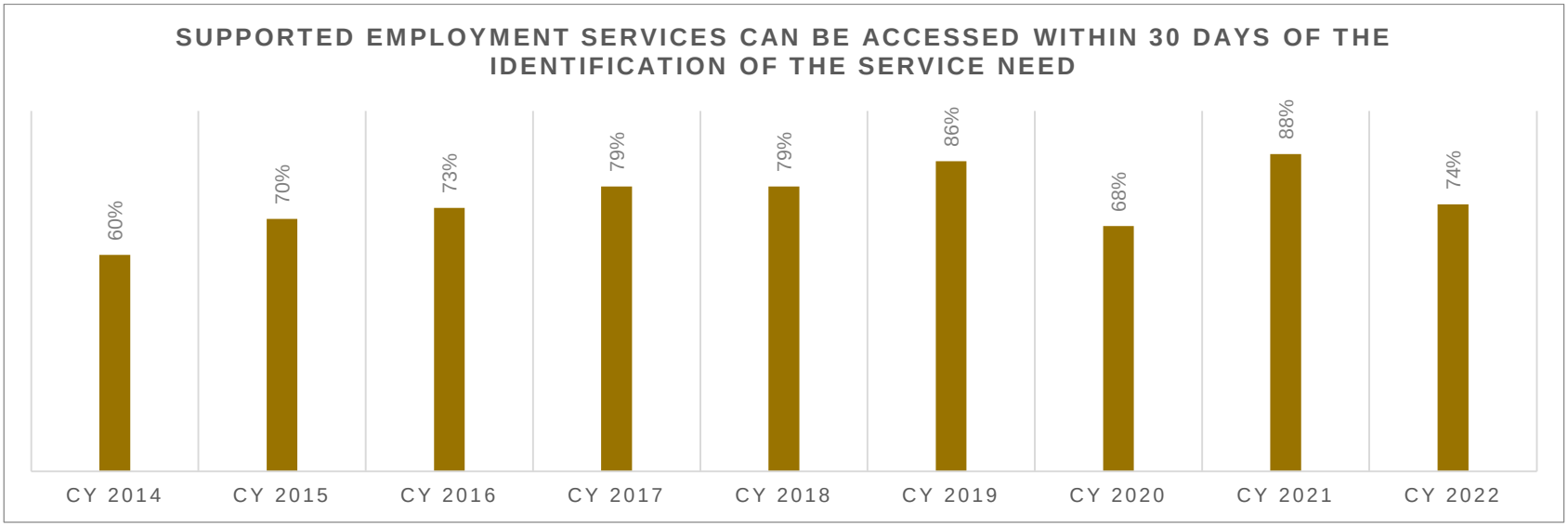
- Member declines services
- Transportation barriers
- Lack of capacity/no service provider available
- Staff turnover

Efficient Utilization

Eighty-six percent of the responses indicated that supported employment services were being utilized efficiently or were utilized efficiently most of the time, a similar finding from last year (88%). Fourteen percent of respondents indicated that supported employment services were not utilized efficiently.

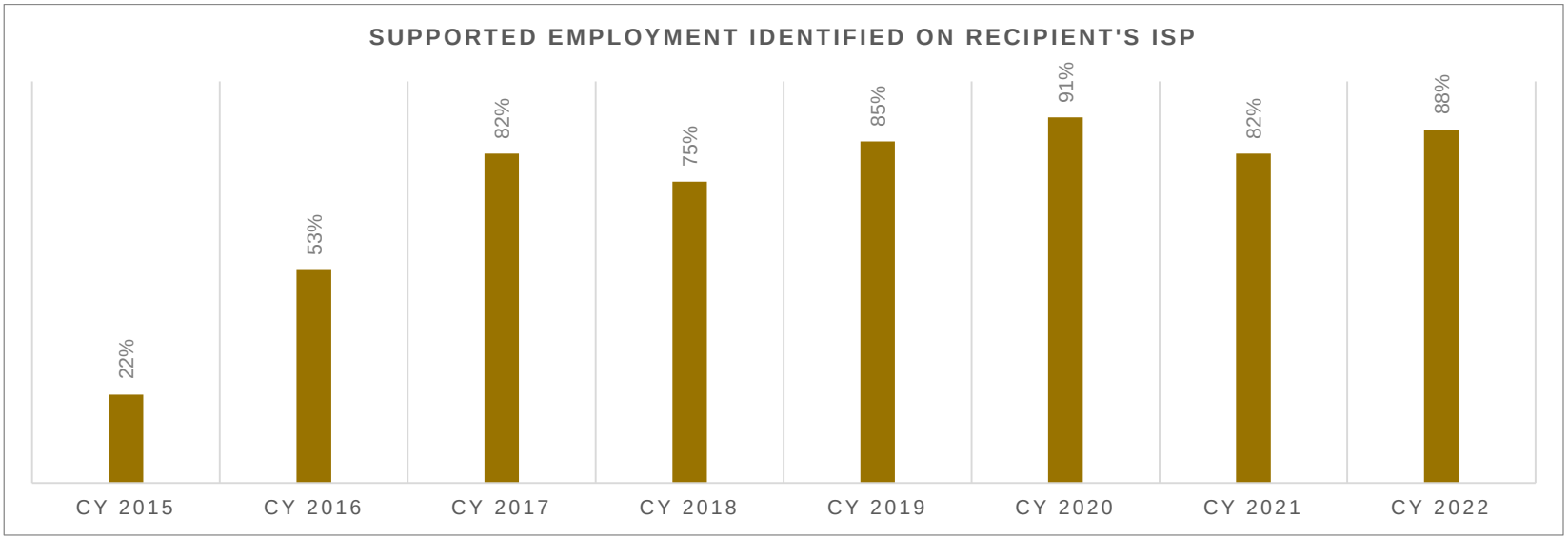
Timeliness

Seventy-four percent of the survey respondents report that supported employment services can be accessed within 30 days of the identification of the service need. This compares to 88% during CY 2021, 68% during CY 2020, 86% during CY 2019, 79% during CY 2018, 79% during CY 2017, 73% during CY 2016, 70% during CY 2015, and 60% during CY 2014. Sixteen percent of the survey respondents reported that it would take an average of six weeks or longer to access supported employment services.



Medical Record Review

The results of the medical record review demonstrate that supported employment services are identified as a need on either the recipient's assessment and/or ISP in 60% of the cases reviewed, 11 percentage points less than last year (71%). Supported employment services were identified as a service on the recipient's ISP in 88% of the cases reviewed when assessed as a need (compared to: CY 2014 — 26%; CY 2015 — 22%; CY 2016 — 53%; CY 2017 — 82%; CY 2018 — 75%; CY 2019 — 85%; CY 2020 — 91%; and CY 2021 – 82%).



Forty-six percent of the recipients included in the medical record review sample received at least one unit of supported employment during CY 2022 based on a review of service utilization data.

In 71 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 46% of those cases in which the person did not access the service despite an identified need — lower than the rate identified during CY 2021 (57%).

In many of these cases, there were inconsistencies between the functional assessment and the ISP, with the assessment typically including an explicit statement from the member that they did not wish to pursue employment opportunities. Yet, in many of these same cases, the clinical team listed supported employment services on the ISP in the absence of any assessed need. As a result, 66% of the cases lacked evidence that the member received supported employment services despite the service being listed on the ISP. As noted in prior service capacity assessments, ISPs are not always based on the member's assessed or individualized needs and can include generic language and/or services that fail to differentiate each member's unique circumstances and needs. In other cases, there is evidence that clinical team members do not understand the appropriate application of supported employment services and/or list supported employment service codes (e.g., H2027, H2025) to reflect the health home's policy to have all members meet with a rehabilitation specialist one time per year.

Service Utilization Data

Three distinct billing codes are available to reflect the provision of supported employment services. Available billing codes 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 but are not limited to the following: career/educational counseling, job shadowing, job training, assistance in the use of educational resources necessary to obtain employment; attendance to VR/Rehabilitation Services Administration (RSA) Information sessions; attendance to job fairs; training in resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), work activities, professional decorum, time management, and assistance in finding employment.

H2025 — Ongoing Support to Maintain Employment

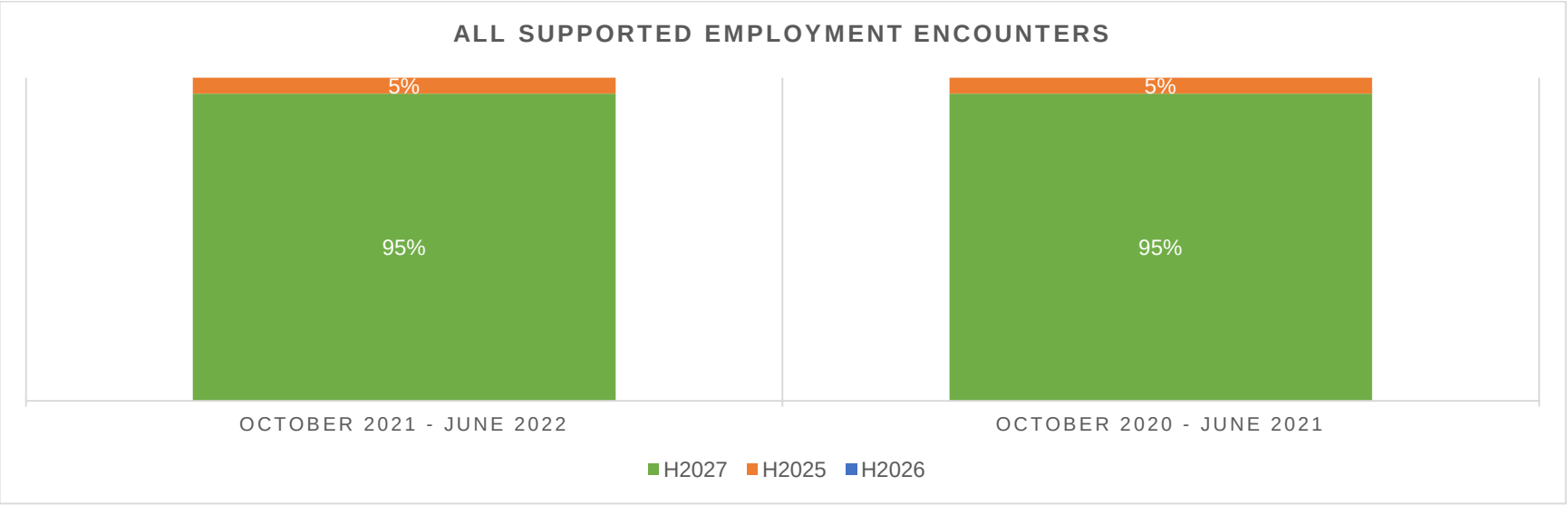
Includes support services that enable a person to maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, and supportive counseling.

H2026 — Ongoing Support to Maintain Employment (per Diem)

Includes support services that enable a person to maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, and supportive counseling.

Service Utilization Trends

For the time period October 1, 2021 through June 30, 2022, H2027 (pre-job training and development) accounts for 95% of the total supported employment services (the same finding as last year). H2025 (ongoing support to maintain employment/15-minute billing unit) represents 5% of the supported employment utilization (CY 2021 — 5%). H2026 (ongoing support to maintain employment/per diem billing unit) accounted for less than 1% of the overall supported employment utilization.



Historic challenges with providing ongoing support to maintain employment (H2025) include members opting out of supported employment services once competitively employed or the member's inability to attend meetings with job coaches due to commitments related to full-time employment.

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

- Overall, 30% of the recipients received at least one unit of supported employment during the review period, two percentage points less than CY 2021 (32%) and four percentage points lower than CY 2020 (34%).
- Access to the service was split between Title XIX (31%) and non-Title XIX groups (25%).

Persistence in Services

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

Persistence in Supported Employment Services October 2021–June 2022			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
1	59.0%	70.5%	60.9%
2	14.7%	12.0%	14.2%
3–4	12.7%	8.5%	12.0%
5–6	5.9%	4.5%	5.7%
7–8	2.7%	1.7%	2.5%
9+	5.0%	2.8%	4.7%

- More than 60% of the recipients who received at least one unit of supported employment services during the review period accessed the service during a single month. This finding aligns with low utilization of ongoing support to maintain employment; a supported employment service and support that lends to consistent participation over a series of months.
- 12% of the recipients received supported employment services for three to four consecutive months during the review period.
- Almost 5% of the recipients received the service for at least nine consecutive months.

Coordinating With Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR)

The supported employment specialists associated with contracted supported employment providers and rehabilitation specialists assigned to the health homes also coordinate closely with staff employed with the Arizona Department of Economic Security (DES)/RSA and assigned to some of the health homes. At the onset of the COVID-19 pandemic, RSA/VR counselors suspended in-person services and coordinated with health homes and supported employment providers virtually. In July 2022, VR counselors initiated a “hybrid” model and reintroduced some in-person services. One supported employment provider reported that coordination with RSA/VR is strong and the relationship between the health home, community-based supported employment providers, and VR counselors is producing positive outcomes for members.

Twenty-seven full-time DES/RSA counselors are dedicated to persons with SMI, co-located and represented at all the health home clinic locations. Four vacancies were reported as of September 2022. VR counselors meet regularly with health home clinic rehabilitation specialists and contracted supported employment providers and work in coordination to meet member’s supported employment needs.

The VR program for persons with SMI is tracking targeted outcomes. Overall, there have been modest increase across all metrics when compared to CY 2021. DES/RSA data secured from the Maricopa County RBHA includes the following:

- Members referred to VR/RSA — 847 between January 1, 2022 and September 30, 2022

- Members served in the VR program — 1,406 between January 1, 2022 and September 30, 2022
- Members open in the VR program — 1,165 between January 1, 2022 and September 30, 2022
- Members in service plan status with VR — 559 between January 1, 2022 and September 30, 2022

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 30% of members received at least one unit of supported employment during CY 2022, a decrease of 2% from last year and continuing a trend of year-to-year decreases in utilization. (CY 2013 — 39%; CY 2014 — 20%; CY 2015 — 17%; CY 2016 — 26%; CY 2017 — 26%; CY 2018 — 29%; CY 2019 — 31%; CY 2020 — 34%; and CY 2021 — 32%).
- 13% of survey respondents felt that supported employment services were difficult to access, less than last year (17%). One respondent (4%) indicated that the service was not available. Eighty-three percent of respondents indicated that supported employment services were easy to access or having “fair” access, the same finding as CY 2021.
- Adult members expressed a need for additional part-time work opportunities. For some members, this tied to worries about losing their benefits if they worked. For others, it was overwhelming to consider working full-time. Several members expressed how difficult it was to find employers who offer part-time options.
- Case managers and provider participants shared positive feedback about co-located employment providers who are active at the clinics. Case managers were pleased that some now attend morning meetings and the providers shared they are working hard to reconnect with clinical teams following the pandemic.
- In prior years, focus group participants discussed the unavailability of clinic-based benefit specialists. This year, case manager and provider participants shared that benefit specialists are only available on a part-time basis at designated clinics. The benefit specialists reportedly no longer provide eligibility determination guidance for SSI and SSDI benefits and primarily focus on identifying community-based resources to assist members.
- Supported employment services were identified as a service on the recipient’s ISP in 88% of the cases reviewed when assessed as a need. (CY 2021 — 82%).

- 66% of the medical record review cases lacked evidence that the member received supported employment services despite the service being listed on the ISP.
- For the time period October 1, 2021 through June 30, 2022, H2027 (pre-job training and development) accounts for 95% of the total supported employment services (the same finding during CY 2021). H2025 (ongoing support to maintain employment/ 15-minute billing unit) represents 5% of the supported employment utilization.

Recommendations: Supported Employment

- Assess the inventory of available part-time job opportunities available via supported employment providers. As indicated, expand offerings so that members have adequate opportunities to pursue part-time work.
- Clarify the appropriate billing/service code modifier to capture annual rehabilitation specialists' vocational/meaningful day assessments or annual vocational activity profiles. Train rehabilitation specialists to record and bill the services in a consistent manner.
- Continue to monitor and address the practice of documenting supported employment services on members' ISPs without evidence of an assessed need for the service. Train clinical teams to develop ISPs that are individualized and reflect the member's unique circumstances and needs *(repeat recommendation from last year).*
- Designate staffing resources to serve in the role of benefit specialists (use of peer support specialists, case managers, etc.) to address member concerns about securing employment without jeopardizing eligibility for public assistance programs (e.g., AHCCCS eligibility, SSDI) *(repeat recommendation from last year).*

5.4 Multi-Evaluation Component Analysis — Supportive Housing

Service Description[51]

Supportive 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. Supportive housing also includes rental subsidies or vouchers and bridge funding to cover deposits and other household necessities, although these items alone do not constitute supportive housing.

Focus Groups

Focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants. Findings collected from focus group participants regarding supportive housing services included the following themes:

- There was consensus across all focus groups that there are not enough stable, safe, and affordable housing options in Maricopa County. Additionally, there are not sufficient subsidized vouchers available, wait lists remain excessively long, and finding landlords willing to accept vouchers at fair market value is increasingly difficult. One family member shared that options for affordable housing where vouchers are accepted can be “scary places”.
- Case manager focus group participants shared that voucher expiration dates are a source of stress among members. Due to the challenges of finding available units and/or landlords willing to accept the vouchers, the vouchers often expire before housing can be located.
- Provider focus group participants reported that there are challenges in working with the Centralized Housing Administrator for the AHCCCS Housing program. Focus group participants were unclear how the housing application process works and reported that it can be challenging to get responses by telephone or email from the administrator. Adult focus group members expressed similar confusion regarding the voucher “wait list” and not receiving updates on the status of the wait list. One parent shared that her son’s health home team tells her that he has been placed on a housing wait list, but they will not provide additional details. The family member added that she does not believe that the health home team is actively pursuing housing for her son.

[51] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation* which may not reflect the terminology utilized to currently describe these services.

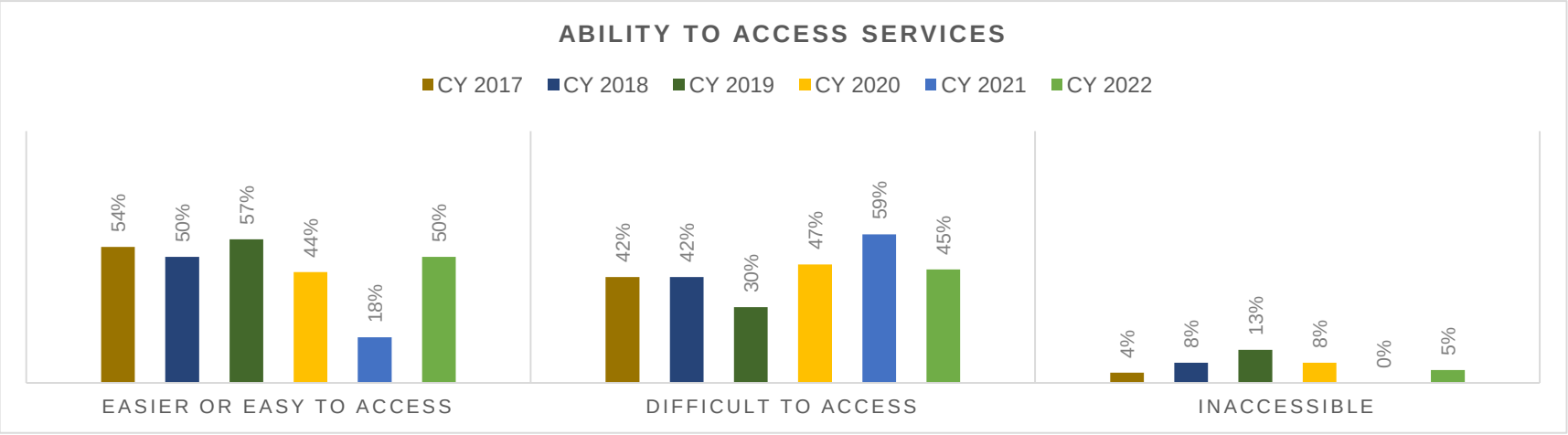
- Given her own advancing age, one parent shared that she would like to explore housing options for her daughter who lives with her. However, she does not know much about the options. The parent has not been successful in discussing the situation with her daughter's health home team as she reports the team will "not answer the telephone".
- Provider focus group participants shared that there are not enough step-down or transitional housing options for members who need to move gradually to more independent settings. Similarly, focus group participants expressed a need for specialty housing that can accommodate the needs of members who are aging and those with complex medical needs.
- Providers and case managers participating in the focus groups agreed that there are not enough clinic-based housing specialists, and many clinics only have one housing specialist for the entire clinic. In some cases, housing specialists cover multiple clinics. One health home representative reported they have access to two housing specialists that are assigned to four clinics. Focus group participants noted that burnout levels can be high due to the demands of the job.
- None of the case manager focus group participants could identify a supportive housing service other than obtaining a voucher or receiving flex funds. The case managers described providing "supportive housing" to members by initiating referrals for vouchers or flex funds. Community-based providers participating in the focus groups agreed that health home teams need more training about supportive housing services and how to access the services.
- Some health homes provide an overview of supportive housing services during new employee orientation, but most case managers participating in the focus groups shared that they receive "no training" regarding what constitutes supportive housing and how to identify opportunities to offer the service.
- Community-based providers participating in the focus groups indicated that referrals typically come from the health home-based housing specialists. The focus group participants reported the referral process is generally smooth, but there were challenges around responsiveness from the health home teams.
- Case manager focus group participants shared they do not receive training on the Landlord Tenant Act and would like more training on tenancy rights. One case manager shared, "I feel completely uneducated on housing in Arizona" and another shared that he "had to educate myself about it." Community-based housing providers participating in the focus groups indicated that case managers are unlikely to know much about tenant rights.
- Case managers and adult members participating in the focus groups reported that health home teams have resumed regular home visits with members. Case managers reported regularly assessing for housing quality and housing risk during home visits and during the ISP update process. One health home has embedded a social determinant of health questionnaire into a home visit progress note template, which prompts the team member to inquire about the member's housing stability and status.

Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding the availability, quality, and accessibility of supportive housing services, a key informant survey was administered. The survey tool included questions and rating assignments related to the priority mental health services. 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 not be construed to be representative of the total population of system stakeholders.

Level of Accessibility

Forty-five percent of the survey respondents felt that supportive housing services were difficult to access (compared to CY 2021 — 59%; CY 2020 — 47%; and CY 2019 — 30%). One respondent (5%) indicated that supportive housing services were inaccessible.



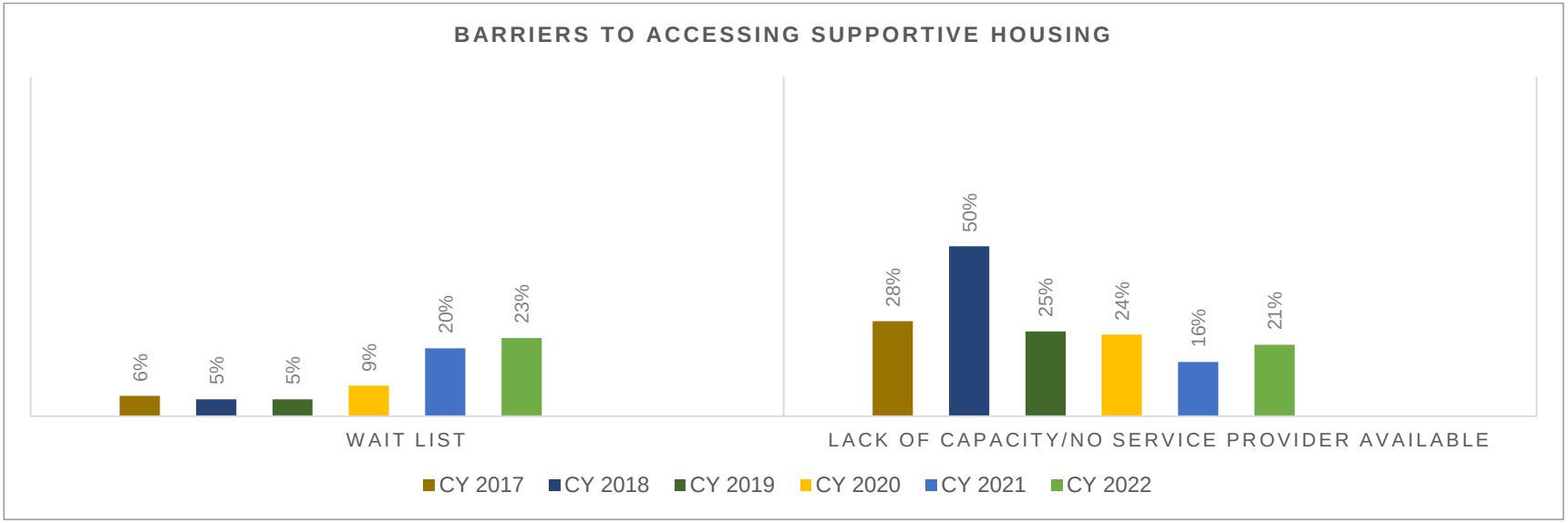
Fifty percent of respondents indicated that supportive housing services had “fair access” or were easy to access; a significant increase from CY 2021 (18%).

Factors that Hinder Access

When asked about the factors that negatively impact accessing supportive housing services, responses include:

- 23% of the responses selected wait list exist for services.
- 21% of responses indicated a lack of capacity/no service provider available.

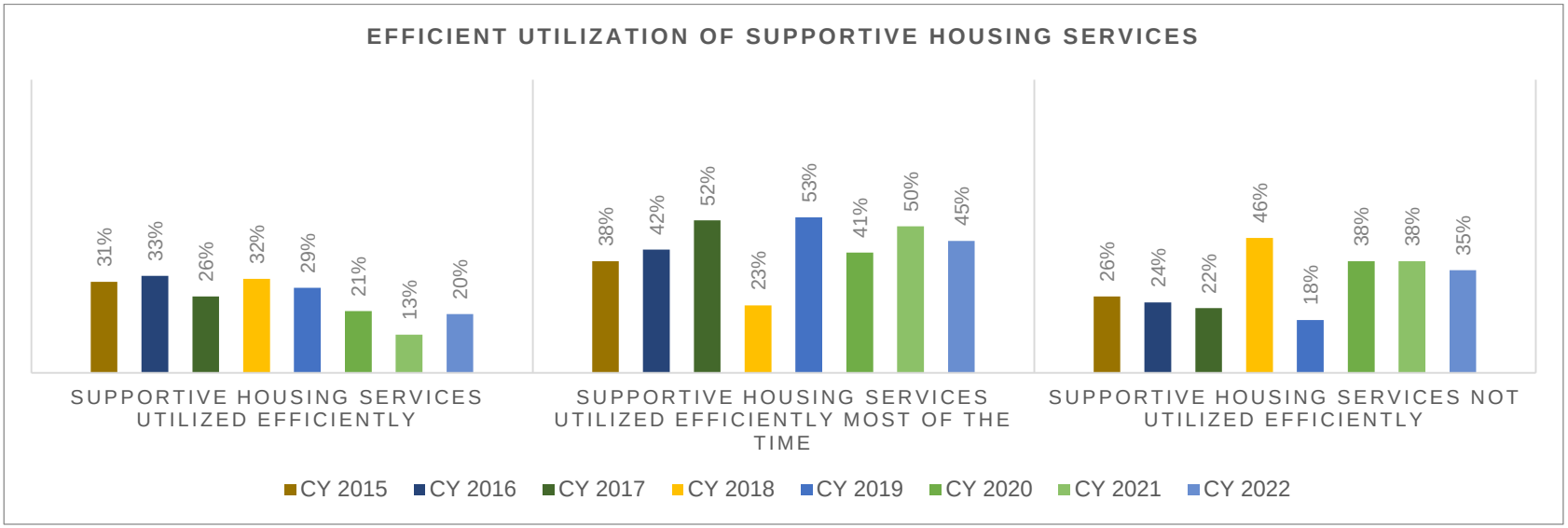
- 16% of the responses indicated staff turnover.



Efficient Utilization

In terms of efficient utilization of supportive housing services:

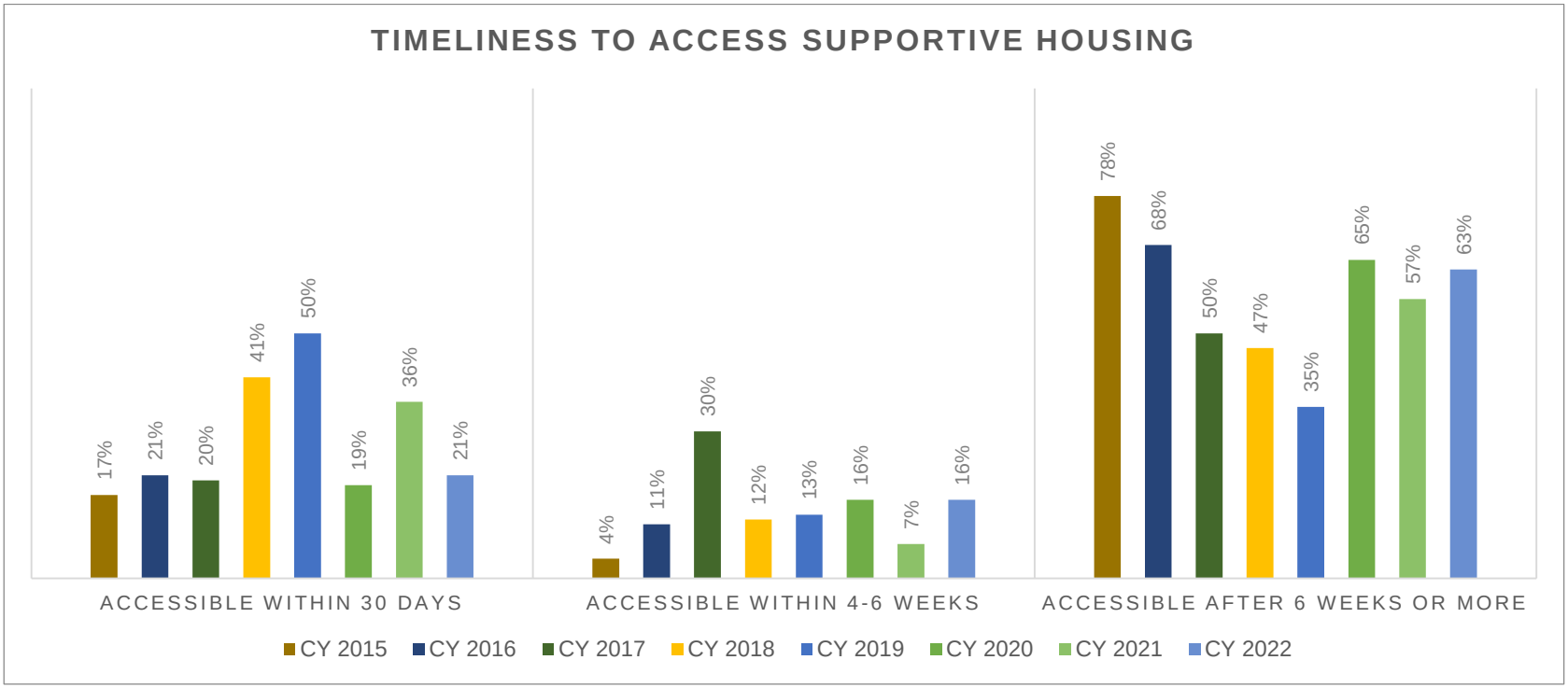
- 20% of the responses indicated that the services were being utilized efficiently (compared to 10% during CY 2013; 25% during CY 2014; 31% during CY 2015; 33% during CY 2016; 26% during CY 2017; 32% during CY 2018; 29% during CY 2019; 21% during CY 2020; and 13% during CY 2021).
- 45% responded that the services were utilized efficiently most of the time (compared to 30% during CY 2013; 50% during CY 2014; 38% during CY 2015; 42% during CY 2016; 52% during CY 2017; 23% during CY 2018; 53% during CY 2019; 41% during CY 2020; and 50% during CY 2021).
- 35% of the respondents indicated that supportive housing services were not utilized efficiently (compared to 60% during CY 2013; 25% during CY 2014; 26% during CY 2015; 24% during CY 2016; 22% during CY 2017; 46% during CY 2018; 18% during CY 2019; 38% during CY 2020; and 38% during CY 2021).



Timeliness

In terms of the amount of time to access supportive housing services:

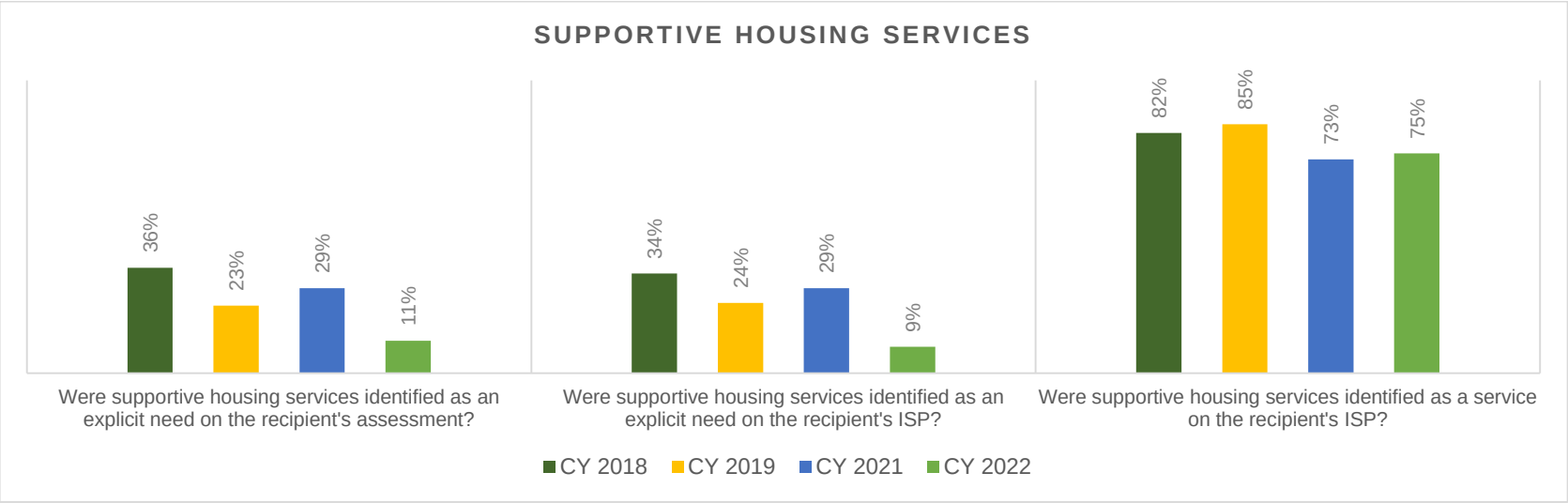
- 21% of the survey respondents reported that supportive housing services could be accessed within 30 days of the identification of the service need (compared to 11% during CY 2013; 0% during CY 2014; 17% during CY 2015; 21% during CY 2016; 20% during CY 2017; 41% during CY 2018; 50% during CY 2019; 19% during CY 2020; and 36% during CY 2021).
- 16% of the respondents indicated that the service could be accessed on average within four to six weeks (compared to 22% during CY 2013; 0% during CY 2014; 4% during CY 2015; 11% during CY 2016; 30% during CY 2017; 12% during CY 2018; 13% during CY 2019; 16% during CY 2020; and 7% during CY 2021).
- 63% of the survey respondents reported that it would take an average of six weeks or longer to access supportive housing services (compared to 67% during CY 2013; 92% during CY 2014; 78% during CY 2015; 68% during CY 2016; 50% during CY 2017; 47% during CY 2018; 35% during CY 2019; 65% during CY 2020; and 57% during CY 2021).



Medical Record Review

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

- Supportive housing services were identified as a need on either the recipient's assessment and/or recipient's ISP in 12% of the cases reviewed, substantially less than last year's finding (32%).
- Supportive housing was identified as a service on the recipient's ISP in 75% of the cases when identified as a need. An increase from last year when 73% of the ISPs with a documented need included supportive housing.
- 26% of the recipients included in the medical record review sample received a unit of supportive housing during CY 2022.



In 10 cases, reviewers were able to review progress notes and record the reasons that the person was unable to access supportive housing services after housing-related assistance was included on the person's ISP. Consistent with the two years, 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.

Service Utilization Data

Permanent supportive housing utilization includes skills training and development services to help members obtain and maintain community-based independent living arrangements. In addition to these services, targeted services for contracted permanent supportive 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, 5,525 (compared to 6,722 last review cycle) Title XIX eligible (Medicaid) recipients and 887 (compared to 1,266 last review cycle) non-Title XIX recipients were affiliated with the service during the period of October 1, 2021–December 31, 2022 from a total population of 37,107.[52]

[52] Mercer queried the following codes to delineate supportive housing service utilization when provided by a contracted supportive housing provider: H0043 (SupportiveHousing); H2014 (Skills Training and Development); H2017 (Psychosocial Rehabilitation Services); and T1019 and T1020 (Personal Care Services).

Available Housing Programs

Mercer interviewed a current supportive housing provider that administers permanent supportive housing programs, provides direct 1:1 services, and offers supports for members in community living placements. Under the permanent supportive housing program, the provider serves approximately 60 members by helping locate housing units for persons with income and/or housing vouchers. 1:1 services include intensive supports in the member's home and can extend up to 16 hours per day. Supports for persons in community living placements include assistance with independent living skills, budgeting, and mediation services for tenants and landlords. The agency serves approximately 20 members in the community living program. On average, member tenure in the supportive housing programs is approximately four to six months.

Despite the overall reduction in supportive housing utilization during CY 2022, the provider has not noticed a decrease in utilization or demand for supportive housing services. The provider feels that currently there is a significant demand for housing related supports and notes that there has been an increase with members in need of adequate housing. In addition, housing specialists employed by the agency are always at full capacity, which includes caseloads of 12 members per housing specialist for the permanent supportive housing program and 16 members per caseload for the community living program. The provider has not been experiencing workforce challenges, the teams are fully staffed, and staff turnover is reported to be low. Housing related challenges include a lack of housing vouchers, ambiguity regarding how homelessness is defined to qualify for services, a lack of affordable housing, a lack of housing accepting subsidies, members struggling with substance abuse disorders, and safety issues with available housing (e.g., one placement recently failed inspections on three different occasions).

The provider has also experienced issues with the Centralized Housing Administrator for the AHCCCS Housing program, citing challenges with timely access to open housing units. The provider reported that they are aware of available housing units or rooms, but the housing administrator does not always timely initiate referrals to the housing providers to fill the openings.

Key Findings and Recommendations

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

Findings: Supportive Housing

- Service utilization data reveals that 17% of members received at least one unit of supportive housing during the review period, a significant decrease when compared to the last two years (22%). In addition, over 1,500 less members received supportive housing services during CY 2022 when compared to CY 2021.
- None of the case manager focus group participants could identify a supportive housing service other than obtaining a voucher or receiving flex funds. The case managers described providing "supportive housing" to members by initiating referrals for vouchers or flex funds. Community-based providers participating in the focus groups agreed that health home teams need more training about supportive housing services and how to access the services.

- Provider focus group participants shared that there are not enough step-down or transitional housing options for members who need to move gradually to more independent settings. Similarly, focus group participants expressed a need for specialty housing that can accommodate the needs of members who are aging and those with complex medical needs.
- Some health homes provide an overview of supportive housing services during new employee orientation, but most case managers participating in the focus groups shared that they receive "no training" regarding what constitutes supportive housing and how to identify opportunities to offer the service.
- 45% of the survey respondents felt that supportive housing services were difficult to access (compared to CY 2021 — 59%; CY 2020 — 47%; and CY 2019 — 30%). One respondent indicated that supportive housing services were inaccessible.
- 63% of the survey respondents reported that it would take an average of six weeks or longer to access supportive housing services.
- When asked about the factors that negatively impact accessing supportive housing services, 23% of the responses indicated staff turnover.
- Supportive housing services were identified as a need on either the recipient's assessment and/or recipient's ISP in 12% of the cases reviewed, substantially less than last year's finding (32%).

Recommendations: Supportive Housing

- Investigate and mitigate reported concerns with the Centralized Housing Administrator related to delays in referring available housing units to permanent supportive housing providers.
- Continue efforts to identify safe and affordable housing options for recipients through collaboration with other community stakeholders, the AHCCCS contracted housing administrator, and supportive housing providers *(repeat recommendation from last year).*
- Initiate improvement actions to address challenges related to securing housing for members including a lack of housing vouchers, ambiguity regarding how homelessness is defined to qualify for services, a lack of affordable housing, a lack of housing accepting subsidies, members struggling with substance abuse disorders, and safety issues with available housing.
- Enhance health home team training regarding available housing programs and how to access the services. Consider a one-time review of current health home provider training curriculum to ensure accuracy and completeness of training materials.

5.5 Multi-Evaluation Component Analysis — Assertive Community Treatment

Service Description[53]

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

Focus Groups

Focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants. Findings collected from focus group participants regarding ACT team services included the following themes:

- Case managers participating in the focus groups expressed appreciation for ACT teams and how the teams support members.
- One adult member who uses ACT services shared that she is currently homeless and living in a shelter. The member's ACT team is still engaged with the member and meets with her regularly at her assigned health home. The member stated: "I am really happy (with the ACT team support) and it's had a good impact."
- An adult member participating in the focus groups has been assigned to an ACT team for 10 years. The member commented that he is comfortable with his team and hopes that he can continue to receive support, although the member added that the ACT team could be doing more to assist him with his recovery. The member is contemplating moving to a 16-hour residential placement and was concerned about losing his ACT services if he moves into a supervised setting.
- Case manager focus group participants expressed that there are still not enough ACT teams and believe that each health home should have at least one ACT team available. When a health home does not offer ACT services, members must transition to another health home to access the service.
- Case manager focus group participants shared some knowledge of the admission criteria for accessing ACT services, but none of the case managers have reviewed written criteria or received training on how members qualify for assignment to an ACT team.
- When completing an in-house referral to ACT services, case managers prepare a written summary about why the member may benefit from ACT services and present the rationale to the ACT team. However, case managers participating in the focus groups reportedly have not received training about ACT services and how to identify clinical indicators that could be addressed effectively through an ACT team.

[53] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation* which may not reflect the terminology utilized to currently describe these services.

- Case managers participating in the focus group shared that many referrals to ACT are denied, but these denials are processed informally and do not appear to go through a formal screening. Case managers typically receive an email from the ACT team stating the person was denied, but the denials do not reference how the member fails to meet admission criteria.
- Case manager focus group participants reported that once a person is accepted to ACT, it takes about one and a half weeks for the services to be initiated.
- The focus groups included adult members who utilize ACT and ACT team providers with both groups reporting high turnover with ACT team staff that serve members. One member participating in the focus group stated that he must “tell my story over and over again to new people. I don’t like having to start over.”
- ACT team providers participating in the focus group shared that due to the high turnover, ACT teams are frequently understaffed and therefore, the on-call rotation for remaining staff is shorter. Being on-call more frequently leads to higher levels of burnout among existing staff.
- ACT team providers participating in the focus group expressed that fidelity metrics used to evaluate the effectiveness of ACT team services are unachievable. Some of the providers feel more support could be offered by management by providing the teams with guidance on how to achieve higher scores. Another ACT provider shared that the Maricopa County managed care organization that contracts with AHCCCS periodically offers technical assistance which has helped improve performance on the metrics.
- One ACT provider participating in the focus group states that their ACT teams has recently transitioned to a four-day, 10 hour per day work schedule, hired a dedicated staff person to assist with the transcription of progress notes, and offers staff two hours per day of do-not-disturb time. The provider reports that the changes have improved staff morale, increased productivity levels, and has resulted in reduced staff burnout.

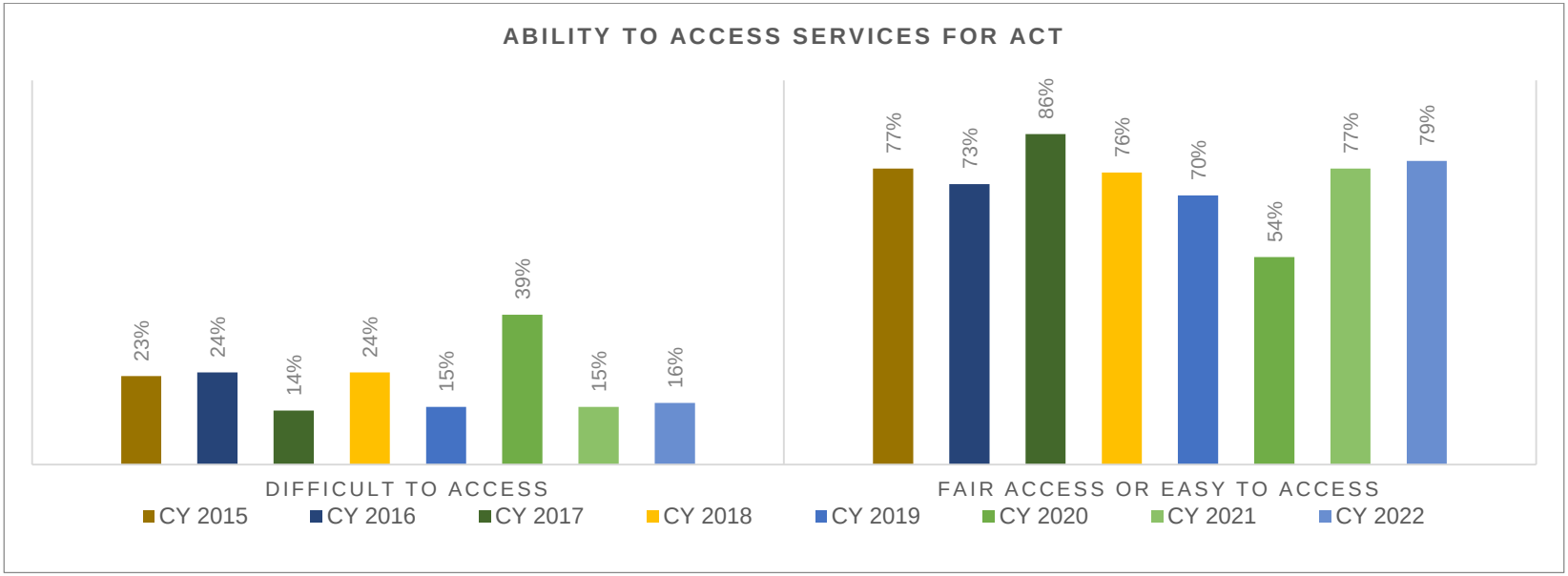
Key Informant Survey Data

As part of an effort to obtain input from key system stakeholders regarding the availability, quality, and access to ACT team services, a key informant survey was administered. The survey tool included questions and rating assignments related to ACT team services. 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 not be construed to be representative of the total population of system stakeholders.

Level of Accessibility

Sixteen percent of survey respondents reported that ACT team services were difficult to access (compared to 46% during CY 2013; 33% during CY 2014; 23% during CY 2015; 24% during CY 2016; 14% during CY 2017; 24% during CY 2018; 15% during CY 2019; 39% during CY 2020; and 15% during CY 2021). One respondent indicated that the service was unavailable.

Seventy-nine percent of respondents indicated that ACT team services had “fair access” or were easy to access (compared to 36% during CY 2013; 50% during CY 2014; 77% during CY 2015; 73% during CY 2016; 86% during CY 2017; 76% during CY 2018; 70% during CY 2019; 54% during CY 2020; and 77% during CY 2021).



Factors that Hinder Access

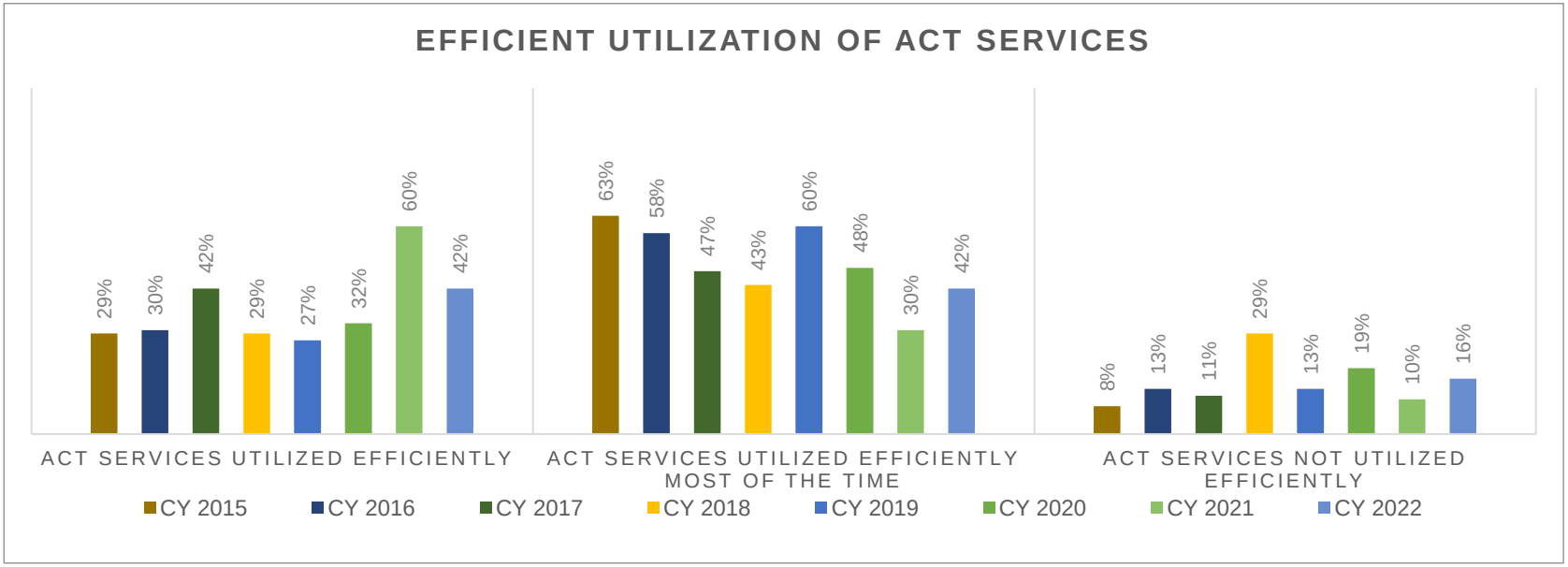
When asked about the factors that negatively impact accessing ACT team services, the CY 2022 responses are as follows:

- Staff turnover
- Member declines services
- Lack of capacity/no service provider available

Efficient Utilization

In terms of the efficiency of service utilization in CY 2022:

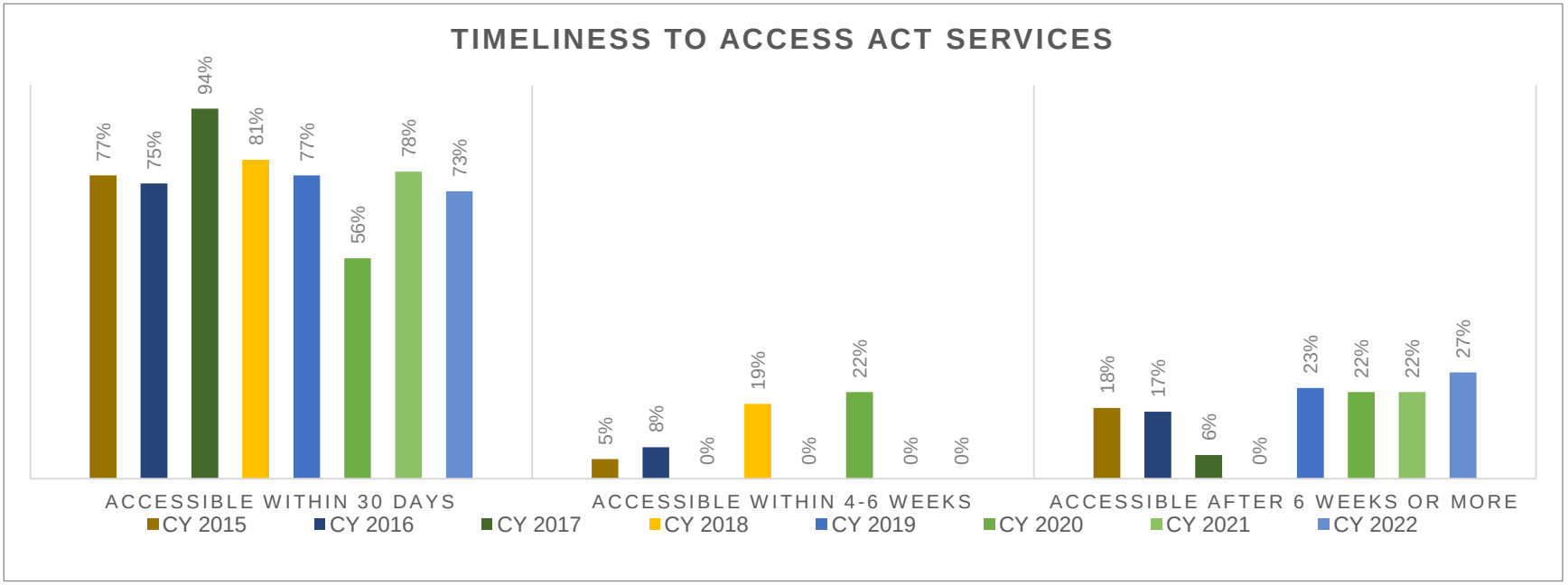
- 42% of the responses indicated that the services were being utilized efficiently (compared to 27% — CY 2013; 19% — CY 2014; 29% — CY 2015; 30% — CY 2016; 42% — CY 2017; 29% — CY 2018; 27% — CY 2019; 32% — CY 2020; and 60% — CY 2021).
- 42% responded that the services were utilized efficiently most of the time (compared to 18% — CY 2013; 56% — CY 2014; 63% — CY 2015; 58% — CY 2016; 47% — CY 2017; 43% — CY 2018; 60% — CY 2019; 48% — CY 2020; and 30% — CY 2021).
- 16% of the respondents indicated that ACT team services were not utilized efficiently (compared to 55% during CY 2013; 6% during CY 2014; 8% during CY 2015; 13% during CY 2016; 11% during CY 2017; 29% during CY 2018; 13% during CY 2019; 19% during CY 2020; and 10% during CY 2021).



Timeliness

In terms of the amount of time to access ACT team services in CY 2022:

- 73% of the survey respondents reported that ACT team services could be accessed within 30 days of the identification of the service need (compared to CY 2013 — 60%; CY 2014 — 58%; CY 2015 — 77%; CY 2016 — 75%; CY 2017 — 94%; CY 2018 — 81%; CY 2019 — 77%; CY 2020 — 56%; and CY 2021 — 78%).
- 0% of the survey respondents indicated that the service could be accessed on average, within four to six weeks (compared to CY 2013 — 20%; CY 2014 — 6%; CY 2015 — 5%; CY 2016 — 8%; CY 2017 — 0%; CY 2018 — 19%; CY 2019 — 0%; CY 2020 — 22%; and CY 2021 — 0%).
- 27% of survey respondents reported that it would take an average of six weeks or longer to access ACT team services (compared to CY 2013 — 20%; CY 2014 — 33%; CY 2015 — 18%; CY 2016 — 17%; CY 2017 — 6%; CY 2018 — 0%; CY 2019 — 23%; CY 2020 — 22%; and CY 2021 — 22%).

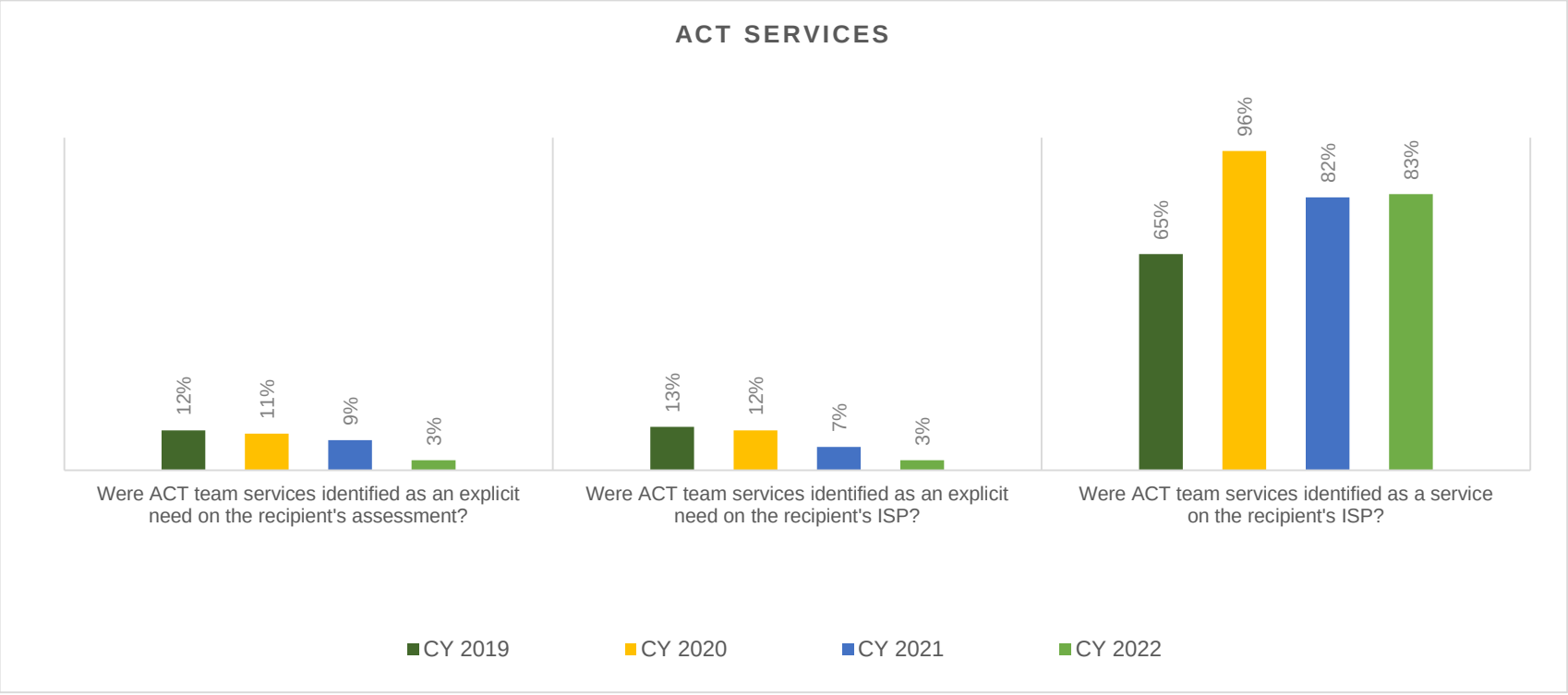


Medical Record Review

Consistent with findings from previous years, 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 when clinically appropriate.

In six cases (3%), ACT team services were identified as a need on recipients' assessments and/or ISPs. Eighty-three percent of the cases with an assessed need for ACT included ACT or case management services on the ISP.

Eight percent of the recipients included in the sample were assigned to an ACT team.

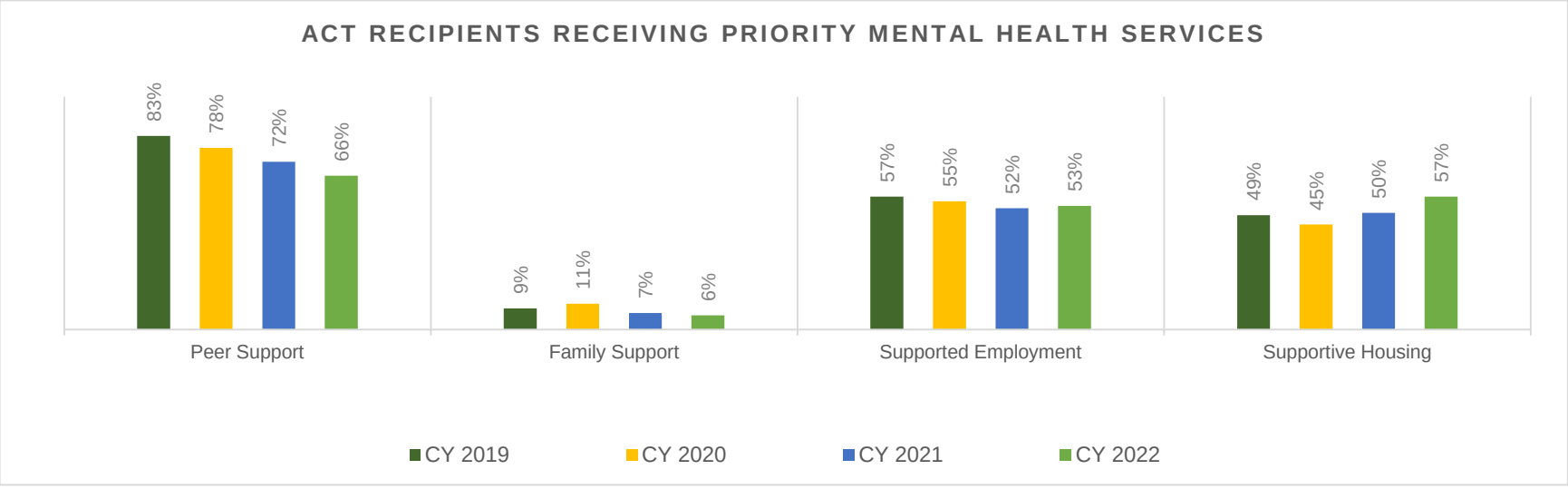


Service Utilization Data

ACT team services are not assigned a specific billing code. Therefore, ACT team services are not uniquely reflected in the service utilization data file. Mercer did complete an analysis of service utilization for recipients that were assigned to an ACT team. CY 2022 service utilization profiles for 2,093 ACT team members 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, supportive housing, peer support services, and/or family support services).

The analysis found:

- 66% of the ACT team members received peer support services during the review period.
- 6% of the ACT team members received family support services.
- 53% of ACT recipients received supported employment services.
- 57% of ACT recipients received supportive housing services.



Interviews with ACT Providers

Mercer facilitated interviews with two separate ACT providers that manage multiple ACT teams, including FACT teams. During the interviews, Mercer captured the following findings:

- Many of the teams are currently below capacity due to recent requests to transition members off ACT teams when the members are also residing in a supervised residential setting. One provider reported that fidelity standards stipulate that no more than 10% of services be provided outside of the ACT team as well as the perception that services are duplicative for ACT team members residing in supervised settings. Mercer received conflicting information if ACT team providers are informed that members assigned to ACT teams and residing in supervised residential settings must be transitioned off ACT teams to other levels of case management or the provider would not be reimbursed.
- Provider workforce challenges have resulted in temporary holds for transitioning new referrals to the ACT teams. Recruiting and retaining nurses on the ACT teams has been particularly challenging with one provider reporting 40% to 50% of ACT team nursing positions as vacant.
- One ACT team provider reports utilizing inpatient admissions, crisis episodes, and jail booking data to identify potential candidates for the ACT teams.
- New hire orientation and regular training is provided to the ACT teams including the use of billing codes, specialty roles on the teams, time management, outreach techniques, and a review of an ACT manual. One provider also offers trainings to clinical supervisors at the health homes and to community-based providers.

Key Findings and Recommendations

Findings: ACT Team Services

- As a percentage of the total population with SMI, 5.7% of all members are assigned to an ACT team. Almost 150 less members are utilizing ACT when compared to CY 2021.
- The focus groups included adult members who utilize ACT and ACT team providers with both groups reporting high turnover with ACT team staff that serve members.
- One ACT provider participating in the focus group states that their ACT teams recently transitioned to a four-day, 10 hour per day work schedule, hired a dedicated staff person to assist with the transcription of progress notes, and offers staff two hours per day of do-not-disturb time. The provider reports that the changes have improved staff morale, increased productivity levels, and has resulted in reduced staff burnout.

- Case manager focus group participants shared some knowledge of the admission criteria for accessing ACT services, but none of the case managers have reviewed written criteria or received training on how members qualify for assignment to an ACT team.
- 16% of survey respondents reported that ACT team services were difficult to access, compared to 15% during CY 2021. One respondent indicated that the service was unavailable.
- 66% of the ACT team members received peer support services, 53% received supported employment services, and 57% received supportive housing services during the review period.
- In all medical record review cases, there was 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. An ACT provider reported that a level of care assessment tool is applied by the ACT team for existing members, but the use of the tool is up to the discretion of the team and is not reviewed on a set schedule. The provider added that decisions to transition members to less intensive supports occurs intuitively and is based on team member perceptions that the member is stable.
- 101 members with SMI and associated with the highest aggregate behavioral health service costs during CY 2022 were reviewed by Mercer. The analysis found that 19% 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, 23% during CY 2015, 25% during CY 2016, 26% during CY 2017, 29% during CY 2018, 36% during CY 2019, 33% during CY 2020, and 26% during CY 2021.
- Of the 19 members assigned to ACT and included on the list of the top 100 members with the highest behavioral health service costs; 12 (63%) also reside 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. In other cases, placement in a supervised behavioral health residential setting and assignment to ACT may be appropriate for some members (e.g., medical co-morbidities, challenging behaviors).
- Overall, 70 of the 101 (69%) members reside 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 23% of the highest cost utilizers could potentially be candidates for assignment 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., 11 months — January 2022 through November 2022) and to 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:
  - 464 members experienced at least two jail bookings during the period under review (408 in CY 2015; 467 in CY 2016; 391 in CY 2017; 426 in CY 2018; 527 in CY 2019; 328 in CY 2020; and 448 in CY 2021).

- Of these 464 members, 49 (11%) were assigned to an ACT team during the review period (CY 2015 — 23%; CY 2016 — 25%; CY 2017 — 16%; CY 2018 — 22%; CY 2019 — 18%; CY 2020 — 14%; and CY 2021 — 14%).
- Of the 49 members assigned to an ACT team, 11 (22%) are assigned to a forensic specialty ACT team (CY 2015 — 20%; CY 2016 — 22%; CY 2017 — 29%; CY 2018 — 28%; CY 2019 — 22%; CY 2020 — 21%; and CY 2021 – 23%).
- 14 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, a reduction of four members when compared to last year.
- 186 members were incarcerated three or more times but are not assigned to an ACT or forensic specialty ACT team.

Recommendations: ACT Team Services

- To address current ACT team vacancies, actively monitor the ongoing capacity of all ACT teams and continue efforts to identify 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 members with SMI *(repeat recommendation from last year).*
- Establish a schedule (e.g., every 6 months) to review the member's assigned level of case management (i.e., connective, supportive, ACT) and determine if the member is assigned to the appropriate level of case management based on the member's clinical needs. Document the review activity and outcome in the member's medical record.
- Continue efforts to address workforce challenges to assist with recruitment and retention of ACT team staff members. Consider offering flexible work schedules, incentives, and other innovative approaches to support workers and improve job satisfaction.

Section 6

Outcomes Data Analysis

The service capacity assessment included a limited 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. The relationships between outcomes and service utilization trends may be identified, but those relationships do not necessarily reflect causal effects. As such, 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.

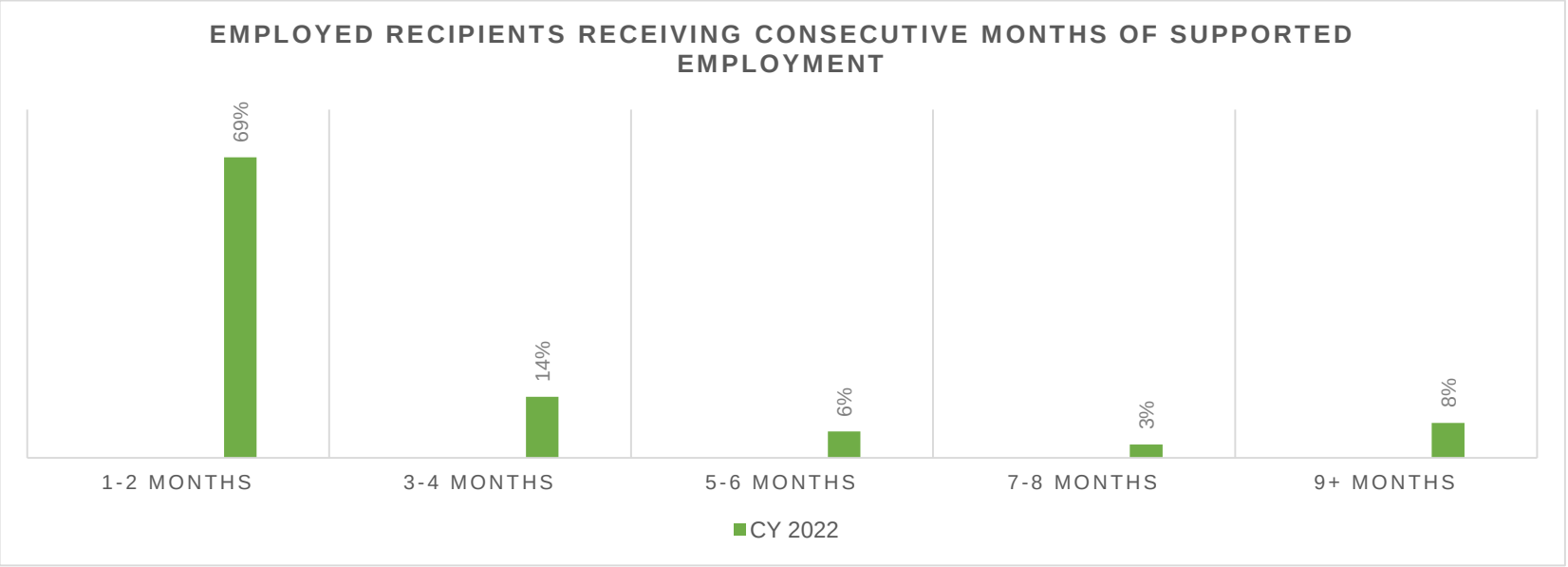
The following outcome indicators were reviewed:

- Employment status
- Criminal justice records (i.e., number of arrests)

During CY 2022, 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 and employment status. The relationship is further strengthened when the recipient sustains consistent participation in the priority service over an extended period.

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

- The percentage of recipients identified as employed full-time or part-time decreases as the continuing duration with supported employment services extends. Nearly 70% of the recipients identified as employed full-time or part-time 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 18% of the total employed group.
- This finding may suggest that supported employment services are effective at helping recipients gain employment relatively quickly and that ongoing supported employment services are utilized less once a person gains employment status. This finding also aligns with the disproportionate utilization of pre-job training and development (supported employment bill code H2027) when compared to ongoing support to maintain employment (bill code H2025). For example, Mercer found that 95% of all supported employment services were associated with pre-job training and development.



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

- Recipients who received peer support services for a duration of one to two months accounted for 68% of all incarcerations for these same recipients during the review period (i.e., CY 2022). Recipients who received peer support services for five or more consecutive months accounted for 10% of the total number of arrests during the review period. Sustained involvement in peer support services may contribute to fewer incarcerations.
- For full-time and part-time employed recipients, 73% of the recipients received one or two months of peer support services. This same group accounted for 65% of all arrests during the same time period. As sustainment in peer support services grows, employed recipients appear to experience fewer incarcerations.

Appendix A

Focus Group Invitation

Are you looking for a way to provide feedback about the behavioral health system in Maricopa County ***and*****,** you are:

- An ***adult with a serious mental illness*** (SMI) living in Maricopa County and receiving services from the behavioral health system.
- A ***family member of an adult with SMI*** living in Maricopa County who is receiving services from the behavioral health system.
- A ***direct care clinic case manager*** providing services for adults with SMI in Maricopa County.
- Or a ***provider of a priority mental health service (PMHS)*** in Maricopa County. PMHS include: Assertive Community Treatment (ACT), Supportive Housing or Permanent Supportive Housing (SH), Supported Employment (SE), or Peer and Family Support Services.

If so, consider registering for one of the stakeholder sessions below. *Attendees may only attend one session that best matches their role in the behavioral health system.*

Stakeholder Group One: For ***Adults with SMI*** receiving at least one PMHS

Tuesday, January 31, 2023
10:00 am–12:00 pm

Stakeholder Group Two: For ***Direct Care Clinic Case Managers*** providing PMHS to adults with SMI

Tuesday, January 31, 2023
2:00 pm–4:00 pm

Stakeholder Group Three: For ***Providers of ACT, SH, SE, Peer and Family Support Services***

Wednesday, February 1, 2023
10:00 am–12:00 pm

Stakeholder Group Four: For ***Family Members of Adults with SMI*** receiving at least one PMHS

Wednesday, February 1, 2023
2:00 pm–4:00 pm

All sessions will be held *in-person* at the following location:

Stand Together and Recover Services (S.T.A.R.) Central — 2502 E. Washington Street, Phoenix, AZ 85034

Space is available for 15 participants per stakeholder group. All RSVPs will be confirmed by email.
Once capacity is reached, interested participants will be placed on a waiting list.
RSVP by January 27, 2023 to Liza Auterino at liza.auterino@mercer.com or via phone at +1 480 238 9161.

Information gathered in these stakeholder sessions will be provided to the Arizona Health Care Cost Containment System (AHCCCS) as part of the annual assessment of PMHS in Maricopa County and help to expand access to recovery-oriented services. Attendee names will be kept confidential.

Priority Mental Health Services – Definitions

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.

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.

Supportive housing or permanent supportive 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. Supportive housing also includes rental subsidies or vouchers and bridge funding to cover deposits and other household necessities, although these items alone do not constitute supportive housing.

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

Appendix B

Key Informant Survey

Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2023

Q13 Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2023

Q1 1. Please indicate if you provide the following behavioral health services to adults with a serious mental illness (SMI).

	Yes (1)	No (2)
Assertive Community Treatment (ACT) (1)	O	O
Family Support Services (2)	O	O
Peer Support Services (3)	O	O
Supported Employment (4)	O	O
Supportive Housing (5)	O	O

Q2 2. Based on your experience as a provider, rate the level of accessibility to each of the priority services. 1=No Access/Service Not Available, 2=Difficult Access, 3=Fair Access, 4=Easy Access, NA=I do not have experience with this service

	1 (1)	2 (2)	3 (3)	4 (4)	N/A (5)
ACT (1)	O	O	O	O	O
Family Support Services (2)	O	O	O	O	O
Peer Support Services (3)	O	O	O	O	O
Supported Employment (4)	O	O	O	O	O
Supportive Housing (5)	O	O	O	O	O

Q3 3. Please identify the factors that hinder access to each of the priority services (select * all that apply).

	Member Declines Service (1)	Wait List Exists for Service (2)	Language or Cultural Barrier (3)	Transportation Barrier (4)	Clinical Team Unable to Engage/Contact Member (5)	Lack of Capacity/No Service Provider Available (6)	Admission Criteria for Services too Restrictive (7)	Staffing Turnover (8)	Other (9)
ACT (1)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family Support Services (2)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Peer Support Services (3)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Supported Employment (4)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Supportive Housing (5)	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q4 If you checked other above please specify:

_____

Q5

4. Are the priority services below being utilized efficiently?

	Yes (1)	Most of the Time (2)	No (3)	N/A (4)
ACT (1)	O	O	O	O
Family Support Services (2)	O	O	O	O
Peer Support Services (3)	O	O	O	O
Supported Employment (4)	O	O	O	O
Supportive Housing (5)	O	O	O	O

Q6 5. After a priority service need is identified by the clinical team, member, and family (as applicable), how much time elapses before the member accesses the service? Please respond for each priority service. NA = I do not have experience with this service.

	1-2 Weeks (1)	3-4 Weeks (2)	4-6 Weeks (3)	Longer than 6 weeks (4)	NA (5)
ACT (1)	O	O	O	O	O
Family Support Services (2)	O	O	O	O	O
Peer Support Services (3)	O	O	O	O	O
Supported Employment (4)	O	O	O	O	O
Supportive Housing (5)	O	O	O	O	O

Q7 6. Over the past 12 months, to what degree has access to each of the priority services changed? 1=easier to access, 2=more difficult to access 3=no change

	1 (1)	2 (2)	3 (3)
ACT (1)	O	O	O
Family Support Services (2)	O	O	O
Peer Support Services (3)	O	O	O
Supported Employment (4)	O	O	O
Supportive Housing (5)	O	O	O

Q8 7. Describe the most significant service delivery issue(s) for the persons with a SMI accessing behavioral health services in Maricopa County.

_____

Q9 8. What is your job role/title?

O CEO (1)

O Executive Management (2)

O Clinical Leadership (behavioral health) (3)

O Clinical Leadership (medical) (4)

O Specialty Case Manager (5)

O Direct Services Staff (BHP/BHT) (6)

O Other (please specify) (7) _____

Q10 9. From the list below, please select which best describes * your organization.

- O ACT Team Provider (1)
- O Behavioral Health Provider for Adults with a SMI Only (2)
- O Behavioral Health Provider for Adults with a SMI, Children, General Mental Health/Substance Abuse (3)
- O Consumer Operated Agency (peer support services/family support services for adults) (4)
- O Crisis Provider (5)
- O Hospital (6)
- O Provider Network Organization or other Administrative Entity within the Maricopa County Regional Behavioral Health Authority System (7)
- O Supported Employment Provider (8)
- O Supportive Housing Provider (9)
- O Other (please specify) (10) _____

Q11 10. As a result of the COVID pandemic, timely access to the priority mental health services was more difficult during calendar year 2022.

- O Strongly Agree (1)
- O Agree (2)
- O No Impact (3)
- O Disagree (4)
- O Strongly disagree (5)

Appendix C

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, 2022 – December 31, 2022*

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						
Supportive Housing						
Peer Support Services						

Appendix D

Summary of Recommendations

Service	Recommendations
Peer Support Services (PSS)	PSS 1: Consistent with the *AHCCCS Contractor Operations Manual, Policy 407, Workforce Development*[54]*,* examine factors contributing to high turnover and vacancies across peer support specialists operating within the service delivery system and take appropriate actions to improve recruitment and retention. PSS 2: Monitor reductions in the utilization of peer support services and identify the most prominent causal factors contributing to reduced utilization. As appropriate, take corrective actions to improve access and increase utilization.
Family Support Services (FSS)	FSS 1: Provide training and supervision to ensure that health home clinical team members understand the appropriate application of family support services and to recognize the value of family support services as an effective service plan intervention.
Supported Employment Services (SES)	SES 1: Assess the inventory of available part-time job opportunities available via supported employment providers. As indicated, expand offerings so that members have adequate opportunities to pursue part time work. SES 2: Clarify the appropriate billing/service code modifier to capture annual rehabilitation specialists' vocational/meaningful day assessments or annual vocational activity profiles. Train rehabilitation specialists to record and bill the services in a consistent manner. SES 3: Continue to monitor and address the practice of documenting supported employment services on members' ISPs without evidence of an assessed need for the service. Train clinical teams to develop ISPs that are individualized and reflect the member's unique circumstances and needs *(repeat recommendation from last year).*

[54] This policy specifies contractor requirements to establish and maintain a Workforce Development Operation (WFDO) to monitor and collect information about the workforce, collaboratively plan workforce development initiatives, and when necessary, provide direct assistance to strengthen provider workforce development programs.

Service	Recommendations
	SES 4: Designate staffing resources to serve in the role of benefit specialists (use of peer support specialists, case managers, etc.) to address member concerns about securing employment without jeopardizing eligibility for public assistance programs (e.g., AHCCCS eligibility, SSDI) *(repeat recommendation from last year).*
Supportive Housing Services (SH)	SH 1: Investigate and mitigate reported concerns with the Centralized Housing Administrator related to delays in referring available housing units to permanent supportive housing providers. SH 2: Continue efforts to identify safe and affordable housing options for recipients through collaboration with other community stakeholders, the AHCCCS contracted housing administrator, and supportive housing providers. SH 3: Initiate improvement actions to address challenges related to securing housing for members including a lack of housing vouchers, ambiguity regarding how homelessness is defined to qualify for services, a lack of affordable housing, a lack of housing accepting subsidies, members struggling with substance abuse disorders, and safety issues with available housing. SH 4: Enhance health home team training regarding available housing programs and how to access the services. Consider a one-time review of current health home provider training curriculum to ensure accuracy and completeness of training materials.
Assertive Community Treatment (ACT)	ACT 1: To address current ACT team vacancies, actively monitor the ongoing capacity of all ACT teams and continue efforts to identify 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 members with SMI. ACT 2: Establish a schedule (e.g., every six months) to review the member's assigned level of case management (i.e., connective, supportive, ACT) and determine if the member is assigned to the appropriate level of case management based on the member's clinical needs. Document the review activity and outcome in the member's medical record. ACT 3: Continue efforts to address workforce challenges to assist with recruitment and retention of ACT team staff members. Consider offering flexible work schedules, incentives, and other innovative approaches to support workers and improve job satisfaction.

Service	Recommendations
General Recommendations (GR)	GR 1: Perform an assessment of the work processes at the health homes that focuses on the timely implementation of members' ISPs, including timely referral to needed services. Consider initiating referrals on the same day that the member's ISP is reviewed/updated. GR 2: Continue efforts to monitor the timely completion of annual member assessments and ISPs. When compiling the sample for medical record reviews, 11% of the cases (from a sample of 200) did not include current assessments/ISPs. GR 3: Consider a one-time review of health home new employee orientation and ongoing training curriculum to ensure that health home clinical team members understand the appropriate application of the priority mental health services and how to assist members with accessing the services when medically necessary. GR 4: Review each contracted health home's electronic medical record templates for documenting assessments and ISPs and ensure that the templates include all minimum data fields. Mercer noted that one provider's ISP template does not include a field to identify the covered services needed to address the member's objectives and needs.

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