

Priority Mental Health Services 2021

Service Capacity Assessment

Arizona Health Care Cost Containment System

November 30, 2021



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Section 1

Executive Summary

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency, engaged Mercer Government Human Services Consulting (Mercer) to implement a network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI) in Maricopa County, Arizona. This report represents the eighth 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, supported 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:* A sample (n=200) of class members is drawn to support an evaluation of clinical assessments, individual service plans (ISPs), and progress notes to examine recipient's assessed needs and timely delivery of 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 and progressive time intervals (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:* The analysis of outcome data including homeless prevalence, employment data, and criminal justice information.
- *Benchmark analysis:* The analysis evaluates priority service prevalence and penetration rates in other states and local systems that represent relevant comparisons for 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) 2020, though for some units of analysis that rely on service utilization data, the timeframe was adjusted (e.g., October 2019–June 30, 2020 and October 2019–December 2020) to account for potential lags in processing administrative claims data.

Service Capacity Assessment Conclusions

Mercer’s current service capacity assessment found sustained capacity of the priority mental health services as established and documented in prior year service capacity assessments. In fact, CY 2020 utilization rates for each of the priority mental health services increased as percentage of the overall population for all of the priority mental health services when compared to CY 2019.

Table 1 — Summary of Priority Mental Health Services Utilization, CY 2020 and CY 2019

CY 2020 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Service utilization data	35,114	41%	6%	34%	22%	6.6% ¹

CY 2019 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Service utilization data	34,451	35%	5%	31%	15%	6.6% ²

¹ ACT services were not included as part of the service utilization file, but based on the current ACT roster, 6.6% of all active SMI recipients are assigned to ACT teams.

² ACT services were not included as part of the service utilization file, but based on the current ACT roster, 6.6% of all active SMI recipients are assigned to ACT teams.

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 2020 and the Impact of the COVID-19 Pandemic

In March 2020, the Maricopa County SMI delivery system underwent a dramatic shift in response to the COVID-19 pandemic, with many direct care clinics and providers suspending or limiting in-person services and pivoting to telephonic and telehealth modalities to meet members' behavioral health needs. To better understand the impact of COVID-19 and possible effects on the availability of the priority mental health services, Mercer intentionally asked focus group participants 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 impact of the COVID-19 pandemic. A summary of observations derived from the focus groups and how the COVID-19 pandemic influenced access to the priority mental health services is presented below:

- Peer support groups went virtual due to COVID-19 — while perceived as supportive, the groups are reportedly less effective due to the growth in the numbers of members attending. Prior to COVID-19, in-person peer support groups were described as phenomenal and very supportive.
- All clinics have been impacted by declines in the available work force due to the COVID-19 pandemic. Focus group participants reported that there are less resources available, and caseloads are too high with high turnover.
- One provider's response to COVID-19 was described as rigid, with frequent cleanings and fogging of vehicles used to transport members. The provider never closed the clinic, but barriers with engaging members emerged making the transition to limited contact challenging for members.
- One participant reported they are having trouble finding employment after being laid off due to COVID-19. Another focus group participant noted that resources available to members to explain the impact of working on benefits are no longer available due to COVID-19.
- As a result of COVID-19, members expressed concerns about having to travel to work sites to receive requisite job training and are generally more willing to accept opportunities that allow remote working arrangements.
- One barrier for members seeking employment opportunities relates to clinical team restrictions on providing transportation to the work site once the person is employed. Public transportation options can result in members spending several hours in transit only to work three to four hours per day, as well as concerns about exposure to COVID-19.

- Challenges related to 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. Mercer also heard accounts of members opting out of supported employment services due to the COVID-19 pandemic.
- Due to COVID-19, there are more challenges than ever in finding available housing.

Overall, the system was able to adapt and overcome many of the challenges related to the COVID-19 pandemic. Innovative approaches to service delivery emerged, with AHCCCS implementing policy changes to allow more services to be provided telephonically, expanding the utilization of telehealth, providers accepting verbal consent from members to expedite the processing of service referrals, and the widespread distribution of tablets to members to facilitate virtual participation in accessing the priority mental health services. Despite challenges with the COVID-19 pandemic, the volume of recipients increased year-to-year with higher percentages of individuals receiving peer support, family support, supported employment, supported housing, and ACT during 2020 based on an analysis of service utilization data.

Consumer Operated Services (Peer Support and Family Support)

41% of all members with an SMI received at least one unit of peer support during the period of October 2019 through December 31, 2020. Varied opportunities exist for members to access and participate in peer support services. Peer support specialists are available within the direct care clinics, through multi-disciplinary teams providing ACT team services, via participation in an expansive array of clinic-based education and support groups, provide supported housing services, and/or within the community by attending one of many available consumer operated peer support programs. In addition, many members attend peer support groups virtually in response to the COVID-19 pandemic and related restrictions on in-person services. However, one half of key informant survey respondents felt that peer support services were easy to access, a decrease from the prior year's survey results in which 64% of the survey respondents indicated that the services were easy to access.

Only three cases out of a total of 200 medical records included an assessed need for family support services and 6% of all recipients received family support services over the review period. As observed in prior year service capacity assessments, a lack of available or engaged family members, member choice to not involve family members in treatment, and persistent evidence that clinical teams don't fully understand how to apply the service and/or appreciate the benefits that family support services can provide, continue to be the most prominent factors contributing to the relatively low utilization of the services. As such, opportunities still exist to promote the use of family support services and for clinical teams to better appreciate the value of the services by identifying instances in which family support services can be leveraged to further members' individual recovery journeys.

Supported Employment

Service utilization data demonstrates 34% of members received at least one unit of supported employment during CY 2020, an increase of 3% from last year and the third consecutive year of year-to-year increases in utilization. Maricopa County's supported employment utilization rate of 34% and ongoing supported employment utilization rate of 9% (which is considered to be closer to high-fidelity supported employment) are among the highest in a benchmark analysis comparing comparable service delivery systems across the nation. The national utilization rate for supported employment is less than 2%.

Focus group participants estimated that 30% of the SMI population was fearful of losing benefits if earning income. There appears to be a need for ongoing education regarding member fear of losing benefits or their housing vouchers if income is earned. Awareness and utilization of the Disability Benefits 101 website resource can be an effective tool to illustrate how income does not necessarily jeopardize a member's public assistance/benefits.

Mercer's medical record review team continues to note that clinical teams identify supported employment services on the member's individual service plan in the absence of an assessed need for the services. Over one third of the cases Mercer reviewed lacked evidence that the member received supported employment services despite the service being listed on the member's service plan.

Supported Housing

Programs and adequate capacity exists for persons in need of housing; offering a wide array of support services and community resources to help individuals achieve and maintain integrated and independent housing. Permanent supported housing providers operate permanent supported housing programs and multiple service contractors are available to provide supported housing services under a community living program. Available housing supports also extend to housing providers who manage properties and oversee scattered site housing subsidies for individuals who qualify. However, focus group participants described the lack of affordable and safe housing for members as a "crisis", with rent substantially increasing over the review period and a perception that much of the available housing is not maintained satisfactorily and is perceived to be unsafe.

Assertive Community Treatment

The system currently has 24 functional ACT teams, the same number of teams as last year with more members being served under ACT (i.e., 39 more members during CY 2020 than CY 2019).

Clinical teams should ensure that regular and consistent assessments are occurring for new ACT team candidates and for individuals who have had a prolonged tenure on an ACT team that should be considered for less intensive supports. In addition, data elements such as service cost data, hospitalization rates, crisis intervention episodes and jail booking data can support the identification of

potential candidates that may benefit from ACT team services. Capacity of available ACT teams still appears to be adequate to meet the current needs of the system and recommendations are consistent with prior year assessments (e.g., actively promote the identification of appropriate candidates for ACT via periodic analyses of relevant data sources). The managed care organization responsible for the oversight of the SMI delivery system is working to develop a risk stratification tool that factors in social determinants of health, incarceration data, and other relevant data elements to help identify high-risk members who may benefit from ACT services.³

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

³ Per telephonic interview with the current managed care organization under contract with AHCCCS (conducted on November, 15, 2021).

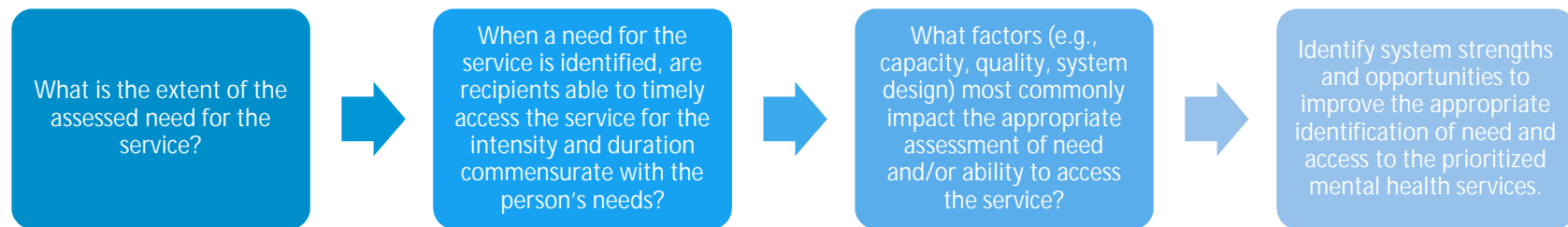
Section 2

Overview

AHCCCS engaged Mercer to implement an annual network sufficiency evaluation of four prioritized mental health services available to persons determined to have a SMI⁴. The service capacity assessment included a need and allocation evaluation of consumer operated services (peer support services and family support services), supported employment, supported housing, and 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 analysis of summary level service utilization data related to the prioritized mental health services and aggregated available functional and clinical outcomes data.

⁴ The determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis.

Section 3

Background

During the review period, AHCCCS served as the single State authority to provide coordination, planning, administration, regulation and monitoring of all facets of the State public behavioral health system. AHCCCS contracts with managed care organizations to administer integrated physical health and behavioral health services throughout the State of Arizona. 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, supported housing, case management, and expansion of organizations run by and for people living with SMI. The two-year agreement included activities aimed to assess the quality of services provided, member outcomes, and overall network sufficiency.

On January 8, 2014, a final agreement was reached in the Arnold v. Sarn case. The final settlement extends access to community based services and programs agreed upon by the State and plaintiffs, including crisis services; supported employment and housing services; ACT; family and peer support; life skills training and respite care services. The State was required to adopt national quality standards outlined by the Substance Abuse and Mental Health Services Administration, 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 the SMI population.

SMI 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 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, Regional Behavioral Health Authorities are required to 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 an SMI in Maricopa County, the designated managed care organization has contracts with adult provider network organizations (PNOs) and multiple administrative entities that manage ACT teams and/or operate direct care clinics throughout the geographic service area. Table 2 below identifies the adult PNOs and administrative entities and assigned direct care clinics.

Table 2 — Maricopa County Direct Care Clinics

Organization	Direct Care Clinics	Organization	Direct Care Clinics
Chicano Por La Causa	Centro Esperanza	Partners in Recovery Network	Gateway Campus
Community Bridges, Inc.	Mesa Heritage		Hassayampa Campus
Community Partners, Inc.	Community Partners		Metro Campus
	Integrated Healthcare		West Valley Campus
Jewish Family and Children Services	East Valley Health Center	PSA (Resilient Health)	Higley Integrated Healthcare Center
	Michael R. Zent Healthcare Clinic	Southwest Network	Estella Vista
LaFrontera/EMPACT	Comunidad		Northern Star
	EMPACT — San Tan		Saguaro
	EMPACT — SPC Apache Junction		San Tan
Lifewell Behavioral Wellness	Desert Cove	Terros	Priest
	Oak		23rd Avenue
	South Mountain		51st Avenue
	Windsor		Red Mountain
Partners in Recovery Network	Arrowhead Campus	Valleywise	First Episode Center
	East Valley Campus		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.⁵

Table 3 — ACT Teams (24 teams serving 2,317 recipients)⁶

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Community Bridges: 99th Avenue	PCP Partnership	100	94	6%
Community Bridges: Avondale	PCP Partnership	100	98	2%
Community Bridges: FACT Team 1	Forensic Team & PCP Partnership	100	99	1%
Community Bridges: FACT Team 2	Forensic Team & PCP Partnership	100	100	0%
Community Bridges: FACT Team 3	Forensic Team & PCP Partnership	100	100	0%
Community Bridges: Mesa Heritage	PCP Partnership	100	98	2%
La Frontera/ EMPACT: Tempe	PCP Partnership	100	96	4%
La Frontera/EMPACT: Capitol Center	PCP Partnership	100	95	5%
La Frontera/EMPACT: Comunidad	PCP Partnership	100	98	2%
Lifewell Behavioral Wellness: Desert Cove	PCP Partnership	100	91	9%
Lifewell Behavioral Wellness: South Mountain	PCP Partnership	100	98	2%
Partners in Recovery/COPA Health: Gateway	PCP Partnership	100	81	19%
Partners in Recovery/COPA Health: Indian School	Medical Team	100	98	2%
Partners in Recovery/COPA Health: Metro Campus — Omega Team	PCP Partnership	100	96	4%

⁵ As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2021.

⁶ As of December 1, 2020.

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Partners in Recovery/COPA Health: Metro Campus — Varsity Team	PCP Partnership	100	95	5%
Partners in Recovery/COPA Health: West Valley Campus	PCP Partnership	100	97	3%
Southwest Network: Northern Star	PCP Partnership	100	100	0%
Southwest Network: Saguaro	PCP Partnership	100	97	3%
Southwest Network: San Tan		100	97	3%
Terros: 51st Avenue	PCP Partnership	100	99	1%
Terros: Enclave		100	99	1%
Terros: Townley 1	PCP Partnership	100	100	0%
Terros: Townley 2		100	99	1%
Valleywise — Mesa Riverview	PCP Partnership	100	92	8%
Totals		2,400	2,317	3.50%

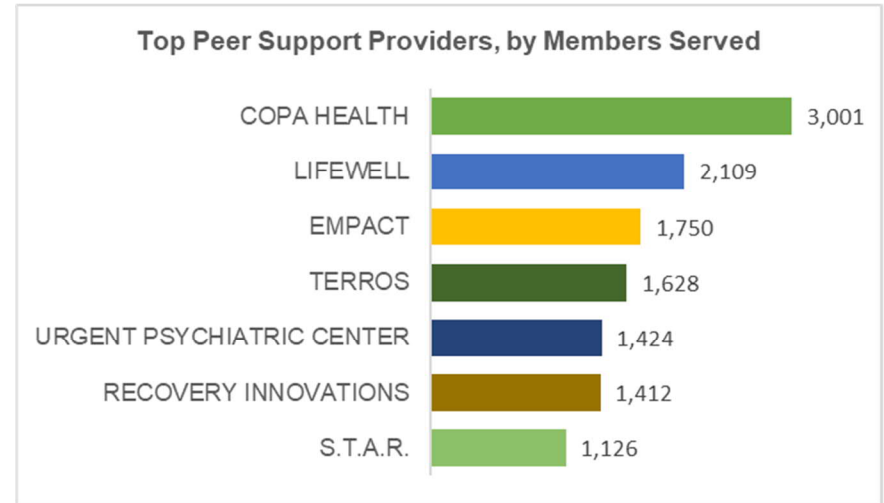
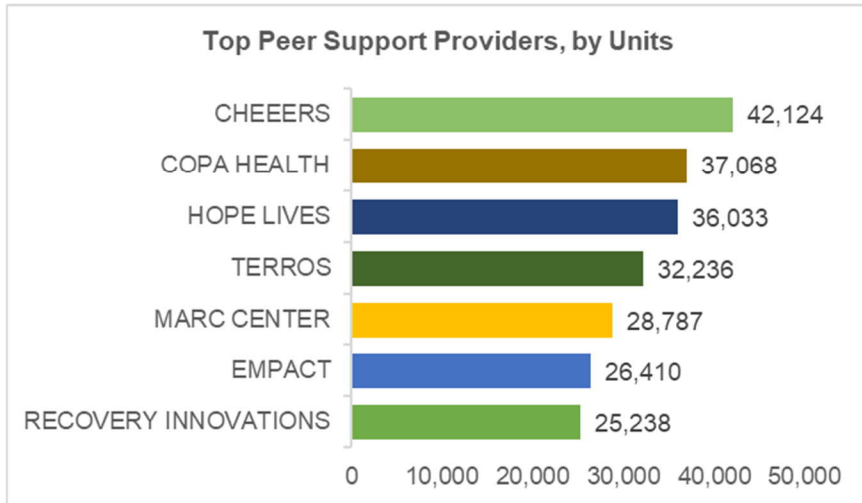
An analysis of service utilization data is presented below to identify the volume of units and unique members affiliated with each priority mental health service provider. The results identify the most prominent providers of the priority mental health services. The analysis was completed for the following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

Consumer Operated Services (peer support and family support) Providers⁷

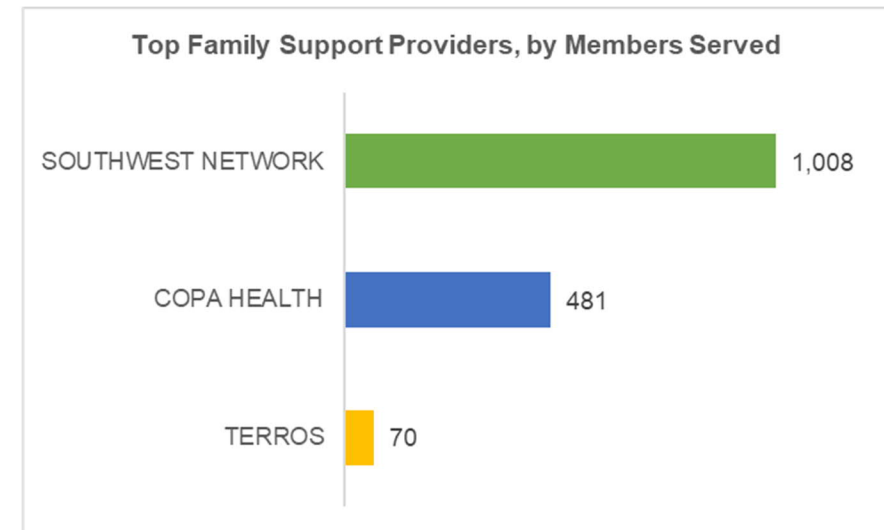
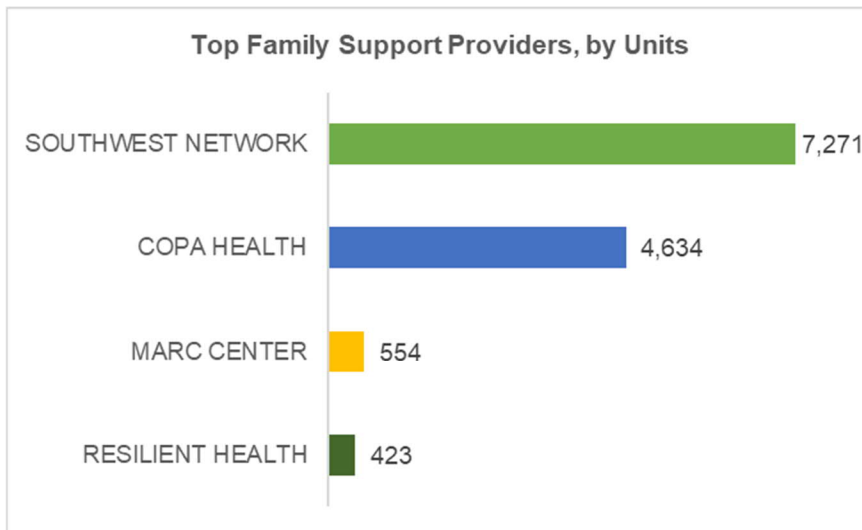
- CHEEERS
- Chicanos Por La Causa (CPLC)

⁷ As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2021.

- Community Bridges, Inc.
- Community Partners Integrated Health Care (CPIH)
- Copa Health
- Hope Lives — Vive la Esperanza
- La Frontera/EMPACT
- Lifewell Behavioral Wellness
- National Council on Alcoholism and Drug Dependence (NCADD)
- NAZCARE
- Recovery Empowerment Network
- Recovery Innovations International
- Resilient Health
- Southwest Behavioral Health
- Southwest Network
- Stand Together and Recover (STAR)
- TERROS
- Valle del Sol
- Valleywise

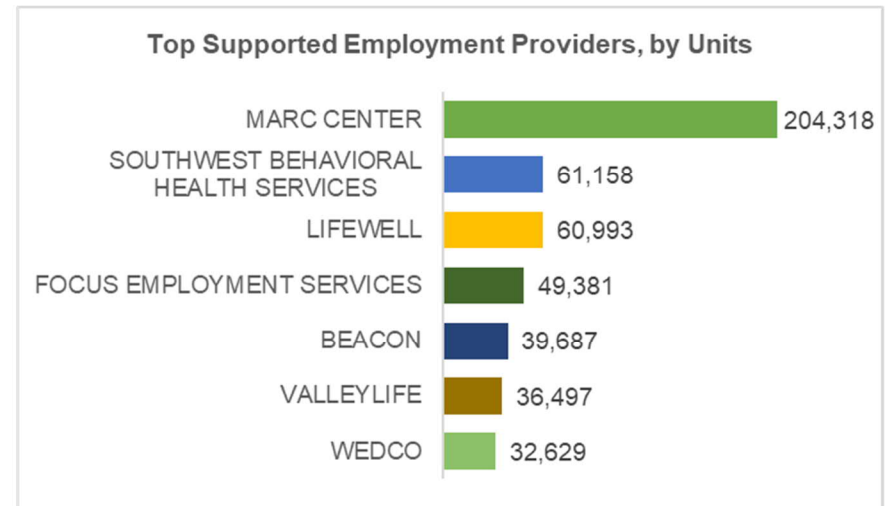
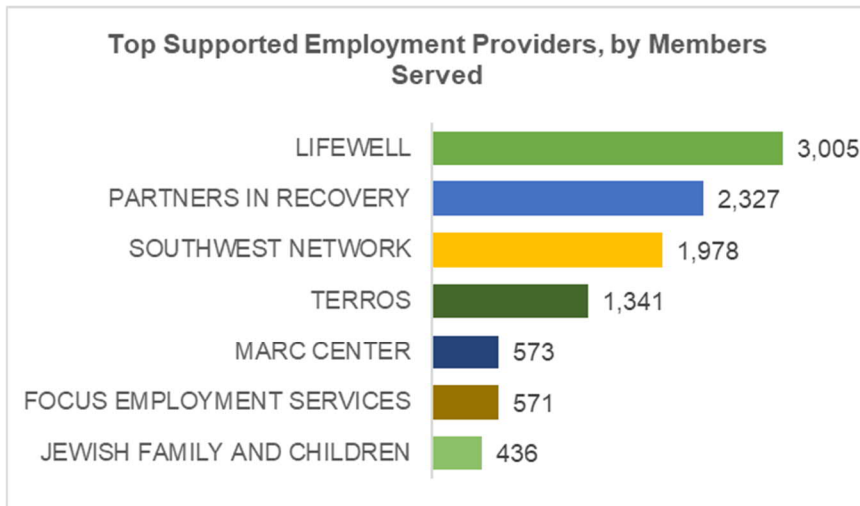


Consumer Operated Services (family support)



Supported Employment Providers⁸

- Beacon Group
- Focus Employment Services
- Lifewell Behavioral Wellness
- Marc Community Resources
- REN
- Valleylife
- Wedco



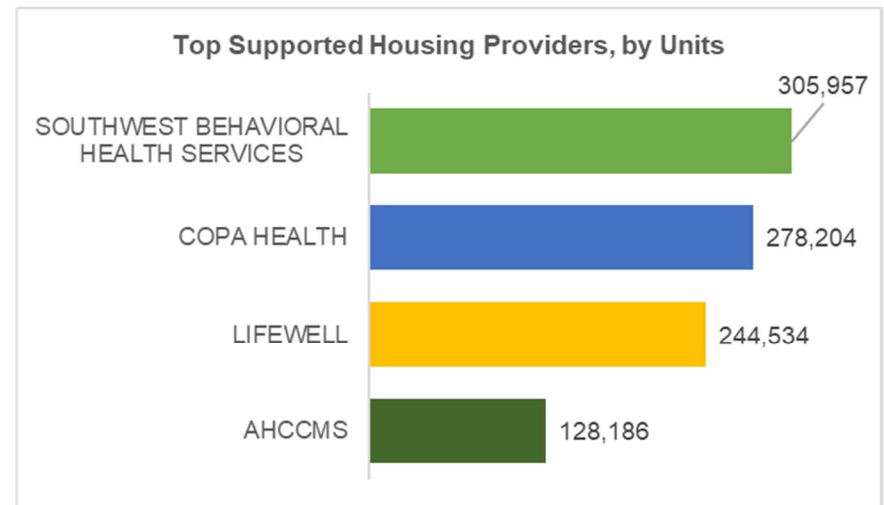
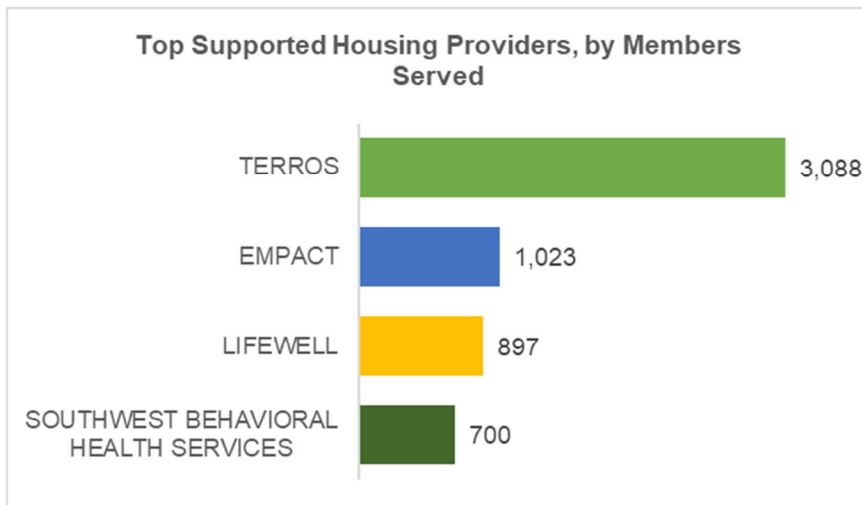
⁸ As reported by the Maricopa County Regional Behavioral Health Authority administering the AHCCCS contract in January 2021.

Supported Housing Providers⁹

- Arizona Behavioral Health Corporation
- Arizona Mentor
- AZ Health Care Contract Management Services
- Biltmore Properties
- Chicanos Por La Causa
- Child and Family Support Services
- City of Tempe
- Community Bridges, Inc.
- Community Partners Integrated Health
- Florence Crittenton
- Helping Hearts
- Housing Authority of Maricopa County
- La Frontera/EMPACT
- Lifewell Behavioral Wellness
- Marc Community Resources

⁹ As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2021.

- Native American Connections
- ProMarc
- Resilient Health
- RI International
- Save the Family
- Southwest Behavioral & Health Services
- Terros Health



Section 4

Methodology

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

- *Key informant surveys, interviews, and focus groups:* 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, 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 homeless prevalence, employment data, and criminal justice information.
- *Benchmark analysis:* Analysis of priority service penetration rates in other states and local systems that represent relevant comparisons for Maricopa County.

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

Focus Groups

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

Participation in the focus groups was solicited by an invitation created by Mercer, which was reviewed and approved by AHCCCS¹⁰.

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

The focus groups targeted the following participants:

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

A total of 26 stakeholders participated in the four two-hour focus groups conducted on August 17, 2021 and August 18, 2021. All four focus groups were held via Zoom teleconference. 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:

¹⁰ See Appendix A: Focus Group Invitation.

- 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 impact of the COVID-19 pandemic.

Key Informant Surveys and Interviews

One objective of the service capacity assessment was to obtain comprehensive stakeholder feedback regarding the availability of each of the priority mental health services. As a result, a key informant survey was created using Survey Monkey®. The survey tool included questions with rating assignments related to accessing the priority mental health services, including the ease of access and timeliness of access to the services.¹¹ 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 via email with a hyperlink to the online survey. A total of 37 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 PNOs, direct care clinics and levels of case management (i.e., assertive, supportive and connective).

¹¹ See Appendix B: Key Informant Survey.

The final sample included 200 randomly chosen cases stratified by PNO and clinic and selected using the following parameters:

- The recipient was identified as SMI and received a covered behavioral health service during October 1, 2019 and December 31, 2020.¹²
- The recipient had an assessment date between January 1, 2020 and November 15, 2020.¹³

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

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

Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient's current annual assessment update or initial assessment and/or a current psychiatric evaluation, the recipient's current ISP, and all clinical team progress notes following each recipients' assessment date through December 31, 2020.

To complete the medical record audit, two 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.

¹² The total population of unique SMI recipients who received behavioral health services is 35,114 for the period October 1, 2019 through December 31, 2020.

¹³ 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.

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, 2019 and December 31, 2020.

Specific queries are run to identify utilization of each prioritized mental health service.¹⁴ 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.

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 each year of the service capacity assessment are illustrated in the following tables and are compared to the characteristics of the total population of active users.

CY 2020 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Sample Group	200	50%	1%	44%	5%	12%
Service utilization data	35,114	41%	6%	34%	22%	6.6% ¹⁵

¹⁴ 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.

¹⁵ ACT services were not included as part of the service utilization file, but based on the current ACT roster, 6.6% of all active SMI recipients are assigned to ACT teams.

CY 2019 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Sample Group	200	52%	6%	51%	22%	12%
Service utilization data	34,451	35%	5%	31%	15%	6.6% ¹⁶

CY 2018 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Sample Group	200	47%	4%	41%	20%	10%
Service utilization data	34,264	36%	4%	29%	15%	6%

CY 2017 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Group 1	121	36%	2%	27%	9%	3%
Group 2	199	49%	2%	35%	9%	18%
Service utilization data	31,712	37%	2%	26%	7%	7%

¹⁶ ACT services were not included as part of the service utilization file, but based on the current ACT roster, 6.6% of all active SMI recipients are assigned to ACT teams.

CY 2016 Service Capacity Assessment Time Period — Utilization

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

CY 2015 Service Capacity Assessment Time Period — Utilization

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

CY 2014 Service Capacity Assessment Time Period — Utilization

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

CY 2013 Service Capacity Assessment Time Period — Utilization

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

Analysis of Outcomes Data

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

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

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

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

- Unemployed
- Volunteer
- Unpaid rehabilitation activities
- Homemaker
- Student
- Retired
- Disabled
- Inmate of institution
- Competitive employment full-time

- Competitive employment part-time
- Work adjustment training
- Transitional employment placement
- Unknown

Penetration and Prevalence Analysis

As part of the service capacity assessment, a review of utilization and penetration rates of the priority mental health services ACT, supported employment, supported housing, and peer support¹⁷ is conducted. Penetration rates were compared to benchmarks, as described below.

The following review process was completed by Mercer:

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

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

¹⁷ Peer support services are not currently reported on the SAMHSA Mental Health National Outcome Measures (NOMS) report.

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 analysis of each priority mental health service:
 - Focus groups
 - Key informant survey data
 - Medical record reviews
 - Service utilization data
 - Outcomes data analysis

5.1 SMI 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 defined time period. As depicted in Table 4 below, a relatively small percentage (22%) of the estimated number of adults with SMI were served through the publicly funded system in Maricopa County in 2020. The penetration rate is below the national (publicly funded) penetration rate of 33%; however, it is higher than some states' statewide rates and is similar to some communities of a similar size. Within the Maricopa County Medicaid system, the penetration rate (35%) exceeds the national average (33%) and other regions of similar size in Texas. (i.e., Harris County (Houston) and Bexar County (San Antonio) both have penetration rates of 30% and 29%, respectively). Thus, Maricopa County's lower penetration rate, as compared to some other states and cities, appears to be due to the relatively low penetration rate among people without Medicaid coverage (7%).

The Maricopa County system excels in certain areas of EBP utilization. For example, supported housing and supported employment are more available in Maricopa County (especially to Medicaid recipients) compared to the national average. Maricopa County also has strong access to peer support services at a level that could be considered a best practice benchmark.

In addition, Maricopa County has greater capacity to provide ACT than most comparison communities included in this analysis. 2,317 people received ACT services in Maricopa County in 2020. A study by ACT services researchers estimated that 4.3% of adults with SMI served in a mental health system needed an ACT level of care.¹⁸ Few communities around the country provide ACT to 4.3% or more of their adults who have SMI, but 6.6% of Maricopa County residents with SMI received ACT in 2020.

Maricopa County has 24 ACT teams, including several specialty ACT teams, such as teams that partner with primary care providers (PCPs), medical specialty teams, and forensic teams. Some people in need of ACT-level services are also living with chronic (and sometimes acute) physical health conditions. Consumers with high physical health needs are best served by a team that works closely with a PCP and, when possible, other medical professionals. Maricopa County has over 20 ACT teams that integrate medical professionals or partner with PCPs. Separately, they have three Forensic ACT (FACT) teams that attend to the needs of adults with SMI who have historically high utilization of the criminal justice system. This allocation of resources for justice-involved consumers reflects responsiveness to the stated concerns of many system stakeholders. Among these FACT teams, each one also includes a PCP partnership.

¹⁸ 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 serious mental illnesses in the Portland, Oregon area.

Table 4 — Service System Penetration Rates for Persons with Serious Mental Illness

Penetration Rates					
Region	Adult Population (≥ 18 Years Old) ¹⁹	Estimated Rate of SMI in the Adult Population ²⁰	Estimated Number of Adults with SMI in the Population ²¹	Number of Adults with SMI Served ²²	Penetration Rate among Adults with SMI ²³
United States	255,035,935	4.9%	12,522,264	4,096,666	33%
Arizona	5,631,345	5.6%	313,103	114,989	37%
Maricopa County ²⁴	3,433,264	4.6%	156,900	34,303	22%
Adults with Medicaid	748,643	10.1%	75,613	26,153	35%
Non-Medicaid Adults	2,684,620	4.4%	118,471	8,150	7%
Texas	21,606,493	4.3%	933,400	306,029	33%
Harris County (Houston)	3,402,853	3.4%	114,336	33,792	30%
Bexar County (San Antonio)	1,495,154	3.5%	51,882	15,008	29%
New York	15,402,725	4.4%	670,019	544,572	81%

¹⁹ 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, 2019.*

²⁰ National and state-level SMI estimates: SAMHSA. (2020). *2018-2019 National Survey on Drug Use and Health: Model-based prevalence estimates (50 states and the District of Columbia)*. National Survey on Drug Use and Health Report. Retrieved from <https://www.samhsa.gov/data/report/2018-2019-nsduh-state-prevalence-estimates>
County-level SMI estimates: SAMHSA. (2020). *2016-2018 NSDUH substate region estimates – tables*. National Survey on Drug Use and Health Report. Retrieved from <https://www.samhsa.gov/data/report/2016-2018-nsduh-substate-region-estimates-tables>

²¹ 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 respective region or state.

²² The national and state-level percentages of people with an SMI served was obtained from SAMHSA. (2021). *2020 Uniform Reporting System (URS) output tables*. Retrieved from <https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables>

²³ 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), divided by the estimated number of adults with SMI in the adult population.

²⁴ The number of people with SMI served in Maricopa County is based on Arizona Health Care Cost Containment System's 2020 service utilization data file received through personal communication with Dan Wendt on June 29, 2021.

Penetration Rates					
Region	Adult Population (≥ 18 Years Old) ¹⁹	Estimated Rate of SMI in the Adult Population ²⁰	Estimated Number of Adults with SMI in the Population ²¹	Number of Adults with SMI Served ²²	Penetration Rate among Adults with SMI ²³
New York County (New York City) ²⁵	1,389,282	4.5%	62,518	91,191	146% ²⁶
Colorado	4,496,944	5.5%	248,681	67,961	27%
Denver City/County ²⁷	587,832	5.9%	34,565	17,350	50%
Nebraska	1,457,645	4.9%	71,716	13,154	18%
California	30,600,304	4.5%	1,386,194	412,758	30%
Illinois	9,855,564	4.5%	444,486	22,702	5%
Kansas	2,211,421	5.7%	126,936	26,155	21%
Minnesota	4,338,738	4.9%	212,164	151,444	71%
Wisconsin	4,551,366	5.3%	239,402	32,832	14%
Tennessee	5,321,320	5.4%	288,416	192,292	67%
Indiana	5,160,249	5.4%	279,685	82,540	30%
Delaware	768,939	5.4%	41,830	7,611	18%
New Hampshire	1,102,260	4.9%	53,460	16,168	30%
North Carolina	8,170,925	4.8%	388,119	72,073	19%

²⁵ Utilization data are based on personal communication 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, May 2019.

²⁶ The penetration data for New York County are based on provider surveys reporting the number of people served. In aggregate, the survey results include duplication of consumers receiving services from multiple providers. Additionally, there may be an underestimation of the SMI prevalence in the county. As such, the penetration data for SMI might be overestimated.

²⁷ 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 Kristi Mock and her staff at the Mental Health Center of Denver, June 14, 2021.

Overview of EBP Utilization Benchmark Analyses

Data in Table 5 below depict the utilization rates for ACT, supported employment, and supported housing among adults with SMI served in the Maricopa County behavioral health system. Maricopa County has an ACT utilization rate of 6.6%, which exceeds researchers’ best estimate of the percentage of people with SMI who need ACT (4.3%).²⁸ The county’s utilization rates for supported housing and supported employment services also exceed the national average benchmarks. Maricopa County’s supported employment utilization rate of 34% and ongoing supported employment utilization rate of 9% (which is considered to be closer to high-fidelity supported employment) are among the highest in this benchmark analysis. The national utilization rate for supported employment is less than 2%. The utilization rate for supported housing (22%) in Maricopa County is more than eight times greater than the national average and greater than the utilization rates found in all other regions in the analysis.

Table 5 — EBP Utilization Rates among Persons with SMI Who Were Served in the System²⁹

EBP Utilization Rates						
Region	ACT		Supported Employment		Supported Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
United States	66,159	1.6%	66,662	1.6%	70,648	1.7%
Arizona	Not Available ³⁰	Not Available	14,071	12.2%	1,268	1.1%

²⁸ Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services*, 57, 1803–1806.

²⁹ National and state-level data on the number of people utilizing EBPs were obtained from SAMHSA. (2021). *2020 Uniform Reporting System (URS) output tables*. Retrieved from <https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables>

³⁰ 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.

EBP Utilization Rates						
Region	ACT		Supported Employment		Supported Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2020) ^{31,32}	2,317	6.6%	11,890	33.8%	7,558	21.5%
Maricopa County — Medicaid	1,806	6.9%	9,470	35.6%	6,308	23.7%
Maricopa County — non-Medicaid	386	4.7%	2,420	28.3%	1,250	14.6%
<i>Maricopa County (Supported Employment Ongoing)³³</i>	Not Applicable	Not Applicable	3,265	9.2%	Not Applicable	Not Applicable
Texas	7,791	2.5%	9,753	3.2%	9,692	3.2%
Harris County (Houston)	1,137	4.5%	4,563	13.5%	1,946	5.8%
Bexar County (San Antonio)	297	2.6%	470	3.1%	1,451	9.7%
New York	8,281	1.5%	1,017	0.2%	25,098	4.6%
New York County (New York City) ³⁴	1,218	1.3%	Not available	Not available	4,717	5.2%

³¹ Supported employment services in Maricopa County are associated with one of five billing codes H2025, H2025 HQ, H2026, H2027, and H2027 HQ. Codes H2025 through H2026 are labeled as ongoing support to maintain employment. H2027 and H2027 HQ are labeled as psychoeducation. 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 be related to high fidelity supported employment.

³² The number served in Maricopa County with evidence-based services is based on Arizona Health Care Cost Containment System’s 2020 service utilization data file received through personal communication with Dan Wendt on June 29, 2021.

³³ *Ongoing supported employment refers to the employment/vocational services associated with obtaining and maintaining employment (H2025, H2025 HQ, H2025 SE, and H2026) and excludes people who only received pre-job training and development services (H2027 HQ and H2027 SE).*

³⁴ Utilization data are based on personal communication 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, May 2019.

EBP Utilization Rates						
Region	ACT		Supported Employment		Supported Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Colorado	595	0.9%	516	0.8%	51	0.1%
Denver City/County (MHCD) ³⁵	671	3.9%	154	0.9%	1,463	8.4%
Nebraska	85	0.6%	789	6.0%	949	7.2%
California	5,147	1.2%	409	0.1%	840	0.2%
Illinois	669	2.9%	1,512	6.7%	Not available	Not available
Kansas	Not available	Not available	992	3.8%	1,913	7.3%
Minnesota	2,221	1.5%	1,570	1.0%	1,722	1.1%
Tennessee	105	0.1%	898	0.5%	986	0.5%
Indiana	763	0.9%	1,281	1.6%	3,216	3.9%
Delaware	407	5.3%	2	<0.1%	35	0.5%
New Hampshire	1,246	7.7%	3,779	23.4%	Not available	Not available
North Carolina	4,501	6.2%	Not available	Not available	Not available	Not available

³⁵ 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 Kristi Mock and her staff of the Mental Health Center of Denver, June 14, 2021.

Changes in EBP Utilization from 2013 through 2020

Table 6 below compares utilization of ACT, supported employment, and supported housing in Maricopa County from 2013 through 2020. Highlights of the findings based on comparisons of utilization/penetration rates across those years include the following:

- *ACT:* Between 2013 and 2019, Maricopa County experienced a steady increase each year in the total number of adults with SMI who received ACT services, achieving a penetration rate that ranged from 6.4% to 7.0%, which consistently exceeded the benchmark penetration rate for ACT services (4.3%). The ACT penetration rate in 2020 remained the same as 2019 (6.6%), with 40 additional members being served.
- *Supported Employment:* In 2019, the overall penetration rate for supported employment reached its highest point since 2013 (30.8%) and increased to 33.8% in 2020. This analysis marks all-time highs in the number of consumers who received *ongoing* supported employment (which is more reflective of evidence-based supported employment). Since 2013, the percentage of adults with SMI using ongoing supported employment services has increased significantly (2.5% to 9.2%).
- *Supported Housing:* In the initial years, this penetration rate analysis for supported housing was informed by a single supported housing billing code that was infrequently utilized (H0043). As a result, changes in the supported housing penetration rate could not be calculated between 2013 and 2014. A slight improvement in supported housing utilization was evident in the overall percentage of adults with SMI using supported housing from 2014 to 2015; the penetration rate increased from 3.3% to 3.7% (using H0043). An additional billing code (H2014) was added in 2016 to reflect utilization of supported housing services by a contracted supported housing provider. With the addition of the H2014 code (skills training and development), the supported housing penetration rate increased from 3.7% in 2015 to 4.6% in 2016, and then again to 6.6% in 2017. In 2018, additional service codes were included (T1019 and T1020 — Personal Care Services; and H2017 — Psychosocial Rehabilitation Services) for services rendered by a contracted supported housing provider. As a result, the penetration rate for supported housing more than doubled to 15.1%, and the total number of people served with supported housing also increased dramatically. The level of supported housing services increased substantially between 2019 (14.9%) and 2020 (21.5%).

Table 6 — Maricopa County EBP Utilization Rates: 2013 through 2020

Maricopa County EBP Utilization Rates among People with SMI Served in the System							
Year	Number of Adults with SMI Served	ACT		Supported Employment		Supported Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP ³⁶	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%
<i>SE Ongoing</i>	-	-	-	3,265	9.2%	-	-
Maricopa County (2019)	34,451	2,278	6.6%	10,615	30.8%	5,149	14.9%
<i>SE Ongoing</i>	-	-	-	2,436	7.1%	-	-
Maricopa County (2018)	34,264	2,241	6.5%	9,861	28.8%	5,160	15.1%
<i>SE Ongoing</i>	-	-	-	2,376	6.9%	-	-
Maricopa County (2017)	31,712	2,233	7.0%	8,168	25.8%	2,098	6.6%
<i>SE Ongoing</i>	-	-	-	1,708	5.4%	-	-
Maricopa County (2016)	30,440	2,093	6.9%	7,930	26.1%	1,408	4.6%
<i>SE Ongoing</i>	-	-	-	1,544	5.1%	-	-
Maricopa County (2015)	24,608	1,693	6.9%	4,230	17.2%	902	3.7%
<i>SE Ongoing</i>	-	-	-	725	3.0%	-	-
Maricopa County (2014)	23,977	1,526	6.4%	5,634	23.4%	793	3.3%
<i>SE Ongoing</i>	-	-	-	657	2.7%	-	-

³⁶ For additional information regarding “ongoing” supported employment, see footnote 19.

Maricopa County EBP Utilization Rates among People with SMI Served in the System							
Year	Number of Adults with SMI Served	ACT		Supported Employment		Supported Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP ³⁶	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2013)	20,291	1,361	6.7%	7,366	36.3%	Not Available	Not Available
<i>SE Ongoing</i>	-	-	-	515	2.5%	-	-

ACT Benchmarks

In recent years, Maricopa County has enhanced its capacity to provide ACT services to people with SMI. 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 ACT level of care. The Maricopa County ACT penetration rate, relative to all people with SMI served in the system (as well as relative to the 4.3% estimate provided by Cuddeback, et al.), is presented in Table 4 below.³⁷

Maricopa County’s ACT penetration rate (6.6%) exceeds the benchmark in the Cuddeback et al. study (4.3%),³⁸ compares favorably with other communities nationally, and could be considered a best practice benchmark level, especially given that Maricopa County includes FACT teams that can respond to the special needs of adults with SMI who also have histories of involvement with the criminal justice system. Additionally, most ACT teams are integrated with primary care partnerships.

³⁷ Some readers might conclude from this analysis that Maricopa County provides ACT to too many people with SMI, given that its penetration rate of 6.4% 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 used 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 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 a sufficient number of hospitalizations to qualify for ACT. Maricopa County has extended ACT to these clients and the overall penetration rate for ACT likely reflects the 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.

³⁸ 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.

Table 7 — ACT Utilization Relative to Estimated Need among People with SMI

ACT Utilization					
Region	Number of Adults with SMI Served in Public System ³⁹	Number of Adults Estimated to Need ACT ⁴⁰	Number of Adults Who Received ACT ⁴¹	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
<i>Ideal Benchmark</i> ⁴²	-	-	-	4.3%	100%
United States	4,096,666	176,157	66,159	1.6%	38%
Arizona	114,989	4,945	Not available	Not available	Not available
Maricopa Co.	35,114	1,475	2,317	6.6%	149%
Maricopa Co. — Medicaid	26,567	1,125	1,907	7.1%	161%
Maricopa Co. — non-Medicaid	8,547	350	410	4.7%	110%
Texas	306,029	13,159	7,791	2.5%	59%
Harris County (Houston)	33,792	1,453	1,137	3.4%	78%
Bexar County (San Antonio)	15,008	645	297	2.0%	46%

³⁹ The national and state-level percentages of people with an SMI served were obtained from SAMHSA. (2021). 2020 Uniform Reporting System (URS) output tables. Retrieved from <https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables>

⁴⁰ Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services*, 57, 1803–1806. This study examined the prevalence of people with SMI who need an ACT level of care and concluded that 4.3% of adults with SMI receiving mental health services needed an ACT level of care. The authors stipulated that people with SMI needed an ACT level of care if they met three criteria: they received treatment for at least 1 year for a qualifying mental health disorder, had been enrolled in SSI or SSDI and in treatment for at least 2 years, and had three or more psychiatric hospitalizations within a single year.

⁴¹ National and state-level penetration counts for ACT services received were obtained from SAMHSA. (2021). 2020 Uniform Reporting System (URS) output tables. Retrieved from <https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables>. Arizona's state mental health authority was among the states that did not report the number of people receiving ACT statewide to the Uniform Reporting System.

⁴² 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 ³⁹	Number of Adults Estimated to Need ACT ⁴⁰	Number of Adults Who Received ACT ⁴¹	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
New York	544,572	23,417	8,281	1.5%	35%
New York County (New York City) ⁴³	91,191	3,921	1,218	1.3%	31%
Colorado	67,961	2,922	595	0.9%	20%
Denver County (MHCD) ⁴⁴	17,350	746	671	3.9%	90%
King County (Seattle, WA)	4037	174	300	7.4%	173%
Nebraska	13,154	566	85	0.6%	15%
California	412,758	17,749	5,147	1.2%	29%
Illinois	22,702	976	669	2.9%	69%
Minnesota	151,444	6,512	2,221	1.5%	34%
Tennessee	192,292	8,269	105	0.1%	1%
Indiana	82,540	3,549	763	0.9%	21%
Delaware	7,611	327	407	5.3%	124%
New Hampshire	16,168	695	1,246	7.7%	179%

⁴³ Utilization data are based on personal communication 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, May 2019.

⁴⁴ 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 directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, June 14, 2021.

ACT Utilization					
Region	Number of Adults with SMI Served in Public System ³⁹	Number of Adults Estimated to Need ACT ⁴⁰	Number of Adults Who Received ACT ⁴¹	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
North Carolina	72,073	3,099	4,501	6.2%	145%

Supported Employment Benchmarks

In the provision of employment-oriented services, Maricopa County provides some aspects of supported employment to a relatively high percentage of the estimated need for this EBP: 34% of people with SMI in the public mental health system received at least vocational assessment or some other type of pre-vocational services. However, far fewer (9.2%) received services specifically associated with obtaining and maintaining a job (3,265). Based on our understanding of the supported employment service codes and on previously conducted clinical record reviews, interviews with recipients, and observations of other stakeholders who participated in previous years’ focus groups, we conclude that the 9.2% figure represents a best estimate of the percentage of individuals who received the complete supported employment EBP.

Table 8 — Supported Employment Utilization Relative to Estimated Need among Persons with SMI

Supported Employment (SE) Utilization					
Region	Number of Adults with SMI Served in System ⁴⁵	Number of Adults in Need of SE ⁴⁶	Number of Adults Who Received SE ⁴⁷	Supported Employment (SE) Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
<i>Ideal Benchmark</i>	-	-	-	45%	100%
United States	4,096,666	1,843,500	66,662	1.6%	4%
Arizona ⁴⁸	114,989	51,745	14,071	12.2%	27%
Maricopa Co. — Total Served	35,114	15,436	11,890	33.8%	68%
<i>SE Ongoing</i>	35,114	15,436	3,265	9.2%	18%
Maricopa Co. — Medicaid	26,567	11,769	9,470	35.6%	72%
<i>SE Ongoing</i>	26,567	11,769	2,605	9.8%	19%
Maricopa Co. — non-Medicaid	8,547	3,668	2,420	28.3%	57%
<i>SE Ongoing</i>	8,547	3,668	660	7.7%	15%
Texas	306,029	137,713	9,753	3.2%	7%
Harris County (Houston)	33,792	15,206	4,563	13.5%	30%
Bexar County (San Antonio)	15,008	6,754	470	3.1%	7%

⁴⁵ The number of people with an SMI served at the national and state-level was obtained from SAMHSA. (2021). *2020 Uniform Reporting System (URS) output tables*. Retrieved from <https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables>

⁴⁶ Approximately 90% of consumers with SMI are unemployed. Consumer preference research suggests approximately 50% desire to work. These two proportions were applied to the estimated SMI population to determine the estimated number of consumers who need supported employment.

⁴⁷ The number of people that received supported employment National and state-level were obtained from SAMHSA. (2021). *2020 Uniform Reporting System (URS) output tables*. Retrieved from <https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables>

⁴⁸ 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 associated with services that help people obtain and maintain employment.

Supported Employment (SE) Utilization					
Region	Number of Adults with SMI Served in System ⁴⁵	Number of Adults in Need of SE ⁴⁶	Number of Adults Who Received SE ⁴⁷	Supported Employment (SE) Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
New York	544,572	245,057	1,017	0.2%	0%
Colorado	67,961	30,582	516	0.8%	2%
Denver County (MHCD) ⁴⁹	17,350	7,808	154	0.9%	2%
Nebraska	13,154	5,919	789	6.0%	13%
California	412,758	185,741	409	0.1%	0%
Illinois	22,702	10,216	1,512	6.7%	15%
Kansas	26,155	11,770	992	3.8%	8%
Tennessee	192,292	86,531	898	0.5%	1%
Indiana	82,540	37,143	1,281	1.6%	3%
Delaware	7,611	3,425	2	0.0%	0%
New Hampshire	16,168	7,276	3,779	23.4%	52%

Peer Support Benchmarks

Maricopa County excels in making peer support services available to people in need. The penetration rates for 2013–2020 were relatively high and represent a best practice benchmark in terms of access to peer support.

⁴⁹ 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 directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, June 14, 2021.

Table 9 — Peer Support Penetration Rates

Peer Support		
Region	Peer Support Received	Peer Support Penetration Rate
Arizona		
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 ⁵⁰	733	4%

⁵⁰ 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 directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, June 14, 2021. The Mental Health Center of Denver peer support services for adults with SMI are provided by peer mentors and peer specialists. This figure may include some duplication of those served by both a peer mentor and a peer specialist.

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

Service Descriptions

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

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

Focus Groups

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

- One participant indicated that the clinic did not reach out to inform her of the option for peer support services and that when she inquired the case manager did not return her telephone calls. Other participants noted that there was a several month wait to hear back from the clinic about accessing peer support services.
- One participant has been “in the system for 13 years” and has been “in and out” of peer support services. This individual expressed that she wants and needs support and is trying to receive peer support presently.
- Peer support groups have gone virtual due to COVID-19 — while perceived as supportive, the groups are reportedly less effective due to the growth in the numbers of members attending. Prior to COVID-19, in-person peer support groups were described as phenomenal and very supportive.
- A participant noted that some peer support specialists fail to meet members where they are and may treat members as if they are better than the other person. This participant pointed to the need for more intensive training of peer support workers (“can't be trained in 4 days”). The enhanced training currently available through Relias was perceived to be helpful.

- Agencies are still reticent to hire part-time peer support workers.
- One participant noted that there is only one peer support specialist available at their assigned clinic and another participant stated that there are not enough peer support specialists at the clinics. Some participants were unaware that peer support specialists were available at the clinics.
- Participants noted that peer support is a very effective service and indicated that there are over 8,000 certified peer support specialists in the system.
- A peer support specialist at a consumer operated agency indicated that they get a lot of inquiries about peer support services. However, they are unable to initiate services without a referral from the person's direct care clinic. The participant noted that the direct care clinic referral process can be a barrier to accessing peer support services. Participants noted that case managers are required to fax the current assessment and ISP to the peer support community provider. This can cause delays in accessing the service — up to two months in some cases.
- All clinics have been impacted by declines in the available work force due to the COVID-19 pandemic. Focus group participants reported that there are less resources available, caseloads are too high, high turnover, and that case managers get paid more than peer support specialists.
- Due to the pandemic, one case manager reported that there have been reductions in the numbers of members attending peer support groups via Doxy (telemedicine software). Normally 10-12 members would participate; now only 4 members tend to call-in. Due to the interactive nature of the peer support service; members are missing opportunities to socialize and desire in-person contact. Overall, recruiting members to attend the virtual peer support sessions is difficult.
- For clinics that have resumed in-person peer support groups, the number of members who can attend has been reduced to ensure appropriate social distancing practices are in place.
- It was reported that some clinics do not have sufficient numbers of peer support specialists on staff (e.g., one peer support specialist per team).
- The process to refer members to community-based peer support providers is much more efficient with changes in how consent can be obtained (some providers are accepting verbal consent when processing referrals).
- The group reported no issues with finding available peer support providers and confirmed that there are no wait lists for the service.

- Participants noted a decrease in the availability of peer support specialists during the review period and one participant reported that her assigned clinic imposed a hiring freeze. At this particular clinic, two peer support specialists were covering six clinical teams.
- Telephonic peer support groups were implemented which led to an increase in the number of members participating. Participants felt that telephonic peer support groups were still effective.
- During the pandemic, peer support specialists utilized telephonic peer support, Zoom teleconference groups, and 1:1 virtual meetings with members. The use of peer support was perceived to be more comfortable for members who tend to be less social and prefer to stay at home. One participant wished to retain these alternative ways of delivering peer support.
- One provider noted an initial decrease in attendance, but reported that the numbers of members participating in peer support had returned to pre-pandemic levels. This provider expressed concern with the more vulnerable members, many of which never returned and may now be without any meaningful support.
- Providers employed innovative practices to continue services during the pandemic and continued services despite a decrease in available peer support specialists due to high turnover.
- One provider's response to COVID-19 was described as rigid, with frequent cleanings and fogging of vehicles used to transport members. The provider never closed the clinic, but barriers with engaging members emerged making the transition to limited contact challenging for members.
- One provider deployed Chrome Books to members to aid their ability to participate in services virtually and all of the providers engaged in frequent outreach to check on the welfare of members and caregivers.
- One provider noted that peer support groups have not resumed and, over an extended period of time, referrals authorizing the service from the direct care clinics expire, resulting in providers not being permitted to contact members (though many authorizations were renewed and members maintained services).
- The use of verbal consent is recognized by some providers, but not all. AHCCCS did not formally authorize the practice and focus group participants reported that there is inconsistency across the system in terms of whether providers accept verbal consent. AHCCCS did authorize the use of telephonic peer support during the pandemic.
- One focus group participant felt that access to peer support was easy and that the system does a good job with the service.

- Community Service Agencies (CSAs) typically do not employ behavioral health professionals, a designation that is required to endorse the assessment and ISP. This limits the ability of the CSAs to process self-referrals and the agencies must coordinate with the member's assigned clinic to get services authorized prior to service delivery. This can result in delays for members to access peer support services.
- A peer support specialist relatively new in her position reported a preference for in-person peer support. She indicated that her assigned clinic has two peer support specialists, but is recruiting for a third position. Despite the limited number of peer support specialists, she reported that her caseload is manageable.
- One peer support specialist has initiated tours (virtually and in-person) of community-based peer support agencies to help members become familiar with available services and supports.
- All peer support specialists reported concerns with productivity expectations, with some reporting that they must generate 30 to 40 units per day to meet minimum production requirements. This results in peer support specialists spending time completing case management tasks, such as arranging transportation or calling members to remind them of upcoming appointments.
- One participant was unaware of the availability of family support services and reported that she and her family would have benefited from the service if they knew it was available. Other participants agreed that they did not know about the service.
- One participant stated that some family members don't want to participate in services like family support because they don't want to be identified as a person receiving mental health services.
- Participants indicated that family support services were not advertised sufficiently and that there is not enough of an emphasis on the service.
- Participants indicated that family support services were not available after hours and at times convenient to family members.
- Providing family support services telephonically renders the service as less effective per one participant.
- There are community agencies that can serve as a resource for families and these agencies should be promoted more by the clinics.
- There is a lack of education regarding the availability and benefit of family support services.

- Participants noted that more education is needed regarding the value and availability of family support services and that the system does not have enough resources to maximize use of the service.
- One case manager reported that the clinical coordinator at her assigned clinic is a licensed marriage and family therapist and emphasizes the value of including the member's family and extended support system as part of the person's overall treatment approach. As such, the case manager reaches out to her assigned member's families each week.
- One case manager who has served as a case manager for five years reported that she has never sought family support services on behalf of her clients and was unaware that the service was an option. She added that she would not know what agencies could provide the service, though she noted her clinic was now recruiting for a family support specialist.
- Two case managers noted that the clinics used to employ family mentors, but the positions have been vacant for the past several months.
- Some participants noted that members commonly decline to have family members involved in their treatment and family members don't always understand the member's rights to choose if they want others involved in their treatment.
- One participant noted that family mentors do not stay employed at the clinics for very long and that unrealistic expectations related to meeting productivity goals contributes to frequent turnover in the positions.
- One focus group participant reported that there is not much demand for family support services, noting that out of 250 members on her caseload, only 4 expressed a desire to engage in the service.
- One participant previously oversaw a family program and indicated that family support specialists tend to leave their positions frequently and that training is not as readily available as peer support training.
- There is confusion regarding how "family" is defined and should be interpreted to be any person that supports the member.
- One participant noted that some clinical teams attempt to "triangulate" between members and their family members and that family members "are made the enemy".
- One provider noted that many peer support providers do not have access to family support billing codes and therefore are unable to perform the service.

Key Informant Survey Data

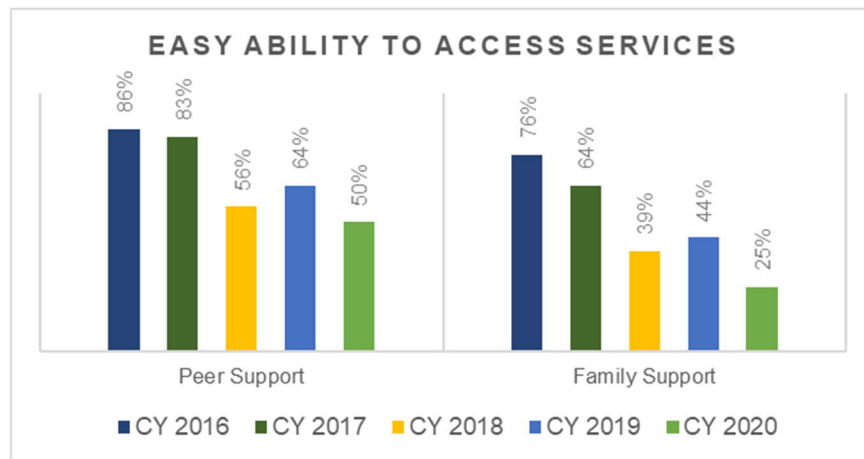
As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to the priority services, a key informant survey was administered. The survey tool included questions and rating assignments related to the priority mental health services. It should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

Level of Accessibility

One half of the survey respondents felt that peer support services were easy to access (50%), a decrease from last year’s survey results in which 64% of the respondents indicated that the services were easy to access. 13% of survey respondents indicated that peer support services were difficult to access and only 3% of the respondents believed that the services were inaccessible. Consistent with the last seven years, peer support services were perceived as the easiest of all the priority services to access.

36% of survey respondents felt that family support services were difficult to access while only 25% of the respondents indicated that family support services were easy to access. The remaining 39% of respondents rated access to family support services as “fair”.

Overall, respondents felt that accessing peer support and family support services was more challenging during CY 2020 when compared to CY 2019.



** Beginning with CY 2017, the key informant survey tool was modified and respondents were asked to rate access to services as “easy to access”, “fair access”, “difficult to access”, and “no access/service unavailable”. Prior to CY 2017, the survey tool included ratings of “easy to access” and “easier to access” and responses were combined and referred to as “easy ability to access” which contributes to the higher ratings during CY 2016.*

Factors that Hinder Access

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

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

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

- Lack of capacity/no service provider available
- Staffing turnover
- Member declines service
- Clinical team unable to engage/contact member

Efficient Utilization

In terms of service utilization, 94% of the responses indicated that peer support services were being utilized efficiently or were utilized efficiently most of the time. Only 6% of respondents indicated that the peer support services were not utilized efficiently.

67% of the responses indicated that family support services were being utilized effectively or were utilized efficiently most of the time.

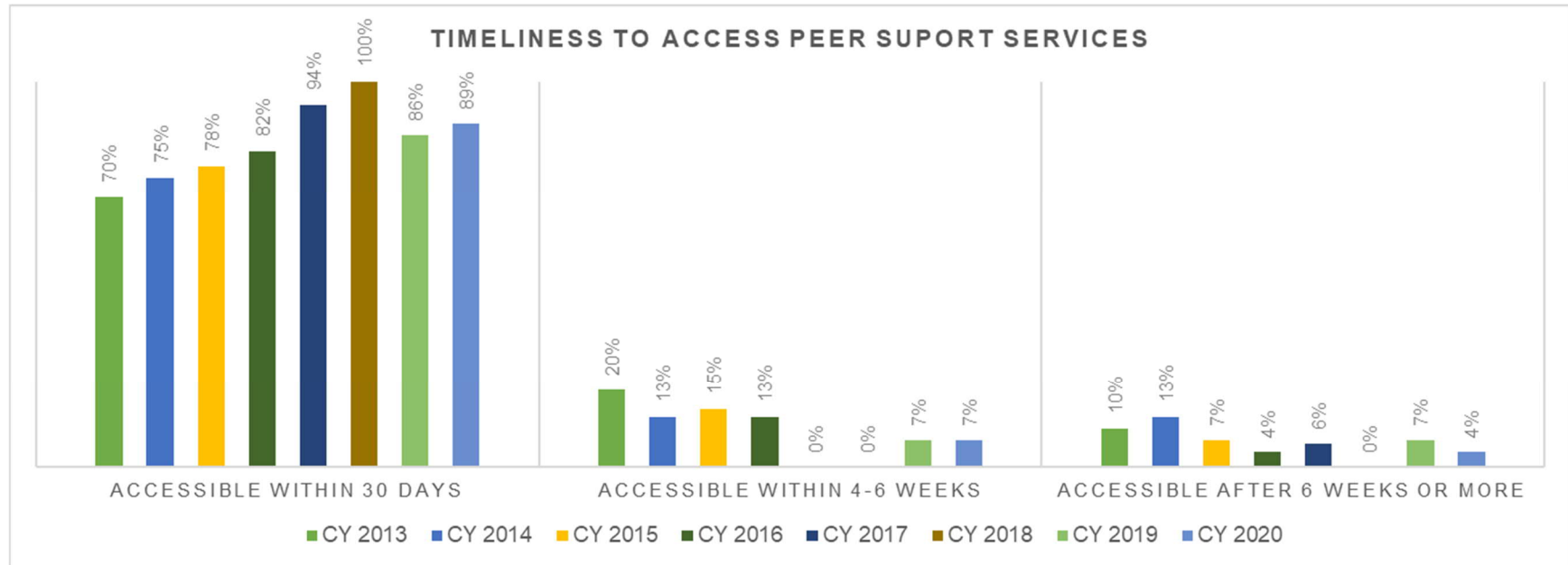
Alternatively, 33% of the responses indicated that family support services were not utilized efficiently.

Timeliness

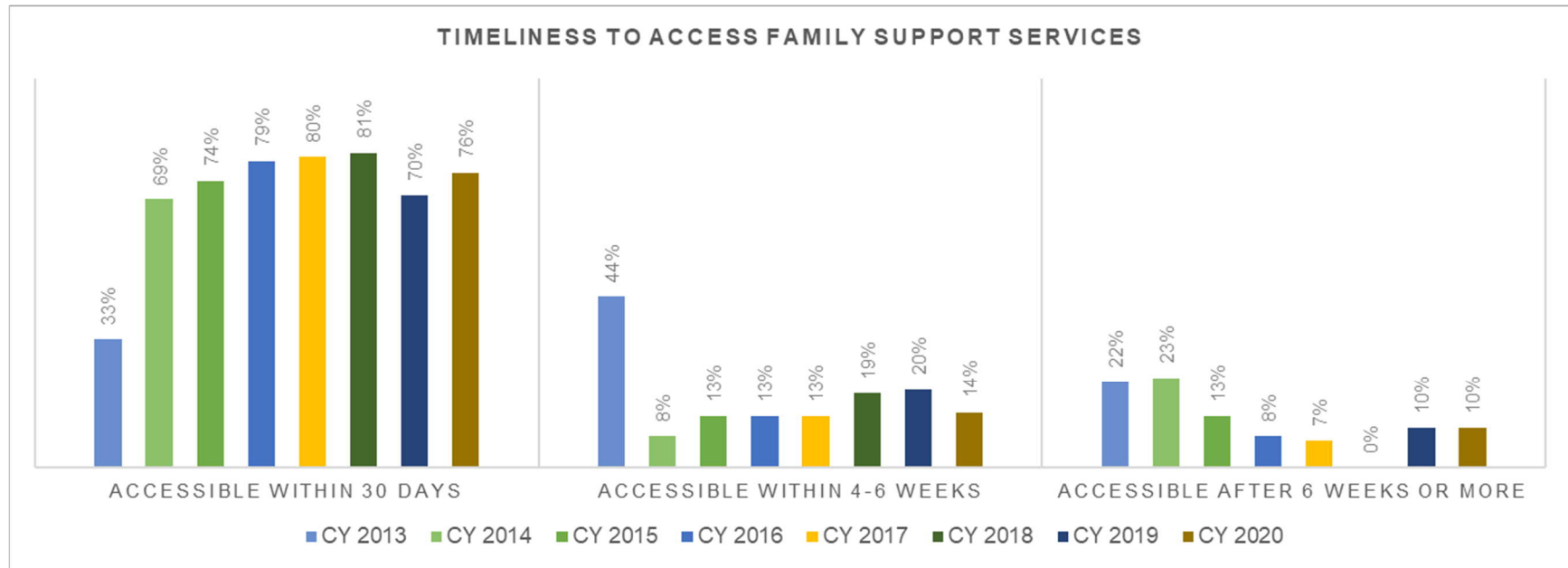
Regarding the duration of time to access peer support services and family support services after a need has been identified:

- 89% 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 and 86% during CY 2019.

- 7% reported it taking four to six weeks to access peer support services following the identification of need (20% — CY 2013; 13% — CY 2014; 15% — CY 2015; 13% — CY 2016; 0% — CY 2017; 0% — CY 2018; 7% - CY 2019).
- 4% of the survey respondents reported that it would take an average of six weeks or longer to access peer support services (10% — CY 2013; 13% — CY 2014; 7% — CY 2015; 4% — CY 2016; 6% — CY 2017; 0% — CY 2018; 7% - CY 2019).



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



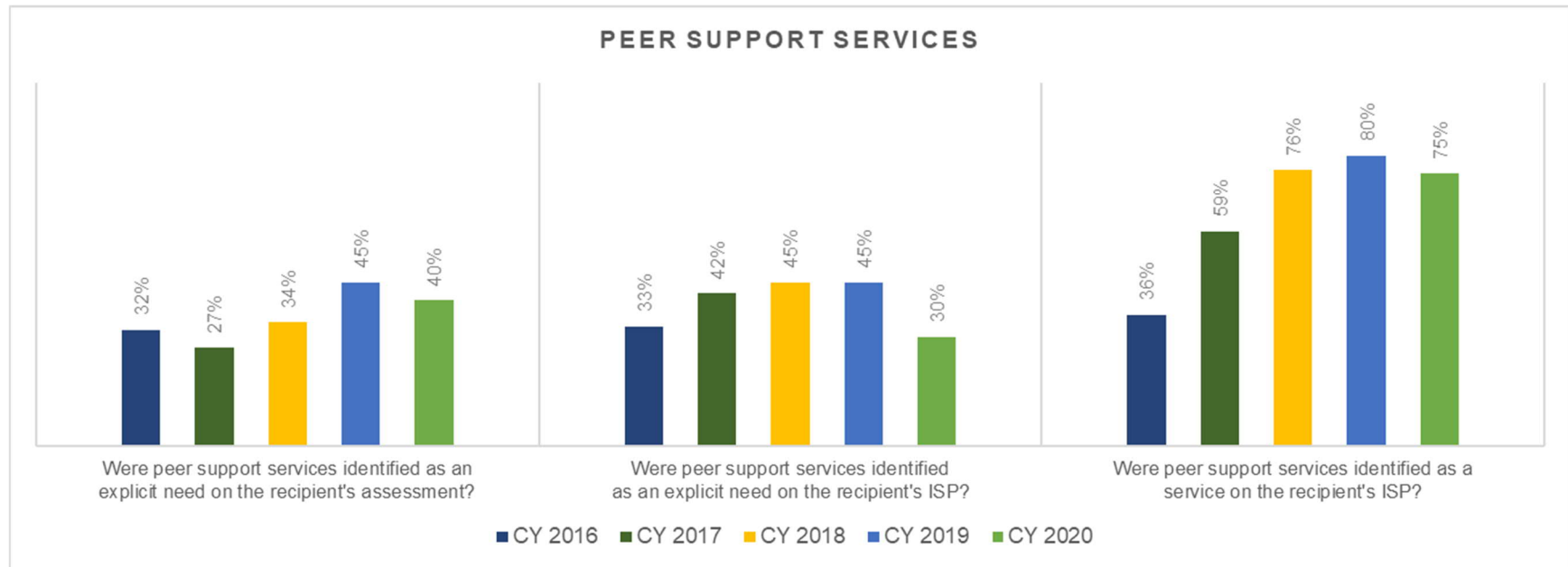
Medical Record Reviews

Mercer reviewed a random sample of 200 SMI recipients’ medical record documentation to assess the consistency in which peer support services and family support services were assessed by the clinical team, identified as a needed service to support the recipient and included as part of the ISP.

Peer Support Services

75% of the ISPs included peer support services when assessed as a need; a slight decrease when compared to CY 2019 (80%).

Half (50%) of the recipients included in the sample received at least one unit of peer support during CY 2020 based on a review of service utilization data.



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:

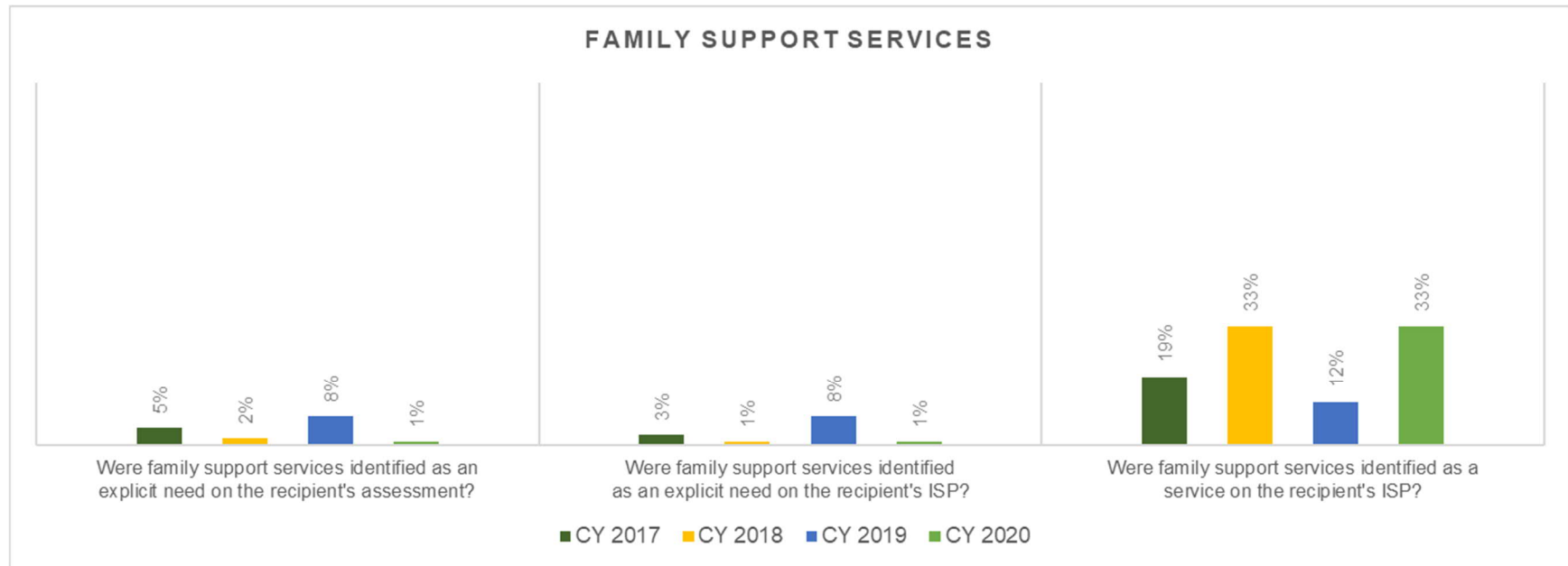
- The clinical team did not follow up with initiating a referral for the service.
- The member declined services.
- Inability to contact the member.
- The member was incarcerated.

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.

33% of the ISPs included family support services when identified as a need as part of the recipient’s assessment and/or ISP. Yet, only 3 cases out of a total of 200 included an assessed need for family support services.

1% of the recipients included in the sample received at least one unit of family support during CY 2020 based on a review of service utilization data.



Year over year, family support services are less apt to be identified as a need on the assessment and ISP, a trend that continued during CY 2020. For CY 2020, family support services were rarely included as a distinct service on a member’s ISP. Of the three 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.

In two cases, the person was unable to access family support services after the service was recommended by the clinical team. Reviewers were able to review progress notes and determined that there was no documentation that the clinical team initiated a referral for the service.

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, 2019 through June 30, 2020; 33,992 unique users were represented in the service utilization data file. Of those, 76% were Medicaid eligible and 24% were non-Title XIX eligible.

- Overall, 32% of the recipients received at least one unit of peer support services during the time period (two percentage points lower than last year).

Access to the service favored Title XIX eligible members (34%) over the non-Title XIX population (26%).

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

- Approximately 4 out of 10 members who received at least one unit of peer support during the review period accessed the service during a single month, a decrease when compared to CY 2019 (~50%).
- 53% 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 2019, 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 direct care clinic. The nature of the service lends to episodic participation and less dependent on sustained participation to be an effective support and intervention.

Persistence in Peer Support Services October 2019 — June 2020			
Consecutive Months of Service	Medicaid Recipients	Non-Medicaid Recipients	All Recipients
1	37.6%	41.3%	38.3%
2	15.3%	13.0%	14.8%
3–4	13.9%	12.3%	13.6%
5–6	6.1%	4.7%	5.8%
7–8	2.0%	1.9%	2.0%
9+	3.1%	2.4%	3.0%

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, 4.3% of the recipients received at least one unit of family support services during the time period (4.9% over a comparable time period last year). Over the eight years that the service capacity assessment has been conducted, family support service utilization rates have been consistently at 2% to 5%. A number of factors may be influencing these results including the absence of supportive family members, member choice to not include 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 split between Title XIX (4.4%) and non-Title XIX groups (4.1%).

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

- About half of the members who received at least one unit of family support during the review period accessed the service during a single month, down from 71.4% during CY 2019 and 76.8% during CY 2018.
- 63% 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 88% during CY 2019.

Persistence in Family Support Services October 2019 — June 2020			
Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	50.9%	52.0%	51.2%
2	12.0%	12.4%	12.1%
3–4	7.7%	8.8%	8.0%
5–6	2.0%	1.1%	1.8%
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 time period. For the time period of October 1, 2019 through December 31, 2020, 41% of all members with an SMI received at least one unit of peer support. During the prior year, 35% of members received peer support services. (2013 — 38%; 2014 — 31%; 2015 — 29%; 2016 — 38%; 2017 — 37%; 2018 — 36%; 2019 — 35%).
- Peer support groups have gone virtual due to COVID-19 — while perceived as supportive, the groups are reportedly less effective due to the growth in the numbers of members attending.
- A peer support specialist at a consumer operated agency indicated that they get lots of inquiries about peer support services. However, they are unable to initiate services without a referral from the person's direct care clinic. The participant noted that the direct care clinic referral process can be a barrier to accessing peer support services. Participants noted that case managers are required to fax the current assessment and ISP to the peer support community provider. This can cause delays in accessing the service — up to two months in some cases.
- Providers employed innovative practices to continue services during the pandemic and continued services despite a decrease in available peer support specialists due to high turnover.
- One half of the survey respondents felt that peer support services were easy to access (50%), a decrease from last year's survey results in which 64% of the respondents indicated that the services were easy to access. 13% of survey respondents indicated that peer support services were difficult to access and only 3% of the respondents believed that the services were inaccessible. Consistent with the last seven years, peer support services were perceived as the easiest of all the priority services to access.
- 75% of the ISPs included peer support services when assessed as a need; a slight decrease when compared to CY 2019 (80%).
- Several medical records did not include assessed needs for peer support and did not include peer support services on the ISP. However, many of these cases resulted in the same members receiving peer support services.
- Half (50%) of the recipients included in the sample received at least one unit of peer support during CY 2020 based on a review of service utilization data.

- 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 finding was that the clinical team did not follow up with initiating a referral for the service.
- Maricopa County continues to demonstrate strong access to peer support services and, based on Mercer's national penetration and prevalence analyses, utilization is at a level that is considered to be a best practice benchmark.
- Approximately 4 out of 10 members who received at least one unit of peer support during the review period accessed the service during a single month, a decrease when compared to CY 2019 (~50%).

Findings: Family Support

- Service utilization data demonstrates that 6% of members received at least one unit of family support services during 2020, the same finding as last year. (2013 — 2%; 2014 — 3%; 2015 — 2%; 2016 — 2%; 2017 — 2%; 2018 — 4%; 2019 — 6%).
- 33% of the ISPs included family support services when identified as a need within the recipient's assessment and/or ISP. Only 3 cases out of a total of 200 included an assessed need for family support services.
- 1% of the recipients included in the medical record review sample received at least one unit of family support during CY 2020 based on a review of service utilization data.
- 14% of the key informant survey respondents indicated that it would take four to six weeks to access family support services following the identification of need.
- One focus group participant reported that there is not much demand for family support services, noting that out of 250 members on her caseload, only 4 expressed a desire to engage in the service.
- Focus group participants noted that more education is needed regarding the value and availability of family support services and that the system does not have enough resources to maximize use of the service.

Recommendations: Peer Support

- System stakeholders should examine changes in service delivery modalities and policies in response to the COVID-19 pandemic and retain practices that promote more efficient access to peer support services (e.g., accepting verbal consent to process service referrals).

- In the event that peer support services and related health promotion groups continue to be offered virtually, develop and implement standard operating protocols to help ensure recipients benefit from the services (e.g., limits on numbers of members attending, procedures for soliciting input from participants, ensuring all participants have opportunities to engage and contribute to group discussions).
- Examine requirements that direct care clinics must initiate referrals prior to a recipient accessing peer support services from a community-based consumer-run organization. To promote independence and autonomy, recipients should be able to self-refer to access peer support services without having to go through the recipient's assigned direct care clinic as this can result in significant delays in accessing the services.

Recommendations: Family Support

- Provide training and supervision to ensure that direct care 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.
- Ensure that the member's ISP includes family support as an intervention after members affirm that they would like a family member involved in treatment.

5.3 Multi-Evaluation Component Analysis — Supported Employment

Service Description

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

Focus Groups

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

- Despite system wide promotion, at least one participant was unaware of the availability of supported employment or vocational rehabilitation services.
- One participant reported they are having trouble finding employment after being laid off due to COVID-19. She reported that her case manager was not helping her find other employment opportunities or resources.
- One participant recounted following her release from prison she was trained as a peer support specialist through a supported employment program and that her case manager followed up with her for over a year after she found employment as a peer support specialist.
- One member, who was recently determined SMI and was employed but struggling with the stresses of maintaining his job, reported that the clinical team told him he was not qualified to receive supported employment services.
- One participant stated that she had an excellent experience with supported employment services and that the supported employment provider helped her maintain employment when she had to take a leave due to symptoms of her mental illness.
- Another participant who was employed had to take family medical leave on four occasions and would have benefitted greatly from supported employment services.
- Many participants reported good experiences with supported employment services, though one participant noted she had multiple job coaches assigned due to them leaving every 4 to 5 months. However, each new job coach had new insights and the member felt she benefitted from the varied employment opportunities.

- One participant reported using a community supported employment provider recently and was pursuing three job openings with interviews scheduled the next day (many employers are hiring entry level positions and finding work is likely easier now).
- One participant speculated that 30% of the SMI population was fearful of losing benefits if earning income. There is a need for ongoing education regarding member fear of losing benefits or their housing voucher if income is earned.
- Many members do not want “free money through the government” and have a desire to work.
- There is a balance between needing to work more hours to earn enough money to cover living expenses and making too much and losing benefits.
- One participant noted that resources available to members to explain the impact working can have on eligibility for benefits are no longer available due to COVID-19.
- Case managers perceived that it was “easy” to refer members for supported employment services by engaging the clinic’s rehabilitation specialist and initiating referrals to co-located supported employment providers.
- As a result of COVID-19, members expressed concerns about having to travel to work sites to receive requisite job training and are generally more willing to accept opportunities that allow remote working arrangements.
- One barrier for members seeking employment opportunities relates to clinical team restrictions on providing transportation to the work site once the person is employed. Public transportation options can result in members spending several hours in transit only to work three to four hours per day as well as concerns about exposure to COVID-19.
- At least one case manager felt that the demand for supported employment services did not significantly decrease as a result of the pandemic. She reported the presence of a co-located supported employment provider at the clinic and that communication between the clinical team and the supported employment provider was good.
- All of the participants were aware of the Disability Benefits 101 website and most reported that the resource was easy to navigate and a valuable tool to evaluate the impact of earned income on member’s eligibility for public benefits. However, one case manager reported that she has not accessed the website for several years and another case manager expressed a need for more frequent training regarding the use and capabilities of the resource.
- There were conflicting perspectives regarding the observed practice of including supported employment services on a member’s ISP in the absence of an identified need for the service. One case manager stated that federal and state law stipulates that any

person determined to have a disability, including persons with SMI, must be assessed by a rehabilitation specialist at least one time per year, thus necessitating the presence of the supported employment service code on the member's ISP. Another case manager shared that "management" directed clinical teams to add the service to all ISPs in order to pass audits conducted by the managed care organization.

- Providers reported the presence of co-located vocational rehabilitation specialists and supported employment providers within many of the direct care clinics. Awareness and utilization of the Disability Benefits 101 website resources is common and is perceived to be an effective tool to illustrate how income does not necessarily jeopardize a member's public assistance/benefits.
- One provider expressed a desire to have strengthened relationships and partnerships between peer support specialists and supported employment providers.
- Some peers are being trained to be benefit specialists and work collaboratively with vocational rehabilitation specialists and supported employment providers.
- One provider noted that the Vocational Rehabilitation (VR)/Rehabilitation Services Administration (RSA) recently required providers to execute a contract in order to co-locate a vocational rehabilitation counselor. This practice was perceived to create challenges for some providers who may not be willing to subcontract.
- One provider reported that reimbursement for pre-job training and development supported employment services is higher than ongoing support to maintain supported employment and reasoned that this was a contributing factor for higher utilization of the former type of supported employment.
- The group questioned the helpfulness and viability of supported employment services and if the service resulted in meaningful outcomes for members. Participants felt that many members will not work because they are told that they will lose their social security disability insurance.

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

21% of survey respondents felt that supported employment services were difficult to access, more than last year (14%), but significantly less than CY 2013 and CY 2014 (75% — CY 2013; 33% — CY 2014). 76% of respondents indicated that supported employment services were easy to access or having “fair” access, a decrease from CY 2019 (81%) and but considerably higher than CY 2014 (66%).

Factors that Hinder Access

Factors that negatively impact accessing supported employment services include:

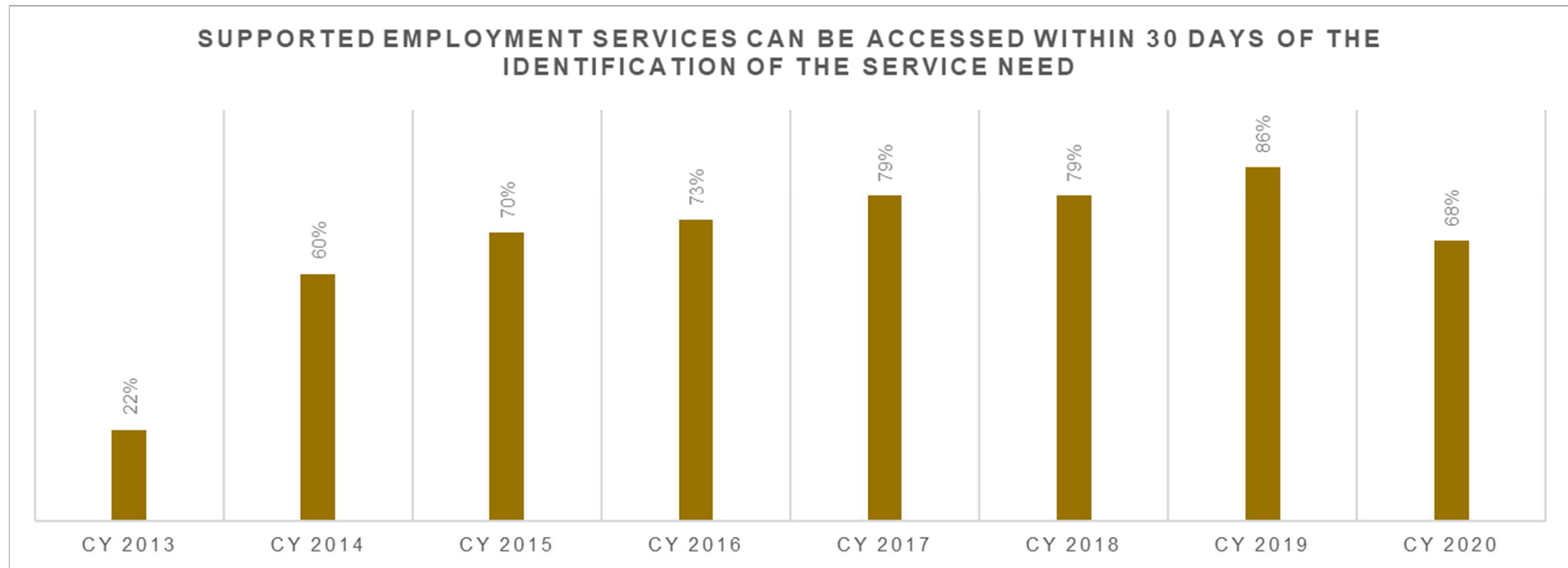
- Member declines services
- Clinical team unable to engage/contact member
- Lack of capacity/No service provider available

Efficient Utilization

87% of the responses indicated that supported employment services were being utilized efficiently or were utilized efficiently most of the time, the same finding from last year. 13% of respondents indicated that supported employment services were not utilized efficiently.

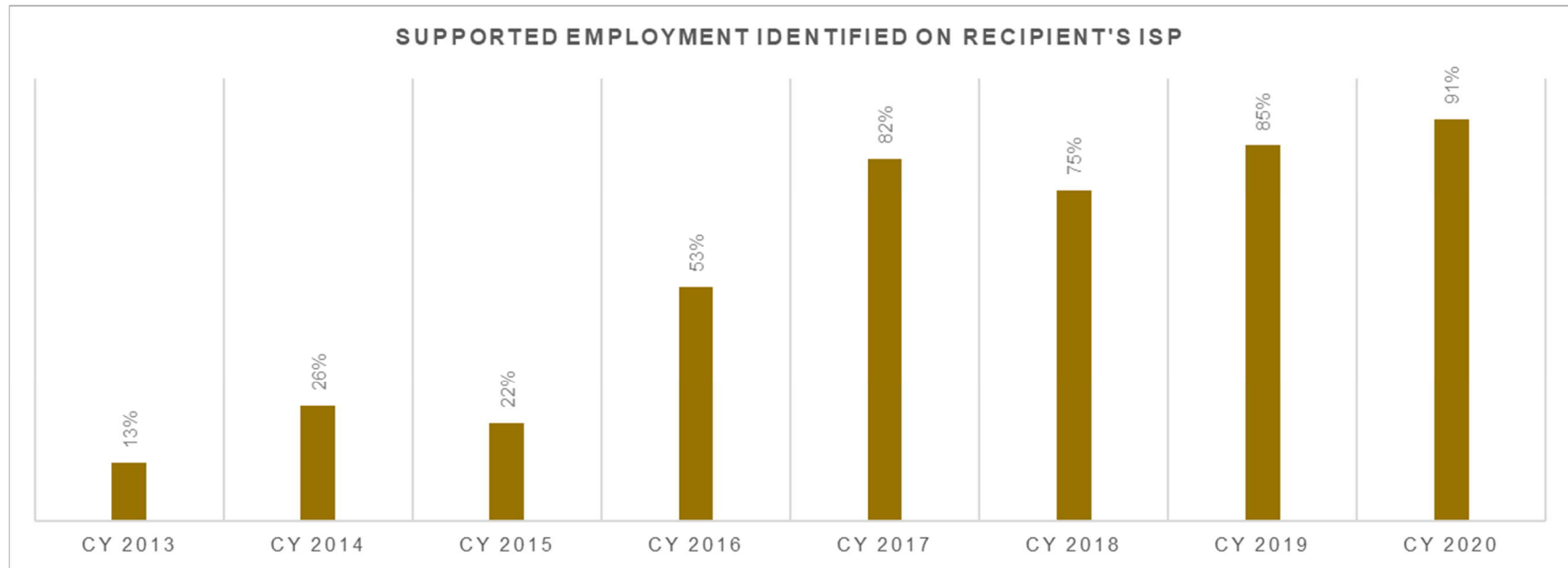
Timeliness

68% 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 86% during CY 2019, 79% during CY 2018, 79% during CY 2017, 73% during CY 2016, 70% during CY 2015, 60% during CY 2014 and 22% during CY 2013. 8% 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, six percentage points more than last year (54%). Supported employment services were identified as a service on the recipient’s ISP in 91% of the cases reviewed when assessed as a need. (CY 2013 — 13%; CY 2014 — 26%; CY 2015 — 22%; CY 2016 — 53%; CY 2017 — 82%; CY 2018 — 75%; CY 2019 — 85%).



44% of the recipients included in the sample received at least one unit of supported employment during CY 2020 based on a review of the service utilization data.

In 42 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 81% of those cases in which the person did not access the service despite an identified need — significantly more than the rate identified during CY 2019 (49%). In many of these cases, there was 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, over one third 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 needs and can include generic language that does not differentiate each member’s unique circumstances and needs.

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, including Work Adjustment Training; assistance in the use of educational resources necessary to obtain employment; attendance to VR/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.

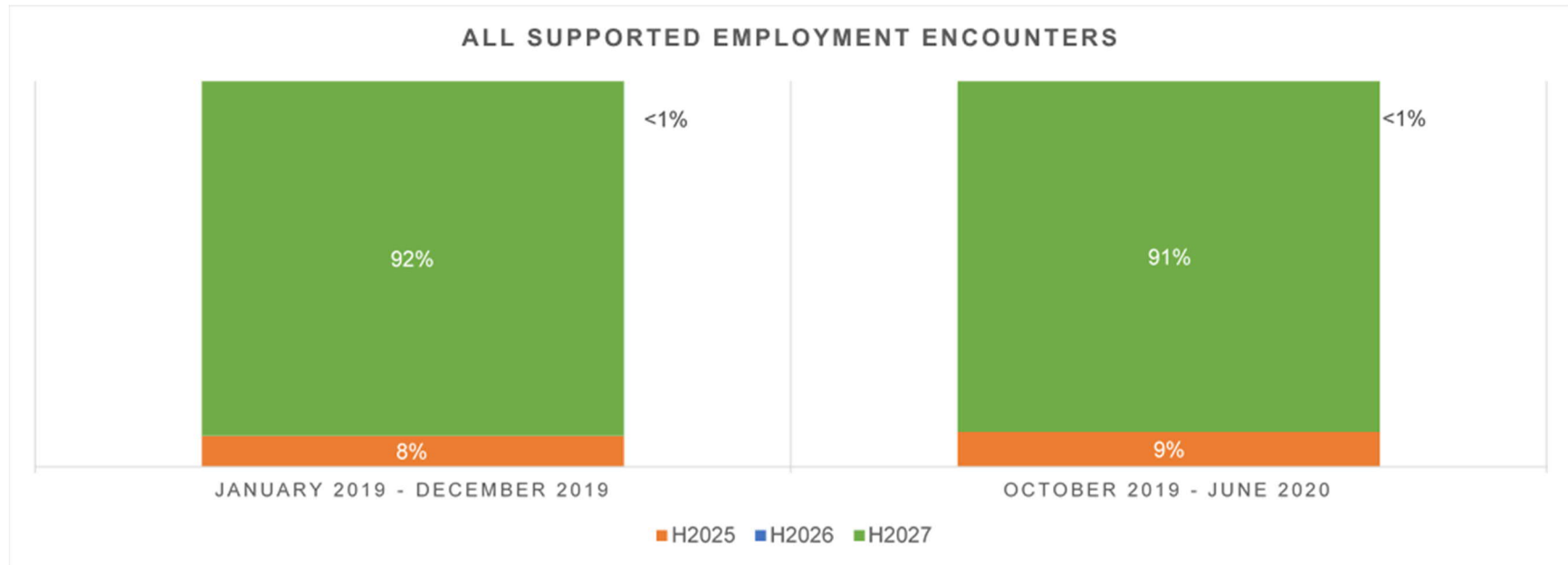
H2026 — Ongoing Support to Maintain Employment (per diem)

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, 2019 through June 30, 2020, H2027 (pre-job training and development) accounts for 91% of the total supported employment services (a slight decrease from CY 2018 — 93% and CY 2019 - 92%). H2025 (ongoing support to maintain employment/15-minute billing unit) represents 9% of the supported employment utilization (CY 2018 — 7%; CY 2019 — 8%). H2026

(ongoing support to maintain employment/per diem billing unit) accounted for less than 1% of the overall supported employment utilization.



A billing modifier (i.e., SE) is applied in conjunction with billing code H2027. The intended use of the modifier is to track members who are engaged in rapid job search with an expected outcome of securing employment within 45 days of engaging in supported employment services. Mercer analyzed the presence of this code and modifier within the service utilization data file. H2027 SE represents 8% (CY 2018 and CY 2019 — 9%) of the overall supported employment utilization.

Challenges related to 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. Mercer also heard accounts of members opting out of supported employment services due to the COVID-19 pandemic.

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

- Overall, 34% of the recipients received at least one unit of supported employment during the review period, three percentage points higher than CY 2019 and five percentage points higher than CY 2018.
- Access to the service was split between Title XIX (32%) and non-Title XIX groups (26%).

To increase access to supported employment services, the Maricopa County Regional Behavioral Health Authorities (RBHA), PNOs/administrative entities and the supported employment providers have partnered to co-locate supported employment specialists and job developers in many of the direct care clinics. The clinical teams and the supported employment specialists meet regularly to integrate and coordinate services for members interested in obtaining and/or maintaining employment.

The supported employment specialists and rehabilitation specialists assigned to the clinics also coordinate closely with staff employed with the Arizona Department of Economic Security (DES)/RSA. Twenty-six full-time DES/RSA Counselors are dedicated to persons with SMI, co-located and represented at all the direct care clinic locations. Five vacancies were reported in January 2021. VR counselors meet regularly with direct care clinic rehabilitation specialists and contracted supported employment providers and work in coordination to meet member's supported employment needs.

Overall, the VR program targeting persons with SMI in Maricopa County is achieving targeted outcomes. DES/RSA data secured from the Maricopa County RBHA includes the following:

- Members referred to VR/RSA — 1,467 (January 1, 2020–November 30, 2020)
- Members served in the VR program — 1,729 (quarter ending December 31, 2020)
- Members open in the VR program — 1,584 (quarter ending December 31, 2020)
- Members in service plan status with VR — 1,208 (quarter ending December 31, 2020)

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 2019 — June 2020			
Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	60.5%	67.0%	61.9%
2	15.1%	14.2%	14.9%
3–4	12.3%	10.9%	12.0%
5–6	6.4%	4.9%	6.1%
7–8	2.4%	1.1%	2.1%
9+	3.2%	1.9%	3.0%

- 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.
- 12% of the recipients received supported employment services for three to four consecutive months during the review period.
- 3% of the recipients received the service for at least nine consecutive months.

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 34% of members received at least one unit of supported employment during CY 2020, an increase of 3% from last year and the third consecutive year of year-to-year increases in utilization. (CY 2013 — 39%; CY 2014 — 20%; CY 2015 — 17%; CY 2016 — 26%; CY 2017 — 26%; CY 2018 — 29%; CY 2019 — 31%).
- 21% of survey respondents felt that supported employment services were difficult to access, more than last year (14%), but significantly less than CY 2013 and CY 2014 (75% — CY 2013; 33% — CY 2014).
- 76% of survey respondents indicated that supported employment services were easy to access or having “fair” access, a decrease from CY 2019 (81%) and but considerably higher than CY 2014 (66%).

- Providers reported the presence of co-located vocational rehabilitation specialists and supported employment providers within many of the direct care clinics. Awareness and utilization of the Disability Benefits 101 website resources is common and is perceived to be an effective tool to illustrate how income does not necessarily jeopardize a member's public assistance/benefits.
- At least one case manager felt that the demand for supported employment services did not significantly decrease as a result of the pandemic. She reported the presence of a co-located supported employment provider at the clinic and that communication between the clinical team and the supported employment provider was good.
- One participant speculated that 30% of the SMI population was fearful of losing benefits if earning income. There is a need for ongoing education regarding member fear of losing benefits or their housing voucher if income is earned.
- Supported employment services were identified as a service on the recipient's ISP in 91% of the cases reviewed when assessed as a need. (CY 2013 — 13%; CY 2014 — 26%; CY 2015 — 22%; CY 2016 — 53%; CY 2017 — 82%; CY 2018 — 75%; CY 2019 — 85%).
- The medical record review team continues to note that clinical teams identify supported employment services on the member's individual service plan in the absence of an assessed need. Over one third 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 needs and can include generic language that does not differentiate each member's unique circumstances and needs.
- For the time period October 1, 2019 through June 30, 2020, H2027 (pre-job training and development) accounts for 91% of the total supported employment services (a slight decrease from CY 2019 — 92%). H2025 (ongoing support to maintain employment/15-minute billing unit) represents 9% of the supported employment utilization (CY 2019 — 8%).

Recommendations: Supported Employment

- Continue efforts to promote the broader utilization of ongoing support to maintain employment. Consider the following steps:
 - Educate supported employment specialists about effective ways to present and promote the service to recipients;
 - Examine current reimbursement rates for each type of supported employment service and ensure that the rates incentivize and reinforce appropriate utilization;

- Consider adopting an alternative service code and/or service code modifier to capture annual rehabilitation specialists' vocational/meaningful day assessments as these activities do not align with current supported employment service code descriptions.
- Ensure ongoing education is available to case managers and clinical team members regarding how members can gain employment without jeopardizing eligibility for public assistance programs (e.g., AHCCCS eligibility, social security disability insurance).
- Continue to monitor and address as needed the practice of documenting supported employment services on members' ISPs without evidence of an assessed need for the service.

5.4 Multi-Evaluation Component Analysis — Supported Housing

Service Description

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

Focus Groups

Key themes related to supported housing services included:

- Participants noted that there is a need for more support, more options and more opportunities for members seeking independent living. One participant reported that current housing options have bed bugs, rodents, lack of air conditioning, are located in high crime/illicit drug areas, and are of a generally poor environment and substandard housing conditions.
- One participant is now back on a waiting list for housing due to a lack of follow-up from her case manager and her perception that the clinic is unwilling to help.
- There is a lack of communication and updates regarding a members housing application. The clinics sometimes tell members that the managed care organization has not communicated the status of the member's housing application.
- Due to COVID-19, there are more challenges than ever in finding available housing.
- One member received help with her independent living skills and has found permanent supported housing which has helped her get back on track.
- There is a need for appropriate, supervised housing and one parent stated that over 3,000 members are on a wait list for housing. The United States Department of Housing and Urban Development homelessness criteria is perceived to be too restrictive.
- Wait lists exist for independent housing arrangements and there is a perception that there are too many clients needing the service than the system can accommodate.

- One participant noted that housing specialists at the clinics are overwhelmed with demand and job responsibilities and recommended hiring more peer support specialists to assist housing specialists with helping members find and maintain housing.
- Members should be educated on tenancy rights and related laws as one participant noted that some apartment complexes are refusing to accept housing vouchers and evicting tenants with a 30 day notice.
- Participants recommended that the managed care organization or the state “own” apartment complexes that could accommodate individuals who have housing vouchers.
- One family noted that the lack of affordable and safe housing has contributed to increases in involuntary commitments, incarcerations and homelessness.
- Case managers reported an emerging practice by landlords to increase rent in recent months, negatively impacting members who receive a static amount of support via housing vouchers.
- While some clinics employ housing specialists to assist members with obtaining and maintaining affordable housing, one case manager reported that her assigned clinic has not had a housing specialist for over a year. She went on to report that case managers do not receive training on how to apply for Section 8 housing and, in the absence of an available housing specialist, must refer members to community-based housing support providers.
- All members reported the lack of housing support resources, extended waiting lists for housing vouchers, and challenges with obtaining information regarding a person’s housing application status from clinic leadership and the managed care organization.
- Many housing options that accept housing vouchers are located in high crime or drug infested neighborhoods that can be counter-therapeutic for members with anxiety and/or substance use disorders.
- ACT housing is only available through designated provider network organizations and clinics that don’t have direct access to the resource are unaware of how to get members into ACT housing.
- One provider indicated that his agency does not work much with supported housing services other than to help members make connections and refer back to the member’s clinical team to complete the required paperwork to apply for housing supports.
- One provider has made available “housing kits” to help members get started in each room of the residence (e.g., sets of dishes, alarm clocks, hygiene supplies, etc.).

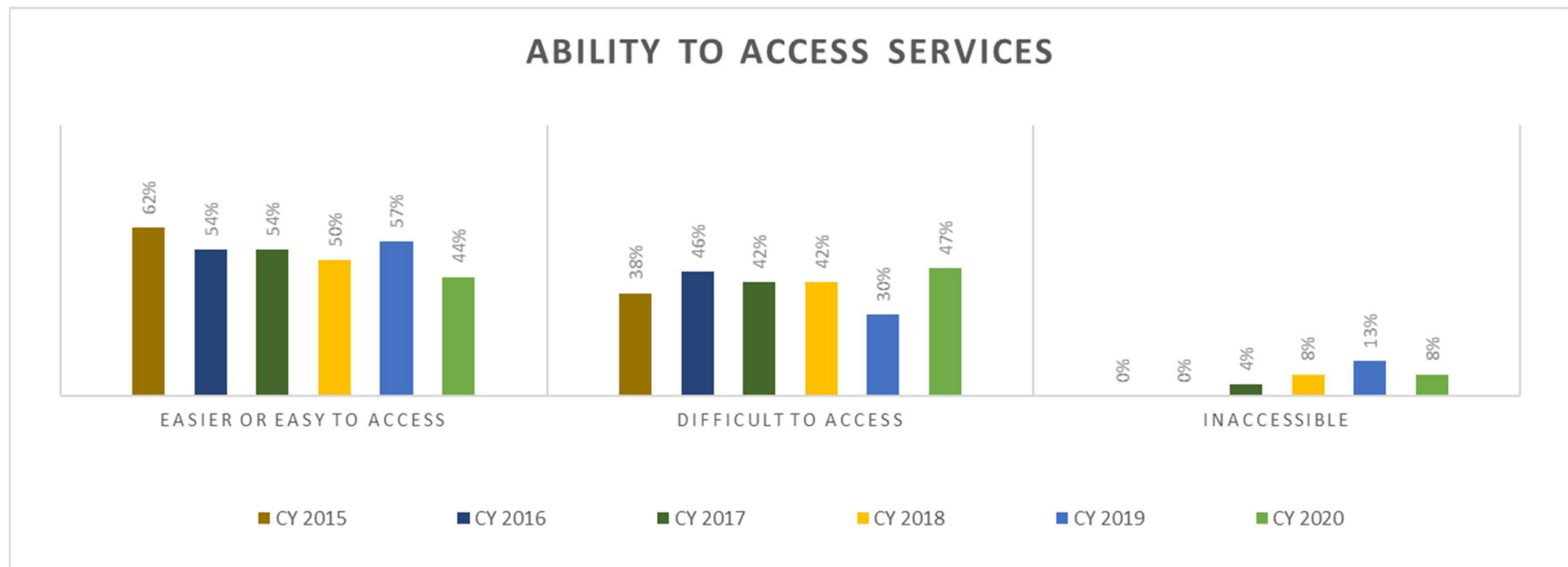
- Many participants described the lack of affordable and safe housing for members as a crisis, with rent increasing for those who are in housing. The housing that is available is not maintained satisfactorily and is perceived to be unsafe.

Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding the availability, quality and accessibility of supported 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

47% of the survey respondents felt that supported housing services were difficult to access; significantly higher than CY 2019 (30%). Three (13%) respondents indicated that supported housing services were inaccessible, the same finding from CY 2019.

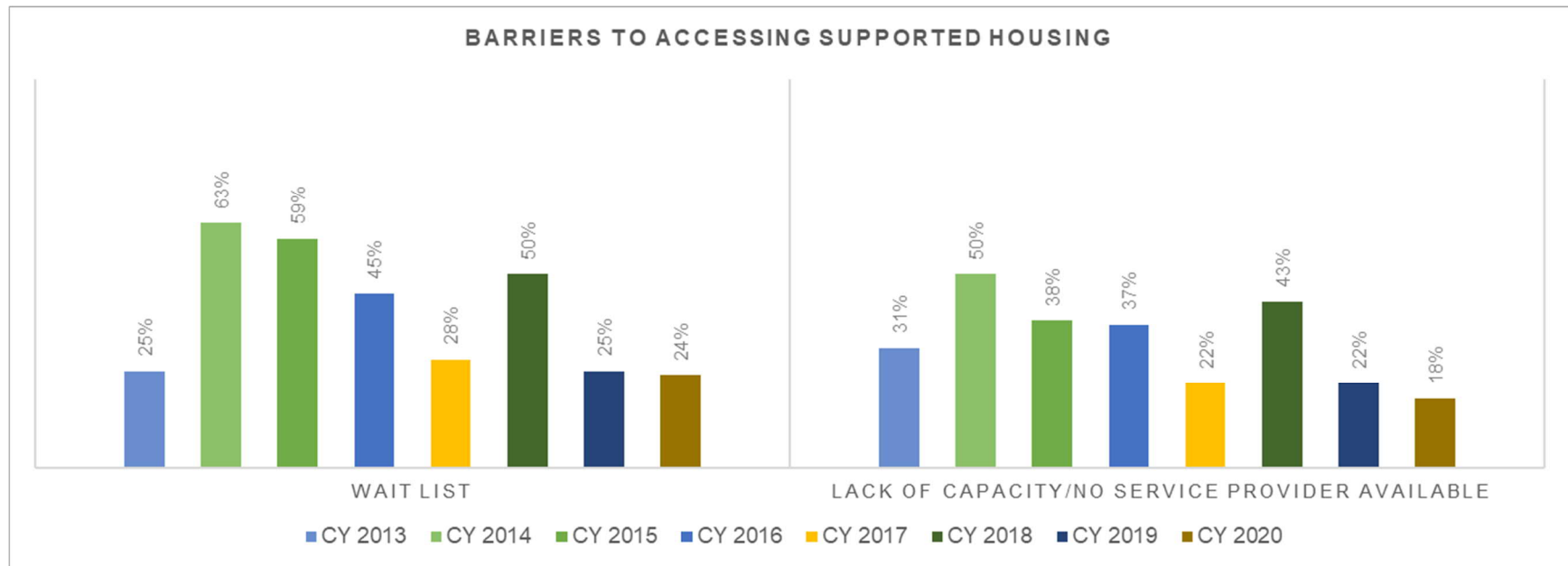


44% of respondents indicated that supported housing services had “fair access” or were easy to access; the lowest rate in the past five years.

Factors that Hinder Access

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

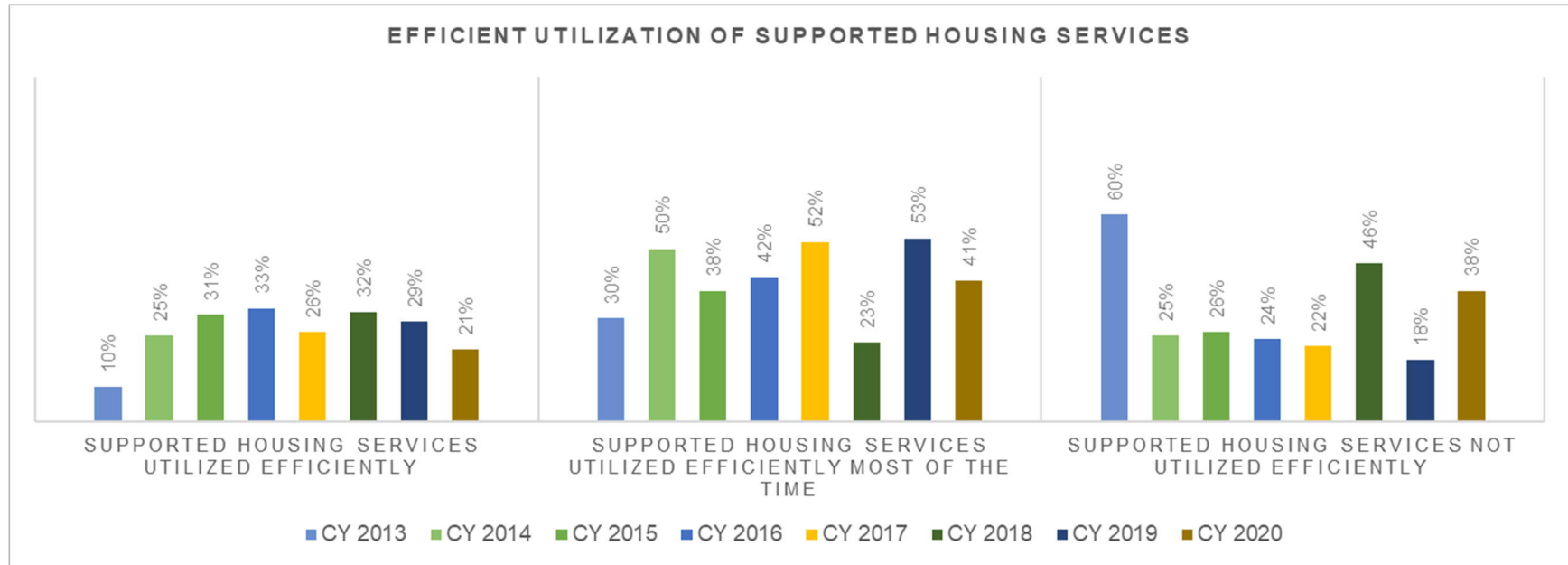
- 24% of the responses indicated that a wait list exists for the service; (25% during CY 2013; 63% during CY 2014; 59% during CY 2015; 45% during CY 2016; 28% during CY 2017; 50% during CY 2018; 25% during CY 2019).
- 18% of the responses were directed to a lack of capacity/no service provider available (31% during CY 2013; 50% during CY 2014; 38% during CY 2015; 37% during CY 2016; 22% during CY 2017; 43% during CY 2018; 22% during CY 2019).
- 14% of responses indicated that the clinical team was unable to engage the member.



Efficient Utilization

In terms of efficient utilization of supported housing services:

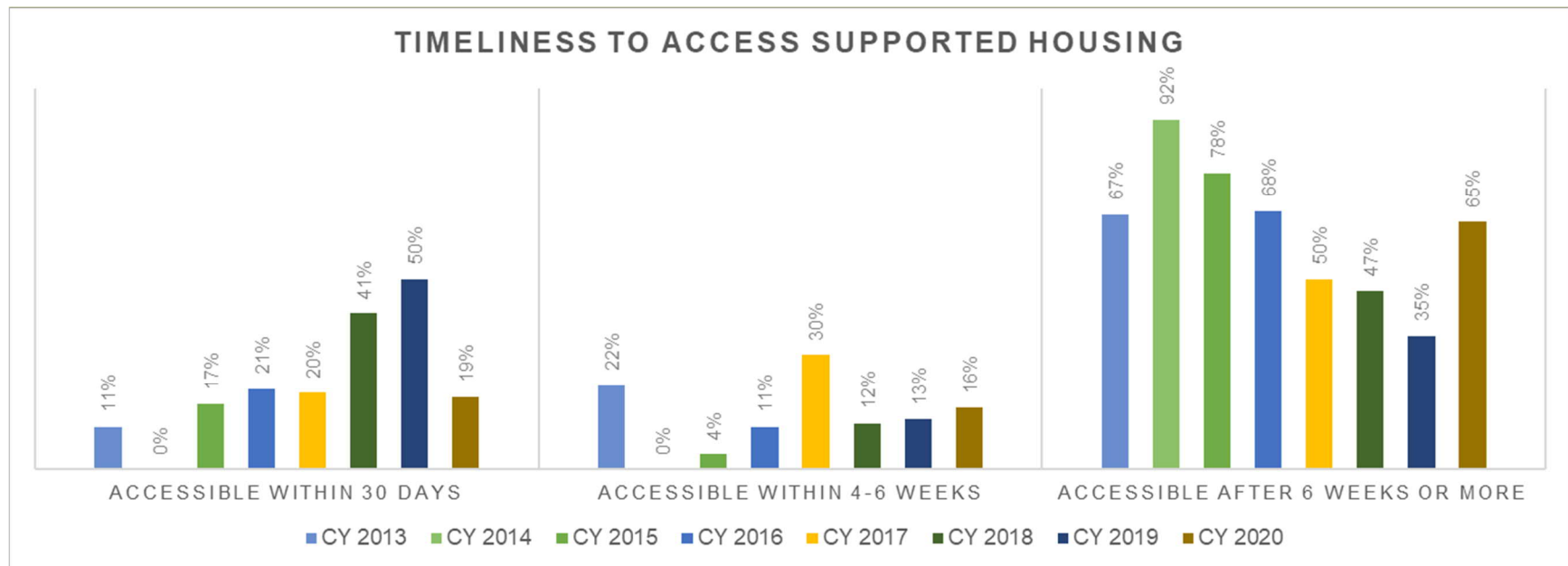
- 21% of the responses indicated that the services were being utilized efficiently (10% during CY 2013; 25% during CY 2014; 31% during CY 2015; 33% during CY 2016; 26% during CY 2017; 32% during CY 2018; 29% during CY 2019).
- 41% responded that the services were utilized efficiently most of the time (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).
- 38% of the respondents indicated that supported housing services were not utilized efficiently (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).



Timeliness

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

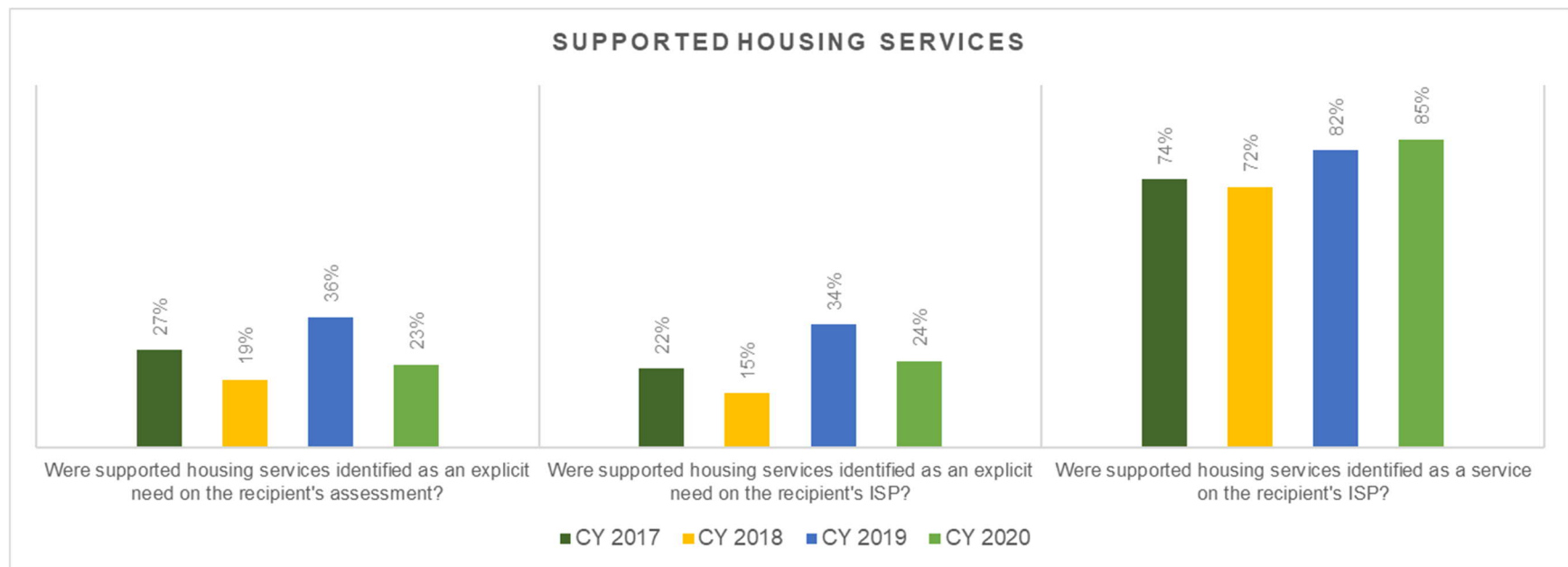
- 19% of the survey respondents reported that supported housing services could be accessed within 30 days of the identification of the service need (11% during CY 2013; 0% during CY 2014; 17% during CY 2015; 21% during CY 2016; 20% during CY 2017; 41% during CY 2018; 50% during CY 2019).
- 16% of the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



Medical Record Review

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

- Supported housing services were identified as a need on either the recipient’s assessment and/or recipient’s ISP in 27% of the cases reviewed.
- Supported housing was identified as a service on the recipient’s ISP in 85% of the cases when identified as a need. (An increase from last year when 82% of the ISPs with a documented need included supported housing).
- 5% of the recipients included in the sample received a unit of supported housing during CY 2020.



In 11 cases, reviewers were able to review progress notes and record the reasons that the person was unable to access supported housing services after housing-related assistance was identified as a need by the clinical team. The most common reason was that there was a lack of evidence that the clinical team followed up with initiating a referral for the service.

In some cases, Mercer’s review team noted that the clinical team assessed a need for supported housing, but the corresponding individual service plan did not include a supported housing service or intervention (n=7 cases or 16% of the cases in which there was an assessed need for supported housing).

Service Utilization Data

Permanent supported 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 supported housing providers can include behavioral health prevention and education, peer support, case management, behavioral health screening and assessment, non-emergency transportation, medication training and support, counseling, personal care and psychoeducational services.

As indicated within the service utilization data file, 6,308 (compared to 5,770 last review cycle) Title XIX eligible (Medicaid) recipients were affiliated with the service during the time period of October 1, 2019 — December 31, 2020 and 1,250 (compared to 1,114 last review cycle) non-Title XIX recipients received the service from a total population of 35,114⁵¹.

Key Findings and Recommendations

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

Findings: Supported Housing

- Service utilization data reveals that 22% of members received at least one unit of supported housing during the review period.
- All members reported the lack of housing support resources, extended waiting lists for housing vouchers, and challenges with obtaining information regarding a person’s housing application status from clinic leadership and the managed care organization.
- Wait lists exist for independent housing arrangements and there is a perception that there are too many clients needing the service than the system can accommodate.
- While some clinics employ housing specialists to assist members with obtaining and maintaining affordable housing, one case manager reported that her assigned clinic has not had a housing specialist for over a year. She went on to report that case

⁵¹ Mercer queried the following codes to delineate supported housing service utilization when provided by a contracted supported housing provider: H0043 (Supported Housing); H2014 (Skills Training and Development); H2017 (Psychosocial Rehabilitation Services); and T1019 & T1020 (Personal Care Services).

managers do not receive training on how to apply for Section 8 housing and, in the absence of an available housing specialist, must refer members to community-based housing support providers.

- Many participants described the lack of affordable and safe housing for members as a crisis, with rent increasing for those who are in housing. The housing that is available is not maintained satisfactorily and is perceived to be unsafe.
- Focus group participants reported that due to COVID-19, there are more challenges than ever in finding available housing.
- 47% of the survey respondents felt that supported housing services were difficult to access; significantly higher than CY 2019 (30%).
- When asked about the factors that negatively impact accessing supported housing services, 24% of the responses indicated that a wait list exists for the service (25% during CY 2019).
- Supported housing was identified as a service on the recipient's ISP in 85% of the cases when assessed as a need. (An increase from last year when 82% of the ISPs with a documented need included supported housing).

Recommendations: Supported Housing

- Assess the availability and capacity of housing specialists to assist recipients with housing related needs. Consider expanding the number of positions, cross-training other clinical team members to support recipients in need of supported housing, and/or hiring peer support specialists to share housing specialists' workloads.
- Through training and supervision, ensure that recipients supported housing needs are timely addressed and that clinical teams follow-up with initiating referrals for the services after a need has been identified.
- Continue efforts to identify safe and affordable housing options for recipients through collaboration with other community stakeholders, city and county housing authorities, and supported housing providers.

5.5 Multi-Evaluation Component Analysis — Assertive Community Treatment

Service Description

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

Focus Groups

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

- Participants thought that ACT was an invaluable service that helped many people restore functioning and independence. One participant reported that ACT saved her friends life and another reported ACT as a good program and that she has now been off of an ACT team for the past 5 years.
- Participants suggested several ideas to help determine the appropriateness of ACT services, including a review of past behavior, more frequent reviews to determine if the person should stay on an ACT team, tracking periods of stability for members assigned to ACT, and considering members on court ordered treatment who could benefit from ACT. For the latter, one participant noted that a member had her COT amended after she missed her dose of medication. She was arrested by law enforcement and taken to the hospital. If she was on an ACT team, it is believed that this outcome could have been avoided.
- While standardized ACT admission criteria is available, not all of the clinical teams apply the criteria consistently.
- One case manager reported that there are not enough ACT teams available, while observing that the existing ACT teams were not consistently at capacity. Other participants noted that once approved for ACT, members can wait for several months before completing the transition to the ACT team.
- One case manager reported that many of the ACT clinical team members are unaware of the fidelity requirements of ACT.
- There was a suggestion to cross-train ACT clinical team members to avoid gaps in services. For example, one ACT team did not have access to a housing specialist and the rest of the team did not know the process to initiate a housing application on behalf of the member.
- Most participants reported that ACT was a very valuable service and that members benefit from the service. There was awareness and appreciation for the work that the forensic specialty ACT teams provide.

- One provider shared the following observations: “Overall the teams work with us. Of course you have team members that communicate better with us than others. At this time we have a pretty good relationship with the FACT/ACT teams and communication between us is good when it comes to us keeping the team informed about what is going on with the member or we inform the team that the member needs assistance. The only problem I can see is that if something does happen with the member we are not kept in loop unless we call and inquire about a specific member”.
- As for the courts, one focus group participant noticed that the teams are dealing with staff shortages and team members switch very frequently. Requirements from the court fall between the cracks at times and the member is not receiving the services ordered by the court. Examples include counseling, anger management, substance abuse treatment, and peer support.
- One participant feels that the pandemic made things worse for members and recounted that her son would routinely “cheek” his medication when monitored via teleconference by his ACT team. She reported that this eventually resulted in her son being hospitalized.

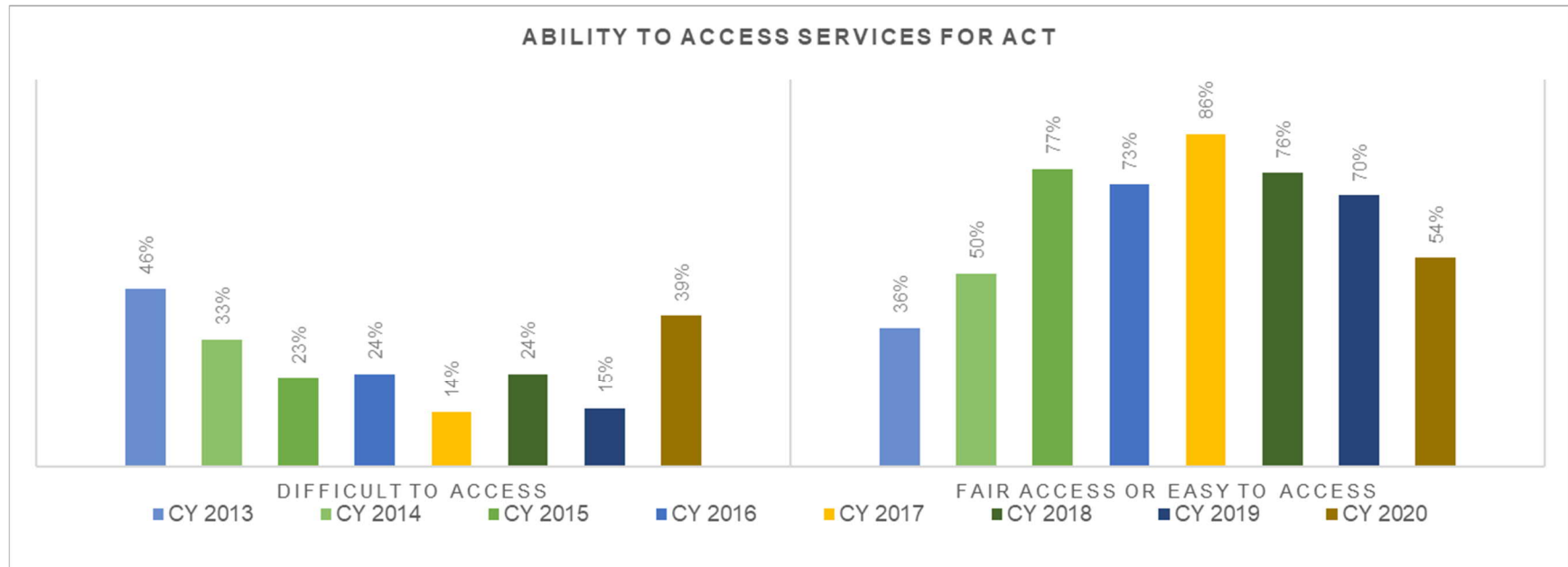
Key Informant Survey Data

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 be not be construed to be representative of the total population of system stakeholders.

Level of Accessibility

39% of survey respondents reported that ACT team services were difficult to access (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) and two respondents (7%) indicated that the service was inaccessible.

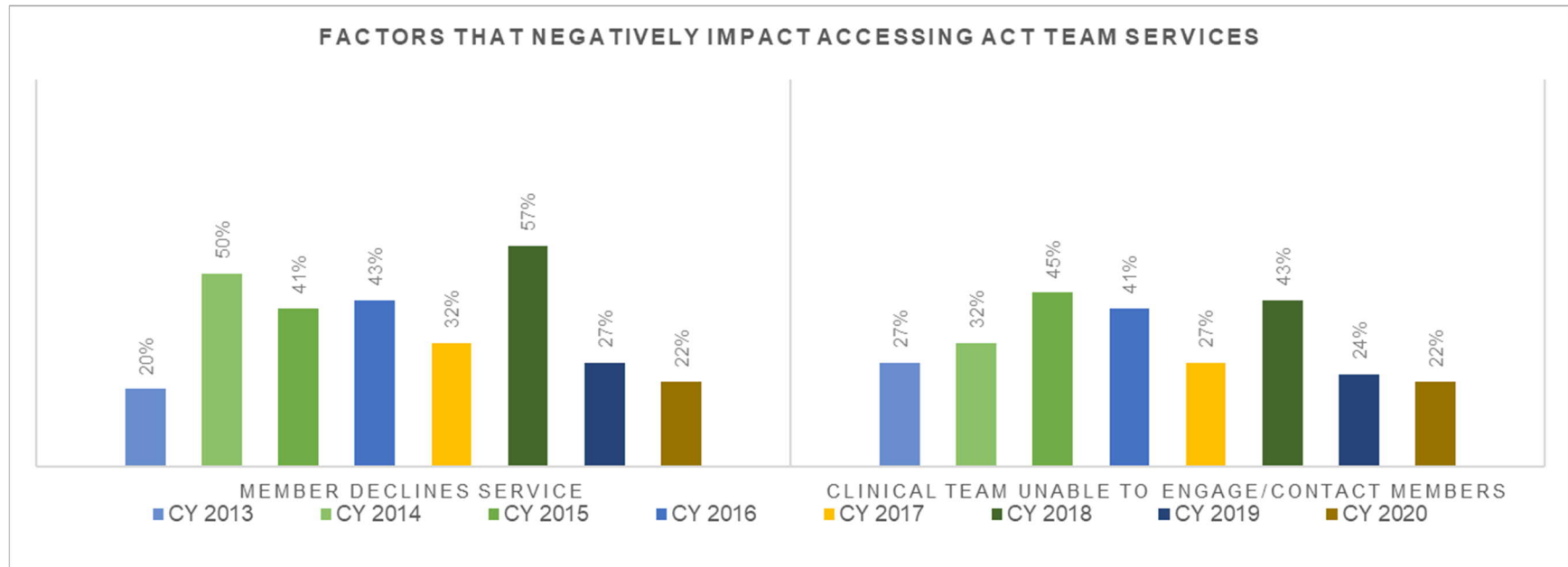
54% of respondents indicated that ACT team services had “fair access” or were easy to access (36% during CY 2013; 50% during CY 2014; 77% during CY 2015; 73% during CY 2016; 86% during CY 2017; 76% during CY 2018; 70% during CY 2019).



Factors that Hinder Access

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

- 22% indicated that the member declines service (20% — CY 2013; 50% — CY 2014; 41% — CY 2015; 43% — CY 2016; 32% — CY 2017; 57% — CY 2018; 27% — CY 2019).
- 22% of the responses identified clinical team unable to engage/contact member (27% during CY 2013; 32% during CY 2014; 45% — CY 2015; 41% — CY 2016; 27% — CY 2017; 43% — CY 2018; 24% — CY 2019).

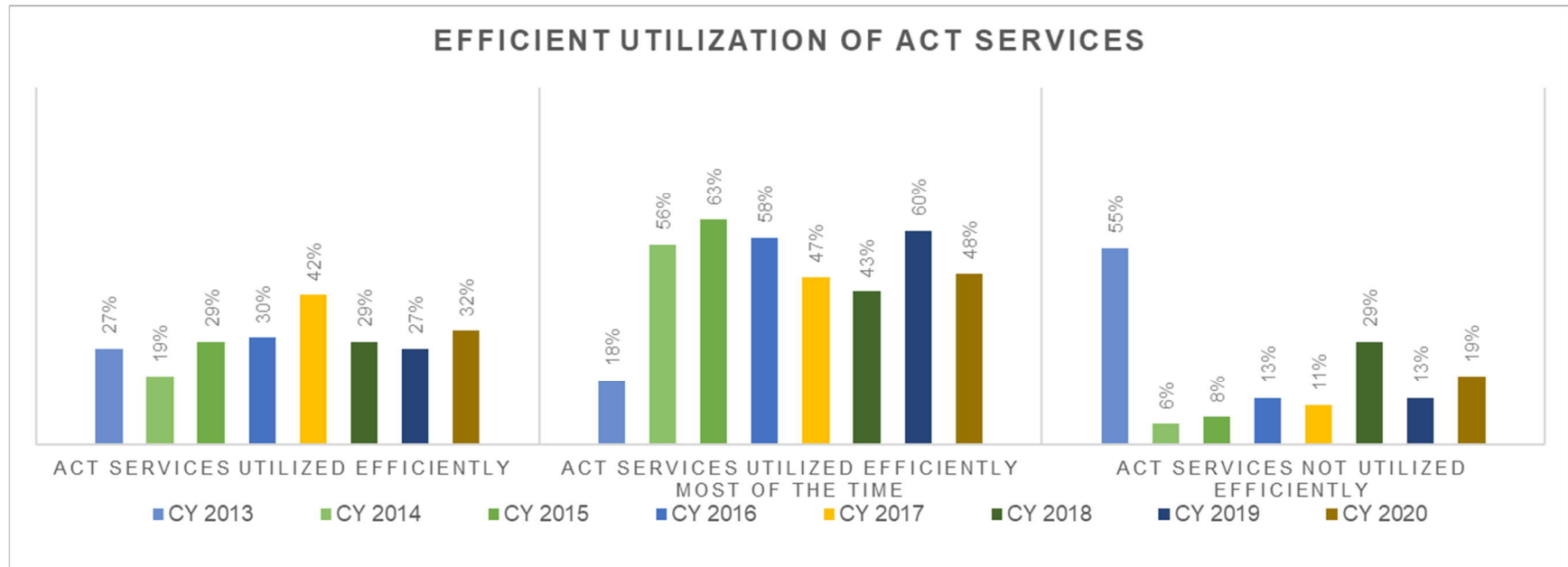


- 14% selected admission criteria too restrictive
- 14% indicated staffing turnover.

Efficient Utilization

In terms of the efficiency of service utilization:

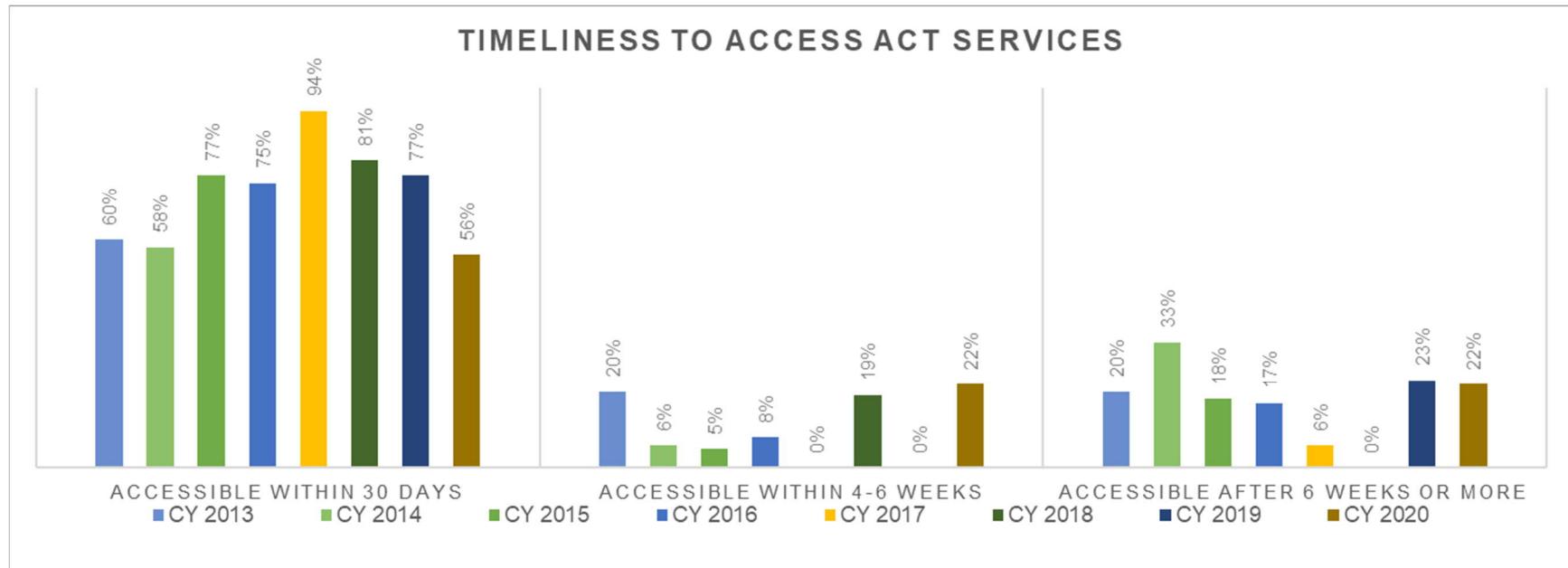
- 32% of the responses indicated that the services were being utilized efficiently (CY 2013 — 27%; 19% — CY 2014; 29% — CY 2015; 30% — CY 2016; 42% — CY 2017; 29% — CY 2018; 27% - CY 2019).
- 48% responded that the services were utilized efficiently most of the time (CY 2013 — 18%; CY 2014 — 56%; CY 2015 — 63%; CY 2016 — 58%; CY 2017 — 47%; CY 2018 — 43%; CY 2019 – 60%).
- 19% of the respondents indicated that ACT team services were not utilized efficiently (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).



Timeliness

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

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

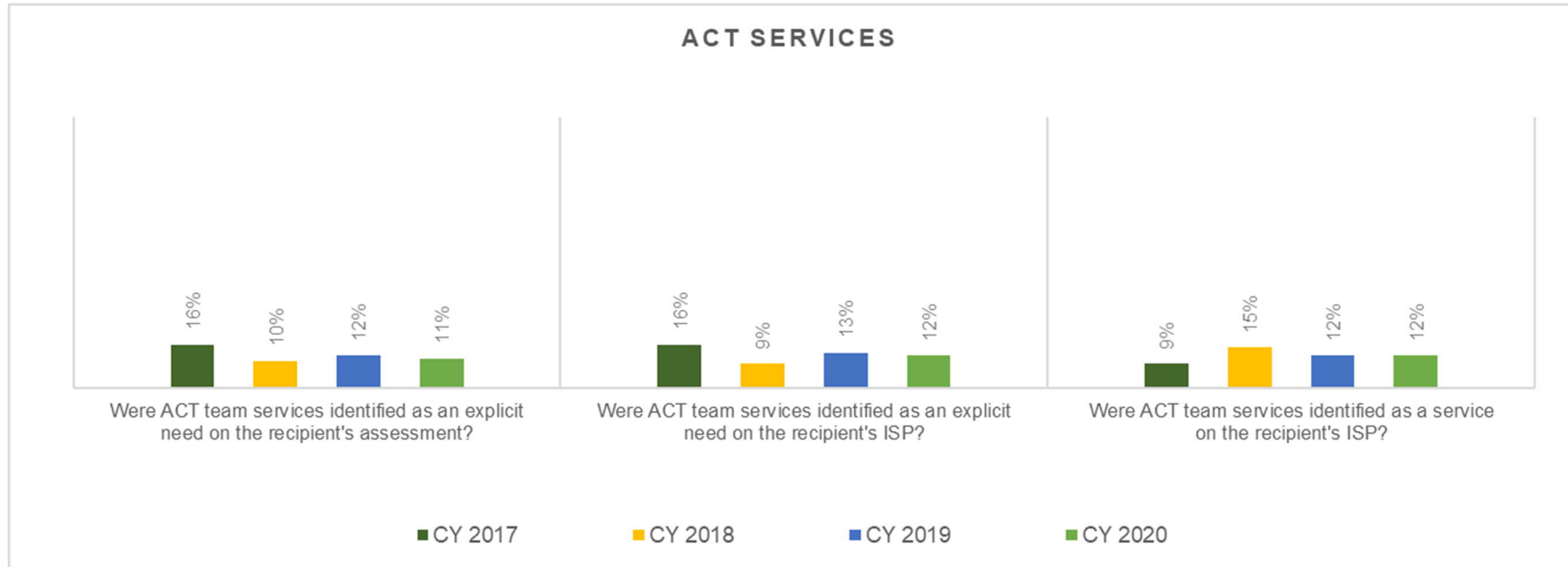


Medical Record Review

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.

In twenty-three cases (12%), ACT team services were identified as a need on recipients' assessments and/or ISPs. 96% of the cases with an assessed need for ACT included ACT or case management services on the ISP.

12% of the recipients included in the sample were assigned to an ACT team.



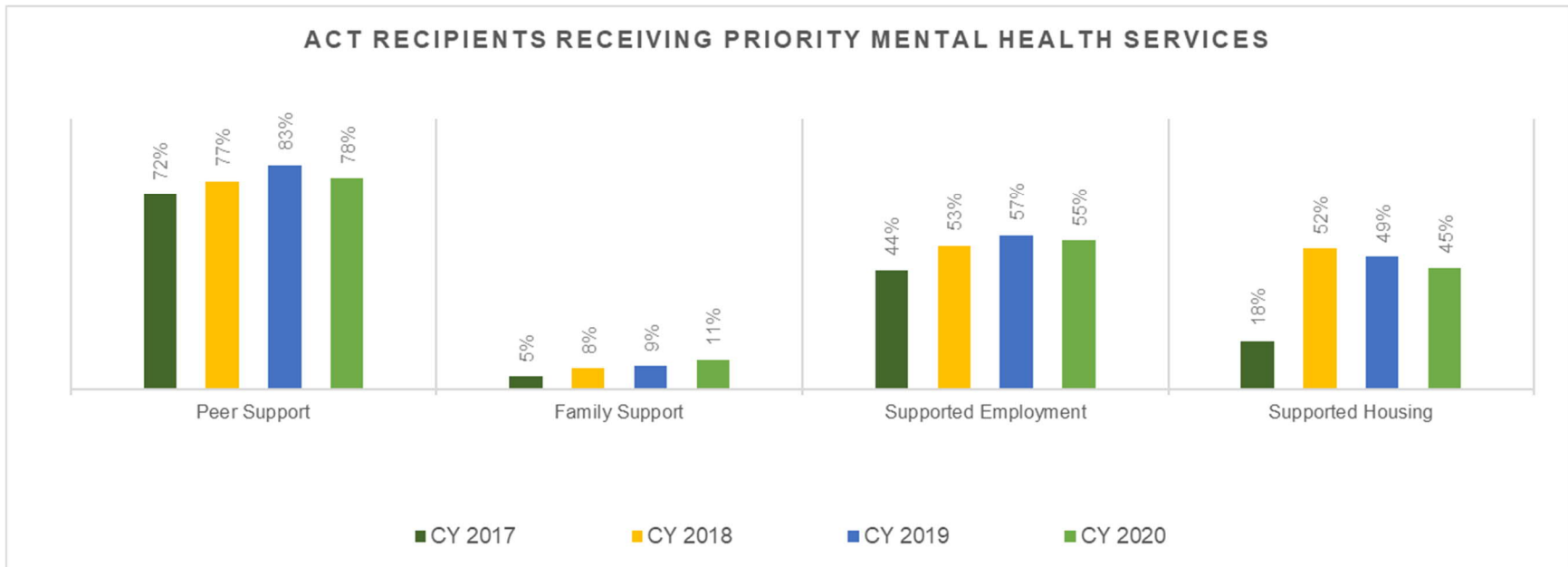
Service Utilization Data

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 2020 service utilization profiles for 2,192 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, supported housing, peer support services and/or family support services).

The analysis found:

- 78% of the ACT team members received peer support services during the review period;
- 11% of the ACT team members received family support services;

- ACT recipients who received supported employment services was determined to be 55%; and
- Utilization of supported housing services was found to be 45% across the identified ACT team members.



Key Findings and Recommendations

Findings: ACT Team Services

- As a percentage of the total SMI population, 6.6% of all members are assigned to an ACT team. This is a similar finding observed over the past five years.
- Most focus group participants reported that ACT was a very valuable service and that members benefit from the service. There was awareness and appreciation for the work that the forensic specialty ACT teams provide.

- One case manager reported that there are not enough ACT teams available, while observing that the existing ACT teams were not consistently at capacity. Other participants noted that once approved for ACT, members can wait for several months before completing the transition to the ACT team.
- During one focus group, there was a suggestion to cross-train ACT clinical team members to avoid gaps in services. For example, one ACT team did not have access to a housing specialist and the rest of the team did not know the process to initiate a housing application on behalf of the member.
- 39% of survey respondents reported that ACT team services were difficult to access (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) and two respondents (7%) indicated that the service was inaccessible.
- 78% of the ACT team members received peer support services during the review period. ACT recipients who received supported employment services was determined to be 55%. Utilization of supported housing services was found to be 45% across the identified ACT team members.
- In most medical record review cases, 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.
- A review of 100 SMI members that represent the highest aggregate behavioral health service costs during CY 2020 was conducted. It was determined that 33% 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, and 36% during CY 2019.
- Of the 33 members assigned to ACT and included on the list of the top 100 members with the highest behavioral health service costs; 21 (64%) also resided in supervised behavioral health residential settings. During times of transition (admission or discharge from ACT team services), it may be appropriate to temporarily have a member assigned to ACT and placed in a supervised setting, but this should be time-limited due to the duplicative nature of the services.
- Overall, 58 of the 100 (58%) members resided in a supervised behavioral health residential setting, which may contribute to higher service costs for those members and may discourage clinical teams from considering or referring a member to an ACT team. If members placed in a supervised behavioral health residential setting (and not currently assigned to an ACT team) are excluded from the analysis, then 52% of the highest cost utilizers are assigned to an ACT team.

- An analysis of jail booking data was completed to identify members that have had multiple jail bookings over a defined period (i.e., eleven months — January 2020 through November 2020) and determine if the member was subsequently referred and assigned to an ACT team, including one of the three forensic specialty ACT teams. The analysis found:
 - 328 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).
 - Of these 328 members, 47 (14%) 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%)
 - Of the 47 members assigned to an ACT team, 10 (21%) are assigned to a forensic specialty ACT team (CY 2015 — 20%; CY 2016 — 22%; CY 2017 — 29%; CY 2018 — 28%; CY 2019 — 22%).
 - 18 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.
 - 121 members were incarcerated 3 or more times but are not assigned to an ACT or forensic specialty ACT team.

Recommendations: ACT Team Services

- 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 SMI recipients.
- Periodically 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. In addition, clinical teams should regularly evaluate opportunities for current ACT team members to step down to a lower level of care as clinically appropriate and document when these reviews occur as part of the member's medical record.
- Continue efforts to clarify ACT admission criteria to direct care clinic staff, providers, and referral sources to help ensure appropriate and consistent identification of ACT team candidates.

Section 6

Outcomes Data Analysis

The service capacity assessment included a limited analyses 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.

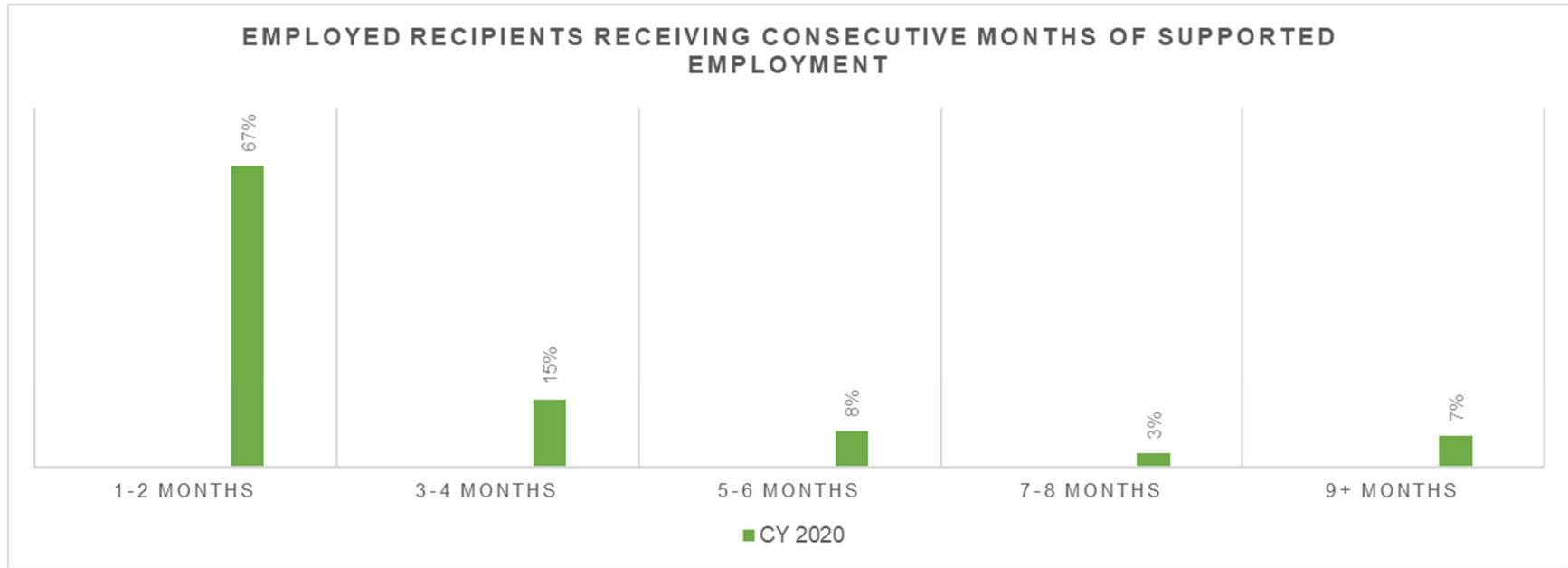
The following outcome indicators were reviewed:

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

During CY 2020, 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 of time.

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. Over two thirds of 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 only 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 91% 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 66% of all incarcerations during the same time period (i.e., CY 2020). Recipients who received peer support services for five or more consecutive months accounted for 14% 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 81% 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

On behalf of the Arizona Health Care Cost Containment System (AHCCCS), Mercer Government Human Services Consulting (Mercer) would like to invite you to attend one of four stakeholder groups that will be held in-person in Maricopa County or via the option of a Zoom teleconference.

The focus groups will evaluate access to Priority Mental Health Services (PMHS) in Maricopa County for persons with a serious mental illness (SMI). The PMHS include: Assertive Community Treatment (ACT), Supported Housing (SH), Supported Employment (SE) and Peer and Family Support Services. A description of each service can be found on Page 2 of this invitation. Mercer's evaluation includes a review of system strengths and challenges related to access to and availability of the PMHS'. The information gathered through the stakeholder groups is used to help the adult SMI system of care in Maricopa County continue to expand access to recovery-oriented services.

Focus groups will be held at the following location:
Stand Together and Recover Services (S.T.A.R.) Central
2502 E. Washington Street
Phoenix, AZ 85034
Or optional via Zoom teleconference*

***Dial-in instructions and details will be provided to individuals once registered.**

Stakeholder Group One

Adults receiving at least one SMI PMHS

**Tuesday, August 17, 2021
11:00 am–1:00 pm**

S.T.A.R. Central or join via Zoom teleconference

Stakeholder Group Two

Direct Care Clinic Case Managers involved in providing PMHS to Adults with SMI

**Tuesday, August 17, 2021
3:00 pm–5:00 pm**

S.T.A.R. Central or join via Zoom teleconference

Stakeholder Group Three

Providers of ACT, SH, SE, Peer and Family Support Services to adults receiving SMI PMHS

**Wednesday, August 18, 2021
3:00 pm–5:00 pm**

S.T.A.R. Central or join via Zoom teleconference

Stakeholder Group Four

Family Members of Adults with SMI Receiving at least one PMHS

**Wednesday, August 18, 2021
6:00 pm–8:00 pm**

S.T.A.R. Central or join via Zoom teleconference

Space is available for 15 participants per stakeholder group and all RSVPs will be confirmed by email. Once capacity is reached, interested participants will be placed on a waiting list. Refreshments will be provided. RSVP by August 6, 2021 to Dan Wendt (dan.wendt@mercerc.com) or call Dan @ 602-522-8578.

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.

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

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 2021

Q13 Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2021

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)	<input type="radio"/>	<input type="radio"/>
Family Support Services (2)	<input type="radio"/>	<input type="radio"/>
Peer Support Services (3)	<input type="radio"/>	<input type="radio"/>
Supported Employment (4)	<input type="radio"/>	<input type="radio"/>
Supported Housing (5)	<input type="radio"/>	<input type="radio"/>

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Support Services (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Support Services (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Employment (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Housing (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Support Services (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer Support Services (3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported Employment (4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported Housing (5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Support Services (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Support Services (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Employment (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Housing (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Support Services (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Support Services (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Employment (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Housing (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Support Services (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Support Services (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Employment (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Housing (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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?

- CEO (1)
 - Executive Management (2)
 - Clinical Leadership (behavioral health) (3)
 - Clinical Leadership (medical) (4)
 - Specialty Case Manager (5)
 - Direct Services Staff (BHP/BHT) (6)
 - Other (please specify) (7) _____
-

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

- ACT Team Provider (1)
 - Behavioral Health Provider for Adults with a SMI Only (2)
 - Behavioral Health Provider for Adults with a SMI, Children, General Mental Health/Substance Abuse (3)
 - Consumer Operated Agency (peer support services/family support services for adults) (4)
 - Crisis Provider (5)
 - Hospital (6)
 - Provider Network Organization or other Administrative Entity within the Maricopa County Regional Behavioral Health Authority System (7)
 - Supported Employment Provider (8)
 - Supported Housing Provider (9)
 - 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 2020.

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

Appendix C

Group 2 — Medical Record Review Tool

Log-in screen [1]

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

Date ___/___/___ Provider Network Organization _____ Direct Care Clinic _____

Date of most recent assessment ___/___/___ Date of most recent ISP ___/___/___ Sample period: *January 1, 2017 – December 31, 2017*

Chart Review [2]

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

Appendix D

Summary of Recommendations

Service	Recommendations
Peer Support Services (PSS)	<p>PSS 1: System stakeholders should examine changes in service delivery modalities and policies in response to the COVID-19 Pandemic and retain practices that promote more efficient access to peer support services (e.g., accepting verbal consent to process service referrals).</p> <p>PSS 2: In the event that peer support services and related health promotion groups continue to be offered virtually, develop and implement standard operating protocols to help ensure recipients benefit from the services (e.g., limits on numbers of members attending, procedures for soliciting input from participants, ensuring all participants have opportunities to engage and contribute to group discussions).</p> <p>PSS 3: Examine requirements that direct care clinics must initiate referrals prior to a recipient accessing peer support services from a community-based consumer-run organization. To promote independence and autonomy, recipients should be able to self-refer to access peer support services without having to go through the recipient's assigned direct care clinic as this can result in significant delays in accessing the services.</p>
Family Support Services (FSS)	<p>FSS 1: Provide training and supervision to ensure that direct care 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.</p> <p>FSS 2: Ensure that the member's ISP includes family support as an intervention after members affirm that they would like a family member involved in treatment.</p>
Supported Employment Services (SES)	<p>SES 1: Continue efforts to promote the broader utilization of ongoing support to maintain employment. Consider the following steps:</p> <ul style="list-style-type: none"> – Educate supported employment specialists about effective ways to present and promote the service to recipients;

Service	Recommendations
	<ul style="list-style-type: none"> – Examine current reimbursement rates for each type of supported employment service and ensure that the rates incentivize and reinforce appropriate utilization; – Consider adopting an alternative service code and/or service code modifier to capture annual rehabilitation specialists’ vocational/meaningful day assessments as these activities do not align with current supported employment service code descriptions. – Ensure ongoing education is available to case managers and clinical team members regarding how members can gain employment without jeopardizing eligibility for public assistance programs (e.g., AHCCCS eligibility, social security disability insurance). <p>SES 2: Continue to monitor and address as needed the practice of documenting supported employment services on members’ ISPs without evidence of an assessed need for the service.</p>
<p>Supported Housing Services (SHS)</p>	<p>SHS 1: Assess the availability and capacity of housing specialists to assist recipients with housing related needs. Consider expanding the number of positions, cross-training other clinical team members to support recipients in need of supported housing, and/or hiring peer support specialists to share housing specialists’ workloads.</p> <p>SHS 2: Through training and supervision, ensure that recipients supported housing needs are timely addressed and that clinical teams follow-up with initiating referrals for the services after a need has been identified.</p> <p>SHS 3: Continue efforts to identify safe and affordable housing options for recipients though collaboration with other community stakeholders, city and county housing authorities, and supported housing providers.</p>
<p>Assertive Community Treatment (ACT)</p>	<p>ACT 1: 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 SMI recipients.</p> <p>ACT 2: Periodically 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. In addition, clinical teams should regularly evaluate opportunities for current ACT team members to step</p>

Service	Recommendations
	<p>down to a lower level of care as clinically appropriate and document when these reviews occur as part of the member's medical record.</p> <p>ACT 3: Continue efforts to clarify ACT admission criteria to direct care clinic staff, providers, and referral sources to help ensure appropriate and consistent identification of ACT team candidates.</p>



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