MERCER

Service Capacity Assessment

Priority Mental Health Services 2020

Arizona Health Care Cost Containment System
October 22, 2020

Contents

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 seventh in a series of annual service capacity assessments performed by Mercer.

The service capacity assessment included 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). Mercer assessed 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 for 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. 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 2019 (CY 2019), though for some units of analysis that rely on service utilization data, the timeframe was adjusted (e.g., October 2018–June 30, 2019) 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. CY 2019 utilization rates for each of the priority mental health services is stable and consistent with findings derived over the past four years as illustrated in the following table.

Table 1 — Summary of Priority Mental Health Services Utilization, Year to Year

2019 Service Capacity Assessment	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Service Utilization Data	34,451	35%	5%	31%	15%	6.6%[1]
2018 Service Capacity Assessment						
Service Utilization Data	34,264	36%	4%	29%	15%	6.5%
2017 Service Capacity Assessment						
Service Utilization Data	31,712	37%	2%	26%	7%	7%
2016 Service Capacity Assessment						
Service Utilization Data	30,440	38%	3%	26%	10%	7%

Based on service utilization trends, the volume of recipients has increased year-to-year with a higher percentage of individuals receiving supported employment, family support and ACT during 2019. Supported housing and supported employment are more available in Maricopa

[1] ACT services were not included as part of the service utilization file. ACT utilization percentages are based on year-to-year ACT rosters that identify recipients who are assigned to ACT teams.

County (especially to Medicaid recipients) compared to the national average. Maricopa County consistently 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. 2,278 people received ACT services in Maricopa County in 2019. A national study by leading ACT researchers estimated that 4.3% of adults with SMI served in a mental health system needed an ACT level of care.[2] 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 2019.

Service specific examples of opportunities to improve the identification of need and access to the services, as well as system strengths, are noted below. Interviews completed subsequent to this analysis revealed that the system has been working to address issues noted in prior service capacity assessment reports including the provision of ISP training, maintenance of value-based purchasing arrangements specific to some of the priority services, and development and dissemination of a provider reference guide that addresses all aspects of care related to the covered population.

Consumer Operated Services (Peer Support and Family Support)

Multiple opportunities continue to 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. Peer support utilization as measured via administrative data has been consistently strong year-to-year. The system has excelled at developing and implementing innovative opportunities for peer support to expand availability across a number of care settings and services.

Only 5% of all recipients received family support services over the review period. A lack of available or engaged family members, member choice to not involve family members in treatment, and indications 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. Participants in all focus groups reported that family support services are not widely utilized and that engagement with families is lacking. The family member focus group expressed that while family support has been generally helpful, they could use more engaged support and, in general, need to be informed about the breadth of services available.

[2] 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 finding from an analysis of data on the services of the services of people with serious mental illnesses in the Portland Oregon area.

Supported Employment

Supported employment providers are co-located within many direct care clinics and work with vocational rehabilitation/Rehabilitation Services Administration (VR/RSA), rehabilitation specialists and clinical teams to coordinate and provide supported employment services. Service utilization data demonstrates 31% of members received at least one unit of supported employment during CY 2019, an increase of 2% from last year and the second consecutive year of year-to-year increases in utilization.

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. 16% of the medical records included supported employment services as an ISP intervention without a corresponding need identified in the member's assessment.

The system has implemented value-based purchasing agreements with supported employment providers and offers incentives if providers achieve targeted outcomes that include (1) facilitating a first contact between a member and potential employer within the first 30 days of program enrollment, (2) providing ongoing support to maintain employment once the member is employed; and (3) successfully transitioning members to VR/RSA funding following enrollment with the supported employment provider.

Supported Housing

Programs exist for persons in need of affordable and safe housing; offering a wide array of support services and community resources to help individuals achieve and maintain integrated housing. Permanent supported housing 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. Alternative payment arrangements have been designed and implemented with supported housing providers that promote desired outcomes, including measures to reduce homelessness, avoid hospitalization, increasing the volume of members who can contribute to rental payments and reductions in crisis service utilization. During CY 2019, enhancements to the incentive program include the addition of a metric to track housing retention.

The system is successfully maintaining the current inventory of supported housing services. Many system stakeholders, including focus group participants and supported housing providers, continue to report ongoing needs for transitional housing options to help address immediate needs for housing for members at-risk for homelessness. Locating safe and affordable housing in the current housing market is a challenge and reduces the number of housing options available to persons in need.

Promptly addressing a member's needs for housing and related supports has a significant impact on that person's health outcomes. Delays in accessing housing can result in hospitalizations, incarcerations and the need for crisis intervention services. Opportunities continue to exist to expedite member's linkages to available supported housing options when a housing need is identified. Medical record reviews demonstrate

that 18% of cases with an assessed need for supported housing did not include an ISP intervention to address the need. While an improvement compared to CY 2018, teams responsible for the oversight of member care should ensure unmet needs, especially critical needs such as housing and related supports, are recognized and addressed through appropriate and timely interventions.

As indicated within the service utilization data file, 4,807 Title XIX eligible (Medicaid) recipients were affiliated with the service during the time period of October 1, 2018–December 31, 2019 and 1,114 non-Title XIX recipients received the service from a total population of 35,236[3]. While the percentage of members in receipt of supported housing is unchanged between CY 2018 and CY 2019, over 1,775 more members received a supported housing service during the review period.

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., 37 more members during CY 2019 than CY 2018). As of December 1, 2019, total member counts across all 24 ACT teams found the teams to be operating at 5% below capacity. Mercer estimates that a given ACT team may periodically operate at 5% or less below capacity to accommodate periods of transitions of persons leaving the teams and new referrals being added to the teams. Three of the ACT teams, or 13% of the total number of available teams, were at 10% or more below capacity. All of these metrics improve upon CY 2018 when the teams were at 7% below capacity and five teams were at 10% or more below capacity.

To ensure that the current ACT team capacity is maximized and used to support all recipients who may be in need of this intensive level of services, the system needs to ensure that regular and consistent assessments are occurring — not only for new ACT team candidates, but for individuals who have had a prolonged tenure on an ACT team and may be appropriate for less intensive supports. Clinical teams should periodically assess the appropriateness of ACT team services for those members under their care. In addition, key metrics and indicators, 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.

The service capacity assessment included a random review of medical record documentation as well as a review of incarceration events and an analysis of a list of members who represent the highest aggregate behavioral health service costs over a defined period (i.e., one year). These analyses sought to determine if the system was missing opportunities to identify and refer appropriate candidates to the available ACT teams.

[3] 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).

Results of a review of annual assessments as well as corresponding ISPs and progress notes revealed very few formal assessments or other documented considerations related to the clinical team reviewing members' appropriateness for ACT team services — including current ACT team recipients and those who should have been considered for the service.

The analysis of jail booking data found that 18% of 527 members that experienced at least two jail bookings over the review period were assigned to an ACT team. Further analyses of this multiple incarceration cohort demonstrated that over 22% of the members affiliated with an ACT team were assigned to one of three forensic specialty ACT teams. As of December 1, 2019, the three available forensic ACT teams had capacity to accommodate new members as the percent below capacity ranged from 7% to 14%. Opportunities continue to exist to link members with jail recidivism to available ACT teams. More recently, Mercer has learned that the three forensic ACT teams are close to capacity as the system responds to the demand for these specialty teams.

A list of the top 100 members that were associated with the highest aggregate behavioral health service costs determined that 36% were actively assigned to an ACT team — a percentage that surpasses similar analyses that have been conducted over the past six years and continues a trend of year-to-year improvement.

Capacity of available ACT teams appear to be adequate to meet the current needs of the system. Recommendations include implementing an organized and structured approach to support an ongoing assessment of need at the direct clinics and performance of periodic data driven review of relevant system indicators that supports the appropriate identification and transition of ACT team members.

Current Assessment Documentation

Last year, Mercer found that 31% of the initial sample of records did not include a current assessment and/or service plan. Regular assessments and service plan updates ensure that members are periodically evaluated and any needs for the prioritized services are identified and addressed. When selecting an oversample of records for this year's medical record review activity, Mercer determined that 7,900 (30%) cases out of a total of 26,293 valid cases did not have a current assessment during CY 2019. Of these 7,900 cases, 57% were assigned to "navigator status" — a designation that necessitates periodic outreach to the member but does not include expectations that the member has a current assessment and/or ISP. When the navigator status cases are removed from the analysis, 16% of the cases did not have a current assessment.

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

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 SMI[4]. 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:

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

Limitations and Conditions

Mercer did not independently verify the accuracy and completeness of service utilization data, outcomes data and other primary source information collected 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

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

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

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
Terros	Priest	**Southwest Network**	Saguaro
	23rd Avenue		Osborn
	51st Avenue		San Tan
			Estella Vista
Lifewell Behavioral Wellness	Oak	**Chicano Por La Causa**	Centro Esperanza
	Windsor		
	South Mountain		
	Royal Palms		
		Valleywise	First Episode Center
			Mesa Behavioral Health Specialty Clinic
LaFrontera/EMPACT	Comunidad	**Partners in Recovery Network**	Metro Center Campus
	EMPACT — San Tan		West Valley Campus
	EMPACT — SPC Apache Junction		Arrowhead Campus
Jewish Family and Children Services	Michael R. Zent Healthcare Clinic		East Valley Campus

Organization	Direct Care Clinics	Organization	Direct Care Clinics
	East Valley Health Center		Hassayampa Campus
Community Partners, Inc.	Community Partners Integrated Healthcare		Gateway Campus
PSA (Resilient Health)	Higley Integrated Healthcare Center	**Valle Del Sol**	Red Mountain
Community Bridges, Inc.	Mesa Heritage		

Current Service Capacity

The information presented below reflects the contracted capacity for each of the prioritized services during the period under review.[5]

ACT Teams (24 teams serving 2,278 recipients)[6]

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Southwest Network: San Tan		100	93	7%
Southwest Network: Saguaro		100	99	1%
Southwest Network: Osborn		100	92	8%
Lifewell Behavioral Wellness: Royal Palms		100	97	3%
Lifewell Behavioral Wellness: South Mountain		100	95	5%
Terros: Enclave		100	96	4%

[5] As reported by the Maricopa County RBHA administering the AHCCCS contract in December 2019.
[6] As of December 1, 2019.

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Terros: Townley	Primary Care Provider (PCP) Partnership	100	98	2%
Terros: Townley 2		100	100	0%
Terros: 51st Avenue	PCP Partnership	100	98	2%
Chicanos Por La Causa: Centro Esperanza		100	91	9%
La Frontera/ EMPACT: Tempe	PCP Partnership	100	94	6%
La Frontera/EMPACT: Comunidad		100	99	1%
La Frontera/EMPACT: Capitol Center		100	98	2%
Partners in Recovery: Metro Center Campus — Omega Team		100	97	3%
Partners in Recovery: Metro Center Campus — Varsity Team		100	97	3%
Partners in Recovery: Indian School	Medical Team	100	85	15%
Partners in Recovery: West Valley Campus	PCP Partnership	100	98	2%
Community Bridges: FACT Team 1	Forensic Team & PCP Partnership	100	93	7%
Community Bridges: FACT Team 2	Forensic Team & PCP Partnership	100	89	11%
Community Bridges: FACT Team 3	Forensic Team & PCP Partnership	100	86	14%
Community Bridges: Avondale	PCP Partnership	100	95	5%
Community Bridges: 99th Avenue	PCP Partnership	100	98	2%

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Community Bridges: Mesa Heritage		100	99	1%
Maricopa Integrated Health System — Mesa Riverview	PCP Partnership	100	91	9%
Totals		**2,400**	**2,278**	**5%**

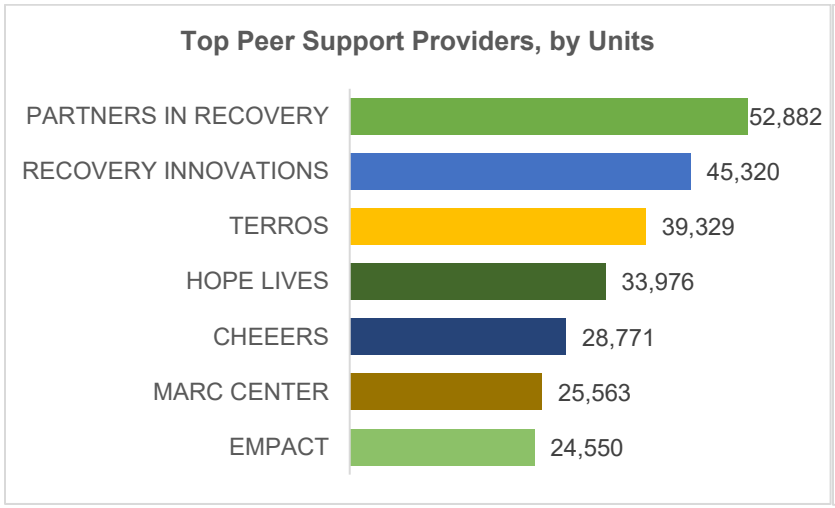
An analysis of service utilization data is presented below to identify the volume of units and unique members affiliated with each priority mental health service provider. The results identify the most prominent providers of the priority mental health services. The analysis was completed for the following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

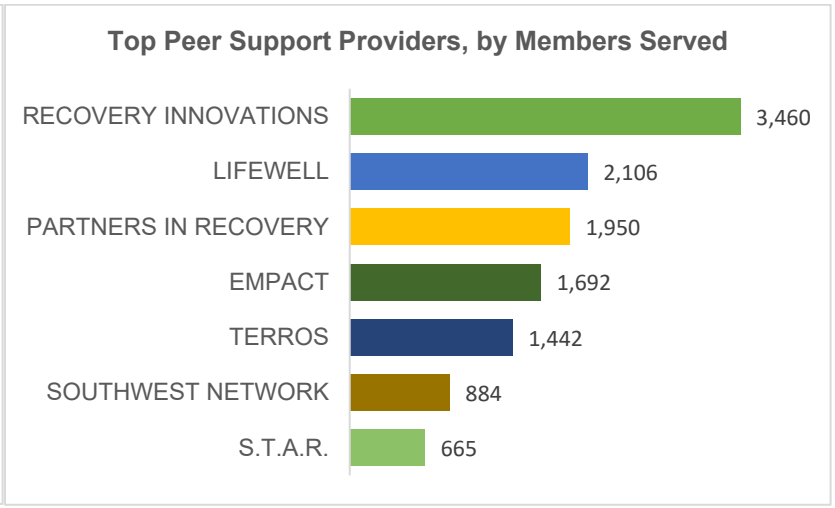
Consumer Operated Services (peer support and family support) Providers[7]

- CHEEERS
- Chicanos Por La Causa (CPLC)
- Community Bridges, Inc.
- Community Partners Integrated Health Care (CPIH)
- Family Involvement Center
- Hope Lives — Vive la Esperanza
- La Frontera/EMPACT
- Lifewell Behavioral Wellness

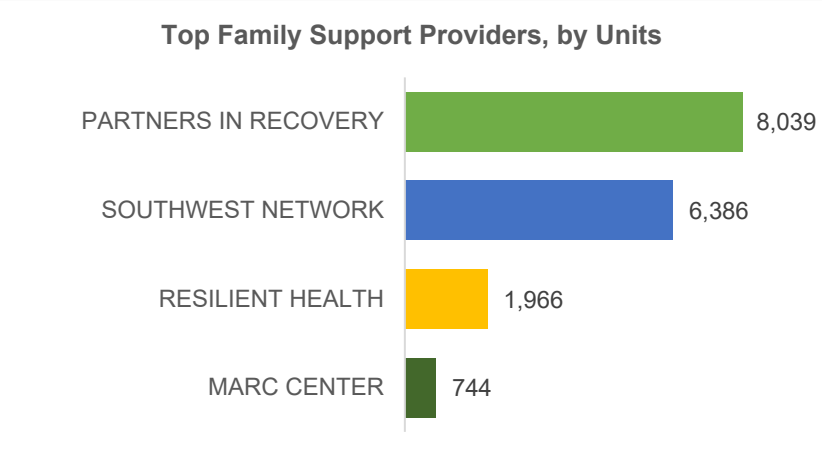
[7] As reported by the Maricopa County RBHA administering the AHCCCS contract in December 2019.

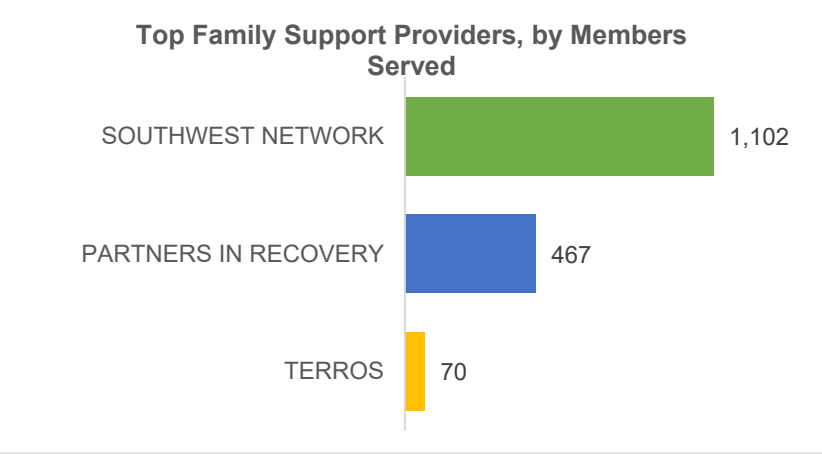
- Marc Community Resources
- National Council on Alcoholism and Drug Dependence (NCADD)
- NAZCARE
- Partners in Recovery
- Recovery Empowerment Network
- Recovery Innovations International
- Resilient Health
- Southwest Behavioral Health
- Southwest Network
- Stand Together and Recover (STAR)
- TERROS
- Valle del Sol
- Valleywise


Top Peer Support Providers, by Units
PARTNERS IN RECOVERY
52,882
RECOVERY INNOVATIONS
45,320
TERROS
39,329
HOPE LIVES
33,976
CHEEERS
28,771
MARC CENTER
25,563
EMPACT
24,550


Top Peer Support Providers, by Members Served
RECOVERY INNOVATIONS
3,460
LIFEWELL
2,106
PARTNERS IN RECOVERY
1,950
EMPACT
1,692
TERROS
1,442
SOUTHWEST NETWORK
884
S.T.A.R.
665

Consumer Operated Services (family support)

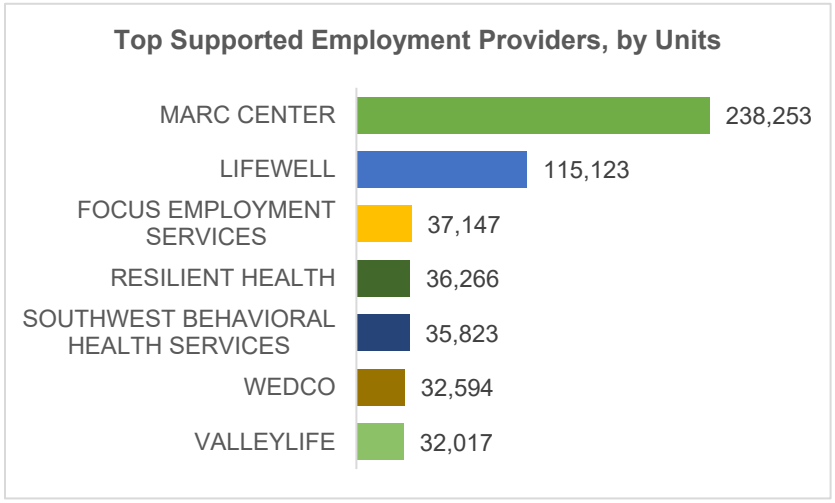


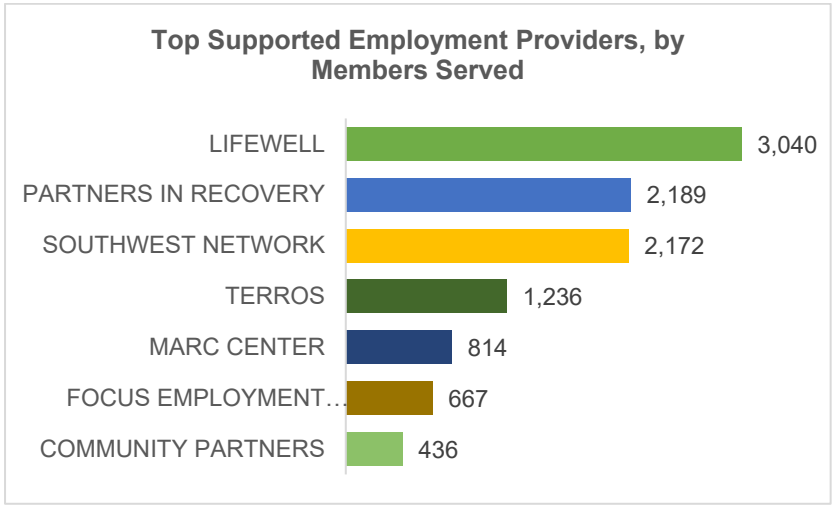


Supported Employment Providers[8]

- 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 December 2019.



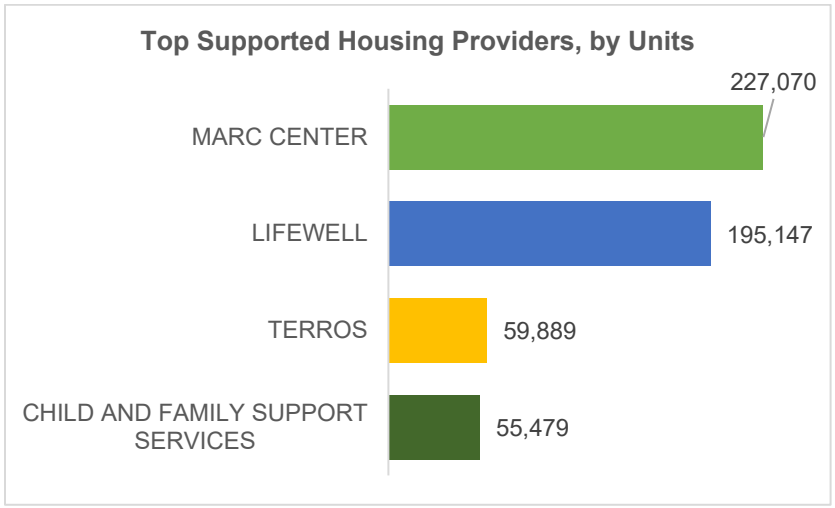


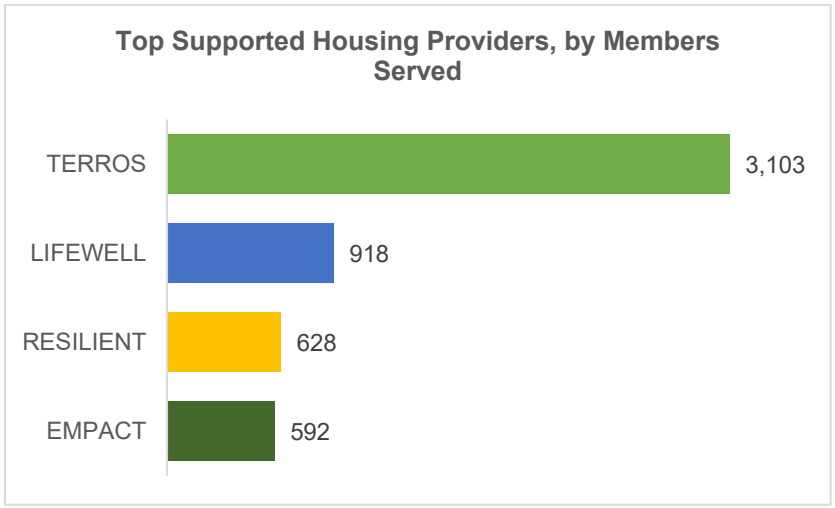
Supported Housing Providers[9]

- 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

[9] As reported by the Maricopa County RBHA administering the AHCCCS contract in December 2019.

- Community Bridges, Inc.
- Florence Crittenton
- Housing Authority of Maricopa County
- La Frontera/EMPACT
- Lifewell Behavioral Wellness
- Marc Community Resources
- Native American Connections
- ProMarc
- Resilient Health
- RI International
- Save the Family
- Southwest Behavioral & Health Services
- Terros Health


Top Supported Housing Providers, by Units
227,070
MARC CENTER
LIFEWELL
195,147
TERROS
59,889
CHILD AND FAMILY SUPPORT SERVICES
55,479


Top Supported Housing Providers, by Members Served
TERROS
3,103
LIFEWELL
918
RESILIENT
628
EMPACT
592

4
Methodology

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

- *Key informant surveys, interviews and focus groups:* 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 AHCCCS[10].

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 27 stakeholders participated in the four two-hour focus groups conducted on March 4, 2020 and March 5, 2020. All four focus groups were held at the Burton Barr Library in Phoenix. 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:

- A handout defining each of the priority mental health services was provided to each group of participants at the onset of the focus groups.

[10] See Appendix A: Focus Group Invitation.

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

Key Informant Surveys and Interviews

One objective of the service capacity assessment was to obtain comprehensive stakeholder feedback regarding the availability of each of the priority mental health services. As a result, a key informant survey was created using Survey Monkey®. The survey tool included questions with rating assignments related to accessing the priority mental health services, including the ease of access and timeliness of access to the services.[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 be 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 25 respondents completed the survey tool.

In addition, multiple 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).

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

[11] See Appendix B: Key Informant Survey.

- The recipient was identified as SMI and received a covered behavioral health service during October 1, 2018 and December 31, 2019.[12]
- The recipient had an assessment date between January 1, 2019 and November 15, 2019.[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, 2019.

To complete the medical record audit, three licensed clinicians review medical record documentation and record results in a data collection tool. As applicable, additional comments may be added to the tool to further clarify scoring and findings. Inter-rater reliability testing prior to the medical record audit as well as documented scoring guidelines helps to ensure that each reviewer consistently applies the review tool.

Analysis of Service Utilization Data

Mercer initiated a request to AHCCCS for a comprehensive service utilization data file. The service utilization data file includes all adjudicated service encounters for any person designated as SMI and assigned to the Maricopa County GSA with dates of service between October 1, 2018 and December 31, 2019.

[12] The total population of unique SMI recipients who received behavioral health services is 35,236 for the period October 1, 2018 through December 31, 2019.
[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.

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 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%[15]

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%

[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.

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
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%

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%

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
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:

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

- Employment status

The outcome indicators listed above are described as part of the AHCCCS Demographic and Outcomes Data Set User Guide, which provides information for the completion and submission of the demographic data set, a set of data elements that 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).

Primary Residence

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

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

Employment Status

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

- Unemployed
- Volunteer

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

Penetration and Prevalence Analysis

As part of the service capacity assessment, a review of utilization and penetration rates of the priority mental health services ACT, supported employment, supported housing and peer support[16] 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.

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

- National data from the 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.

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

SMI Prevalence and Penetration — Overview of Findings

Service system penetration is defined as the percentage of people who received services among the estimated number considered eligible for services during a defined time period. As depicted in the table below, a relatively small percentage (25%) of the estimated number of adults with SMI are served through the publicly funded system in Maricopa County in 2019. The penetration rate is below the national (publicly funded) penetration rate of 35%, but higher than that of some communities of relatively similar size. For example, in Texas, Harris County (Houston) and Bexar County (San Antonio) both have penetration rates similar to Maricopa County's (21% and 25%, respectively). Within the Maricopa County Medicaid system, the penetration rate (34%) is similar to the national average (35%). Thus, the overall lower penetration rate

for Maricopa County, compared to some other states and cities, appears to be due to the relatively low penetration rate among people without Medicaid coverage (15%).

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. More than 2,200 people received ACT services in Maricopa County in 2019. A national study by leading ACT researchers estimated that 4.3% of adults with SMI served in a mental health system needed an ACT level of care.[17] 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 2019.

Maricopa County has 24 ACT teams available, including several specialty ACT teams such as partnerships with PCP, 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 primary care provider and, when possible, other medical professionals. Maricopa County has nearly ten ACT teams that include integration of medical professionals or partnerships 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 system-involved consumers reflects responsiveness to the stated concerns of many system stakeholders. Among these FACT teams, at least one also includes a PCP partnership.

[17] 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 finding from an analysis of data on the services of the services of people with serious mental illnesses in the Portland Oregon area.

Table 1 — Service System Penetration Rates for Persons with Serious Mental Illness

Penetration Rates					
Region	Adult Population (≥ 18 Years Old)[18]	Estimated Rate of SMI in the Adult Population[19]	Estimated Number of Adults with SMI in the Pop.[20]	Number of Adults with SMI Served[21]	Penetration Rate Among Adults with SMI[22]
U.S.	253,768,092	4.5%	11,543,781	3,985,416	35%
Arizona	5,528,989	4.8%	265,281	48,917	18%
Maricopa County[23]	3,413,400	4.1%	139,267	34,451	25%
Adults with Medicaid	640,528[24]	11.7%[25]	74,942	25,232	34%
Non-Medicaid Adults	2,772,872	2.3%	64,325	9,219	14%

[18] 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, 2018.

[19] SAMHSA. (2019). *State estimates of serious mental illness from the 2016 National Surveys on Drug Use and Health*. National Survey on Drug Use and Health Report. Retrieved from https://www.samhsa.gov/data/nsduh/state-reports-NSDUH-2018. The estimated rate of SMI statewide for Arizona was used for all Maricopa County adults.

[20] SAMHSA. (2017). *State estimates of serious mental illness from the 2018 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report*. Retrieved from https://www.samhsa.gov/data/us_map?map=1.

[21] The state-level percentage of people with an SMI served was obtained from SAMHSA. (2018). *Mental health NOMS: Center for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system. The number of people with SMI served by the mental health authority was estimated by multiplying the percentage of adults with SMI who received treatment through the mental health authority (see state Mental Health NOMS report table page 10) by the total number of adults served by the mental health authority (see state Mental Health NOMS report table page 4).

[22] SAMHSA. (2018). *Mental health NOMS: Center for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system. Number of adults with SMI served within the system (for states, see calculation note above), divided by the estimated number of adults with SMI in the total adult population. The U.S. penetration rate of 35% was based on the cumulative reporting of publicly-funded mental health services across all states in the Uniform Reporting System.

[23] Number served in Maricopa County based on Arizona Health Care Cost Containment System's 2019 service utilization data file received through personal communication with Dan Wendt on June 10, 2020.

[24] The adult population for Medicaid is based on 1) the total number of Medicaid enrollees in Maricopa County, and 2) the estimated statewide proportion of eligible Medicaid members who were adults, versus children/youth, according to the Arizona Health Care Cost Containment System's Acute Enrollment CYE 2019 report and Demographic report for April, July, and October 2019. Retrieved from https://archive.azahcccs.gov/ and https://www.azahcccs.gov/Resources/Reports/population.html, respectively.

[25] Based on the 2014 Mercer ADHS/DBHS Service Capacity Assessment report estimate of SMI among Medicaid recipients.

Penetration Rates					
Region	Adult Population (≥ 18 Years Old)[18]	Estimated Rate of SMI in the Adult Population[19]	Estimated Number of Adults with SMI in the Pop.[20]	Number of Adults with SMI Served[21]	Penetration Rate Among Adults with SMI[22]
Texas	21,303,746	3.9%	821,454	291,842	36%
Harris County (Houston)	3,459,581	3.5%	119,356	25,072	21%
Bexar County (San Antonio)	1,490,644	3.0%	44,421	11,233	25%
New York	15,474,107	3.8%	595,524	549,872	92%
New York County (New York City)[26]	1,395,801	4.5%	62,811	91,191	145%[27]
Colorado	4,430,329	5.6%	249,931	70,850	28%
Denver City–County[28]	585,405	4.7%	27,455	20,997	76%
Nebraska	1,452,427	4.4%	63,746	11,001	17%
California	30,567,090	4.1%	1,265,292	447,945	35%
Illinois	9,883,814	4.2%	410,498	43,327	11%
Kansas	2,205,544	5.2%	114,178	18,674	16%
Minnesota	4,308,564	4.3%	187,341	133,344	71%
Wisconsin	4,537,465	5.5%	248,839	31,827	13%
Tennessee	5,263,790	4.9%	258,634	203,897	79%

[26] Utilization data based on personal communication with Marleen Radigan, DrPH, 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.

[27] The penetration data for New York County are based on provider surveys reporting the number of people served. In aggregate, the survey results may include a duplication of consumers receiving services from multiple providers. As such, the penetration data for SMI might be overestimated.

[28] 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, 2020.

Penetration Rates					
Region	Adult Population (≥ 18 Years Old)[18]	Estimated Rate of SMI in the Adult Population[19]	Estimated Number of Adults with SMI in the Pop.[20]	Number of Adults with SMI Served[21]	Penetration Rate Among Adults with SMI[22]
Indiana	5,123,748	4.2%	212,801	81,623	38%
Delaware	763,555	5.6%	43,115	7,925	18%
New Hampshire	1,098,288	5.3%	58,601	15,893	27%
North Carolina	8,082,975	4.6%	368,258	64,200	17%

Overview of EBP Utilization Benchmark Analyses

Data in the table 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 the best estimate of the percentage of people with SMI who need ACT (4.3%) that is available in the researchers' literature.[29] 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 31% and on-going supported employment utilization rate of 7.1% (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 under 2%, for example. The utilization rate for supported housing (14.9%) in Maricopa County is more than six times greater than the national average, and greater than the utilization rate found in all other regions in the analysis.

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

Table 2 —EBP Utilization Rates among Persons with SMI Who Were Served in the System[30]

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
U.S.	76,802	1.9%	70,310	1.8%	91,920	2.3%
Arizona	N/A[31]	N/A	11,694	23.9%[32]	2,551	5.2%
Maricopa County (2019)[33,34]	2,209	6.4%	10,615	30.8%	5,149	14.9%
Maricopa County — Medicaid	1,748	6.9%	8,167	32.4%	4,213	16.7%
Maricopa County — Non-Medicaid	461	5.0%	2,448	26.6%	936	10.2%
Maricopa County (Supported Employment ongoing)[35]	*N/A*	*N/A*	*2,436*	*7.1%*	*N/A*	*N/A*

[30] National and state-level data on the number of people utilizing EBPs are reported from: SAMHSA (2016). *Mental Health NOMS: Central Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/us_map. Rates are based on number with SMI served in the system.

[31] Arizona did not report the number of people served with ACT statewide to SAMHSA's Center for Mental Health Services Uniform Reporting System.

[32] The reported statewide rate may not necessarily reflect the penetration rate for high-fidelity supported employment and may not be comparable to the Maricopa County SE-ongoing penetration rate.

[33] 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 on-going 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 most likely to be related to high fidelity supported employment.

[34] Number served in Maricopa County with evidence-based services based on Arizona Health Care Cost Containment System's 2019 service utilization data file received through personal communication with Dan Wendt on June 10, 2020.

[35] We conducted a second analysis of supported employment utilization, including ongoing support to maintain employment, but excluding pre-job training and development. Mercer found in its 2013 review of clinical records that the latter services (pre-job training and development), which accounted for 94% of supported employment services coded at that time, often indicated brief discussions with clients about employment, outside of the context of a comprehensive, evidence-based supported employment program. The 2,436 people receiving "supported employment

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
Texas	6,515	2.2%	10,893	3.7%	12,215	4.2%
Harris County (Houston)	1,190	4.7%	*N/A*	*N/A*	*N/A*	*N/A*
Bexar County (San Antonio)	236	2.1%	*N/A*	*N/A*	*N/A*	*N/A*
New York	6,902	1.3%	1,321	0.2%	24,415	4.4%
New York County (New York City)[36]	1,218	1.3%	N/A	N/A	4,717	7.5%
Colorado	1,588	2.2%	997	1.4%	216	0.3%
Denver City–County (MHCD)[37]	712	3.4%	574	2.7%	1,527	7.3%
Nebraska	96	0.9%	756	6.9%	802	7.3%
California	8,301	1.9%	568	0.1%	1,172	0.3%
Illinois	855	2.0%	2,272	5.2%	N/A	N/A
Kansas	N/A	N/A	1,235	6.6%	2,207	11.8%
Minnesota	2,182	1.6%	1,521	1.1%	1,137	0.9%

ongoing" services represent a subset of consumers receiving evidence-based supported employment However, we do not know the extent to which other states' reporting of supported employment references the full evidence-based model.

[36] Utilization data based on personal communication with Marleen Radigan, DrPH, 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.

[37] 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, April 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
Wisconsin	3,866	12.1%	1,461	4.6%	1,070	3.4%
Tennessee	109	0.1%	837	0.4%	867	0.4%
Indiana	647	0.8%	1,038	1.3%	4,475	5.5%
Delaware	405	5.1%	6	0.1%	26	0.3%
New Hampshire	1,282	8.1%	3,789	23.8%	N/A	N/A
North Carolina	5,216	8.1%	N/A	N/A	N/A	N/A

Changes in EBP Utilization from 2013 through 2019

The table on the next page compares utilization of ACT, supported employment, and supported housing in Maricopa County from 2013 through 2019. Highlights of the findings based on comparisons of utilization/penetration rates across those years include the following:

- *ACT*. Since 2013, Maricopa County has experienced a steady increase each year in the total number of adults with SMI who received ACT services and has had a penetration rate that has ranged from 6.4% to 7.0%, which has consistently exceeded the benchmark penetration rate for ACT services (4.3%).

- *Supported Employment*. In 2019, the overall penetration rate for supported employment reached its highest point since 2013. 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), as well as briefer supported employment services that do not reflect the full supported employment model (e.g., brief vocational checks or offers to engage in supported employment services). Since 2013, the percentage of adults with SMI using ongoing supported employment services has increased nearly five percentage points.

- *Supported Housing*. In previous years, the analysis for supported housing penetration 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 was added (H2014) in 2016 to reflect utilization of supported housing services by the contracted supported housing provider at that time. 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), if the services were 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 provision continued unabated in 2019.

Table 3 — Maricopa County EBP Utilization Rates: 2013–2019

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[38]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2019)	34,451	2,209	6.4%	10,615	30.8%	5,149	14.9%
SE Ongoing				*2,436*	*7.1%*		
Maricopa County (2018)	34,264	2,241	6.5%	9,861	28.8%	5,160	15.1%
SE Ongoing				*2,376*	*6.9%*		
Maricopa County (2017)	31,712	2,233	7.0%	8,168	25.8%	2,098	6.6%
SE Ongoing				*1,708*	*5.4%*		
Maricopa County (2016)	30,440	2,093	6.9%	7,930	26.1%	1,408	4.6%
SE Ongoing				*1,544*	*5.1%*		

[38] The number of people with SMI receiving supported employment included a very high percentage of people who only received pre-job training and development employment services, but no other aspects of the evidence-based supported employment model. However, those receiving "SE Ongoing" likely were receiving the full evidence-based package of SE services.

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[38]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2015)	24,608	1,693	6.9%	4,230	17.2%	902	3.7%
SE Ongoing				*725*	*3.0%*		
Maricopa County (2014)	23,977	1,526	6.4%	5,634	23.4%	793	3.3%
SE Ongoing				*657*	*2.7%*		
Maricopa County (2013)	20,291	1,361	6.7%	7,366	36.3%	No Data	No Data
SE Ongoing				*515*	*2.5%*		

ACT Benchmarks

In recent years, Maricopa County has enhanced its capacity to provide ACT team services to people with SMI. An important 2006 study by Cuddeback, Morrissey, and Meyer estimated that over a 12-month period 4.3% of adults with SMI in an urban mental health system needed the 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 the table below.[39]

[39] Some readers might conclude from this analysis that Maricopa County is serving too much ACT to people with SMI, given that its penetration rate of 6.6% exceeds the estimated percentage of people with SMI in need of ACT. 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 several years ago. That study is the only U.S.-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 a given person needs Assertive Community Treatment. 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 and types of ACT to its clients in need of that level of care.

Maricopa County's ACT penetration rate (6.6%) exceeds the benchmark in the Cuddeback study (4.3%),[40] 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, some ACT teams are integrated with primary care partnerships.

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

ACT Utilization					
Region	**Number of Adults with SMI Served in Public System[41]**	**Number of Adults Estimated to Need ACT[42]**	**Number of Adults Who Received ACT[43]**	**ACT Penetration**	
				Percentage of All Adults With SMI Who Received ACT	**Percentage of the Estimated Number in Need of ACT Who Received ACT**
Ideal Benchmark[44]				*4.3%*	*100%*
U.S.	3,985,416	171,373	76,802	1.9%	45%
Arizona	48,917	2,103	N/A	N/A	N/A
Maricopa Co. — AHCCCS Total	34,451	1,481	2,209	6.4%[45]	149%

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

[41] The state-level proportion of people with an SMI served was obtained from SAMHSA. (2018). *Mental Health NOMS: Center for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI, according to state-level estimates of SMI from the National Survey of Drug Use and Health (2018).

[42] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 180–1806. 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 one year for a qualifying mental health disorder, had been enrolled in SSI or SSDI and in treatment for at least two years, and had three or more psychiatric hospitalizations within a single year.

[43] National and state-level penetration counts for ACT services received were obtained from SAMHSA. (2016). *Mental Health NOMS: Center for Mental Health Services Uniform Reporting System.* Retrieved from https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system. Arizona was among the states that did not report the number of people receiving ACT statewide.

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

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

ACT Utilization					
Region	**Number of Adults with SMI Served in Public System[41]**	**Number of Adults Estimated to Need ACT[42]**	**Number of Adults Who Received ACT[43]**	**ACT Penetration**	
				Percentage of All Adults With SMI Who Received ACT	**Percentage of the Estimated Number in Need of ACT Who Received ACT**
Maricopa Co. — Medicaid	25,232	1,085	1,748	6.9%	161%
Maricopa Co. – Gen Adult Pop	9,219	396	461	5.0%	116%
Texas	291,842	12,549	6,515	2.2%	52%
Harris County (Houston)	25,072	1,078	1,190	4.7%	110%
Bexar County (San Antonio)	11,233	483	236	2.1%	49%
New York	549,872	23,644	6,902	1.3%	29%
New York County (New York City)[46]	91,191	3,921	1,218	1.3%	31%
Colorado	70,850	3,047	1,588	2.2%	52%
Denver County (MHCD)[47]	20,997	903	712	3.4%	79%
King County (Seattle, WA)	N/A	991	270	N/A	27%
Nebraska	11,001	473	96	0.9%	20%
California	447,945	19,262	8,301	1.9%	43%
Illinois	43,327	1,863	855	2.0%	46%

[46] Utilization data based on personal communication with Marleen Radigan, DrPH, 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.

[47] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, April 2019.

ACT Utilization					
Region	Number of Adults with SMI Served in Public System[41]	Number of Adults Estimated to Need ACT[42]	Number of Adults Who Received ACT[43]	ACT Penetration	
				Percentage of All Adults With SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
Minnesota	133,344	5,734	2,182	1.6%	38%
Wisconsin	31,827	1,369	3,866	12.1%	283%
Tennessee	203,897	8,768	109	0.1%	1%
Indiana	81,623	3,510	647	0.8%	18%
Delaware	7,925	341	405	5.1%	119%
New Hampshire	15,893	683	1,282	8.1%	188%
North Carolina	64,200	2,761	5,216	8.1%	189%

Supported Employment Benchmarks

Maricopa County meets a high percentage of the estimated need for supported employment services, although there was a smaller percentage (7%) of people who appeared to be receiving ongoing supported employment services, which we can say with more certainty are evidence-based. More than 8,000 people received pre-job training and development services, but fewer received services associated with obtaining and maintaining a job (~2,400). Based on previously conducted clinical record reviews, interviews with recipients, and observations of other stakeholders who participated in previous years' focus groups, it is more likely that a large volume of pre-vocational services is being provided, but fewer people are receiving the more intensive "ongoing support" for obtaining and maintaining employment in Maricopa County.

Nevertheless, Maricopa County's 2019 penetration rate for ongoing supported employment services to those estimated to be in need (16%[48]), compared favorably to national benchmarks. It exceeded the U.S. penetration rate of 4% and among all comparison communities, it only trailed New Hampshire (53%).

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

Supported Employment (SE) Utilization					
				Supported Employment (SE) Penetration	
Region	**Number of Adults with SMI Served in System[49]**	**Number of Adults in Need of SE[50]**	**Number of Adults Who Received SE[51]**	**Percentage Served Among Adults with SMI**	**Percentage Served Among Adults Estimated to Need SE**
Ideal Benchmark				*45%*	*100%*
U.S.	3,985,416	1,793,437	70,310	1.8%	4%
Arizona[52]	48,917	22,013	11,694	23.9%	53%
Maricopa Co. — Total served	34,451	15,503	10,615	31%	69%
Maricopa Co. (Supported Employment ongoing)	34,451	15,503	2,436	7%	16%
Maricopa Co. — Medicaid	25,232	11,354	8,167	32%	72%

[48] The overall ongoing supported employment penetration rate for adults with SMI was 7.1%, but based on estimates of the number of people already employed as well as surveys of unemployed people with SMI concerning the perceived desirability of employment, we estimated about half of the people with SMI served in the system need supported employment and that, therefore, 15% of those in need received it.

[49] The state-level proportion of people with an SMI served was obtained from SAMHSA. (2018). *Mental Health NOMS: Center for Mental Health Services Uniform Reporting System.* Retrieved from https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI, according to state-level estimates of SMI from the National Survey of Drug Use and Health (2018).

[50] 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.

[51] National and state-level penetration supported employment counts were obtained from SAMHSA (2018). *Mental Health NOMS: Center for Mental Health Services Uniform Reporting System.* Retrieved from https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system.

[52] The penetration rates for Arizona are likely comparable to the "total served" rates for Maricopa County and not to its SE ongoing penetration rates.

Supported Employment (SE) Utilization					
				Supported Employment (SE) Penetration	
Region	**Number of Adults with SMI Served in System[49]**	**Number of Adults in Need of SE[50]**	**Number of Adults Who Received SE[51]**	**Percentage Served Among Adults with SMI**	**Percentage Served Among Adults Estimated to Need SE**
Medicaid (Supported Employment ongoing)	25,232	11,354	1,808	*7%*	*16%*
Maricopa Co. — Gen Adult Population	9,219	4,149	2,448	27%	59%
Non-Medicaid (Supported Employment ongoing)	9,219	4,149	*628*	*7%*	*15%*
Texas	291,842	131,329	10,893	4%	8%
New York	549,872	247,442	1,321	<1%	1%
Colorado	70,850	31,883	997	1%	3%
Denver County (MHCD)[53]	20,997	9,449	574	3%	6%
Nebraska	11,001	4,950	756	7%	15%
California	447,945	201,575	568	<1%	<1%
Illinois	43,327	19,497	2,272	5%	12%
Kansas	18,674	8,403	1,235	7%	15%
Wisconsin	31,827	14,322	1,461	5%	10%
Tennessee	203,897	91,753	837	<1%	1%
Indiana	81,623	36,730	1,038	1%	3%

[53] 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, 2019.

Supported Employment (SE) Utilization					
				Supported Employment (SE) Penetration	
Region	Number of Adults with SMI Served in System[49]	Number of Adults in Need of SE[50]	Number of Adults Who Received SE[51]	Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
Delaware	7,925	3,566	6	<1%	<1%
New Hampshire	15,893	7,152	3,789	24%	53%

Peer Support Benchmarks

Maricopa County excels in making peer support services available to people in need. The penetration rates for 2013–2019 were relatively high and represent a best practice benchmark in terms of access to peer support.

Table 6 — Peer Support Penetration Rates

Peer Support		
Region	Peer Support Received	Peer Support Penetration Rate
Arizona		
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	3,650	3%

Peer Support		
Region	Peer Support Received	Peer Support Penetration Rate
Bexar County	3,050	7%
Colorado		
Denver City–County[54]	406	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:

- Adult and family focus group participants expressed general satisfaction with peer and family support services. The groups reported that peer support professionals often play a complimentary role to case managers because they are able to explain things in a way that is relatable and share resources that case managers did not.

[54] 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, 2019. 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.

- Similar to last year, the adult member focus group reported that peer support services are some of the most valuable services provided in the behavioral health system. Most members were aware of this services option and reported being able to access it without difficulty, when needed.

- Participants from focus groups echoed themes from the last few years. They report that vacancies are not immediately filled and turnover remains high. They also reported that not every direct care clinic has peer or family support specialists on staff. These same participants shared that additional on-the-job support and ongoing training would help to reduce attrition rates.

- Also similar to previous years, participants in the provider, case manager, and family member groups expressed concerns that peer and family support specialists seem overwhelmed by their caseload size and work demands. The perception is that they are spread too thin by demands from many directions. They reported that peer support specialists feel they need to be all things to all people.

- As reported in prior years, participants in all focus groups expressed that clinical teams do not consistently understand the appropriate role of the peer support specialist, peer or recovery navigator and/or family support specialist. This has led to ongoing confusion about how best to use these services.

- Similar to last year, participants in the provider and case manager focus groups reported that, in general, there are many barriers to not only become, but to find and retain, skilled peer support specialists. Requirements including reliable access to transportation and stringent background check requirements can be challenging for peer support specialists to achieve. As in prior years, participants expressed that the availability of part-time peer support positions would encourage more peers to consider the role and promote longer tenure in the positions.

- As with last year, participants in the case manager and provider focus group reported concerns that peer support specialists are not competitively paid in comparison to other clinic staff. This contributes to turnover rates and the appearance that peer support staff are not valued as highly as other clinic staff.

- As with prior years, adult and case manager group respondents expressed that after-hour availability of peer and family support specialists would be beneficial to members. Members reported a desire to speak to someone with lived experience similar to theirs after hours as a less intensive solution to a crisis line.

- Similar to the past several years, family members, individuals receiving services and case managers all agree that family members would benefit from a service delivery system navigational guide and/or a compendium of available supports and resources that can be accessed when needed.

- Participants in all focus groups reported that family support services are not widely utilized and that engagement with families is lacking. The family member focus group expressed that while family support has been generally helpful, they could use more engaged support and, in general, need to be informed about the breadth of all services available. Family members also reported feeling some frustration that family support services does not adequately address underlying problems. Case managers reported that families are fatigued and seem to lack the motivation and energy to engage with family support specialists. Both of these groups acknowledged that providing additional training to family support specialists might address some of these issues.

Key Informant Survey Data

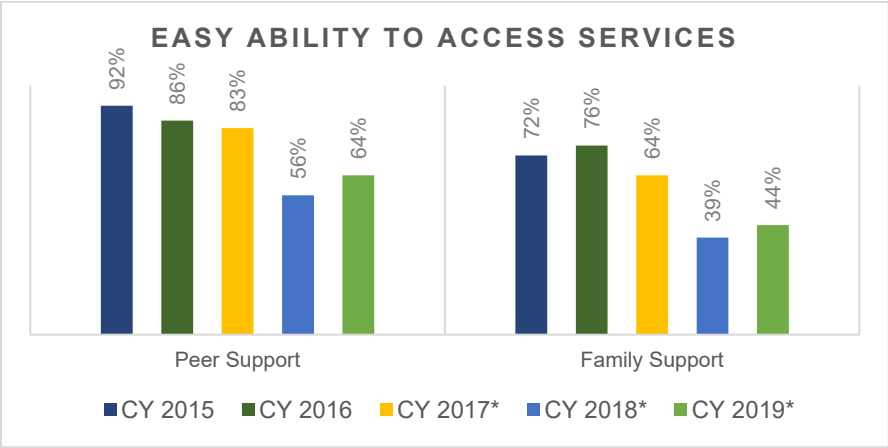
As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to the priority services, a key informant survey was administered. The survey tool included questions and rating assignments related to the priority mental health services. It should 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

Almost two-thirds of survey respondents felt that peer support services were easy to access (64%), a significant increase from last year's survey results in which 56% of the respondents indicated that the services were easy to access. 14% of survey respondents indicated that peer support services were difficult to access and 9% of the respondents believed that the services were inaccessible. Consistent with the last six years, peer support services were perceived as the easiest of all the priority services to access.

25% of survey respondents felt that family support services were difficult to access or that no access was available while 44% of the respondents indicated that family support services were easy to access. The remaining 31% of respondents rated access to family support services as "fair".

Overall, respondents felt that accessing peer support and family support services was easier during CY 2019 when compared to CY 2018.



*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 2015 and 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:

- Clinical team unable to engage/contact member
- Member declines service
- Lack of capacity/no service provider available, staffing turnover, and transportation barrier (all of these factors received the same number of responses)

Efficient Utilization

In terms of service utilization, 80% of the responses indicated that peer support services were being utilized efficiently or were utilized efficiently most of the time. 20% of respondents indicated that the peer support services were not utilized efficiently.

75% of the responses indicated that family support services were being utilized effectively or were utilized efficiently most of the time.

Alternatively, 25% 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:

- 86% 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, and 100% during CY 2018.
- 70% 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 and 81% during CY 2018.
- 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).
- 20% 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).
- 7% 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).
- 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).

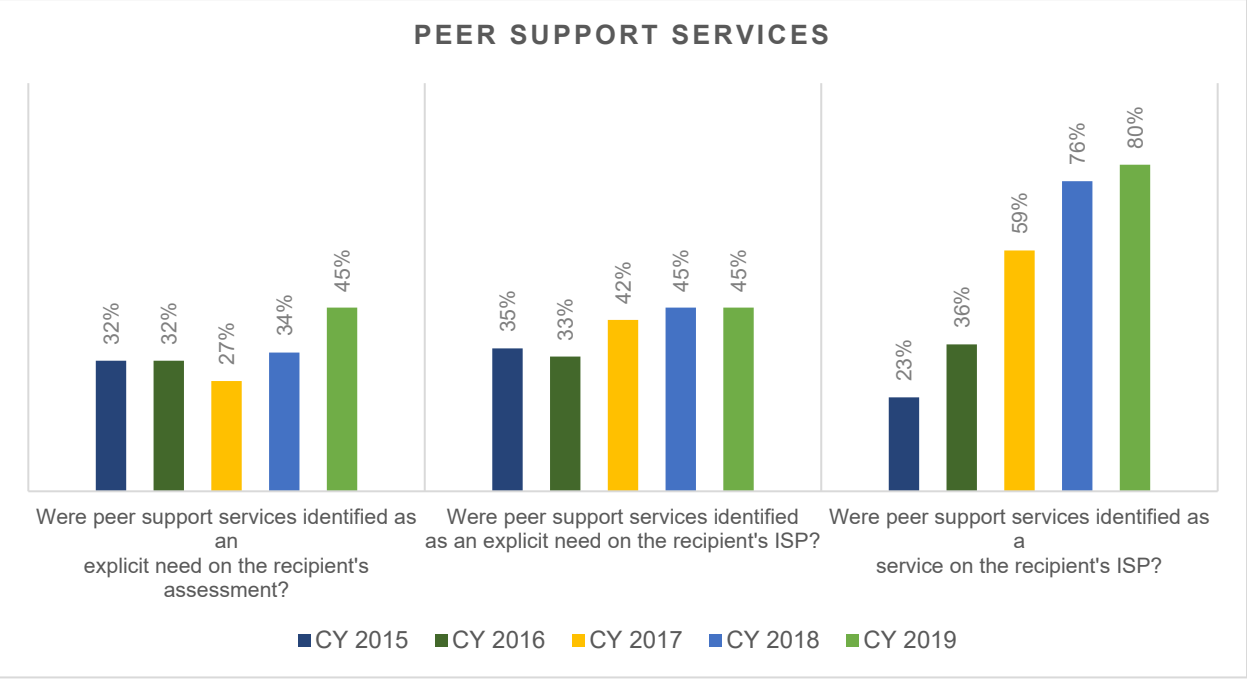
Medical Record Reviews

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

80% of the ISPs included peer support services when assessed as a need; continuing a trend of improvement over the past three years.

Over half (52%) of the recipients included in the sample received at least one unit of peer support during CY 2019 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:

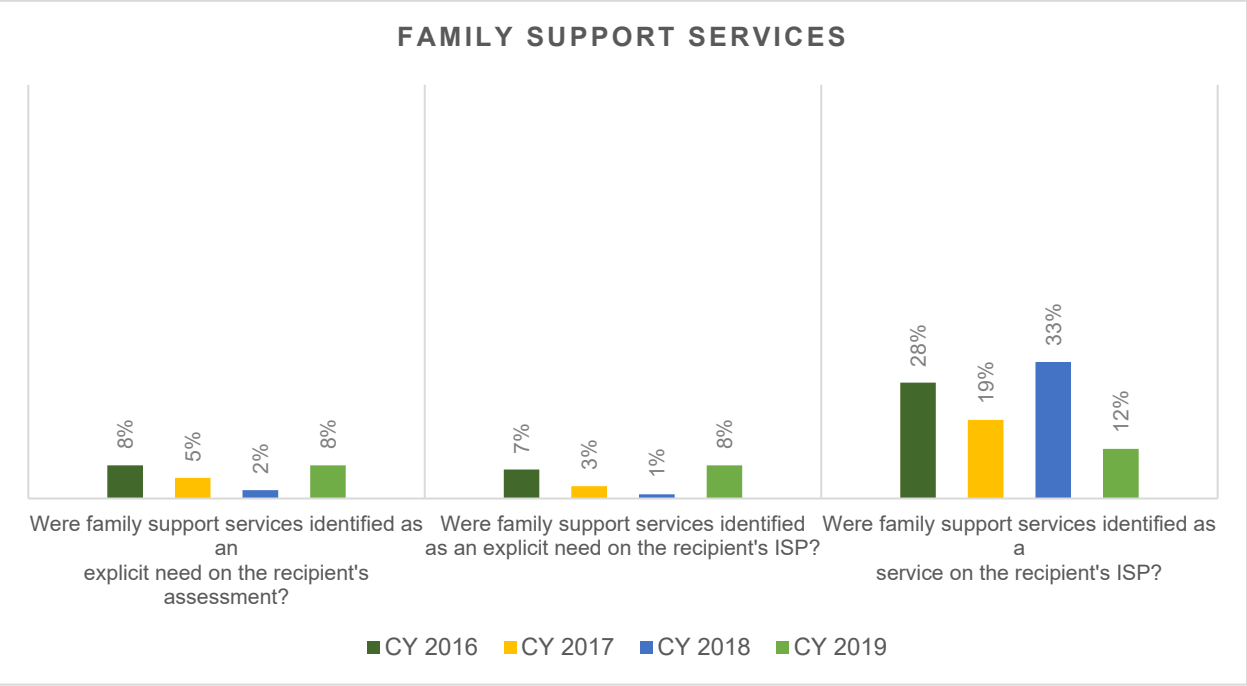
- The clinical team did not follow up with initiating a referral for the service.
- The member was hospitalized.
- Inability to contact the member.

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.

Only 12% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP.

6% of the recipients included in the sample received at least one unit of family support during CY 2019 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. For CY 2019, family support services were rarely included as a distinct service on a member's ISP.

In one case, 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

During the time period of October 1, 2018 through June 30, 2019; 34,199 unique users were represented in the service utilization data file. Of those, 73% were Medicaid eligible and 27% were non-Title XIX eligible.

- Overall, 33% of the recipients received at least one unit of peer support services during the time period (four percentage point less than last year).

Access to the service favored Title XIX eligible members (26%) over the non-Title XIX population (7%).

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

- Over half of the members who received at least one unit of peer support during the review period accessed the service during a single month.
- Over 70% of all members who received at least one unit of peer support during the review period accessed the service for one or two months. 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 2018 — June 2019**

Consecutive Months of Service	Medicaid Recipients	Non-Medicaid Recipients	All Recipients
1	48.7%	57.1%	50.6%
2	20.2%	20.2%	20.2%
3–4	16.9%	11.6%	15.7%

Persistence in Peer Support Services October 2018 — June 2019			
5–6	6.1%	3.9%	5.6%
7–8	2.8%	3.2%	2.9%
9+	5.0%	3.7%	4.7%
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, 4.9% of the recipients received at least one unit of family support services during the time period (2.6% over a comparable time period last year). Over the seven years that the service capacity assessment has been conducted, family support service utilization rates have been consistently at 2% to 4%. 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 of the service.

Access to the service was split between Title XIX (3.7%) and non-Title XIX groups (1.1%).

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

- 71.4% 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 76.8% last year.

- 88% of all members who received at least one unit of family support during the review period accessed the service for one or two months.

Persistence in Family Support Services October 2017 — June 2018			
Consecutive months of service	**Medicaid recipients**	**Non-Medicaid recipients**	**All recipients**
1	70.3%	74.8%	71.4%

Persistence in Family Support Services October 2017 — June 2018			
Consecutive months of service	**Medicaid recipients**	**Non-Medicaid recipients**	**All recipients**
2	16.6%	16.5%	16.6%
3–4	7.7%	5.7%	7.3%
5–6	2.0%	1.5%	1.9%
7–8	1.1%	0.7%	1.0%
9+	1.9%	0.5%	1.6%
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, 2018 through December 31, 2019, 38% of all members with an SMI received at least one unit of peer support. During the prior year, 36% of members received peer support services. (2013 — 38%; 2014 — 31%; 2015 — 29%; 2016 — 38%; 2017 — 37%).

- Similar to last year, the adult member focus group reported that peer support services are some of the most valuable services provided in the behavioral health system. Most members were aware of this services option and reported being able to access it without difficulty, when needed.
- As with last year, participants in the case manager and provider focus group reported concerns that peer support specialists are not competitively paid in comparison to other clinic staff. This contributes to turnover rates and the appearance that peer support staff are not valued as highly as other clinic staff.
- Almost two-thirds of survey respondents felt that peer support services were easy to access (64%), a significant increase from last year's survey results in which 56% of the respondents indicated that the services were easy to access. Consistent with the last six years, peer support services were perceived as the easiest of all the priority services to access.
- 80% of the ISPs included peer support services when assessed as a need; continuing a trend of improvement over the past three years.
- Revisions to annual assessment templates utilized at some direct care clinics now include a prompt for the assessor to indicate if peer support services were offered to the member. However, the template does not provide an opportunity for documenting the member's response to the question.
- Over half (52%) of the recipients included in the medical record review sample received at least one unit of peer support during CY 2019 based on a review of service utilization data.
- Direct care clinic documentation occasionally revealed that peer support specialists were billing peer support service codes when the description of the service appeared more aligned to a case management service (e.g., arranging transportation to clinic appointments).

- Maricopa County continues to demonstrate strong access to peer support services and, based on Mercer's national penetration and prevalence analysis, utilization is at a level that is considered to be a best practice benchmark.
- Over 70% of all members who received at least one unit of peer support during the review period accessed the service for one or two months. The nature of the service lends to episodic participation and is less dependent on sustained participation to be an effective support and intervention.

Findings: Family Support

- Service utilization data demonstrate an increase in the percentage of members who received at least one unit of family support services during 2019 (6%) when compared to prior years (2013 — 2%; 2014 — 3%; 2015 — 2%; 2016 — 2%; 2017 — 2%; 2018 — 4%).
- Only 12% of the ISPs included family support services when identified as a need within the recipient's assessment and/or ISP.
- 6% of the recipients included in the medical record review sample received at least one unit of family support during CY 2019 based on a review of service utilization data.
- 20% 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.
- Participants in all focus groups reported that family support services are not widely utilized and that engagement with families is lacking. The family member focus group expressed that while family support has been generally helpful, they could use more engaged support and, in general, need to be informed about the breadth of services available.

Recommendations: Peer Support

- Ensure continued opportunities for members to access peer support services when a member indicates a preference for the service.
- Provide education and oversight to peer support specialists operating within the direct care clinics regarding the types of activities that constitute a peer support service and the appropriate bill code to apply when performing a case management activity.
- The system should evaluate stakeholder feedback regarding the perceived need for direct care clinic peer support specialists to receive increased support, lower caseloads, and competitive pay to mitigate turnover and role dissatisfaction.

Recommendations: Family Support

- Provide training and supervision to ensure that direct care clinical team members understand the appropriate application of family support services.
- Provide additional training and supervision 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.
- Conduct a comprehensive root-cause analysis to identify the most prominent factors that result in under-utilization of family support services. Once causal factors are identified, develop and implement interventions to mitigate barriers.

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:

- Among members, there was consensus and satisfaction regarding the supported employment services they have received from the rehabilitation specialists at their clinics and supported employment providers. Members expressed the service is valuable, but may not be adequately promoted.
- As was the case during the last two evaluation years, with few exceptions, adult member, case managers, and family members expressed some success in obtaining employment provided by VR. They echoed prior year remarks that increased access to VR services continues to improve.
- Similar to the last few years, while case manager and provider focus group participants reported at least an awareness of the Disability Benefits 101 website, most adult and family member participants were not aware of the resource. For those providers and case managers

with some working knowledge of Disability Benefits 101, they expressed support for universal training for direct care clinic staff and more promotion of the resource to members. Providers and case managers reported that they have had success using this website with members to calculate their employment income against and other government benefits including food assistance and SSI. Both providers and case managers feel that better training and use of Disability Benefits 101 will help members that may be reticent to seek employment over fear of it affecting their other government benefits.

- Similar to the last three years, participants in the provider and case manager focus groups expressed that co-locating supported employment providers within the direct care clinics is beneficial and helps to promote a variety of employment prospects outside of peer support specialist training and employment.

- Adult members, case managers, and providers all reported that transportation dynamics are a priority for supported employment. Particularly, they expressed that the difficulty in coordinating reliable transportation and the lack of geographic availability as a barrier to stable employment. In addition, Case managers reported experience with unreliable transportation providers.

- Most family member focus group participants reported not being aware that supported employment services were an option. They expressed a desire that clinical team members promote this option more regularly in the clinics. Family members also voiced concern over a lack of options for members who cannot work at all and suggested alternative options like volunteerism opportunities or other ways employment specialists might work to create meaning in a person's life. For those family members that did have experience with supported employment services, they expressed a desire that direct care clinic staff accentuate strengths in planning and generally use more strength-based and supportive language.

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

Level of Accessibility

14% of survey respondents felt that supported employment services were difficult to access, less than last year (19%) and significantly less than CY 2013 and CY 2014 (75% — CY 2013; 33% — CY 2014). 81% of respondents indicated that supported employment services were easy to access or having "fair" access, a decrease from CY 2018 (89%) and but considerably higher than CY 2014 (66%).

Factors that Hinder Access

Factors that negatively impact accessing supported employment services include:

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

Efficient Utilization

87% of the responses indicated that supported employment services were being utilized efficiently or were utilized efficiently most of the time, up significantly from 75% last year. 13% of respondents indicated that supported employment services were not utilized efficiently.

Timeliness

86% 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 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. 7% 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 54% of the cases reviewed, five percentage points less than last year (59%). Supported employment services were identified as a service on the recipient's ISP in 85% 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%).

51% of the recipients included in the sample received at least one unit of supported employment during CY 2019 based on a review of the service utilization data.

In 37 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 49% of those cases in which the person did not access the service despite an identified need — significantly less than the rate identified during CY 2018 (78%).

The review team noted that in some cases the clinical team identifies supported employment services on the member's individual service plan in the absence of an assessed need. The review team found that 16% of the cases included supported employment services as an ISP intervention without a corresponding need identified in the member's assessment. Predictably, medical record documentation did not include evidence that the member received supported employment services in over two thirds of these cases. 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.

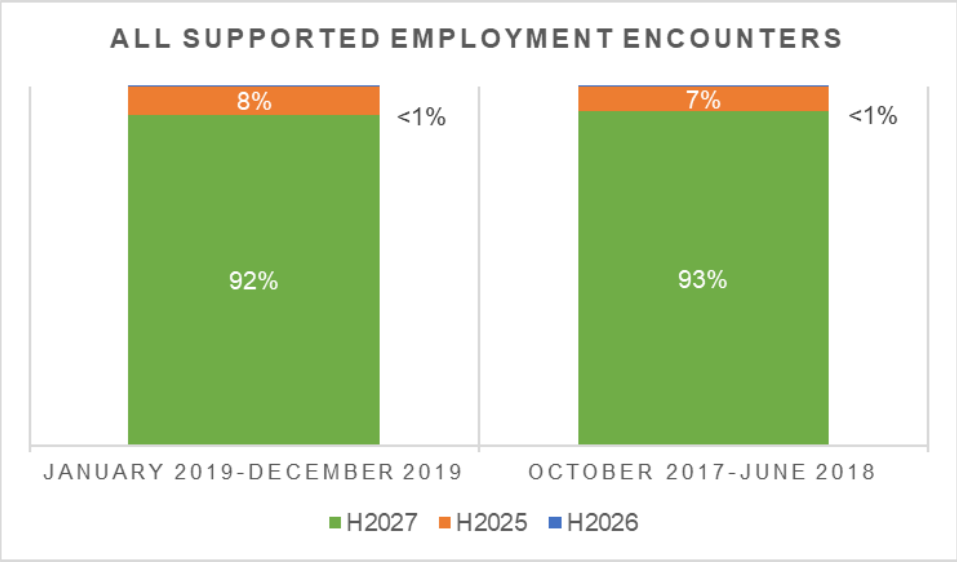
H2026 — Ongoing Support to Maintain Employment (per diem)

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 January 1, 2019 through December 31, 2019, H2027 (pre-job training and development) accounts for 92% of the total supported employment services (a slight decrease from CY 2018 — 93%). H2025 (ongoing support to maintain employment/15-minute billing unit) represents 8% of the supported employment utilization (CY 2018 — 7%). 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 (see graphic below). H2027 SE represents 9% (CY 2017 — 9%; CY 2018 — 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. Until recently, billing procedures prohibited the application of the service telephonically.

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

- Overall, 31% of the recipients received at least one unit of supported employment during the review period, five percentage points higher than during CY 2017 and CY 2018.
- Access to the service was split between Title XIX (32%) and non-Title XIX groups (27%).

To increase access to supported employment services, the Maricopa County 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-five full-time DES/RSA Counselors are dedicated to persons with SMI, co-located and represented at all the direct care clinic locations. Staff turnover in these positions has recently stabilized and vacancies are less prevalent (two vacancies reported in December 2019). 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 — 1,946 (January 1, 2019 — November 30, 2019)
- Members served in the VR program — 1,681 (quarter ending December 31, 2019)
- Members open in the VR program — 1,331 (quarter ending December 31, 2019)
- Members in service plan status with VR — 1,054 (quarter ending December 31, 2019)

Rehabilitation specialist vacancies identified during the CY 2017 service capacity assessment have been largely resolved and staffing is generally stable with a few exceptions. Progress has been made over the past few years in clarifying the roles of the rehabilitation specialists.

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 2018 — June 2019			
Consecutive months of service	**Medicaid recipients**	**Non-Medicaid recipients**	**All recipients**
1	58.1%	63.9%	59.4%
2	16.9%	15.7%	16.6%
3–4	13.0%	11.6%	12.7%
5–6	5.2%	4.4%	5.0%
7–8	2.9%	1.9%	2.7%
9+	3.7%	2.3%	3.4%

- Almost 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 31% of members received at least one unit of supported employment during CY 2019, an increase of 2% from last year and the second 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%).

- 14% of survey respondents felt that supported employment services were difficult to access, less than last year (19%) and significantly less than CY 2013 (75%) and CY 2014 (33%).
- 81% of respondents indicated that supported employment services were easy to access or having "fair" access, a decrease from CY 2018 (89%) and but considerably higher than CY 2014 (66%).
- As was the case during the last two evaluation years, with few exceptions, adult member, case managers, and family members expressed some success in obtaining employment provided by VR. Access to VR services continues to improve.
- Most family member focus group participants reported not being aware that supported employment services were an option. They expressed a desire that clinical team members promote this option more regularly in the clinics. Family members also voiced concern over a lack of options for members who cannot work at all and suggested alternative options like volunteer opportunities or other ways employment specialists might work to create meaning in a person's life.
- Supported employment services were identified as a service on the recipient's ISP in 85% 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%).
- The review team noted that in some cases the clinical team identifies supported employment services on the member's individual service plan in the absence of an assessed need. The review team found that 16% of the cases included supported employment services as an ISP intervention without a corresponding need identified in the member's assessment.
- For the time period January 1, 2019 through December 31, 2019, H2027 (pre-job training and development) accounts for 92% of the total supported employment services (a slight decrease from CY 2018 — 93%). H2025 (ongoing support to maintain employment/15-minute billing unit) represents 8% of the supported employment utilization (CY 2018 — 7%).

Recommendations: Supported Employment

- Continue efforts to address instances in which the clinical team identifies supported employment services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services. Consider establishing operating protocols that require clinical teams and case managers to immediately/timely act on securing services following the completion of the member's ISP.
- 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.

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 in the case manager group reported they are very pleased with supported housing specialists and navigators as an invaluable, collaborative resource for helping members access housing supports. Case managers reported that they did not have any difficulty accessing these staff as needed. Case managers also expressed that supported housing is the one priority service that deserves enhanced funding.
- Similar to the last several years, the availability of affordable and safe housing units, including transitional housing, remains a primary concern of all focus group participants. It remains a particular challenge to locate housing for members with records of multiple evictions or felonies.
- All focus group participants reported having trouble in not only obtaining, but also being able to find placements that will accept housing vouchers. Case managers also reported that frequently members do not understand how the voucher system works and suggested enhanced education around the process. There was consensus from all focus groups that a primary concern is the duration of the waitlist process (too long).
- All focus group participants expressed strong concerns about the criteria to qualify for supported housing, including the definition of homelessness. Adult members voiced anxiety over the criteria that they had to demonstrate homelessness for 3 years prior to receiving supports and that, generally, this criteria was unreasonable. There was a reported perception that members had to be in dire circumstances to qualify, but also expressed confusion over why “couch surfing” would disqualify them from obtaining vouchers.
- Participants in each focus group reported that members have difficulty maintaining housing. Each focus group’s participants suggested that supported housing recipients need enhanced therapeutic support to keep their housing once obtained. Both adult members and case

managers reported that members lack the skills needed to avoid events like eviction and turnover. Provider focus group participants cited the following as areas to enhance member training and support:

  - Fostering good relations between tenants and landlords (controlling member visitor foot traffic, cleanliness standards, paying rent).
  - Good communication with supported housing specialists to assist with housing violations.
  - Appropriate training on strategies for symptomatic members that do not involve law enforcement as to avoid strained neighbor and property owner relationships.

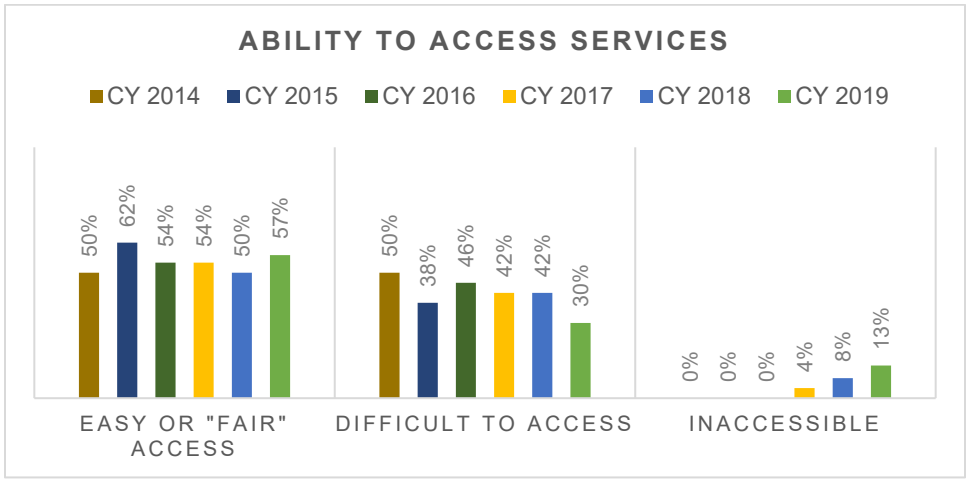
- Provider and case manager focus group participants suggested the following structural changes could improve the effectiveness of housing supports:
  - Enhanced communication between agencies related to placement (e.g. probation/parole, VA).
  - More centralized and coordinated provider agencies (e.g. direct care clinic and supported employment provider co-location).
  - Inclusion of housing record details in members health records and/or on health information exchanges.

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

Level of Accessibility

30% of the survey respondents felt that supported housing services were difficult to access; significantly less than CY 2018 (42%). Three (13%) respondents indicated that supported housing services were inaccessible, an increase from CY 2018 when 8% of the key informants felt that the services were inaccessible.



57% of respondents indicated that supported housing services had “fair access” or were easy to access.

Factors that Hinder Access

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

- 25% 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).
- 22% 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% CY 2018).
- 3% indicated that admission criteria for services were too restrictive (25% during CY 2013; 31% during CY 2014; 26% during CY 2015; 20% during CY 2016; 15% during CY 2017; 14% during CY 2018).

Efficient Utilization

In terms of service utilization:

- 29% 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).

- 53% 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).
- 18% 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).

Timeliness

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

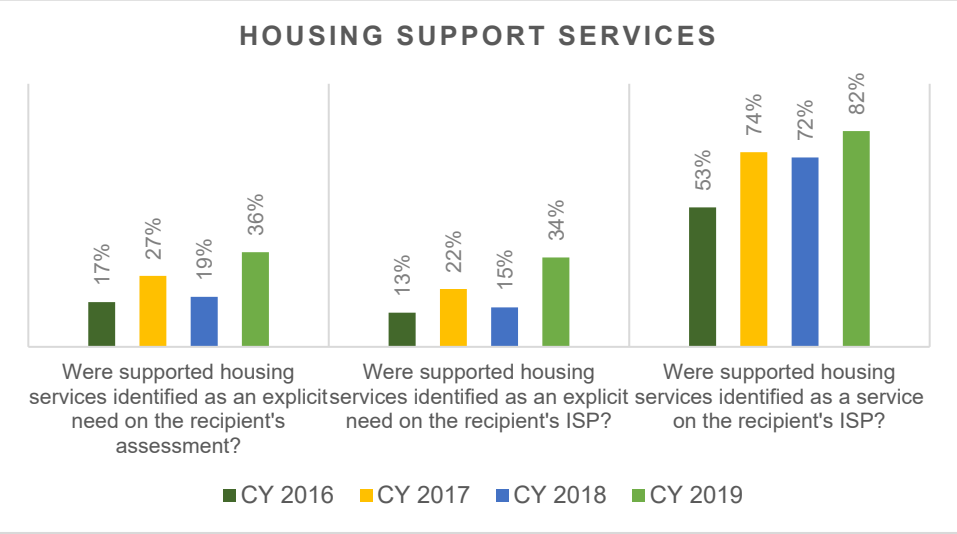
- 50% of the survey respondents reported that supported housing services could be accessed within 30 days of the identification of the service need (11% during CY 2013; 0% during CY 2014; 17% during CY 2015; 21% during CY 2016; 20% during CY 2017; 41% during CY 2018).
- 13% of the respondents indicated 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).
- 35% 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).

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 40% of the cases reviewed.
- Supported housing was identified as a service on the recipient's ISP in 82% of the cases when identified as a need. (An increase from last year when 72% of the ISPs with a documented need included supported housing).

22% of the recipients included in the sample received a unit of supported housing during CY 2019.



In 12 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=8 cases or 11% 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, 4,807 Title XIX eligible (Medicaid) recipients were affiliated with the service during the time period of October 1, 2018 — December 31, 2019 and 1,114 non-Title XIX recipients received the service from a total population of 35,236[55].

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 15% of members received at least one unit of supported housing during the period of January 1, 2019–December 31, 2019.
- Participants in each focus group reported that members have difficulty maintaining housing. Each focus group's participants suggested that supported housing recipients need enhanced therapeutic support to keep their housing once obtained. Both adult members and case managers reported that members lack the skills needed to avoid events like eviction and turnover.
- All focus group participants reported having trouble in not only obtaining, but also being able to find placements that will accept housing vouchers. Case managers also reported that frequently members do not understand how the voucher system works and suggested enhanced education around the process.
- All focus group participants expressed strong concerns about the criteria to qualify for supported housing, including the definition of homelessness.
- 30% of the survey respondents felt that supported housing services were difficult to access; significantly less than CY 2018 (42%).
- When asked about the factors that negatively impact accessing supported housing services, 25% of the responses indicated that a wait list exists for the service (50% during CY 2018).
- Supported housing was identified as a service on the recipient's ISP in 82% of the cases when assessed as a need. (An increase from last year when 72% of the ISPs with a documented need included supported housing).

[55] 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).

- A supported housing provider that offers permanent supported housing programming reported that current demand was approximately at 50% of contracted capacity.

Recommendations: Supported Housing

- Continue to promote clinical supervision and oversight of case managers and other direct care clinic team members that ensures regular and timely consultation to address the ongoing supported housing needs of members. When supported housing needs are identified, prioritize service interventions to address and stabilize immediate housing needs prior to engaging the member in less urgent services (e.g., clinic-based health promotion groups).
- Consider enhancing the capacity of the system to respond to unexpected and immediate supported housing needs (e.g., transitional housing and supports) to offer critical temporary support to members transitioning from acute clinical settings to the community.
- As part of supported housing provider assessment, identify supported housing providers that are operating significantly below capacity and determine the feasibility of transitioning services from providers that are consistently exceeding contracted capacity.

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:

- All focus group participants voiced that experience with ACT teams was overall positive. Case managers did express some concern over high caseload size with the teams, but members also reported that turnover did not seem as significant as with other services.
- Family member participants reported that there was no family mentor or specialist in their ACT team composition. Some family members reported that their ACT team did not seem to know how to effectively engage with an involved parent.
- Case manager and family member focus group participants expressed that the transition from an ACT team to a non-ACT team is difficult for members to navigate. Both groups independently advocated for some type of transitional ACT team as a "step-down" measure. Case

managers cited that this transitional phase should focus on increasing community and non-ACT group engagement as the perception is that some ACT recipients develop a certain level of dependency on their teams.

- Similar to the last three years, participants in the case manager focus group reported that criteria for ACT admissions remains unclear and reasons for non-acceptance of ACT team services are not always provided. Case managers added that a large percentage of referrals are denied and there appears to be a difference between admissions criteria set by MMIC and those set by the individual clinics.

- Similar to the last two years, provider focus group participants shared that case managers do not seem to understand which members are appropriate for ACT and recommend training to support appropriate identification and referral. Additionally, provider representatives reported there is a need for community-wide education regarding ACT services and appropriateness of referrals, particularly for hospital systems.

- For the last several years, participants in the provider focus group reported that not all clinics have an ACT team or an ACT team in close proximity to the clinic. Case managers expressed that co-location of ACT teams at the clinics is beneficial.

- Similar to the last two years, participants in the case manager and provider focus groups stated that ACT teams are frequently at capacity and there is a need for more specialty ACT teams such as medical and forensic ACT teams. This year, case managers expressed the need for more integration and communication between specialty ACT teams because there are inherent therapeutic overlaps from the members' perspective.

- Similar to the last three years, some ACT teams are fully staffed while others experience higher attrition rates and frequent staff vacancies (particularly for peer support specialist positions).

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

15% 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) and three respondents (15%) indicated that the service was

inaccessible. 70% 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).

Factors that Hinder Access

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

- 27% indicated that the member declines service (20% — CY 2013; 50% — CY 2014; 41% — CY 2015; 43% — CY 2016; 32% — CY 2017; 57% — CY 2018).
- 24% 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).
- 15% selected wait list exists for the service (CY 2016 — 35%; CY 2017 — 18%; CY 2018 — 7%).

Efficient Utilization

In terms of the efficiency of service utilization:

- 27% 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).
- 60% 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%).
- 13% of the respondents indicated that ACT team services were not utilized efficiently (55% during CY 2013; 6% during CY 2014; 8% during CY 2015; 13% during CY 2016; 11% during CY 2017; 29% during CY 2018).

Timeliness

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

- 77% 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%).

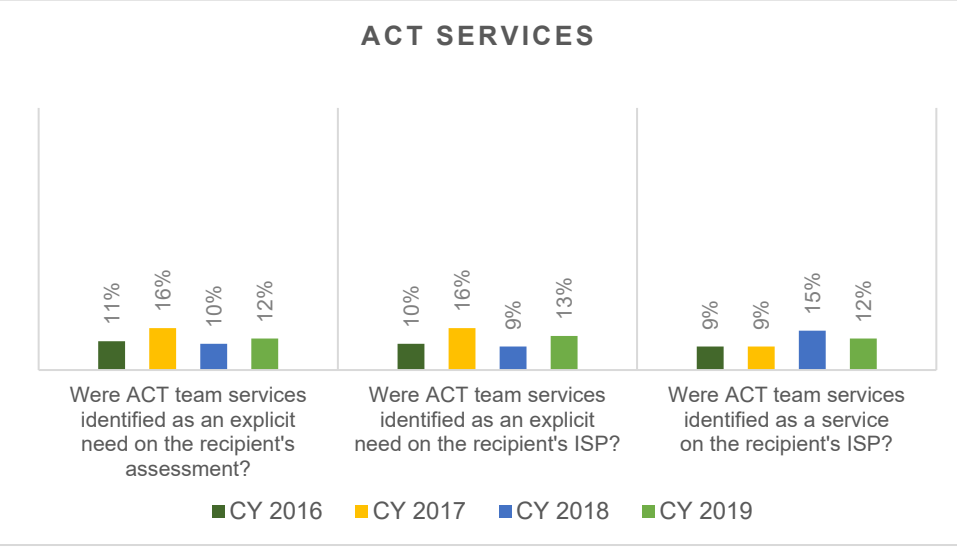
- 0% indicated that the service could be accessed on average, within four to six weeks (20% — CY 2013; 6% — CY 2014; 5% — CY 2015; 8% — CY 2016; 0% — CY 2017; 19% — CY 2018).
- Three respondents (23%) reported that it would take an average of six weeks or longer to access ACT team services (20% — CY 2013; 33% — CY 2014; 18% — CY 2015; 17% — CY 2016; 6% — CY 2017; 0% — CY 2018).

Medical Record Review

With a few exceptions, 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-five cases (13%), 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.



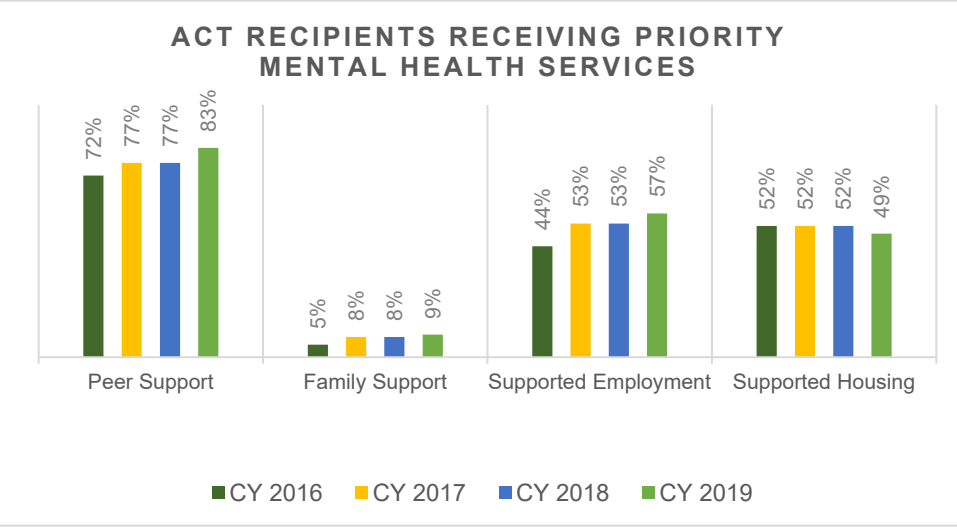
Service Utilization Data

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 2019 service utilization profiles for 2,209 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 that 83% of the ACT team members received peer support services during the review period. ACT recipients who received supported employment services was determined to be 57%. Utilization of supported housing services was found to be 49% 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 during CY 2015, CY 2016, CY 2017, and CY 2018.

- Case manager and family member focus group participants expressed that the transition from an ACT team to a non-ACT team is difficult for members to navigate. Both groups independently advocated for some type of transitional ACT team as a "step-down" measure.

- 15% 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) and three respondents (15%) indicated that the service was inaccessible. 70% 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).

- 83% of the ACT team members received peer support services during the review period. ACT recipients who received supported employment services was determined to be 57%. Utilization of supported housing services was found to be 49% across the identified ACT team members.

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

- A review of 100 SMI members that represent the highest aggregate behavioral health service costs during CY 2019 was conducted. It was determined that 36% 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 and 29% during CY 2018. Of the 36 members assigned to ACT and included on the list of the top 100 members with the highest behavioral health service costs; 24 (67%) 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, 55 of the 100 (55%) 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 2019 through November 2019) 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:
  - 527 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).
  - Of these 527 members, 94 (18%) were assigned to an ACT team during the review period. (CY 2015 — 23%; CY 2016 — 25%; CY 2017 — 16%; CY 2018 — 22%)
  - Of the 94 members assigned to an ACT team, 21 (22%) are assigned to a forensic specialty ACT team (CY 2015 — 20%); CY 2016 — 22%; CY 2017 — 29%; CY 2018 — 28%).
  - 40 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.

Recommendations: ACT Team Services

- Continue efforts to actively facilitate the identification of appropriate candidates for ACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns and adverse incidents involving SMI recipients.
- As part of the annual assessment update, intentionally 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. As part of the annual assessment update, document that this review occurred.
- 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. Establish triggers (e.g., length of stay) that would necessitate a review of the ongoing appropriateness of ACT team services and determine if a member could be transitioned to a less intensive level of case management.
- Provide education to system stakeholders (e.g., direct care clinic staff, providers, and referral sources) regarding the ACT team admission criteria to help ensure appropriate and consistent identification and referral of ACT team candidates.

Outcomes Data Analysis

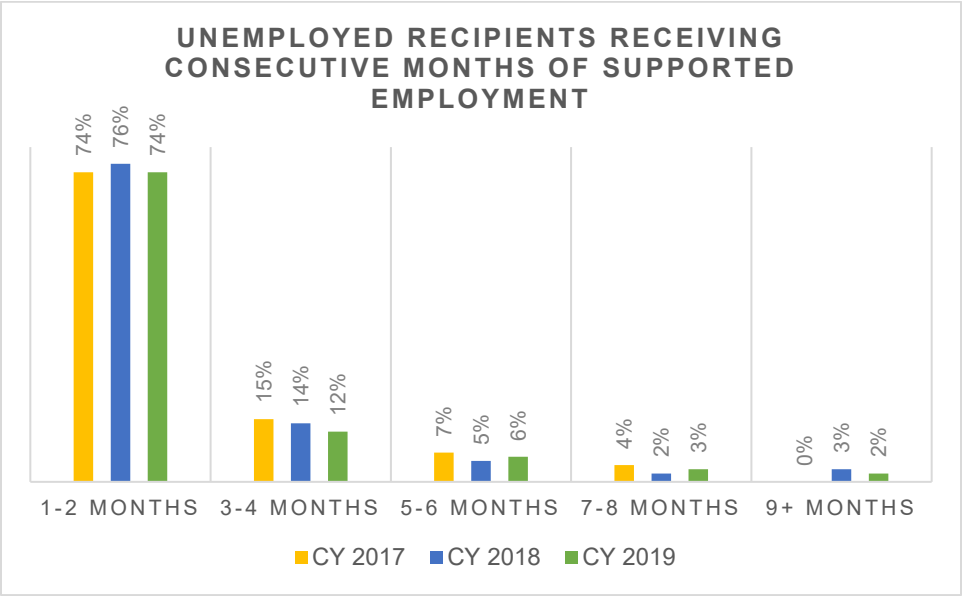
The service capacity assessment included an analysis of recipient outcome data in an attempt to link receipt of one or more of the priority mental health services with improved functional outcomes. The relationships between outcomes and service utilization trends may be identified, but those relationships 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. Consistent with prior year's analyses, the following outcome indicators were reviewed:

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

During CY 2019, an analysis was completed that compared recipients' persistence with receiving supported employment services and peer support services for each of the outcome indicators selected. Overall, there are strong relationships between receipt of the priority services and improved outcomes related to incarcerations, living situation and employment status. The relationship is further strengthened when the recipient sustains consistent participation in the priority service over an extended period of time.

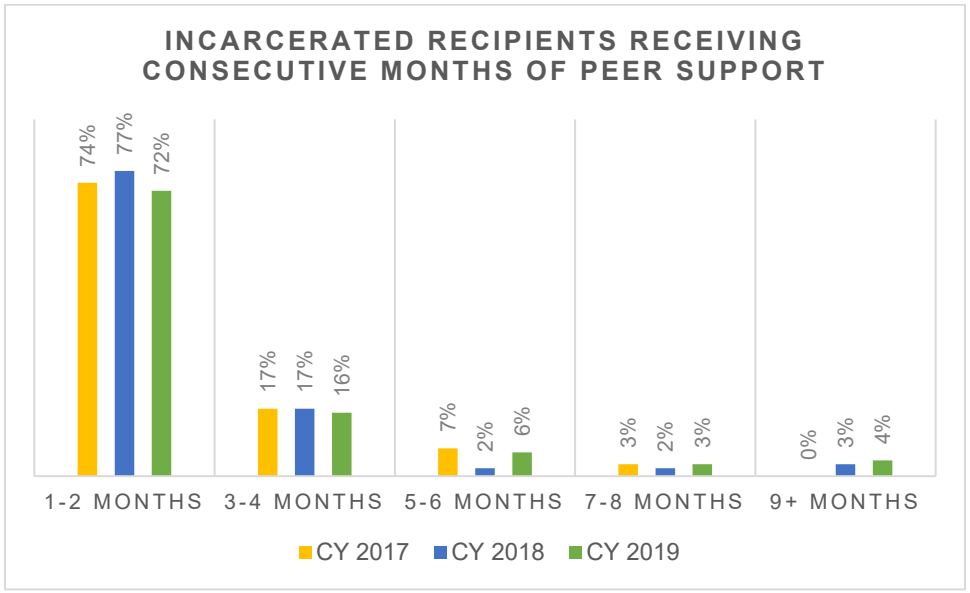
The following results were noted when reviewing select outcomes for recipients who had received supported employment services:

- Similar to CY 2017 and CY 2018 results, the percentage of recipients identified as unemployed decreases as the duration with supported employment services increases. 74% of recipients identified as unemployed are associated with two or less consecutive months of supported employment services. Alternatively, recipients who experienced five or more consecutive months of supported employment services constituted only 11% of the total unemployed group.



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

- Of the group of recipients who were incarcerated during the review period, only 3% received seven to eight consecutive months of peer support services. 72% of recipients who had experienced an incarceration received peer support services during a single month or during two consecutive months during the review period.
- Members noted to be homeless or residing in a boarding home, crisis shelter, hotel, or behavioral health treatment setting represented 14% of recipients that received peer support services during the review period.
- Longer periods of consecutive peer support services are also associated with lower unemployment rates. 71% of the recipients identified as unemployed received one or two months of peer support services; the percentage of unemployed recipients who received peer support services for seven or eight consecutive months was determined to be 3%.


INCARCERATED RECIPIENTS RECEIVING CONSECUTIVE MONTHS OF PEER SUPPORT
74%
77%
72%
17%
17%
16%
7%
2%
6%
3%
2%
3%
0%
3%
4%
1-2 MONTHS
3-4 MONTHS
5-6 MONTHS
7-8 MONTHS
9+ MONTHS
CY 2017
CY 2018
CY 2019

Appendix A

Focus Group Invitation

MERCER
MAKE TOMORROW, TODAY

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 Maricopa County.

The focus groups will evaluate access to Priority Mental Health Services in Maricopa County for persons with a serious mental illness (SMI). The Priority Mental Health Services 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 Priority Mental Health Services. The information gathered through the stakeholder groups is used to help the adult system of care in Maricopa County continue to expand access to recovery-oriented services.

Focus groups will be held at the following location:

The Burton Barr Library
1221 N. Central Ave, Phoenix, AZ 85004

Stakeholder Group One

Adults **receiving at least one SMI Priority Mental Health Service**

Wednesday, March 4, 2020
10:00 am–12:00 pm
Meeting Room B (First Floor)

Stakeholder Group Two

Direct Care Clinic Case Managers **involved in providing Priority Mental Health Services to Adults with SMI**

Wednesday, March 4, 2020
2:00 pm–4:00 pm
Meeting Room B (First Floor)

Stakeholder Group Three

Providers of ACT, SH, SE, Peer and Family Support Services **to adults receiving SMI Priority Mental Health Services**

Thursday, March 5, 2020
2:00 pm–4:00 pm
Meeting Room A (First Floor)

Stakeholder Group Four

Family Members of Adults with SMI
Receiving at least one Priority Mental Health Service

Thursday, March 5, 2020
6:00 pm–8:00 pm
Meeting Room A (First Floor)

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 Wednesday, February 12, 2020 to Alec Zuber at alec.zuber@mercer.com or 602-522-6590.

MARSH & McLENNAN COMPANIES

Appendix B

Key Informant Survey

Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2020

Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2020

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

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

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

Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2020

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

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

If you checked other above (please specify)

* 4. Are the priority services below being utilized efficiently?

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

Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2020

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

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

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

* 8. What is your job role/title?

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

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

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

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)	PSS 1: Ensure continued opportunities for members to access peer support services when a member indicates a preference for the service. PSS 2: Provide education and oversight to peer support specialists operating within the direct care clinics regarding the types of activities that constitute a peer support service and the appropriate bill code to apply when performing a case management activity. PSS 3: The system should evaluate stakeholder feedback regarding the perceived need for direct care clinic peer support specialists to receive increased support, lower caseloads, and competitive pay to mitigate turnover and role dissatisfaction.
Family Support Services (FSS)	FSS 1: Provide training and supervision to ensure that direct care clinical team members understand the appropriate application of family support services. FSS 2: Provide additional training and supervision to recognize the value of family support services as an effective service plan intervention. FSS 3: 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. FSS 4: Conduct a comprehensive root-cause analysis to identify the most prominent factors that result in under-utilization of family support services. Once causal factors are identified, develop and implement interventions to mitigate barriers.
Supported Employment Services (SES)	SES 1: Continue efforts to address instances in which the clinical team identifies supported employment services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services. Consider establishing operating protocols

Service	Recommendations
	that require clinical teams and case managers to immediately/timely act on securing services following the completion of the member's ISP. 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.
Supported Housing Services (SHS)	SHS 1: Continue to promote clinical supervision and oversight of case managers and other direct care clinic team members that ensures regular and timely consultation to address the ongoing supported housing needs of members. When supported housing needs are identified, prioritize service interventions to address and stabilize immediate housing needs prior to engaging the member in less urgent services (e.g., clinic-based health promotion groups). SHS 2: Consider enhancing the capacity of the system to respond to unexpected and immediate supported housing needs (e.g., transitional housing and supports) to offer critical temporary support to members transitioning from acute clinical settings to the community. SHS 3: As part of supported housing provider assessment, identify supported housing providers that are operating significantly below capacity and determine the feasibility of transitioning services from providers that are consistently exceeding contracted capacity.
Assertive Community Treatment (ACT)	ACT 1: Continue efforts to actively facilitate the identification of appropriate candidates for ACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns and adverse incidents involving SMI recipients. ACT 2: As part of the annual assessment update, intentionally 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. As part of the annual assessment update, document that this review occurred. ACT 3: 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. Establish triggers (e.g., length of stay) that would necessitate a review of

Service	Recommendations
	the ongoing appropriateness of ACT team services and determine if a member could be transitioned to a less intensive level of case management. ACT 4: Provide education to system stakeholders (e.g., direct care clinic staff, providers, and referral sources) regarding the ACT team admission criteria to help ensure appropriate and consistent identification and referral of ACT team candidates.
General Recommendations	GR 1: Continue efforts to ensure that annual assessment updates and ISPs are current for all active members. GR 2: Initiate service referrals at the time that the individual service plan is reviewed and signed by the member to help ensure that services on the ISP are timely referred following completion of individual's service plan.

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