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SERVICE CAPACITY ASSESSMENT PRIORITY MENTAL HEALTH SERVICES 2015

ARIZONA DEPARTMENT OF HEALTH SERVICES/ DIVISION OF BEHAVIORAL HEALTH SERVICES

AUGUST 12, 2015

MARSH & McLENNAN COMPANIES

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Executive Summary

The Arizona Department of Health Services/Division of Behavioral Health Services engaged Mercer Government Human Services Consulting (Mercer) to design and implement a network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI). This report represents the second in a series of annual service capacity assessments performed by Mercer.

The service capacity assessment included a need and allocation evaluation of supported housing, supported employment, consumer operated services (peer support services and family support services), and assertive community treatment (ACT). Mercer performed a service capacity assessment of the priority mental health services to assess unmet needs utilizing the following methods:

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

Overview of Findings and Recommendations

Select findings and recommendations regarding the accessibility and provision of the priority services are summarized below. When applicable and available, comparisons of findings and results from the prior year review are presented.

The review period, which was primarily targeted to calendar year 2014 (CY2014), was marked by significant system transitions and changes. Beginning on April 1, 2014, a new regional behavioral health authority implemented a revised health care delivery system that provides integrated physical and behavioral health services to Medicaid eligible adults determined to have a serious mental illness. Historically, the introduction of a new entity responsible for the administration of the behavioral health system in Maricopa County has resulted in some initial challenges and disruptions across different aspects of the publicly funded program. It is not uncommon to experience data processing interruptions and delays during large system transformations such as the one that took place in Maricopa County during CY2014. Therefore, reported decreases in utilization of the priority services when compared to baseline measures recorded during CY2013 may be attributed, in part, to encounter processing errors and omissions during the initial months of contract implementation.

As such, the findings of the service capacity assessment should be considered in the context of the expanded scope of the contract and the introduction of a new contractor responsible to coordinate the delivery of health care services to eligible persons in Maricopa County.

Service Capacity Assessment Conclusions

The predominant finding that emerged as a result of this year's annual service capacity assessment is that the system demonstrated significant expansions of all the targeted priority mental health services. For the current fiscal year, capacity increased or is progressing at rates commensurate with the final settlement agreement. Given the significant system transition (i.e., new contractor, expanded scope of contract), the progress achieved in expanding the capacity of the priority mental health services is exceptional and noteworthy.

Despite funding increases, program development and additional providers, the added capacity has not yet equated to consistent access to the priority mental health services for SMI members with a demonstrated need for the services. The service capacity assessment revealed that the system is regularly missing key opportunities to identify, engage, and provide members with needed services. With the exception of the great demand for housing and the associated wait lists, adequate capacity to provide peer and family support, supported employment and ACT team services appears to be evident in the current service delivery system. However, multiple barriers are present that interfere with a member's ability to access the priority mental health services when needed. Examples of these barriers are illustrated throughout this report and include assessed needs failing to be translated to the member's individual service plan, administrative requirements (and sometimes misperceptions) that delay timely access to care, a lack of integration and coordination across direct care clinics and providers and inconsistency with following through to achieve the goals and objectives of a member's service plan. In addition, it is important to note that the transition to the new contractor and expanded scope of the contract resulted in some initial system challenges with service encounter submission, which likely resulted in the under reporting of all covered services, including the priority mental health services.

In the coming year, the system should emphasize the analysis and resolution of these service delivery and administrative barriers to accessing the priority mental health services. The capability of the system to support members' with their recovery is in place; efforts now need to be focused on the basics of assessment, planning, engagement and the timely delivery of services that most effectively meet each member's unique preferences and needs.

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

Assessments and Service Planning

One opportunity noted by the review team concerned findings related to the clinical assessment and service planning processes implemented via the direct care clinics. During the review period, each provider network organization implemented unique electronic medical record systems to support member management and clinical documentation requirements. As a result of these changes, each PNO created revised clinical documentation forms, including service plan templates available to the direct care clinic teams. As part of the medical record review component of the service capacity assessment, the review team observed that the service plan templates often lacked important information and data fields were commonly left unpopulated (e.g., specific services and frequency). In discussions with representatives of the current regional behavioral health authority, it was determined that the PNO service plan templates were not reviewed or approved by the RBHA prior to implementation.

The review team also experienced challenges with compiling a complete sample for the Group 2 medical record reviews due to missing and out-of-date clinical assessment information. Consistent with system requirements, each member is required to participate with an annual assessment update. However, the review team was required to repeatedly select sample replacement cases due to members lacking current assessments during the review period. Mercer later confirmed that the RBHA has imposed formal performance improvement plans on all four PNOs related to deficiencies with current assessments and individual service plans.

Other issues noted with assessment and service planning activities included the following:

- The individual service plan often did not include services to meet assessed needs, including needs that can be addressed by the priority mental health services;
- Most individual service plans are limited to services available within the direct care clinics (e.g., case management, medication management, nursing services), even when members had identified service needs that could only be met by providers outside of the clinic; and
- Clinical team progress notes are rarely oriented to the individual service plan objectives and goals. The individual service planning and development process appears to be a static event that occurs one time per year and is not revisited until the next annual update is due. Progress notes often reflected activities related to symptom management as opposed to proactive steps to support recovery and assess progress with the member's individualized service plan goals.

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

- Efforts continue to increase the number of peers employed within and outside the system. Community-based providers are utilizing peers in expanded roles, such as health and wellness coaches, serving as crisis navigators and engaging the chronically homeless via co-location at homeless shelters.
- It was noted that some of the assessments reviewed included an identified need for peer support but had corresponding ISPs that did not include services to address the specified need.

- Rarely do the direct care clinic teams consider the value of peer support in engaging members and inspiring an attitude of recovery during service planning development. Alternately, there is an over-emphasis on the indiscriminate promotion of social groups hosted at the clinics (e.g., Karaoke Group).
- Service utilization data demonstrates a reduction in the percentage of members who received at least one unit of peer support services over the respective review periods (CY2013 — 38%; CY2014 — 31%).
- Family members reported that support to families to help navigate the behavioral health system continues to be an unmet need. Many focus group participants noted that family support specialists and family mentors are often involved in facilitating groups rather than providing 1:1 support to family members.
- Eighty-five percent of the records found evidence that natural and family supports were assessed by the clinical team. However, ISPs rarely included family support services.
- The Maricopa County RBHA is completing work on a family resource manual that addresses the facilitation of family support groups, training regarding family engagement and guidelines about information sharing rules and requirements.
- Service utilization data demonstrates minor differences in the percentage of members who received at least one unit of family support services over the respective review periods (CY2013 — 2%; CY2014 — 3%).

Supported Employment Services

- Thirty-three percent of survey key informant survey respondents felt that supported employment services were difficult to access, significantly less than last year when seventy-five percent felt that supported employment services were difficult to access or were inaccessible.
- Thirty-seven of the one hundred twenty-four cases (30%) indicated that supported employment services were identified as a need by the clinical team. However, the ISPs did not consistently include supported employment services to meet the assessed need.
- Similar to last year, the service utilization data set demonstrates significant variation in the volume of the three available service codes for supported employment. For the time period October 1, 2013 through June 30, 2014, H2027 (pre-job training and development) accounts for 94% of the total supported employment services (compared to 93% during a comparable timeframe last year).
- Community-based supported employment providers have expanded potential career tracts through partnerships with local businesses. Members seeking employment now have more options such as operating a bistro within a community hospital, working as chefs in local restaurants and performing jobs at super markets and pharmacy outlets.
- Service utilization data demonstrates a significant reduction in the percentage of members who received at least one unit of supported employment over the respective review periods (CY2013 – 39%; CY2014 – 20%). The observed reduction in utilization may be attributed, in part, to an emphasis on the delivery of comprehensive and evidence-based supported employment services.

Supported Housing Services

- During key informant interviews, some providers described coordination with the direct care clinics as challenging when arranging supported housing services. When a referral has been initiated, the direct care clinic must provide member demographic information and a current ISP that names the supported housing provider (or at least the service – the review team received conflicting accounts

regarding which was needed). Some providers described barriers in obtaining needed documentation from the direct care clinic team that resulted in delays with member's access to supported housing services.

- Participants in all four focus groups indicated a need for increased transparency of supported housing wait lists and available housing opportunities. Clinic staff and members are not able to access information about the length of waiting lists and where a member is positioned on the waiting list.
- Half of the key informant survey respondents felt that supported housing services were difficult to access, the same finding as last year. However, none of the respondents indicated that supported housing services were inaccessible, an improvement from last year when 17% of the key informants felt the services were inaccessible.
- When asked about factors that negatively impact accessing supported housing services, the most prevalent key informant survey responses were that a wait list exists for the service and a lack of capacity/no service provider available.
- Service utilization data demonstrates a significant increase in the percentage of members who received at least one unit of supported housing (as measured through service code H0043) over the respective review periods (CY2013 – 0.02%; CY2014 – 3%).
- Supported housing expansion efforts have added capacity to serve an additional 300 members with a total added capacity of 425 anticipated by June 30, 2015.

ACT Team Services

- One thousand five hundred twenty-six recipients (1,526) were assigned to 18 ACT teams as of February 3, 2015. An increase of three teams and 165 members since CY2013. Another new ACT team is planned to be implemented during May 2015.
- With the exception of the three new ACT teams added during the second half of CY2014 and the first quarter of CY2015, existing ACT team capacity averages 96%; a significant improvement when compared to the capacity of ACT teams during CY2013.
- Fifty percent of key informant respondents indicated that ACT team services were easier to access or easy to access (an increase from 36% during CY2013).
- In response to varied admission criteria for ACT team services as evidenced during the CY2013 service capacity assessment, the new RBHA has developed an ACT operations manual that includes an ACT admission screening criteria checklist. In addition, the RBHA has been more actively involved in identifying potential ACT candidates through the application of predictive modeling algorithms and regular clinical staffings with adult PNOs and direct care clinical teams.
- As a percentage of the total SMI population, 6% of all members are assigned to an ACT team. This is the same finding derived during CY2013.

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Overview

The Arizona Department of Health Services (ADHS)/Division of Behavioral Health Services (DBHS) engaged Mercer Government Human Services Consulting (Mercer) to implement an annual network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI).[1] The service capacity assessment included a need and allocation evaluation of supported housing, supported employment, consumer operated services (peer support services and family support services), and assertive community treatment (ACT).

Goals and Objectives of Analyses

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

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

Limitations and Conditions

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

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

Contributors to Project

The review team consisted of the following personnel.

Core Team

Daniel Wendt, Principal

Daniel is a Principal at Mercer and performs clinical and behavioral health consulting. Daniel possesses over 25 years of experience with Medicaid managed care programs and clinical service delivery systems. Daniel has a clinical background and is experienced in quality performance improvement concepts and approaches.

Stacia Ortega, Associate

Stacia has over 15 years of experience in the human services field. Stacia has subject matter expertise and national presenter experience in the areas of cultural competency, transitioning young adults, substance abuse, autism, children and adult behavioral health systems of care, and project management of federal prevention grants.

Michal Anne Pepper, Ph.D., Senior Associate

Michal Anne brings extensive experience in managed care, as well as experience as a service provider, clinical supervisor and administrator in a variety of treatment settings. Michal Anne participates in behavioral health plan reviews and audits, state reviews of behavioral health-managed care organization quality initiatives, organizational development initiatives, and business development.

Jim Zahniser, Ph.D., Principal and Senior Consultant (TriWest Group)

Jim has over 20 years of experience in research and evaluation of health and human services. Jim has been an overall methodological and/or statistical lead on several large-scale evaluations. Jim has expertise in needs assessments, having worked with national epidemiological data, regional data, and state data multiple times to apply prevalence estimates to specific communities and states. In addition, Jim has expertise in evidence-based practices (EBPs) for adults, including ACT, supported employment, and supported housing and regularly consults with states on those practices.

Other Project Team Members

Jeanie Aspiras
Dillon Davis
Laura Henry
Jesse Seiger-Walls (TriWest Group)

Acknowledgments

Mercer would like to thank the following ADHS/DBHS staff: Kelli Donley, Paul Galdys, Anne Dye, and Jacqueline Picone for assistance with project coordination and responding to data requests.

A special thank you to Mercy Maricopa Integrated Care and the Adult Provider Network Organizations, including Choices Network, People of Color Network, Partners in Recovery Network, and Southwest Network and their staff for timely responses to information requests and for facilitating access to the direct care clinics and medical record documentation.

Mercer also expresses gratitude to the focus group participants and the key informants who provided valuable insight, completed survey tools, and granted interviews.

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Background

The ADHS/DBHS serves as the single State authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health system. ADHS/DBHS contracts with community-based organizations, known as regional behavioral health authorities (RBHAs), to administer integrated physical health (to select populations) and behavioral health services throughout the State of Arizona.

History of *Arnold v. Sarn*

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

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

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

SMI Service Delivery System in Maricopa County

Beginning October 1, 2015, ADHS/DBHS will contract with RBHAs to deliver integrated physical health (to select populations) and behavioral health services in three geographic service areas (GSAs) across Arizona. Each RBHA must manage a network of providers to deliver all covered physical health and behavioral health services. RBHAs contract with behavioral health providers to provide the full array of covered physical health and behavioral health services, including the four prioritized mental health services that are the focus of this assessment.

For persons determined to have a SMI in Maricopa County, the RBHA has contracted with four adult provider network organizations (PNOs) that operate direct care clinics throughout the county. The PNOs include Choices Network, People of Color Network, Partners in Recovery Network, and Southwest Network. The table below identifies the four adult PNOs and affiliated direct care clinics.

PNO	Direct Care Clinics	PNO	Direct Care Clinics
Choices Network	Arcadia Center	**Southwest Network**	Saguaro
	Enclave		Highland
	South Central		San Tan
	Midtown		Bethany Village
	Townley Center		Garden Lakes
	West McDowell		Hampton
			Osborn
People of Color Network	Comunidad	**Partners in Recovery Network**	Metro Center Campus
	Capitol Center		West Valley Campus
	Centro Esperanza		Arrowhead Campus
			East Valley Campus
			Hassayampa Campus

The direct care clinics provide a range of recovery focused services to SMI recipients such as medication services, medical management, case management, transportation, peer support services, family support services, and health and wellness groups. ACT teams are available at 15 different direct care clinic locations and one community provider. Access to other covered behavioral health services, including supported employment and supported housing is primarily accessible to SMI recipients through RBHA contracted community-based providers.

Current Service Capacity

The information presented below reflects the contracted capacity for each of the prioritized services during the period under review.[2]

ACT Teams (18 teams serving 1,526 recipients)[3]

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Southwest Network: San Tan		100	96	4%
Southwest Network: Saguaro*		100	24	76%
Southwest Network: Hampton		100	94	6%
Southwest Network: Osborn		100	97	3%
Southwest Network: Bethany Village	Young Adult Team	100	97	3%
Choices: Enclave		100	96	4%
Choices: South Central		100	94	6%
Choices: Townley Center		100	98	2%
Choices: West McDowell		100	91	9%
People of Color Network: Centro Esperanza		100	95	5%
People of Color Network: Comunidad -- Team 1		100	91	9%
People of Color Network: Comunidad --Team 2	Forensic Team	100	100	0%
People of Color Network: Capitol Center		100	97	3%
Partners in Recovery: Metro Center Campus -- Team 1		100	97	3%
Partners in Recovery: Metro Center Campus -- Team 2		100	98	2%
Partners in Recovery: Arrowhead*	Medical Team	100	0	100%
Partners in Recovery: West Valley Campus		100	100	0%
Community Bridges: Community Bridges*	Forensic Team	100	61	39%
	Totals	**1800**	**1526**	**10%****

***** Represent new ACT teams since the last review. The teams are working to build capacity consistent with fidelity to SAMHSA's evidence-based practice model.

**When new teams are excluded, the percent below full capacity is 4%.

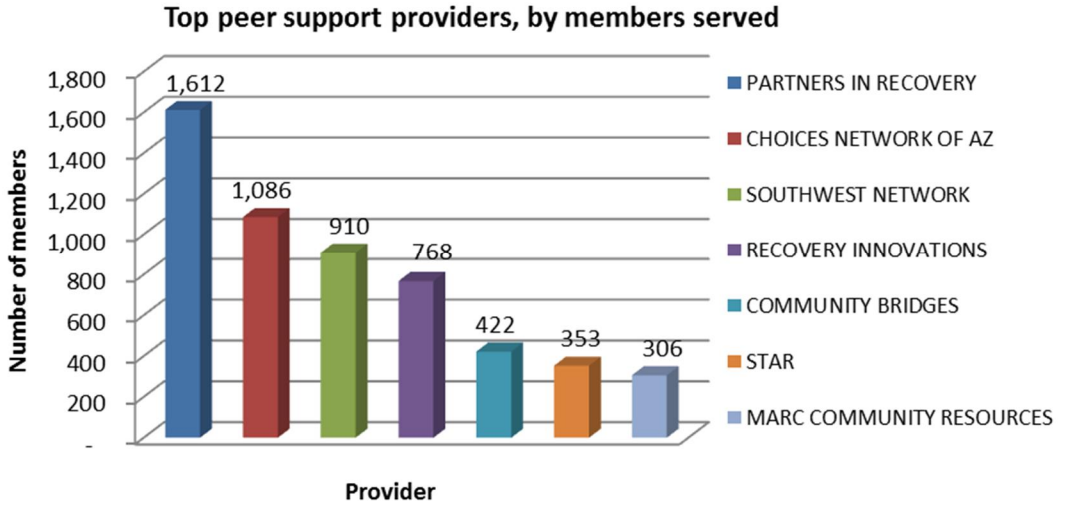
[2] As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in February 2015.

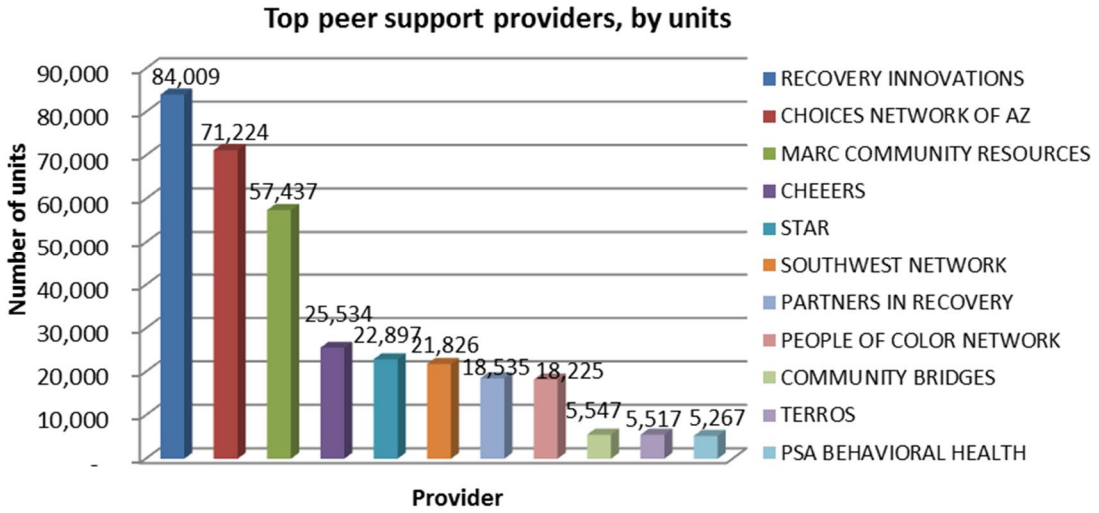
[3] As of February 3, 2015.

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

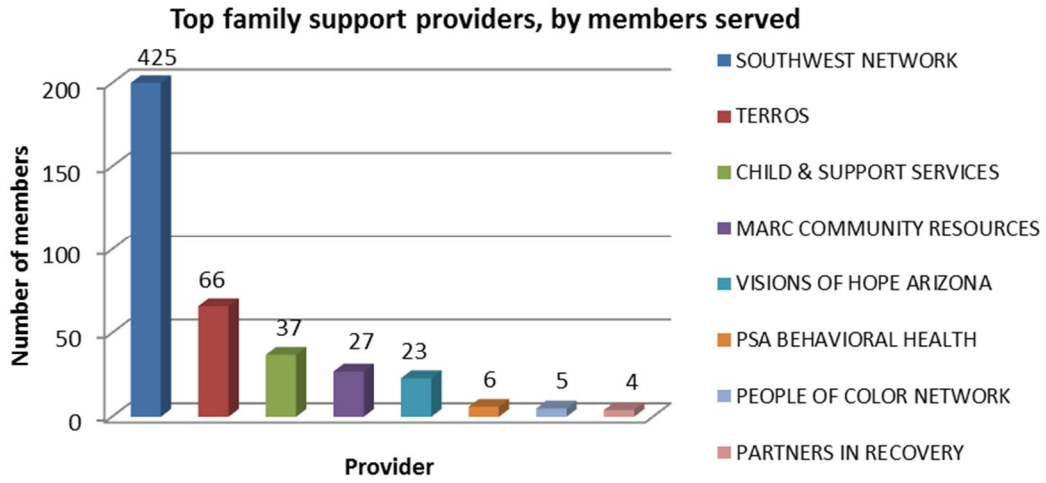
Consumer Operated Services (peer support and family support)[4]

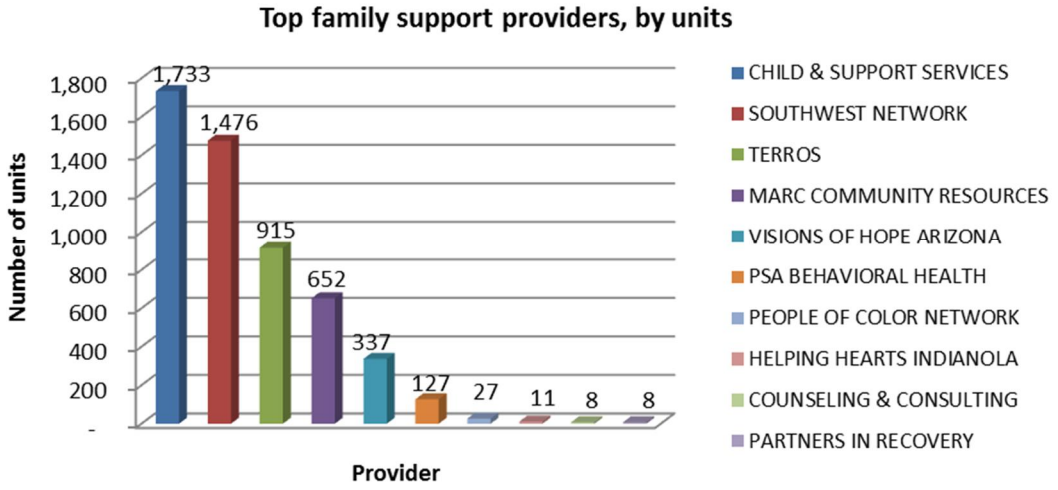
- CHEEERS.
- Recovery Empowerment Network (REN).
- Hope Lives Vive La Esperanza.
- Marc Community Resources.
- Stand Together and Recover (STAR).
- Community Bridges Incorporated.
- Lifewell.
- PSA.
- Mountain Health and Wellness
- Recovery Innovations of Arizona
- Terros
- Choices Network.
- People of Color Network.
- Partners in Recovery Network.
- Southwest Network.





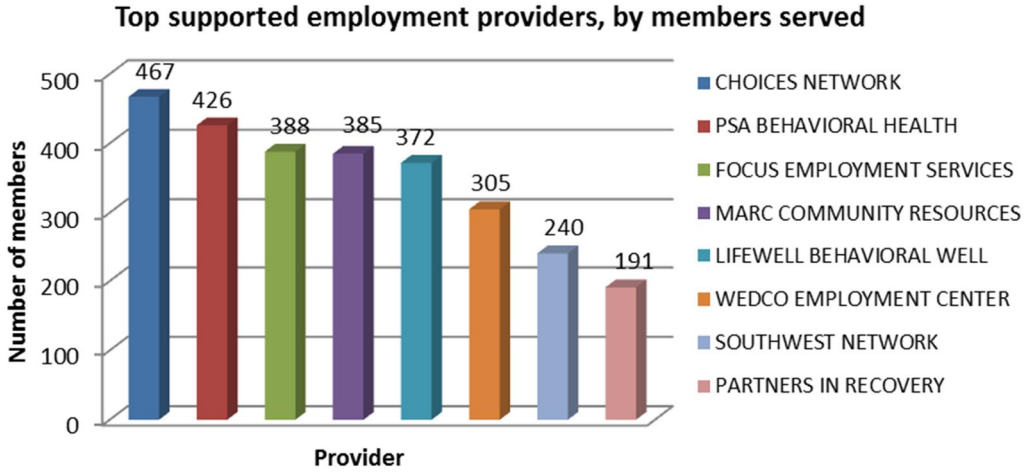
[4] As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in February 2015.

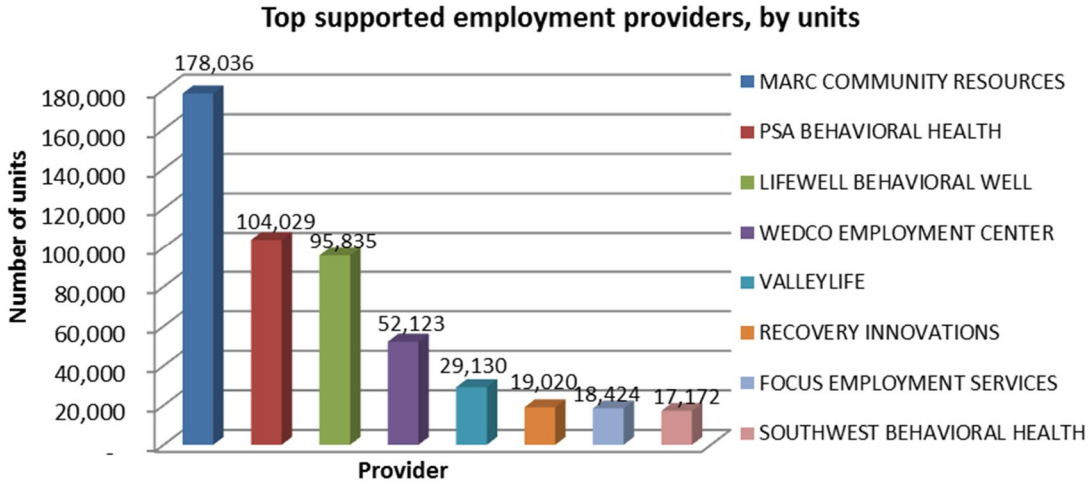

Top family support providers, by members served
Number of members
Provider
425
66
37
27
23
6
5
4
SOUTHWEST NETWORK
TERROS
CHILD & SUPPORT SERVICES
MARC COMMUNITY RESOURCES
VISIONS OF HOPE ARIZONA
PSA BEHAVIORAL HEALTH
PEOPLE OF COLOR NETWORK
PARTNERS IN RECOVERY


Top family support providers, by units
Number of units
Provider
1,733
1,476
915
652
337
127
27
11
8
8
CHILD & SUPPORT SERVICES
SOUTHWEST NETWORK
TERROS
MARC COMMUNITY RESOURCES
VISIONS OF HOPE ARIZONA
PSA BEHAVIORAL HEALTH
PEOPLE OF COLOR NETWORK
HELPING HEARTS INDIANOLA
COUNSELING & CONSULTING
PARTNERS IN RECOVERY

Supported Employment Providers[5]

- Beacon Group (TETRA).
- DK Advocates.
- Focus Employment Services.
- Lifewell Behavioral Wellness.
- Marc Community Resources.
- Valleylife.

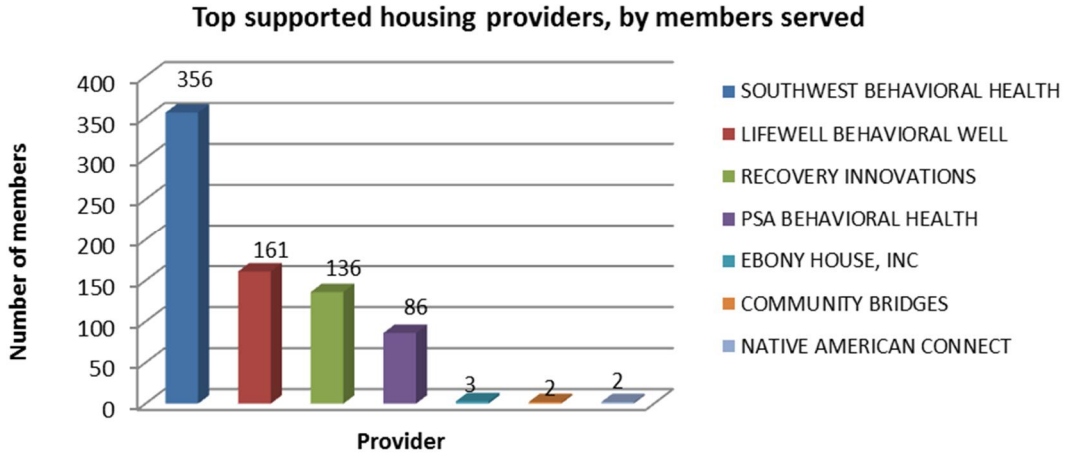


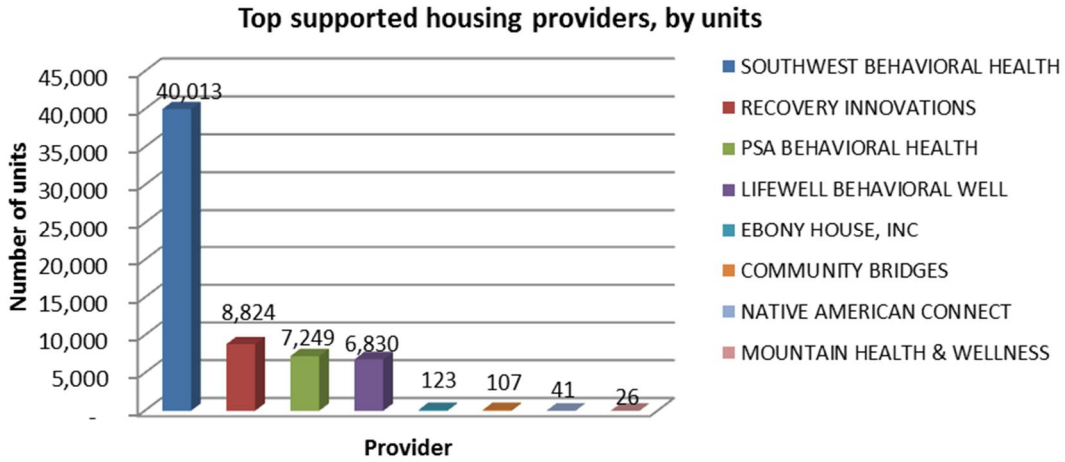


[5] As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in February 2015.

Supported Housing Providers[6,7]

- Lifewell.
- Southwest Behavioral Health Services.
- Marc Community Resources.
- Arizona Health Care Contract Management (AHCCMS).
- Child and Family Support Services.
- Terros.
- PSA Behavioral Health Agency.
- Community Bridges.
- Arizona Mentors.





[6] As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in February 2015.
[7] Supported housing services were not significantly represented within the service utilization data file.

4

Methodology

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

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

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

Focus Groups

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

reviewed and approved by the ADHS/DBHS Office of Family Affairs[8]. The focus groups were also communicated to key stakeholders in the community, a notice was sent to the four Adult PNOs, and electronic invitations were sent out to family and peer run organizations.

The focus groups included the following participants with experience with ACT team services, peer and family support services, supported housing, and supported employment:

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

A total of 38 stakeholders participated in the four two-hour focus groups conducted on February 18, 2015 and February 19, 2015. The adults receiving behavioral health services and family members of adult's focus groups were held at Quality Care Network's administrative offices in Phoenix, Arizona. The direct care clinic case managers and providers of the priority services focus groups were held at the Burton Barr Central Library in Phoenix, Arizona. A total of ten direct care clinic staff, nine providers, eleven family members and eight adult recipients participated.

The methodology included the following approach:

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

Key Informant Surveys and Interviews

One objective of the service capacity assessment was to obtain comprehensive stakeholder input. As a result, a key informant survey was created using *Survey Monkey®.* The survey tool included 10 questions with rating assignments related to accessing the priority mental health services, including the ease of access and timeliness of access to the services.[9]

The survey was disseminated to key system stakeholders via email with a hyperlink to the online survey. The survey remained accessible for two and half weeks during March and April 2015.

[8] See Appendix A, Focus Group Invitation.
[9] See Appendix B, Key Informant Survey.

A total of 21 respondents completed portions of the survey tool with a total number of 16 respondents completing the full survey.

In addition, four in-depth interviews were conducted with key system stakeholders to gather information regarding system strengths and potential barriers to accessing the priority mental health services. Interviews were completed with leaders representing supported housing, supported employment and peer and family support providers as well as an administrator from the current Maricopa County Regional Behavioral Health Authority (RBHA).

Medical Record Reviews (Group 1 and Group 2)

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

Group 1

The Group 1 sample included 124 randomly selected cases, identified using the following criteria:

- The recipient was identified as SMI, assigned to GSA-6 and received a covered behavioral health service during October 1, 2013 and December 31, 2014; and
- The recipient participated in an assessment during October, November, or December 2014.

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

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

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

Mercer developed an interview guide[10] to support the assessment of the recipient's perception regarding the need for one or more of the priority services. Mercer's review team conducted an orientation and review of the interview tool to help ensure consistent application of the guide across reviewers.

Group 1 recipients were engaged by a clinical team member at their assigned direct care clinic to determine if the recipient was willing to participate in the interview. Prior to the clinical team members contacting recipients, Mercer provided talking points to each direct care clinic to guide the introduction and purpose of the interview activity. Attempts were made to coordinate the interview activity at the recipient's assigned direct care clinic, either as part of a scheduled visit or as a request to present at the clinic on a designated day and time.

Ninety- out of one hundred twenty-four recipients (73%) completed the interviews. In a small number of cases and at the request of the recipient, the interviews were completed over the telephone or at the person's private residence.

Group 1 medical record documentation for the sample (n=124) was reviewed by a behavioral health professional and recorded in a data collection tool. Documentation regarding the priority mental health services was analyzed and recorded by reviewing assessments and ISPs. Additional comments were included to further clarify findings. Findings from the recipient interviews were added to the data collection tool to support a comparative analysis between the medical record documentation findings and the recipient's recorded responses to the interview questions.

Group 2

For Group 2, the final sample included 197 randomly selected cases, selected using the following criteria:

- The recipient was identified as SMI and received a covered behavioral health service during October 1, 2013 and December 31, 2014.[11]
- The recipient had an assessment date between January 1 and November 15, 2014.[12]

[10] See Appendix C, Assessment Verification Interview Tool.

[11] The total population of unique SMI recipients who received behavioral health services is 24,476 for the period October 1, 2013 through December 31, 2014.

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

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

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

Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient's current annual assessment update or initial assessment, a current psychiatric evaluation (if available), the recipient's current ISP, and all clinical team progress notes following each recipients' assessment date through December 31, 2014.

Group 2 medical record documentation for the sample (n=197) was reviewed by four licensed clinicians and recorded in a data collection tool.[13] The data collection tool was pre-loaded to include recipient identifying information and each recipient's unique service utilization profile. Additional comments were recorded to further clarify findings. Prior to conducting the medical record reviews, inter-rater reliability testing was completed over a two day period with all reviewers using actual cases to ensure at least 90% agreement on ratings.

[13] See Appendix D, Group 2 Medical Record Review Tool.

Analysis of Service Utilization Data

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

The specified time frame for the file included dates of service between October 1, 2013 and December 31, 2014. Encounter submission lag times can impact the completeness of the data set. In addition, claims processing challenges were noted with the new RBHA contractor during the review period and ADHS/DBHS reported encounter data transfer issues that may have contributed to under reporting of service encounters by an estimated 10% of the total volume.

Specific queries were developed to identify the presence of each prioritized mental health service.[14] Analysis was conducted to evaluate the volume of unique users, billing units, and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, a special analysis was completed to determine "persistence" in treatment. Through the evaluation, proportions of recipients who only received the service in a single month were calculated. Additional progressive consecutive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months, and nine months) to determine the volume of recipients who sustained consistent participation in each of the prioritized services. For ACT team services, a roster of ACT team members was obtained and a corresponding analysis of service utilization (priority services and case management services) was also performed.

The service utilization data file also supported the extraction of the Group 1 and Group 2 medical record samples and allowed for an analysis of the service utilization profile for each recipient selected, as well as supporting an aggregated view of service utilization for each sample group (total sample size across Group 1 and Group 2 = 321). Group 1 and Group 2 sample characteristics are illustrated in the table below and compared to the overall sampling frame or population characteristics.

[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.

Current service capacity assessment time period

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%[15]

Last years' service capacity assessment time period

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%

[15] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 6% of all active SMI recipients are assigned to ACT teams.

Analysis of Outcomes Data

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

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

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

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

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

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

ADHS/DBHS 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 the utilization and penetration rates of the priority mental health services (ACT, supported employment, supported housing, and peer support[16]) was performed. Penetration rates were compared to benchmarks, as described below.

The following review process was completed:

- Select academic publications were reviewed and Mercer corresponded with national experts regarding the prioritized services; and
- Review of national data from SAMHSA on EBP penetration rates at the State level.

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

Service Expansions — Comparison of Select States

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

[16] Peer support services are not currently reported on the SAMHSA 2012 Mental Health National Outcome Measures (NOMS) report.

5

Findings and Recommendations

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

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

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

SMI Prevalence and Penetration

Penetration is defined as the percentage of potential individuals who receives services during a defined time period. As depicted in the table below, a relatively small percentage (17%) of the estimated number of adults with SMI is served through the publicly funded system in Maricopa County. The national penetration rate is just under 50%, and even communities of relatively similar size (Harris County (Houston) Texas and New York City) have higher penetration rates. Within the Maricopa County Medicaid system, however, the penetration rate is comparable to the national average. The smaller penetration rate in Arizona and Maricopa County appears to be due to the fact that such a small percentage of non-Medicaid persons are served.

Service System Penetration Rates for People with Serious Mental Illness

Penetration Rates					
Region	**Adult Population (≥18 Years Old)[17]**	**Estimated Rate of SMI in the Adult Population[18]**	**Estimated Number of Adults with SMI in the Pop.[19]**	**Number of Adults with SMI Served[20]**	**Penetration Rate Among Adults with SMI[21]**
US	244,563,362	4.2%	10,271,661	4,925,080	48%
Arizona	5,016,058	4.6%	230,739	47,997	21%
Maricopa County [22]	2,995,031	4.6%	137,771	23,977	17%
Maricopa County — Medicaid	355,141[23]	11.7%[24]	41,551	18,464	44%
Maricopa County Gen. Adult Pop.	2,639,890	4.6%	96,220	5,513	6%[25]
Texas	19,720,194	4.1%	808,528	231,665	29%

[17] US Census Bureau 2013 population estimates for adults (18 years of age and older).

[18] SAHMSA. (2014). State Estimates of Serious Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report. Retrieved from http://www.samhsa.gov/data/sites/default/files/sr170-mental-illness-state-estimates-2014/sr170-mental-illness-state-estimates-2014/sr170-mental-illness-state-estimates-2014.htm. The estimated rate of SMI statewide for Arizona was used for all Maricopa County adults.

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

[20] State-level penetration counts are reported from SAHMSA (2013) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. We calculated the number of people with SMI served by multiplying the reported total number of adults served by the percentage with SMI.

[21] Number of adults with SMI served within the system (calculated, based on SAMHSA's reported percentage of people served who have SMI), divided by the estimated number of adults with SMI in the total adult population.

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

[23] The number of Title XIX-eligible adults as of June 2014. Data received from MMIC in April, 2015.

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

[25] Please note that the RBHA would not be expected to serve all adults with SMI in Maricopa Co., as some of them are not low-income persons.

Penetration Rates					
Region	**Adult Population (≥18 Years Old)[17]**	**Estimated Rate of SMI in the Adult Population[18]**	**Estimated Number of Adults with SMI in the Pop.[19]**	**Number of Adults with SMI Served[20]**	**Penetration Rate Among Adults with SMI[21]**
Harris County (Houston)	3,191,924	4.1%	130,869	64,000[26]	49%
New York	15,441,413	3.6%	555,891	411,561	74%
New York County (NY City)[27]	1,387,114	3.6%	49,936	22,864	46%
Colorado	4,033,146	4.2%	167,376	54,114	32%
Denver City-County[28]	513,101	4.2%	21,294	8,000	38%
Nebraska	1,403,596	4.4%	61,758	13,828	22%
California	29,246,290	3.6%	1,055,791	385,360	36%
Illinois	9,861,272	3.2%	316,547	96,259	30%
Kansas	2,171,851	4.3%	94,041	17,040	18%
Minnesota	4,142,454	3.9%	159,899	93,609	59%
Wisconsin	4,433,560	4.0%	176,899	41,427	23%
Tennessee	5,002,897	4.3%	212,623	128,378	60%
Indiana	4,987,171	4.5%	224,921	68,785	31%
Delaware	721,687	4.4%	31,610	6,068	19%
New Hampshire	1,051,480	4.6%	48,053	10,976	23%
North Carolina	7,563,968	4.3%	328,276	109,477	33%

[26] The estimated number of adults with SMI served by the largest community behavioral health providers in Harris County (Houston), Texas – MHMRA of Harris County and Harris Health Systems – and by Medicaid HMOs. Meadows Mental Health Policy Institute for Texas, personal communication, March 27, 2015.

[27] New York State Office of Mental Health. (2013). (Online Dashboard) Patient Characteristics Survey- Summary Reports: New York County. Retrieved from https://my.omh.ny.gov/webcenter/faces/pcs/planning?wc.contextURL=/spaces/pcs&_adf.ctrl-state=1akxeosyer_4&wc.contextURL=/spaces/pcs&wc.contextURL=%2Fspaces%2Fpcs&wc.originURL=%2Fspaces%2Fpcs&_afrLoop=44553068891870 on February 24, 2015.

[28] Mental Health Center of Denver (2014). Key Informant Interviews with Roy Starks and Kristi Mock, clinical/administrative directors.

Evidenced-Based Practice (EBP) Utilization Benchmark Analyses

Data in the table below show the penetration rates for Assertive Community Treatment (ACT), Supported Employment, and Supported Housing among those served in the Maricopa County system. Maricopa County has an ACT penetration rate of 6%, but the penetration rate for supported housing services is low (as measured by service code H0043). The penetration rate for supported employment appears adequate. However, the "ongoing support to maintain employment" service codes may provide a better indication of the number of people receiving evidence-based supported employment and the number of people receiving that service is small relative to the population in need.

EBP Utilization Rates Among People with SMI Who Were Served in the System[29]

	Assertive Community Treatment		Supported Employment		Supported Housing	
Region	**Number of Adults with SMI Using EBP**	**Percentage of Adults with SMI Using EBP**	**Number of Adults with SMI Using EBP**	**Percentage of Adults with SMI Using EBP**	**Number of Adults with SMI Using EBP**	**Percentage of Adults with SMI Using EBP**
US	63,445	1%	48,880	1%	75,879	2%
Arizona	Not reported	Not Reported	10,666	22%	2,383	5%
Maricopa County	1,526	6%	5,634	23%	793	3%
Maricopa County (SE ongoing)[30]	*n/a*	*n/a*	*657*	*3%*	*n/a*	*n/a*
Maricopa County — Medicaid	No data	No data	5,159	28%	785	4%
Maricopa County — Gen Adult Pop	No data	No data	475	9%	8	<1%
Texas	3,335	1%	4,525	2%	5,077	2%
Harris County	281	<1%	1,287	2%	823	1%
New York	6,189	2%	1,634	<1%	19,864	5%

[29] National and State-level data on the number of people utilizing EBPs are reported from the SAHMSA (2013). *Mental Health NOMS: Central Mental Health Services Uniform Reporting System.* Retrieved from http://www.samhsa.gov/data/us_map?map=1. Rates are based on number with SMI served in the system.

[30] 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 2014 review of clinical records that the latter service code, which accounted for 94% of SE services coded, often indicated brief discussions with clients about employment, outside of the context of a comprehensive, evidence-based supported employment program.

EBP Utilization Rates Among People with SMI Who Were Served in the System[29]						
	Assertive Community Treatment		Supported Employment		Supported Housing	
Region	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
New York County (NY City)	1,126[31]	5%	No data	No data	845[32]	4%
Colorado	3,514	7%	1,001	2%	202	<1%
Denver City-County (MHCD)[33]	800	10%	680	9%	1,650	21%
Nebraska	223	2%	497	4%	772	6%
Omaha (Region 6)[34]	110	1%	260	3%	273	3%
California	5,227	1%	893	<1%	1,360	<1%
Illinois	979	1%	2,047	2%	Not available	Not available
Kansas	N/A	N/A	1,382	8%	3,505	21%
Minnesota	1,992	2%	294	<1%	685	1%
Wisconsin	3,572	9%	647	2%	944	2%
Tennessee	417	<1%	238	<1%	697	1%
Indiana	476	1%	1,131	2%	2,523	4%
Delaware	334	6%	43	1%	71	1%
New Hampshire	263	2%	1,244	11%	No Data	No Data
North Carolina	4652	4%	No Data	No Data	No Data	No Data

[31] New York State Office of Mental Health. (2014). (Online Dashboard) Assertive Community Treatment Length Of Stay – January 2015. Retrieved from http://bi.omh.ny.gov/act/statistics?p=los on January 13, 2015.

[32] New York State Office of Mental Health (2013). (Online Dashboard) Residential Program Indicators Report: New York County. Retrieved from http://bi.omh.ny.gov/adult_housing/reports?p=rpi&g=New+York&y=2013&q=Dec+31 on January 13, 2015. Figure represents an estimated annual count based on quarterly reports.

[33] Data are for the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver Colorado. Personal communication with Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2014 and 2015.

[34] Triwest Group. (2014). *Omaha Area Adult Mental Health System Assessment: Final Summary of Findings and Recommendations*. (Study Conducted for the Behavioral Health Foundation.) Unpublished Manuscript. Boulder, CO: TriWest Group. The estimated 9,158 people with SMI served in the system is based on number of people reported to receive pharmacological management (9,158) in community mental health center and federally qualified health center settings.

The following table compares utilization of ACT, supported employment, and supported housing in 2013 versus in 2014. While there was a substantial increase in the number of adults with SMI who received ACT services in 2014, the penetration rate remained stable because the overall population of members with SMI increased. The penetration rate for supported employment appeared to drop significantly between 2013 and 2014. This may be due to a decrease in the reported number of people receiving pre-job training and development services; the number of people receiving ongoing support to maintain employment services actually increased from 2013 to 2014. In 2013, the supported housing billing code was rarely utilized. As a result, changes in the supported housing penetration rate could not be calculated.

Maricopa County EBP Utilization in 2013 and 2014

Maricopa County: 2013-2014 Comparison of EBP Utilization Rates Among People with SMI Served in the System							
Year	Number of Adults with SMI Served	Assertive Community Treatment		Supported Employment		Supported Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[35]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2014)	23,977	1,526	6%	5,634	23%	793	3%
SE Ongoing				*657*	*3%*		
Maricopa County (2013)	20,291	1,361	6%	7,366	33%	No Data	No Data
SE Ongoing				*515*	*2.5%*		

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

Assertive Community Treatment Benchmarks

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

Maricopa County's ACT penetration rate (6%) exceeds the benchmark in the Cuddeback study. This may be partly because the adults with SMI actually served may include more people in need of ACT than those not served. Those who come to the attention of the system may require more intensive supports and services.

Assertive Community Treatment Utilization Relative to Estimated Need Among People with SMI					
Region	SMI Pop. Served	Need ACT[36]	ACT Received[37]	ACT Penetration	
				All SMI Served	Need ACT
US	4,925,080	211,778	63,445	1%	30%
Arizona	47,997	2,064	No Data	No Data	No Data
Maricopa Co. (Total SMI Pop.)	*137,771*	*5,924*	*1,526*	*1%*	*26%*
Maricopa Co. — RBHA Total	27,088	1,165	1,526	6%	131%
Maricopa Co. — Medicaid	21,187	911	No data	No data	No data
Maricopa Co. — Gen Adult Pop	5,901	254	No data	No data	No data
Texas	231,665	9,962	3,335	1%	33%
Harris County[38]	64,000	2,752	281	0%	10%
New York	411,561	17,697	6,189	2%	35%
New York County (NY City)[39]	22,864	983	1,126	5%	115%

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

[37] National and State-level penetration counts for ACT received are reported from SAHMSA. (2013). Mental Health NOMS: Central Mental Health Services Uniform Reporting System. Retrieved from http://www.samhsa.gov/data/us_map?map=1.

[38] Harris County is only based on LMHA only service data.

Assertive Community Treatment Utilization Relative to Estimated Need Among People with SMI					
Region	SMI Pop. Served	Need ACT[36]	ACT Received[37]	ACT Penetration	
				All SMI Served	Need ACT
Colorado	54,114	2,327	3,514	7%	151%
Denver County (MHCD)[40]	8,000	344	800	10%	233%
Nebraska	13,848	595	223	2%	38%
Omaha (Region 6)[41]	9,158	394	110	1%	28%
California	387,588	16,570	5,227	1%	32%
Illinois	96,259	4,139	979	1%	24%
Minnesota	93,609	4,025	1,992	2%	49%
Wisconsin	41,427	1,781	3,572	9%	201%
Tennessee	128,378	5,520	417	0%	8%
Indiana	68,785	2,958	476	1%	16%
Delaware	6,068	261	334	6%	128%
New Hampshire	10,976	472	263	2%	56%
North Carolina	109,477	4,707	4,652	4%	99%

Supported Employment Benchmarks

While Maricopa County meets a high percentage of the estimated need for supported employment services among those receiving services, there is a very small percentage of people who appear to be receiving evidence-based supported employment services. Over 5,000 people receive pre-job training and development services, but very few receive services associated with maintaining a job. This could mean that supported employment services in Maricopa County rarely result in people obtaining jobs, or that the number of people receiving the full array of supported employment services is under-reported. However, we think it is more likely that a large volume of pre-vocational services are being provided, but relative few people are actually receiving the full, evidence-based supported employment model. Denver is a good

[39] New York State Office of Mental Health. (2014). (Online Dashboard) Assertive Community Treatment Length Of Stay – January 2015. Retrieved from http://bi.omh.ny.gov/act/statistics?p=los on January 13, 2015.

[40] Roy Starks & Kristi Mock. (2014). Key Informant Interview.

[41] Triwest Group. (2014). *Omaha Area Adult Mental Health System Assessment: Final Summary of Findings and Recommendations*. (Study Conducted for the Behavioral Health Foundation.) Unpublished Manuscript. Boulder, CO: TriWest Group.

benchmark community, with nearly 20% in need receiving supported employment services. The number receiving supported employment services in Denver County receive the full evidence-based approach.[42]

Supported Employment Utilization Relative to Estimated Need Among People with SMI					
Region	SMI Pop. Served	Estimated Need SE[43]	SE Received[44]	SE Penetration	
				All SMI Served	Need SE
US	4,925,080	2,216,286	48,880	1%	2%
Arizona	47,997	21,599	10,666	22%	49%
Maricopa Co. (Total SMI Pop.)	137,771	61,997	5,634	4%	9%
Maricopa Co. (Total served)	23,977	12,000	5,634	23%	47%
Maricopa Co. (SE Ongoing)	23,977	12,000	657[45]	3%	5%
Maricopa Co. - Medicaid	18,464	9,200	5,154	28%	56%
Medicaid (SE Ongoing)	18,464	*9,200*	*607*	*3.2%*	*6.5%*
Maricopa Co. — Gen Adult Pop	5,513	2,750	475	9%	17%
Adult Gen Pop (SE Ongoing)	5,513	*2,750*	*50*	*<1%*	*2%*
Texas	231,665	104,249	4,525	2%	4%
Harris County[46]	64,000	28,800	1,287	2%	4%
New York	411,561	185,202	1,634	<1%	1%
Colorado	54,114	24,351	3,182	6%	13%

[42] Please note that we do not have good estimates of the percentage of people in need of Supported Housing and, for this reason, we do not embellish on the data provided above, in which we compare basic penetration rates for all three core EBPs – ACT, SE, and SH.

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

[44] National and State-level penetration supported employment counts are reported from the SAHMSA. (2013). Mental Health NOMS: Central Mental Health Services Uniform Reporting System. Retrieved from http://www.samhsa.gov/data/us_map?map=1.

[45] Analysis only includes ongoing support to maintain employment and excludes pre-job training and development.

[46] County data is only based on LMHA service data.

Supported Employment Utilization Relative to Estimated Need Among People with SMI					
Region	SMI Pop. Served	Estimated Need SE[43]	SE Received[44]	SE Penetration	
				All SMI Served	Need SE
Denver County (MHCD)[47]	8,000	3,600	680	9%	19%
Nebraska	13,848	6,232	497	4%	8%
Omaha (Region 6)[48]	9158	4,121	260	3%	6%
California	385,360	173,412	893	<1%	1%
Illinois	96,259	43,317	1,001	1%	2%
Kansas	17,040	7,668	1,382	8%	18%
Minnesota	93,609	42,124	2,233	2%	5%
Wisconsin	41,427	18,642	647	2%	3%
Tennessee	128,378	57,770	238	<0%	<0%
Indiana	68,785	30,953	1,131	2%	4%
Delaware	6,068	2,731	43	1%	2%
New Hampshire	10,976	4,939	1,244	11%	25%
North Carolina	109,477	49,264	N/A	N/A	N/A

[47] Roy Starks & Kristi Mock. (2014). Key Informant Interview.

[48] Triwest Group. (2014). *Omaha Area Adult Mental Health System Assessment: Final Summary of Findings and Recommendations*. (Study Conducted for the Behavioral Health Foundation.) Unpublished Manuscript. Boulder, CO: TriWest Group.

Peer Support Benchmarks

Maricopa County excels in making peer support services available to persons in need. The penetration rate in 2014, while down somewhat from 2013, is still relatively high. The Omaha area of Nebraska does provide a "best practice" benchmark, in terms of access (we cannot make a determination about quality, given the data available), and the current penetration rate in Maricopa County could be seen as a strength upon which to develop even more opportunities for people to receive peer support.

Peer Support Penetration Rates — 2014		
Region	**PS Received**	**PS Penetration Rate**
Arizona		
Maricopa County (Total) - 2014	7,522	31%
Maricopa County (Total) - 2013	8,385	41%
Texas		
Harris County[49]	600	4%
Nebraska		
Region 6 (Omaha)	3,957	43%
Colorado		
Denver City-County	150	2%

[49] A rough estimate of 50 people served per Peer Support worker, per year, based on 12 Peer Specialists reported by MHMRA of Harris County as on staff, December 2014. (Personal communication with MHMRA of Harris County, December, 2014). Denominator is number of people with SMI served by MHMRA of Harris County in FY 2014 (16,359).

Service Expansions — Comparison of Select States

A comparative analysis was performed with selected states and included a review of negotiated agreements to increase capacity and services to populations of persons identified to have serious and persistent mental illness. This year's analysis included interviews with state staff tasked to oversee the implementation of the respective settlement agreements. The information shared provided an informative backdrop to the opportunities and challenges each state experienced with their settlement agreement implementation. Each state reviewed has proposed service expansions for one or more of the prioritized services. The review supports a comparison of other states with Maricopa County's agreement to expand service capacity. States reviewed included Delaware, New Hampshire, and North Carolina as each state has recently negotiated settlements that include many of the same priority services for comparable disability populations.

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

ACT Team Services

At the conclusion of the service expansion agreement in FY 2017, Maricopa County will have 28 ACT teams capable of serving 2,800 recipients. Based on current enrollment, 11.6% of recipients will be engaged with ACT team services. This rate compares to 13.3% in Delaware, 12.5% in North Carolina, and 10.1% in New Hampshire at the time each respective agreement is finalized.[50]

Achieving the milestones for ACT team services appears to be the area in which each of the state's report the most success. Delaware and North Carolina have both met their settlement agreement benchmarks for ACT team services for 2014 and 2015. New Hampshire met their 2014 benchmark for 11 statewide ACT teams and Maricopa County is on track to meet the established benchmark for the number of ACT teams.

Supported Housing Services

Maricopa County will expand supportive housing services to serve an additional 1,500 recipients by FY 2017. The increase represents added capacity of 6.2% when based on the current enrolled population.

In comparison, Delaware's agreement calls for added capacity of 7.8% (by 2015); North Carolina will add capacity of 7.5% based on the reported enrolled population (by 2020); and New Hampshire will add capacity of 4%. All three states met their 2014 targets for supported housing services and Maricopa County appears to be on track to meet negotiated expansion goals for supported housing services.

[50] These penetration rate estimates were not included in the benchmarking analysis because they represent future, projected penetration rates.

Supported Employment Services

Maricopa County will expand supported employment services to 1,250 additional recipients by FY 2017. The increase represents added capacity of 5.2% based on the current enrolled population.

In comparison, Delaware's agreement calls for added capacity of 4.8%; North Carolina's agreement will result in increased capacity of 6.2%; and New Hampshire will increase capacity of supported employment services resulting in an overall penetration rate of 18.6%. This service was reported as the one that presented the most challenges for the states. Reported challenges include how to allocate funding and ensuring fidelity to the supported employment model.

Peer Support Services and Family Support Services

Maricopa County's' agreement, based on last year's member enrollment, would result in an increase of 7.4% in peer and family support service capacity.

Delaware is committing to an increased capacity of 12.1%; North Carolina's and New Hampshire's agreements do not specify how much peer and family support services capacity will be added. Delaware reports meeting compliance for peer and family support services expansion and Maricopa County is adding capacity consistent with agreed expansion rates.

Based on the comparative analysis, Maricopa County's plan for expanded services appears to be consistent with the selected states reviewed. See the table below for a summary of each state's plan and updated status to expand services.

State	Enrollment	Timelines	ACT	Supported Housing	Supported Employment	Peer and Family Support Services
Arizona[51]						
		FYs 2015-2016 (2014-2016)	8 teams (some specailty)	Services for 1,200 class members	Services for 750 Class Members	Services for 1,500 Class Members
		FY 2017 (2016-2017)	5 teams (some specialty)	Services for 300 more Class Members	Services for 500 Class Members	NA
Updated 2015	23,167[52]		As of January 2015: Six ACT teams (Three Specialty) 1,526 Class Members[53] served	815[54]	4,763[55]	7,522[56]
Delaware[57]						
		FY 2014	Add 1 additional team	Vouchers/Subsidies/Bridge Funding to 550 Individuals	Supported Employment Up to Additional 300 Individuals/Year	Provide Family or Peer Support to 250 Additional Individuals/Year

[51] Stipulation agreement January 8, 2014

[52] Arizona Department of Health Services/Behavioral Health Services, *MMIC Enrolled Episode of Care March 2015 Penetration Report*.

[53] Class member assigned to MMIC ACT Roster as of January 1, 2015

[54] CY 2014 ADHS/DBHS Service utilization data Medicaid Title 19 recipients and Non 19 recipients

[55] Ibid.

[56] Ibid.

[57] Settlement agreement July 6, 2011.

State	Enrollment	Timelines	ACT	Supported Housing	Supported Employment	Peer and Family Support Services
		FY 2015	Add 1 additional team	Vouchers/Subsidies/Bridge Funding to 650 Individuals	Supported Employment Up to Additional 400 Individuals/Year	Provide Family or Peer Support to 250 Additional Individuals/Year
		FY 2016	NA	State Will Provide Vouchers/Subsidies/Bridge Funding to Anyone in the Target Population Who Needs this Support	NA	NA
Updated 2015[58]	11,131[59]		16 ACT teams	550+ Individuals	396 Individuals	1000 individuals
New Hampshire[60]						
		June 2014	Each Mental Health Region has an ACT Team	240 Supported Housing Units	Increase Penetration Rate by 2% over 2012 Penetration Rate of 12.1 to 14.1%	Maintain Family Support Services Consistent with the Agreement. Have a System of Peer Support Services Offered Through Peer Support Centers Open a Minimum of 8 Hours Per Day for 5.5 Days Per Week in Each Mental Health Region of the State

[58] March 26, 2015 interview with Carlyle F.H. Hoof, Coordinator USDOJ Settlement Agreement, Director Behavioral Health Community Integration – Housing, DSAMH

[59] Fifth report of Court Monitor on Progress Toward Compliance with the Agreement: U.S. v. State of Delaware, U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS, May 19, 2014, page 7.

[60] Settlement Agreement December 19, 2013.

State	Enrollment	Timelines	ACT	Supported Housing	Supported Employment	Peer and Family Support Services
		October 2014	All 11 ACT Teams Operate Within the Standards of the Settlement	December 2014 Additional 50 Housing Units Total = 290	All Individuals Receiving ACT will have Access to Supported Employment from Employment Specialist on their ACT Team	
		June 2015	Serve at Least 1,300 of the Target Population	50 Additional for a Total of 340	Increase Penetration to 2% to 16.1%	
		June 2016 Serve Additional 200 People for Capacity to 1,500		Additional 110 Total of 450	Increase 2% to 18.1%	
				Additional 150 for a Total of 600	Increase 5% to 18.6% Maintain a List of Individuals with SMI who Would Benefit from Supported Employment Services but for Whom it is Not Available	
Updated 2015[61]	10,952[62]		11 teams throughout state's ten CMHC regions, serving a total of 641 individuals[63]	As of October 2014, there are 225 people in leased or approved for bridge subsidy housing[64]	Average penetration rate across 10 CMHC regions reported to be 12.7%.[65]	Reported to have maintaining capacity as specified in the settlement agreement, with an estimated 44 hours/week available to members.[66]

[61] February 11, 2015 interview with Raymond S. Perry, Jr., Esq., Director, Office of Client and Legal Services, Legal Counsel Bureau of Behavioral Health, New Hampshire Department of Health and Human Services.

[62] Ibid.

North Carolina[67]						
		July 2014	Increase to 34 Teams Serving 3,467 Individuals	150 Additional	Provide Supported Employment to Total of 250 Individuals	Not specified
		July 2015	Increase to 37 Teams Serving 3,727 Individuals	At Least 708 Individuals	Provide Supported Employment to a Total of 708 Individuals	
		July 2016	Increase to 40 Teams Serving 4,006 Individuals	At Least 1,166 Individuals	Provide Supported Employment to a Total of 1,166 Individuals	
		July 2017-2020	Increases incrementally for a total of 10 additional teams serving an additional 994 individuals	At least an additonal 1,834 individiuals	Provide to a total of 1,334 additional individuals	
Updated 2015[68]	108,490[69]		67 teams serving 4609 Individuals[70]	254 Individuals[71]	98	

[63] http://www.samhsa.gov/data/sites/default/files/URSTables2013/NewHampshire.pdf, *2013 CMHS Uniform Reporting System (URS) Output tables* ***Access Domain: Adults with SMI and Children with SED Served in Community Mental Health Programs by Age and Gender, FY 2013****,Demographics Age 18-65+ only, page 8.*

[64] New Hampshire Community Mental Health Agreement: Expert Reviewer Report Number One, December 26, 2014.

[65] Ibid.

[66] Ibid.

[67] February 26, 2014, Interview with Jessica Keith, Special Advisor on ADA.

[68] Ibid.

[69] Ibid.

[70] Ibid.

[71] Ibid.

Consumer Operated Services

Multi-Evaluation Component Analysis

Service Descriptions:

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

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

Focus Groups

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

- Efforts continue to increase the number of peers employed by the system. Participants reported that many peer support specialists and peers work in non-peer roles (e.g., case manager).
- Despite increases across the delivery system, participants reported that capacity of peer support specialists located within the direct care clinics remains insufficient to meet demand.
- Similar to findings last year, focus group participants reported that the direct care clinical teams do not consistently apply peer support services in a recovery-based manner. Rather, peer support is often manifested as a group, class or social activity that is led by a peer and does not include recovery-oriented coaching or modeling. Peer support specialists located within the direct care clinics spend a majority of their time facilitating groups rather than delivering 1:1 peer support services.
- Peer support specialists that participated in the focus group expressed frustration that they continue to be utilized in case management roles.
- One peer support specialist stated "Our system does not allow us to develop a person-centered service plan. The service plan is tailored to system requirements, not the person".
- Peer support specialists reported that they were recently made aware of a distinct peer support billing code and had previously been documenting interactions with members using the case management billing procedure code.
- Participants shared that oversight of peer support training and certification processes needs to be established due to varying applications of the expectations across the system.

Consumer Operated Services

- A new barrier reported this year is the cumbersome referral process to access a community-based peer support provider. Focus group participants reported that the intake referral packet requires too much documentation and duplicates information already available to the provider. Even when a member is currently receiving services at an agency, clinical teams must re-submit the entire referral packet when requesting additional services at the same agency.
- As with most of the priority mental health services, peer support agencies also require the ISP to explicitly identify the rendering provider on the ISP. This is no longer true, but the misperception persists despite communication from the regional behavioral health authority that it is no longer required to list specific providers, just the services.
- Participants reported that family mentors located at the direct care clinics help families navigate the system and often provide the guidance that they feel the clinical teams are unable to provide.
- Family members report that helping families navigate the behavioral health system continues to be an unmet need. Similarly, as reported with peer support services, many focus group participants noted that family support specialists and family mentors are often involved in facilitating groups rather than providing 1:1 support to family members.
- Family members continue to experience barriers with the interpretation of information sharing requirements by the direct care clinical teams, leading to their exclusion from service planning development activities.
- Participants representing the consumer and family member focus groups reported that many of the direct care clinic staff genuinely cares about the members being served in the system.

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.

Most respondents felt that peer support services were easier or easy to access (78%) as opposed to difficult to access or having no ability to access (17%). Consistent with last year, peer support services were perceived as the easiest of the priority services to access.

39% of survey respondents felt that family support services were difficult to access or were inaccessible while over half (56%) of the respondents indicated that family support services were easier to access or easy to access.

Overall, perceptions regarding the ease of accessing peer support and family support services increased during CY2014.

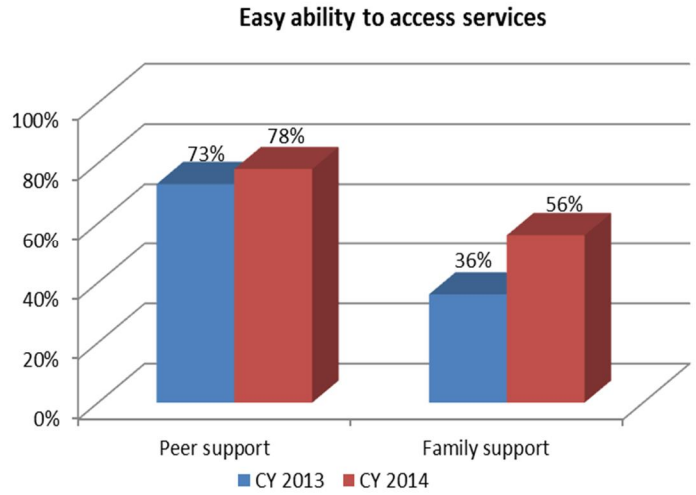
Consumer Operated Services

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

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

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

- Clinical team unable to engage/contact member.
- Lack of capacity/no service provider available.
- Transportation barriers.



Consumer Operated Services

In terms of service utilization, 76% (up almost 10% from CY2013) of the responses indicated that peer support services were being utilized effectively or were utilized effectively most of the time. 13% of respondents indicated that the peer support services were not utilized effectively (less than the 33% reported during CY2013).

69% of the responses indicated that family support services were being utilized effectively or were utilized effectively most of the time (up from 50% during CY2013). Alternatively, 19% of the responses indicated that family support services were not utilized effectively (50% of respondents reported that family support services were not utilized effectively during CY2013).

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

- 75% of the survey respondents perceived that peer support services could be accessed within 30 days of the identification of the service need. This finding compares to 70% during CY2013.
- 69% of the survey respondents perceived that family support services could be accessed within 30 days of the identification of service need. This finding compares to 33% during CY2013.
- 13% reported it taking four to six weeks to access peer support services following the identification of need (20% — CY2013).
- Eight percent reported it taking four to six weeks to access family support services following the identification of need (44% — CY2013).
- 13% of the survey respondents reported that it would take an average of six weeks or longer to access peer support services (10% — CY2013).
- 23% of the survey respondents reported that it would take an average of six weeks or longer to access family support services (22% — CY2013).

Medical Record Reviews Group 1

A random sample of 124 recipients was identified to support an analysis of assessment and service planning documentation. The review evaluated how well the clinical teams were identifying needs for peer support services and family support services. When identified as needed service to benefit the recipient, information was reviewed to determine if the need was translated to the recipient's ISP and identified as a specific intervention. A subgroup of the sample was subsequently interviewed to collect information regarding their perceived needs for the same services.

A review of medical record documentation revealed that the clinical teams are regularly assessing the recipient's need and desire for social and community integration. This finding continues to represent the strength in the current system and establishes the ability to identify opportunities to apply targeted interventions to address identified needs, such as peer support services.

Consumer Operated Services

However, only 17% of the cases explicitly identified peer support as a need. Further, even when assessed as a need, peer support services were identified on the recipient's ISP only 14% of the time.

It was noted that some of the assessments reviewed included an identified need for peer support but had corresponding ISPs that did not include services to address the specified need. When needs are identified through the assessment process, there should be a specific intervention identified on the ISP to address those needs.

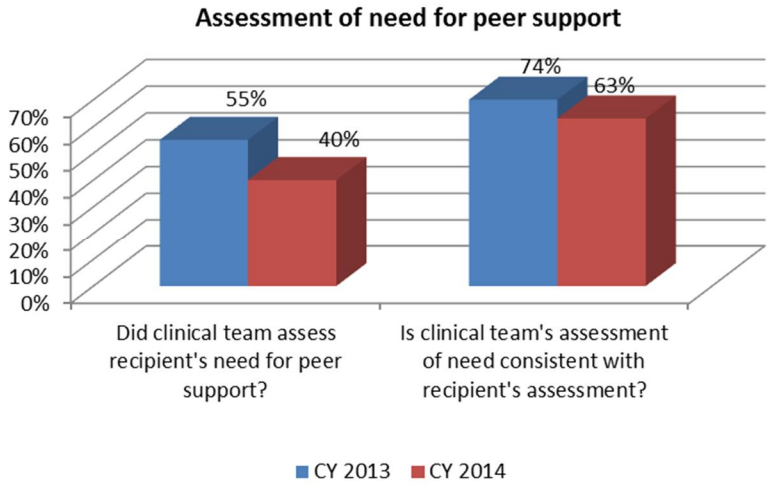
29% of the Group 1 recipients received at least one unit of peer support services during CY 2014.

Interviews

Ninety Group 1 recipients agreed to and participated in an interview regarding the prioritized mental health services.

The interview asked the following:

- Did the clinical team assess the recipient's need for peer support services? Less than half of the respondents indicated that the clinical team had discussed peer support service opportunities.
- Is the clinical team's assessment consistent with the recipient's perception regarding the need for one or more of the priority mental health services? In a majority of the cases (63%), the clinical team's determination of need matched the recipient's perception of need.



Consumer Operated Services

Family Support Services

The clinical teams continue to consistently identify and document natural and family supports that are important to the recipient. 85% of the records found evidence that natural and family supports were assessed by the clinical team. Family support services can be an appropriate service for family members to develop skills to effectively interact and support the person in the home and community. Despite the clinical team's identification of natural and family supports, ISPs rarely included family support services.

The low percentage of cases in which family support services were identified as an ISP service suggests that opportunities continue to be missed. Consistent with findings during CY2013, opportunities exist to leverage family support services to support recipients in achieving their ISP goals.

Less than 10% of the assessments reviewed identified a related need for family support services. In these cases, none of the ISPs explicitly identified family support services as an intervention to address the need.

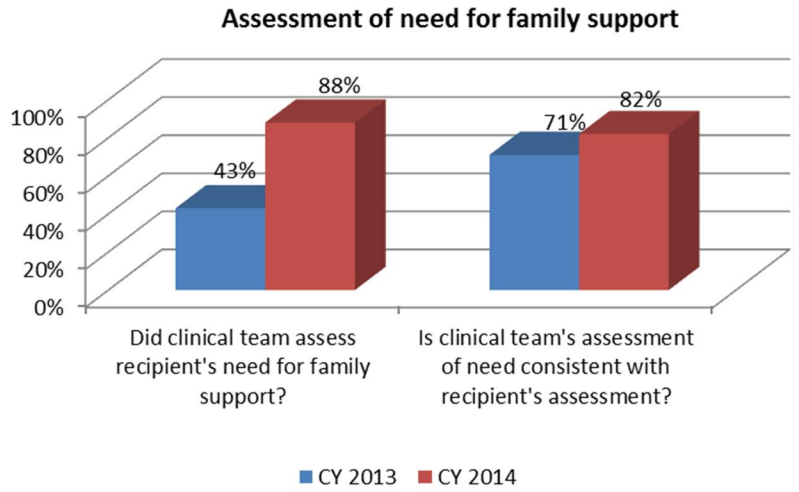
Only 2% of the Group 1 recipients received at least one unit of family support services during CY 2014.

Interviews

Ninety Group 1 recipients agreed to and participated in an interview regarding the prioritized mental health services.

The interview asked the following:

- Did the clinical team assess the recipient's and family's need for family support services? A large majority of the respondents recalled discussing the service with the clinical team.
- The clinical team's assessment was found to be consistent with the recipient's perception regarding the need for family support services in 82% of the applicable cases.



Medical Record Reviews: Group 2

A random sample of 197 SMI recipients' medical record documentation was reviewed to assess the consistency in which peer support services and family support services were assessed by the clinical team, identified as a needed service to support the recipient, and included as part of the ISP.

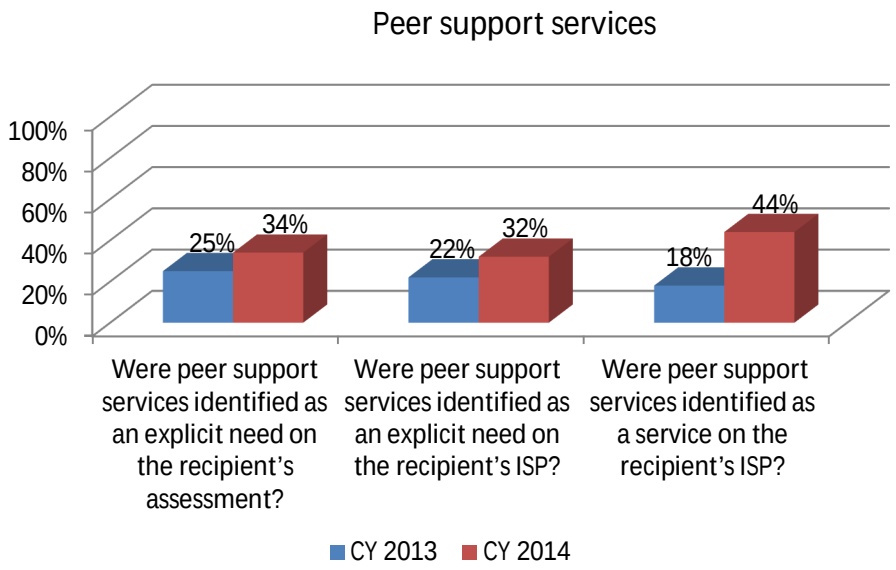
Consumer Operated Services

Overall, clinical teams did not consistently recognize opportunities to utilize peer support services as an intervention during the service planning process.

44% of the ISPs included peer support services when assessed as a need. Documentation in many of these cases identified needs for the recipient to attend direct care clinic peer-led groups.

30% of the recipients included in the sample received at least one unit of peer support during CY 2014. Many recipients who had needs for socialization were referred to peer-led socialization and recreational activities.

Consistent with findings during CY2013, rarely did the documentation of peer support services include awareness of coaching and modeling recovery-oriented attitudes, beliefs, motivations, and behaviors.



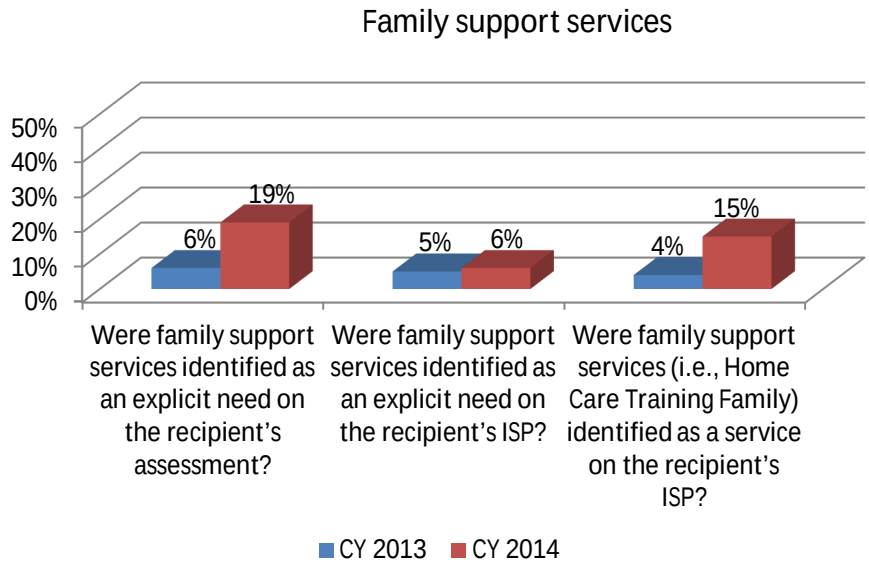
Consumer Operated Services

In 18 cases, 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;
- Billing/service description errors (medical record documentation described alternative services such as case management services);
- The member was hospitalized; and
- The member declined to attend the service.

Family Support Services

As part of the clinical assessment process, information is routinely collected and documented by the clinical team regarding the natural and family supports available and important to the recipient. However, this information was rarely characterized as an assessed need for family support services and was infrequently utilized as part of service planning development. Similar to observations last year, missed opportunities to leverage family members were noted when the clinical team identified challenges with engaging members and ensuring follow up with treatment recommendations.



15% of the ISPs included family support services when identified as a need as part of the recipient's assessment, a significant improvement when compared to CY 2013. Examples in which the review team determined that a need for family support services existed included circumstances in which the recipient had explicitly expressed a desire for a family member to be involved in treatment and/or clinical team documentation was present that identified a need for the recipient to seek support and/or engage with involved family members.

Only 3% of the recipients included in the sample received at least one unit of family support during CY 2014.

- In three cases the person was unable to access family support services after the service was recommended by the clinical team. Reviewers were able to review progress notes and determined that the clinical team did not follow up with initiating a referral for the service.

Consumer Operated Services

Service Utilization Data

During the time period of October 1, 2013 through June 30, 2014, 23,977 unique users were represented in the service utilization data file. Of those, 77% were Medicaid eligible and 23% were non-Title XIX eligible.

- Overall, 31% of the recipients received at least one unit of peer support services during the time period (33% over a comparable time period last year).

Access to the service was split between Title XIX (32%) and non-Title XIX groups (26%). As reported last year, many of the PNOs have adopted administrative policies that result in the assignment of a peer support specialist (in lieu of a case manager) to a non-Title XIX eligible recipient who is assigned to a connective level of case management. This practice may explain the relatively equal access to peer support services across eligibility groups.

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

- Fifty one percent of members who received at least one unit of peer support during the review period accessed the service during a single month.
- Sixteen percent of members received peer support services for three to four consecutive months during the review period and almost 6% received the service for nine consecutive months.

**Persistence in Peer Support Services
October 2013 — June 2014**

Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	48.2%	62.0%	50.9%
2	17.6%	16.1%	17.3%
3–4	16.5%	14.7%	16.1%
5–6	7.7%	4.1%	7.0%
7–8	3.6%	1.3%	3.2%
9	6.4%	1.8%	5.5%

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

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

- Overall, 2.2% of the recipients received at least one unit of family support services during the time period (1.4% over a comparable time period last year).

Access to the service was unevenly split between Title XIX (2.5%) and non-Title XIX groups (1.2%).

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

Consumer Operated Services

- 77% of the members who received at least one unit of family support during the review period accessed the service during a single month.
- 6% of the members received family support services for three to four consecutive months during the review period and 1.5% received the service for seven to eight consecutive months.

Persistence in Family Support Services
October 2013 — June 2014

Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	77.3%	76.6%	77.2%
2	10.8%	15.6%	11.4%
3–4	6.2%	6.3%	6.2%
5–6	3.3%	0.0%	2.9%
7–8	1.5%	1.6%	1.5%
9	0.9%	0.0%	0.8%

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

Key Findings and Recommendations

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

Findings: Peer Support

- Efforts continue to increase the number of peers employed within and outside the system. Community-based providers are utilizing peers in expanded roles, such as health and wellness coaches, serving as crisis navigators and engaging the chronically homeless via co-location at homeless shelters.
- Similar to findings last year, peer support services provided in the direct care clinics are often manifested as a group, class or social activity that is facilitated by a peer. Many members who had needs for socialization were referred to peer-led socialization and recreational activities. Rarely did the direct care clinic documentation of peer support services include awareness of coaching and modeling recovery-oriented attitudes, beliefs, motivations and behaviors.
- It was noted that some of the assessments reviewed included an identified need for peer support but had corresponding ISPs that did not include services to address the specified need.
- In one case reviewed, the direct care clinic progress notes included documentation that the member's transportation to the clinic was contingent on the member attending a specified number of socialization and education groups at the clinic during a given month.
- Rarely do the direct care clinic teams consider the value of peer support in engaging members and inspiring an attitude of recovery during service planning development. Alternately, there is an over-emphasis on the indiscriminate promotion of social groups hosted at the clinics (e.g., Karaoke Group).
- Service utilization data demonstrates a reduction in the percentage of members who received at least one unit of peer support services over the respective review periods (CY2013 — 38%; CY2014 — 31%).
- Peer support and family support expansion efforts are in process with a goal of added capacity to serve an additional 750 members by June 30, 2015.

Consumer Operated Services

Findings: Family Support

- Family members reported that support to families to help navigate the behavioral health system continues to be an unmet need. Many focus group participants noted that family support specialists and family mentors are often involved in facilitating groups rather than providing 1:1 support to family members.
- Family members continue to experience barriers with the interpretation of information sharing requirements by the direct care clinical teams, leading to their exclusion from service planning development activities.
- 69% of the key informant survey respondents perceived that family support services could be accessed within 30 days of the identification of need. This finding compares to only 33% during CY2013.
- 85% of the records found evidence that natural and family supports were assessed by the clinical team. However, ISPs rarely included family support services.
- Family mentors are available on some of the clinical teams at most of the direct care clinics. However, caseload ratios were reported as high as 1:1,200 and the role of the family mentor lacks clarity and consistency. For example, documentation in the direct care clinic records demonstrated that some family mentors were tasked with arranging members' transportation to the clinic and completing appointment reminder calls.
- One community-based provider has recently implemented a psychosocial education program offering family members relevant information about the service delivery system (e.g., how family members can assist their loved ones during crisis events).
- The Maricopa County RBHA is completing work on a family resource manual that addresses the facilitation of family support groups, training regarding family engagement and guidelines about information sharing rules and requirements.
- Service utilization data demonstrates minor differences in the percentage of members who received at least one unit of family support services over the respective review periods (CY2013 — 2%; CY2014 — 3%).

Recommendations: Peer Support

- Ensure that the assessment of and progress with recovery-oriented needs and goals is consistently documented in the record. Promote awareness and skill development through training and monitor expectations via ongoing supervision.
- Provide additional training and supervision to recognize the value of peer support services and family support services as effective service plan interventions.(similar recommendation from last year)
- Most peer support provided within the direct care clinics appears to occur within the context of group settings; attempts should be made to balance the delivery with individualized peer support (current approach within the direct care clinics does not consistently promote individual relationship and trust building).(same recommendation from last year)

Recommendations: Family Support

- Rather than just identifying family supports available to the recipient, incorporate family members into treatment plans. Establish annual training for staff and supervisors that goes beyond understanding at a conceptual level to focus on specific strategies to actively promote the availability and use of family support services. (same recommendation from last year)
- Clarify and standardize the roles and expectations of family mentors assigned to the direct care clinics with an emphasis on connecting family members to needed supports and education.

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:

- Participants identified an increased commitment for supported employment services as evidenced by an improved administrative rehabilitation team implemented by the new regional behavioral health authority. This was viewed as a positive change from last year.
- Participants reported that there is value in having co-located supported employment providers available at the direct care clinics. However, others indicated that the clinical teams create barriers for providers such as requiring additional authorizations to release information. Other direct care clinic staff report that their clinics do not have co-located vocational rehabilitation counselors and this is an ongoing concern.
- Participants indicated that there are still wait lists to access vocational rehabilitation services and that physicians working on behalf of vocational rehabilitation deny members by deeming them too disabled to work. Denials for vocational rehabilitation services outweigh the number of successful referrals.
- Challenges include inconsistent messaging between the RBHA, PNOs and direct care clinics regarding policies for referring and obtaining supported employment services. For example, there is perceived miscommunication regarding the requirement to list a rendering provider's name on members' individual service plans. This can result in barriers to timely access to needed services.
- Participants in all four focus groups expressed concern regarding effective communication with direct care clinic case managers. It is perceived that case managers are too busy managing member crisis events and meeting documentation requirements.
- Case managers are taking a more active role assisting members to access supported employment services in response to a reduction of available rehabilitation specialists at the direct care clinics.
- Similar to last year, participants were not able to articulate a consistent description of supported employment services and supports.
- Participants reported concerns that members receive limited employment options outside of peer support specialist training. Exploration of employment options needs to be expanded and should be tailored to the member's individual interests and preferences.
- Long wait lists for vocational rehabilitation services continues to be a concern.
- It was noted that some employment specialists on ACT teams primarily perform case management activities versus supported employment tasks.

Supported Employment

- Participants reported that there are not enough experts in the system helping members understand the possibilities of working while maintaining public assistance and health insurance benefits. Many more members would pursue employment if they understood that employment does not have to jeopardize their benefits.
- Focus group participants indicated that it was important for the system to do a better job of assessing an individual's employment goals and to individualize employment supports for people, rather than simply attempting to connect them with group employment opportunities involving set-aside jobs for people with serious mental illness.
- As reported last year, adults receiving behavioral health services and family members reported that some medical staff at the direct care clinics are discouraging members from pursuing employment due to their behavioral health challenges.

Key Informant Survey Data

33% of survey respondents felt that supported employment services were difficult to access, significantly less than last year when 75% felt that supported employment services were difficult to access or were inaccessible. 66% of respondents indicated that supported employment services were easy to access or easier to access.

"Employment is a process. There should be flexibility in the system to allow for exploration."

When asked about the factors that negatively impact accessing supported employment services, factors impacting access included:

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

81% of the responses indicated that supported employment services were being utilized effectively or were utilized effectively most of the time, up from 30% last year. Alternatively, 19% of respondents indicated that supported employment services were not utilized effectively.

60% of the survey respondents perceived that supported employment services could be accessed within 30 days of the identification of the service need. This compares to 22% last year. 20% of the survey respondents reported that it would take an average of six weeks or longer to access supported employment services.

Medical Record Reviews Group 1

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

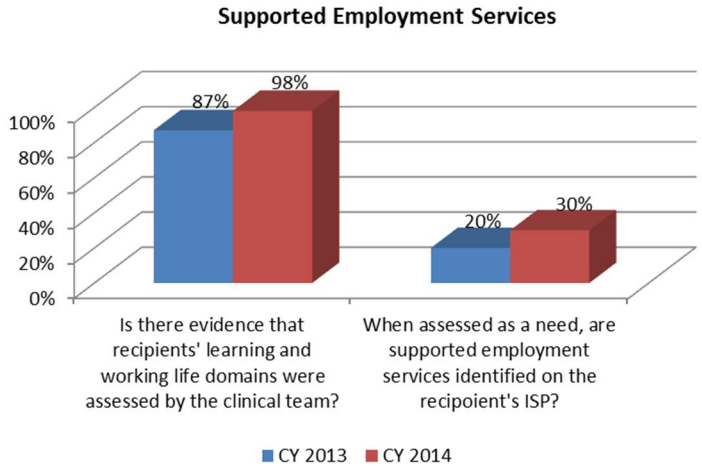
- Is there evidence that the need for supported employment services was assessed by the clinical team?

Supported Employment

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

Findings specific to supported employment services are presented below.

The medical record review determined that 98% of recipients' learning and working life domains were assessed by the clinical team.



In most cases the ISPs did not include explicit references to supported employment services. The record review found that when a work-related goal was assessed as a need, supported employment services were identified on the recipient's ISP 30% of the time. This finding represents an increase from last year when 20% of the ISPs reviewed included supported employment services.

For 43% of the assessments that included an identified need for supported employment, the ISP did not include *any* services to meet the specified need. In some cases reviewed, the direct care clinic team ISP form included data fields that were incomplete (e.g., specific services and frequency). In other cases, the ISP would limit services to only those directly available via the direct care clinic (e.g., case management, medication management, nursing services).

Only 10% of the Group 1 recipients received at least one unit of supported employment services during CY2014.

Interviews
The interview revealed the following findings:

Supported Employment

- A majority (95%) of the interview respondents concurred that there was an assessment regarding supported employment needs and available services.
- In 68% of the cases, the clinical team's assessment of need for supported employment services was consistent with the recipient's perception.

Medical Record Reviews: Group 2

The results of the medical record review for Group 2 showed that supported employment services were identified as an explicit need on either the recipient's assessment or ISP in slightly less than half the cases reviewed (48%). However, supported employment services were only identified as a service on the recipient's ISP in 26% of the cases reviewed when assessed as a need. (The CY 2013 finding was 13%).

When expanding the potential services and considering ISPs that included supported employment services and/or skills training and development services, it increased the finding to 41%.

18% of the recipients included in the sample received at least one unit of supported employment during CY 2014.

In 44 cases, reviewers were able to review progress notes and record the reasons that the person was unable to access supported employment services after a supported employment need was identified by the clinical team. The most common reason was a lack of evidence that the clinical team followed up with initiating a referral for the service.

Service Utilization Data

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

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

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

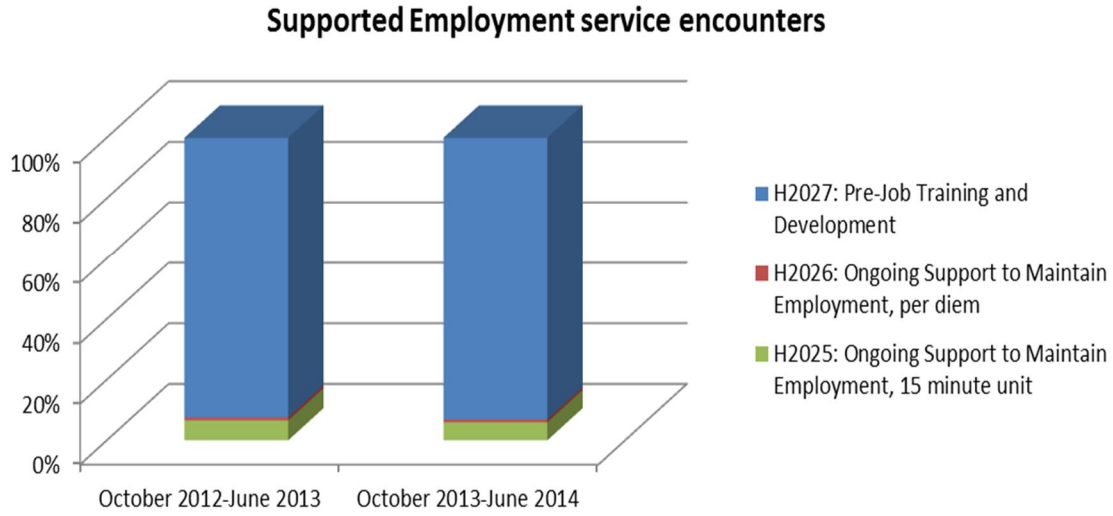
Supported Employment

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

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

Supported Employment

Similar to last year, the service utilization data set demonstrates significant variation in the volume of the three available service codes for supported employment. For the time period October 1, 2013 through June 30, 2014, H2027 (pre-job training and development) accounts for 94% of the total supported employment services. H2025 (ongoing support to maintain employment/15 minute billing unit) represents slightly less than 7% of the supported employment utilization. Finally, H2026 (ongoing support to maintain employment/per diem billing unit) represents less than 1% of the utilization of supported employment. This finding illustrates that the emphasis with the delivery of supported employment is still directed to pre-job training and development and that very few individuals receive ongoing support to maintain employment, such as connections to employment/job coaches. This finding also suggests that there may continue to be a lack of available providers and/or programs that deliver supported employment programming designed to engage recipients in intensive supports throughout the work day (per diem code) to ensure skill mastery and job retention and/or may be indicative of the need to educate service providers regarding the appropriate application of the available billing codes.



Supported Employment

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

- Overall, 23% of the recipients received at least one unit of supported employment during the time period.
- Access to the service was unevenly split between Title XIX (28%) and non-Title XIX groups (9%).

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

- Almost 57% of the recipients who received at least one unit of supported employment services during the review period accessed the service during a single month (this finding may be related to the disproportionate utilization of pre-job training and development);
- 13% of the recipients received supported employment services for three to four consecutive months during the review period; and
- 6% of the recipients received the service for nine consecutive months.

Persistence in Supported Employment Services
October 2013 — June 2014

Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	56.6%	56.0%	56.6%
2	15.2%	17.3%	15.4%
3–4	12.4%	16.2%	12.7%
5–6	6.2%	4.8%	6.1%
7–8	2.9%	1.5%	2.8%
9	6.6%	4.2%	6.4%

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

- Focus group participants reported that there is value in having co-located supported employment providers available at the direct care clinics. However, others indicated that the clinical team can sometimes create barriers for providers such as requiring additional authorizations to release information. Other direct care clinic staff report that their clinics do not have co-located vocational rehabilitation counselors and this is an ongoing concern.
- Per focus group participants, challenges included inconsistent messaging between the RBHA, PNOs, and direct care clinics regarding policies for referring and obtaining supported employment services. For example, there is a perceived miscommunication regarding the requirement to list a rendering provider's name on the member's direct care clinic ISP. This can result in barriers to timely access to needed services.
- 33% of key informant survey respondents felt that supported employment services were difficult to access, significantly less than last year when 75% felt that supported employment services were difficult to access or were inaccessible.
- 60% of the key informant survey respondents perceived that supported employment services could be accessed within 30 days of the identification of the service need. This compares to only 22% last year.

Supported Employment

- Thirty-seven of the one hundred twenty-four cases (30%) indicated that supported employment services were identified as a need by the clinical team. However, the ISPs did not consistently include supported employment services to meet the assessed need.
- For 43% of the assessments that included an identified need for supported employment, the ISP did not include any services to meet the specified need. In some cases reviewed, the direct care clinic team ISP form included data fields that were incomplete (e.g., specific services and frequency). In other cases, the ISP would limit services listed on the ISP to only those directly available via the direct care clinic (e.g., case management, medication management, and nursing services).
- Reviewers were able to review progress notes and record the reasons that the person was unable to access supported employment services after a supported employment need was identified by the clinical team. The most common reason was a lack of evidence that the clinical team followed up with initiating a referral for the service.
- Similar to last year, the service utilization data set demonstrates significant variation in the volume of the three available service codes for supported employment. For the time period October 1, 2013 through June 30, 2014, H2027 (pre-job training and development) accounts for 94% of the total supported employment services.
- Collaboration between the Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR) and community-based supported employment providers is insufficient due to staffing shortages at RSA/VR.
- Community-based supported employment providers have expanded potential career tracts through partnerships with local businesses. Members seeking employment now have more options such as operating a bistro within a community hospital, working as chefs in local restaurants and performing jobs at super markets and pharmacy outlets.
- When engaged in supported employment services, community-based supported employment providers may send monthly progress updates to the direct care clinics. It is unclear how or if this information is utilized by the direct care clinical teams. A review of 197 direct care clinic records and associated progress notes revealed only a few references to the status of services received outside of the clinic.
- Direct care clinics now have co-located community-based supported employment providers available on designated days of the week.
- The RBHA is currently evaluating the role and responsibilities of the rehabilitation specialist found in many of the direct care clinics.
- Service utilization data demonstrates a significant reduction in the percentage of members who received at least one unit of supported employment over the respective review periods (CY2013 – 39%; CY2014 – 20%). The observed reduction in utilization may be attributed, in part, to an emphasis on the delivery of comprehensive and evidence-based supported employment services and/or issues with accurate and complete service encounter submission and reporting.
- Supported employment expansion efforts have added capacity to serve an additional 425 members during CY2014–2015.

Supported Employment

Recommendations: Supported Employment

- Explore opportunities to expand the presence of vocational rehabilitation specialists at the direct care clinics. (same recommendation as last year)
- Continue efforts through Disability Benefits 101-Arizona to meet workforce development needs, link recipients to resources knowledgeable regarding accessing public assistance (e.g., disability compensation, health insurance) and review potential implications of additional income related to employment. Examine the feasibility of utilizing peer support specialists in these roles. (same recommendation as last year)
- Through training and supervision, ensure that clinical team members recognize the value of supported employment services in meeting a recipient's employment related goals. When assessed as a need, ensure that supported employment services are included as an intervention on the ISP. (similar recommendation last year)
- Develop and implement ongoing monitoring activities that assess the completeness and implementation of individual service plans. The ISP monitoring tools should include standards that (1) determine if assessed needs are being met through specific service plan interventions, (2) all critical ISP template data fields are complete (e.g., specific services and frequency), and (3) clinical teams follow up and ensure that recommended ISP services are made available to members within reasonable timeframes.
- Direct care clinic progress notes should be oriented to the member's current ISP goals and objectives. Progress notes should regularly reflect the status of all recommended ISP services, including noted barriers to accessing the services and the evolving needs of the member. All services and related status updates should be integrated and reviewed by the member's clinical team, including services provided outside the direct care clinic by community-based providers. Promote awareness and skill development through training and monitor expectations via ongoing supervision.
- Supported employment for ongoing support service encounters are disproportionately less than pre-job training and development. Assess the sufficiency of contracted providers to support the provision of ongoing support to maintain employment services and ensure that the appropriate billing code is being utilized by community providers when ongoing support to maintain employment is delivered. (similar recommendation last year)
- Ensure that clinical team members actively and continuously engage recipients regarding opportunities to participate in employment related supports and services. Promote awareness and skill development through training and monitor expectations via ongoing supervision. (same recommendation as last year)

Supported Employment

Case in Point: *The individual service planning and development process appears to be a static event that occurs one time per year and is not revisited until the next annual update is due.*

As part of the annual assessment update, a member's clinical team documents that the member wants to secure a part-time job. The rehabilitation specialist recommends that the member continue his job search and attend a community provider to develop employment skills and pursue employment opportunities. The member reports to his clinical team that he has been trying to find a job over the past 6 months.

As a result of the member's involvement with a community-based supported employment provider, he has attended several job interviews. In May, a representative from the supported employment provider attends a direct care clinic staffing to discuss the member's status in the program.

Supported employment services were addressed by the clinical team at time of assessment as described above. However, a review of direct care clinic progress notes for the remainder of the review period (May – December) does not include another reference to supported employment or the member's progress related to his ISP employment goal. Based on the clinical documentation, it is unclear what the member's status is with the goal of part-time employment.

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

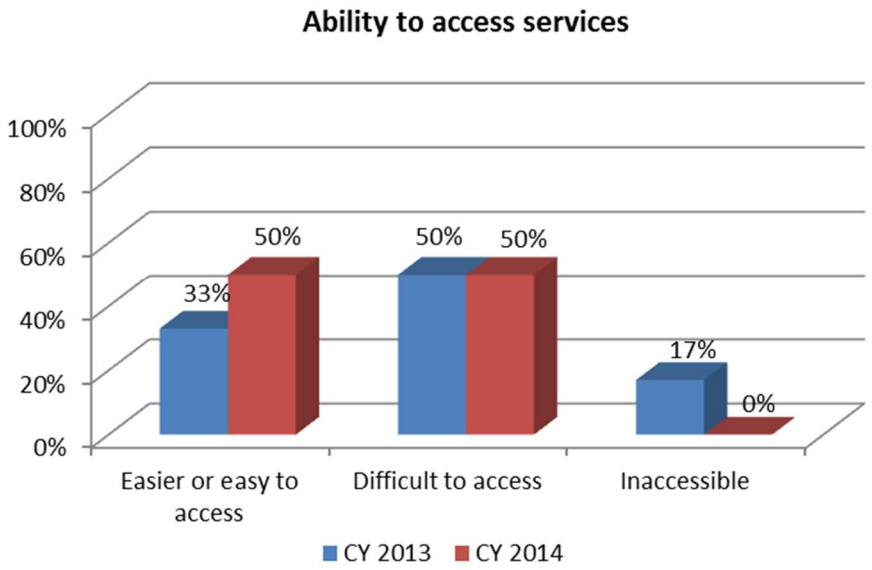
Key themes related to supported housing services included:

- Participants reported that the new RBHA increased supported housing funding for both Title XIX and Non-Title XIX eligible SMI members.
- All of the focus groups recommended the need for a less burdensome application and referral process for supported housing services. Even when a member is already receiving services through a provider agency, clinical team members must re-submit the entire referral packet when requesting additional services at the same agency.
- Participants in all four focus groups indicated a need for increased transparency of supported housing wait lists and available housing opportunities. Clinic staff and members are not able to access information about the length of waiting lists and where a member is positioned on the waiting list.
- Participants in all focus groups identified increases in scattered-site housing as a new enhancement of the service delivery system.
- Participants reported that, despite recent increases in funding, supported housing options remain limited and that admission criteria are too strict.
- The case manager focus group reported that they utilize a case management billing code when providing supported housing services to members.
- Participants reported that the high turnover rate among case management staff results in a lack of knowledge about supported housing options and resources.
- Participants reported that the RBHA offers limited training on the topic of supported housing. The lack of training has resulted in a reduced awareness, particularly for new staff, of available supported housing resources and programs.
- Similar to last year, participants reported insufficient capacity of housing units, including transitional housing for members seeking discharge for inpatient hospital settings.
- Family members expressed concern with supported housing providers that are not promoting a higher level of independence for their family members participating in supported housing programs.

Supported Housing

Key Informant Survey Data

Half of the survey respondents felt that supported housing services were difficult to access, the same finding as last year. However, none of the respondents indicated that supported housing services were inaccessible, an improvement from last year when 17% of the key informants felt the services were inaccessible.



The remaining 50% of respondents indicated that supported housing services were easier to access or easy to access. When asked about the factors that negatively impact accessing supported housing services, the responses are as follows:

- 63% of the responses indicated that a wait list exists for the service; (25% during CY2013);
- 50% of the responses were directed to a lack of capacity/no service provider available (31% during CY2013); and
- 31% percent selected admission criteria for services too restrictive (25% during CY2013).

In terms of service utilization:

- 25% of the responses indicated that the services were being utilized effectively (10% during CY2013);
- 50% responded that the services were utilized effectively most of the time (30% during CY2013); and
- 25% of the respondents indicated that supported housing services were not utilized effectively (60% during CY2013).

None of the survey respondents perceived that supported housing services could be accessed within 30 days of the identification of the service need (11% during CY2013). In fact, none of the respondents indicated that the service could be accessed on average within four to six weeks (22% during CY2013). 92% of the survey respondents reported that it would take an average of six weeks or longer to access supported housing services (67% during CY2013).

Supported Housing

Medical Record Reviews: Group 1

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

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

Findings specific to supported housing services are presented below.

- The medical record review looked for evidence that the recipients were in need of supported housing services. 48 cases or 39% of the sample demonstrated an assessed need for supported housing.

Most of the ISPs reviewed did not include explicit references to supported housing services.

- When assessed as a need, supported housing services were identified on the recipient's ISP in 19%* of the records (20% during CY2013). **None of the recipient's ISPs included supported housing as a distinct service. The ISPs included subsidized living arrangements, case management and/or flex funds.*

For 48% of the assessments that included an identified need for supported housing, the ISP did not include *any* services to meet the specified need (down from 59% during CY2013). 2% of the Group 1 recipients received at least one unit of supported housing services during CY 2014 as measured by the presence of service code H0043.

Interviews

Ninety Group 1 recipients agreed to and participated in an interview regarding the prioritized mental health services.

The interview revealed the following:

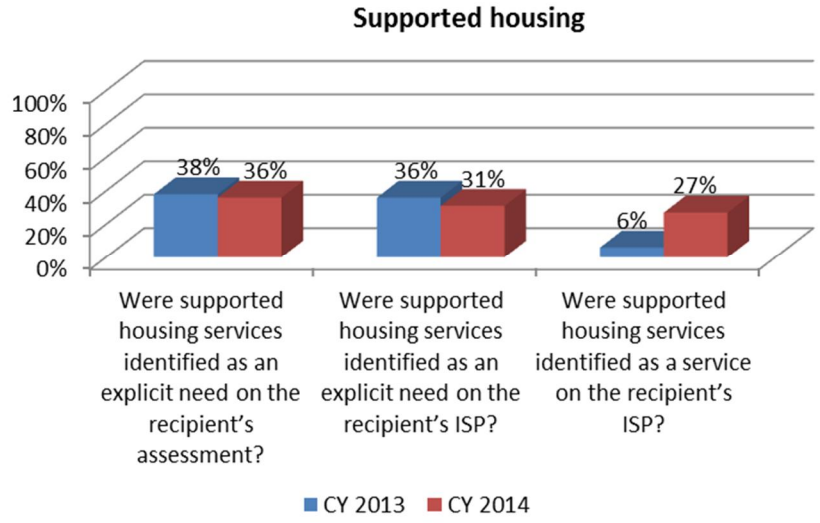
- A majority (91%) of the recipients interviewed reported that the clinical team did discuss housing related needs and services.
- There was not always agreement between the clinical team's identification of need and the recipient's perception of need for supported housing services. Disagreement between the clinical team's assessment and the recipient's perception of need was found in 44% of the cases reviewed (up slightly from 41% during CY2013).

Supported Housing

Medical Record Reviews: Group 2

Consistent with CY2013, in all cases reviewed, the recipient's living situation was assessed and documented and, in most cases, included the recipient's expressed preferences related to housing.

- Supported housing services were identified as a need on either the recipient's assessment or recipient's ISP in approximately one-third of the cases reviewed.
- Supported housing was identified as a service on the recipient's ISP in 27% of the cases. (up substantially from last year when only 6% of the ISPs included supported housing)



It should be noted that the ISPs that included supported housing services predominantly described the service as subsidized housing, case management or flex funds. Only five ISPs in the sample explicitly named supported housing as a distinct service.

4% of the recipients included in the Group 2 sample received a unit of supported housing (as evidenced by the presence of bill code H0043) during CY 2014.

In seven 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 the clinical team did not follow up with initiating a referral for the service.

Service Utilization Data

The last report established that the supported housing billing code (H0043) is rarely utilized. However, this year's analysis demonstrates a significant increase in providers billing H0043. As indicated within the service utilization data file, 785 Title XIX eligible (Medicaid) recipients were affiliated with the service during the time period of October 1, 2013 — June 30, 2014 and eight non-Title XIX recipients received the service from a total population of 23,977 (3.3%). During a comparable time period last year, no recipients were affiliated with the H0043 service code.

Supported Housing

It was determined that the supported housing billing code is not consistently utilized by supported housing providers. Invoices are submitted to the RBHA to support reimbursement for housing units and supported housing services are billed using established service codes with a supported housing modifier. The supported housing services can include personal assistance, living skills training, peer supports, medication monitoring and other supports and services to help members obtain and maintain community-based independent living arrangements. The RBHA is currently tracking data from contracted supported housing providers, including a roster of members being served in the programs.

Key Findings and Recommendations

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

Findings: Supported Housing

- All of the focus groups recommended the need for a less burdensome application and referral process for supported housing services. Even when a member is already receiving services through a provider agency, clinical team members must re-submit the entire referral packet when requesting additional services at the same agency.
- Some providers described coordination with the direct care clinics as challenging when arranging supported housing services. When a referral has been initiated, the direct care clinic must provide member demographic information and a current ISP that names the supported housing provider (or at least the service – the review team received conflicting accounts regarding which was needed). Some providers described barriers in obtaining needed documentation from the direct care clinic team that resulted in delays with member's access to supported housing services.
- Several providers and system stakeholders confirmed that participation in supported housing wrap-around services is not a contingency to maintain a member's housing subsidy and/or housing unit.
- Participants in all four focus groups indicated a need for increased transparency of supported housing wait lists and available housing opportunities. Clinic staff and members are not able to access information about the length of waiting lists and where a member is positioned on the waiting list.
- It is unclear what occurred with the housing wait list maintained by the former RBHA when the new RBHA implemented the contract on April 1, 2014. An analysis of the community housing wait lists spanning CY2013 and CY2014 found:
  - 72 member matches or 11% across both wait lists. The disposition of the 580 members who are no longer on the current wait list is unknown.
  - Only one member on the current wait list has a start date that pre-empts the contract implementation date (April 1, 2014).
  - 14 members who were on the original wait list with start dates during 2011 are now listed on the current wait list, but have later start dates (2014 and 2015).

Supported Housing

- In an interview with a RBHA representative, it was described that outreach with the clinics occurred to assess the relevancy of the former housing wait list. Each member on the list was reportedly reviewed to determine who needed to remain on the list. Wait list members are prioritized for openings based on individual circumstances (hospitalized, incarcerated, homeless, repeated crisis events, transition age youth). However, a provider in the community questioned the accuracy of the current housing wait list and reported that case managers sometimes do not maintain regular contact with the individuals placed on the wait list. The representative added that the allocation of available housing units is not prioritized for those most in need (i.e., the homeless).
- Similar to last year, participants reported insufficient capacity of housing units, including transitional housing for members seeking discharge from inpatient hospital settings.
- Half of the key informant survey respondents felt that supported housing services were difficult to access, the same finding as last year. However, none of the respondents indicated that supported housing services were inaccessible, an improvement from last year when 17% of the key informants felt the services were inaccessible.
- When asked about factors that negatively impact accessing supported housing services, the most prevalent key informant responses were that a wait list exists for the service and a lack of capacity/no service provider available.
- None of the key informant survey respondents perceived that supported housing services could be accessed within 30 days of the identification of the service need and 92% of the survey respondents reported that it would take an average of six weeks or longer to access supported housing services.
- Service utilization data demonstrates a significant increase in the percentage of members who received at least one unit of supported housing (as measured through service code H0043) over the respective review periods (CY2013 – 0.02%; CY2014 – 3%).
- Supported housing expansion efforts have added capacity to serve an additional 300 members with a total added capacity of 425 anticipated by June 30, 2015.

Recommendations: Supported Housing

- Examine the referral process for supported housing services, especially the respective roles and responsibilities of the RBHA, PNO/direct care clinics, housing agency and supported housing provider. Clarify and disseminate (1) roles and expectations, (2) required documentation, and (3) timelines. Conduct regular oversight of the expectations and take appropriate actions to address identified deficiencies.
- Ensure the ongoing relevancy and accuracy of the current housing wait lists (community housing and scattered site housing). Consider developing and disseminating standards regarding (1) the procedures to be placed on the wait list, (2) how members are prioritized and offered housing when available and (3) the method for members, direct care clinic staff and system stakeholders to review the status of the waitlist on an ongoing basis.
- Through training and supervision, ensure that clinical team members recognize the value of supported housing services in meeting a recipient's independent living related goals. When assessed as a need, ensure that supported housing services are included as an intervention on the ISP.

Supported Housing

- Develop and implement ongoing monitoring activities that assess the completeness and implementation of individual service plans. The ISP monitoring tools should include standards that (1) determine if assessed needs are being met through specific service plan interventions, (2) all critical ISP template data fields are complete (e.g., specific services and frequency), and (3) clinical teams follow up and ensure that recommended ISP services are made available to members within reasonable timeframes.
- Direct care clinic progress notes should be oriented to the member's current ISP goals and objectives. Progress notes should regularly reflect the status of all recommended ISP services, including noted barriers to accessing the services and the evolving needs of the member. All services and related status updates should be integrated and reviewed by the member's clinical team, including services provided outside the direct care clinic by community-based providers. Promote awareness and skill development through training and monitor expectations via ongoing supervision.
- Supported housing service encounters have increased, but do not appear to be consistently utilized by all supported housing providers. Ensure that the appropriate billing codes are being utilized by all community providers when supported housing services are delivered. (Some providers appear to be utilizing service code H0043 while others are billing direct support services, such as personal assistance and living skills training).

Supported Housing

Case in Point: *The review identified inconsistencies with following through to achieve the goals and objectives of a member's service plan.*

At time of assessment, an adult female is being evicted from housing for repeated violations of the lease by her husband whom she lives with along with their 3 year-old daughter. In September, the member requests a homeless housing application from the rehabilitation specialist at her assigned direct care clinic. The member explains that the family lost their subsidized apartment as she could not afford the rent payment. At the time, the rehabilitation specialist recommended that the member go to a homeless shelter or find a $99 move – in special apartment. The rehabilitation specialist further advised the member that he could not facilitate the housing application unless he witnessed the member as homeless.

By the end of the month, the member was staying at a homeless shelter. Approximately two weeks later, the clinical liaison at the direct care clinic directed the assigned case manager to contact the member to schedule a time to fill out a housing application and wait for housing to become available. Over the next four weeks, the member made repeated calls and inquiries to her clinical team trying to complete the housing application. On at least two occasions, the member's case manager did not return the member's calls when she left messages with other team members inquiring about the status of her housing application.

By the end of October, the member was working 40 hours per week at a retail store and was still homeless. In early December, the member contacted the rehabilitation specialist and asked about the status of her housing. The rehabilitation specialist stated that the case manager and clinical coordinator were out of the office, but indicated that someone would contact her. The medical record documentation did not include any evidence that a clinical team member followed up with the member.

Assertive Community Treatment Teams

Service Description:

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

Focus Groups

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

- Focus group participants reported a need for increased consistency in transitioning or graduating ACT members to lower levels of care.
- In all four focus groups, there continues to be a belief that some direct care clinics decline members who may benefit from an ACT team due to high acuity and challenging behaviors. Participants in the case manager focus groups reported that current ACT teams were accepting members with less intensive needs.
- The housing specialists, substance abuse specialists and peer support specialists assigned to the ACT teams reported that they often function primarily as case managers and do not always get to focus on their specialized area. These participants also reported that it is challenging to provide specialized services due the high volume of members on ACT teams and requirements for documenting frequent member contact.
- Participants reported that the criteria for referral to an ACT team are inconsistent across the PNOs and sometimes even between the clinics within the same PNO. Access to documented criteria for ACT teams is difficult to obtain for clinic staff and family members.
- An emerging concern reported was the emphasis on ACT fidelity and the perception that there is insufficient funding for ACT teams to perform at fidelity.
- Participants reported that there is a perception that members are not interested in receiving ACT services due to the intrusive nature of ACT. Many case managers expressed frustration that potential members for ACT were discouraged from agreeing to the service by the receiving ACT team.
- As with other priority mental health services, the ACT teams experienced a similar lack of specialty skills that are needed for the ACT teams. It was reported that many case managers want to transfer to an ACT team due to smaller member caseloads but are not equipped with the requisite skill set to adequately serve members on an ACT team.

Assertive Community Treatment Teams

Key Informant Survey Data

33% of survey respondents felt that ACT team services were difficult to access (down from 46% during CY2013) and none of the respondents indicated that the service was inaccessible (18% perceived the services inaccessible during CY2013). 50% of respondents indicated that ACT team services were easier to access or easy to access (an increase from 36% during CY2013).

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

- 50% indicated that the member declines service (up from 20% during CY2013);
- 32% of the responses identified clinical team unable to engage/contact member (up from 27% during CY2013; and
- 32% selected staffing turnover (new top three categories for this year).

Assertive Community Treatment Teams

In terms of the effectiveness of service utilization:

- 19% of the responses indicated that the services were being utilized effectively (decrease from CY2013 — 27%);
- 56% responded that the services were utilized effectively most of the time (significant increase from CY2013 — 18%); and
- Only 6% of the respondents indicated that ACT team services were not utilized effectively (was 55% during CY2013).

58% of the survey respondents perceived that ACT team services could be accessed within 30 days of the identification of the service need (CY2013 — findings were 60%). 6% indicated that the service could be accessed on average, within four to six weeks (20% during CY2013). The remaining 33% of the survey respondents reported that it would take an average of six weeks or longer to access ACT team services (up from 20% during CY2013).

Medical Record Reviews: Group 1

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

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

Five cases (4%) indicated a possible need for ACT team services, but there was no evidence that the clinical team assessed the person's need for the service.

All of the records reviewed included documentation that ACT team services were included on the ISP when identified as a need.

Seven of the one hundred twenty-four cases (6%) included recipients assigned to an ACT team.

Interviews

Ninety Group 1 recipients agreed to and participated in an interview regarding the prioritized mental health services.

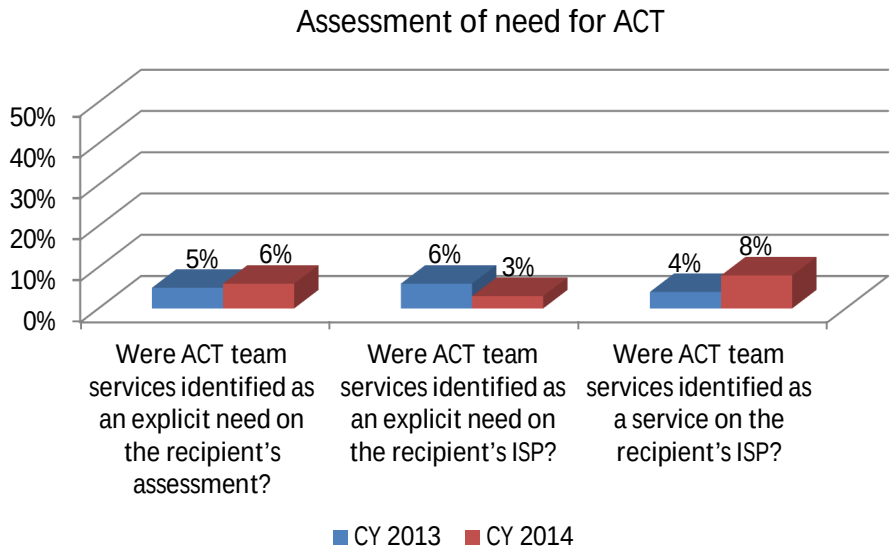
Assertive Community Treatment Teams

The interview disclosed the following:

- Most the recipients (98%) agreed that the clinical team reviewed the level of case management during the assessment and service planning process and assessed the recipient's need for ACT team services.
- Only two of the ninety (3%) recipients interviewed expressed a need to access ACT team services.

Medical Record Reviews: Group 2

ACT team services were not noted to be a documented component of the formal assessment and treatment planning process. In most cases reviewed, there was little to no documented evidence that the clinical team was considering or recommending a change in the level of case management, including referring a person to an ACT team or stepping down a recipient assigned to an ACT team to a less intensive level of case management. In a few cases, a review of the appropriateness of referring a member to an ACT team was documented in progress notes by the clinical team in response to a member's increase in symptoms and repeated need for intensive interventions.



In twelve cases, ACT team services were identified as an explicit need on recipients' assessments and/or ISPs. However, only one of these cases explicitly identified ACT team services on the ISP.

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

4% of the recipients included in the sample were assigned to an ACT team.

Assertive Community Treatment Teams

Service Utilization Data

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

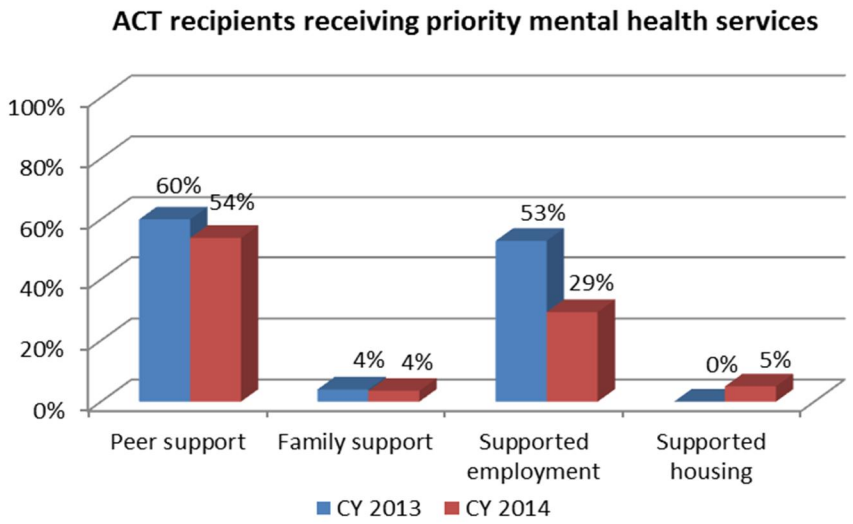
However, Mercer did complete an analysis of service utilization for recipients that were assigned to an ACT team. CY 2014 service utilization profiles for 1,443 ACT recipients who received a behavioral health service were analyzed.

The analysis sought to identify the utilization of one or more of the priority services (supported employment, supported housing, peer support services, family support services) as well as the proportion of case management services provided as compared to overall service utilization for ACT team recipients.

The analysis found:

- In CY 2013, case management services constituted greater than 50% of all services received for 36% of the ACT team recipients. During CY 2014, case management services constituted greater than 50% of all services for 24% of the ACT team recipients.
- For 30% of ACT team recipients, case management services represented 25% or less of their overall behavioral health service utilization.

Fewer ACT team recipients received peer support services during CY 2014 than in CY 2013 (54% versus 60%). ACT recipients who received supported employment services dropped 24% as compared to recipients in CY 2013. The utilization data indicated that 69 ACT recipients (5%) received supported housing services in CY 2014, as compared to none in CY 2013.



Assertive Community Treatment Teams

Key Findings and Recommendations

Findings: ACT Team Services

- 1,526 recipients were assigned to 18 ACT teams as of February 3, 2015. An increase of three teams and 165 members since CY 2013. Another new ACT team is planned to be implemented during May 2015.
- With the exception of the three new ACT teams added during the second half of CY 2014 and the first quarter of CY 2015, existing ACT team capacity averages 96%; a significant improvement when compared to the capacity of ACT teams during CY 2013.
- In all four focus groups, there continues to be a belief that some direct care clinics decline members who may benefit from an ACT team due to high acuity and challenging behaviors. Participants in the case manager focus groups reported that current ACT teams were accepting members with less intensive needs.
- 50% of key informant respondents indicated that ACT team services were easier to access or easy to access (an increase from 36% during CY 2013).
- When asked about the factors that negatively impact accessing ACT team services, the key informants' most common response was that the member declined the service.
- Five cases (4%) included in the medical record review sample indicated a possible need for ACT team services, but there was no evidence that the clinical team assessed the member's need for the service. In a few other cases, a review of the appropriateness of referring a member to an ACT team was documented in progress notes by the clinical team in response to a member's increase in symptoms and repeated need for intensive interventions.
- A lower percentage of ACT team members received peer support services during CY 2014 than in CY 2013 (54% versus 60%). ACT team members who received supported employment services dropped 24% as compared to members in CY 2013. The utilization data indicated that 69 ACT members (5%) received supported housing services in CY 2014, as compared to none in CY 2013.
- In response to varied admission criteria for ACT team services as evidenced during the CY 2013 service capacity assessment, the new RBHA has developed an ACT operations manual that includes an ACT admission screening criteria checklist. In addition, the RBHA has been more actively involved in identifying potential ACT candidates through the application of predictive modeling algorithms and regular clinical staffings with adult PNOs and direct care clinical teams.
- As a percentage of the total SMI population, 6% of all members are assigned to an ACT team. This is the same finding derived during CY 2013.
- A review of 100 SMI members that represent the highest aggregate service costs was conducted. It was determined that only 18% of the members were currently assigned to an ACT team. This compares to 20% when the same analysis was completed during CY 2013. The RBHA clarified that some of the members on the list may have high service costs due to expensive medications. Other explanations include high costs related to co-occurring medical (physical health) conditions or that some of the members may be placed in twenty-four hour supervised settings which may not be compatible with concurrent ACT services.

Assertive Community Treatment Teams

- An analysis of jail booking data was completed to identify members that have had multiple jail bookings over a defined period (i.e., six months) and determine if the member was subsequently referred and assigned to an ACT team, including one of the two forensic specialty ACT teams. The analysis found:
  - 105 members experienced at least two jail bookings during the period under review.
  - Of these 105 members, 25 (24%) were assigned to an ACT team.
  - Of the 25 members assigned to an ACT team, 8 (32%) were assigned to a forensic specialty ACT team.

Recommendations: ACT Team Services

- 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. (similar recommendation as last year)
- Ensure that ACT team members are routinely informed regarding the availability of the priority mental health services, including supported employment and peer support services.
- Continue efforts between the RBHA and PNOs/direct care clinical teams for regular consultation and identification of members who may benefit from ACT team services.
- Provide technical assistance and/or training to direct care clinic team members regarding how to message and describe ACT team services to members under consideration for ACT team services. Consider the use of peer support specialists when engaging members regarding the possibility of receiving ACT team services.

Outcomes Data Analysis

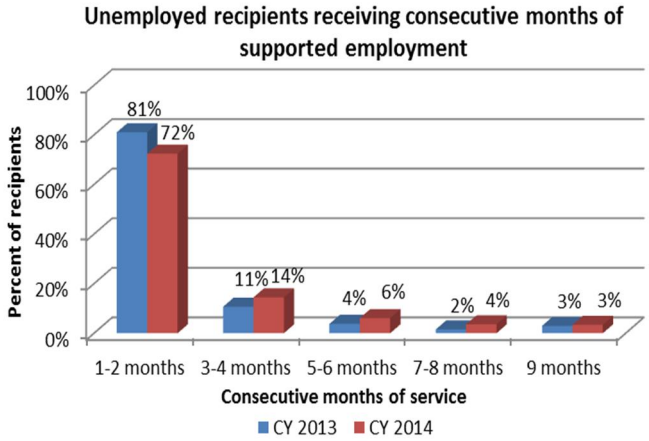
The service capacity assessment utilized an analysis of recipient outcome data in an attempt to correlate receipt of one or more of the priority mental health services with improved functional outcomes. Consistent with last year's analysis, the review team selected the following outcome indicators to support the analysis:

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

During CY 2014, an analysis was completed that compared recipients' persistence with receiving supported employment services and peer support services[72] for each of the outcome indicators selected. Overall, there are strong correlations 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 outcomes were noted when reviewing select outcomes for recipients who had received supported employment services:

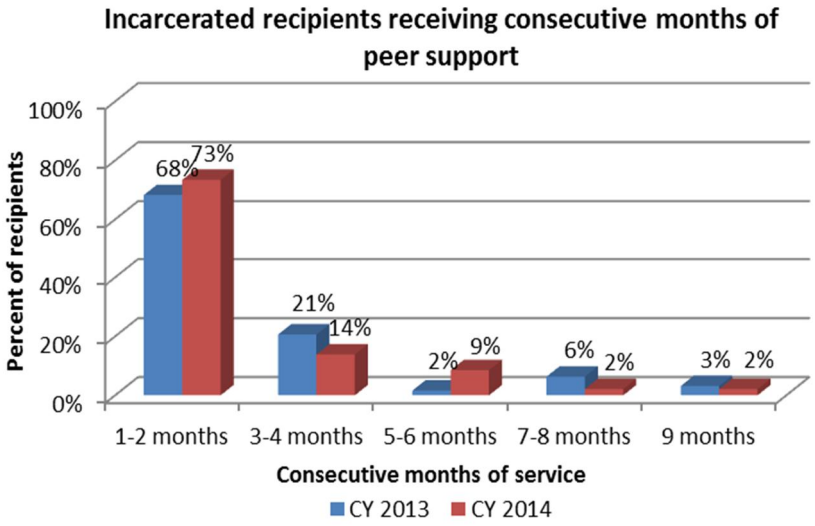
- Similar CY 2013 results, the percentage of recipients identified as "unemployed" decreases as the duration with supported employment services increases. For example, 72% of recipients identified as "unemployed" are associated with two or less consecutive months of supported employment services. Alternatively, recipients who experienced five or more consecutive months of supported employment services constituted only 13% of the total "unemployed" group.



[72] Supported housing services and family support services were excluded from the analysis due to the relative absence of the service code in the data set. ACT team services are not assigned a unique billing code.

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 2% received nine consecutive months of peer support services. However, 73% of incarcerated recipients had only received peer support services during a single month or during two consecutive months during the review period.
- Only 17% of recipients noted to be homeless or residing in a boarding home, crisis shelter, hotel, or behavioral health treatment setting received peer support services during the review period. Alternatively, recipients who received seven or more consecutive months of peer support were less likely to reside in these types of settings (10%).
- Longer periods of consecutive peer support services are associated with lower unemployment rates. For example, 72% of the recipients identified as unemployed received one or two months of peer support services; the percentage of unemployed recipients who received peer support services for seven or more consecutive months was determined to be only 7%.



Case in Point: *Demonstrating resiliency and positive outcomes in the face of significant challenges…*

An adult male proudly shared his story of recovery and success following his release from prison after several years. Upon his release, the member found himself homeless and sleeping outdoors for two months. He was discovered by a staff member from a direct care clinic who recognized his need for services.

Today, this member credits his path to recovery to his direct care clinical team who offered him the support and encouragement he needed to be successful. The member currently enjoys stable housing and serves as a recovery coach inspiring others to reach for their goals. The member expressed his immense gratitude to each member of his direct care clinic team for believing in his potential and ability to succeed.

APPENDIX A

Focus Group Invitation

MERCER

On behalf of the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), Mercer Government Human Services Consulting is conducting four focus groups in Maricopa County.

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

Focus groups **One** and **Two** will be held at the following location:

Quality Care Network
5326 E. Washington, Bldg. B
Phoenix, AZ 85034

Focus Group One	Focus Group Two
Adults receiving behavioral health services	**Family Members of Adults receiving behavioral health services**
February 18, 2015	**February 18, 2015**
9:00 am–11:00 am	**1:00 pm–3:00 pm**

Focus groups **Three** and **Four** will be held at the following location:

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

Focus Group Three	Focus Group Four
Direct Care Clinic Case Managers providing services to adults receiving behavioral health services	**Providers of ACT, SH, SE, Peer and Family support services to adults receiving behavioral health services**
February 19, 2015	**February 19, 2015**
1:00 pm–3:00 pm	**5:00 pm–7:00 pm**

Space is available for 10 participants per focus group on a first come first reserved basis.
Once capacity is reached, interested participants will be placed on a waiting list.
RSVP by Thursday, February 12, 2015 to Stacia Ortega at **stacia.ortega@mercer.com.**
Refreshments will be provided.

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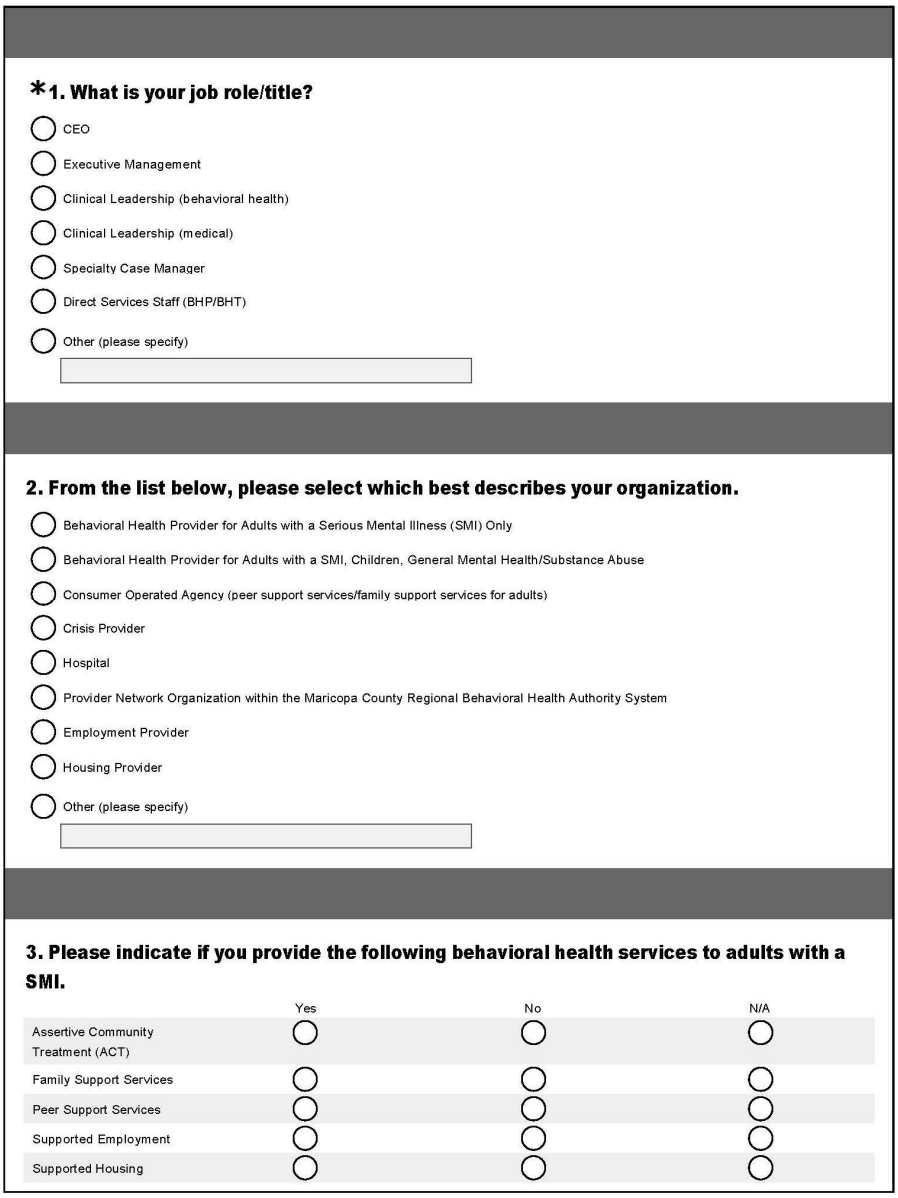
APPENDIX B

Key Informant Survey



***1. What is your job role/title?**

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

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

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

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

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

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

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

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

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

If you checked other above (please specify)

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

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

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

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

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

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

***9. What would you say is the most significant service delivery issue for the persons with a SMI accessing care in Maricopa County?**

* Asterisks designate questions that must be answered.

APPENDIX C

Assessment Verification Interview Tool

MERCER

ASSESSMENT VERIFICATION INTERVIEW

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

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

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

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

____ Yes ____ No

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

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

___No

APPENDIX D

Group 2 Medical Record Review Tool

MERCER

Network sufficiency record review tool—Group Two

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, 2014 – December 31, 2014*

Chart review [2]

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

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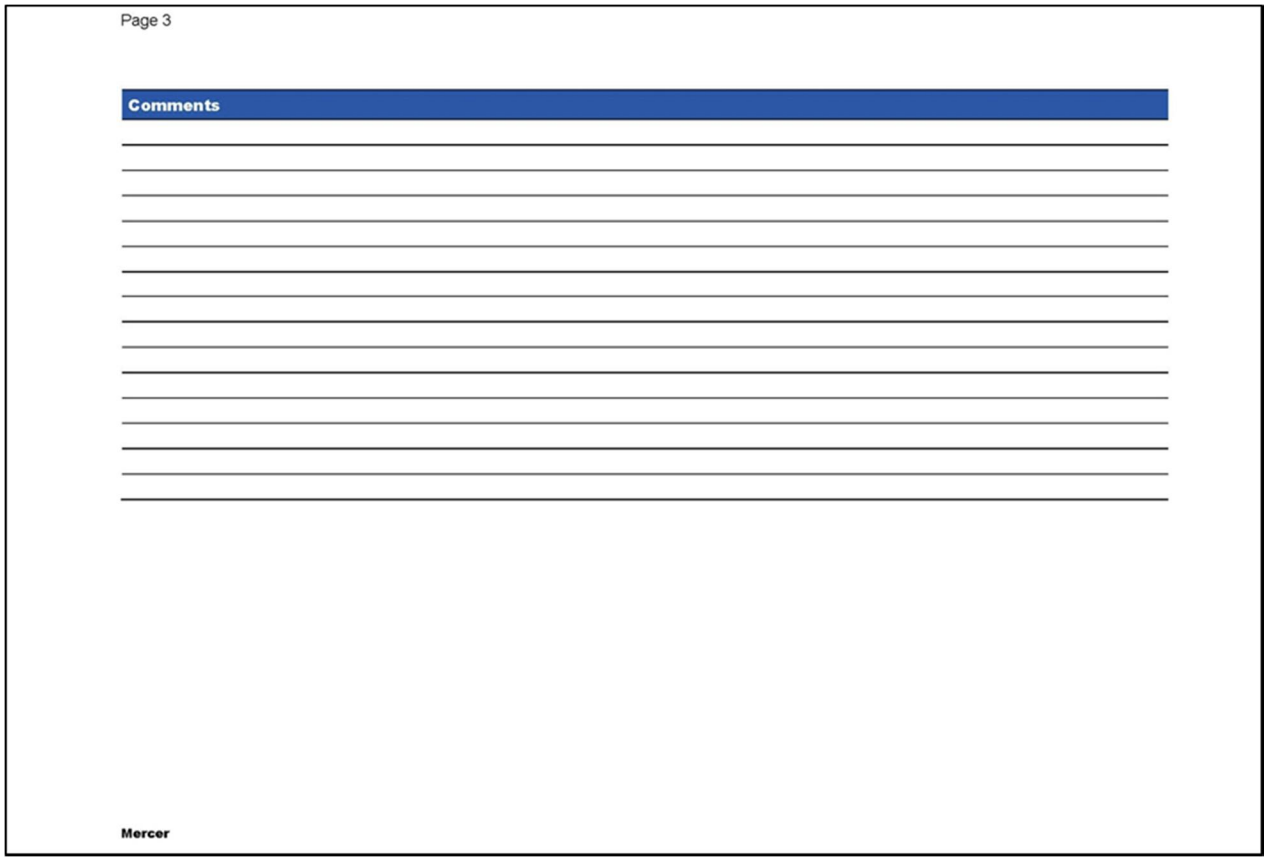
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Comments
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APPENDIX E

Summary of Recommendations

Service	Recommendations
Peer Support Services (PSS)	PSS1. Ensure that assessment of and progress on recovery-oriented needs and goals is consistently documented in the record. Promote awareness and skill development through training and monitor expectations via ongoing supervision. PSS2. Provide additional training and supervision to recognize the value of peer support services and family support services as effective service plan interventions. PSS3. Most peer support provided within the direct care clinics appears to occur within the context of group settings; attempts should be made to balance the delivery with individualized peer support.
Family Support Services (FSS)	FSS1. Rather than just identifying family supports available to the recipient, incorporate family members into treatment plans. Establish annual training for staff and supervisors that goes beyond understanding at a conceptual level to focus on specific strategies to actively promote the availability and use of family support services. FSS2. Clarify and standardize the roles and expectations of family mentors assigned to the direct care clinics with an emphasis on connecting family members to needed supports and education.

Service	Recommendations
Supported Employment (SE)	SE1. Explore opportunities to expand the presence of vocational rehabilitation specialists at the direct care clinics. SE2. Continue efforts through Disability Benefits 101-Arizona to meet workforce development needs, link recipients to resources knowledgeable regarding accessing public assistance (e.g., disability compensation, health insurance) and review potential implications of additional income related to employment. Examine the feasibility of utilizing peer support specialists in these roles. SE3. Through training and supervision, ensure that clinical team members recognize the value of supported employment services in meeting a recipient's employment related goals. When assessed as a need, ensure that supported employment services are included as an intervention on the ISP. SE4. Develop and implement ongoing monitoring activities that assess the completeness and implementation of individual service plans. The ISP monitoring tools should include standards that (1) determine if assessed needs are being met through specific service plan interventions, (2) all critical ISP template data fields are complete (e.g., specific services and frequency), and (3) clinical teams follow up and ensure that recommended ISP services are made available to members within reasonable timeframes. SE5. Direct care clinic progress notes should be oriented to the member's current ISP goals and objectives. Progress notes should regularly reflect the status of all recommended ISP services, including noted barriers to accessing the services and the evolving needs of the member. All services and related status updates should be integrated and reviewed by the member's clinical team, including services provided outside the direct care clinic by community-based providers. Promote awareness and skill development through training and monitor expectations via ongoing supervision. SE6. Supported employment for ongoing support service encounters are disproportionately less than pre-job training and development. Assess the sufficiency of contracted providers to support the provision of ongoing support to maintain employment services and ensure that the appropriate billing code is being utilized by community providers when ongoing support to maintain employment is delivered.

Service	Recommendations
	SE7. Ensure that clinical team members actively and continuously engage recipients regarding opportunities to participate in employment related supports and services. Promote awareness and skill development through training and monitor expectations via ongoing supervision. SE8. Clinical programs are supportive of the philosophy, principles, and practices of IPS supported employment.

Service	Recommendations
Supported Housing (SH)	SH1. Examine the referral process for supported housing services, especially the respective roles and responsibilities of the RBHA, PNO/direct care clinics, housing agency and supported housing provider. Clarify and disseminate (1) roles and expectations, (2) required documentation, and (3) timelines. Conduct regular oversight of the expectations and take appropriate actions to address identified deficiencies. SH2. Ensure the ongoing relevancy and accuracy of the current housing wait lists (community housing and scattered site housing). Consider developing and disseminating standards regarding (1) the procedures to be placed on the wait list, (2) how members are prioritized and offered housing when available and (3) the method for members, direct care clinic staff and system stakeholders to review the status of the waitlist on an ongoing basis. SH3. Through training and supervision, ensure that clinical team members recognize the value of supported housing services in meeting a recipient's independent living related goals. When assessed as a need, ensure that supported housing services are included as an intervention on the ISP. SH4. Develop and implement ongoing monitoring activities that assess the completeness and implementation of individual service plans. The ISP monitoring tools should include standards that (1) determine if assessed needs are being met through specific service plan interventions, (2) all critical ISP template data fields are complete (e.g., specific services and frequency), and (3) clinical teams follow up and ensure that recommended ISP services are made available to members within reasonable timeframes.

Service	Recommendations
	SH5. Direct care clinic progress notes should be oriented to the member's current ISP goals and objectives. Progress notes should regularly reflect the status of all recommended ISP services, including noted barriers to accessing the services and the evolving needs of the member. All services and related status updates should be integrated and reviewed by the member's clinical team, including services provided outside the direct care clinic by community-based providers. Promote awareness and skill development through training and monitor expectations via ongoing supervision. SH6. Supported housing service encounters have increased, but do not appear to be consistently utilized by all supported housing providers. Ensure that the appropriate billing codes are being utilized by all community providers when supported housing services are delivered. (Some providers appear to be utilizing service code H0043 while others are billing direct support services, such as personal assistance and living skills training).
ACT Team Services (ACT)	ACT1. 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. (similar recommendation as last year) ACT2. Ensure that ACT team members are routinely informed regarding the availability of the priority mental health services, including supported employment and peer support services. ACT3. Continue efforts between the RBHA and PNOs/direct care clinical teams for regular consultation and identification of members who may benefit from ACT team services. ACT4. Provide technical assistance and/or training to direct care clinic team members regarding how to message and describe ACT team services to members under consideration for ACT team services. Consider the use of peer support specialists when engaging members regarding the possibility of receiving ACT team services.

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Government Human Services Consulting
Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 6500

MARSH & McLENNAN COMPANIES