

**SERVICE CAPACITY ASSESSMENT
PRIORITY MENTAL HEALTH SERVICES
2016**

ARIZONA DEPARTMENT OF HEALTH SERVICES/
DIVISION OF BEHAVIORAL HEALTH SERVICES

JUNE 30, 2016

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

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

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

Overview of Findings and Recommendations

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 prior year reviews are presented.

The review period, which was primarily targeted to calendar year 2015 (CY 2015), marked the first full year that the current regional behavioral health authority (RBHA) managed an integrated physical and behavioral health services delivery system designed for Medicaid eligible adults determined to have a serious mental illness. During CY 2014, observed decreases in utilization of the priority services when compared to baseline measures recorded during CY 2013 were partially attributed to encounter processing errors and omissions during the initial months of contract implementation.

Service Capacity Assessment Conclusions

As reported by the Maricopa County RBHA, the system expanded capacity for all the priority mental health services during the review period. For each priority mental health service, it was reported that established goals for additional service capacity were met and exceeded as outlined in the *Stipulation for Providing Community Services and Terminating the Litigation* (dated January 8, 2014). The service capacity assessment independently concluded that, for the current review period (January 1, 2015 – December 31, 2015), service capacity increased or is projected to increase in the coming months that will result in achieving targeted increases for supported housing services, supported employment services, assertive community treatment teams and family and peer support services by the completion of State Fiscal Year 2016 (June 30, 2016). Mercer's service capacity evaluation activities supported the reported service expansions and confirmed increased opportunities to access the services. For example, a sample of key system stakeholders shared the strongest rating perceptions to date regarding the availability of the services, the effectiveness of service delivery and the timeliness of receiving the priority mental health services when needs were identified.

Service utilization rates (percentages of unduplicated members that received one or more of the prioritized services) analyzed during the review period demonstrated slight decreases for peer support, family support and supported employment services when compared to last year. Supported housing services and ACT team services are not amenable to an analysis of service claims data (i.e., a single supported housing code is not consistently utilized; ACT does not have a unique service code assigned). However, Mercer did review data that indicated over 1,750 members accessed a supported housing service (service and/or subsidy support) and an additional 167 members were assigned to an ACT team since the last assessment, including the establishment of three new ACT teams.

The Maricopa County RBHA settled in for the initial full year of implementing and managing the SMI service delivery system, but changes continued to occur at the administrative level for contracted entities responsible for overseeing the day-to-day operations of the direct care clinics. Since the last Mercer review, two of the four existing provider network organizations (PNOs) that oversee the direct care clinics discontinued operations and were replaced by four different administrative entities. In some instances, transitions to the new organizations included changes to electronic medical record systems that created and continue to cause disruptions with member medical record documentation, which also subsequently influenced findings for the medical record evaluation components of this study. For example, when abstracting a sample of members and reviewing direct care clinic documentation to support the service capacity assessment, the review team encountered issues with the accurate tracking and completion of assessments and ISPs and, in some cases, was required to access two separate databases to evaluate clinical team progress notes spanning the review period. When requesting a final sample of members to support the Group 2 medical record reviews, Mercer determined that nearly 30% of the initial sample did not have a current assessment during CY 2015 as required by ADHS/DBHS policy. The Maricopa County RBHA had imposed performance improvement plans on each of the PNOs during Calendar Year 2014 related to deficiencies with current assessments and ISPs. For this year's review, Mercer received

confirmation that all of the performance improvement plans had subsequently been resolved and closed. However, the RBHA has recently noted a reoccurrence of the issue and plans to initiate a performance improvement process in the near future¹.

The issue with untimely assessments and/or ISPs can have a direct impact on a member's ability to access one or more of the priority mental health services. The finding is relevant because member's may not be regularly assessed for needed services, identified needs may not be addressed and referrals for accessing the services and the member's utilization of the services may not be initiated and monitored by the clinical team. In addition, inefficiencies are created when clinical team members must access multiple record keeping systems to support a full view of a member's treatment history and experience with care. In some cases, clinical team members may not be aware that additional clinical information is available, and/or how to access the information and/or be willing to invest the time necessary to retrieve the information.

As noted in previous service capacity assessments, the added capacity has not always resulted in member's accessing the priority mental health services when needed. Mercer found that member's assessed needs were not always translated to the member's individual service plan, a lack of integration and coordination across direct care clinics and community-based providers continues to be evident and there were noted inconsistencies with the member's clinical team initiating referrals to secure covered services identified on the member's ISP. In addition, variation exists with ISP templates across the PNOs and administrative entities which resulted in relevant information being routinely absent on some versions of the ISP (i.e., specific services and frequency) and non-Title XIX SMI members may not receive a thorough assessment and/or are issued brief ISPs that do not appear individualized or comprehensive enough to support the provision of covered behavioral health services.

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

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

- Service utilization data demonstrates a progressive reduction in the percentage of members who received at least one unit of peer support services over the respective review periods (CY 2013 — 38%; CY 2014 — 31%; CY 2015 — 29%).
- The Maricopa County system excels in certain areas of evidence-based practice utilization. For example, Maricopa County has strong access to peer support services to the extent that the utilization is deemed as a “best practice benchmark”.
- Despite the clinical team's identification of natural and family supports, ISPs rarely included family support services.
- In contrast to CY 2014, only about one in four recipients recalled discussing family support services with the clinical team.
- Service utilization data demonstrates minor differences in the percentage of members who received at least one unit of family support services over the respective review periods (CY 2013 — 2%; CY 2014 — 3%; CY 2015 — 2%).
- By March 2016, peer support and family support expansion efforts have resulted in added capacity to serve an additional 1,530 members.

¹ Written communication with Mercy Maricopa Integrated Care RBHA, May 3, 2016.

Supported Employment Services

- Service utilization data demonstrates a steady reduction in the percentage of members who received at least one unit of supported employment over the respective review periods (CY 2013 – 39%; CY 2014 – 20%; CY 2015 – 17%).
- 70% 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% during CY 2013 and 60% during CY 2014.
- Similar to previous years, the service utilization data set demonstrates significant variation in the volume of the available service codes for supported employment. For the time period October 1, 2014 through June 30, 2015, H2027 and H2027 SE (pre-job training and development) accounts for 91% of the total supported employment services.
- Supported employment expansion efforts resulted in additional capacity to serve 765 members during CY 2015.

Supported Housing Services

- 38% of the survey respondents felt that supported housing services were difficult to access, down from 50% a year ago.
- In eleven cases, reviewers were able to review progress notes and record the reasons that the member 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 a lack of evidence that the clinical team followed up with initiating a referral for the service.
- Supported housing service expansion efforts resulted in 1,769 members accessing a supported housing service (service and/or subsidy support) during CY 2015². The specific break-out of supported housing services included: 481 members receiving permanent supported housing subsidy supports; 515 members receiving permanent supported housing service supports; and 773 members receiving community living subsidy supports.

ACT Team Services

- As a percentage of the total SMI population, 7% of all members are assigned to an ACT team. This is slightly higher than the finding derived during CY 2013 and CY 2014 (6%).
- A review of 101 SMI members that represent the highest aggregate behavioral health service costs was conducted. It was determined that 23% of the members were assigned to an ACT team. This compares to 20% when the same analysis was completed during CY 2013 and 18% during CY 2014.
- An analysis of jail booking data was completed to identify members that have had multiple jail bookings over a defined period (i.e., eleven months—January through November 2015) 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:
 - 408 members experienced at least two jail bookings during the period under review.
 - Of these 408 members, 91 (22%) were assigned to an ACT team.
 - Of the 91 members assigned to an ACT team, 18 (20%) were assigned to a forensic specialty ACT team.

² As reported by the Maricopa County RBHA administering the ADHS/DBHS contract (January 2016).

- 1,693 recipients were assigned to 21 ACT teams as of December 1, 2015. An increase of three teams and 167 members since CY 2014. Another new ACT team was planned to be implemented during May 2016.

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

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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).³ The service capacity assessment included a need and allocation evaluation of supported housing, supported employment, consumer operated services (peer support services and family support services), and assertive community treatment (ACT).

Goals and Objectives of Analyses

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

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

Limitations and Conditions

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

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

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 30 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 and 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 block 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. As a senior associate with Mercer, 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. (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

Laura Henry

Jesse Seiger-Walls (TriWest Group)

Acknowledgments

Mercer would like to thank Kelli Donley of ADHS/DBHS for assistance with project coordination and responding to data requests.

Mercer would also like to extend a thank you to Mercy Maricopa Integrated Care and the Adult Provider Network Organizations (Southwest Network, Partners in Recovery) as well as the following administrative entities and providers: Terros, Lifewell Behavioral Wellness, Chicano Por La Causa, LaFrontera/Empact and Focus Employment Services, LLC.

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

During the review period, ADHS/DBHS served 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 RBHAs, to administer integrated physical health (to select populations) and behavioral health services throughout the State of Arizona. Effective July 1, 2016, the Arizona Health Care Cost Containment System (AHCCCS) and DBHS' administrative structure and personnel will be merged in an effort to eliminate areas of duplication while strengthening the expertise of a single, unified administrative agency. As such, AHCCCS will administer and oversee the full spectrum of services to support integration efforts at the health plan, provider and member levels.

History of *Arnold v. Sarn*

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

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

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

SMI Service Delivery System

Beginning October 1, 2015, ADHS/DBHS contracted with RBHAs to deliver integrated physical health (to select populations) and behavioral health services in three geographic service areas (GSAs) across Arizona. Each RBHA must manage a network of providers to deliver all

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

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

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

The direct care clinics provide a range of recovery focused services to SMI recipients such as medication services, medical management, case management, transportation, peer support services, family support services, and health and wellness groups. 21 ACT teams are available at different direct care clinics and community provider locations. Access to other covered behavioral health services, including supported employment and supported housing is primarily accessible to SMI recipients through RBHA contracted community-based providers.

Current Service Capacity

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

ACT Teams (21 teams serving 1,693 recipients)⁵

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Southwest Network: San Tan		100	99	1%
Southwest Network: Saguaro		100	91	9%
Southwest Network: Hampton		100	93	7%
Southwest Network: Osborn		100	92	8%
Southwest Network: Bethany Village	Young Adult Team	100	99	1%
Lifewell Behavioral Wellness: South Central		100	100	0%
Terros: Enclave		100	94	6%
Terros: Townley Center		100	93	7%
Terros: West McDowell		100	98	2%
Chicanos Por La Causa: Centro Esperanza		100	91	9%
Chicanos Por La Causa: Maryvale*		100	18	82%
Circle the City: Circle the City Team*		100	51	49%
LaFrontera/EMPACT: Comunidad***		100	99	1%
LaFrontera/EMPACT: Capitol Center		100	90	10%
Partners in Recovery: Metro Center Campus – Omega Team		100	99	1%
Partners in Recovery: Metro Center Campus – Varsity Team		100	95	5%
Partners in Recovery: Arrowhead	Medical Team	100	53	47%
Partners in Recovery: West Valley Campus		100	90	10%
Community Bridges: FACT Team 1	Forensic Team	100	96	4%
Community Bridges: FACT Team 2*	Forensic Team	100	38	62%
Community Bridges: Avondale*		100	14	86%
	Totals	2,100	1,693	19%**

* 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 5%.

***Previously included two teams; now consolidated to a single team at this site.

⁴ As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in January 2016.

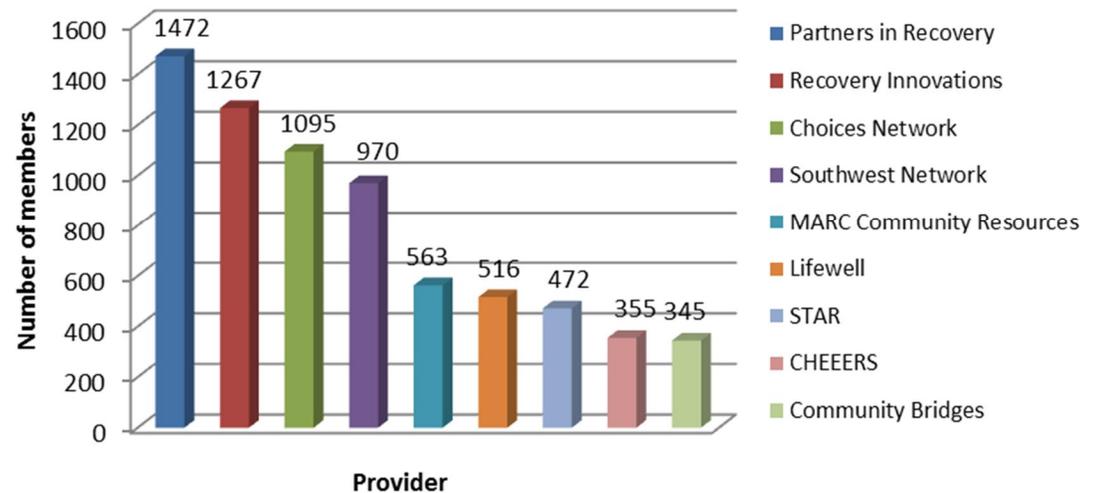
⁵ As of December 1, 2015.

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.

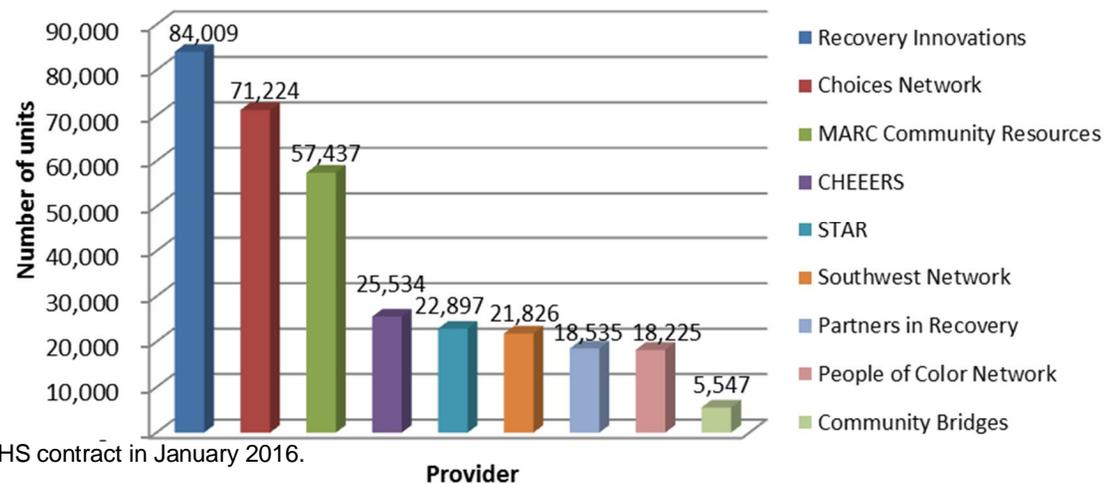
Consumer Operated Services (peer support and family support)⁶

- CHEEERS.
- Community Bridges, Inc.
- Hope Lives Vive la Esperanza.
- Horizon Health and Wellness.
- Lifewell Behavioral Wellness.
- Marc Community Resources.
- National Council on Alcoholism and Drug Dependence (NCADD).
- NAZCARE.
- Partners in Recovery.
- PSA.
- Recovery Empowerment Network (REN).
- Recovery Innovations of Arizona (RIAZ).
- Southwest Behavioral Health.
- Southwest Network.
- Stand Together and Recover (STAR).
- Terros.

Top peer support providers, by members served



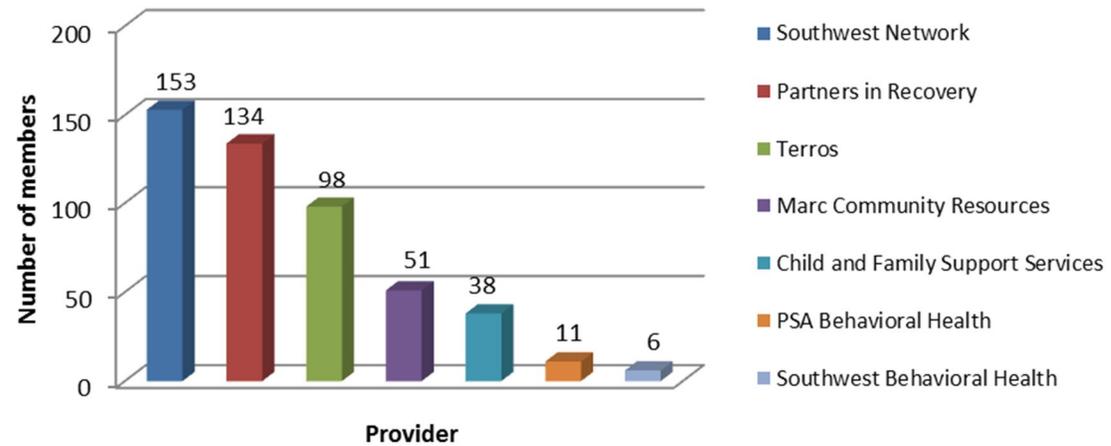
Top peer support providers, by units



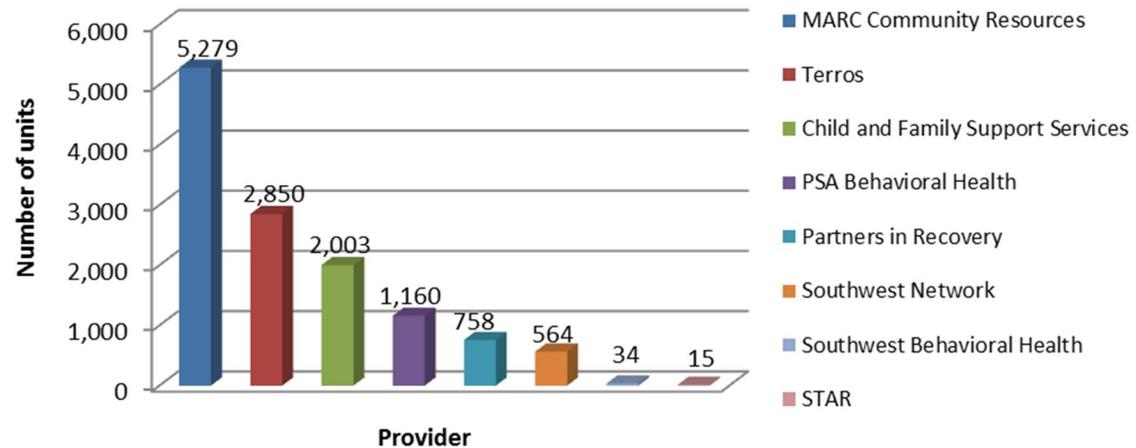
⁶ As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in January 2016.

Consumer Operated Services (family support)⁷

Top family support providers, by members served



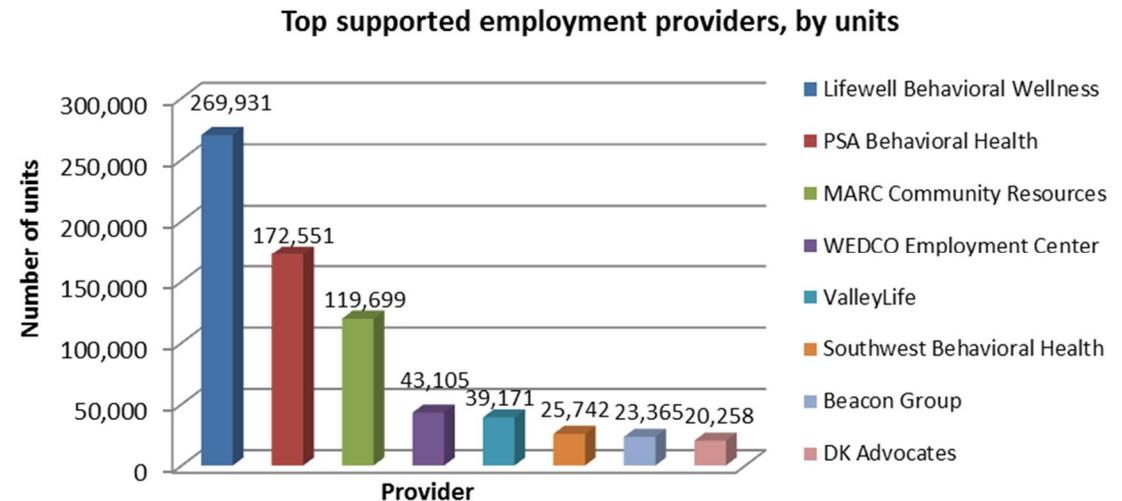
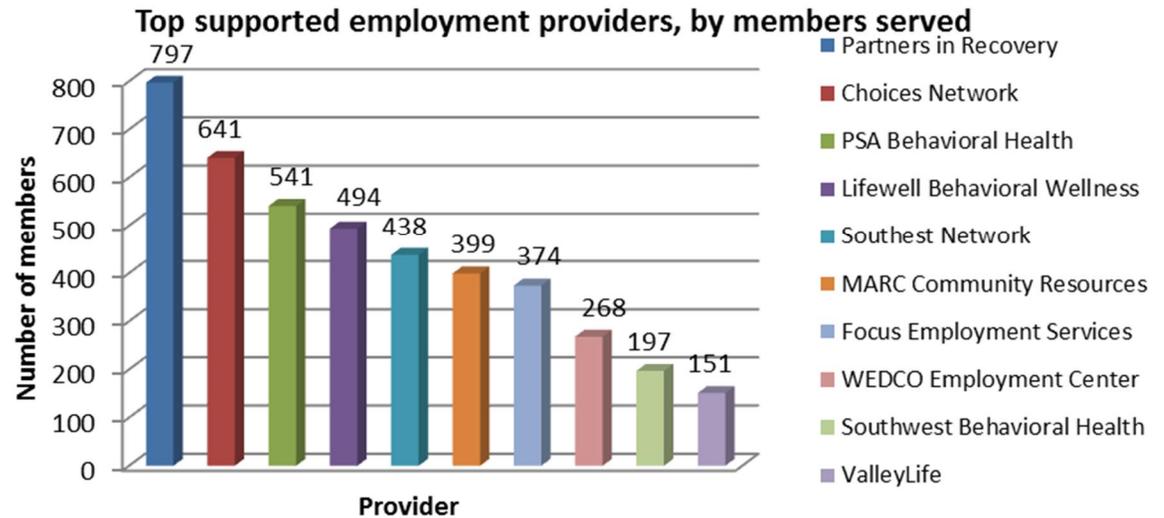
Top family support providers, by units



⁷ As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in January 2016.

Supported Employment Providers⁸

- Beacon Group.
- DK Advocates.
- Focus Employment Services.
- Lifewell Behavioral Wellness.
- LaFrontera/Empact.
- Marc Community Resources.
- Partners in Recovery.
- Southwest Network.
- Valleylife.

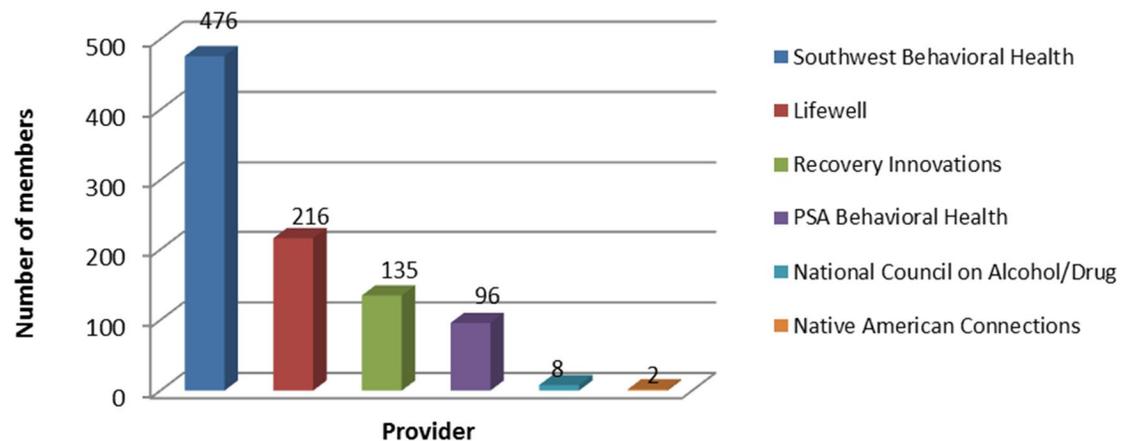


⁸ As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in January 2016.

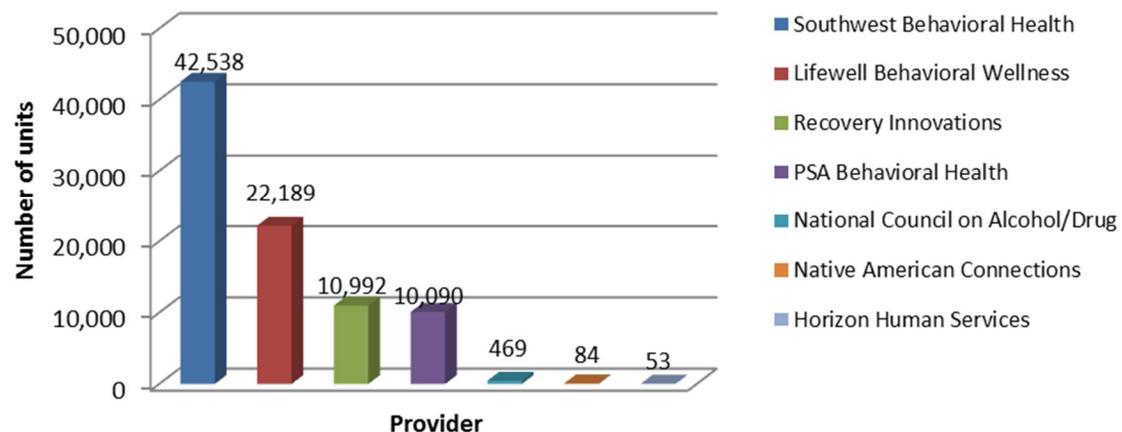
Supported Housing Providers^{9,10}

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

Top supported housing providers, by members served



Top supported housing providers, by units



⁹ As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in January 2016.

¹⁰ A single supported housing code is not consistently utilized.

4

Methodology

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

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

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

Focus Groups

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

Participation in the focus groups was solicited by an invitation created by Mercer, which was reviewed and approved by ADHS/DBHS¹¹.

¹¹ See Appendix A: Focus Group Invitation.

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

The focus groups included the following participants:

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

A total of 27 stakeholders participated in the four two-hour focus groups conducted on January 27, 2016 and January 28, 2016. All four focus groups were held at the Touchstone Behavioral Health Phoenix office. Eight direct care clinic staff, nine providers, four family members and six SMI adult recipients participated.

The methodology included the following approach:

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

Key Informant Surveys and Interviews

One objective of the service capacity assessment was to obtain comprehensive stakeholder input. As a result, a key informant survey was created using *Survey Monkey*®. The survey tool included questions with rating assignments related to accessing the priority mental health services, including the ease of access and timeliness of access to the services.¹²

The survey was disseminated to key system stakeholders via email with a hyperlink to the online survey. A total of 29 respondents completed the survey tool.

In addition, 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.

¹² See Appendix B: Key Informant Survey.

Medical Record Reviews (Group 1 and Group 2)

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

Group 1

The Group 1 sample included 119 randomly selected cases.

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

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

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

Mercer developed an interview guide¹³ 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 a training with peer reviewers regarding the use of the interview tool to help ensure consistent application of the guide across reviewers.

All Group 1 recipients completed in-person interviews.

Group 1 medical record documentation for the sample (n=119) was reviewed by two behavioral health professionals and recorded in a data collection tool. Documentation regarding the priority mental health services was analyzed by reviewing assessments and ISPs, the findings from which were recorded in the data collection tool. Findings from the recipient interviews were added to the data collection tool to support a comparative analysis between the medical record documentation findings and the recipient’s recorded responses to the interview questions.

¹³ See Appendix C: Assessment Verification Interview Tool.

Group 2

For Group 2, the final sample included 201 randomly cases, selected using the following criteria:

- The recipient was identified as SMI and received a covered behavioral health service during October 1, 2014 and December 31, 2015.¹⁴
- The recipient had an assessment date between January 1 and November 15, 2015.¹⁵

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

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

Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient's current annual assessment update or initial assessment and/or a current psychiatric evaluation, the recipient's current ISP, and all clinical team progress notes following each recipients' assessment date through December 31, 2015.

Group 2 medical record documentation for the sample (n=201) was reviewed by three licensed clinicians and recorded in a data collection tool.¹⁶ Additional comments were recorded to further clarify findings. Prior to conducting the medical record reviews, inter-rater reliability testing was completed over a two day period with all reviewers using actual cases, resulting in 90% agreement on each scoring tool question.

¹⁴ The total population of unique SMI recipients who received behavioral health services is 24,841 for the period October 1, 2014 through December 31, 2015.

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

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

Analysis of Service Utilization Data

Mercer initiated a request to 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, 2014 and December 31, 2015. As noted in previous service capacity assessment reports, encounter submission lag times can impact the completeness of the data set.

Specific queries were developed to identify the presence of each prioritized mental health service.¹⁷ Analysis was conducted to evaluate the volume of unique users, billing units, and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to determine “persistence” in treatment. Through the evaluation, proportions of recipients who only received the service in a single month were calculated. Additional progressive consecutive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months, and nine months) to determine the volume of recipients who sustained consistent participation in each of the prioritized services. For ACT team services, a roster of ACT team members was obtained and a corresponding analysis of service utilization (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 = 320). Group 1 and Group 2 sample characteristics for each year of the service capacity assessment are illustrated in the following tables and are compared to the characteristics of the total population of active users.

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

2015 Service Capacity Assessment Time Period – Utilization

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

2014 Service Capacity Assessment Time Period – Utilization

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

2013 Service Capacity Assessment Time Period – Utilization

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

¹⁸ ACT services were not included as part of the service utilization file, but based on the current ACT roster, 7% of all active SMI recipients are assigned to ACT teams.

Analysis of Outcomes Data

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

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

The outcome indicators listed above are described as part of the 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 timeframes, 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 utilization and penetration rates of the priority mental health services (ACT, supported employment, supported housing, and peer support¹⁹) was conducted. Penetration rates were compared to benchmarks, as described below.

The following review process was completed by Mercer:

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

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

Service Expansions — Comparison of Select States

During the initial year of the service capacity assessment, a comparative analysis was performed with selected states and included a review of negotiated agreements to increase capacity and services to populations of persons identified to have serious and persistent mental illness, as well as interviews with key state staff involved in the implementation of each state's settlement agreements. Each state reviewed has proposed service expansions for one or more of the prioritized services. The review supports a comparison of other states with Maricopa County's agreement to expand service capacity. States reviewed included Delaware, New Hampshire, and North Carolina as each state has recently negotiated settlements that include many of the same priority services for comparable disability populations. For the 2015 Service Capacity Assessment, Mercer contacted representatives from each state to update and track progress as applicable and available.

¹⁹ Peer support services are not currently reported on the SAMHSA 2014 Mental Health National Outcome Measures (NOMS) report.

5

Findings and Recommendations

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

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

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

SMI Prevalence and Penetration — Overview of Findings

Penetration is defined as the percentage of individuals who received services among the estimated number of individuals considered eligible for services during a defined time period. As depicted in the table below, a relatively small percentage (20%) of the estimated number of adults with SMI is served through the publicly funded system in Maricopa County. The national penetration rate is 43%, 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 other state-level averages but still slightly lower than the national average. The penetration rate in Arizona and Maricopa County may be due to the fact that a small percentage of non-Medicaid persons are served through the public behavioral health system.

However, the Maricopa County system excels in certain areas of evidence-based practice utilization. For example, supported housing is more available in Maricopa County (especially to Medicaid recipients) compared to the national average. Maricopa County also has strong access to peer support services, such that it is deemed as a “best practice benchmark”. Most notably, Maricopa County has more Assertive Community Treatment (ACT) teams than most comparison communities included in this analysis. Just fewer than 1,700 people received

ACT services in CY 2015; representing 7% of the adults with SMI served in the mental health system. Based on a published study by leading ACT researchers nationally, a benchmark of 4.3% was used to estimate the percentage of adults with SMI who need the ACT level of care. Based on a review of available data, many communities do not achieve that level of penetration. Maricopa County exceeds the estimated 4.3% benchmark for access to ACT team services.

In addition, Maricopa County has two Forensic ACT (FACT) teams that attend to the needs of adults with SMI who have historically high utilization of the criminal justice system. While this allocation of resources for justice system-involved consumers reflects responsiveness to the stated concerns of many system stakeholders, it would be beneficial to the system to add more FACT teams and/or refine linkages between justice involved members and available FACT team services. In discussions with the Maricopa County RBHA, a new FACT team was scheduled to be implemented on May 1, 2016. Cuddeback and colleagues have estimated that 3.7% of adults with SMI need FACT services in any given year.²⁰

²⁰ Cuddeback, G.S., Morrissey, J.P., & Cusack, K.J. (2008). How many forensic assertive community treatment teams do we need? *Psychiatric Services*, 59, 205-208.

Service System Penetration Rates for Persons with Serious Mental Illness

Table 1: Penetration Rates					
Region	Adult Population (≥18 Years Old) ²¹	Estimated Rate of SMI in the Adult Population ²²	Estimated Number of Adults with SMI in the Pop. ²³	Number of Adults with SMI Served ²⁴	Penetration Rate Among Adults with SMI ²⁵
US	245,201,076	4.2%	10,175,845	4,408,739	43%
Arizona	5,109,196	4.1%	208,966	45,138	22%
Maricopa County ²⁶	3,061,307	4.1%	125,207	24,608	20%
Maricopa County — Medicaid	412,830 ²⁷	11.7%	48,301	19,617	41%
Maricopa County Gen. Adult Pop.	2,648,477	2.9%	76,906	4,991	6%
Texas	22,048,321	3.8%	833,427	239,561	29%
Harris County (Houston)	3,237,759	3.8%	122,387	65,000	52%
Bexar County (San Antonio)	1,882,834	4.5%	84,916	27,564	32%

²¹ US Census Bureau 2014 population estimates for adults (18 years of age and older).

²² SAMHSA. (2015). State Estimates of Serious Mental Illness from the 2014 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report. Retrieved from <http://www.samhsa.gov/data/population-data-nsduh/reports> The estimated rate of SMI statewide for Arizona was used for all Maricopa County adults. Please note that the estimated rate of SMI in the adult population was lower than what we reported in the past. This is due to some changes in the methodology used by the National Survey on Drug Use and Health. See *National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 Population Percentages (50 States and the District of Columbia)*. However, these changes were made nationwide and with all other states.

²³ Calculation: Estimated SMI rate multiplied by adult population.

²⁴ The state-level proportion of people served with a serious mental illness is reported from SAHMSA (2014) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI.

²⁵ Number of adults with SMI served within the system (for states, see calculation note above), divided by the estimated number of adults with SMI in the total adult population.

²⁶ Maricopa County data received through analysis of the service utilization data file.

²⁷ The adult population for Medicaid is based on a 12-month average (December 2014 – November 2015) of adults enrolled in at least one episode of care. Data was derived from the Maricopa County Eligibility and Enrollment Report generated on February 9, 2016.

New York	15,520,534	3.8%	583,572	418,953	72%
New York County ²⁸ (NY City) ²⁹	1,395,737	3.8%	52,480	16,376	82%
Colorado	4,107,949	3.7%	153,227	60,246	39%
Denver City-County ³⁰	525,115	3.7%	19,587	8,000	41%
Nebraska	1,414,890	4.4%	61,972	13,769	22%
California	29,645,110	3.8%	1,117,621	392,459	35%
Illinois	9,892,285	3.8%	370,961	96,521	26%
Kansas	2,180,920	4.1%	89,418	17,502	20%
Minnesota	4,174,737	4.5%	187,863	101,075	54%
Wisconsin	4,456,355	4.2%	186,276	48,901	26%
Tennessee	5,056,100	4.7%	238,648	150,171	63%
Indiana	5,013,610	4.8%	242,659	77,369	32%
Delaware	731,650	3.9%	28,681	6,954	24%
New Hampshire	1,060,124	4.4%	46,433	10,504	23%
North Carolina	7,656,852	4.9%	374,420	113,352	30%

Overview of Evidence-Based Practice Utilization Benchmark Analyses

Data in the table below depict the penetration rates for Assertive Community Treatment (ACT), Supported Employment, and Supported Housing among those served in the Maricopa County behavioral health system. Maricopa County has an ACT penetration rate of 7%, which is at a best practice level.³¹ The County's penetration rate for supported housing services (as measured by service code H0043) easily exceeds the national average benchmark but trails best practice benchmarks. The penetration rate for supported employment appears to be at a best practice level. However, ongoing support to maintain employment services may provide a better indication of the number and percentage of people receiving evidence-based supported employment. Ongoing supported employment services represent a much smaller number served relative to the estimated population in need.

²⁸ The New York State Office of Mental Health report mental health data at the county-level across five (5) primary regions (Western, Central New York, Long Island and New York City). The New York City region includes five (5) counties (Bronx, Kings, New York, Queens and Richmond – also referred to as boroughs within New York City). Within this report, only New York County was included for benchmarking purposes.

²⁹ New York State Office of Mental Health. (2015). (Online Dashboard) Patient Characteristics Survey- Summary Reports: New York County. Retrieved from https://my.omh.ny.gov/webcenter/faces/pcs/planning?wc.contextURL=/spaces/pcs&_adf.ctrl-state=1akxeosyer_4&wc.contextURL=/spaces/pcs&wc.contextURL=%2Fspaces%2Fpcs&wc.originURL=%2Fspaces%2Fpcs&_afLoop=44553068891870 on January 15, 2016.

³⁰ Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015 and 2016.

³¹ Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services*, 57, 1803-1806.

Table 2: EBP Utilization Rates Among Persons with SMI Who Were Served in the System ³²						
Region	Assertive Community Treatment		Supported Employment		Supported Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
US	63,445	1.0%	61,511	1.4%	81,422	1.8%
Arizona	N/A ³³	N/A	12,786	28.3%	1,932	4.3%
Maricopa County	1,693	7%	4,230	17.2%	902	3.7%
Maricopa County — Medicaid	1,406	7%	3,755	19.1%	890	4.5%
Maricopa County — Non-Medicaid	287	6%	475	9.5%	12	<1%
Maricopa County (SE ongoing) ³⁴	n/a	n/a	725	3.0%	n/a	n/a
Texas	3,335	1.3%	11,116	4.6%	11,549	4.8%
Harris County (Dallas)	281	0.4%	1,287	2.0%	823	1.3%
Bexar County (San Antonio)	255	1.0%	982	3.6%	1,982	7.2%
New York	6,189	1.1%	1,837	0.4%	21,377	5.1%
New York County (NY City)	1,245	8%	N/A	N/A	845	5%
Colorado	3,514	4.7%	1,286	2.1%	294	0.5%
Denver City-County (MHCD) ³⁵	690	8.6%	521	6.5%	1,650	20.6%
Nebraska	223	1.1%	843	6.1%	734	5.3%
Omaha (Region 6) ³⁶	110	1%	260	3%	273	3%
California	5,227	1.1%	419	0.1%	1,079	0.3%

³² National and State-level data on the number of people utilizing EBPs are reported from the SAHMSA (2014). *Mental Health NOMS: Central Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. Rates are based on number with SMI served in the system.

³³ Arizona did not report the number of people served with Assertive Community Treatment statewide.

³⁴ We conducted a second analysis of Supported Employment utilization, including ongoing support to maintain employment but excluding pre-job training and development. Mercer found in its 2013 review of clinical records that the latter services, which accounted for 94% of SE services coded, often indicated brief discussions with clients about employment, outside of the context of a comprehensive, evidence-based supported employment program. The 725 people receiving “SE ongoing” services represent a subset of consumers receiving SE.

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

³⁶ 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.

Table 2: EBP Utilization Rates Among Persons with SMI Who Were Served in the System³²

Region	Assertive Community Treatment		Supported Employment		Supported Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Illinois	979	1.0%	2,489	2.6%	N/A	N/A
Kansas	<i>n/a</i>	<i>n/a</i>	1,367	7.8%	3,231	18.5%
Minnesota	1,992	1.4%	338	0.3%	497	0.5%
Wisconsin	3,572	4.0%	701	1.4%	648	1.3%
Tennessee	417	0.2%	1014	0.7%	1026	0.7%
Indiana	476	0.6%	1,311	1.7%	3,005	3.9%
Delaware	334	4.8%	39	0.6%	79	1.1%
New Hampshire	263	0.8%	1218	11.6%	N/A	N/A
North Carolina	4,652	2.9%	N/A	N/A	N/A	N/A

Changes in Evidenced-Based Practice (EBP) Utilization from 2013 to 2015

The table below compares utilization of ACT, supported employment, and supported housing in 2013, 2014 and 2015.

- *Assertive Community Treatment.* There have been steady increases in the number of adults with SMI who received ACT services in 2014 and 2015. Although the penetration rate had decreased between 2013 and 2014, the penetration rate exceeded the 2013 baseline in 2015.
- *Supported Employment.* The overall penetration rate for supported employment dropped from 2013 to 2014, and then dropped further in 2015. This may be due to a decrease in the reported number of people receiving pre-job training and development services, because the number of people receiving ongoing support to maintain employment services (which is more reflective of evidence-based supported employment) actually increased from 2013 to 2014, and again in 2015. In fact, in terms of the number of people receiving supported employment services, the data demonstrates an increase of 41% from 2013 to 2015.
- *Supported Housing.* In previous years, the supported housing billing code was not often utilized. As a result, changes in the supported housing penetration rate could not be calculated between 2013 and 2014. Analysis of the data indicated that there was an increase of nearly 14% in supported housing utilization from 2014 and 2015. An improvement in supported housing utilization from 2014 to 2015 also was evident in the overall percentage of adults with SMI using supported housing — the penetration rate increased from 3.3% to 3.7%.

Maricopa County EBP Utilization in 2013, 2014, and 2015

Table 3: Maricopa County: 2013-2014 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 ³⁷	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2015)	24,608	1,693	6.9%	4,230	17.2%	902	3.7%
<i>SE Ongoing</i>				725	3.0%		
Maricopa County (2014)	23,977	1,526	6.4%	5,634	23.4%	793	3.3%
<i>SE Ongoing</i>				657	2.7%		
Maricopa County (2013)	20,291	1,361	6.7%	7,366	36.3%	No Data	No Data
<i>SE Ongoing</i>				515	2.5%		

³⁷ 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 (7%) exceeds the benchmark in the Cuddeback study (4.3%). This may be partly due to the fact that the adults with SMI actually served may include more people in need of ACT than those not served. That is, those who come to the attention of the system may require more intensive supports and services. This is summarized in a different way within the proceeding column, where the total percentage of people served compared to the estimated number of people in need of an ACT level of care is reported. When this analysis is applied, Maricopa County is found to be comparable to other benchmark communities like New York City and Denver.

In addition, it is noteworthy that among the ACT teams in Maricopa County, there are two Forensic ACT teams that aim to meet the treatment and recovery needs of adults with SMI who have a history of criminal justice system involvement. These teams served 134 people in 2015. Many communities do not have any FACT teams and these teams represent a vital resource in Maricopa County. To the extent Maricopa County plans to expand ACT programs, it should consider adding FACT teams, as national experts have estimated that 3.7% of adults with SMI need FACT programs.

Table 4: Assertive Community Treatment Utilization Relative to Estimated Need Among People with SMI					
Region	Number of Adults with SMI ³⁸	Number with SMI Who Need ACT ³⁹	Number Received ACT ⁴⁰	ACT Penetration	
				Percent of All People With SMI Who Received ACT	Percent of the Number in Need of Act Who Received ACT
<i>Ideal Benchmark</i> ⁴¹				4.3%	100%
US	4,408,739	189,576	63,445	1%	33%
Arizona	208,966	8,968	n/a	n/a	n/a
<i>Maricopa Co. (Total SMI Pop.)</i>	<i>125,207</i>	<i>5,384</i>	<i>1,639</i>	<i>1%</i>	<i>31%</i>
Maricopa Co. — RBHA Total	24,608	1,058	1,639	7%	160%
Maricopa Co. — Medicaid	19,617	844	1,406	7%	167%
Maricopa Co. — Gen Adult Pop	4,991	215	287	6%	136%
Texas	239,561	10,301	3,335	1%	32%
Harris County (Dallas)	64,000	2,752	281	0%	10%
Bexar County (San Antonio)	27,564	1,185	255	1%	22%
New York	418,953	18,015	6,189	1%	34%
New York County (NY City) ⁴²	16,376	704	1,245	8%	177%
Colorado	60,246	2,591	3,514	6%	136%
Denver County (MHCD) ⁴³	8,000	344	690	9%	201%

³⁸ The state-level proportion of people served with a serious mental illness is reported from SAHMSA (2014) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. We calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI.

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

⁴⁰ National and State-level penetration counts for ACT received are reported from SAHMSA. (2014). *Mental Health NOMS: Central Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. Arizona was among the states that did not report the number receiving ACT statewide.

⁴¹ See Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006).

⁴² New York State Office of Mental Health. (2016). (Online Dashboard) Assertive Community Treatment Length Of Stay – January 2016. Retrieved from <http://bi.omh.ny.gov/act/statistics?p=los> on January 15, 2016.

Table 4: Assertive Community Treatment Utilization Relative to Estimated Need Among People with SMI					
Region	Number of Adults with SMI³⁸	Number with SMI Who Need ACT³⁹	Number Received ACT⁴⁰	ACT Penetration	
				Percent of All People With SMI Who Received ACT	Percent of the Number in Need of Act Who Received ACT
Nebraska	13,769	592	223	2%	38%
Omaha (Region 6) ⁴⁴	9,158	394	110	1%	28%
King County (Seattle, WA)	66,326	2,852	90	<1%	3%
California	392,459	16,876	5,227	1%	31%
Illinois	96,521	4,150	979	1%	24%
Minnesota	101,075	4,346	1,992	2%	46%
Wisconsin	48,901	2,103	3,572	7%	170%
Tennessee	150,171	6,457	417	0%	6%
Indiana	77,369	3,327	476	1%	14%
Delaware	6,954	299	334	5%	112%
New Hampshire	10,504	452	263	3%	58%
North Carolina	113,352	4,874	4,652	4%	95%

⁴³ Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015 and 2016.

⁴⁴ Triwest Group. (2014). *Omaha Area Adult Mental Health System Assessment: Final Summary of Findings and Recommendations*. Unpublished Manuscript. Boulder, CO: TriWest Group.

Supported Employment Benchmarks

While Maricopa County meets a high percentage of the estimated need for supported employment services among those receiving services, there are a very small percentage of people who appear to be receiving evidence-based supported employment services. Over 4,000 people receive pre-job training and development services, but very few receive services associated with obtaining and maintaining a job. This could mean that supported employment services in Maricopa County rarely result in people obtaining jobs, or that the number of people receiving the full array of supported employment services is under-reported. However, based on previous clinical record reviews and interviews with recipients, as well observations of other stakeholders previously interviewed in focus groups, it is more likely that a large volume of pre-vocational services are being provided, but relatively few people are actually receiving the full, evidence-based supported employment model in Maricopa County. Denver is a good benchmark community, with nearly 14% in need receiving supported employment services. The states of Kansas and New Hampshire report even higher penetration rates. Members receiving supported employment services in Denver County receive the full evidence-based approach.⁴⁵

Table 5: Supported Employment Utilization Relative to Estimated Need Among Persons with SMI					
Region	Number of Adults with SMI ⁴⁶	Number of People in Need of SE ⁴⁷	Number of People Who Received SE ⁴⁸	SE Penetration	
				Percent Served Among People With SMI	Percent Served Among People Who Need SE
<i>Ideal Benchmark</i>				45%	100%
US	4,408,739	1,983,933	61,511	1%	3%
Arizona	45,138	20,312	12,786	28%	63%
<i>Maricopa Co. (Total SMI Pop.)</i>	<i>125,207</i>	<i>11,074</i>	<i>4,230</i>	<i>3%</i>	<i>8%</i>
Maricopa Co. (Total served)	24,608	11,074	4,230	17%	38%
<i>Maricopa Co. (SE Ongoing)</i>	<i>24,608</i>	<i>11,074</i>	<i>725</i>	<i>3%</i>	<i>7%</i>
Maricopa Co. - Medicaid	19,617	8,828	3,755	19%	43%
<i>Medicaid (SE Ongoing)</i>	<i>19,617</i>	<i>8,828</i>	<i>639</i>	<i>3%</i>	<i>6%</i>

⁴⁵ Personal communication with Roy Starks of the Mental Health Center of Denver, January 2016.

⁴⁶ The state-level proportion of people served with a serious mental illness is reported from SAHMSA (2014) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1. We calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI.

⁴⁷ 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.

⁴⁸ National and State-level penetration supported employment counts are reported from the SAHMSA. (2014). *Mental Health NOMS: Central Mental Health Services Uniform Reporting System*. Retrieved from http://www.samhsa.gov/data/us_map?map=1.

Table 5: Supported Employment Utilization Relative to Estimated Need Among Persons with SMI					
Region	Number of Adults with SMI ⁴⁶	Number of People in Need of SE ⁴⁷	Number of People Who Received SE ⁴⁸	SE Penetration	
				Percent Served Among People With SMI	Percent Served Among People Who Need SE
Maricopa Co. — Gen Adult Pop	4,991	2,246	475	10%	21%
<i>Non-Medicaid (SE Ongoing)</i>	4,991	2,246	86	2%	4%
Texas	239,561	107,802	11,116	5%	10%
Harris County (Dallas)	64,000	28,800	1,287	2%	4%
Bexar County (San Antonio)	27,564	12,404	982	4%	8%
New York	418,953	188,529	1,837	<1%	1%
Colorado	60,246	27,111	1,286	2%	5%
Denver County (MHCD) ⁴⁹	8,000	3,600	521	7%	14%
Nebraska	13,769	6,196	843	6%	14%
Omaha (Region 6) ⁵⁰	9158	4,121	260	3%	6%
California	392,459	176,606	419	<1%	<1%
Illinois	96,521	43,434	2,489	3%	6%
Kansas	17,502	7,876	1,367	8%	17%
Minnesota	101,075	45,484	338	0%	1%
Wisconsin	48,901	22,005	701	1%	3%
Tennessee	150,171	67,577	1014	1%	2%
Indiana	77,369	34,816	1,311	2%	4%
Delaware	6,954	3,129	39	1%	1%
New Hampshire	10,504	4,727	1218	12%	26%
North Carolina	113,352	51,008	N/A	N/A	N/A

⁴⁹ Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015 and 2016.

⁵⁰ 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 2015, while down slightly from 2014, is still relatively high. The Omaha area of Nebraska has a slightly higher penetration rate, but Maricopa County also constitutes a “best practice” benchmark in terms of access to peer support.

Table 6: Peer Support Penetration Rates — 2015		
Region	PS Received	PS Penetration Rate
Arizona		
Maricopa County (Total) - 2015	7,173	29%
Maricopa County (Total) - 2014	7,522	31%
Maricopa County (Total) - 2013	8,385	41%
Texas		
Harris County	600	4%
Nebraska		
Region 6 (Omaha)	3,957	43%
Colorado		
Denver City-County	150	2%

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 2016, Maricopa County will have 23 ACT teams capable of serving 2,300 recipients. Based on current enrollment, 9.3% 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.⁵¹

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 1,200 recipients by FY 2016. The increase represents added capacity of 5% 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.

⁵¹ 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 750 additional recipients by FY 2016. The increase represents added capacity of 3% 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		FYs 2015-2016 (2014-2016)	8 teams (some specialty)	Services for 1,200 class members	Services for 750 class members	Services for 1,500 class members
Updated 2016	24,608		As of January 2016: Six additional ACT teams 1,693 class members served	815	4,763	7,673

Delaware						
		FY 2014	Add 1 additional team	Vouchers/Subsidies/Bridge Funding to 650 Individuals	Supported Employment Up to Additional 300 Individuals/Year	Provide Family or Peer Support to 250 Additional Individuals/Year
		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 2016 ⁵²	6,953		16 ACT team serving 1,533 individuals	749 Individuals	663 individuals	2500 individuals

⁵² <http://www.samhsa.gov/data/sites/default/files/URSTables2014/Delaware.pdf>

New Hampshire					
	June 2014	Each Mental Health Region has an ACT Team	240 Supported Housing Units	Increase Penetration Rate by 2% over 2012 Penetration Rate of 12.1 to 14.1%	Maintain Family Support Services Consistent with the Agreement. Have a System of Peer Support Services Offered Through Peer Support Centers Open a Minimum of 8 Hours Per Day for 5.5 Days Per Week in Each Mental Health Region of the State
	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	Additional 110 Total of 450	Increase 2% to 18.1%	

		for Capacity to 1,500	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 2016 ⁵³	10,812	101 teams throughout state's ten CMHC regions, serving a total of 669 individuals	As of September 2015 , there are 376 people in leased or approved for bridge subsidy housing	Average penetration rate across 10 CMHC regions reported to be 15.7%.	3069 members received peer support services.

⁵³ <http://www.samhsa.gov/data/sites/default/files/URSTables2014/NewHampshire.pdf>.

North Carolina					
	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 additional 1,834 individuals	Provide to a total of 1,334 additional individuals	
Updated2016 ⁵⁴	92,502	77 teams serving 5,054 individuals	375 Individuals	460	

⁵⁴ 2016, LME/MCO Monthly Monitoring Report, January 2016.

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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:

- Since the last service capacity assessment, the RBHA provided training regarding the use of bill codes for peer and family support services. Participants reported a clear understanding of the availability and use of peer and family support services and how they were distinguished from case management services.
- The referral process for peer support services is perceived to be less cumbersome and participants found the process to be more efficient. The miscommunication regarding the requirements to specifically identify a provider agency's name on the ISP was perceived by focus group participants to be resolved. However, provider focus group participants reported that obtaining updated ISPs and documentation from the clinics is particularly difficult and can create a barrier to care.
- There has been some progress and participants reported that they observe more peer support specialists providing peer-related work such as facilitating WRAP classes and leading skill-building classes and health and wellness groups.
- Similar to last year, participants reported that there are not enough peer and family support specialists co-located at the direct care clinics. Turnover is high and once positions are vacant, some clinics reportedly eliminated the positions due to a lack of funding.
- Participants reported that the family mentors who are available at the direct care clinics provide effective support services to families. However, the family mentors appear to be overwhelmed by the size of member caseloads. During one focus group, it was reported that a family mentor is assigned to over 1,500 family members.
- Participants in the provider, case manager and adult member focus groups expressed that some clinical teams still do not fully understand the role of the peer support specialist, recovery navigator and family support specialists/mentors. In the case manager focus group, one clinical supervisor reported that even in his role, he still does not really understand the role of peer staff on the clinical team. One Recovery Navigator stated, "I end up doing case management work — my team really doesn't understand my role."

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- Peer support specialists and family support specialists reported that they are not viewed as key members of the clinical team. One peer support specialist reported, “I have been a peer support specialist for seven years but I still don’t feel like I am a respected part of the team. I think this is related to stigma.”
- Peer and family support specialists report they are often overwhelmed by the demands of their work. They do not receive supported employment services after they are hired and are not always supported by the clinical teams to manage work-related stress. One recovery navigator noted, “I am the only recovery navigator at my clinic. I do feel very overwhelmed.”
- As was reported over the last two years, family members continue to experience issues with the interpretation of the release of personal health information by clinical teams. Focus group members felt that the restrictions lead to the exclusion of family members from the ISP process.
- Family members, adults and provider representatives all agree that family members would benefit from a navigational guide or set of resources that are easily accessible in a centralized location. One provider agency does offer a 9-month program for family members to assist them with their role. Participants in the family member focus group provided positive feedback about this program.
- Participants reported that one of the biggest barriers to engaging family members is the lack of available supports and services outside of normal business hours.
- Participants expressed the need to employ or house additional peer and family support specialists in crisis centers and hospital settings.

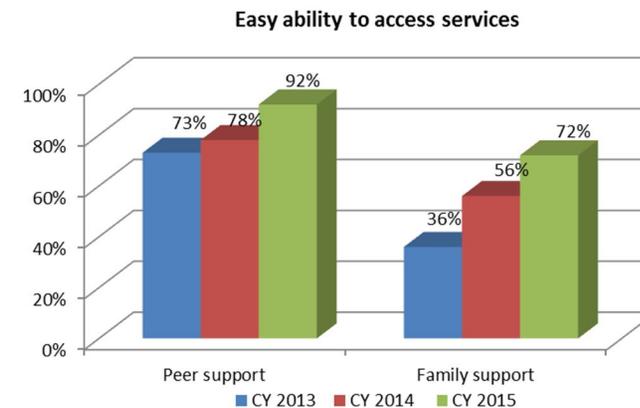
Key Informant Survey Data

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 (92%) as opposed to difficult to access or having no ability to access (8%). Consistent with the last two years, peer support services were perceived as the easiest of all the priority services to access.

28% of survey respondents felt that family support services were difficult to access or were inaccessible while (72%) 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 continued to increase during CY 2015.



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

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

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

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

In terms of service utilization, 92% (up from 76% during CY 2014) of the responses indicated that peer support services were being utilized effectively or were utilized effectively most of the time. 8% of respondents indicated that the peer support services were not utilized effectively.

84% of the responses indicated that family support services were being utilized effectively or were utilized effectively most of the time (up from 69% during CY2013). Alternatively, 16% of the responses indicated that family support services were not utilized effectively.

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

- 78% 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 CY 2013 and 75% during CY 2014.
- 74% 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 CY 2013 and 69% during CY 2014.
- 15% reported it taking four to six weeks to access peer support services following the identification of need (20% – CY 2013; 13% – CY 2014).
- 13% percent reported it taking four to six weeks to access family support services following the identification of need (44% – CY 2013; 8% – CY 2014).
- 7% of the survey respondents reported that it would take an average of six weeks or longer to access peer support services (10% – CY 2013; 13% – CY 2014).
- 13% of the survey respondents reported that it would take an average of six weeks or longer to access family support services (22% – CY 2013; 23% – CY 2014).

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Medical Record Reviews Group 1

A random sample of 119 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. The entire sample of recipients was subsequently interviewed to collect information regarding their perceived needs for the same services.

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

20% of the assessments explicitly identified peer support as a need. When assessed as a need, peer support services were identified on the recipient's ISP 63% of the time.

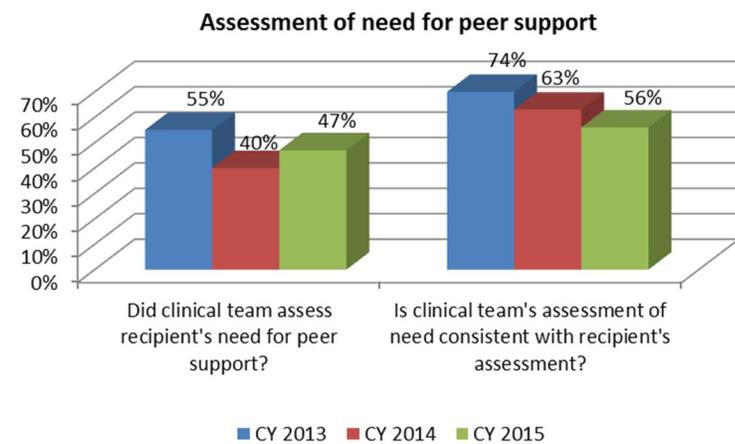
22% of the Group 1 recipients received at least one unit of peer support services during CY 2015.

Interviews

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

The interview asked the following:

- Did the clinical team assess the recipient's need for peer support services? 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 (56%), the clinical team's determination of need matched the recipient's perception of need.



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Family Support Services

The clinical teams consistently identify and document natural and family supports that are important to the recipient as part of the initial or annual assessment update process. Most of the records reviewed included evidence that family supports were at least identified by the clinical team. Family support services can be an 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.

Consistent with findings during CY 2013 and CY 2014, opportunities exist to leverage family support services to support recipients in achieving their ISP goals.

12% of the assessments reviewed identified a related need for family support services. In these cases, only one of the ISPs explicitly identified family support services as an intervention to address the need.

3% of the Group 1 recipients received at least one unit of family support services during CY 2014.

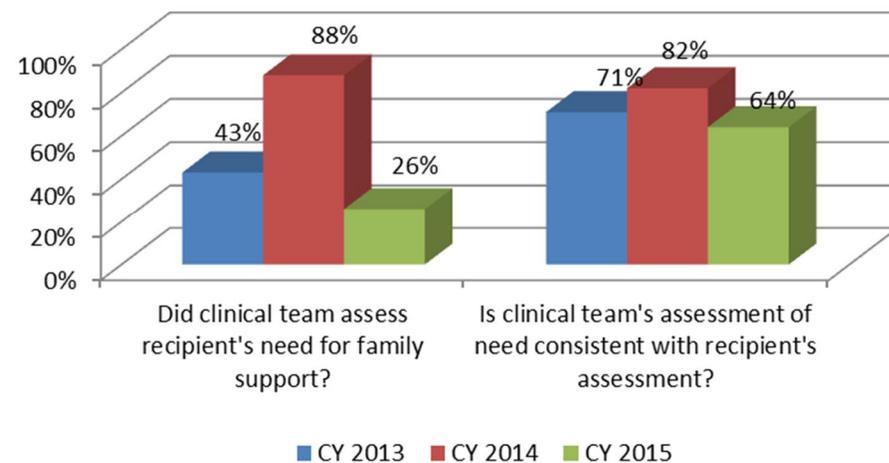
Interviews

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

The interview asked the following:

- Did the clinical team assess the recipient's and family's need for family support services? In contrast to CY 2014, only about one in four recipients recalled discussing family support services with the clinical team.
- The clinical team's assessment was found to be consistent with the recipient's perception regarding the need for family support services in 64% of the cases.

Assessment of need for family support



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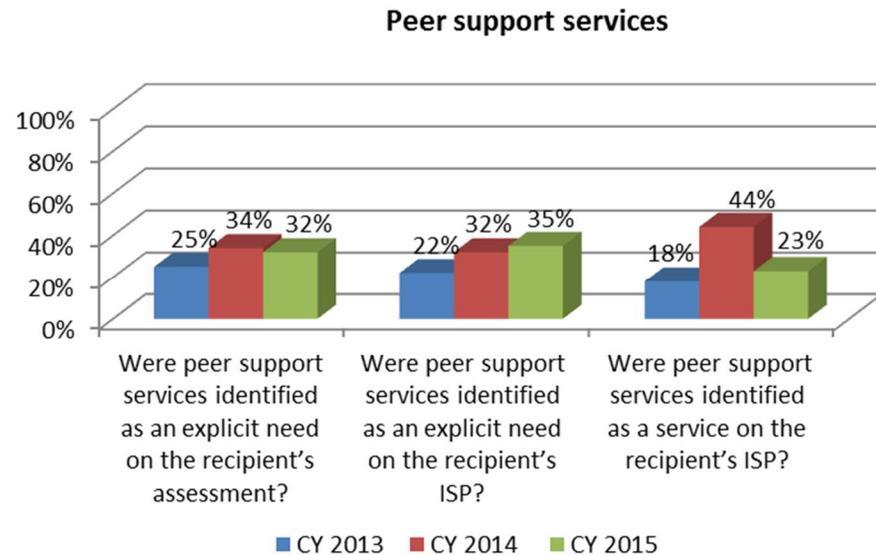
Medical Record Reviews: Group 2

A random sample of 201 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.

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

23% of the ISPs included peer support services when assessed as a need. ISPs often identified case management as the intervention to address peer support service needs.

30% of the recipients included in the sample received at least one unit of peer support during CY 2015.



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

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

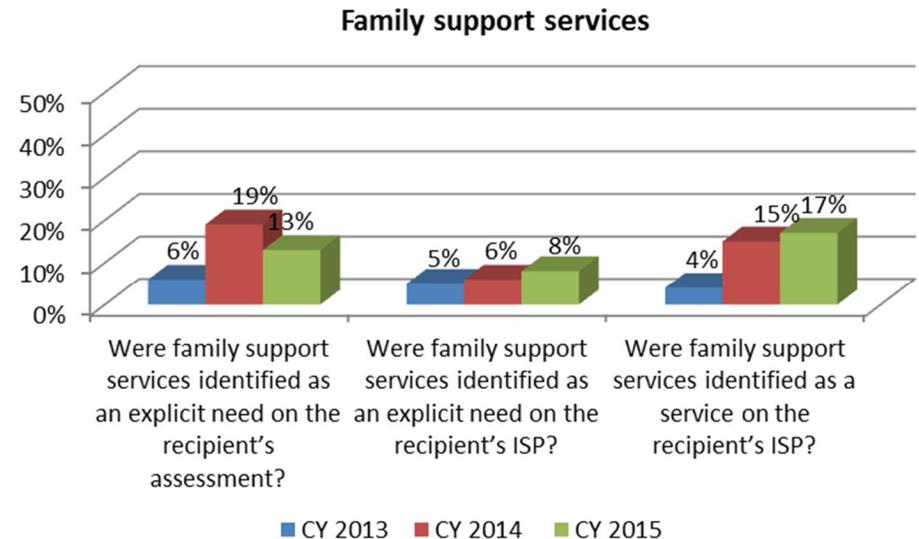
Family Support Services

As part of the clinical 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 infrequently utilized as part of service planning development. Similar to observations the past two years, missed opportunities to leverage family members were noted when the clinical team identified challenges with engaging members and ensuring follow up with treatment recommendations.

17% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP, a slight improvement when compared to CY 2014. 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.

4% of the recipients included in the sample received at least one unit of family support during CY 2015.

- In ten cases the person was unable to access family support services after the service was recommended by the clinical team. Reviewers were able to review progress notes and determined that in 50% of these cases, there was no evidence that the clinical team initiated a referral for the service.



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Service Utilization Data

During the time period of October 1, 2014 through June 30, 2015, 24,841 unique users were represented in the service utilization data file. Of those, 80% were Medicaid eligible and 20% were non-Title XIX eligible.

- Overall, 29% of the recipients received at least one unit of peer support services during the time period (31% over a comparable time period last year).

Access to the service was evenly split between Title XIX (27%) and non-Title XIX groups (30%).

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

- Forty-eight 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 (identical to last year) and 7% received the service for nine consecutive months.

Persistence in Peer Support Services October 2014 — June 2015			
Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	45.9%	55.6%	47.8%
2	18.4%	17.6%	18.3%
3–4	16.9%	12.5%	16.1%
5–6	7.7%	5.0%	7.1%
7–8	3.6%	3.6%	3.6%
9	7.4%	5.7%	7.1%

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, 1.9% of the recipients received at least one unit of family support services during the time period (2.2% over a comparable time period last year).

Access to the service was split between Title XIX (2.0%) and non-Title XIX groups (1.5%).

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

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

Persistence in Family Support Services October 2014 — June 2015			
Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	75.9%	83.8%	77.1%
2	9.7%	10.8%	9.9%
3-4	5.5%	5.4%	5.5%
5-6	3.0%	0.0%	2.5%
7-8	2.5%	0.0%	2.1%
9	3.5%	0.0%	2.9%

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

Key Findings and Recommendations

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

Findings: Peer Support

- Service utilization data demonstrates a progressive reduction in the percentage of members who received at least one unit of peer support services over the respective review periods (CY 2013 — 38%; CY 2014 — 31%; CY 2015 — 29%).
- The referral process for peer support services is perceived to be less cumbersome and participants found the process to be more efficient. The miscommunication regarding the requirements to specifically identify a provider agency's name on the ISP was perceived by focus group participants to be resolved. However, provider focus group participants reported that obtaining updated ISPs and documentation from the clinics is particularly difficult and can create a barrier to care.
- Overall, perceptions regarding the ease of accessing peer support services continued to increase during CY 2015.
- 23% of the ISPs included peer support services when assessed as a need. ISPs often identified case management as the intervention to address peer support service needs.
- The Maricopa County system excels in certain areas of evidence-based practice utilization. For example, Maricopa County has strong access to peer support services to the extent that the utilization is deemed as a “best practice benchmark”.
- By March 2016, peer support and family support expansion efforts have resulted in added capacity to serve an additional 1,530 members.

Consumer Operated Services

Findings: Family Support

- 74% 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 CY 2013 and 69% during CY 2014.
- 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.
- Despite the clinical team's identification of natural and family supports, ISPs rarely included family support services.
- Mercer found that member's assessed needs were not always translated to the member's individual service plan. For example, 12% of the assessments reviewed identified a related need for family support services. In these cases, only one of the ISPs explicitly identified family support services as an intervention to address the need.
- In contrast to CY 2014, only about one in four recipients recalled discussing family support services with the clinical team.
- Service utilization data demonstrates minor differences in the percentage of members who received at least one unit of family support services over the respective review periods (CY 2013 — 2%; CY 2014 — 3%; CY 2015 — 2%).

Recommendations: Peer Support

- The system should regularly monitor to identify deficiencies with current assessments and ISPs. Initiate appropriate corrective actions to address any identified performance deficiencies.
- As part of monitoring and oversight activities, assess the impact of timely access to care when delays occur with obtaining updated ISPs and documentation from the clinics as part of the referral process for each of the priority mental health services, including peer support services. Initiate appropriate corrective actions to address any identified performance deficiencies.
- 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.

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.

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 in all four focus groups indicated a clearer understanding of the appropriate application of supported employment services. This was a positive change in comparison to feedback received last year.
- There has been a reported increase in the number of Vocational Rehabilitation (VR) specialists located at the clinics. While there is variation in the skill level of each VR counselor and the speed of access to VR services, overall, participants expressed that the increased availability has been a positive change.
- It was reported that VR no longer denies members for services based on “readiness to work” and this has increased the number of members engaged with VR services.
- Over the past year, there has also been a reported increase in the number and availability of job coaches in the system.
- New this year, participants reported that most of the supportive case management teams now have rehabilitation specialists. They do not carry caseloads and are dedicated to rehabilitation related tasks. The rehabilitation specialists conduct work readiness reviews and have the capacity to explore member’s individualized employment and educational interests.
- The referral process for supported employment services is reportedly improving and not as cumbersome. Participants commented that the process seemed more efficient. However, provider focus group participants reported that obtaining updated ISPs and documentation from the clinics can be difficult and may create a barrier to care.
- Unlike past years, participants stated that members are now encouraged to pursue a wider variety of employment opportunities outside of peer support specialist work. The model of rapid job searching and placement is proving to be effective and is helping members to obtain employment in a more expedient manner.
- Similar to last year, adults and family members expressed concerns about the availability of case managers and their capacity to support a member’s desire to work. One adult member stated, “I have worked my entire life and I want to work again. My clinical team asks me if I’m interested about working again but there hasn’t been any follow through. I think my case manager is too overloaded with work. I’m now looking for employment on my own.”
- Focus group participants reported that benefit specialists are available in some clinics, but they are often overwhelmed by the volume of members needing assistance. Participants also stated that appointments to meet with benefit specialists are often scheduled 2 to 3 months out. Most focus group participants agreed that the skill sets of benefit specialists vary, but that many are knowledgeable and able to provide members with information about how employment may impact a member’s benefits. It was also reported that Disability 101 trainings are still being offered at the clinics and are typically facilitated by the benefit specialists.

Supported Employment

- Participants also expressed that, while there has been a philosophical shift in which clinical teams encourage members to explore employment options if desired, there are still some clinical teams that discourage employment. One recovery navigator reported, “My clinical team kept pushing me towards applying for disability even though I wanted to work. I was 23 years-old and didn’t want to sit on my couch. I kept getting told that I shouldn’t try to work because it was too stressful. I had to fight for a referral to REN who gave me pre-vocational support. I earned a Peer Support Certification and sought a job on my own as a recovery navigator.” A family member shared that she witnessed her son being told that due to his body odor and poor oral health hygiene, he would not be able to get hired for a job.
- Family members reported that access to supported employment services depends on the skills and knowledge level of the assigned case manager. One family member reported that his son expressed an interest in working and brought a viable option to his case manager, however, there was no follow up. His son eventually gave up on the option and it has been difficult to engage him further regarding new employment options.
- 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.

Supported Employment

Key Informant Survey Data

17% of survey respondents felt that supported employment services were difficult to access, significantly less than the last two years (75% – CY 2013; 33% – CY 2014). 83% of respondents indicated that supported employment services were easy to access or easier to access, up from 66% last year.

Factors that negatively impact accessing supported employment services included:

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

83% of the responses indicated that supported employment services were being utilized effectively or were utilized effectively most of the time, up from 81% last year. Alternatively, 17% of respondents indicated that supported employment services were not utilized effectively.

70% 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% during CY 2013 and 60% during CY 2014. 15% 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.

32 of 119 (27%) Group 1 records identified an assessed need for supported employment services.

Only 16% of the Group 1 recipients received at least one unit of supported employment services during CY 2015.

Interviews

The interview revealed the following findings:

- Less than half (47%) of the interview respondents reported that there was an assessment regarding supported employment needs and available services.
- In 61% 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 less than half the cases reviewed (44%). Supported employment services were only identified as a service on the recipient's ISP in 22% of the cases reviewed when assessed as a need. (The CY 2013 finding was 13% and the CY 2014 finding was 26%).

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 36% (41% during CY 2014).

21% of the recipients included in the sample received at least one unit of supported employment during CY 2015.

In 47 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. A lack of evidence that the clinical team followed up with initiating a referral for the service was noted in 53% of the cases in which the person did not access the service despite an identified need.

Supported Employment

Service Utilization Data

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

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

H2027 — Psychoeducational Services (Pre-Job Training and Development)

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

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

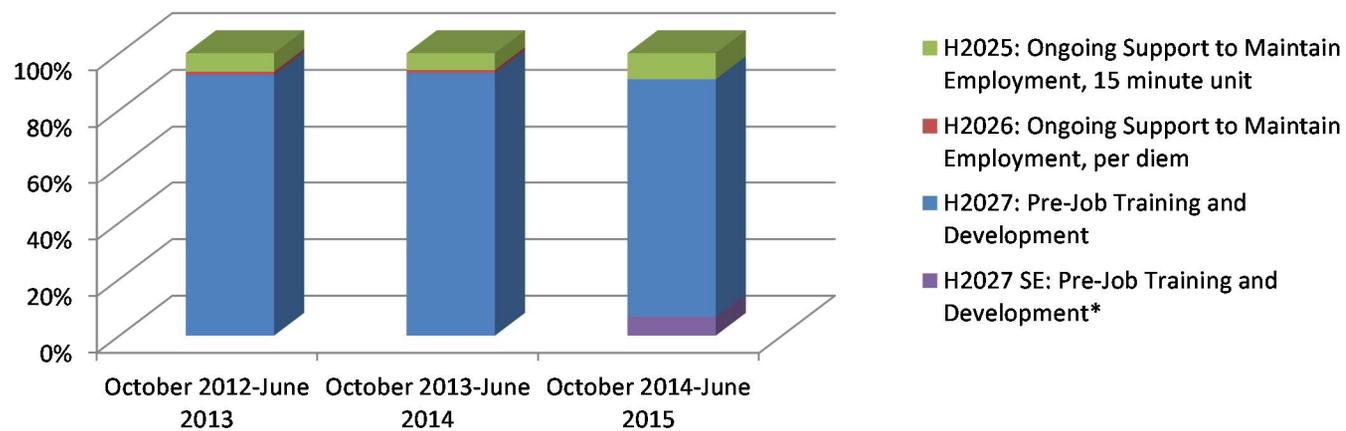
H2026 — Ongoing Support to Maintain Employment (per diem)

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

Supported Employment

The service utilization data set demonstrates continued variation in the volume of the three available service codes for supported employment. For the time period October 1, 2014 through June 30, 2015, H2027 (pre-job training and development) accounts for 84% of the total supported employment services (a decrease from CY 2013 – 93% and CY 2014 – 94%). H2025 (ongoing support to maintain employment/15 minute billing unit) represents 9% of the supported employment utilization (an increase from CY 2013 – 7% and CY 2014 – 6%). Finally, H2026 (ongoing support to maintain employment/per diem billing unit) represents less than 1% of the utilization of supported employment (comparable to CY 2013 and CY 2014 findings). In partial response to these year-to-year findings, the Maricopa County RBHA collaborated with ADHS/DBHS to develop a unique billing modifier (i.e., SE) to be utilized in conjunction with billing code H2027. Mercer analyzed the presence of this code and modifier within the service utilization data file (see graphic below). H2027 SE represented 7% of the overall supported employment utilization. Upon review of the provider notification that was distributed on December 4, 2014 introducing the new modifier and explaining its appropriate use, it is unclear how the intent of the modifier (H2027 SE) is distinguished from the service description of H2027. For example, both service descriptions have the following in common: career/educational counseling, training in resume preparation, job interview skills, professional decorum and dress and assistance with finding employment. The only discernable difference is guidance that specifies that the modifier should be applied when employment related services are provided in coordination with the member’s goal of obtaining employment within the next 45 days and/or the member is actively searching for a job. It is unknown how and if the modifier may impact the relative under-utilization of ongoing support to maintain employment (H2025).

Supported Employment service encounters



Supported Employment

Information collected during a key informant interview provided some insight into the challenges associated with the provision of ongoing support to maintain employment. The key informant was affiliated with a RBHA contracted supported employment provider and shared that the majority of individuals who access ongoing support to maintain employment are non-Title XIX eligible. Subsequent service utilization decreases have been observed since providers have experienced reductions in non-Title XIX funding over the past few years. Per the key informant, ongoing supported employment services are typically not provided at the member's job site; rather more job coaching is done outside of the work site. It was reported that the current emphasis with supported employment services is to secure employment, with less emphasis on ongoing support; primarily because the employed person becomes less available. Other reported challenges were that the ongoing support to maintain employment service description did not allow billing for telephone calls or texting of members and a perception that meetings with the person outside of the job site were not feasible. In terms of the application of the new modifier, the representative from the supported employment provider reported that the modifier was intended to be used by the new expanded supported employment staff and utilization of the modifier would be a focus for future evidence-based fidelity practice reviews.

Despite the reported challenges with the provision of ongoing supported employment services, the key informant acknowledged that there was a need to shift to more support once a person gained employment. The interviewee expressed that recently employed members typically don't receive enough support and often have questions about the impact of employment on maintaining eligibility criteria for health and disability benefits. The agency is attempting to promote additional job coaching which requires supported employment staff to have skills with engagement and time to establish meaningful relationships with the member. To do this effectively, supported employment specialists must maintain manageable caseload sizes – yet, as reported by the interviewee, the system persistently demands service encounter productivity and reinforces the volume of service over the quality of service.

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

- Overall, 17% 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 (18%) and non-Title XIX groups (9%).

Supported Employment

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

- Forty-seven percent of the recipients who received at least one unit of supported employment services during the review period accessed the service during a single month (this finding is consistent with the observed disproportionate utilization of pre-job training and development);
- 17% of the recipients received supported employment services for three to four consecutive months during the review period; and
- 9% 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	47.4%	46.4%	47.3%
2	15.0%	15.9%	15.1%
3–4	17.8%	16.6%	17.6%
5–6	6.9%	8.2%	7.1%
7–8	3.6%	3.8%	3.6%
9	9.2%	9.3%	9.3%

Key Findings and Recommendations

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

Findings: Supported Employment

- Service utilization data demonstrates a steady reduction in the percentage of members who received at least one unit of supported employment over the respective review periods (CY 2013 – 39%; CY 2014 – 20%; CY 2015 – 17%).
- Less than half (47%) of the interview respondents reported that there was an assessment regarding supported employment needs and available services.
- 17% of survey respondents felt that supported employment services were difficult to access, significantly less than the last two years (75% – CY 2013; 33% – CY 2014). 83% of respondents indicated that supported employment services were easy to access or easier to access, up from 66% last year.
- 70% 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% during CY 2013 and 60% during CY 2014.
- Supported employment services were only identified as a service on the recipient’s ISP in 22% of the cases reviewed when assessed as a need. (The CY 2013 finding was 13% and the CY 2014 finding was 26%). In some 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).
- A lack of evidence that the clinical team followed up with initiating a referral for the service was noted in 53% of the cases in which the person did not access the service despite an identified need.

Supported Employment

- Similar to previous years, the service utilization data set demonstrates significant variation in the volume of the available service codes for supported employment. For the time period October 1, 2014 through June 30, 2015, H2027 and H2027 SE (pre-job training and development) accounts for 91% of the total supported employment services.
- When engaged in supported employment services, community-based supported employment providers may send monthly progress updates to the direct care clinics or, when co-located, may attend treatment team meetings. It is unclear how or if this information is utilized by the direct care clinical teams. A review of 201 direct care clinic records and associated progress notes revealed only a few references to the status of services received by community-based or co-located providers.
- One supported employment provider has staff co-located in eleven different direct care clinics, expanding the number of staffing positions by four since the last review period.
- While Medicaid (Title XIX) and non-Medicaid (non-Title XIX) members both have access to covered supported employment services, one community based supported employment provider reported that the agency's overall funding is primarily targeted to Title XIX eligible members (75% Title XIX; 25% non-Title XIX). There was a reported need for additional non-Title XIX member referrals for supported employment services. It was also perceived that these individuals have historically achieved successful outcomes when engaged with supported employment services. However, the medical record reviews found that some non-Title XIX SMI members do not receive a comprehensive assessment and/or are issued brief ISPs that do not appear individualized or detailed enough to support the provision of covered behavioral health services.
- Supported employment providers co-located at direct care clinics are unable to access the clinical team's electronic medical record system. As an alternative, a basic monthly summary is developed and provided to the clinical team. Co-located supported employment providers regularly attend clinical team meetings and provide a brief status update for shared members that are engaged with the supported employment provider. Despite these efforts, Mercer's review team noted that a lack of integration and coordination across direct care clinics and community-based providers continues to be evident.
- The service utilization data file revealed agencies that were providing high volumes of supported employment services, yet some of those providers were not identified as contracted to provide the service with the Maricopa County RBHA.⁵⁵
- Supported employment expansion efforts resulted in additional capacity to serve 765 members during CY 2015.

⁵⁵ As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in January 2016.

Supported Employment

Recommendations: Supported Employment

- Through training and supervision, ensure that clinical team members assess and 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.
- 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.
- 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.
- Initiate improvement actions to address the noted lack of integration and coordination between the direct care clinics and community-based providers.

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:

- Case managers report that housing providers are highly responsive to requests for assistance and are observing success with members who receive services.
- The referral process for supported housing services is perceived to be more efficient. However, provider focus group participants reported that obtaining updated ISPs and documentation from the clinics can be challenging and may create a barrier to care.
- Similar to last year, participants reported high turnover rates and insufficient training for case management staff results in a lack of knowledge about housing options and resources.
- Similar to last year, the insufficient capacity of available housing units, including transitional housing, and limited housing vouchers remains a primary concern of focus group members. Case managers and providers expressed growing concern about the lack of available safe and affordable housing in Maricopa County and the impact on member's utilization of the crisis system and inpatient services and encounters with law enforcement.
- Participants expressed that case managers do not have sufficient time and knowledge to assist members in locating safe and affordable housing. The ratio of case managers to members is perceived to still be too high. Participants recommended that the direct care clinics employ housing specialists or housing navigators who can assist members with housing needs.
- Focus group participants reported that after securing housing, members often have outstanding utility bills, require assistance with move-in deposits, and lack the necessities of a home. All of these issues are perceived to impact the long-term stability of a member's housing. Participants commented that there are not enough resources to assist members with the totality of their housing needs.
- Similar to last year, participants in all four focus groups indicated a need for increased transparency of supported housing provider wait lists and available housing opportunities. It was reported that clinical teams and members are not able to access information about the length of waiting lists and a member's position on a wait list.

Supported Housing

Key Informant Survey Data

38% of the survey respondents felt that supported housing services were difficult to access, down from 50% a year ago. As noted during CY 2014, none of the respondents indicated that supported housing services were inaccessible, a sustained improvement from CY 2013 when 17% of the key informants felt that the services were inaccessible.

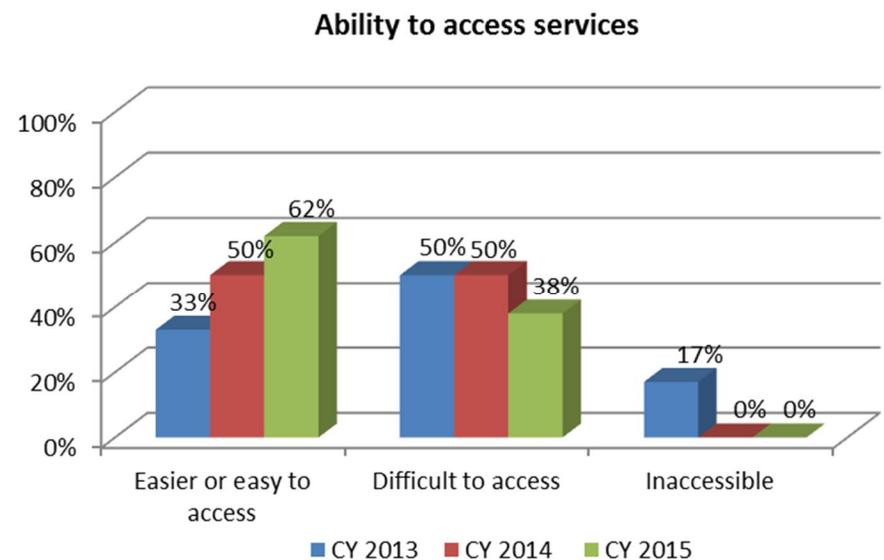
62% of respondents indicated that supported housing services were easier to access or easy to access. When asked about the factors that negatively impact accessing supported housing services, the responses are as follows:

- 59% of the responses indicated that a wait list exists for the service; (25% during CY 2013; 63% during CY 2014);
- 38% of the responses were directed to a lack of capacity/no service provider available (31% during CY 2013; 50% during CY 2014); and
- 24% percent selected admission criteria for services too restrictive (25% during CY 2013; 31% during CY 2014).

In terms of service utilization:

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

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



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. 15 cases or 13% of the sample demonstrated an assessed need for supported housing.

Most of the ISPs reviewed did not include explicit references to supported housing services, typically identifying case management as the intervention to address a supported housing need.

- When assessed as a need, supported housing related services were identified on the recipient's ISP in 50% of the records (20% during CY 2013; 19% during CY 2014).

3% 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

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

The interview revealed the following:

- 39% of the recipients interviewed reported that the clinical team did discuss housing related supports and services.
- Disagreement between the clinical team's assessment and the recipient's perception of need was found in 41% of the cases reviewed (down slightly from 44% during CY 2014).

Supported Housing

Medical Record Reviews: Group 2

Consistent with CY 2013 and CY 2014, in all cases reviewed, the recipient's living situation was assessed and documented.

- Supported housing services were identified as a need on either the recipient's assessment or recipient's ISP in 27% of the cases reviewed.
- Supported housing was identified as a service on the recipient's ISP in 48% of the cases. (up substantially from last year when 27% of the ISPs included supported housing)

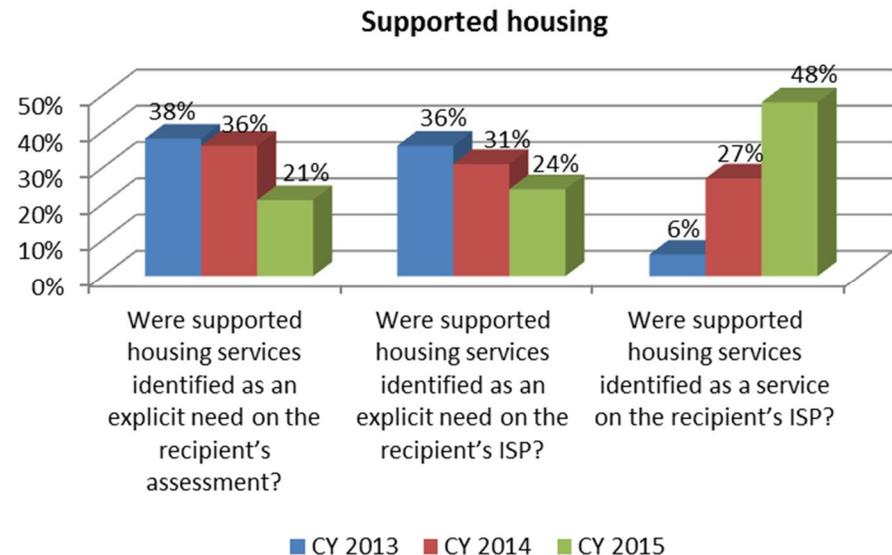
It should be noted that the ISPs that included supported housing services predominantly described the service as subsidized housing, case management or flex funds. None of the ISPs in the sample explicitly named supported housing as a distinct service.

3% 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 2015.

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

Service Utilization Data

The last two service capacity assessments established that the supported housing billing code (H0043) is rarely utilized and that a multitude of other covered services may be encountered in the context of providing supported housing services. Supported housing services can include personal assistance, living skills training, peer support, medication monitoring and other supports and services to help members obtain and maintain community-based independent living arrangements. As indicated within the service utilization data file, 715 Title XIX eligible (Medicaid) recipients were affiliated with the service during the time period of October 1, 2014 – June 30, 2015 and 15 non-Title XIX recipients received the service from a total population of 24,841 (2.9%). During a comparable time period last year, 3.3% of recipients were affiliated with the H0043 service code. The RBHA reported that 1,769 members accessed a supported housing type service (service and/or subsidy support) during CY 2015.



Supported Housing

Key Findings and Recommendations

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

Findings: Supported Housing

- As indicated within the service utilization data file, 715 Title XIX eligible (Medicaid) recipients were affiliated with the service during the time period of October 1, 2014 – June 30, 2015 and 15 non-Title XIX recipients received the service from a total population of 24,841 (2.9%). During a comparable time period last year, 3.3% of recipients were affiliated with the H0043 service code.
- Focus group participants reported that obtaining updated ISPs and documentation from the clinics necessary to process a referral for supported housing services can be challenging and may create a barrier to accessing the service.
- Most of the ISPs reviewed did not include explicit references to supported housing services; typically identifying case management as the intervention to address a supported housing need. In fact, the medical record review demonstrated that 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.
- In some versions of the ISP template used by the direct care clinics, relevant information was absent such as the specific service to meet an ISP objective and/or the proposed frequency of the service.
- 38% of the survey respondents felt that supported housing services were difficult to access, down from 50% a year ago.
- 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.
- In eleven cases, reviewers were able to review progress notes and record the reasons that the member 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 a lack of evidence that the clinical team followed up with initiating a referral for the service.
- Supported housing service expansion efforts resulted in 1,769 members accessing a supported housing service (service and/or subsidy support) during CY 2015⁵⁶. The specific break-out of supported housing services included: 481 members receiving permanent supported housing subsidy supports; 515 members receiving permanent supported housing service supports; and 773 members receiving community living subsidy supports.

⁵⁶ As reported by the Maricopa County RBHA administering the ADHS/DBHS contract (January 2016).

Supported Housing

Recommendations: Supported Housing

- 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.
- 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.
- As part of oversight and monitoring activities, assess the impact of timely access to care when delays occur with obtaining updated ISPs and documentation from the clinics as part of the referral process for each of the priority mental health services, including supported housing services. Initiate appropriate corrective actions to address any identified performance deficiencies.

Assertive Community Treatment Teams

Service Description:

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

Focus Groups

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

- Adult members who currently utilize or have utilized ACT team services in the past stated that the ACT team was beneficial. One adult member stated, "I find my ACT team to be really helpful and I don't want to lose my ACT team until I have been working for a while again. The housing specialist was really helpful in teaching me how to maintain my home. My case manager saw me every Friday and I really appreciate that he stopped by every week."
- Focus group participants reported that the Maricopa County RBHA is now offering specialized training to staff assigned to ACT teams.
- According to focus group participants, many specialty ACT teams have been disbanded over the past year. Participants expressed that these ACT teams were very effective in meeting the unique needs of the members they served and the perception was that the teams should be reinstated.
- Participants in the case manager focus group reported that criteria for ACT admission are now accessible and clear. However, providers reported they are unable to access the ACT admission criteria. Additionally, family members reported that they were unable to obtain the criteria after their son was denied ACT services. The family reported that the need for the service was dismissed by the case manager without review by the broader clinical team.
- Per the focus group attendees, the referral process for ACT services has improved. As reported last year, participants expressed that they do not hear members being discouraged from ACT team services. One group noted that, as a result of the expansion of the number of ACT teams, many are not operating at full capacity.
- Focus group participants reported that not all clinics have an ACT team or an ACT team in close proximity to a member's assigned direct care clinic. The group identified that some members who would benefit from ACT services decline enrollment with an ACT team because they do not want to change clinics to be closer to an ACT team.
- Similar to last year, participants reported that some ACT team members do not seem to have the requisite skill set to effectively support members. Per the group, this has been particularly problematic for ACT teams experiencing high turnover rates. Participants reported that newly hired case managers are often assigned to ACT teams and that the new case managers do not have sufficient experience to assist members with complex needs.
- Participants in two focus groups expressed concerns that members residing in twenty-four residential settings do not receive any additional recovery support services while residing in residential placements. Participants reported that residential settings typically provide services in group settings and residents would benefit from the individual services provided by ACT teams.

Assertive Community Treatment Teams

Key Informant Survey Data

23% of survey respondents felt that ACT team services were difficult to access (down from 46% during CY 2013 and down from 33% during CY 2014) and none of the respondents indicated that the service was inaccessible (18% perceived the services inaccessible during CY 2013). 77% of respondents indicated that ACT team services were easier to access or easy to access (an increase from 36% during CY 2013 and an increase from 50% during CY 2014).

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

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

In terms of the effectiveness of service utilization:

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

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

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?

Assertive Community Treatment Teams

Four of the 119 cases (3%) included recipients assigned to an ACT team.

Interviews

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

The interview disclosed the following:

- Only one in five (21%) of recipients recalled the clinical team discussing ACT team services during the annual assessment and service planning process. ACT team services are usually not documented as part of the annual assessment and treatment planning process.
- 72% of the recipients agreed with the clinical team's assessment regarding the need for ACT team services.

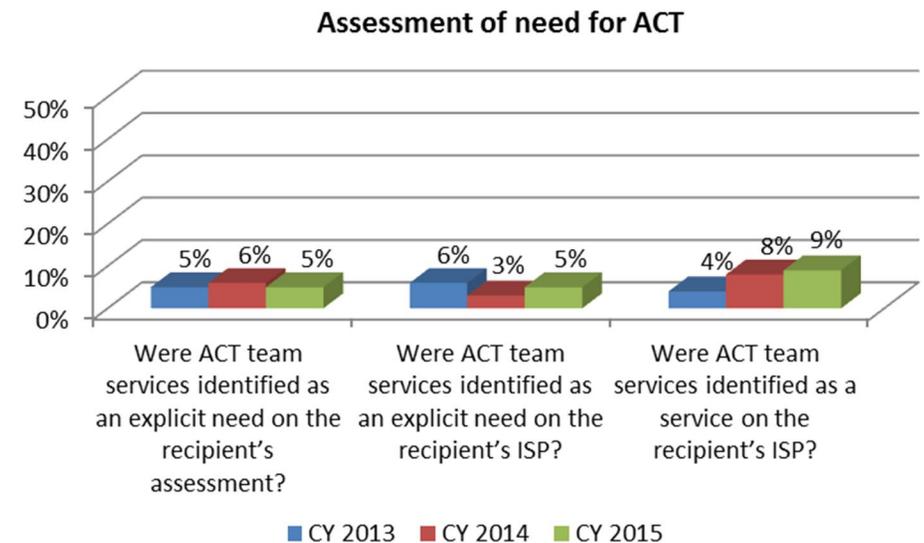
Medical Record Reviews: Group 2

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

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

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

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



Assertive Community Treatment Teams

Service Utilization Data

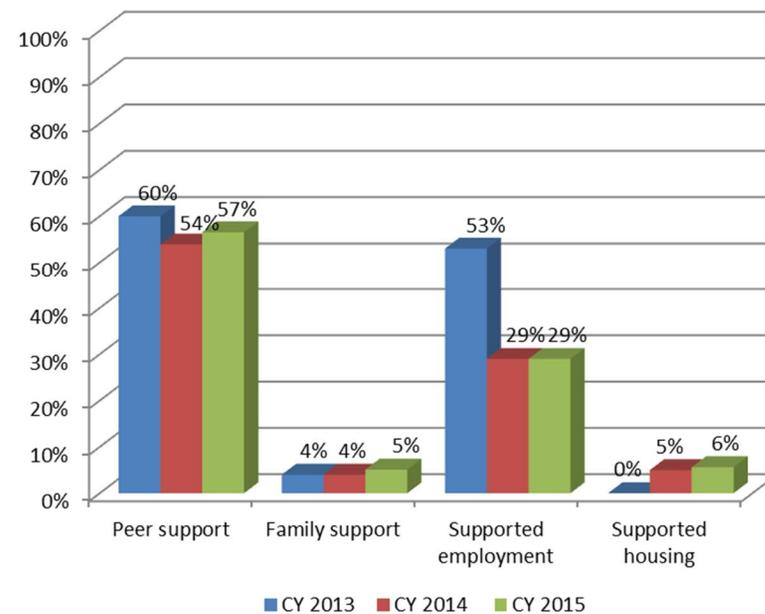
ACT team services are not assigned a specific billing code. Therefore, ACT team services are not uniquely reflected in the service utilization data file.

However, Mercer did complete an analysis of service utilization for recipients that were assigned to an ACT team. CY 2015 service utilization profiles for 1,369 ACT recipients who received a behavioral health service were analyzed.

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

The analysis found 57% of the ACT team recipients received peer support services during CY 2015. ACT recipients who received supported employment services was determined to be 29%, the same finding as CY 2014.

ACT recipients receiving priority mental health services



Assertive Community Treatment Teams

Key Findings and Recommendations

Findings: ACT Team Services

- As a percentage of the total SMI population, 7% of all members are assigned to an ACT team. This is slightly higher than the finding derived during CY 2013 and CY 2014 (6%).
- Per the focus group attendees, the referral process for ACT services has improved. As reported last year, participants expressed that they do not hear members being discouraged from ACT team services. One group noted that, as a result of the expansion of the number of ACT teams, many are not operating at full capacity.
- 23% of survey respondents felt that ACT team services were difficult to access (down from 46% during CY 2013 and down from 33% during CY 2014) and none of the respondents indicated that the service was inaccessible (18% perceived the services inaccessible during CY 2013).
- 63% responded that ACT team services were utilized effectively most of the time (CY 2013 – 18%; CY 2014 – 56%).
- In eleven cases, ACT team services were identified as a need on recipients' assessments and/or ISPs. However, only one of these cases explicitly identified ACT team services on the ISP.
- A review of 101 SMI members that represent the highest aggregate behavioral health service costs was conducted. It was determined that 23% of the members were assigned to an ACT team. This compares to 20% when the same analysis was completed during CY 2013 and 18% during CY 2014. In previous years, the RBHA clarified that some of the members on the list may have high service costs due to expensive psychotropic medications and/or expenditures related to physical health covered services. For the current year analysis (CY 2015), Mercer requested a list of the top 100 aggregate *behavioral health* service costs, so expenditures related to co-occurring medical (physical health) conditions were excluded from this year's analysis. Of the 23 members assigned to ACT and included on the list of the top 101 members with the highest behavioral health service costs; 13 (57%) also resided in Level II or Level III supervised settings. During times of transition (admission or discharge from ACT team services), it may be appropriate to temporarily have a member assigned to ACT and placed in a supervised setting, but this should be time-limited due to the duplicative nature of the services. Overall, 45 of the 101 (45%) members resided in a level II or level III residential setting, which may contribute to higher service costs for those members and may discourage clinical teams from considering or referring a member to an ACT team. If members placed in a level II or level III residential setting (and not currently assigned to an ACT team) are excluded from the analysis, then 41% of the highest cost utilizers are assigned to an ACT team.
- An analysis of jail booking data was completed to identify members that have had multiple jail bookings over a defined period (i.e., eleven months—January through November 2015) 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:
 - 408 members experienced at least two jail bookings during the period under review.
 - Of these 408 members, 91 (22%) were assigned to an ACT team.
 - Of the 91 members assigned to an ACT team, 18 (20%) were assigned to a forensic specialty ACT team.
- 1,693 recipients were assigned to 21 ACT teams as of December 1, 2015. An increase of three teams and 167 members since CY 2014. Another new ACT team was planned to be implemented during May 2016.

Assertive Community Treatment Teams

Recommendations: ACT Team Services

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

Outcomes Data Analysis

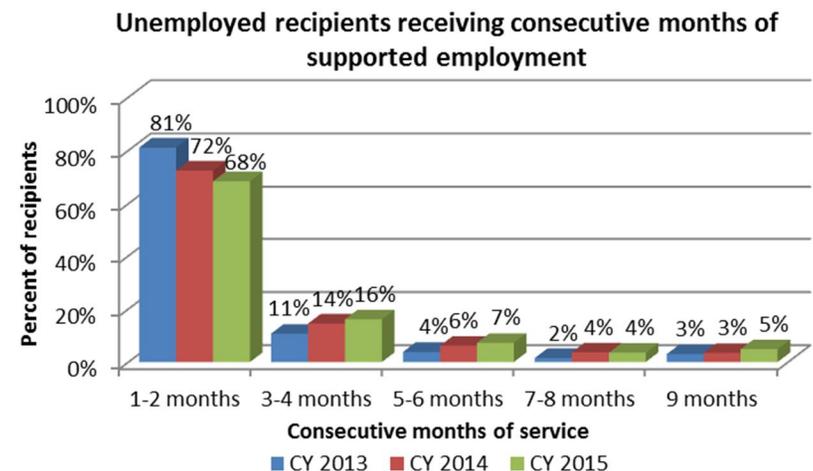
The service capacity assessment utilized an analysis of recipient outcome data in an attempt to correlate receipt of one or more of the priority mental health services with improved functional outcomes. Consistent with the last two year's analysis, the review team selected the following outcome indicators:

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

During CY 2015, an analysis was completed that compared recipients' persistence with receiving supported employment services and peer support services⁵⁷ 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:

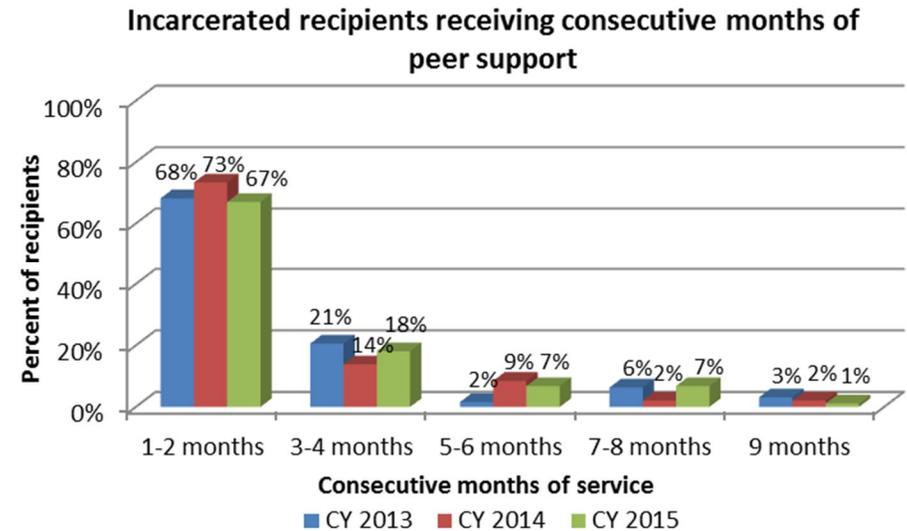
- Similar to CY 2013 and CY 2014 results, the percentage of recipients identified as unemployed decreases as the duration with supported employment services increases. For example, 68% of recipients identified as unemployed are associated with two or less consecutive months of supported employment services. Alternatively, recipients who experienced five or more consecutive months of supported employment services constituted only 7% of the total unemployed group.



⁵⁷ 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 1% received nine consecutive months of peer support services. However, 67% of incarcerated recipients had only received peer support services during a single month or during two consecutive months during the review period.
- Only 15% 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 (13%).
- Longer periods of consecutive peer support services are also associated with lower unemployment rates. For example, 68% of the recipients identified as unemployed received one or two months of peer support services; the percentage of unemployed recipients who received peer support services for seven or more consecutive months was determined to be only 8%.



APPENDIX A

Focus Group Invitation



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 third 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 will be held at the following location:

Touchstone Behavioral Health
3602 E. Greenway Road, Suite 102, Phoenix, AZ 85032

Focus Group One
Family Members of Adults
Receiving behavioral health services
January 27, 2016
12:00 pm–2:00 pm

Focus Group Three
Adults receiving behavioral health services
January 28, 2016
9:00 am–11:00 am

Focus Group Two
Direct Care Clinic Case Managers providing services
to adults receiving behavioral health services
January 27, 2016
6:00 pm–8:00 pm

Focus Group Four
Providers of ACT, SH, SE, Peer and Family support
services to adults receiving behavioral health services
January 28, 2016
6:00 pm–8:00 pm

Space is available for 10 participants per focus group based on a confirmed email basis.
Once capacity is reached, interested participants will be placed on a waiting list.
RSVP by Thursday, January 21, 2016 to Stacia Ortega at stacia.ortega@mercerc.com.
Refreshments will be provided.

APPENDIX B

Key Informant Survey

* 1. What is your job role/title?

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

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

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

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

	Yes	No	N/A
Assertive Community Treatment (ACT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Support Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Support Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Employment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 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	<input type="radio"/>				
Family Support Services	<input type="radio"/>				
Peer Support Services	<input type="radio"/>				
Supported Employment	<input type="radio"/>				
Supported Housing	<input type="radio"/>				

* 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Support Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer Support Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Support Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Support Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Employment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	1-2 Weeks	3-4 Weeks	4-6 Weeks	Longer than 6 weeks	NA
ACT	<input type="radio"/>				
Family Support Services	<input type="radio"/>				
Peer Support Services	<input type="radio"/>				
Supported Employment	<input type="radio"/>				
Supported Housing	<input type="radio"/>				

* 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Support Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Support Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Employment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supported Housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

APPENDIX C

Assessment Verification Interview Tool



ASSESSMENT VERIFICATION INTERVIEW

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

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

- Assertive Community Treatment* A team with a doctor, nurse, case manager, peer support worker, and employment and housing case managers. You usually see someone from your assertive community treatment team once a day or multiple times during the week. The team assists you with support and services in the community.

- Supported Employment* Supported employment helps you get a job that you are interested in. It can involve helping you think about what job you want, reviewing your job skills and needs for training, finding jobs you might want, preparing for interviewing or applying for a job, and supporting you once you have a job.

- Supported Housing* Supported housing helps you find and maintain a good place to live. It might help you get the help you need to afford a place to live, work with the landlord when necessary, and make sure you have all the skills and support you need to stay in an apartment or other place to live. It might include coaching and help with the rent.

- Peer Support Services* Peer support services are provided by another person who also receives behavioral health services and has similar lived experiences as you. It may include helping you find the right kind of services and talking to you about your recovery.

- Family Support Services* Family support services helps your family be better at understanding and helping you. It may be provided by a family mentor at your clinic.

**SERVICE CAPACITY ASSESSMENT
PRIORITY MENTAL HEALTH SERVICES
2016**

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

Yes No

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

Yes:

- Assertive Community Treatment
- Supported Employment
- Supported Housing
- Peer Support Services
- Family Support Services

No

APPENDIX D

Group 2 Medical Record Review Tool

Log-in screen [1]

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

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

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

Chart review [2]

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

APPENDIX E

Summary of Recommendations

Service	Recommendations
Peer Support Services (PSS)	<p>PSS1. The system should regularly monitor to identify deficiencies with current assessments and ISPs. Initiate appropriate corrective actions to address any identified performance deficiencies.</p> <p>PSS2. As part of monitoring and oversight activities, assess the impact of timely access to care when delays occur with obtaining updated ISPs and documentation from the clinics as part of the referral process for each of the priority mental health services, including peer support services. Initiate appropriate corrective actions to address any identified performance deficiencies.</p> <p>PSS3. 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.</p> <p>PSS4. Provide additional training and supervision to recognize the value of peer support services and family support services as effective service plan interventions.</p>
Family Support Services (FSS)	<p>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.</p>

Service	Recommendations
<p>Supported Employment Services (SES)</p>	<p>SES1. Through training and supervision, ensure that clinical team members assess and 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.</p> <p>SES2. 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.</p> <p>SES3. 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.</p> <p>SES4. Initiate improvement actions to address the noted lack of integration and coordination between the direct care clinics and community-based providers.</p>

Service	Recommendations
<p>Supported Housing Services (SHS)</p>	<p>SHS1. 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.</p> <p>SHS2. 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.</p> <p>SHS3. As part of oversight and monitoring activities, assess the impact of timely access to care when delays occur with obtaining updated ISPs and documentation from the clinics as part of the referral process for each of the priority mental health services, including supported housing services. Initiate appropriate corrective actions to address any identified performance deficiencies.</p>
<p>Assertive Community Treatment Teams (ACTT)</p>	<p>ACTT.1 Continue efforts to actively facilitate the identification of appropriate candidates for ACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns and adverse incidents involving SMI recipients.</p>



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