Mercer

Government Human Services Consulting

Priority Mental Health Services 2022

Service Capacity Assessment

Arizona Health Care Cost Containment System

October 31, 2022

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Section 1
Executive Summary

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency, engaged Mercer Government Human Services Consulting (Mercer) to implement a network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI) in Maricopa County, Arizona. This report represents the ninth in a series of annual service capacity assessments performed by Mercer.

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

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

Overview of Findings and Recommendations

See Table 1 for a summary of findings and recommendations regarding the accessibility and provision of the priority services. The current review period primarily targets calendar year (CY) 2021, though for some units of analysis that rely on service utilization data,

the timeframe was adjusted (e.g., October 2020–June 30, 2021 and October 2020–December 2021) to account for potential lags in processing administrative claims data.

Service Capacity Assessment Conclusions

Mercer's service capacity assessment found modest decreases in utilization of most of the priority mental health services during CY 2021 when compared to CY 2020, but still slightly higher than CY 2019 as depicted in the following tables.

Table 1 — Summary of Priority Mental Health Services Utilization, CY[1] 2021, CY 2020 and CY 2019

CY 2021 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	36,718	37%	4%	32%	22%	6.2%[2]

CY 2020 Service Capacity Assessment Time Period — Utilization

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

CY 2019 Service Capacity Assessment Time Period — Utilization

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

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

[2] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 6.2% of all active SMI recipients are assigned to ACT teams.

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

CY 2021 and the Ongoing Impact of the COVID-19 Pandemic

In March 2020, the Maricopa County SMI delivery system underwent an unprecedented change in response to the COVID-19 pandemic, with many health home clinics and providers suspending or limiting in-person services and pivoting to telephonic, telehealth, and virtual modalities to meet members' behavioral health needs. To understand the continued impact of COVID-19 during CY 2021 and related workforce challenges as well as how these factors may affect the availability of the priority mental health services, Mercer asked focus group participants to share observations regarding the perceived impact of the ongoing COVID-19 pandemic. A summary of observations derived from the focus groups and how the ongoing COVID-19 pandemic influenced access to the priority mental health services includes:

- During the pandemic, peer support services moved to virtual and telephonic delivery for both group and individual sessions. Some providers have moved back to in-person delivery of peer support as the sole option for provision of this service. Other providers are continuing to offer peer support virtually, telephonically, and in-person.
- The virtual and telephonic delivery of peer support received mixed reviews from participants. Some felt that while these options improved accessibility for some members, it created barriers for others. Notably, barriers existed for those individuals without internet or telephone access and individuals who did not have the ability to navigate a virtual option.
- Participants reported that there is still a portion of members who do not wish to attend peer support in-person due to COVID-19 related fears. For those clinics who no longer offer virtual or telephonic peer support, these individuals do not have access to the service.
- Participants shared conflicting information about if they are still permitted to bill for peer support virtually and telephonically. Some providers believe this pandemic-related billing option has been rescinded while others continue to bill both virtually and telephonically for the service.
- All clinics remain impacted by declines in the available work force due to the COVID-19 pandemic. Focus group participants reported that there are less resources available, caseloads are too high, high turnover persists, and disparities in pay contribute to turnover (i.e., case managers are paid more than peer support specialists).
- Last year, one provider deployed Chrome Books to members to aid their ability to participate in services virtually. This year, the provider shared that these devices are not being used and it is questionable if the technology promotes member engagement.
- Participants shared that the pandemic impacted member engagement in supported employment services. Supported employment specialists did not see members face-to-face during the pandemic which reduced their ability to engage effectively with members.

- Participants agreed that after two years of the pandemic, members are now becoming more interested in working and leaving the house to participate in meaningful activities.
- Participants reported that co-located Vocational Rehabilitation Specialists moved to fully virtual services during the pandemic and they have not returned to the clinics. Vocational Rehabilitation orientation sessions also remain virtual.
- During the pandemic, supportive housing services were offered virtually. Participants agreed that this particular service did not fare well in virtual or telephonic formats. Services are now returning to in-person provision.
- Participants shared that many members did not undergo home inspections during the pandemic. As inspections have resumed, evictions have increased due to issues with home conditions. These evictions are contributing to a rise in homelessness among members who are not able to locate affordable housing.

Overall, the system continues to adapt and overcome many of the challenges related to the ongoing COVID-19 pandemic. As initiated at the onset of the COVID-19 pandemic, innovative approaches to service delivery emerged, with AHCCCS implementing policy changes to allow more services to be provided telephonically, expanding the utilization of telehealth, and providers accepting verbal consent from members to expedite the processing of service referrals.

Consumer Operated Services (Peer Support and Family Support)

Thirty-seven percent of all members with a SMI received at least one unit of peer support during the period of October 1, 2020 through December 31, 2021; a decrease from the prior review period in which 41% of members received peer support services. Peer support specialists are available within the health home clinics, through multi-disciplinary teams providing ACT team services, via participation in an expansive array of clinic-based education and support groups, provide supportive housing services, and/or within the community by attending one of many available consumer operated peer support programs. In addition, many members attend peer support groups virtually in response to the COVID-19 pandemic and related restrictions on in-person services.

Ten percent of the sample of medical records included an assessed need for family support services and 4% of all recipients received family support services over the review period. As observed in prior year service capacity assessments, a lack of available or engaged family members, member choice to not involve family members in treatment, and persistent evidence that clinical teams do not fully understand how to apply the service and/or appreciate the benefits that family support services can provide, continue to be the most prominent factors contributing to the relatively low utilization of the services. As such, opportunities still exist to promote the use of family support services and for clinical teams to better appreciate the value of the services by identifying instances in which family support services can be utilized to support members.

Supported Employment

Service utilization data demonstrates 32% of members received at least one unit of supported employment during CY 2021, a decrease of 2% from last year. Maricopa County's supported employment utilization rate of 32% and ongoing supported employment

utilization rate of 5% (which is considered to be closer to high-fidelity supported employment) are among the highest in a benchmark analysis comparing comparable service delivery systems across the nation.

Focus group participants continue to report that the SMI population is concerned with losing benefits if earning income through employment. There appears to be a need for ongoing education regarding members' concerns of losing benefits or housing vouchers if income is earned. Awareness and utilization of the Disability Benefits 101 website resource is an effective tool to illustrate how income does not necessarily jeopardize a member's public assistance/benefits.

Fifty-six percent of the medical record review cases lacked evidence that the member received supported employment services despite the service being listed on the ISP. As noted in prior service capacity assessments, ISPs are not always based on the member's assessed or individualized needs and can include generic language and/or services that fail to differentiate each member's unique circumstances and needs.

Supportive Housing

Programs and adequate capacity exists for persons in need of housing; offering a wide array of support services and community resources to help individuals achieve and maintain integrated and independent housing. Permanent supportive housing providers operate permanent supportive housing programs and multiple service contractors are available to provide supportive housing services under a community living program. Available housing supports also extend to housing providers who manage properties and oversee scattered site housing subsidies for individuals who qualify.

AHCCCS now separately contracts with a Housing Administrator, which among other duties, is responsible to maintain system processes for the submission of housing applications, waitlist management (including prioritization), and referrals for housing opportunities. The Housing Administrator coordinates with the Regional Behavioral Health Authority (RBHA), community-based supportive housing providers, and health home clinical teams to assess and meet members' housing related needs.

Fifty-nine percent of the survey respondents felt that supportive housing services were difficult to access; continuing a trend of noteworthy increases year-to-year (CY 2020 — 47%; CY 2019 — 30%). Mercer interviewed a current supportive housing provider that administers the Temporary Housing Assistance Program, a supportive housing service that offers temporary housing and supported employment services for Title XIX eligible members. The provider cited several current challenges to secure safe and affordable housing on behalf of members with SMI, including, but not limited to, provider workforce challenges, a lack of affordable housing in Maricopa County, shortages in available housing units, and the impact of the ongoing COVID-19 pandemic.

Assertive Community Treatment

The system currently has 24 functional ACT teams, the same number of teams since 2017. Based on a point in time comparison, the teams are serving less members during CY 2021 (i.e., 52 less members during CY 2021 than CY 2020). Eleven of the 24 ACT teams are operating under the 5% capacity threshold, including a Forensic Assertive Community Treatment (FACT) team that could accept 17 additional members, though some ACT teams are impacted by the nationwide behavioral health workforce shortage and may not

be able to accept new members. When considering that 175 members with three or more incarcerations are not currently assigned to an ACT or FACT team, it appears there may be opportunities to screen and refer members to this level of care.

While ACT is considered a time unlimited service, clinical teams should ensure that regular and consistent assessments are occurring for new ACT team candidates and for individuals who have had a prolonged tenure on an ACT team. In all medical record review cases, there was no documented evidence that the clinical team was considering or recommending a change in the level of case management, including referring a person to an ACT team or stepping down a recipient assigned to an ACT team to a less intensive level of case management when clinically appropriate and medically necessary. In addition, data elements such as service cost data, hospitalization rates, crisis intervention episodes, and jail booking data can support the identification of potential candidates that may benefit from ACT team services.

General Findings and Recommendations

Mercer also noted additional findings and recommendations to improve the appropriate identification and, when indicated, the provision of the priority mental health services members who may benefit from the services. As the entity responsible for oversight of the service delivery system, the RBHA should consider the following:

- Perform an assessment of the work flow at the health homes that focuses on the timely implementation of members' ISPs, including timely referral to needed services. Mercer noted several medical record review cases in which ISPs were completed with recommendations to access the priority mental health services, but interventions were not acted upon.
- Continue efforts to monitor the timely completion of annual member assessments and ISPs. When compiling the sample for medical record reviews, 80% of cases (12 of 15) assigned to one entity responsible for the administration of health home clinics were found to have outdated assessments and/or ISPs. Overall, 92% of the overall sampling frame included records with current assessments and ISPs.
- Several stakeholders reported ongoing challenges related to ensuring an adequate workforce and staffing shortages impacting access to all of the priority mental health services. In addition, multiple sources (e.g., medical records, focus groups) reported high turnover rates with case managers assigned to the health homes. The RBHA should ensure that active strategies and interventions are in place to recruit and retain an adequate provider and health home workforce.

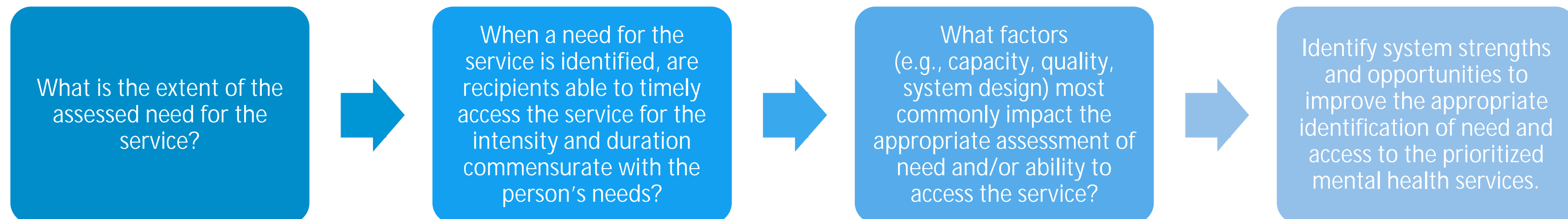
Additional and more detailed findings and recommendations for each of the priority services can be found in *Section 5, Findings and Recommendations.*

Section 2
Overview

The Arizona Health Care Cost Containment System (AHCCCS) retained Mercer Government Human Services Consulting (Mercer) to implement an annual network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI).[3] The service capacity assessment included a need and allocation evaluation of consumer operated services (peer support services and family support services), supported employment, supportive housing, and assertive community treatment (ACT).

Goals and Objectives of Analyses

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



Limitations and Conditions

Mercer did not independently verify the accuracy and completeness of service utilization data, outcomes data, and other primary source information collected from AHCCCS. Service utilization data includes encounter submission lag times that are known to impact the completeness of the data set, although some units of analysis were adjusted to accommodate potential claims run-out limitations. Mercer performed an analysis of summary level service utilization data related to the 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.

Section 3
Background

During the review period, AHCCCS served as the single State of Arizona (Arizona or State) authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health system. AHCCCS contracts with managed care organizations to administer integrated physical health and behavioral health services throughout the State. AHCCCS administers and oversees the full spectrum of covered services to support integration efforts at the health plan, provider, and member levels.

History of Arnold v. Sarn

In 1981, a class action lawsuit was filed alleging that the State, through the Arizona Department of Health Services and Maricopa County, did not adequately fund a comprehensive mental health system as required by State statute. The lawsuit, referred to as Arnold v. Sarn, sought to enforce the community mental health treatment system on behalf of persons with SMI in Maricopa County.

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

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

Serious Mental Illness Service Delivery System

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

Behavioral Health Authorities (RBHAs) are required to ensure that all medically necessary covered behavioral health services are available to enrolled adult individuals (i.e., Non-Title XIX) who meet established criteria for SMI.

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

Table 2 — Maricopa County Health Homes

Organization	Health Home	Organization	Health Home
Chicano Por La Causa	Centro Esperanza	Lifewell Behavioral Wellness	Desert Cove
Community Bridges, Inc.	Mesa Heritage		Oak
Community Partners Integrated Healthcare, Inc.	Osborn		South Mountain
			Windsor
Copa Health	Arrowhead Campus	PSA (Resilient Health)	Higley Integrated Healthcare Center
	East Valley Campus		1st Street
	Gateway Campus	Southwest Behavioral and Health Services	Buckeye Outpatient
	Hassayampa Campus		
	Metro Campus	Southwest Network	Estella Vista
	West Valley Campus		Northern Star
			Saguaro
			San Tan
Horizon Health and Wellness	Plaza	Spectrum	Anywhere Care
Jewish Family and Children Services	East Valley Health Center		
	Michael R. Zent Healthcare Clinic	Terros	Priest
LaFrontera/EMPACT	Comunidad		23rd Avenue

Organization	Health Home	Organization	Health Home
	EMPACT — San Tan		51st Avenue
Valleywise	First Episode Center	Valle Del Sol	Red Mountain
	Mesa Behavioral Health Specialty Clinic		

Current Service Capacity

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

Table 3 — ACT Teams (24 teams serving 2,265 recipients)[5]

Health Home Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Community Bridges: 99th Avenue	Primary Care Provider (PCP) Partnership	100	94	6%
Community Bridges: Avondale	PCP Partnership	100	96	4%
Community Bridges: FACT Team 1	Forensic Team & PCP Partnership	100	83	17%
Community Bridges: FACT Team 2	Forensic Team & PCP Partnership	100	92	8%
Community Bridges: FACT Team 3	Forensic Team & PCP Partnership	100	92	8%
Community Bridges: Mesa Heritage	PCP Partnership	100	91	9%
La Frontera/EMPACT: Tempe	PCP Partnership	100	98	2%
La Frontera/EMPACT: Capitol Center	PCP Partnership	100	86	14%
La Frontera/EMPACT: Comunidad	PCP Partnership	100	93	7%
Lifewell Behavioral Wellness: Desert Cove	PCP Partnership	100	95	5%
Lifewell Behavioral Wellness: South Mountain	PCP Partnership	100	97	3%

[4] As reported by the Maricopa County RBHA administering the AHCCCS contract in February 2022.

[5] As of December 1, 2021.

Health Home Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
COPA Health: Gateway	PCP Partnership	100	98	2%
COPA Health: Metro Campus — Omega Team	PCP Partnership	100	97	3%
COPA Health: Metro Campus — Varsity Team	PCP Partnership	100	97	3%
COPA Health: West Valley	Medical Team	100	94	6%
COPA Health: West Valley Campus	PCP Partnership	100	96	4%
Southwest Network: Northern Star	PCP Partnership	100	93	7%
Southwest Network: Saguaro	PCP Partnership	100	98	2%
Southwest Network: San Tan		100	90	10%
Terros: 51st Avenue	PCP Partnership	100	97	3%
Terros: Priest (Formerly Enclave)		100	94	6%
Terros: 23rd Avenue Recovery Center ACT 1 (Formerly Townley 1)	PCP Partnership	100	100	0%
Terros: 23rd Avenue Recovery Center ACT 2 (Formerly Townley 2)		100	99	1%
Valleywise: Mesa Riverview	PCP Partnership	100	95	5%
Totals		**2,400**	**2,265**	**5.6%**

Current Service Utilization

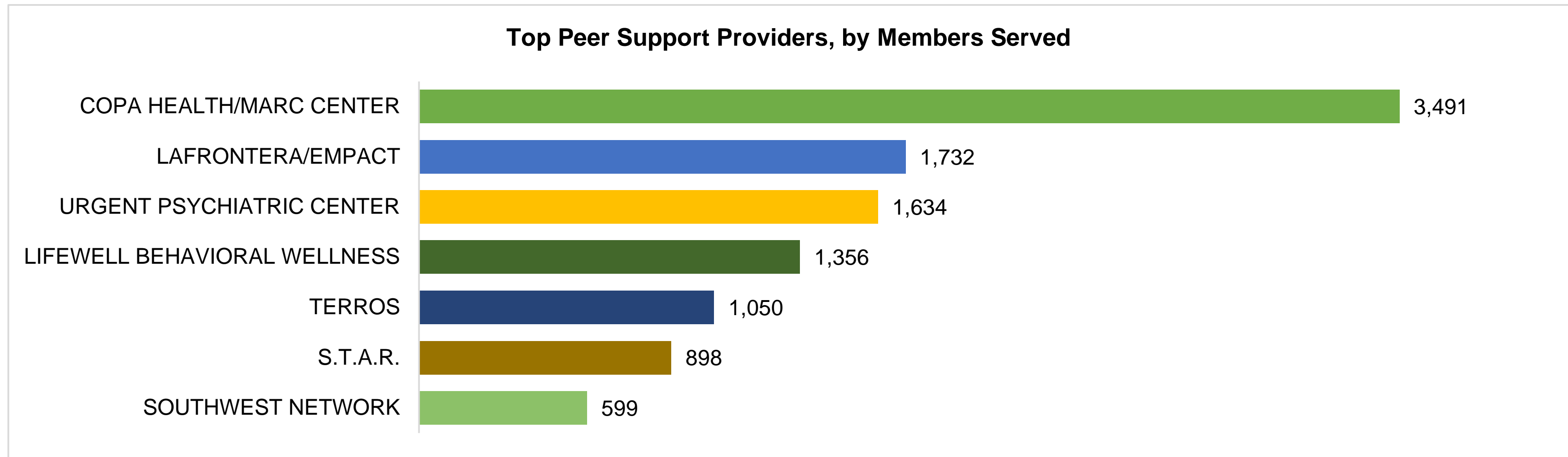
An analysis of service utilization data is presented below to identify the volume of units and unique members affiliated with each priority mental health service provider. The results identify the most prominent providers of the priority mental health services. The analysis was completed for the following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

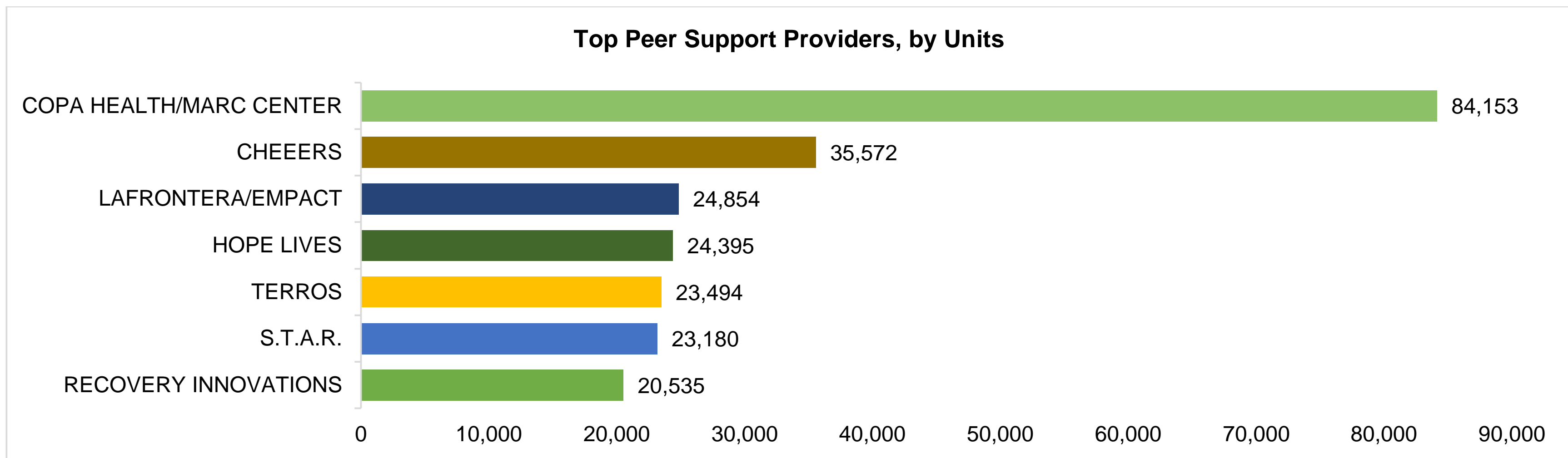
Consumer Operated Services (peer support and family support) Providers[6]

- Arizona Women's Recovery Center
- CHEEERS
- Chicanos Por La Causa (CPLC)
- Community Bridges, Inc.
- Community Partners Integrated Health Care (CPIH)
- Copa Health/Marc Center
- Hope Lives — Vive la Esperanza
- Horizon Health and Wellness
- La Frontera/EMPACT
- Lifewell Behavioral Wellness
- NAZCARE
- Recovery Empowerment Network
- Recovery Innovations
- Resilient Health
- Southwest Behavioral Health
- Southwest Network
- Stand Together and Recover (S.T.A.R.)
- Terros
- Valle del Sol

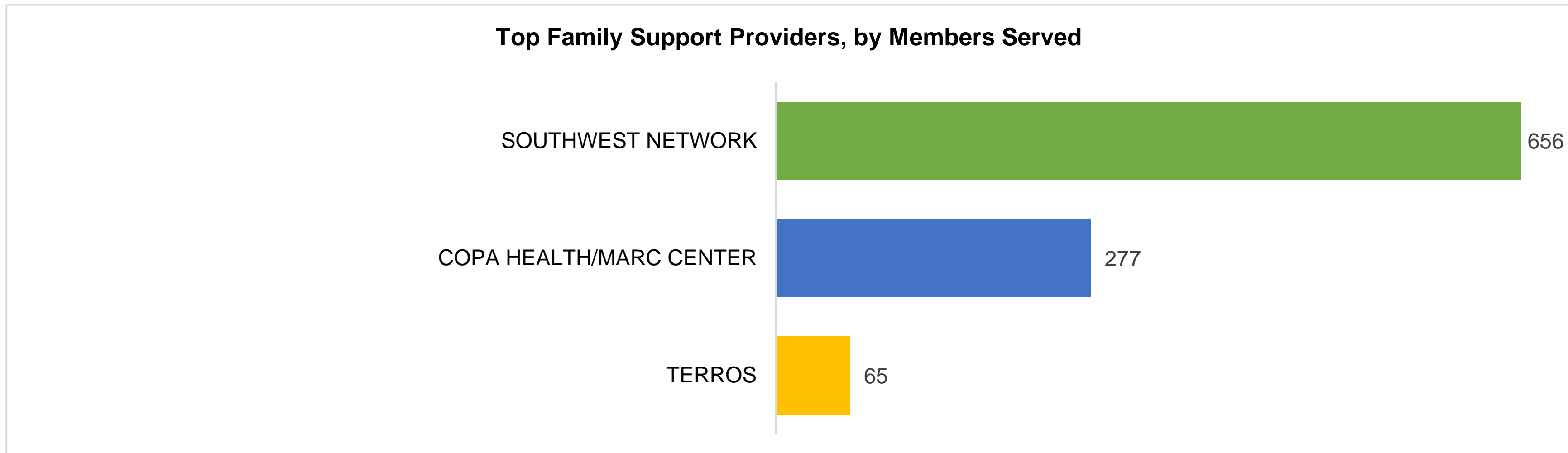
[6] As reported by the Maricopa County RBHA administering the AHCCCS contract in February 2022.

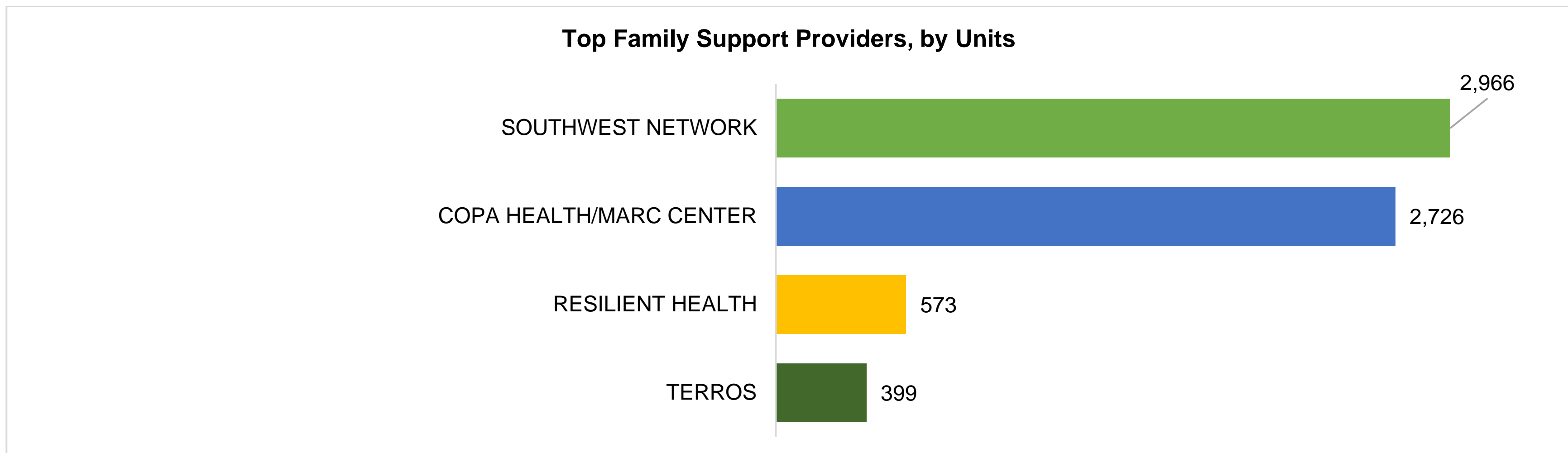
- ValleyWise Health





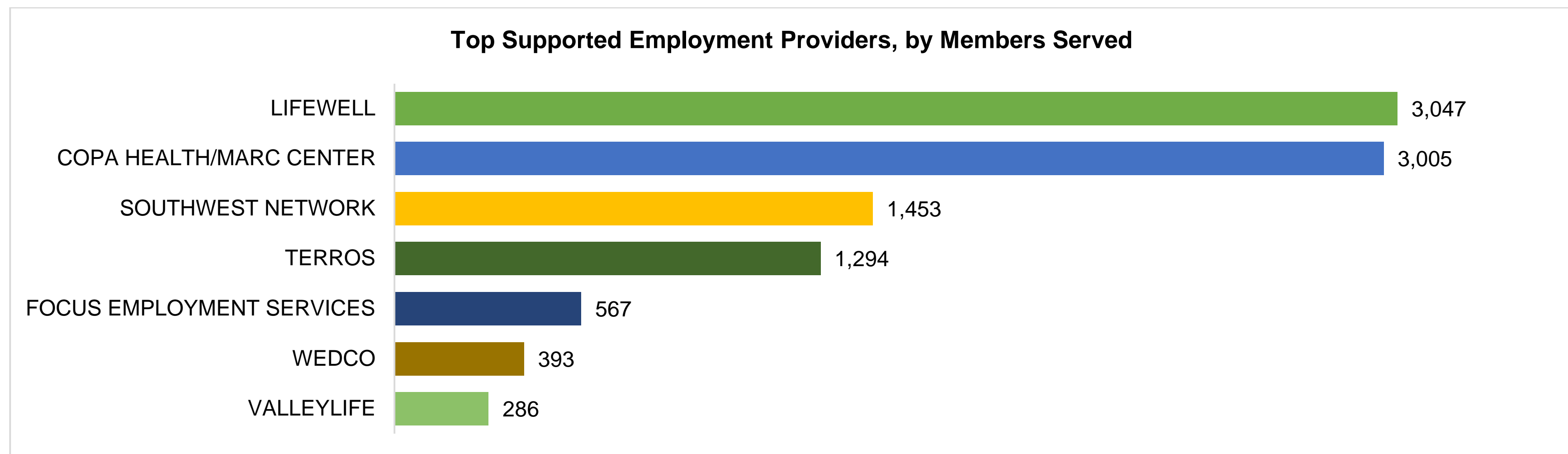
Consumer Operated Services (Family Support)



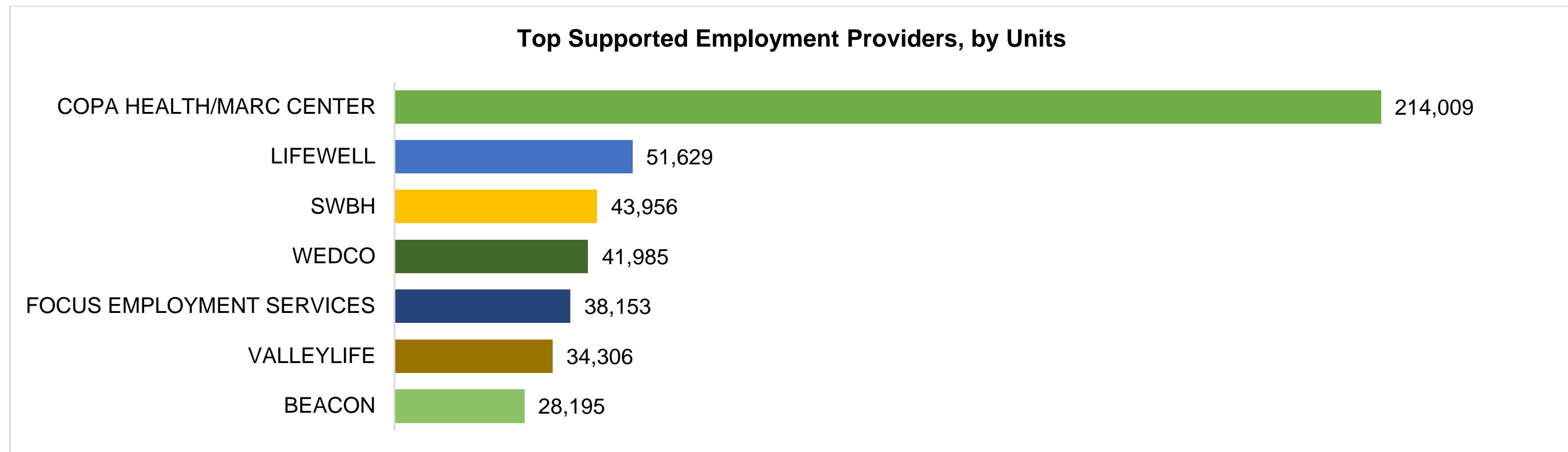


Supported Employment Providers[7]

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



[7] As reported by the Maricopa County RBHAs administering the AHCCCS contract in February 2022.

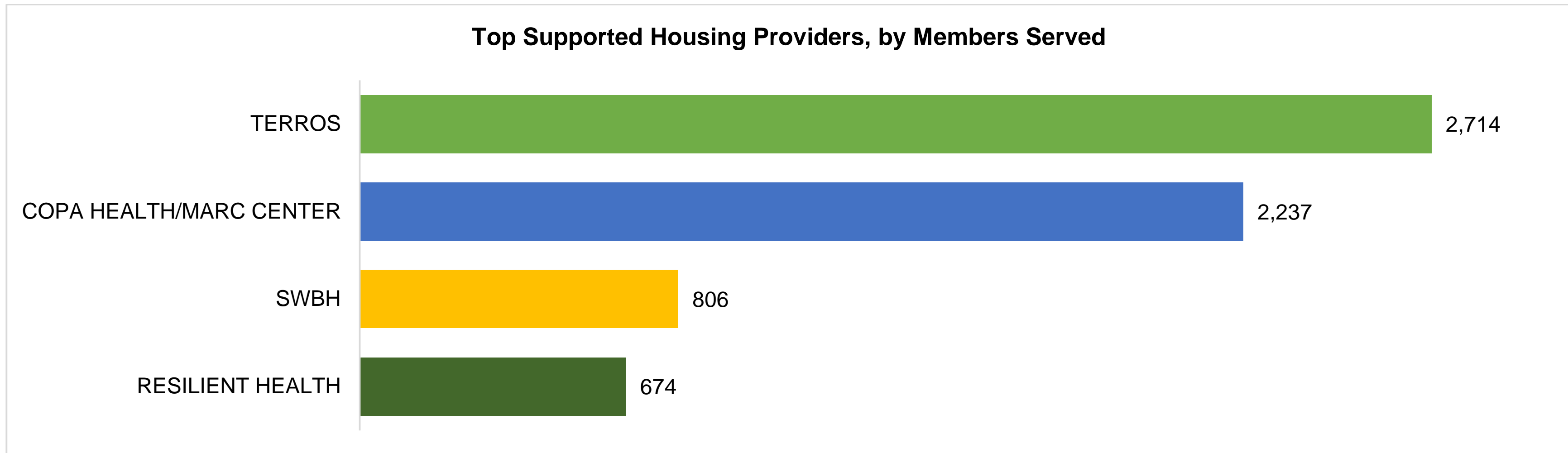


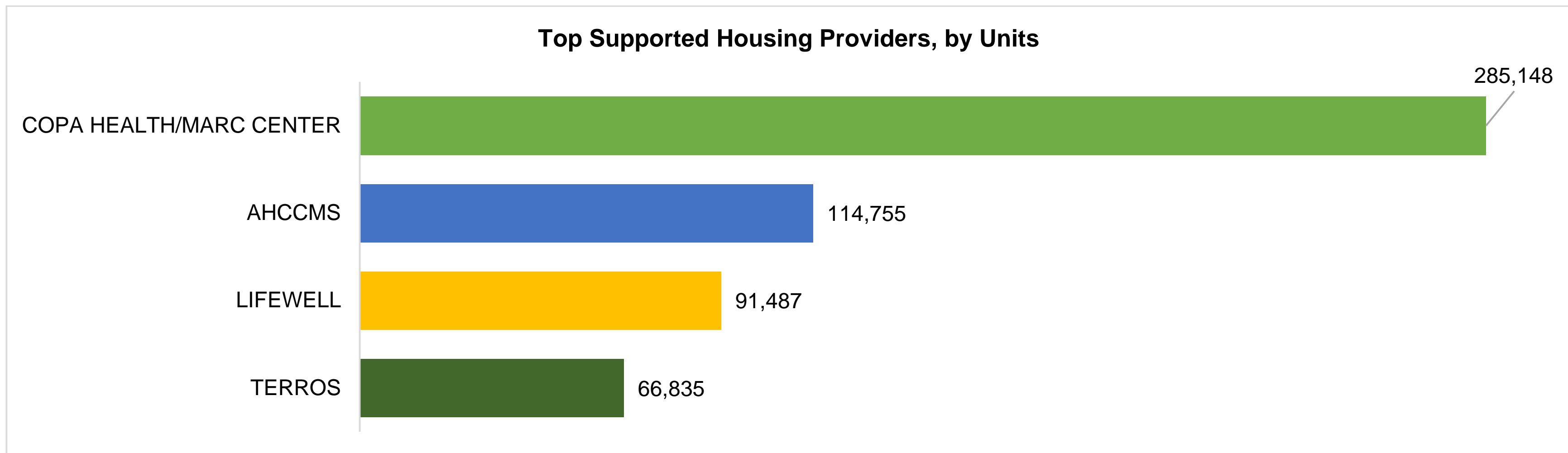
Supportive Housing Providers[8]

- Arizona Mentor
- AZ Health Care Contract Management Services
- Child and Family Support Services
- Community Bridges, Inc.
- Copa Health (formerly Marc Community Resources)
- Helping Hearts
- La Frontera/EMPACT
- Resilient Health
- Southwest Behavioral & Health Services (SWBH)

[8] As reported by the Maricopa County RBHA administering the AHCCCS contract in February 2022. Supportive housing service providers include the temporary housing assistance program, permanent supportive housing services (scattered site and community-based), and community living program providers.

- Terros





Section 4
Methodology

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

- *Key informant surveys, interviews, and focus groups:* Mercer solicits feedback from key informants via interviews and surveys. In addition, members, family members, case managers, and providers participate in focus groups to solicit information about the availability of the priority mental health services.
- *Medical record reviews:* A random sample (n=200) of class members is drawn to support an evaluation of clinical assessments, individual service plans (ISPs), and progress notes. The chart review examines the extent to which recipient's needs for the priority services are assessed and met.
- *Analysis of service utilization data and contracted capacity for each of the priority mental health services:* Mercer evaluates the volume of unique users, billing units, and identifies the most prevalent providers of the priority mental health services. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis is completed to estimate "persistence" in treatment. Persistence was evaluated by calculating the proportion of recipients who only received a priority service during a single month. The persistence in treatment analysis includes additional progressive time intervals (two to three months, three to four months, five to six months, seven to eight months, and nine months) to determine the volume of recipients who sustained consistent participation in the selected prioritized services during the review period.
- *Analysis of outcomes data:* Analysis of data including employment data and criminal justice information.
- *Benchmark analysis:* Analysis of priority service penetration rates in other states and local systems that represent relevant comparisons 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 discussions with participants who have direct experience with the priority mental health services.

Participation in the focus groups was solicited by an invitation created by Mercer, which was reviewed and approved by AHCCCS.[9]

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

The focus groups targeted the following participants:

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

A total of 28 stakeholders participated in the four two-hour focus groups conducted on May 18, 2022 and May 19, 2022. All four focus groups were held in-person at a central location in the city of Phoenix, Arizona. Invitations to voluntarily participate in the focus groups were distributed to a defined list of stakeholders and the actual number of participants does not represent a statistically significant sample. As such, focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants.

The methodology included the following approach:

- Definitions of each of the priority mental health services were communicated to each group of participants at the onset of the focus groups.
- Participants were prompted to discuss experiences related to accessing each of the priority services, including perceived system strengths and barriers.
- Based on findings derived from the prior year's evaluation, participants were asked to share observations regarding any noted system changes, improvements, and/or ongoing and emerging concerns regarding the availability and capacity of the priority mental health services, including the perceived ongoing impact of the COVID-19 pandemic.

[9] See Appendix A: Focus Group Invitation.

Key Informant Surveys and Interviews

One objective of the service capacity assessment was to obtain comprehensive stakeholder feedback regarding the availability of each of the priority mental health services. As a result, a key informant survey was created using Qualtrics®. 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.[10] The survey distribution approach targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should not be construed to be representative of the total population of system stakeholders.

The survey was disseminated to key system stakeholders (e.g., service providers, administrators of health homes, etc.) via email with a hyperlink to the online survey. A total of 20 respondents completed the survey tool.

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

Medical Record Reviews

Mercer pulled a random sample of members and evaluated clinical assessments, ISPs, and clinical team progress notes to determine the extent to which needs for priority services were being considered in service planning and met through service provision. The medical record sample consisted of adults with SMI who were widely distributed across administrative entities, health home clinics, and levels of case management (i.e., assertive, supportive, and connective).

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

- The recipient was identified with a SMI and received a covered behavioral health service during October 1, 2020 and December 31, 2021.[11]
- The recipient had an assessment date between January 1, 2021 and November 15, 2021.[12]

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

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[10] See Appendix B: Key Informant Survey.

[11] The total population of unique recipients with SMI who received behavioral health services is 36,178 for the period October 1, 2020 through December 31, 2021.

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

- Is there evidence that the need for each of the priority mental health services was assessed by the clinical team?
- When assessed as a need, was the priority mental health service(s) identified on the recipient's ISP?
- When identified as a need and listed on the recipient's ISP, is there evidence that the recipient accessed the service consistent with the prescribed frequency and duration and within a reasonable time 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, 2021. Issues with accessing current assessments and ISPs has been a long-standing challenge in performing the medical record reviews as the audit methodology requires access to an assessment and ISP within the designated time period. During CY 2021, 92% of all the initially requested cases included current assessments and ISPs. However, one administrative entity was able to produce current assessments and ISPs for only 20% (3 of 15 cases) of the requested sample, which required Mercer to secure replacement cases.

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

Analysis of Service Utilization Data

Mercer initiated a request to AHCCCS for a comprehensive service utilization data file. The service utilization data file includes all adjudicated service encounters for any person designated as SMI and assigned to the Maricopa County GSA with dates of service between October 1, 2020 and December 31, 2021.

Specific queries are run to identify utilization of each prioritized mental health service.[13] The analysis evaluates the volume of unique users, billing units, and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to determine "persistence" in treatment. Through the evaluation, proportions of recipients who only received the service in a single month were calculated. Additional progressive consecutive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months, and nine months) to determine the volume of recipients who sustained consistent participation in each of the prioritized services.

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

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

The service utilization data file supports the extraction of the medical record review sample and allows for an analysis of the service utilization profile for each recipient selected, as well as supporting an aggregated view of service utilization for the sample group. Sample characteristics for each year of the service capacity assessment are illustrated in the following tables and are compared to the characteristics of the total population of active users.

CY 2021 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample Group	200	35%	5%	32%	22%	7%
Service Utilization Data	36,718	37%	4%	32%	22%	6.2%[14]

CY 2020 Service Capacity Assessment Time Period — Utilization

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

CY 2019 Service Capacity Assessment Time Period — Utilization

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

[14] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 6.2% of all active recipients with SMI are assigned to ACT teams.

CY 2018 Service Capacity Assessment Time Period — Utilization

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

CY 2017 Service Capacity Assessment Time Period — Utilization

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

CY 2016 Service Capacity Assessment Time Period — Utilization

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

CY 2015 Service Capacity Assessment Time Period — Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Group 1	119	24%	1%	18%	3%	2%
Group 2	201	30%	4%	21%	3%	4%

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	24,608	29%	2%	17%	4%	7%

CY 2014 Service Capacity Assessment Time Period — Utilization

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

CY 2013 Service Capacity Assessment Time Period — Utilization

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

Analysis of Outcomes Data

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

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

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

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

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

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

AHCCCS has established valid values for recording each demographic data element, including the selected functional outcomes. Each indicator is described and valid selections are presented below.

Number of Arrests

The outcome indicator records the number of times that the recipient has been arrested within the last 30 days. A valid entry is the number of times (between 0 and 31).

Employment Status

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

- 17 — Unpaid Rehabilitation Activity
- 20 — Student
- 24 — Competitively Employed Full-Time
- 25 — Competitively Employed Part-Time
- 28 — Other Employment

- 29 — Inactive in the Community
- 99 — Unknown

Penetration and Prevalence Analysis

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

The following review process was completed by Mercer:

- Select academic publications were reviewed.
- Mercer consulted with national experts regarding the prioritized services and benchmarks for numbers served.
- National data from 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.

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

Section 5

Findings and Recommendations

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

The service capacity assessment includes the following distinct evaluation components:

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

5.1 Serious Mental Illness Prevalence and Penetration — Overview of Findings

Service system penetration is defined as the percentage of people who received services among the estimated number of people considered eligible for services during a specified time period. As depicted in Table 4 below, a relatively small percentage (16%) of the estimated number of adults with SMI were served through the publicly funded system in Maricopa County in 2021. The penetration rate in Maricopa County is below the national (publicly funded) penetration rate of 29%; however, it is higher than some states' statewide rates and is similar to rates within some communities of a similar size. Within the Maricopa County Medicaid system, the penetration rate (34%) slightly exceeds the national average (33%) and other regions of similar size in Texas (i.e., Harris County [Houston] and Bexar County [San Antonio], which have penetration rates of 23% and 22%, respectively). Thus, Maricopa County's lower overall penetration rate appears to result from the relatively low penetration rate among people without Medicaid coverage (5%). During the public health emergency, many states (including Arizona) expanded their Medicaid eligible populations and members remained enrolled secondary to continuous enrollment provisions. Data for Maricopa County included in this report generally covers CY 2021, while some of the comparison states and communities have not updated information since the public health emergency.

The Maricopa County system excels in certain areas of EBP utilization. For example, supportive housing and supported employment are more available in Maricopa County (especially for Medicaid recipients) than nationwide. Maricopa County also provides strong access to peer support services at a level that could be considered a best practice benchmark. In addition, Maricopa County has a greater capacity to provide ACT than most comparison communities included in this analysis. Two thousand, two hundred and sixty five individuals were assigned to ACT teams in Maricopa County in 2021. A study by ACT services researchers estimated that 4.3% of adults with SMI served in a mental health system need an ACT-level of care.[16] Few communities around the country provide ACT to 4.3% or more of their adults who have SMI, but 6.2% of adults with SMI residing in Maricopa County received ACT in 2021.

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

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

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

Penetration Rates					
Region	Adult Population (≥ 18 Years Old)[17]	Estimated Rate of SMI in the Adult Population[18]	Estimated Number of Adults with SMI in the Population[19]	Number of Adults with SMI Served[20]	Penetration Rate Among Adults with SMI[21]
United States	256,662,010	5.4%	13,958,974	4,096,666	29%
Arizona	5,774,978	6.4%	370,986	114,989	31%
Maricopa County[22]	3,521,609	6.4%	224,995	36,718	16%
Adults with Medicaid	846,261	10.1%	85,472	29,295	34%
Non-Medicaid Adults	2,675,348	5.2%	139,523	7,423	5%
Texas	21,925,627	4.8%	1,049,569	306,029	29%
Harris County (Houston)	3,493,243	4.1%	144,734	33,792	23%
Bexar County (San Antonio)	1,518,790	4.5%	68,322	15,008	22%
New York	15,348,422	4.5%	684,191	544,572	80%
New York County (New York City)[23]	1,381,874	4.8%	66,579	91,191	137%

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

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

County-level SMI estimates: SAMHSA. (2022). *2018-2020 NSDUH substate region estimates – tables.* National Survey on Drug Use and Health Report. Available at: https://www.samhsa.gov/data/report/2018-2020-nsduh-substate-region-estimates-tables

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

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

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

[22] The number of people with SMI served in Maricopa County is based on AHCCCS' 2021 service utilization data file.

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

Penetration Rates					
Region	**Adult Population** (≥ 18 Years Old)[17]	**Estimated Rate of SMI in the Adult Population**[18]	**Estimated Number of Adults with SMI in the Population**[19]	**Number of Adults with SMI Served**[20]	**Penetration Rate Among Adults with SMI**[21]
Colorado	4,557,684	5.9%	270,730	67,961	25%
Denver City/County[24]	598,027	6.7%	40,327	18,639	46%
Nebraska	1,462,537	6.3%	92,325	13,154	14%
California	30,576,844	4.6%	1,394,377	412,758	30%
Illinois	9,809,562	5.4%	533,854	22,702	4%
Kansas	2,217,059	6.7%	149,247	26,155	18%
Minnesota	4,356,123	6.2%	268,565	151,444	56%
Wisconsin	4,574,131	5.6%	256,612	32,832	13%
Tennessee	5,373,433	6.3%	339,577	192,292	57%
Indiana	5,188,514	6.8%	355,035	82,540	23%
Delaware	782,153	5.4%	42,410	7,611	18%
New Hampshire	1,113,141	5.1%	56,283	16,168	29%
North Carolina	8,294,423	5.4%	443,801	72,073	16%

Overview of EBP Utilization Benchmark Analyses

Data in Table 5 below depict the utilization rates of ACT, supported employment, and supportive housing among adults with SMI served in the Maricopa County behavioral health system. Maricopa County has an ACT utilization rate of 6.2%, which exceeds researchers' best estimate of the percentage of people with SMI who need ACT (4.3%).[25] The county's utilization rates for supportive housing and supported employment services also exceed the national average benchmarks. Maricopa County's supported

[24] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative director Kristi Mock and her staff at the Mental Health Center of Denver, June 2, 2022.

[25] Cuddeback GS, Morrissey JP, Meyer PS. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803–1806.

employment utilization rate of 32% and ongoing supported employment utilization rate of 7% (considered closer to high-fidelity supported employment) are among the highest in this benchmark analysis. For example, the national utilization rate for supported employment is less than 2%. The utilization rate for supportive housing (22%) in Maricopa County is greater than the national average and greater than the utilization rates found in all other regions in the analysis.

Table 5 — EBP Utilization Rates among Persons with SMI Who Were Served in the System[26]

EBP Utilization Rates						
Region	ACT		Supported Employment		Supportive Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
United States	66,159	1.6%	66,662	1.6%	70,648	1.7%
Arizona	Not Available[27]	Not Available	14,071	12.2%	1,268	1.1%
Maricopa County (2021)[28,29]	2,265	6.2%	11,790	32.1%	7,988	21.8%
Maricopa County — Medicaid	1,879	6.4%	9,587	32.7%	6,722	22.9%
Maricopa County — non-Medicaid	386	5.2%	2,203	29.7%	1,266	17.1%
Maricopa County (Supported Employment Ongoing)[30]	Not Applicable	Not Applicable	*2,567*	*7.0%*	Not Applicable	Not Applicable
Texas	7,791	2.5%	9,753	3.2%	9,692	3.2%

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

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

[28] Supported employment services in Maricopa County are associated with one of seven billing codes: H2025, H2025 HQ, H2025 SE, H2026, H2027, H2027 HQ, and H2027 SE. Codes H2025 through H2026 are labeled as ongoing support to maintain employment. H2027, H2027 HQ, and H2027 SE are labeled as psychoeducational services (pre-job training and development). For this analysis, we report both the unduplicated number of people who received any service associated with supported employment and separately those who received "ongoing" supported employment. The ongoing billing codes are most likely to be related to high-fidelity supported employment.

[29] The number served in Maricopa County with evidence-based services is based on AHCCCS' 2021 service utilization data file.

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

EBP Utilization Rates						
Region	ACT		Supported Employment		Supportive Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Harris County (Houston)	1,137	4.5%	*4,563*	*13.5%*	*1,946*	*5.8%*
Bexar County (San Antonio)	297	2.6%	*470*	*3.1%*	*1,451*	*9.7%*
New York	8,281	1.5%	1,017	0.2%	25,098	4.6%
New York County (New York City)[31]	1,218	1.3%	Not Available	Not Available	4,717	5.2%
Colorado	595	0.9%	516	0.8%	51	0.1%
Denver City/County (MHCD)[32]	556	3.0%	206	1.1%	1,605	8.6%
Nebraska	85	0.6%	789	6.0%	949	7.2%
California	5,147	1.2%	409	0.1%	840	0.2%
Illinois	669	2.9%	1,512	6.7%	Not Available	Not Available
Kansas	Not Available	Not Available	992	3.8%	1,913	7.3%
Minnesota	2,221	1.5%	1,570	1.0%	1,722	1.1%
Tennessee	105	0.1%	898	0.5%	986	0.5%
Indiana	763	0.9%	1,281	1.6%	3,216	3.9%
Delaware	407	5.3%	2	0.0%	35	0.5%
New Hampshire	1,246	7.7%	3,779	23.4%	Not Available	Not Available

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

[32] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative director Kristi Mock and her staff at the Mental Health Center of Denver, June 2, 2022.

EBP Utilization Rates						
Region	ACT		Supported Employment		Supportive Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
North Carolina	4,501	6.2%	Not Available	Not Available	Not Available	Not Available

Changes in EBP Utilization from 2013 through 2021

Table 6 below compares the utilization of ACT, supported employment, and supportive housing in Maricopa County from 2013 through 2021. Highlights of the findings based on comparisons of utilization/penetration rates across those years include the following:

- *ACT*: Between 2013 and 2020, Maricopa County experienced a steady increase each year in the total number of adults with SMI who received ACT services, consistently achieving penetration rates that ranged from 6.4% to 7.0%, which exceed the benchmark penetration rate for ACT services (4.3%). The ACT penetration rate decreased in 2021 to 6.2%, with the 24 teams serving 2,265 people as of December 1, 2021.

- *Supported Employment*: When comparing 2020 to 2021, there were decreases in the overall penetration rate for supported employment (33.8% to 32.1%) as well as the percentage of adults with SMI using ongoing supported employment services (9.2% to 7.0%). In 2020, the overall penetration rate for supported employment reached its highest point since 2013. The number of individuals who received *ongoing* supported employment during 2020 exceeded 3,200 unique users, but regressed to just over 2,500 people in 2021. Despite the decreases, the percentage of adults with SMI using ongoing supported employment services in 2021 is 4.5 percentage points higher than in 2013 (7.0% versus 2.5%).

- *Supportive Housing*: In the initial years, the penetration rate analysis for supported housing was informed by a single supportive housing billing code that was infrequently utilized (H0043). As a result, the supportive housing penetration rate changes could not be calculated between 2013 and 2014. A slight improvement in supportive housing utilization was evident in the overall percentage of adults with SMI using supportive housing from 2014 to 2015 (from 3.3% to 3.7% [using H0043]). In recognition that supportive housing services can leverage a myriad of interventions and activities, an additional billing code (H2014 — skills training and development) was added in 2016 to reflect the utilization of supportive housing services by contracted supportive housing providers. With the addition of the H2014 code, the supportive housing penetration rate increased from 3.7% in 2015 to 4.6% in 2016 and then to 6.6% in 2017. In 2018, additional service codes were included (T1019 and T1020 — Personal Care Services; and H2017 — Psychosocial Rehabilitation Services) when the services were rendered by contracted supportive housing providers. As a result, the penetration rate for supportive housing more than doubled to 15.1% in 2018, and the total number of

people served with supportive housing also increased significantly. The percentage of supportive housing services increased substantially between 2019 (14.9%) and 2020 (21.5%). Although the total number of people served with supportive housing modestly increased in 2021, the penetration rate for supportive housing was comparable to the 2020 rate (21.8% in 2021 compared to 21.5% in 2020).

Table 6 — Maricopa County EBP Utilization Rates: 2013 through 2021

Maricopa County EBP Utilization Rates among People with SMI Served in the System							
Year	Number of Adults with SMI Served	ACT		Supported Employment (SE)		Supportive Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[33]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2021)	36,718	2,265	6.2%	11,790	32.1%	7,988	21.8%
SE Ongoing	-	-	-	2,567	7.0%	-	-
Maricopa County (2020)	35,114	2,317	6.6%	11,890	33.8%	7,558	21.5%
SE Ongoing	-	-	-	3,265	9.2%	-	-
Maricopa County (2019)	34,451	2,278	6.6%	10,615	30.8%	5,149	14.9%
SE Ongoing	-	-	-	2,436	7.1%	-	-
Maricopa County (2018)	34,264	2,241	6.5%	9,861	28.8%	5,160	15.1%
SE Ongoing	-	-	-	2,376	6.9%	-	-
Maricopa County (2017)	31,712	2,233	7.0%	8,168	25.8%	2,098	6.6%

[33] For additional information regarding "ongoing" supported employment, see footnote 19.

Maricopa County EBP Utilization Rates among People with SMI Served in the System							
Year		ACT		Supported Employment (SE)		Supportive Housing	
	Number of Adults with SMI Served	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[33]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
SE Ongoing	-	-	-	1,708	5.4%	-	-
Maricopa County (2016)	30,440	2,093	6.9%	7,930	26.1%	1,408	4.6%
SE Ongoing	-	-	-	1,544	5.1%	-	-
Maricopa County (2015)	24,608	1,693	6.9%	4,230	17.2%	902	3.7%
SE Ongoing	-	-	-	725	3.0%	-	-
Maricopa County (2014)	23,977	1,526	6.4%	5,634	23.4%	793	3.3%
SE Ongoing	-	-	-	657	2.7%	-	-
Maricopa County (2013)	20,291	1,361	6.7%	7,366	36.3%	Not Available	Not Available
SE Ongoing	-	-	-	515	2.5%	-	-

ACT Benchmarks

In recent years, Maricopa County has enhanced its capacity to provide ACT services to people with SMI. In an important 2006 study, Cuddeback, Morrissey, and Meyer estimated that over a 12-month period 4.3% of adults with SMI in an urban mental health system needed an ACT level of care. The Maricopa County ACT penetration rate, relative to all people with SMI served in the system (as well as relative to the 4.3% estimate provided by Cuddeback, et al.), is presented in Table 7 below.[34]

[34] Some readers might conclude from this analysis that Maricopa County provides ACT to too many people with SMI, given that its penetration rate of 6.2% exceeds the estimated percentage of people with SMI in need of ACT (4.3%). However, it is important to note that the 4.3% estimate we used in this analysis was derived from a study conducted in Portland, Oregon almost 15 years ago. That study is the only United States-based study of its kind that would be pertinent to Maricopa County, and it did use well-accepted criteria concerning the number of psychiatric hospitalizations that would indicate that a given person needs ACT. However, since the Cuddeback et al.

Maricopa County's ACT penetration rate (6.2%) exceeds the benchmark in the Cuddeback et al. study (4.3%),[35] compares favorably with other communities nationally, and could be considered a best practice benchmark level, especially given that Maricopa County includes FACT teams that can respond to the special needs of adults with SMI who also have histories of involvement with the criminal justice system. Additionally, most ACT teams are integrated with primary care partnerships.

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

ACT Utilization					
Region	Number of Adults with SMI Served in Public System[36]	Number of Adults Estimated to Need ACT[37]	Number of Adults Who Received ACT[38]	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
Ideal Benchmark[39]	-	-	-	*4.3%*	*100%*
United States	4,096,666	176,157	66,159	1.6%	38%
Arizona	114,989	4,945	Not available	Not available	Not available
Maricopa Co.	36,718	1,579	2,265	6.2%	143%
Maricopa Co. — Medicaid	29,295	1,260	1,879	6.4%	149%
Maricopa Co. — non-Medicaid	7,423	319	386	5.2%	121%
Texas	306,029	13,159	7,791	2.5%	59%

study was conducted, ACT has been extended to people with SMI who have recurring involvement in the criminal justice system and who may or may not have a sufficient number of hospitalizations to qualify for ACT. Maricopa County has extended ACT to these clients and the overall penetration rate for ACT likely reflects the actual level of need. A more in-depth study would be needed to verify that conclusion, but the overall finding is that Maricopa County is delivering a robust level of ACT as well as varying types of ACT to its clients who need that level of care.

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

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

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

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

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

ACT Utilization					
Region	Number of Adults with SMI Served in Public System[36]	Number of Adults Estimated to Need ACT[37]	Number of Adults Who Received ACT[38]	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
Harris County (Houston)	33,792	1,453	1,137	3.4%	78%
Bexar County (San Antonio)	15,008	645	297	2.0%	46%
New York	544,572	23,417	8,281	1.5%	35%
New York County (New York City)[40]	91,191	3,921	1,218	1.3%	31%
Colorado	67,961	2,922	595	0.9%	20%
Denver County (MHCD)[41]	17,350	746	671	3.9%	90%
King County (Seattle, WA)	4037	174	300	7.4%	173%
Nebraska	13,154	566	85	0.6%	15%
California	412,758	17,749	5,147	1.2%	29%
Illinois	22,702	976	669	2.9%	69%
Minnesota	151,444	6,512	2,221	1.5%	34%
Tennessee	192,292	8,269	105	0.1%	1%
Indiana	82,540	3,549	763	0.9%	21%
Delaware	7,611	327	407	5.3%	124%

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

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

ACT Utilization					
				ACT Penetration	
Region	Number of Adults with SMI Served in Public System[36]	Number of Adults Estimated to Need ACT[37]	Number of Adults Who Received ACT[38]	Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
New Hampshire	16,168	695	1,246	7.7%	179%
North Carolina	72,073	3,099	4,501	6.2%	145%

Supported Employment Benchmarks

In the provision of supported employment-oriented services, Maricopa County provides some aspects of supported employment to a relatively high percentage of the estimated need for this EBP: 32% of people with SMI in the public mental health system received at least a one-time vocational assessment or some other type of pre-vocational services. However, far fewer (7%) received services specifically associated with ongoing support to maintain employment (2,567). Based on our understanding of the supported employment service codes and information gleaned from clinical record reviews, interviews with recipients, and observations of other stakeholders who participated in previous years' focus groups, we conclude that the 7% figure represents a best estimate of the percentage of individuals who received high fidelity supported employment.

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

Supported Employment (SE) Utilization					
Region	Number of Adults with SMI Served in System[42]	Number of Adults in Need of SE[43]	Number of Adults Who Received SE[44]	Supported Employment (SE) Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
Ideal Benchmark	-	-	-	*45%*	*100%*
United States	4,096,666	1,843,500	66,662	1.6%	4%
Arizona[45]	114,989	51,745	14,071	12.2%	27%
Maricopa Co. — Total Served	36,718	16,523	11,790	32.1%	71%
SE Ongoing	36,718	16,523	2,567	7.0%	16%
Maricopa Co. — Medicaid	29,295	13,183	9,587	32.7%	72%
SE Ongoing	29,295	13,183	2,136	7.3%	16%
Maricopa Co. — non-Medicaid	7,423	3,340	2,203	29.7%	66%
SE Ongoing	7,423	3,340	431	5.8%	13%
Texas	306,029	137,713	9,753	3.2%	7%
Harris County (Houston)	33,792	15,206	4,563	13.5%	30%
Bexar County (San Antonio)	15,008	6,754	470	3.1%	7%
New York	544,572	245,057	1,017	0.2%	0%
Colorado	67,961	30,582	516	0.8%	2%

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

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

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

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

Supported Employment (SE) Utilization					
Region	Number of Adults with SMI Served in System[42]	Number of Adults in Need of SE[43]	Number of Adults Who Received SE[44]	Supported Employment (SE) Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
Denver County (MHCD)[46]	17,350	7,808	154	0.9%	2%
Nebraska	13,154	5,919	789	6.0%	13%
California	412,758	185,741	409	0.1%	0%
Illinois	22,702	10,216	1,512	6.7%	15%
Kansas	26,155	11,770	992	3.8%	8%
Tennessee	192,292	86,531	898	0.5%	1%
Indiana	82,540	37,143	1,281	1.6%	3%
Delaware	7,611	3,425	2	0.0%	0%
New Hampshire	16,168	7,276	3,779	23.4%	52%

Peer Support Benchmarks

Maricopa County excels in making peer support services available to people in need. The penetration rates for 2013–2021 are relatively high and represent a best practice benchmark in terms of access to peer support (see Table 9).

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

Table 9 — Peer Support Penetration Rates

Peer Support		
Region	**Peer Support Received**	**Peer Support Penetration Rate**
Arizona		
Maricopa County (Total) — 2021	13,573	37%
Maricopa County (Total) — 2020	14,224	41%
Maricopa County (Total) — 2019	11,943	35%
Maricopa County (Total) — 2018	11,001	41%
Maricopa County (Total) — 2017	11,803	37%
Maricopa County (Total) — 2016	11,629	38%
Maricopa County (Total) — 2015	7,173	29%
Maricopa County (Total) — 2014	7,522	31%
Maricopa County (Total) — 2013	8,385	41%
Texas		
Harris County	3,238	13%
Colorado		
Denver City/County[47]	733	4%

[47] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, June 14, 2021. The Mental Health Center of Denver peer support services for adults with SMI are provided by peer mentors and peer specialists. This figure may include some duplication of those served by both a peer mentor and a peer specialist.

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

Service Descriptions

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

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

Focus Groups

As part of the service capacity assessment of the four priority behavioral health services in Maricopa County, four focus groups were conducted with key system stakeholders. The focus groups were convened to facilitate discussion with participants with direct experience with the priority mental health services. Focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants. Key findings derived from the focus groups regarding the delivery system's capacity to deliver peer support and family support services included:

- Across all focus groups, participants agreed that peer support is a valuable service and that peer support specialists can often bridge the gap in communication with the rest of the clinical team. Some described the role of the peer support specialist as the "most rewarding position" within the system.
- Similar to prior years, varied opportunities exist for members to access and participate in peer support services. However, participants in all focus groups reported that there are still not enough peer support specialists in the system. While many individuals complete the Peer Support Certification process, it is perceived that only a relatively small percentage graduate to become employed as peer support specialists.
- Focus group participants reported that there continues to be a lack of bilingual (Spanish-English and other languages) peer support specialists in the system.
- Participants indicated that turnover rates remain high among peer support specialists. Primary contributors include: low pay, the demands/stress of the position (note-taking and billing requirements), and expectations to drive personal vehicles for business purposes.

- During the pandemic, peer support services moved to virtual and telephonic delivery for both group and individual sessions. Some providers have moved back to in-person delivery of peer support as the sole option for provision of this service. Other providers are continuing to offer peer support virtually, telephonically, and in-person.
- The virtual and telephonic delivery of peer support received mixed reviews from participants. Some felt that while these options improved accessibility to the option for some members, it created barriers for others. Notably, individuals without internet or phone access and individuals who did not have the ability to navigate a virtual option.
- Participants reported that there is still a portion of members who do not wish to attend peer support in-person due to COVID-19 related fears. For those clinics who no longer offer virtual or telephonic peer support, these individuals do not have access to the service.
- Participants shared conflicting information about if they are still permitted to bill for peer support virtually and telephonically. Some providers believe this pandemic-related billing option has been rescinded while others continue to bill both virtually and telephonically for the service.
- Participants reported that peer support specialists typically have the highest billable hour production goals compared to case managers and other roles in the clinic.
- Participants added that peer support specialists do not receive enough support from upper management when they experience mental health symptoms and this can result in termination from the role. One participant stated, "This is when the system fails because the clinics haven't figured out how to establish an organizational culture to support these individuals in their roles."
- Some participants expressed that many individuals are encouraged to become peer support specialists. However, similar to last year, they felt many are not really qualified to serve in the role and the training provided is insufficient to fully prepare an individual to be successful in the role. Participants in the case manager focus group suggested that the training process become more refined and members requested a renewed focus on "wellness" versus "recovery".
- Members advocated for separate peer support certifications for people with substance use disorders and mental health challenges. These participants felt that sometimes peer-to-peer modalities do not align. For example, a peer support specialist with no history of a substance use disorder may not be able to meet the needs of a member whose primary challenge is a substance use disorder.
- The role of the peer support specialist does not appear to be well-understood by behavioral health home leadership, leading to confusion in role responsibilities. Participants reported that peer support specialists are often asked to provide services outside of their scope such as case management services, therapy groups, and substance use services. Clinic-based peer support specialists are perceived as being "spread thin".

- Last year, it was reported that there were barriers to initiating peer support at a peer-run organization because a referral was required from the health home clinic. Participants report that this remains an issue and there continues to be inconsistencies across the peer-run organizations if they will accept verbal consent. Some will permit a verbal consent to be provided to start service referrals and allow the written referral to be sent later. Written referrals require specific verbiage or they may be denied.
- There was also conflicting information if members have the option to self-refer to a peer-run organization. Members reported they believed they could self-refer but case managers indicated that they must be the one to initiate referrals.
- Similar to prior years, participants in all focus groups agree that there are not enough family support specialists in the system. Some clinics only have one family mentor to serve the entire clinic. One provider indicated they only have one family support specialist to serve the entire West Valley. Similar to peer support specialists, family support specialists can be “spread too thin” to provide meaningful support to families.
- There continues to be a lack of education about the availability and benefit of family support services.
- Some clinics offer group meetings for family members (some monthly) which are facilitated by family support specialists. However, despite requests from families for this service, it is not widely available and clinic staff reported they do not have the capacity to provide these groups.
- The role of the family support specialist is often blurred and they take on many other duties outside of their scope (i.e., case management duties).
- Case managers report they receive no training on family support services or how to identify when a member or their family may benefit from the service.
- Case managers shared that clinic leadership still does not understand the role and value of a family support specialist. When there is turnover in this role, the positions are often not replaced.
- Low pay and high billing expectations are contributing factors to high turnover rates of family support specialists.
- One former family support specialist shared that the clinical team seemed to dislike her role, especially when she would advocate for services the team did not have the capacity to provide. She felt family support specialists are seen as “irritators in the system”.
- Similar to prior years, case managers and providers noted that members commonly decline to have family members involved in their treatment and family members do not always understand the member’s rights to choose if they want others involved in their treatment. Participants agreed that family members would benefit from training on family support services and how it could support both them and the member.
- Case manager participants shared that sometimes they skip the conversation with members regarding family services because there are no providers to implement the service. Another case manager participant noted that clinical teams are so busy that

family support services do not come to the forefront in conversation. As a result, “family support services get lost in the services being provided.”

- One member reported that he has only been asked once about family support services following a hospitalization. He was not in a place to say yes to family involvement and has never been asked about it again.
- One parent shared that she used to have a Release of Information (ROI) to participate in her daughter’s care, but is unsure if it is still active. The clinic calls her when they cannot reach her daughter, but they do not share information with her. She is unsure if the clinical team discusses family support services with her daughter or the topic of a new ROI. She would like to have deeper communication with her daughter’s clinical team, especially with prescribers who do not seem to be aware of her daughter’s psychotic episodes.
- One member stated her sister was interested in receiving family support services but the family support specialist did not engage with her sister. The service has not been initiated for this member.
- Case managers and providers felt that that family treatment would be beneficial to members and family members but this is not offered or rarely available. Some shared that this could be an alternative to family support services.

Key Informant Survey Data

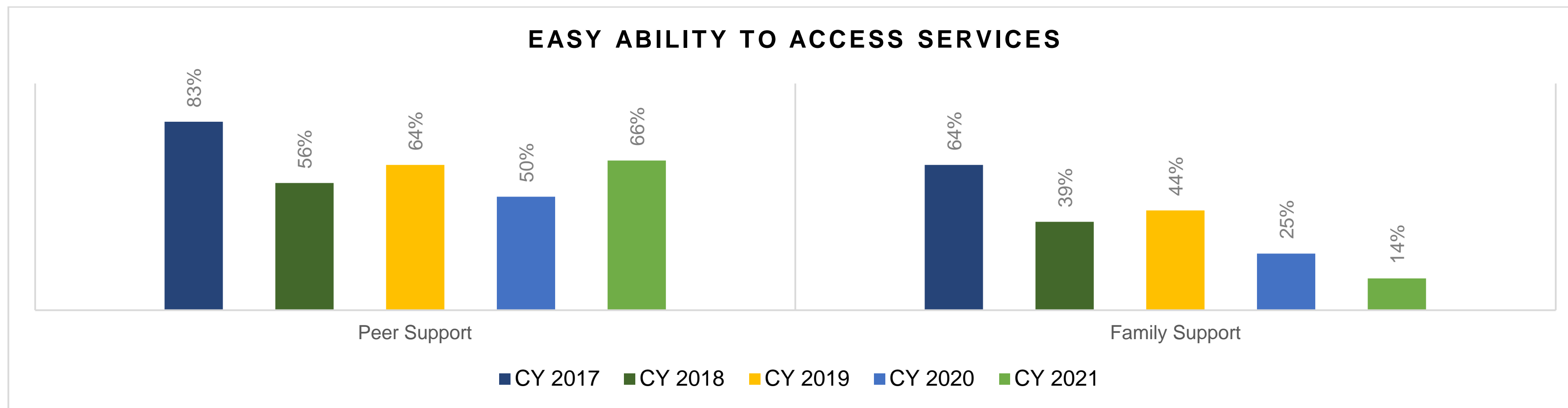
As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to the priority services, a key informant survey was administered. The survey tool included questions and rating assignments related to the priority mental health services. It should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

Level of Accessibility

Two-thirds of the survey respondents felt that peer support services were easy to access, an increase from last year’s survey results in which 50% of the respondents indicated that the services were easy to access. Six percent of survey respondents indicated that peer support services were difficult to access and none of the respondents believed that the services were inaccessible. Consistent with the last eight years, peer support services were perceived as the easiest of all the priority services to access.

Twenty-nine percent of survey respondents felt that family support services were difficult to access while 14% of the respondents indicated that family support services were easy to access. Fifty-seven percent of respondents rated access to family support services as “fair”.

Overall, respondents felt that accessing peer support services was easier during CY 2021 when compared to CY 2020. However, family support services continue to be perceived as challenging to access.



Factors that Hinder Access

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

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

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

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

Efficient Utilization

In terms of service utilization, 82% of the responses indicated that peer support services were being utilized efficiently or were utilized efficiently most of the time. Eighteen percent of respondents indicated that the peer support services were not utilized efficiently.

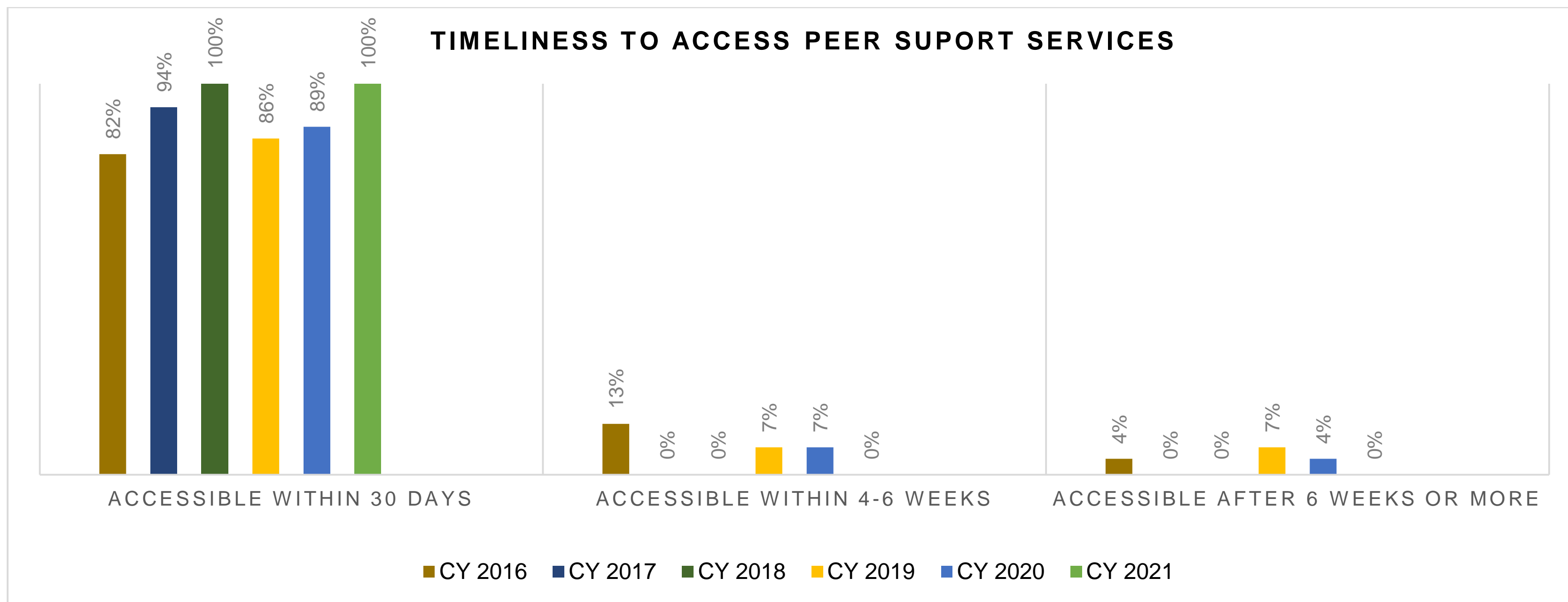
Fifty-eight percent of the responses indicated that family support services were being utilized effectively or were utilized efficiently most of the time.

Forty-two percent of the responses indicated that family support services were not utilized efficiently.

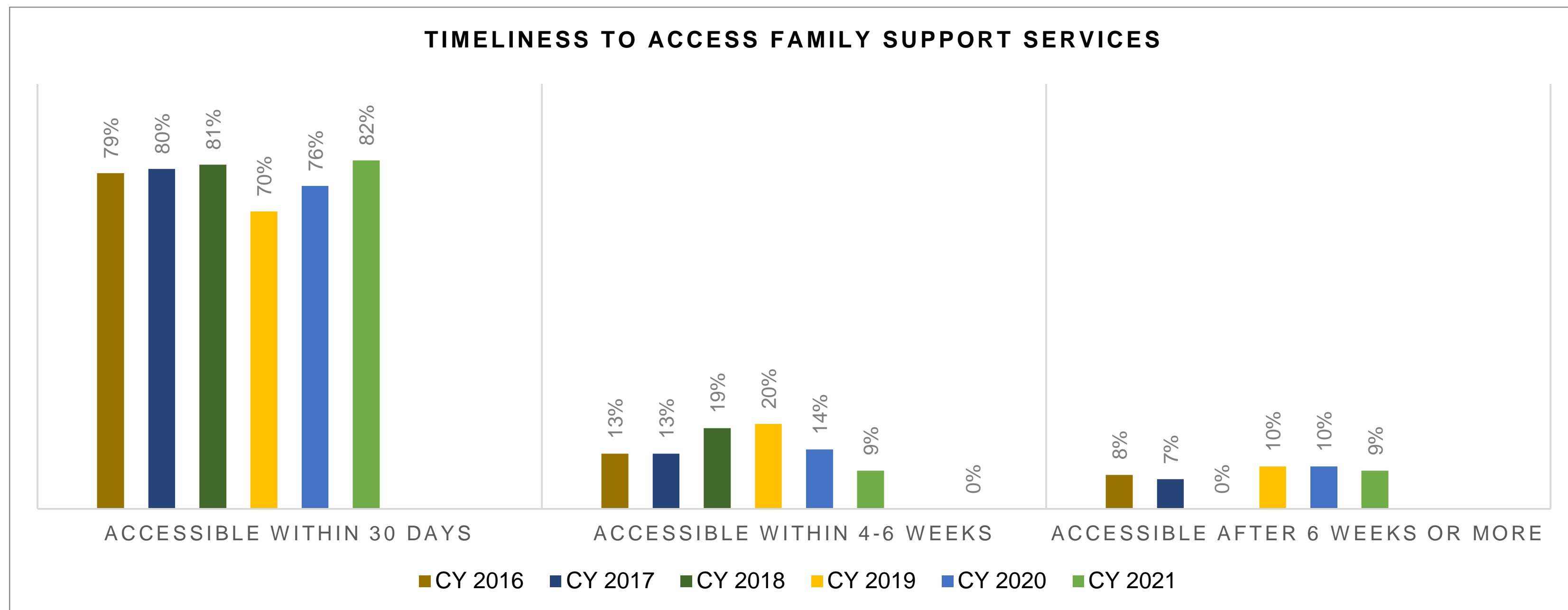
Timeliness

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

- 100% of the survey respondents reported that peer support services could be accessed within 30 days of the identification of the service need. This finding compares to 70% during CY 2013, 75% during CY 2014, 78% during CY 2015, 82% during CY 2016, 94% during CY 2017, 100% during CY 2018, 86% during CY 2019, and 89% during CY 2020.
- 0% reported it taking four to six weeks to access peer support services following the identification of need (compared to: 20% — CY 2013; 13% — CY 2014; 15% — CY 2015; 13% — CY 2016; 0% — CY 2017; 0% — CY 2018; 7% — CY 2019; and 7% — CY 2020).
- 0% of the survey respondents reported that it would take an average of six weeks or longer to access peer support services (compared to: 10% — CY 2013; 13% — CY 2014; 7% — CY 2015; 4% — CY 2016; 6% — CY 2017; 0% — CY 2018; 7% — CY 2019; and 4% — CY 2020).



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



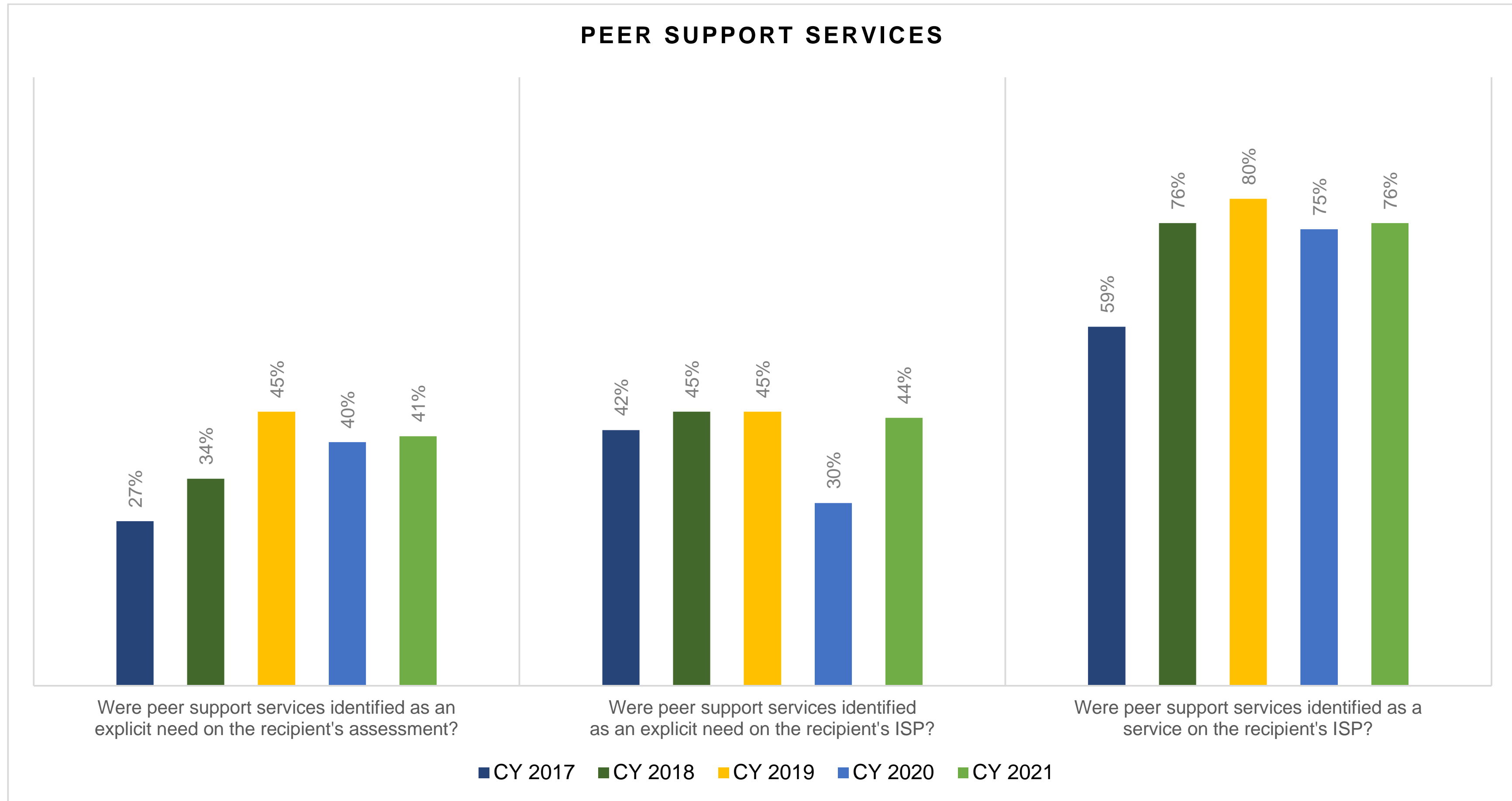
Medical Record Reviews

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

Peer Support Services

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

Thirty-five percent of the recipients included in the sample received at least one unit of peer support during CY 2021 based on an analysis of service utilization data.



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

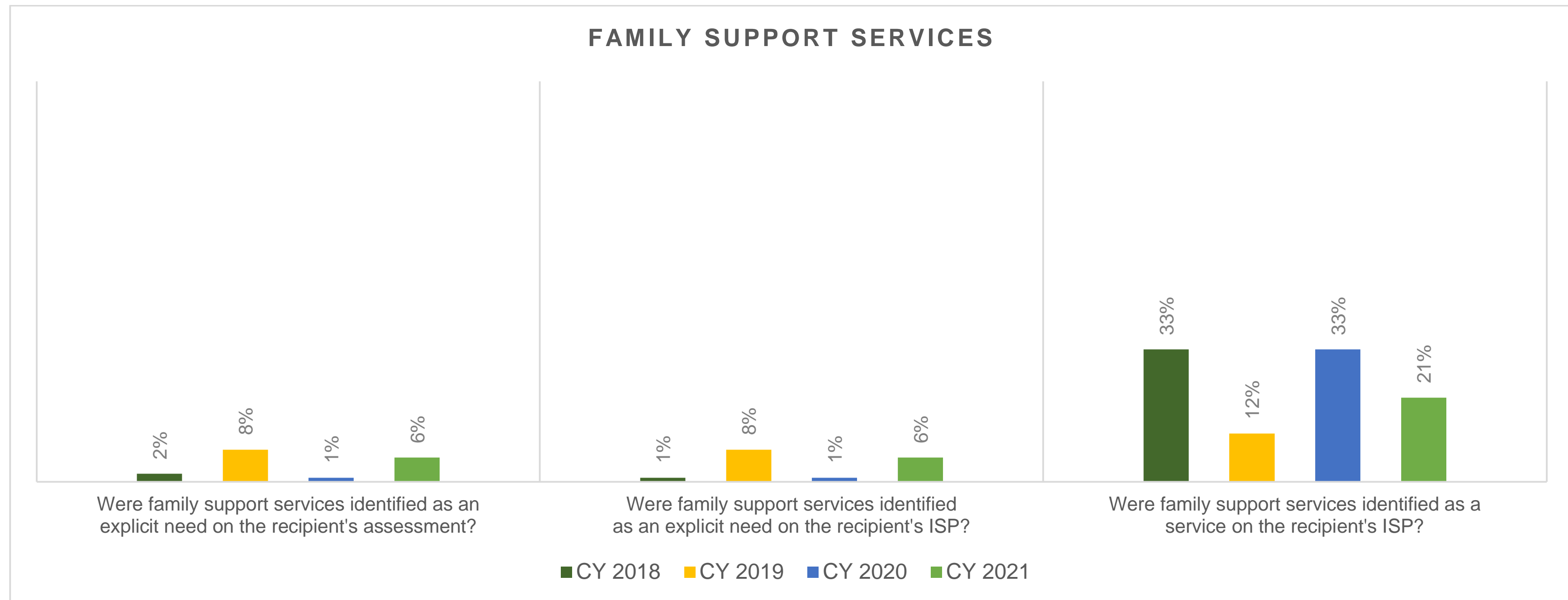
- The clinical team did not follow-up with initiating a referral for the service.
- The member was hospitalized.
- The member declined services.

Family Support Services

As part of the clinical services assessment process, information is routinely collected and documented by the clinical team regarding the natural and family supports available and important to the recipient. However, clinical teams rarely leverage the opportunity to involve others significant to the person during the service planning process by recommending family support services.

Ten percent of the cases included an assessed need for family support services. Of these cases, 21% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP.

Five percent of the recipients included in the sample received at least one unit of family support during CY 2021 based on a review of service utilization data.



Year-over-year, family support services are less apt to be identified as a need on the assessment and ISP, a trend that continued during CY 2021. For CY 2021, family support services were rarely included as a distinct service on a member's ISP. Of the 19 cases in the sample that included an assessed need for family support services, only four ISPs included family support services as an intervention to address the need.

Service Utilization Data — Peer Support Services

Peer support services (i.e., Self-Help/Peer Services) are designated by two unique billing codes (H0038 — 15 minute billing unit and H2016 — per diem). During the time period of October 1, 2020 through June 30, 2021; 35,620 unique users were represented in the service utilization data file. Of those, 80% were Medicaid eligible and 20% were non-Title XIX eligible.

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

Access to the service favored Title XIX eligible members (33%) over the non-Title XIX population (30%).

Persistence in Services

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

- Overall, 52% of members who received at least one unit of peer support during the review period accessed the service during a single month, an increase when compared to CY 2020 (~40%).
- 70% of all members who received at least one unit of peer support during the review period accessed the service for one or two months. During CY 2020, this result was 53%. Peer support services are widely accessible across the system and members may have multiple opportunities to attend a clinic-based peer support group and/or receive peer support services within or outside their assigned health home. The nature of the service can lend to episodic participation and is less dependent on sustained participation to be an effective support and intervention.

Persistence in Peer Support Services October 2020–June 2021			
Consecutive Months of Service	Medicaid Recipients	Non-Medicaid Recipients	All Recipients
1	51.3%	55.1%	52.0%
2	18.6%	17.5%	18.4%
3–4	15.1%	14.5%	15.0%
5–6	6.7%	5.6%	6.5%

Persistence in Peer Support Services October 2020–June 2021			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
7–8	3.3%	2.3%	3.1%
9+	5.0%	5.0%	5.0%
Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.			

Service Utilization Data — Family Support Services

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

- Overall, 3.4% of the recipients received at least one unit of family support services during the time period (4.3% over a comparable time period last year). Over the eight years that the service capacity assessment has been conducted, family support service utilization rates have been consistently at 2% to 5%. A number of factors may be influencing these results including the absence of supportive family members, member choice to not include family members in their treatment, and a lack of understanding by clinical teams regarding the appropriate application and potential benefits of the service.

Access to the service was split evenly between Title XIX (3.4%) and non-Title XIX groups (3.4%).

Persistence in Services

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

- 65% of the members who received at least one unit of family support during the review period accessed the service during a single month, down from 71.4% during CY 2019 and 76.8% during CY 2018, but an increase from last year (CY 2020) when about half of the members accessed the service during a single month.
- 80% of all members who received at least one unit of family support during the review period accessed the service for one or two months. This compares to 63% during CY 2020.

Persistence in Family Support Services October 2020–June 2021			
Consecutive Months of Service	Medicaid Recipients	Non-Medicaid Recipients	All Recipients
1	64.8%	64.0%	64.6%
2	15.8%	15.9%	15.8%
3–4	15.3%	17.2%	15.6%
5–6	2.6%	2.5%	2.6%
7–8	<1.0%	<1.0%	<1.0%
9+	<1.0%	<1.0%	<1.0%
Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.			

Key Findings and Recommendations

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

Findings: Peer Support

- Service utilization data reveals the volume of peer support services provided during a defined time period. For the time period of October 1, 2020 through December 31, 2021, 37% of all members with an SMI received at least one unit of peer support. During the prior year, 41% of members received peer support services (compared to: 2013 — 38%; 2014 — 31%; 2015 — 29%; 2016 — 38%; 2017 — 37%; 2018 — 36%; 2019 — 35%; and 2020 — 41%).
- Similar to prior years, varied opportunities exist for members to access and participate in peer support services. However, participants in all focus groups reported that there are still not enough peer support specialists in the system. While many individuals complete the Peer Support Certification process, it is perceived that only a relatively small percentage graduate to become employed as peer support specialists.
- Participants reported that there is still a portion of members who do not wish to attend peer support in-person due to COVID-19 related fears. For those clinics who no longer offer virtual or telephonic peer support, these individuals do not have access to the service.
- Last year, it was reported that there were barriers to initiating peer support at a peer-run organization because a referral was required from the health home clinic. Participants report that this remains an issue and there continues to be inconsistencies across the peer-run organizations if they will accept verbal consent. Some will permit a verbal consent to be provided to start service referrals and allow the written referral to be sent later. Written referrals require specific verbiage or they may be denied.

- Two-thirds of the survey respondents felt that peer support services were easy to access, an increase from last year's survey results in which 50% of the respondents indicated that the services were easy to access. Six percent of survey respondents indicated that peer support services were difficult to access and none of the respondents believed that the services were inaccessible. Consistent with the last eight years, peer support services were perceived as the easiest of all the priority services to access.
- 69% of the ISPs included peer support services when assessed as a need; a decrease when compared to CY 2020 (75%) and CY 2019 (80%).
- 35% of the recipients included in the medical record review sample received at least one unit of peer support during CY 2021 based on a review of service utilization data.
- Reviewers were able to review progress notes and record the documented reasons that the person was unable to access peer support services when recommended by the clinical team. Consistent with prior years, the most common finding was that the clinical team did not follow-up with initiating a referral for the service.
- Maricopa County continues to demonstrate strong access to peer support services and, based on Mercer's national penetration and prevalence analyses, utilization is at a level that is considered to be a best practice benchmark.
- 52% of members who received at least one unit of peer support during the review period accessed the service during a single month, an increase when compared to CY 2020 (~40%).

Findings: Family Support

- Service utilization data demonstrates that 4% of members received at least one unit of family support services during 2021, a reduction of two percentage points when compared to last year (compared to: 2013 — 2%; 2014 — 3%; 2015 — 2%; 2016 — 2%; 2017 — 2%; 2018 — 4%; 2019 — 6%; and 2020 — 6%).
- 10% of the sample of medical records included an assessed need for family support services. Of these cases, 21% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP.
- 5% of the recipients included in the medical record review sample received at least one unit of family support during CY 2020 based on a review of service utilization data.
- 82% of the survey respondents reported that family support services could be accessed within 30 days of the identification of a service need. This finding compares to 33% during CY 2013, 69% during CY 2014, 74% during CY 2015, 79% during CY 2016, 80% during CY 2017, 81% during CY 2018, 70% during CY 2019, and 76% during CY 2020.
- Case manager participants in the focus groups shared that sometimes they skip the conversation with members regarding family services because there are no providers to implement the service. Another case manager participant noted that clinical teams are

so busy that family support services do not come to the forefront in conversation. As a result, "family support services get lost in the services being provided."

- Some clinics offer group meetings for family members (some monthly) which are facilitated by family support specialists. However, despite requests from families for this service, it is not widely available and clinic staff reported they do not have the capacity to provide these groups.

Recommendations: Peer Support

- Consistent with the *AHCCCS Contractor Operations Manual, Policy 407, Workforce Development*[48], examine factors contributing to high turnover and vacancies across peer support specialists operating within the service delivery system and take appropriate actions to improve recruitment and retention.
- Review the basis for requirements that health home clinics must initiate referrals prior to a recipient accessing peer support services from a community-based consumer-run organization. Clarify and standardize expectations related to the use of verbal consent versus written consent as a condition to access peer support services.
- When peer support services are assessed as a need, ensure that members' ISPs include the service and that clinical teams initiate timely actions to refer and/or engage members in peer support services.

Recommendations: Family Support

- Provide training and supervision to ensure that health home clinical team members understand the appropriate application of family support services and to recognize the value of family support services as an effective service plan intervention.
- Ensure that the member's ISP includes family support services as an intervention when assessed as a need or after members indicate that they would like a family member involved in their treatment.
- Perform a data driven assessment (e.g., inventory of qualified provider) of the service delivery system's capacity to provide family support services. As applicable, increase the volume of contracted providers to address any identified staffing shortages.

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

5.3 Multi-Evaluation Component Analysis — Supported Employment

Service Description

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

Focus Groups

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

- Participants shared that the pandemic impacted member engagement in supported employment services. Supported employment specialists did not see members face-to-face during the pandemic which reduced their ability to engage effectively with members.
- Participants agreed that after two years of the pandemic, members are now becoming more interested in working and leaving the house to participate in meaningful activities.
- Participants reported that some members are being “forced” to consider employment due to the increase in housing costs.
- Participants reported that co-located Vocational Rehabilitation (VR) counselors moved to fully virtual services during the pandemic and they have not returned to the clinics. VR orientation sessions also remain virtual.
- It was reported that VR counselors are now serving multiple clinics and it is possible they are struggling with staffing resources.
- Participants agreed that VR services are minimally available to members and there is a lack of follow-up by the counselors with members. One family member reported that her daughter has been asking for a referral to VR for the last three years and she kept getting referred back and forth between the counselor and the case manager. The parent eventually called the RBHA who helped to initiate the referral.
- Participants shared that members who do engage with VR Services sometimes feel that the process takes too long. Members get discouraged, do not complete the process, and feel deterred from pursuing employment and schooling opportunities.
- One member reported that her experience with VR Services was positive and her counselor was very responsive. She was able to obtain employment as a peer support specialist in a Level 1 facility and held the position for seven months. Her counselor remains in contact with her and has offered to help her regain employment when she is ready.

- Participants shared that referrals to clinic-based employment specialists receive a prompt response of approximately one week. When there is no internal resource, external referrals to community providers take approximately two weeks to be initiated. One member felt it would be beneficial to have an employment specialist at every clinic who could be more “hands-on” with members.
- All participants agreed that referrals for supported employment services made to the clinic’s rehabilitation specialist and initiation of referrals to co-located supported employment providers remain easy and smooth.
- All participants were familiar with community-based supported employment providers and were aware that members could self-refer to these providers if desired.
- Participants reported that once a member engages with supported employment services, the options for employment are often not individualized to the person’s skill set and interests. One member shared that his supported employment specialist only helped him apply for job opportunities in which he lacked qualifications. A case manager expressed that members were often pushed towards gender-based stereotypical job paths that ignored a member’s individualized interests.
- Participants shared that many members enter into Work Adjustment Training (WAT) programs and seem to “get stuck” in these programs. The programs are not reinforcing graduation timeframes, and over time, members do not want to leave due to their level of comfort. These programs are meant to be a stepping-stone to permanent, long term employment.
- Some members expressed concerns about “employment programs” sponsored by certain providers. Members receive part-time pay to complete employment-like tasks for the organization, such as “folding cardboard”. The organizations contract with outside entities to provide this service but the members do not receive employment services which may help them transition to community-based employment. One member felt members who participated benefitted from the income received while another member felt that the setting was “exploiting” the members.
- Participants shared that employers need more training on hiring individuals with SMI and this would promote longer tenure in employment for members. Members often need support once they gain a job but job coaches are not readily available. One member reported that it took a year to find a job coach to support him.
- Similar to last year, case managers reported members remain fearful of the impact of working on their benefits, including their housing vouchers. Case managers shared that between 50%–90% of members they speak to about working do not trust that income earned through employment will be beneficial. They share that “even a small reduction in benefits is enough to deter someone from pursuing employment.”
- Participants shared that stigma about employment remains prevalent in the system. Some members continue to believe that they cannot work because they have a SMI designation. Also, some in leadership positions continue to promote that employment is not an option for individuals with SMI. While other leaders express their support for employment services, participants noted that this stigma continues to be a deterrent.

- All participants reported that members and clinical teams are aware of Disability 101 (DB101), but that many do not trust that it generates accurate answers. Overall, there is mistrust of DB101.
- In prior years, participants discussed the availability of clinic-based benefit specialists. Currently, case managers and rehabilitation specialists appear to be solely responsible for discussing benefits with members. No participants mentioned access to clinic-based benefit specialists as a current service or peers acting in the role of a benefit specialist.
- Participants reported that most clinical team members do not receive formal training on supported employment services and informal, client-specific training is typically provided by the rehabilitation specialist. One rehabilitation specialist shared that he spends a lot of time with case managers helping them to fill out referrals for supported employment services to ensure they have appropriate information.
- Participants shared that clinics seem to appreciate the role of the rehabilitation specialist and there is a push to hire more within the system.
- One member stated that his case manager does not discuss employment options with him and other participants noted that clinical teams often do not follow-up when members ask about employment services. Case managers reported that employment discussions are usually held during ISP sessions, while other case managers try to raise this topic more regularly.
- There continues to be conflicting perspectives regarding the practice of including supported employment services on a member's ISP. Most participants reported that clinical teams are required to include an employment-related goal on the ISP but one participant stated that their clinic does not explicitly require this for all members. At his clinic, members are encouraged to set "thoughtful" goals that are individualized to their unique needs.

Key Informant Survey Data

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

Level of Accessibility

Seventeen percent of survey respondents felt that supported employment services were difficult to access, less than last year (21%), and significantly less than CY 2013 and CY 2014 (75% — CY 2013; 33% — CY 2014). Eighty-three percent of respondents indicated that supported employment services were easy to access or having "fair" access, an increase from CY 2020 (76%).

Factors that Hinder Access

Factors that negatively impact accessing supported employment services include:

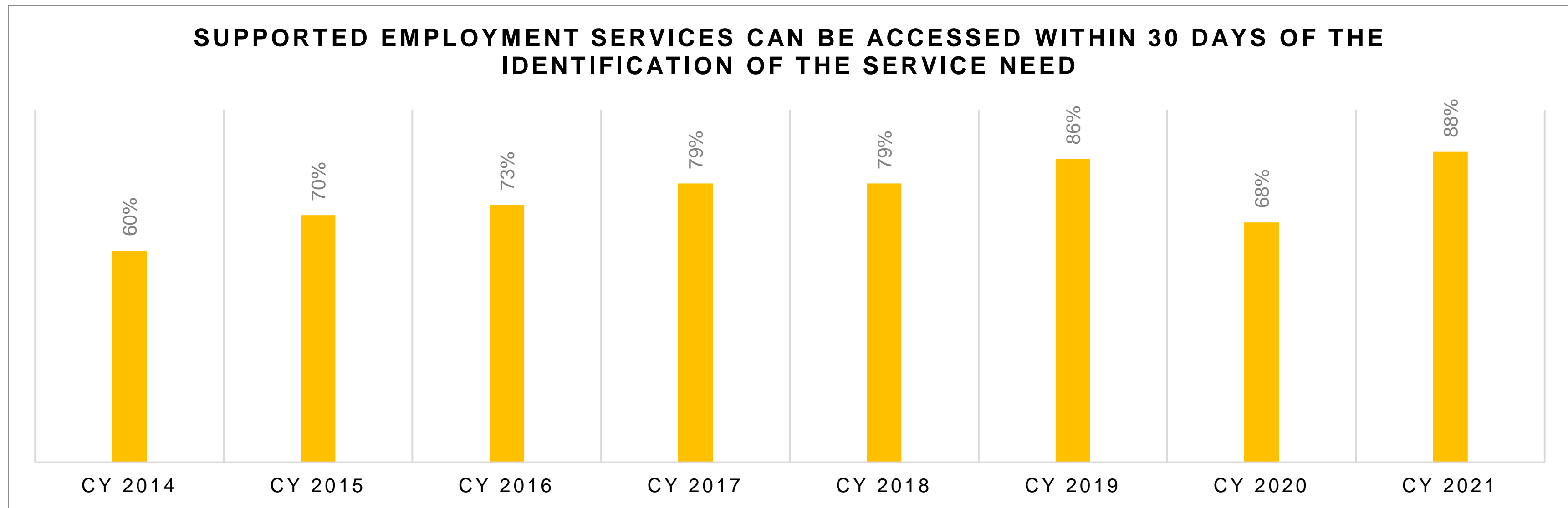
- Member declines services
- Transportation barriers
- Clinical team unable to engage/contact member

Efficient Utilization

Eighty-eight percent of the responses indicated that supported employment services were being utilized efficiently or were utilized efficiently most of the time, similar to the same finding from last year (87%). Twelve percent of respondents indicated that supported employment services were not utilized efficiently.

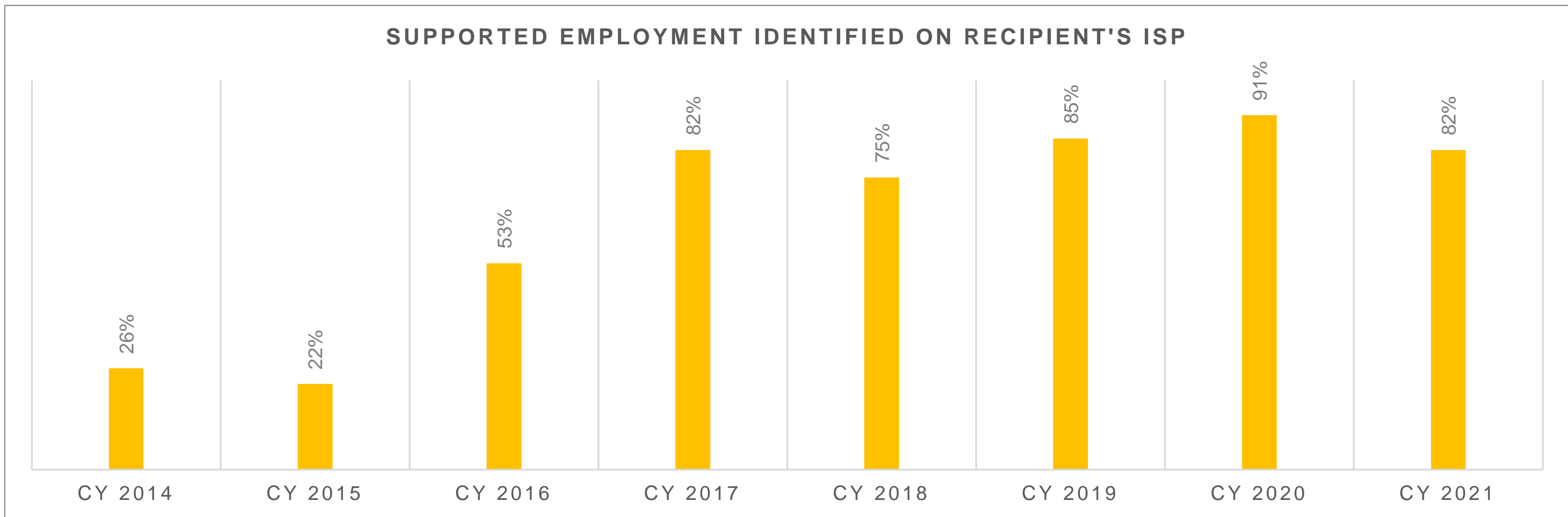
Timeliness

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



Medical Record Review

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



Thirty-two percent of the recipients included in the medical record review sample received at least one unit of supported employment during CY 2021 based on a review of service utilization data.

In 42 cases, reviewers were able to review progress notes and record the reasons that the person did not access supported employment services after a supported employment need was identified by the clinical team. A lack of evidence that the clinical team followed up with initiating a referral for the service was noted in 57% of those cases in which the person did not access the service despite an identified need — significantly less than the rate identified during CY 2020 (81%).

In many of these cases, there were inconsistencies between the functional assessment and the ISP, with the assessment typically including an explicit statement from the member that they did not wish to pursue employment opportunities. Yet, in many of these same cases, the clinical team listed supported employment services on the ISP in the absence of any assessed need. As a result, 56% of the cases lacked evidence that the member received supported employment services despite the service being listed on the ISP. As noted in prior service capacity assessments, ISPs are not always based on the member's assessed or individualized needs and can include generic language and/or services that fail to differentiate each member's unique circumstances and needs.

Continuing a trend observed over the past several years, multiple ISPs analyzed as part of the medical record review included supported employment services in the absence of an assessed need for the service and, at times, in direct conflict to statements attributed to the member regarding their preference not to pursue employment opportunities. In several of these cases, the supported employment services identified on the ISP, which often included pre-job development and training **and** ongoing support to maintain employment, were presented in the context of a one-time meeting between the member and the clinic's rehabilitation specialist to

complete a vocational assessment. In many cases, the vocational assessment was never performed as the member may not have a current interest in employment services. When conducted, variance was noted in terms of how the vocational assessment was billed — with rehabilitation specialists billing H2027 (pre-job training and development), H2014 (skills training and development), or T1016 (case management).

Service Utilization Data

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

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

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

Services which prepare a person to engage in meaningful work-related activities may include but are not limited to the following: career/educational counseling, job shadowing, job training, including WAT; assistance in the use of educational resources necessary to obtain employment; attendance to VR/Rehabilitation Services Administration (RSA) Information Sessions; attendance to Job Fairs; training in resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), work activities, professional decorum, time management, and assistance in finding employment.

H2025 — Ongoing Support to Maintain Employment

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

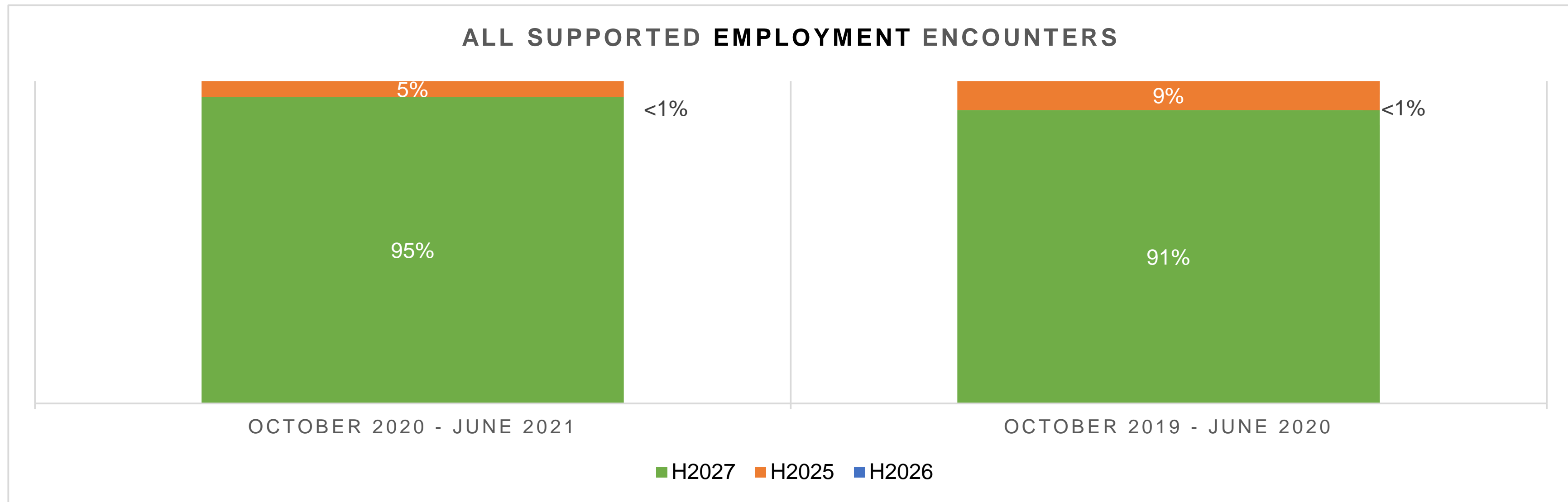
H2026 — Ongoing Support to Maintain Employment (per Diem)

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

Service Utilization Trends

For the time period October 1, 2020 through June 30, 2021, H2027 (pre-job training and development) accounts for 95% of the total supported employment services (an increase from CY 2019 — 92% and CY 2020 — 91%). H2025 (ongoing support to maintain employment/15-minute billing unit) represents 5% of the supported employment utilization (CY 2019 — 8% and CY 2020 — 9%).

H2026 (ongoing support to maintain employment/per diem billing unit) accounted for less than 1% of the overall supported employment utilization.



A billing modifier (i.e., SE) is applied in conjunction with billing code H2027. The intended use of the modifier is to track members who are engaged in rapid job search with an expected outcome of securing employment within 45 days of engaging in supported employment services and/or the member is in an active job search. Mercer analyzed the presence of this code and modifier within the service utilization data file. H2027 SE represents 9% (CY 2020 — 8% and CY 2019 — 9%) of the overall supported employment utilization.

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

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

- Overall, 32% of the recipients received at least one unit of supported employment during the review period, two percentage points less than CY 2020 (34%) and one percentage point higher than CY 2019 (31%).
- Access to the service was split between Title XIX (26%) and non-Title XIX groups (30%).

Persistence in Services

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

Persistence in Supported Employment Services October 2020–June 2021			
Consecutive Months of Service	Medicaid Recipients	Non-Medicaid Recipients	All Recipients
1	60.1%	69.5%	61.9%
2	15.6%	13.8%	15.2%
3–4	12.4%	9.4%	11.9%
5–6	4.9%	3.7%	4.7%
7–8	2.6%	1.2%	2.4%
9+	4.4%	2.4%	4.0%

- More than 60% of the recipients who received at least one unit of supported employment services during the review period accessed the service during a single month. This finding aligns with low utilization of ongoing support to maintain employment; a service and support that lends to consistent participation over a series of months.
- 12% of the recipients received supported employment services for three to four consecutive months during the review period.
- 4% of the recipients received the service for at least nine consecutive months.

Co-Located Supported Employment Providers

Multiple supported employment providers are now co-located within the health homes to coordinate with clinical teams and assist with engaging members in supported employment services. Rehabilitation specialists and case managers routinely initiate referrals to the supported employment specialists. However, retaining rehabilitation specialists during the pandemic has been challenging and periodic vacancies in these positions are reportedly common. Some employment specialists attend team meetings at the clinics that can lead to identifying members who may be interested in employment opportunities.

One co-located supported employment provider reported that a single employment specialist is expected to initiate at least 35 new “episodes of care” during a single year. An episode of care is defined as providing employment related services following an initial intake interview with a member. Employment specialists may be actively engaged with up to eight members at a point in time.

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

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

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

The VR program for persons with SMI is tracking specified outcomes. Overall, there have been significant reductions across all metrics when compared to CY 2020, especially for members in service plan status under the program (reduction of 973 members). DES/RSA data secured from the Maricopa County RBHA includes the following:

- Members referred to VR/RSA — 1,051 (CY 2021)
- Members served in the VR program — 1,415 (quarter ending December 31, 2021)
- Members open in the VR program — 1,142 (quarter ending December 31, 2021)
- Members in service plan status with VR — 235 (quarter ending December 31, 2021)

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 32% of members received at least one unit of supported employment during CY 2021, a decrease of 2% from last year and reversing a trend of year-to-year increases in utilization. (CY 2013 — 39%; CY 2014 — 20%; CY 2015 — 17%; CY 2016 — 26%; CY 2017 — 26%; CY 2018 — 29%; CY 2019 — 31%; and CY 2020 — 34%).
- 17% of survey respondents felt that supported employment services were difficult to access, less than last year (21%), and significantly less than CY 2013 and CY 2014 (75% — CY 2013; 33% — CY 2014).

- 83% of respondents indicated that supported employment services were easy to access or having “fair” access, an increase from CY 2020 (76%).
- One member in the focus groups reported that her experience with VR services was positive and her counselor was very responsive. She was able to obtain employment as a peer support specialist in a Level 1 facility and held the position for seven months. Her counselor remains in contact with her and has offered to help her regain employment when she is ready.
- Similar to last year, case managers reported members remain fearful of the impact of working on their benefits, including their housing vouchers. Case managers shared that between 50%–90% of members they speak to about working do not trust that income earned through employment will be beneficial. They share that “even a small reduction in benefits is enough to deter someone from pursing employment.”
- Participants in the focus groups shared that employers need more training on hiring individuals with SMI and this would promote longer tenure in employment for members. Members often need support once they gain a job but job coaches are not readily available. One member reported that it took a year to find a job coach to support him.
- Supported employment services were identified as a service on the recipient’s ISP in 82% of the cases reviewed when assessed as a need. (CY 2014 — 26%; CY 2015 — 22%; CY 2016 — 53%; CY 2017 — 82%; CY 2018 — 75%; CY 2019 — 85%; and CY 2020 — 91%).
- 56% of the medical record review cases lacked evidence that the member received supported employment services despite the service being listed on the ISP. As noted in prior service capacity assessments, ISPs are not always based on the member’s assessed or individualized needs and can include generic language and/or services that fail to differentiate each member’s unique circumstances and needs.
- For the time period October 1, 2020 through June 30, 2021, H2027 (pre-job training and development) accounts for 95% of the total supported employment services (an increase from CY 2020 — 91%). H2025 (ongoing support to maintain employment/ 15-minute billing unit) represents 5% of the supported employment utilization (CY 2020 — 9%).

Recommendations: Supported Employment

- Educate case managers, rehabilitation specialists, and supported employment specialists about effective ways to present and promote the ongoing supported employment services to recipients.
- Review current reimbursement rates for ongoing support to maintain employment services and ensure that the rates incentivize and reinforce appropriate utilization.
- Perform a data driven assessment (e.g., inventory of qualified providers) of the service delivery system’s capacity to provide ongoing support to maintain employment services. As applicable, increase the volume of contracted providers to address any identified staffing shortages.

- Consider adopting an alternative service code and/or service code modifier to capture annual rehabilitation specialists' vocational/meaningful day assessments as these activities do not align with current supported employment service code descriptions (pre-job training and development and ongoing support to maintain employment). Train rehabilitation specialists to record and bill the services in a consistent manner.
- Continue to monitor and address the practice of documenting supported employment services on members' ISPs without evidence of an assessed need for the service. Train clinical teams to develop ISPs that are individualized and reflect the member's unique circumstances and needs.
- Designate staffing resources to serve in the role of benefit specialists (use of peer support specialists, case managers, etc.) to address member concerns about securing employment without jeopardizing eligibility for public assistance programs (e.g., AHCCCS eligibility, social security disability insurance).

5.4 Multi-Evaluation Component Analysis — Supportive Housing

Service Description

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

Focus Groups

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

- During the pandemic, supportive housing services were offered virtually. Participants agreed that this particular service did not fare well in virtual or telephonic formats. Services are now returning to in-person provision.
- Participants shared that many members did not undergo home inspections during the pandemic. As inspections have resumed, evictions have increased due to issues with home conditions. These evictions are contributing to a rise in homelessness among members who are not able to locate affordable housing.
- Similar to prior years, there was consensus across all focus groups that there are not enough stable, safe, and affordable housing options in Maricopa County. Additionally, there are not sufficient subsidized vouchers available, waitlists remain excessively long and finding landlords willing to accept vouchers at fair market value has become increasingly difficult.
- Similar to last year, case managers and members reported a continued practice by landlords to increase rent, negatively impacting members who receive a static amount of support via housing vouchers.
- Members reported that there is not enough anonymity with vouchers and the stigma of SMI deters landlords from wanting to accept these vouchers.
- Similar to last year, providers and case managers agreed that there are not enough clinic-based housing specialists and many clinics only have one for the entire clinic.
- Clinical team members reported that they are not trained on how to identify indicators for supportive housing services and any guidance/training is left up to the clinic-based housing specialists. One housing specialist shared she provides regular training to her clinic, but this was not available at most clinics.

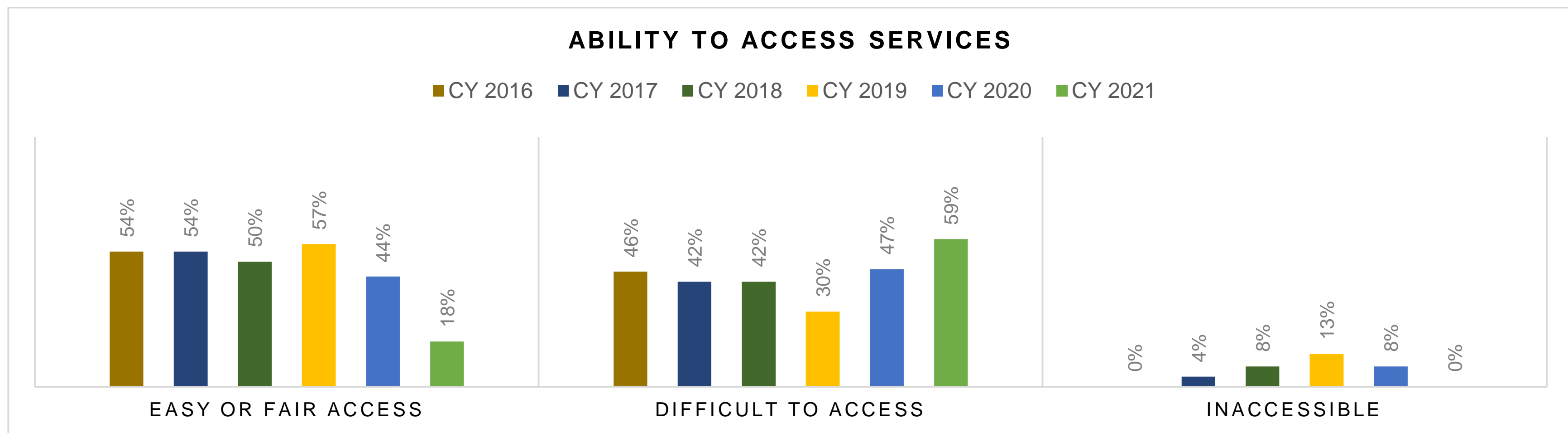
- Despite system wide promotion, several participants, including a clinical coordinator, did not know that this was an available service and most could not identify the cadre of available community-based supportive housing providers. The clinical coordinator reported that her clinic only refers for vouchers.
- Participants were not familiar with the Landlord Tenant Act or how to access legal services to address housing issues. Clinic staff reported that they do not receive information on how to help members who need legal assistance for housing issues.
- Members reported their clinical team does not ask questions about the quality of their housing, if the home is safe, stable, or at risk of being lost. Housing questions are limited to if the person has a roof over their head which misses addressing many factors that could place housing at risk.
- Members shared that they did not know what supportive housing services entail and did not know they could request this service from their clinical team. Some members reported they have shared housing concerns with their clinical team but there has not been any assistance or follow-up provided.
- Most participants were not familiar with housing flex funds that may be used to help with housing needs and expressed a desire for training in this area. Members shared that it would be helpful “a set a person up for success” to access these funds to purchase basic home necessities when moving into a home (i.e., such as a housing starter box).
- Case managers and providers agreed that it would be beneficial to have greater access to housing specialists who can help members to locate housing.
- Last year, it was recommended that peer support specialists become trained to help members locate and maintain housing. Participants shared that this has not occurred. While some peer support specialists saw this as a growth opportunity, others felt this would spread a peer specialist even thinner and contribute to further blurring of the role.

Key Informant Survey Data

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

Level of Accessibility

Fifty-nine percent of the survey respondents felt that supportive housing services were difficult to access; continuing a trend of noteworthy increases year-to-year (compared to CY 2020 — 47%; CY 2019 — 30%). None of the respondents indicated that supportive housing services were inaccessible.

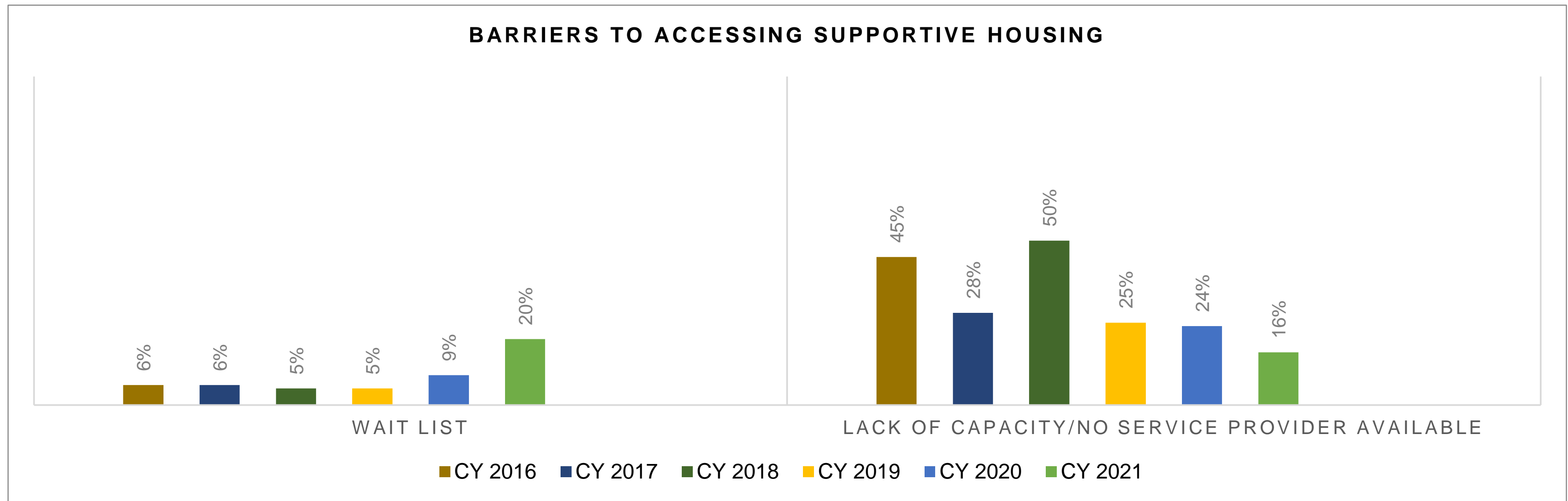


Eighteen percent of respondents indicated that supportive housing services had "fair access" or were easy to access; a significant reduction from CY 2020 (44%).

Factors that Hinder Access

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

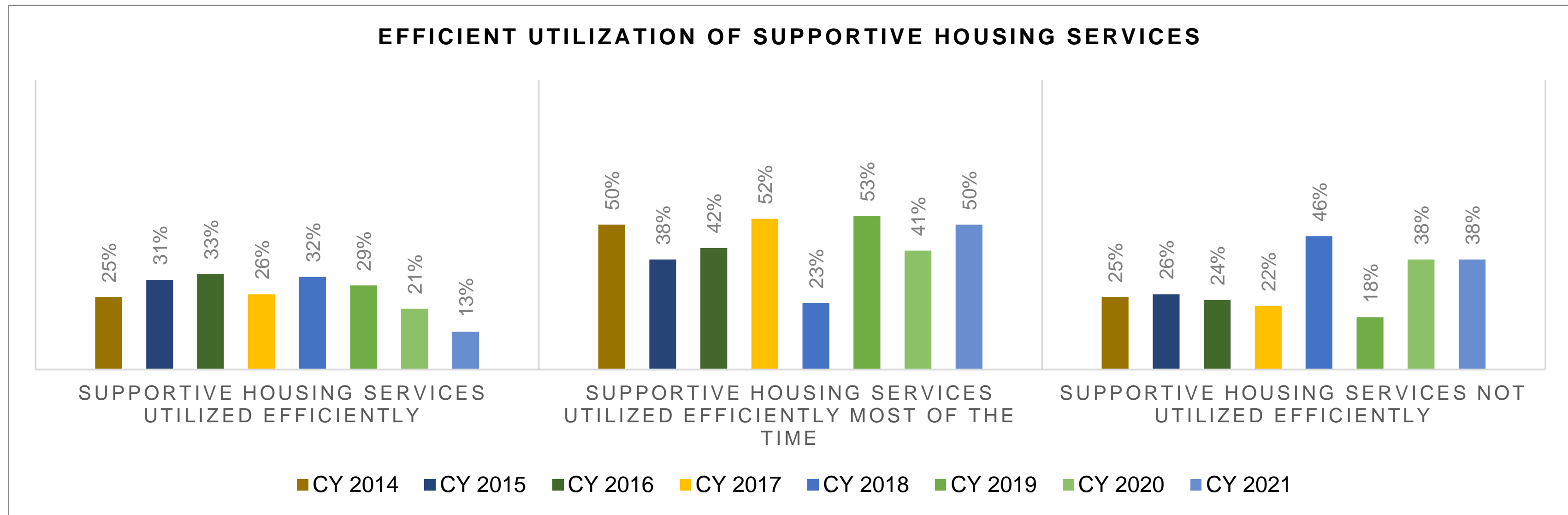
- 20% of the responses selected waitlist exist for services.
- 16% of responses indicated a lack of capacity/no service provider available.
- 11% of the responses indicated staff turnover.



Efficient Utilization

In terms of efficient utilization of supportive housing services:

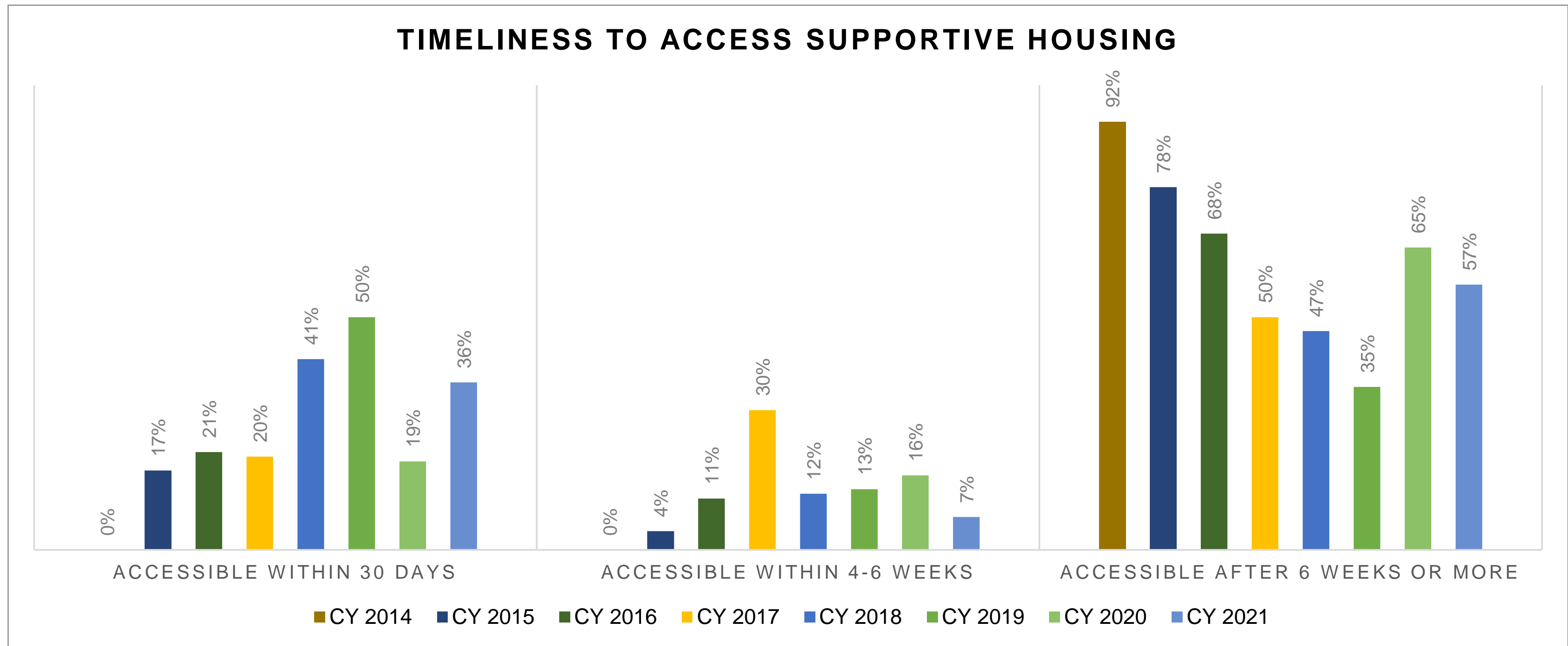
- 13% of the responses indicated that the services were being utilized efficiently (compared to 10% during CY 2013; 25% during CY 2014; 31% during CY 2015; 33% during CY 2016; 26% during CY 2017; 32% during CY 2018; 29% during CY 2019; and 21% during CY 2020).
- 50% responded that the services were utilized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



Timeliness

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

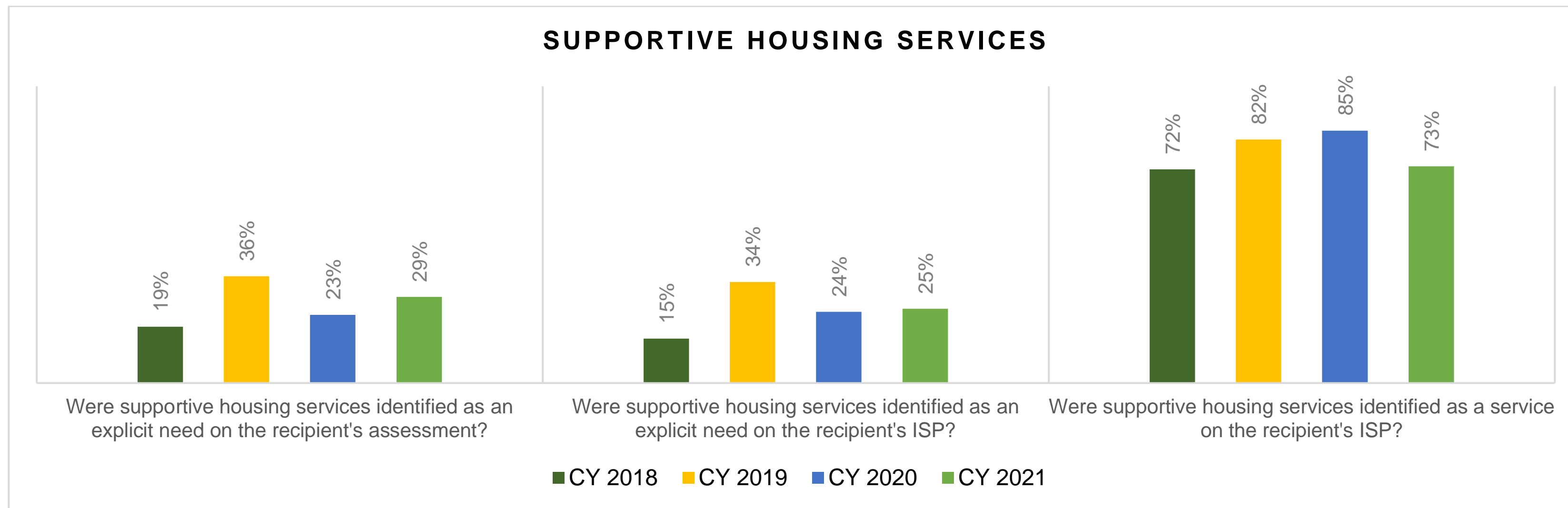
- 36% of the survey respondents reported that supportive housing services could be accessed within 30 days of the identification of the service need (compared to 11% during CY 2013; 0% during CY 2014; 17% during CY 2015; 21% during CY 2016; 20% during CY 2017; 41% during CY 2018; 50% during CY 2019;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



Medical Record Review

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

- Supportive housing services were identified as a need on either the recipient's assessment and/or recipient's ISP in 32% of the cases reviewed.
- Supportive housing was identified as a service on the recipient's ISP in 73% of the cases when identified as a need. (A decrease from last year when 85% of the ISPs with a documented need included supportive housing).
- 22% of the recipients included in the sample received a unit of supportive housing during CY 2021.



In 25 cases, reviewers were able to review progress notes and record the reasons that the person was unable to access supportive housing services after housing-related assistance was included on the person's ISP. Consistent with last year, the most common reason was that there was a lack of evidence that the clinical team followed up with initiating a referral for the service.

Service Utilization Data

Permanent supportive housing utilization includes skills training and development services to help members obtain and maintain community-based independent living arrangements. In addition to these services, targeted services for contracted permanent supportive housing providers can include behavioral health prevention and education, peer support, case management, behavioral health screening and assessment, non-emergency transportation, medication training and support, counseling, personal care, and psychoeducational services.

As indicated within the service utilization data file, 6,722 (compared to 6,308 last review cycle) Title XIX eligible (Medicaid) recipients were affiliated with the service during the time period of October 1, 2020–December 31, 2021 and 1,266 (compared to 1,250 last review cycle) non-Title XIX recipients received the service from a total population of 36,718.[49]

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

Temporary Housing Assistance Program

Mercer interviewed a current supportive housing provider that administers the Temporary Housing Assistance Program, a supportive housing service that offers temporary funding for housing that pairs ongoing supported employment and permanent supportive housing services for Title XIX eligible members. The provider is currently supporting 45 members who are homeless or at risk for homelessness and have a desire to enter the workforce. Referrals for the program are initiated by clinical teams at the health homes and a screening tool has been adopted to assess the member's appropriateness for the program. The provider and the RBHA track specific outcomes, such as retention rates (95% of members retain housing for 12 months), connection with employment within 30 days, reduction in crisis episodes, and ongoing support to maintain employment service utilization.

The provider cited several current challenges to secure safe and affordable housing on behalf of members with SMI, including, but not limited to, provider workforce challenges, a lack of affordable housing in Maricopa County, shortages in available housing units, and the impact of the ongoing COVID-19 pandemic.

Key Findings and Recommendations

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

Findings: Supportive Housing

- Service utilization data reveals that 22% of members received at least one unit of supportive housing during the review period, the same finding as last year.
- Despite system wide promotion, several participants, including a clinical coordinator, did not know that this was an available service and most could not identify the cadre of available community-based supportive housing providers. The clinical coordinator reported that her clinic only refers for vouchers.
- Members shared that they did not know what supportive housing services entail and did not know they could request this service from their clinical team. Some members reported they have shared housing concerns with their clinical team but there has not been any assistance or follow-up provided.
- Members reported their clinical team does not ask questions about the quality of their housing, if the home is safe, stable, or at risk of being lost. Housing questions are limited to if the person has a roof over their head which misses addressing many factors that could place housing at risk.
- 59% of the survey respondents felt that supportive housing services were difficult to access; continuing a trend of noteworthy increases year-to-year (CY 2020 — 47% and CY 2019 — 30%). None of the respondents indicated that supportive housing services were inaccessible.

- When asked about the factors that negatively impact accessing supportive housing services, 11% of the responses indicated staff turnover.
- Supportive housing was identified as a service on the recipient's ISP in 73% of the cases when assessed as a need. (A decrease from last year when 85% of the ISPs with a documented need included supportive housing).

Recommendations: Supportive Housing

- Ensure that the member's ISP includes supportive housing services as an intervention when assessed as a need. When a supportive housing need is identified and included on members' ISPs, ensure that clinical teams initiate service referrals in a timely manner.
- Continue efforts to identify safe and affordable housing options for recipients through collaboration with other community stakeholders, the AHCCCS contracted housing administrator, and supportive housing providers.

5.5 Multi-Evaluation Component Analysis — Assertive Community Treatment

Service Description

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

Focus Groups

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

- Case managers and providers agreed that when ACT is implemented in full alignment with ACT fidelity, the service is highly impactful and positive for members. However, most ACT teams are not fully staffed which impacts the quality of services received by the enrolled members.
- ACT providers expressed concern that they are not able to bill for duplicative services, such as supportive housing or employment, for ACT members. However, due to a lack of available staffing resources, these services are unavailable to the ACT members.
- Participants agreed that there are not enough ACT teams and some are not operating at full capacity.
- Some ACT teams have waitlists which grew during the pandemic. Participants explained that some teams held onto clients for longer than usual during the pandemic due to concerns about prolonged isolation. These teams are now discharging as appropriate thereby reducing waitlist times.
- Similar to prior years, while standardized ACT admission criteria is available, participants shared some knowledge of the criteria, but most have never seen or received training on formal admission criteria.
- Case managers and providers agreed that most case managers are not trained about ACT as a service and how to identify clinical indicators for ACT.
- Case managers shared that many referrals to ACT are denied, but informally and prior to a formal screening. This does not afford members with due process to appeal the denial.
- Case managers and providers were aware that there is a policy requiring that all referrals be screened three times; however, many referrals are not formally screened at all. Members referred from hospital settings seem to be screened more formally and see an expedited process.

- Participants reported that members express confusion and/or disappointment when ACT is denied, especially when the member believes they could benefit from this level of service. One case manager shared that her member requested to be referred to ACT but was denied informally by email and without a screening. The case manager could not provide clear reasons for the denial.
- Participants reported that not all clinics have ACT teams which can complicate the referral process. Some described this as a "disparity" for members who lack an ACT team at their clinic.
- Participants reported that members seem to remain on ACT teams for protracted periods of time. Participants shared that members residing in ACT housing graduate from ACT faster as they seek more permanent housing options.

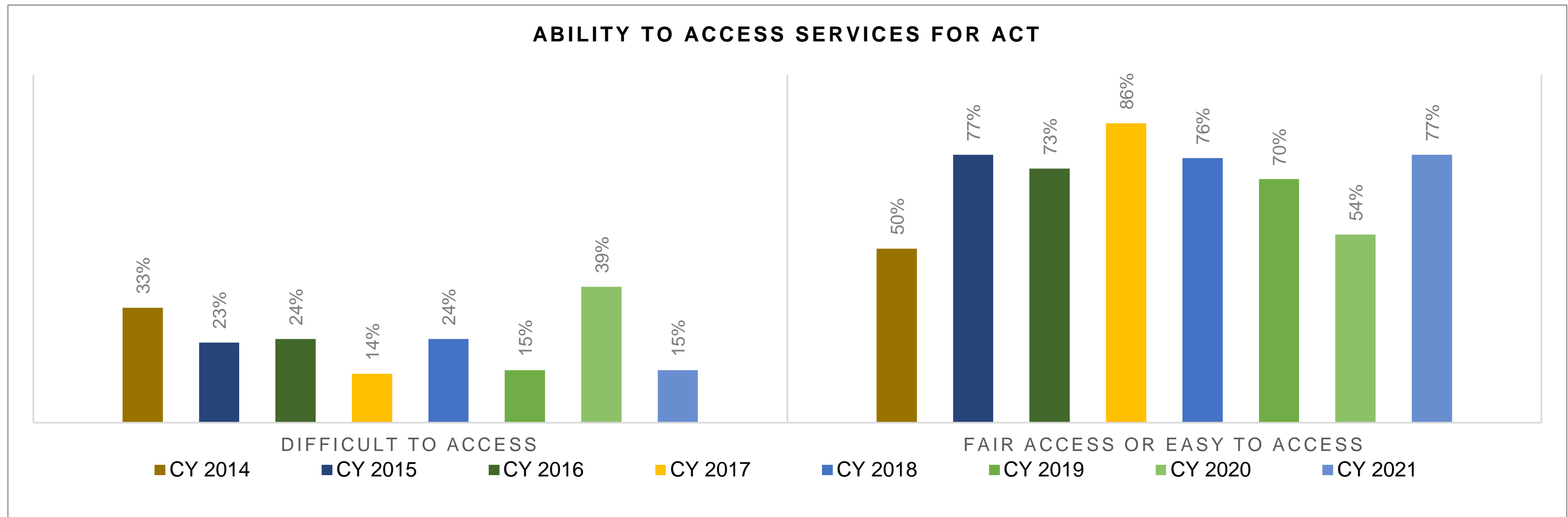
Key Informant Survey Data

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

Level of Accessibility

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

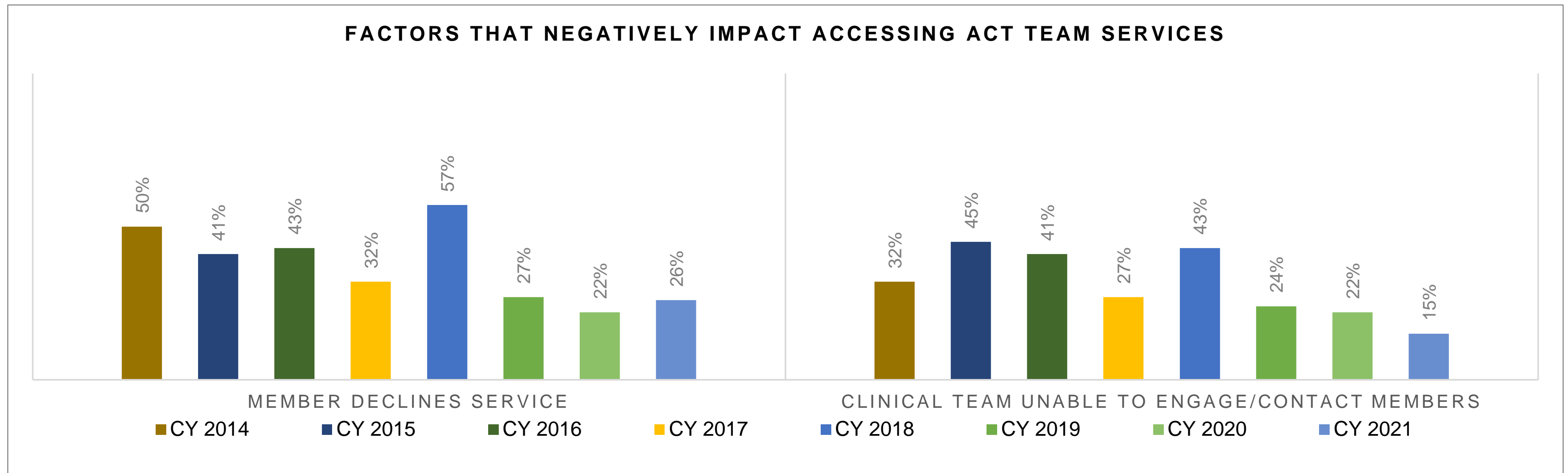
Seventy-seven percent of respondents indicated that ACT team services had "fair access" or were easy to access (compared to 36% during CY 2013; 50% during CY 2014; 77% during CY 2015; 73% during CY 2016; 86% during CY 2017; 76% during CY 2018; 70% during CY 2019; and 54% during CY 2020).



Factors that Hinder Access

When asked about the factors that negatively impact accessing ACT team services, the CY 2021 responses are as follows:

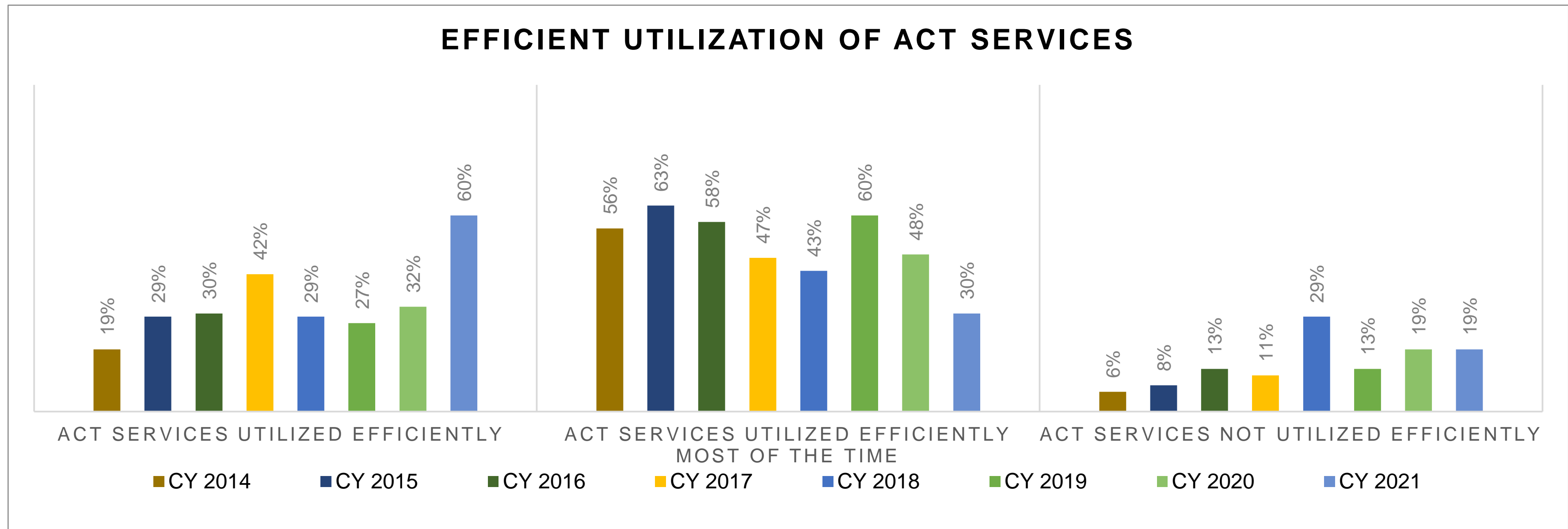
- 26% indicated that the member declines service (compared to 20% — CY 2013; 50% — CY 2014; 41% — CY 2015; 43% — CY 2016; 32% — CY 2017; 57% — CY 2018; 27% — CY 2019; and 22% — CY 2020).
- 15% of the responses identified clinical team unable to engage/contact member (compared to 27% — CY 2013; 32% — CY 2014; 45% — CY 2015; 41% — CY 2016; 27% — CY 2017; 43% — CY 2018; 24% — CY 2019; and 22% — CY 2020).



Efficient Utilization

In terms of the efficiency of service utilization in CY 2021:

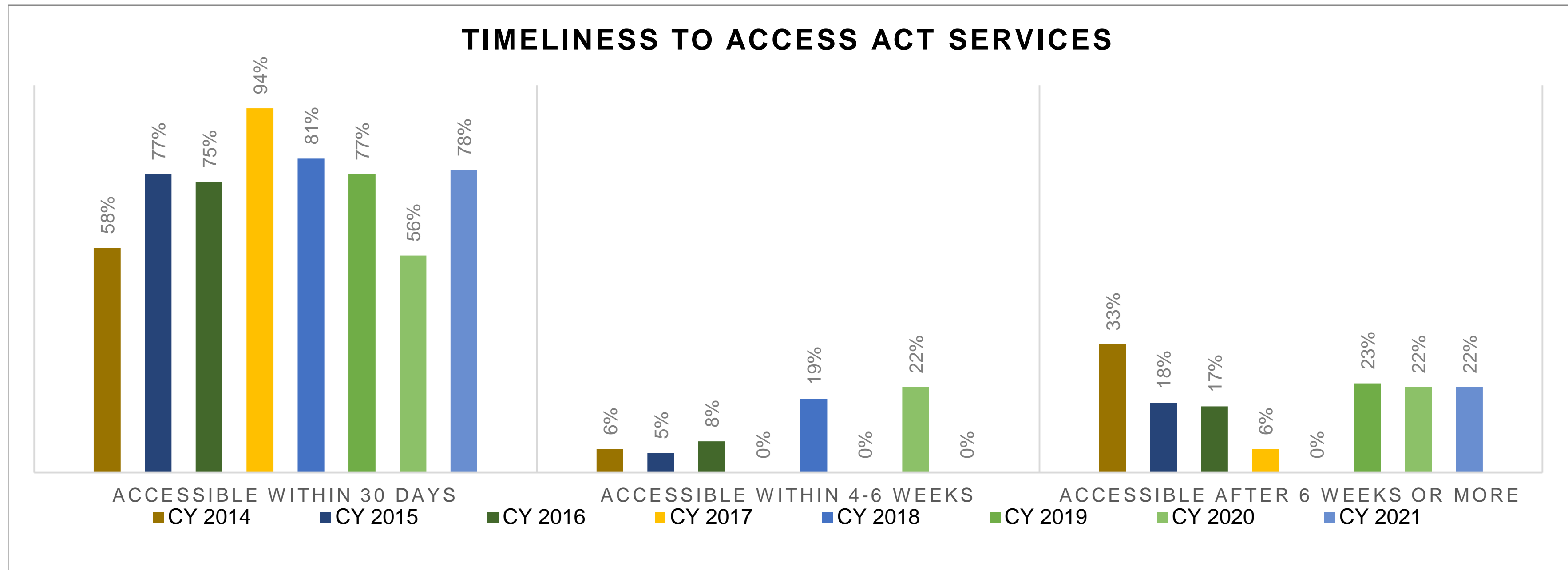
- 60% of the responses indicated that the services were being utilized efficiently (compared to 27% — CY 2013; 19% — CY 2014; 29% — CY 2015; 30% — CY 2016; 42% — CY 2017; 29% — CY 2018; 27% — CY 2019; and 32% — CY 2020).
- 30% responded that the services were utilized efficiently most of the time (compared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



Timeliness

In terms of the amount of time to access ACT team services in CY 2021:

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

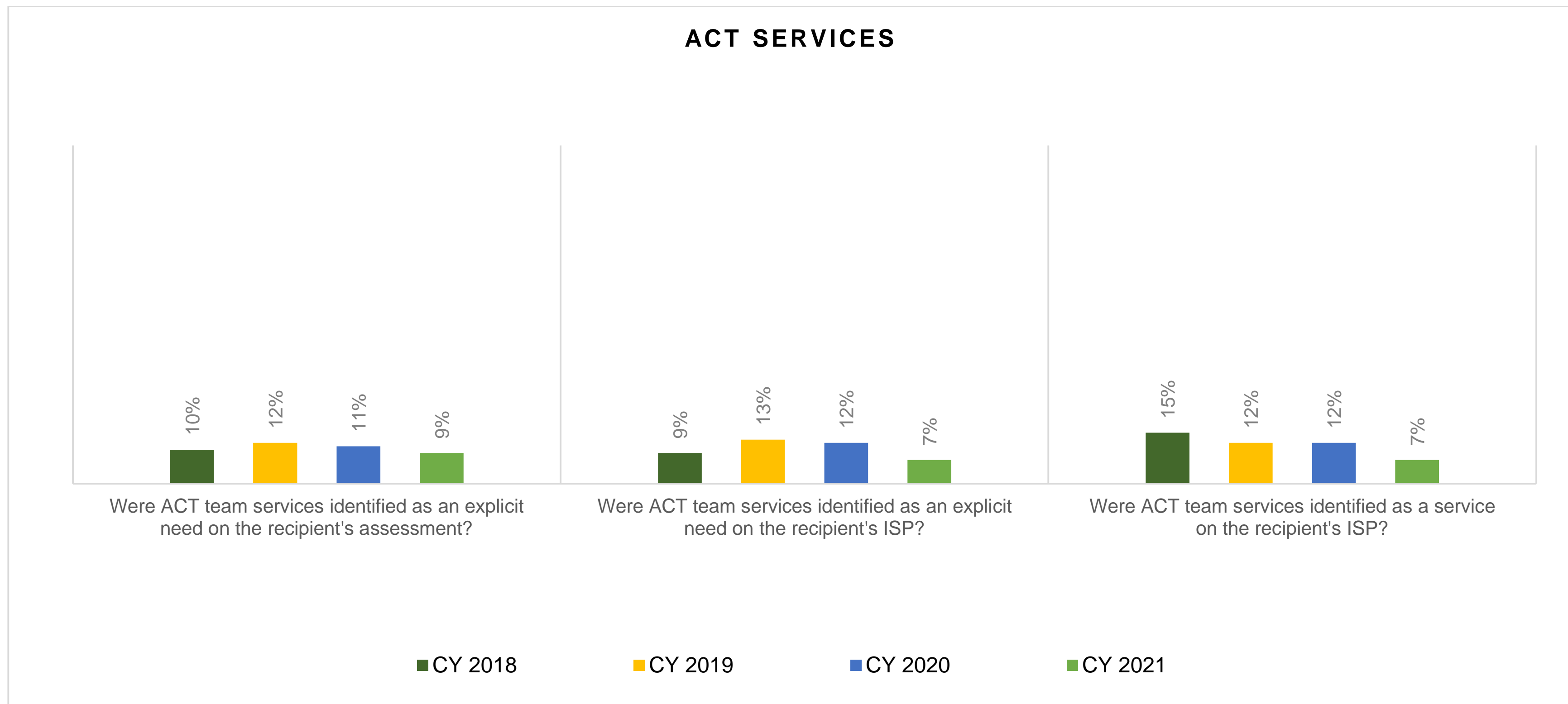


Medical Record Review

Consistent with findings from previous years, there was little to no documented evidence that the clinical team was considering or recommending a change in the level of case management, including referring a person to an ACT team or stepping down a recipient assigned to an ACT team to a less intensive level of case management when clinically appropriate.

In 17 cases (9%), ACT team services were identified as a need on recipients' assessments and/or ISPs. Eighty-two percent of the cases with an assessed need for ACT included ACT or case management services on the ISP.

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



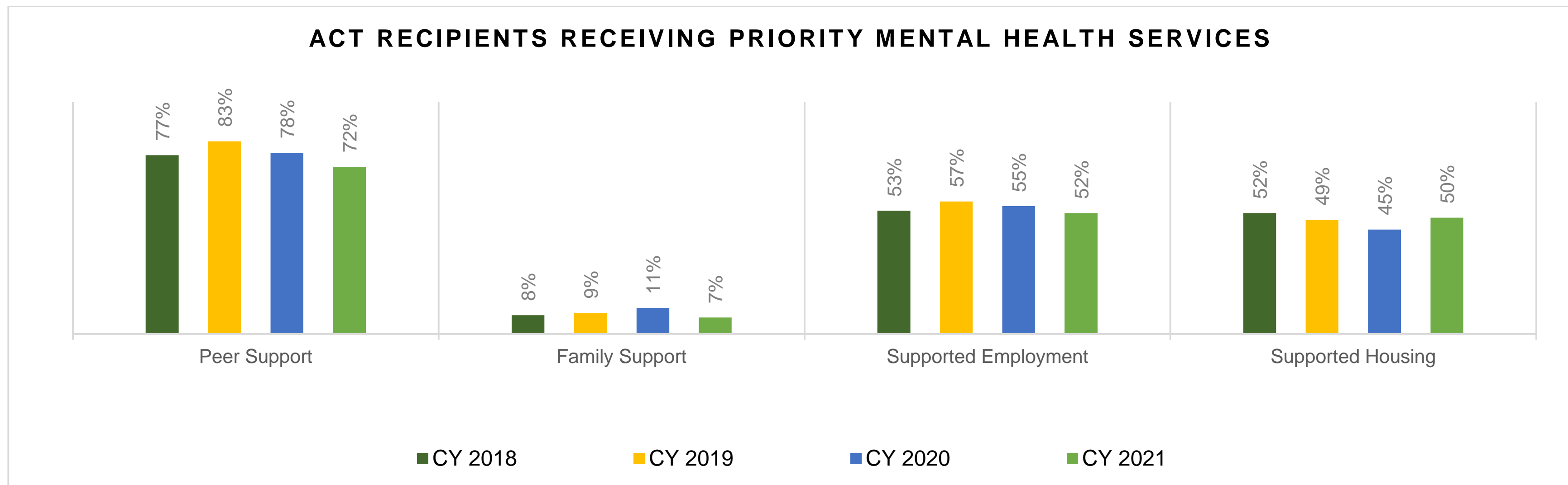
Service Utilization Data

ACT team services are not assigned a specific billing code. Therefore, ACT team services are not uniquely reflected in the service utilization data file. Mercer did complete an analysis of service utilization for recipients that were assigned to an ACT team. CY 2021 service utilization profiles for 2,210 ACT team members who received a behavioral health service were analyzed. The analysis sought to identify the utilization of one or more of the priority services (supported employment, supportive housing, peer support services, and/or family support services).

The analysis found:

- 72% of the ACT team members received peer support services during the review period.
- 7% of the ACT team members received family support services.
- 52% of ACT recipients received supported employment services.

- Utilization of supportive housing services was found to be 50% across the identified ACT team members.



Key Findings and Recommendations

Findings: ACT Team Services

- As a percentage of the total population with SMI, 6.2% of all members are assigned to an ACT team. This is a similar finding observed over the past five years.
- Case managers and providers agreed that when ACT is implemented in full alignment with ACT fidelity, the service is highly impactful and positive for members. However, most ACT teams are not fully staffed which impacts the quality of services received by the enrolled members.
- Participants agreed that there are not enough ACT teams and some are not operating at full capacity (though some teams may not be fully staffed which restricts the team's ability to recruit new members).
- Participants reported that members seem to remain on ACT teams for protracted periods of time. Participants shared that members residing in ACT housing achieved faster discharge as they seek more permanent housing options.
- 15% of survey respondents reported that ACT team services were difficult to access (46% during CY 2013; 33% during CY 2014; 23% during CY 2015; 24% during CY 2016; 14% during CY 2017; 24% during CY 2018; 15% during CY 2019; and 39% during CY 2020) and one respondent indicated that the service was unavailable.

- 72% of the ACT team members received peer support services during the review period. ACT recipients who received supported employment services was determined to be 52%. Utilization of supportive housing services was found to be 50% across the identified ACT team members.
- In all medical record review cases, there was no documented evidence that the clinical team was considering or recommending a change in the level of case management, including referring a person to an ACT team or stepping down a recipient assigned to an ACT team to a less intensive level of case management.
- 100 members with SMI and associated with the highest aggregate behavioral health service costs during CY 2021 were reviewed by Mercer. The analysis found that 26% of the members were assigned to an ACT team. This compares to 20% when the same analysis was completed during CY 2013, 18% during CY 2014, 23% during CY 2015, 25% during CY 2016, 26% during CY 2017, 29% during CY 2018, 36% during CY 2019, and 33% during CY 2020.
- Of the 26 members assigned to ACT and included on the list of the top 100 members with the highest behavioral health service costs; 15 (58%) also reside in supervised behavioral health residential settings. During times of transition (admission or discharge from ACT team services), it may be appropriate to temporarily have a member assigned to ACT and placed in a supervised setting, but this should be time-limited due to the duplicative nature of the services. In other cases, placement in a supervised behavioral health residential setting and assignment to ACT may be appropriate for some members (e.g., medical co-morbidities, challenging behaviors).
- Overall, 63 of the 100 (63%) members reside in a supervised behavioral health residential setting, which may contribute to higher service costs for those members and may discourage clinical teams from considering or referring a member to an ACT team. If members placed in a supervised behavioral health residential setting (and not currently assigned to an ACT team) are excluded from the analysis, then 26% of the highest cost utilizers could potentially be candidates for assignment to an ACT team.
- An analysis of jail booking data was completed to identify members that have had multiple jail bookings over a defined period (i.e., 11 months — January 2021 through November 2021) and to determine if the member was subsequently referred and assigned to an ACT team, including one of the three forensic specialty ACT teams. The analysis found:
  - 448 members experienced at least two jail bookings during the period under review (408 in CY 2015; 467 in CY 2016; 391 in CY 2017; 426 in CY 2018; 527 in CY 2019; and 328 in CY 2020).
  - Of these 448 members, 64 (14%) were assigned to an ACT team during the review period. (CY 2015 — 23%; CY 2016 — 25%; CY 2017 — 16%; CY 2018 — 22%; CY 2019 — 18%; and CY 2020 – 14%)
  - Of the 64 members assigned to an ACT team, 15 (23%) are assigned to a forensic specialty ACT team (CY 2015 — 20%; CY 2016 — 22%; CY 2017 — 29%; CY 2018 — 28%; CY 2019 — 22%; and CY 2020 — 21%).

- 18 members receiving ACT team services have three or more incarcerations over the review period, but are not assigned to one of the three available forensic specialty ACT teams, the same finding as last year.
- 175 members were incarcerated three or more times but are not assigned to an ACT or forensic specialty ACT team.

Recommendations: ACT Team Services

- Actively monitor the ongoing capacity of all ACT teams and continue efforts to identify candidates for ACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns, and adverse incidents involving members with SMI.
- Periodically review the member's assigned level of case management (i.e., connective, supportive, ACT) and determine if the member is assigned to the appropriate level of case management based on medical necessity. In addition, clinical teams should regularly evaluate opportunities for current ACT team members to step down to a lower level of care as clinically appropriate and document when these reviews occur as part of the member's medical record.
- Clarify ACT admission criteria to health home clinic staff, providers, and referral sources to help ensure appropriate and consistent identification of ACT team candidates.

Section 6

Outcomes Data Analysis

The service capacity assessment included a limited analysis of recipient outcome data in an attempt to link receipt of one or more of the priority mental health services with improved functional outcomes. The relationships between outcomes and service utilization trends may be identified, but those relationships do not necessarily reflect causal effects. As such, observed outcomes may be contingent on a number of variables that are unrelated to receipt of one or more of the priority mental health services.

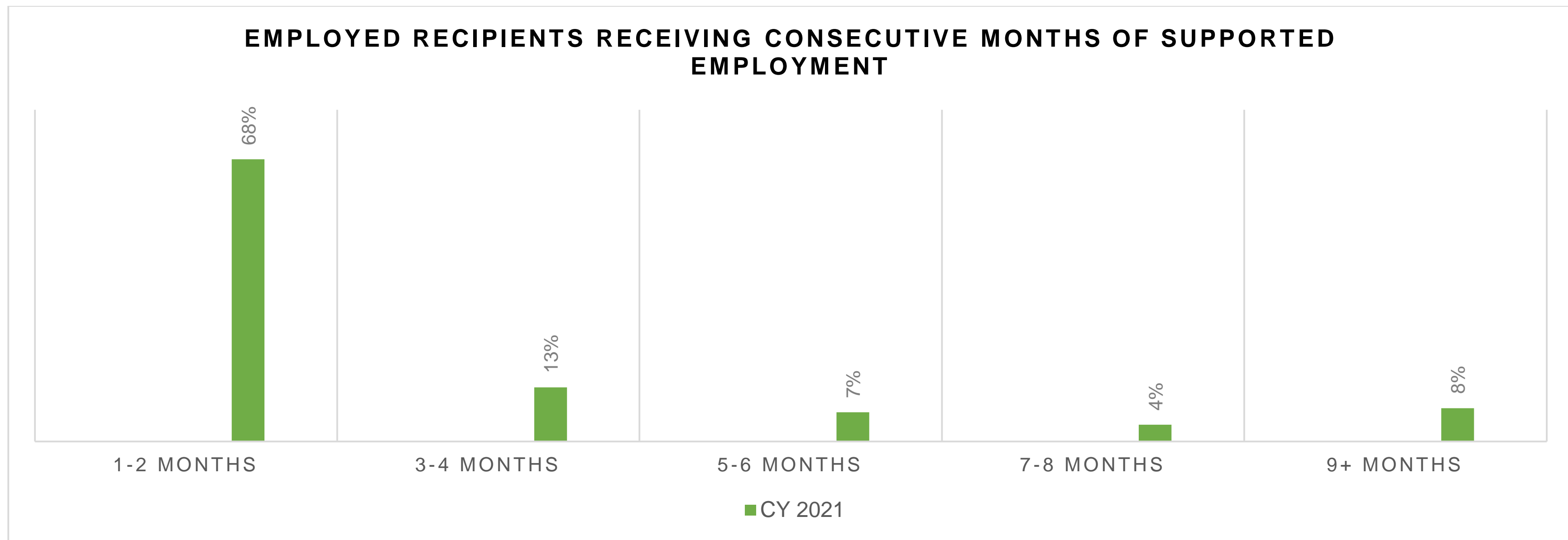
The following outcome indicators were reviewed:

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

During CY 2021, an analysis was completed that compared recipients' persistence with receiving supported employment services and peer support services for each of the outcome indicators selected. Overall, there are strong relationships between receipt of the priority services and improved outcomes related to incarcerations and employment status. The relationship is further strengthened when the recipient sustains consistent participation in the priority service over an extended period of time.

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

- The percentage of recipients identified as employed full-time or part-time decreases as the continuing duration with supported employment services extends. Over one third of recipients identified as employed full-time or part-time are associated with two or less consecutive months of supported employment services.
- Alternatively, recipients who experienced five or more consecutive months of supported employment services constituted only 10% of the total employed group.
- This finding may suggest that supported employment services are effective at helping recipients gain employment relatively quickly and that ongoing supported employment services are utilized less once a person gains employment status. This finding also aligns with the disproportionate utilization of pre-job training and development (supported employment bill code H2027) when compared to ongoing support to maintain employment (bill code H2025). For example, Mercer found that 95% of all supported employment services were associated with pre-job training and development.



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

- Recipients who received peer support services for a duration of one to two months accounted for 30% of all incarcerations during the same time period (i.e., CY 2021). Recipients who received peer support services for five or more consecutive months accounted for 9% of the total number of arrests during the review period. Sustained involvement in peer support services may contribute to fewer incarcerations.
- For full-time and part-time employed recipients, 73% of the recipients received one or two months of peer support services. This same group accounted for 87% of all arrests during the same time period. As sustainment in peer support services grows, employed recipients appear to experience fewer incarcerations.

Appendix A

Focus Group Invitation

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

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

Focus groups will be held in-person at the following location:
Stand Together and Recover Services (S.T.A.R.) Central
2502 E. Washington Street
Phoenix, AZ 85034

Stakeholder Group One

Adults **receiving at least one SMI PMHS**

Wednesday, May 18, 2022
10:00 am–12:00 pm

Stakeholder Group Two

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

Wednesday, May 18, 2022
2:00 pm–4:00 pm

Stakeholder Group Three

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

Thursday, May 19, 2022
3:00 pm–5:00 pm

Stakeholder Group Four

Family Members of Adults with SMI **receiving at least one PMHS**

Thursday, May 19, 2022
6:00 pm–8:00 pm

Space is available for 15 participants per stakeholder group and all RSVPs will be confirmed by email. Once capacity is reached, interested participants will be placed on a waiting list. Refreshments will be provided.
RSVP by May 16, 2022 to Laura Henry at laura.henry@mercer.com **or via phone at +1 602 522 6446.**

Priority Mental Health Services — Definitions

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

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

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

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

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

Appendix B
Key Informant Survey

Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2022

Q13 Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2022

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

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

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

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

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

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

Q4 If you checked other above please specify:

____

Q5
4. Are the priority services below being utilized efficiently?

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

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

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

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

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

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

____

Q9 8. What is your job role/title?

○ CEO (1)

○ Executive Management (2)

○ Clinical Leadership (behavioral health) (3)

○ Clinical Leadership (medical) (4)

○ Specialty Case Manager (5)

○ Direct Services Staff (BHP/BHT) (6)

○ Other (please specify) (7) ____

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

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

Q11 10. As a result of the COVID pandemic, timely access to the priority mental health services was more difficult during calendar year 2021.

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

Appendix C

Group 2 — Medical Record Review Tool

Log-in screen [1]
Reviewer Name ________________________ Client ID _________________________ DOB ___/___/___
Date ______/______/______ Provider Network Organization ____ Direct Care Clinic________________
Date of most recent assessment ___/___/___ Date of most recent ISP___/___/___ Sample period: *January 1, 2017 – December 31, 2017*

Chart Review [2]

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

Appendix D
Summary of Recommendations

Service	Recommendations
Peer Support Services (PSS)	PSS 1: Consistent with the *AHCCCS Contractor Operations Manual, Policy 407, Workforce Development*[50], examine factors contributing to high turnover and vacancies across peer support specialists operating within the service delivery system and take appropriate actions to improve recruitment and retention. PSS 2: Review the basis for requirements that health home clinics must initiate referrals prior to a recipient accessing peer support services from a community-based consumer-run organization. Clarify and standardize expectations related to the use of verbal consent versus written consent as a condition to access peer support services. PSS 3: When peer support services are assessed as a need, ensure that members' ISPs include the service and that clinical teams initiate timely actions to refer and/or engage members in peer support services.
Family Support Services (FSS)	FSS 1: Provide training and supervision to ensure that health home clinical team members understand the appropriate application of family support services and to recognize the value of family support services as an effective service plan intervention. FSS 2: Ensure that the member's ISP includes family support services as an intervention when assessed as a need or after members indicate that they would like a family member involved in their treatment. FSS 3: Perform a data driven assessment (e.g., inventory of qualified providers) of the service delivery system's capacity to provide family support services. As applicable, increase the volume of contracted providers to address any identified staffing shortages.

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

Service	Recommendations
Supported Employment Services (SES)	SES 1: Educate case managers, rehabilitation specialists, and supported employment specialists about effective ways to present and promote the ongoing supported employment services to recipients. SES 2: Continue review of current reimbursement rates for ongoing support to maintain employment services and ensure that the rates incentivize and reinforce appropriate utilization. SES 3: Perform a data driven assessment (e.g., inventory of qualified providers) of the service delivery system's capacity to provide ongoing support to maintain employment services. As applicable, increase the volume of contracted providers to address any identified staffing shortages. SES 4: Consider adopting an alternative service code and/or service code modifier to capture annual rehabilitation specialists' vocational/meaningful day assessments as these activities do not align with current supported employment service code descriptions (pre-job training and development and ongoing support to maintain employment). Train rehabilitation specialists to record and bill the services in a consistent manner. SES 5: Continue to monitor and address the practice of documenting supported employment services on members' ISPs without evidence of an assessed need for the service. Train clinical teams to develop ISPs that are individualized and reflect the member's unique circumstances and needs. SES 6: Designate staffing resources to serve in the role of benefit specialists (use of peer support specialists, case managers, etc.) to address member concerns about securing employment without jeopardizing eligibility for public assistance programs (e.g., AHCCCS eligibility, social security disability insurance).
Supportive Housing Services (SH)	SH 1: Ensure that the member's ISP includes supportive housing services as an intervention when assessed as a need. When a supportive housing need is identified and included on members' ISPs, ensure that clinical teams initiate service referrals in a timely manner. SH 2: Continue efforts to identify safe and affordable housing options for recipients though collaboration with other community stakeholders, the AHCCCS contracted housing administrator, and supportive housing providers.
Assertive Community Treatment (ACT)	ACT 1: Identify and actively monitor the ongoing capacity of all ACT teams and continue efforts to identify candidates for ACT team services through the regular analysis of service utilization trends,

Service	Recommendations
	service expenditures, and the review of jail booking data, quality of care concerns, and adverse incidents involving recipients with SMI. ACT 2: Periodically review the member's assigned level of case management (i.e., connective, supportive, ACT) and determine if the member is assigned to the appropriate level of case management. In addition, clinical teams should regularly evaluate opportunities for current ACT team members to step down to a lower level of care as clinically appropriate and document when these reviews occur as part of the member's medical record. ACT 3: Clarify ACT admission criteria to health home clinic staff, providers, and referral sources to help ensure appropriate and consistent identification of ACT team candidates.
General Recommendations (GR)	GR 1: Perform an assessment of the work flow at the health homes that focuses on the timely implementation of members' ISPs, including timely referral to needed services. GR 2: Continue efforts to monitor the timely completion of annual member assessments and ISPs. GR 3: The RBHA should ensure that active strategies and interventions are in place to recruit and retain an adequate provider and health home workforce.

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