HEALTH WEALTH CAREER

SERVICE CAPACITY ASSESSMENT

PRIORITY MENTAL HEALTH SERVICES 2019

MAY 31, 2019

Arizona Health Care Cost Containment System

CONTENTS

1
EXECUTIVE SUMMARY

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

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

- *Key informant surveys, interviews and focus groups:* Surveys and interviews were completed with key informants and focus groups were conducted with members, family members, case managers and providers.
- *Medical record reviews*: A sample (n=200) of class members was drawn to support an evaluation of clinical assessments, individual service plans (ISPs), and progress notes to examine the extent to which recipient's needs for the priority services were being assessed and met.

- *Analysis of service utilization data and contracted capacity for each of the priority mental health services*: Analysis was conducted to evaluate the volume of unique users, billing units and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to estimate "persistence" in treatment. Persistence was evaluated by calculating the proportion of recipients who only received a priority service during a single month. Additional progressive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months and nine months) to determine the volume of recipients who sustained consistent participation in the selected prioritized services during the review period.

- *Analysis of outcomes data:* Analysis of data including homeless prevalence, employment data and criminal justice information.

- *Benchmark analysis:* Analysis of priority service prevalence and penetration rates in other states and local systems that represent relevant comparisons for Maricopa County.

OVERVIEW OF FINDINGS AND RECOMMENDATIONS

Findings and recommendations regarding the accessibility and provision of the priority services are summarized below. When applicable and available, comparisons of findings and results from prior year reviews are presented. The current review period primarily targeted calendar year 2018 (CY 2018), though for some units of analysis that rely on service utilization data, the timeframe was extended and adjusted (i.e., October 2017 – June 30, 2018) to account for potential lags in processing administrative claims data.

SERVICE CAPACITY ASSESSMENT CONCLUSIONS

Mercer's current service capacity assessment identified that the recently expanded capacity of priority mental health services as established and documented in prior year service capacity assessments was sustained. Over 2,500 additional unique users accessed covered services compared to the previous year.

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

The Maricopa County system excels in certain areas of evidence-based practice (EBP) utilization. For example, supported housing and supported employment are more available in Maricopa County (especially to Medicaid recipients) compared to the national average. Maricopa County also has strong access to peer support services, at a level that could be considered a best practice benchmark. In addition, Maricopa County has greater capacity to provide Assertive Community Treatment (ACT) team services than most comparison communities included in this analysis. More than 2,200 people received ACT services in Maricopa County in 2018.

Based on service utilization trends, the extent of the assessed need appears consistent year-to-year and this year's results are comparable to the past two review cycles. By leveraging additional data sources to supplement the service utilization analysis, Mercer was able to identify factors that appear to be impacting the appropriate assessment of need and/or the ability to access the services. For example, results of a randomly selected medical record review provided insight into the quality of assessments and ISPs and the extent to which ISPs

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

are aligned to address a person's assessed needs for one or more of the priority services. Despite the consistent findings in the volume of unique users accessing the priority mental health services, there are likely opportunities to further expand access to persons who need and could benefit from the services.

Service specific examples of opportunities to improve the identification of need and access to the services, as well as system strengths, are noted below. Interviews completed subsequent to this analysis revealed that the system has been working to address issues noted in prior service capacity assessment reports including the provision of intensive and multi-day trainings, enhancement of value-based purchasing arrangements specific to the priority services, and development and dissemination of a comprehensive guidance document that addresses all aspects of care related to the covered population.

Consumer Operated Services (Peer Support and Family Support)

Multiple opportunities exist for members to access and participate in peer support services. Peer support specialists are available within the direct care clinics, through multi-disciplinary teams providing ACT team services, via participation in an expansive array of clinic-based education and support groups, provide supported housing services, and/or within the community by attending one of many available consumer operated peer support programs. Peer support utilization as measured via administrative data has been consistently strong year-to-year. The system has excelled at developing and implementing innovative opportunities for peer support to expand availability across a number of care settings and services. The success of peer support services has created work force demands that require attention, including access to flexible working hours, availability of workplace supports, and a review of the competitiveness of pay rates.

Family support services are significantly less robust in terms of service utilization data – only 4% of all recipients received the service over the review period. A lack of available or engaged family members, member choice to not involve family members in treatment, and evidence that clinical teams don't fully understand how to apply the service and/or appreciate the benefits that family support services can provide are likely the most prominent factors contributing to the relatively low utilization of the services.

Supported Employment

The system has implemented value-based purchasing agreements with supported employment providers and offers incentives if providers achieve targeted outcomes that include (1) facilitating a first contact between a member and potential employer within the first 30 days of

program enrollment, (2) providing ongoing support to maintain employment once the member is employed; and (3) successfully transitioning members to Vocational Rehabilitation (VR)/RSA funding following enrollment with the supported employment provider.

Direct care clinic rehabilitation specialists initiate most referrals to supported employment providers. Numerous accounts from system stakeholders suggest that last year's rehabilitation specialist staffing vacancies have been largely resolved. Some supported employment providers are co-located within the direct care clinics and work closely with VR/RSA, rehabilitation specialists and clinical teams to coordinate supported employment services on behalf of members. In general, supported employment utilization is increasing and capacity is expanding. During the current review period, 29% of all recipients received at least one unit of supported employment services and one large supported employment provider reports the need to expand staffing resources to meet ongoing demands for services (e.g., the provider reports 40 and 50 new referrals each month).

Despite these increases in supported employment services, reviews of a random sample of medical records found a large number of cases in which the person did not access supported employment services after a need for the service was identified. In 78% of cases with an identified need for supported employment services, the clinical team did not document follow up by initiating a referral to access the services. Mercer identified one promising practice in which a clinical team linked the immediate initiation of all identified service referrals at the time that the individual service plan was reviewed, endorsed and signed by the member. This practice helped ensure that all relevant services on the ISP were timely referred in coordination with the development of the individual's service plan.

The review of medical records revealed ongoing issues that were initially identified during previous service capacity assessments. These issues include:

- Assessed needs and corresponding individual service plan interventions are commonly misaligned and suggest that some clinical teams responsible for developing the service plan in coordination with the member do not fully understand the appropriate application of supported employment services.

  - In one example, within the learning/working domain of an ISP, the stated objective read: "Member needs to explore work/volunteer opportunities in the community." The service category identified to support this objective was documented as "cognitive rehabilitation", with a corresponding service code of "H0004" (behavioral health counseling and therapy). The member in this case was a young adult (21 years-old) with an assessed need for supported employment services. The clinical team's misalignment of the recommended service category and service code reflects a general and pervasive lack of understanding of the appropriate application of covered behavioral health services, and, in this example, supported employment services. Despite the service identified on the ISP, the member ultimately received a supported employment service rendered by the rehabilitation specialist assigned to the direct care clinic.

- Individual service plans are not always based on the member's assessed needs and can include generic language that does not differentiate each member's unique circumstances and needs.[2] Mercer reviewed numerous records that indiscriminately identified supported employment services as a recommended service in the absence of an assessed need.

Supported Housing

Multiple programs exist to support persons in need of affordable and safe housing; offering a wide array of support services and community resources to help individuals achieve and maintain integrated housing. Permanent supported housing providers offer a full continuum of services, including, but not limited to, skills training and development, peer support and case management. Over the past few years, the system has implemented and sustained innovative housing programs for persons with SMI. For example, the Temporary Housing Assistance Program targets individuals who don't have access to housing vouchers and who have a source of income and/or a readiness to secure employment. The program couples supported housing supports with job development resources to help individuals obtain and maintain independent housing. An additional seven providers operate permanent supported housing programs and multiple service

[2] The Maricopa County RBHA has recently communicated to direct care clinics that scripted templates should no longer be utilized when developing individual service plans (Telephonic interview, May 29, 2019).

contractors are available to provide supported housing services under a community living program. Available housing supports also extend to housing providers who manage properties and oversee scattered site housing subsidies for individuals who qualify. Alternative payment arrangements have been designed and implemented with supported housing providers that promote desired outcomes, including measures to reduce homelessness, avoid hospitalization, increasing the volume of members who can contribute to rental payments and reductions in crisis service utilization.

After concerted efforts to expand permanent supported housing service capacity over the past several years, the system has temporarily suspended housing support program development efforts and is exploring ways to maintain the current inventory of supported housing services in the face of possible funding reductions. The critical need for housing and related supports can be insatiable, and many supported housing programs are currently running near or over capacity. One Temporary Housing Assistance Program had 15 pending referrals during May 2019 and another permanent supported housing provider reported that the program is now operating at 90% capacity. Many system stakeholders, including focus group participants and supported housing providers, reported ongoing needs for transitional housing options to help address immediate needs for housing for members at-risk for homelessness. Locating safe and affordable housing in the current housing market has become an increasingly challenging task and has served to reduce the number of housing options available to persons in need.

The fundamental need for permanent housing is a critical element to achieve and maintain a person's stability and support recovery. In the absence of reliable housing, the ability to access and benefit from available supports and services, including the priority mental health services, is substantially compromised. Quickly addressing a member's immediate needs for housing and related supports can have a profound effect on that person's health outcomes – delays in accessing housing can result in hospitalizations, incarcerations and the need for crisis intervention services. While the capacity of these intensive supports and services will always require diligent management and attention, ensuring the appropriate identification of need and referral to available services is paramount. Opportunities continue to exist to more efficiently and effectively identify needs and expedite member's linkages to available supported housing options. For example, results of a random medical record review demonstrated that 26% of cases with an assessed need for supported housing did not include an ISP intervention to address the need. Teams responsible for the oversight of member care need to ensure that timely and effective clinical

supervision is in place that ensures unmet needs, especially critical needs such as housing and related supports, are recognized and addressed through appropriate and timely interventions. This challenge is exasperated by a lack of affordable housing across the community, a critical factor that is not within the direct control of the Maricopa County behavioral health system.

Assertive Community Treatment

The system currently has 24 functional ACT teams, the same number of teams as last year with a comparable number of members being served under ACT (i.e., 8 more members during CY 2018 than CY 2017). As of December 1, 2018, total member counts across all 24 ACT teams found the teams to be operating at slightly less than 7% below capacity. Five of the ACT teams, or 21% of the total number of available teams, were at 10% or more below capacity. Mercer estimates that a given ACT team may periodically operate at 5% or less below capacity to accommodate periods of transitions of persons leaving the teams and new referrals being added to the teams.

To ensure that the current ACT team capacity is maximized and used to support all recipients who may be in need of this intensive level of services, the system needs to ensure that regular and consistent assessments are occurring – not only for new ACT team candidates, but for individuals who have had a prolonged tenure on an ACT team and may be appropriate for less intensive supports. Clinical teams should intentionally assess the appropriateness of ACT team services for those members under their care. In addition, key metrics and indicators, such as service cost data, hospitalization rates, crisis intervention episodes and jail booking data can support the identification of potential candidates that may benefit from ACT team services.

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

The analysis of jail booking data found that approximately 20% of the 400+ members that experienced at least two jail bookings over the review period were assigned to an ACT team. Further analyses of this multiple incarceration cohort demonstrated that over 25% of the members affiliated with an ACT team were assigned to one of three forensic specialty ACT teams. It should be noted that the three available

forensic ACT teams had limited capacity to accommodate new members as the percent below capacity during the review period ranged from 1% to 4%. However, opportunities did exist to link members with jail recidivism to other available ACT teams and should be an ongoing analysis performed by appropriate organizations within the system of care.

A list of the top 100 members that were associated with the highest aggregate behavioral health service costs determined that 29% were actively assigned to an ACT team – a percentage that surpasses similar analyses that have been conducted over the past five years, but could also suggest continued opportunities to identify members who could benefit from ACT team services.

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

While the breadth and capacity of available ACT teams appear to be adequate to meet the current needs of the system, an organized and structured approach to support an ongoing assessment of need is needed at the direct clinical care level, as well as a periodic data driven review of relevant system indicators that supports the appropriate identification and transition of ACT team members.

Current Assessment Documentation

Last year, Mercer found that 27% of the initial sample of records received did not include a current assessment and/or service plan. Regular assessments and service plan updates ensure that members are periodically evaluated and any needs for the prioritized services are identified and addressed. When selecting an oversample of records for this year's medical record review activity, Mercer determined that 327 cases out of a total of 1,046 did not have a current assessment during CY 2018. Of these 327 cases, almost half were assigned to "navigator status" – a designation that necessitates periodic outreach to the member but does not include expectations that the member has a current assessment and/or ISP. When the navigator status cases were removed from the analysis, it was determined that 16% of the applicable cases did not have a current assessment.

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

2
OVERVIEW

AHCCCS engaged Mercer to implement an annual network sufficiency evaluation of four prioritized mental health services available to persons determined to have a SMI[3]. The service capacity assessment included a need and allocation evaluation of consumer operated services (peer support services and family support services), supported employment, supported housing and ACT.

GOALS AND OBJECTIVES OF ANALYSES

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

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

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

- Identify system strengths and opportunities to improve the appropriate identification of need and access to the prioritized mental health services.

LIMITATIONS AND CONDITIONS

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

3
BACKGROUND

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

HISTORY OF ARNOLD V. SARN

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

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

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

the Substance Abuse and Mental Health Services Administration, as well as annual quality service reviews conducted by an independent contractor and an independent service capacity assessment to evaluate the delivery of care to the SMI population.

SMI SERVICE DELIVERY SYSTEM

AHCCCS contracts with RBHAs to deliver integrated physical health (to select populations) and behavioral health services in three geographic service areas (GSAs) across Arizona. Each RBHA must manage a network of providers to deliver all covered physical health and behavioral health services to Medicaid eligible persons determined to have an SMI. RBHAs 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, 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 an SMI in Maricopa County, the RBHA has contracts with adult provider network organizations (PNOs) and multiple administrative entities that manage ACT teams and/or operate direct care clinics throughout the geographic service area. The table below identifies the adult PNOs and administrative entities and assigned direct care clinics[4].

ORGANIZATION	DIRECT CARE CLINICS	ORGANIZATION	DIRECT CARE CLINICS
Terros	Priest	**Southwest Network**	Saguaro
	23rd Avenue		Osborn
	51st Avenue		San Tan
			Estella Vista

[4] Excludes clinics established to serve members assigned to ACT teams.

ORGANIZATION	DIRECT CARE CLINICS	ORGANIZATION	DIRECT CARE CLINICS
Lifewell Behavioral Wellness	Oak	**Chicano Por La Causa**	Centro Esperanza
	Windsor		
	South Mountain		
	Royal Palms		
		Maricopa Integrated Health system	First Episode Center
LaFrontera/EMPACT	Comunidad	**Partners in Recovery Network**	Metro Center Campus
	EMPACT – San Tan		West Valley Campus
	EMPACT – SPC Apache Junction		Arrowhead Campus
			East Valley Campus
			Hassayampa Campus
			Gateway Campus

CURRENT SERVICE CAPACITY

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

[5] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2018.

ACT Teams (24 teams serving 2,241 recipients)[6]

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Southwest Network: San Tan		100	97	3%
Southwest Network: Saguaro		100	96	4%
Southwest Network: Osborn		100	93	7%
Lifewell Behavioral Wellness: Royal Palms		100	93	7%
Lifewell Behavioral Wellness: South Mountain		100	91	9%
Terros: Enclave		100	93	7%
Terros: Townley	Primary Care Provider (PCP) Partnership	100	95	5%
Terros: Townley 2		100	97	3%
Terros: 51st Avenue	PCP Partnership	100	99	1%
Chicanos Por La Causa: Centro Esperanza		100	89	11%

[6] As of December 1, 2017.

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
LaFrontera/EMPACT: Tempe	PCP Partnership	100	89	11%
LaFrontera/EMPACT: Comunidad		100	96	4%
LaFrontera/EMPACT: Capitol Center		100	95	5%
Partners in Recovery: Metro Center Campus – Omega Team		100	96	4%
Partners in Recovery: Metro Center Campus – Varsity Team		100	92	8%
Partners in Recovery: Indian School	Medical Team	100	91	9%
Partners in Recovery: West Valley Campus	PCP Partnership	100	87	13%
Community Bridges: FACT Team 1	Forensic Team & PCP Partnership	100	96	4%
Community Bridges: FACT Team 2	Forensic Team & PCP Partnership	100	99	1%
Community Bridges: FACT Team 3	Forensic Team & PCP Partnership	100	97	3%
Community Bridges: Avondale	PCP Partnership	100	96	4%
Community Bridges: 99th Avenue	PCP Partnership	100	87	13%

PNO/Direct Care Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Community Bridges: Mesa Heritage		100	92	8%
Maricopa Integrated Health System – Mesa Riverview	PCP Partnership	100	85	15%
Totals		**2,400**	**2,241**	**7%**

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

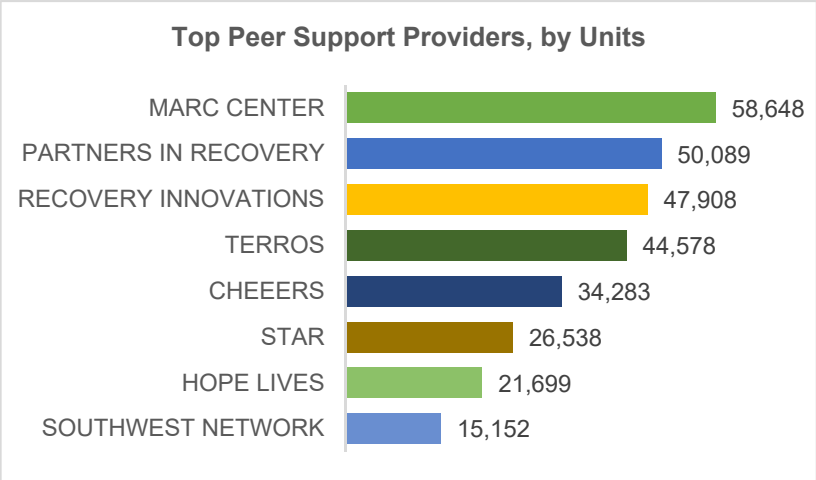
Consumer Operated Services (peer support and family support) Providers[7]

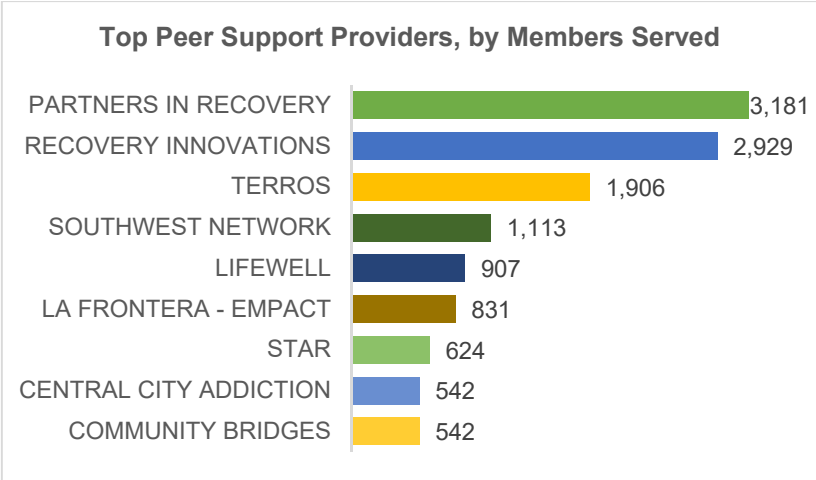
- CHEEERS
- Chicanos Por La Causa (CPLC)
- Community Bridges, Inc.
- Community Partners Integrated Health Care (CPIH)
- Family Involvement Center

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

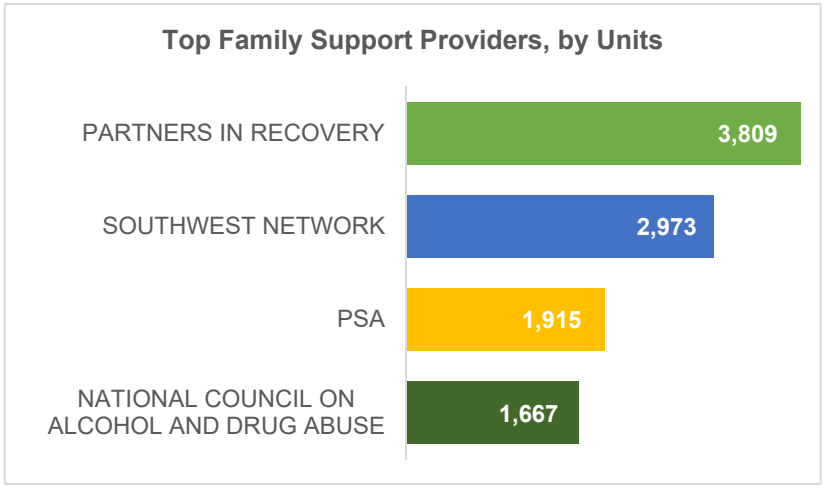
- Hope Lives – Vive la Esperanza
- La Frontera – Empact
- Lifewell Behavioral Wellness
- Marc Community Resources
- Maricopa Integrated Health System
- National Council on Alcoholism and Drug Dependence (NCADD)
- NAZCARE
- Partners in Recovery
- PSA
- Recovery Empowerment Network
- Recovery Innovations International
- Southwest Behavioral Health
- Southwest Network
- Stand Together and Recover (STAR)

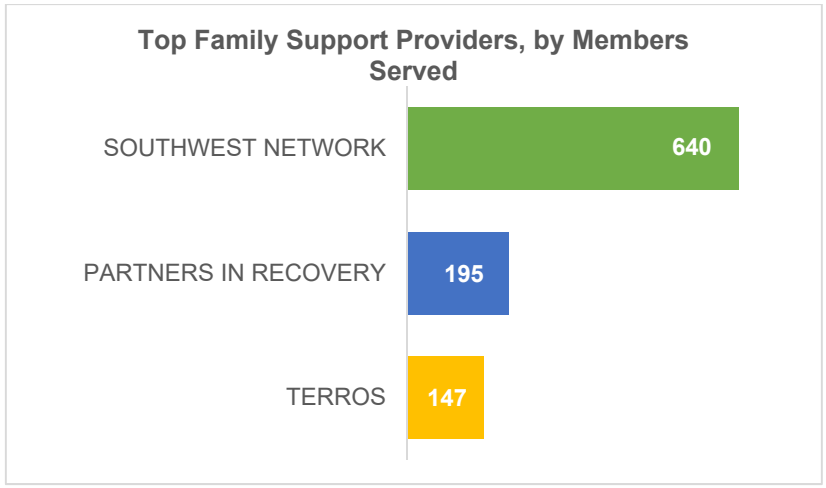
- TERROS
- Valle del Sol





Consumer Operated Services (family support)[8]



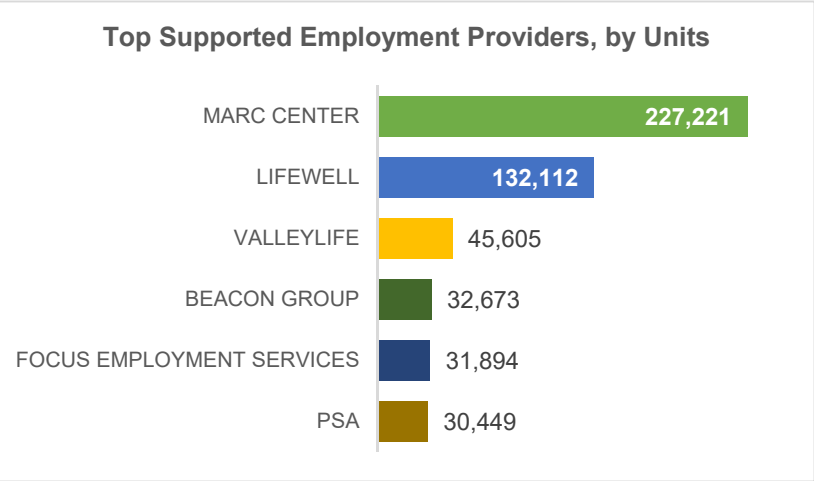


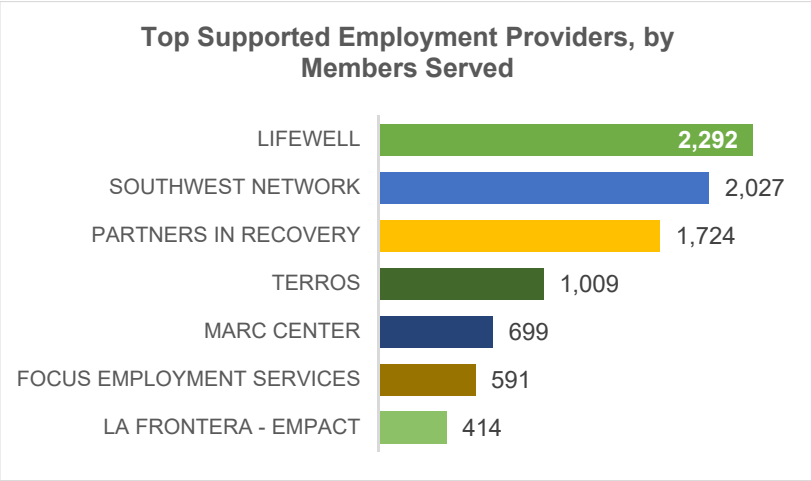
[8] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2019.

Supported Employment Providers[9]

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

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





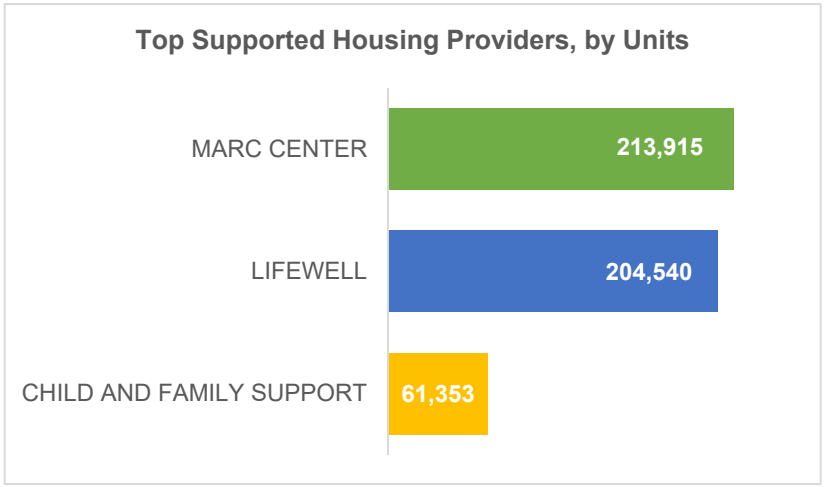
Supported Housing Providers[10]

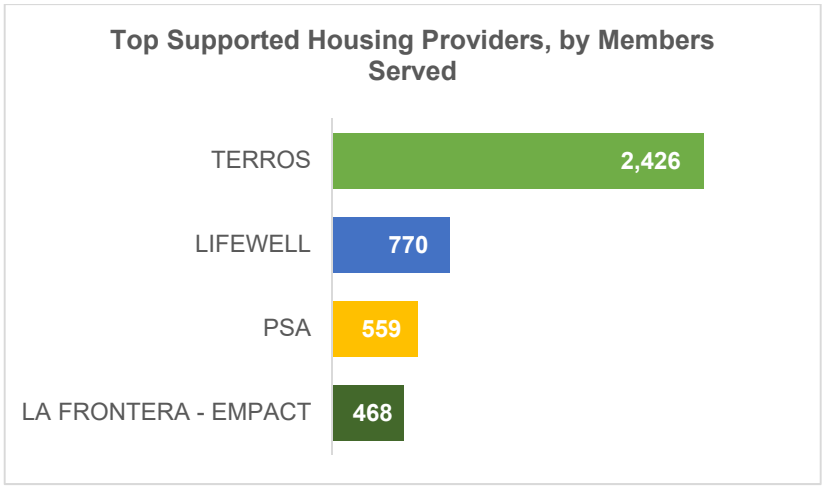
- Arizona Behavioral Health Corporation
- Arizona Mentor
- AZ Health Care Contract Management Services
- Biltmore Properties

[10] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2019.

- Chicanos Por La Causa
- Child and Family Support Services
- City of Tempe
- Community Bridges, Inc.
- Florence Crittenton
- Housing Authority of Maricopa County
- La Frontera – Empact
- Lifewell Behavioral Wellness
- Marc Community Resources
- Native American Connections
- ProMarc
- PSA Behavioral Health Agency
- RI International
- Save the Family

- Southwest Behavioral & Health Services
- Terros Health





4
METHODOLOGY

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

- *Key informant surveys, interviews and focus groups:* Surveys and interviews were completed with key informants and focus groups were conducted with members, family members, case managers and providers.
- *Medical record reviews:* A sample (n=200) of class members was drawn to support an evaluation of clinical assessments, individual service plans (ISPs), and progress notes to examine the extent to which recipient's needs for the priority services were being assessed and met.
- *Analysis of service utilization data and contracted capacity for each of the priority mental health services:* Analysis was conducted to evaluate the volume of unique users, billing units and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to estimate "persistence" in treatment. Persistence was evaluated by calculating the proportion of recipients who only received a priority service during a single month. Additional progressive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months and nine months) to determine the volume of recipients who sustained consistent participation in the selected prioritized services during the review period.
- *Analysis of outcomes data:* Analysis of data including homeless prevalence, employment data and criminal justice information.

- *Benchmark analysis:* Analysis of priority service penetration rates in other states and local systems that represent relevant comparisons for Maricopa County.

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

FOCUS GROUPS

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

Participation in the focus groups was solicited by an invitation created by Mercer, which was reviewed and approved by AHCCCS[11].

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

The focus groups targeted the following participants:

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

[11] See Appendix A: Focus Group Invitation.

- Direct care clinic case managers.

A total of 31 stakeholders participated in the four two-hour focus groups conducted on January 29, 2019 and January 30, 2019. All four focus groups were held at the Burton Barr Library in Phoenix. Invitations to voluntarily participate in the focus groups were distributed to a defined list of stakeholders and the actual number of participants does not represent a statistically significant sample. As such, focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants.

The methodology included the following approach:

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

KEY INFORMANT SURVEYS AND INTERVIEWS

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

access to the services.[12] The survey distribution approach targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

The survey was disseminated to key system stakeholders via email with a hyperlink to the online survey. A total of 23 respondents completed the survey tool.

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

MEDICAL RECORD REVIEWS

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

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

- The recipient was identified as SMI and received a covered behavioral health service during October 1, 2017 and December 31, 2018.[13]

[12] See Appendix B: Key Informant Survey.

[13] The total population of unique SMI recipients who received behavioral health services is 34,264 for the period October 1, 2017 through December 31, 2018.

- The recipient had an assessment date between January 1, 2018 and November 15, 2018.[14]

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

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

Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient's current annual assessment update or initial assessment and/or a current psychiatric evaluation, the recipient's current ISP, and all clinical team progress notes following each recipients' assessment date through December 31, 2018.

The medical record documentation for the sample (n=200) was reviewed by two licensed clinicians and recorded in a data collection tool.[15] Additional comments were recorded to further clarify findings. Prior to conducting the medical record reviews, inter-rater reliability testing

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

[15] See Appendix D: Medical Record Review Tool.

was completed over a two-day period with the reviewers using actual cases, resulting in 95% agreement between reviewers across all scoring tool questions.

ANALYSIS OF SERVICE UTILIZATION DATA

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

The specified time frame for the file included dates of service between October 1, 2017 and December 31, 2018. As noted in previous service capacity assessment reports, encounter submission lag times can impact the completeness of the data set.

Specific queries were developed to identify the presence of each prioritized mental health service.[16] Analysis was conducted to evaluate the volume of unique users, billing units and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to determine “persistence” in treatment. Through the evaluation, proportions of recipients who only received the service in a single month were calculated. Additional progressive consecutive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months and nine months) to determine the volume of recipients who sustained consistent participation in each of the prioritized services. For ACT team services, a roster of ACT team members was obtained and a corresponding analysis of service utilization was also performed.

The service utilization data file supports the extraction of the medical record 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

[16] 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.

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.

2018 Service Capacity Assessment Time Period – Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Sample Group	200	47%	4%	41%	20%	10%
Service utilization data	34,264	36%	4%	29%	15%	6%[17]

2017 Service Capacity Assessment Time Period – Utilization

Sample Group	Number of Recipients	Peer Support	Family Support	Supported Employment	Supported Housing	ACT
Group 1	121	36%	2%	27%	9%	3%
Group 2	199	49%	2%	35%	9%	18%

[17] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 6.5% of all active SMI recipients are assigned to ACT teams.

2016 Service Capacity Assessment Time Period – Utilization

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

2015 Service Capacity Assessment Time Period – Utilization

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

2014 Service Capacity Assessment Time Period – Utilization

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

2013 Service Capacity Assessment Time Period – Utilization

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

ANALYSIS OF OUTCOMES DATA

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

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

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

- Monitor and report on recipients' outcomes;
- Comply with federal, State and/or grant requirements to ensure continued funding for the behavioral health system;

- Assist with financial-related activities such as budget development and rate setting;
- Support quality management and utilization management activities; and
- Inform stakeholders and community members.

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

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

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

Number of Arrests

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

Primary Residence

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

- Independent
- Hotel

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

Employment Status

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

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

PENETRATION AND PREVALENCE ANALYSIS

As part of the service capacity assessment, a review of utilization and penetration rates of the priority mental health services ACT, supported employment, supported housing and peer support[18]) was conducted. Penetration rates were compared to benchmarks, as described below.

The following review process was completed by Mercer:

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

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

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

5
FINDINGS AND RECOMMENDATIONS

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

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

- Penetration and prevalence analysis
- Multi-evaluation component analysis:
  - Focus groups
  - Key informant survey data
  - Medical record reviews
  - Service utilization data
  - Outcomes data analysis

SMI PREVALENCE AND PENETRATION — OVERVIEW OF FINDINGS

Service system penetration is defined as the percentage of people who received services among the estimated number considered eligible for services during a defined time period. As depicted in the table below, 26% of the estimated number of adults with SMI are served through the publicly funded system in Maricopa County. The penetration rate is below the national (publicly funded) penetration rate of 38%, but higher than that of some communities of relatively similar size. For example, in Texas, Harris County (Houston) and Bexar County (San Antonio) both have lower penetration rates than Maricopa County (15% and 21%, respectively). Within the Maricopa County Medicaid system, the penetration rate (44%) exceeds the national average (38%) and both the number of adults with SMI served and the overall penetration rate in the county increased between 2017 and 2018. The overall lower penetration rate for Maricopa County, compared to some other states and cities, appears to be due to the relatively low penetration rate among people without Medicaid coverage (10%).

The Maricopa County system excels in certain areas of evidence-based practice (EBP) utilization. For example, supported housing and supported employment are more available in Maricopa County (especially to Medicaid recipients) compared to the national average. Maricopa County also has strong access to peer support services, at a level that could be considered a best practice benchmark. In addition, Maricopa County has greater capacity to provide Assertive Community Treatment (ACT) team services than most comparison communities included in this analysis. More than 2,200 people received ACT services in Maricopa County in 2018. Based on a national study by leading ACT researchers, a benchmark of 4.3% was used to estimate the percentage of adults with SMI served in the mental health system who need the ACT level of care.[19] With an ACT penetration rate of 6.5%, Maricopa County exceeds the benchmark for access to ACT team services.

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

Maricopa County has three Forensic ACT (FACT) teams that attend to the needs of adults with SMI who have historically high utilization of the criminal justice system. This allocation of resources for justice system-involved consumers reflects responsiveness to the stated concerns of many system stakeholders.

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

PENETRATION RATES					
Region	**Adult Population (≥18 Years Old)[20]**	**Estimated Rate of SMI in the Adult Population[21]**	**Estimated Number of Adults with SMI in the Pop[22]**	**Number of Adults with SMI Served[23]**	**Penetration Rate Among Adults with SMI[24]**
United States[25]	252,070,495	4.1%	10,385,304	3,961,499	38.0%

[20] All state-level population estimates are based on the 2017 SAMHSA estimation methodology sourced from the Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States and States: April 1, 2010 to July 1, 2016. U.S. Census Bureau. Population Division. Release Date, June 2017.

[21] SAMHSA. (2017). State Estimates of Serious Mental Illness from the 2016 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report. Retrieved from https://www.samhsa.gov/data/all-reports?search_api_views_fulltext=NOMS&items_per_page=15. The estimated rate of SMI statewide for Arizona was used for all Maricopa County adults.

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

[23] The state-level proportion of people served with an SMI is reported from SAMHSA (2017) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI according to state-level estimates of SMI from the National Survey of Drug Use and Health (2016).

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

[25] SAMHSA. (2017). State Estimates of Serious Mental Illness from the 2016 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report. Retrieved from https://www.samhsa.gov/data/us_map?map=1. The US penetration data is based on the cumulative reporting of publicly funded mental health services across all states in the Uniform Reporting System.

PENETRATION RATES					
Region	**Adult Population (≥18 Years Old)[20]**	**Estimated Rate of SMI in the Adult Population[21]**	**Estimated Number of Adults with SMI in the Pop[22]**	**Number of Adults with SMI Served[23]**	**Penetration Rate Among Adults with SMI[24]**
Arizona	5,383,542	4.2%	223,955	43,585	19.0%
Maricopa County[26]	3,261,770	4.1%	133,080	34,264	26.0%
Maricopa County – Medicaid	528,600[27]	11.7%	61,846	27,002	44.0%
Maricopa County Gen. Adult Pop.	2,733,170	2.6%	71,234	7,262	10.0%
Texas	20,939,433	3.3%	694,961	281,788	41.0%
Harris County (Houston)	3,334,000	3.5%	115,023	17,612	15.0%
Bexar County (San Antonio)	1,421,439	3.0%	42,359	8,837	21.0%
New York	15,695,902	4.0%	622,463	426,295	68.0%

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

[27] The adult population for Medicaid is based on the estimated proportion of eligible Medicaid members who are adults, versus children/youth, according to the Arizona Health Care Cost Containment System's Acute Enrollment CYE 2018 report and Demographic report for April, July and October 2018. Retrieved from https://archive.azahcccs.gov/ and https://www.azahcccs.gov/Resources/Reports/population.html, respectively.

PENETRATION RATES					
Region	**Adult Population (≥18 Years Old)[20]**	**Estimated Rate of SMI in the Adult Population[21]**	**Estimated Number of Adults with SMI in the Pop[22]**	**Number of Adults with SMI Served[23]**	**Penetration Rate Among Adults with SMI[24]**
New York County (New York City)[28]	1,425,154	4.5%	64,132	90,234	141%[29]
Colorado	4,344,795	4.4%	192,909	67,873	35.0%
Denver City-County[30]	564,417	4.7%	26,471	16,525	62.0%
Nebraska	1,445,479	4.4%	63,023	12,359	20.0%
California	30,479,267	3.6%	1,103,349	399,838	36.0%
Illinois	9,906,933	3.7%	368,538	44,722	12.0%
Kansas	2,200,548	4.2%	92,423	18,813	20.0%
Minnesota	4,278,824	4.3%	184,845	126,139	68.0%
Wisconsin	4,516,122	4.1%	185,613	28,748	15.0%
Tennessee	5,207,732	4.8%	250,492	206,357	82.0%

[28] Utilization data 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, April 2019.

[29] People with serious mental illness are at greater risk for experiencing homelessness and New York has a very high prevalence of homelessness. It is possible that this population is underrepresented in the ACS adult population estimates. Moreover, the penetration data for New York County is based on provider surveys reporting unduplicated counts. In aggregate, the survey results may include duplication of consumers receiving services from multiple providers. As such, the penetration data for SMI is likely overestimated.

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

PENETRATION RATES					
Region	**Adult Population (≥18 Years Old)[20]**	**Estimated Rate of SMI in the Adult Population[21]**	**Estimated Number of Adults with SMI in the Pop[22]**	**Number of Adults with SMI Served[23]**	**Penetration Rate Among Adults with SMI[24]**
Indiana	5,092,787	4.8%	246,491	82,790	34.0%
Delaware	757,626	4.1%	30,911	5,264	17.0%
New Hampshire	1,084,600	5.5%	59,870	30,635	51.0%
North Carolina	7,972,229	4.7%	375,492	87,481	23.0%

Overview of EBP Utilization Benchmark Analyses

Data in the table below depict the utilization rates for ACT, supported employment, and supported housing among adults with SMI served in the Maricopa County behavioral health system. Maricopa County has an ACT utilization rate of 6.5%, which exceeds the best practice level of 4.3%.[31] The county's utilization rates for supported housing and supported employment services also exceed the national average benchmarks. Maricopa County's supported employment utilization rate of nearly 29% and on-going supported employment utilization rate of 6.9% (which is considered to be closer to high-fidelity supported employment) are among the highest in this benchmark analysis – the national utilization rate for supported employment is under 2%. The utilization rate for supported housing (15.1%) in Maricopa County is more than six times greater than the national average, and greater than the utilization rate found in all but one other region in the analysis. Only Bexar County, TX had a higher supported housing utilization rate than Maricopa County.

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

Table 2. EBP Utilization Rates Among Persons with SMI Who Were Served in the System[32]

EBP Utilization Rates						
	Assertive Community Treatment		Supported Employment (SE)		Supported Housing	
Region	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
United States	74,032	1.9%	62,596	1.6%	89,414	2.3%
Arizona	N/A[33]	N/A	6,870	15.8%	1,778	4.1%
Maricopa County	2,241[34]	6.5%	9,861	28.8%	5,160	15.1%
Maricopa County – Medicaid	1,712	6.3%	8,717	32.3%	4,662	17.3%
Maricopa County – Non-Medicaid	276	3.8%	1,144	15.8%	498	6.9%
Maricopa County (SE ongoing)[35]	*N/A*	*N/A*	*2,376*	*6.9%*	*N/A*	*N/A*

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

[33] Arizona did not report the number of people served with ACT statewide.

[34] There were 253 ACT recipients whose Medicaid status could not be determined at the time of this report. This figure also includes those receiving FACT.

[35] We conducted a second analysis of supported employment utilization, including ongoing support to maintain employment, but excluding pre-job training and development. Mercer found in its 2013 review of clinical records that the latter services (pre-job training and development), which accounted for 94% of SE services coded, often indicated brief discussions with clients about employment, outside of the context of a comprehensive, evidence-based supported employment program. The 2,376 people receiving “SE ongoing” services represent a subset of consumers receiving evidence-based SE. However, it is important to note that we do not know the extent to which other states’ reporting of SE references the full-evidence based model.

EBP Utilization Rates						
	Assertive Community Treatment		Supported Employment (SE)		Supported Housing	
Region	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
New Hampshire	1,171	3.8%	3,375	11.0%	*N/A*	*N/A*
North Carolina	6,946	7.9%	*N/A*	*N/A*	*N/A*	*N/A*
Texas	5,228	1.9%	10,434	3.7%	12,359	4.4%
Harris County (Houston)	272	1.5%	3,769	21.4%	1,376	7.8%
Bexar County (San Antonio)	98	1.1%	1,386	15.7%	2,869	32.5%
New York	6,582	1.5%	1,728	0.4%	23,763	5.6%
New York County (NY City)[36]	1,237	1.4%	N/A	*N/A*	4,547	7.1%
Colorado	1,700	2.5%	844	1.2%	70	0.1%
Denver City-County (MHCD)[37]	702	4.2%	501	3.0%	1,490	9.0%
Nebraska	90	0.7%	748	6.1%	911	7.4%

[36] Utilization data 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, April 2019.

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

EBP Utilization Rates						
	Assertive Community Treatment		Supported Employment (SE)		Supported Housing	
Region	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
California	7,686	1.9%	494	0.1%	904	0.2%
Illinois	735	1.6%	2,227	5.0%	N/A	N/A
Kansas	N/A	N/A	1,265	6.7%	2,171	11.5%
Minnesota	2,097	1.7%	N/A	N/A	339	0.3%
Wisconsin	4,065	14.1%	1,140	4.0%	816	2.8%
Tennessee	250	0.1%	806	0.4%	1,057	0.5%
Indiana	879	1.1%	1,203	1.5%	4,800	5.8%
Delaware	456	8.7%	17	0.3%	29	0.6%

Changes in EBP Utilization from 2013 through 2018

Table 3 on the following page compares utilization of ACT, supported employment and supported housing in Maricopa County from 2013 through 2018. Highlights of the findings in comparing utilization/penetration across those years include the following:

- *Assertive Community Treatment*. Since 2013, Maricopa County has experienced a steady increase each year in the total number of adults with SMI who received ACT services. Although the penetration rate decreased slightly between 2017 and 2018, more people received ACT in 2018 than in 2017 and Maricopa County still exceeds the best practice benchmark penetration rate of 4.3%.

- *Supported Employment*. In 2018, the overall penetration rate for supported employment reached its highest point since 2013. This may have been due to the significant increase in the number of people receiving ongoing support to maintain employment services between 2017 and 2018. This result marks all-time highs in the number of consumers who received ongoing supported employment (which is more reflective of evidence-based supported employment) and supported employment of any kind.

- *Supported Housing*. In previous years, the analysis for supported housing penetration was informed by a single supported housing billing code that was infrequently utilized (H0043). As a result, changes in the supported housing penetration rate could not be calculated between 2013 and 2014. A slight improvement in supported housing utilization was evident in the overall percentage of adults with SMI using supported housing from 2014 to 2015; the penetration rate increased from 3.3% to 3.7% (using only H0043). Additional billing codes were added (H2014 – skills training and development and T1019 – personal care services) in 2016 to reflect utilization of supported housing services by contracted supported housing providers. With the addition of the expanded code set, the supported housing penetration rate increased from 3.7% in 2015 to 4.6% in 2016, and then again to 6.6% in 2017. In 2018, the supported housing service utilization query was amended to add living skills training (H2017) when provided by a RBHA contracted supported housing provider. As a result, the penetration rate for supported housing more than doubled (15.1%) during CY 2018.

Table 3. Maricopa County EBP Utilization Rates: 2013-2018

Maricopa County EBP Utilization Rates Among People with SMI Served in the System							
		Assertive Community Treatment		Supported Employment		Supported Housing	
Year	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[38]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2018)	34,264	2,241	6.5%	9,861	28.8%	5,160	15.1%
SE Ongoing				*2,376*	*15.4%*		
Maricopa County (2017)	31,712	2,233	7.0%	8,168	25.8%	2,098	6.6%
SE Ongoing				*1,708*	*5.4%*		
Maricopa County (2016)	30,440	2,093	6.9%	7,930	26.1%	1,408	4.6%
SE Ongoing				*1,547*	*5.1%*		
Maricopa County (2015)	24,608	1,693	6.9%	4,230	17.2%	902	3.7%
SE Ongoing				*725*	*3.0%*		

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

Maricopa County EBP Utilization Rates Among People with SMI Served in the System							
		Assertive Community Treatment		Supported Employment		Supported Housing	
Year	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[38]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2014)	23,977	1,526	6.4%	5,634	23.4%	793	3.3%
SE Ongoing				*657*	*2.7%*		
Maricopa County (2013)	20,291	1,361	6.7%	7,366	36.3%	No Data	No Data
SE Ongoing				*515*	*2.5%*		

ACT Benchmarks

In recent years, Maricopa County has enhanced its capacity to provide ACT team services to people with SMI. An important 2006 study by Cuddeback, Morrissey and Meyer reported that an estimated 4.3% of adults within a mental health system with SMI need an ACT level of care in any given year. The Maricopa County ACT penetration rate, relative to all people with SMI served in the system, as well as relative to the 4.3% estimate provided by Cuddeback, et al. is presented in the table below.

Maricopa County's ACT penetration rate (6.5%) exceeds the benchmark in the Cuddeback study (4.3%), compares favorably with other communities nationally, and should 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. These FACT teams represent a vital resource in Maricopa County that is missing in many other communities.

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

ACT Utilization					
				ACT Penetration	
Region	Number of Adults with SMI Served in Public System[39]	Number with SMI Who Need ACT[40]	Number Received ACT[41]	Percent of All People with SMI Who Received ACT	Percent of the Number in Need of Act
Ideal Benchmark[42]				*4.3%*	*100.0%*
United States	3,961,499	170,344	74,032	1.9%	44.0%
Arizona	43,585	1,874	N/A	N/A	N/A

[39] The state-level proportion of people served with an SMI is reported from: SAMHSA (2016) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/us_map. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI according to state-level estimates of SMI from the National Survey of Drug Use and Health (2016).

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

[41] National and state-level penetration counts for ACT received are reported from: SAMHSA. (2016). Mental Health NOMS: Central Mental Health Services Uniform Reporting System. Arizona was among the states that did not report the number receiving ACT statewide.

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

ACT Utilization					
				ACT Penetration	
Region	Number of Adults with SMI Served in Public System[39]	Number with SMI Who Need ACT[40]	Number Received ACT[41]	Percent of All People with SMI Who Received ACT	Percent of the Number in Need of Act
Maricopa Co. – AHCCCS Total	34,267	1,473	2,241[43]	6.5%[44]	152.0%
Maricopa Co. – Medicaid	27,002	1,161	1,712	6.3%	147.0%
Maricopa Co. – Gen Adult Pop	7,262	312	276	3.8%	88.0%
New Hampshire	30,635	1,317	1,171	3.8%	89.0%
North Carolina	87,481	3,762	6,946	7.9%	185.0%
Texas	281,788	12,117	5,228	1.9%	43.0%
Harris County (Houston)	17,612	1,607	272	1.5%	17.0%
Bexar County (San Antonio)	8,837	665	98	1.1%	15.0%
New York	426,295	18,331	6,582	1.5%	36.0%
New York County (NY City)[45]	90,234	3,880	1,237	1.4%	32.0%

[43] There were 253 ACT recipients whose Medicaid status could not be determined at the time of this report.

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

[45] Utilization data 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, April 2019.

ACT Utilization					
				ACT Penetration	
Region	Number of Adults with SMI Served in Public System[39]	Number with SMI Who Need ACT[40]	Number Received ACT[41]	Percent of All People with SMI Who Received ACT	Percent of the Number in Need of Act
Colorado	67,873	2,919	1,700	2.5%	58.0%
Denver County (MHCD)[46]	16,525	711	702	4.2%	99.0%
King County (Seattle, WA)	13,286	961	270	2.0%	28.0%
Nebraska	12,359	531	90	0.7%	17.0%
California	399,838	17,193	7,686	1.9%	45.0%
Illinois	44,722	1,923	735	1.6%	38.0%
Minnesota	126,139	5,424	2,097	1.7%	39.0%
Wisconsin	28,748	1,236	4,065	14.1%	329.0%
Tennessee	206,357	8,873	250	0.1%	3.0%
Indiana	82,790	3,560	879	1.1%	25.0%
Delaware	5,264	226	456	8.7%	202.0%

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

Supported Employment Benchmarks

Maricopa County meets a high percentage of the estimated need for supported employment services, although there is a smaller percentage (6.9%) of people who appear to be receiving ongoing supported employment services. Nearly 10,000 people received pre-job training and development services, but fewer received services associated with obtaining and maintaining a job (~2,400). It is likely that a large volume of pre-vocational services is being provided, but fewer people are receiving the more intensive, "ongoing support" for obtaining and maintaining employment in Maricopa County.

Nevertheless, Maricopa County's 2018 penetration rate for ongoing supported employment services to those estimated to be in need (15%[47]), which is likely to be more consistent with high fidelity supported employment, compared fairly well to national benchmarks. It exceeded the US penetration rate of 4%, and among all comparison communities it only trailed New Hampshire (25%).

[47] The overall penetration rate for adults with SMI is 6.9%, but based on estimates of the number of people already employed and on surveys of unemployed people with SMI concerning the perceived desirability of employment, we estimated about half of people with SMI served in the system need SE and that 15% of those in need received it.

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

Supported Employment (SE) Utilization					
				SE Penetration	
Region	Number of Adults with SMI Served in System[48]	Number of People in Need of SE[49]	Number of People Who Received SE[50]	Percent Served Among People with SMI	Percent Served Among People Who Need SE
Ideal Benchmark				*45.0%*	*100.0%*
US	3,961,499	1,782,675	62,596	2.0%	4.0%
Arizona	43,585	19,613	6,870	16.0%	35.0%
Maricopa Co. – Total served	34,264	15,419	9,861	29.0%	64.0%
Maricopa Co. (SE Ongoing)	34,264	15,419	2,376	7.0%	15.0%
Maricopa Co. – Medicaid	27,002	12,151	8,717	32.0%	72.0%
Medicaid (SE Ongoing)	27,002	12,151	2,081	*8.0%*	*17.0%*
Maricopa Co. – Gen Adult Pop	7,262	3,268	1,144	16.0%	35.0%
Non-Medicaid (SE Ongoing)	7,262	3,268	*295*	*4.0%*	*9.0%*
New Hampshire	30,635	13,786	3,375	11.0%	25.0%

[48] The state-level proportion of people served with an SMI is reported from: SAMHSA (2016) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/us_map. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI according to state-level estimates of SMI from the National Survey of Drug Use and Health (2016).

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

[50] National and state-level penetration supported employment counts are reported from: SAMHSA (2016). Mental Health NOMS: Central Mental Health Services Uniform Reporting System.

Supported Employment (SE) Utilization					
				SE Penetration	
Region	Number of Adults with SMI Served in System[48]	Number of People in Need of SE[49]	Number of People Who Received SE[50]	Percent Served Among People with SMI	Percent Served Among People Who Need SE
Texas	281,788	126,805	10,434	4.0%	8.0%
Harris County (Dallas)	17,612	44,202	3,769	21.0%	9.0%
Bexar County (San Antonio)	8,837	18,382	1,386	16.0%	8.0%
New York	426,295	191,833	1,728	<1%	1.0%
Colorado	67,873	30,543	844	1.0%	3.0%
Denver County (MHCD)[51]	16,525	7,436	501	3.0%	7.0%
Nebraska	12,359	5,562	748	6.0%	13.0%
California	399,838	179,927	494	<1%	<1%
Illinois	44,722	20,125	2,227	5.0%	11.0%
Kansas	18,813	8,466	1,265	7.0%	15.0%
Wisconsin	28,748	12,937	1,140	4.0%	9.0%
Tennessee	206,357	92,861	806	<1%	1.0%
Indiana	82,790	37,256	1,203	2.0%	3.0%
Delaware	5,264	2,369	17	<1%	1.0%

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

Peer Support Benchmarks

Maricopa County excels in making peer support services available to people in need. The penetration rates for 2016–2018 are relatively high and represent a best practice benchmark in terms of access to peer support.

Table 6. Peer Support Penetration Rates

Peer Support		
Region	**Peer Support Received**	**Peer Support Penetration Rate**
Arizona		
Maricopa County (Total) – 2018	11,001	41.0%
Maricopa County (Total) – 2017	11,803	37.0%
Maricopa County (Total) – 2016	11,629	38.0%
Maricopa County (Total) – 2015	7,173	29.0%
Maricopa County (Total) – 2014	7,522	31.0%
Maricopa County (Total) – 2013	8,385	41.0%
Texas		
Harris County	3,650	3.0%
Bexar County	3,050	7.0%
Colorado		

Peer Support		
Region	**Peer Support Received**	**Peer Support Penetration Rate**
Denver City-County[52]	494	2.0%

[52] Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2019. The Mental Health Center of Denver serves adults with SMI with peer mentors and or peer specialists. This figure may include some duplication of those served by both a peer mentor and a peer specialist.

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 priority mental health services in Maricopa County, four focus groups were conducted with key system stakeholders to facilitate discussions with participants having direct experience with priority mental health services. Key findings derived from the focus groups regarding the delivery system's capacity to deliver peer support and family support services included the following:

- Participants in the adult member focus group reported that peer support services are one of the most valuable services provided in the behavioral health system and would like to see peers included in all aspects of the system.
- Participants in the provider and case manager focus groups feel that peer support services help members to stay out of the hospital and increase length of stay in community-based housing settings (e.g. supporting independence for individuals living alone in an apartment).
- Similar to the last two years, participants in all focus groups reported that not every direct care clinic employs a peer support specialist or family support specialist. Staff turnover remains high and vacancies may not be immediately filled. These same participants shared that additional on-the-job support and ongoing training would help to reduce attrition rates.

- Also similar to previous years, participants in the provider, case manager and family member groups expressed concerns that peer and family support specialists are often overwhelmed by their assigned member case load size and work demands. The specialists appear to be spread too thin across multiple assigned duties.

- As reported in prior year service capacity assessments, participants in all focus groups expressed that clinical teams do not consistently demonstrate an understanding of the appropriate role of the peer support specialist, peer or recovery navigator and/or family support specialist. This lack of clarity has led to confusion regarding how to best utilize these resources. In particular, many family member focus group attendees reported that they were not aware of the availability of peer support or family support specialists or how to access them if needed.

- Similar to last year, participants in the provider and case manager focus groups reported that it can be challenging to find and retain skilled peer support specialists. Due to the requirements of the job, peer support specialists must pass fingerprint clearance reviews, possess strong computer skills and have access to reliable transportation. These requirements, attributes and resources can be challenging for peer support specialists to achieve. Additionally, peer support specialist positions are typically full-time which may be too overwhelming for some of the peers. The availability of part-time peer support positions would encourage more peers to consider the role and promote longer tenure in the positions.

- Participants in the provider focus group expressed concerns that some peer support specialists are not competitively paid in comparison to other clinic staff. This contributes to turnover rates and the appearance that peer support staff are not valued as highly as other clinic staff.

- As reported last year, participants in the case manager group feel that after-hour availability of peer and family support specialists would be beneficial to members. After-hour access to peer support is not currently available unless a member is assigned to an ACT team.

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

Key Informant Survey Data

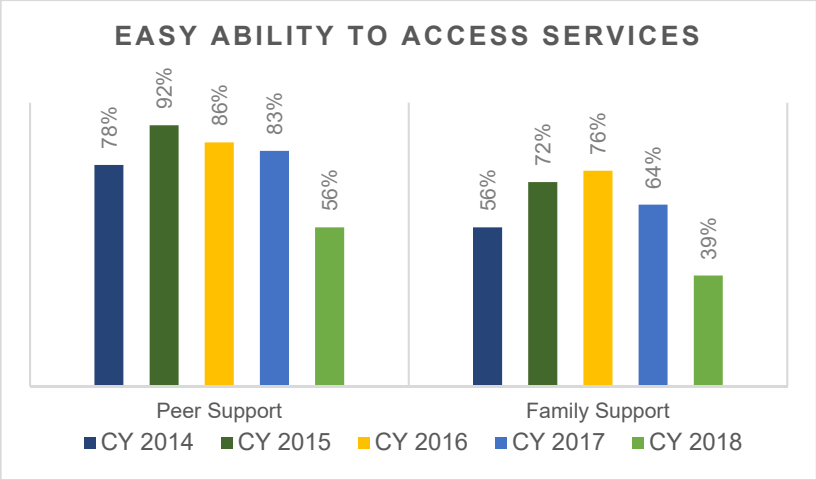
As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to the priority services, a key informant survey was administered. The survey tool included questions and rating assignments related to the priority mental health services. It should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

Level of Accessibility

More than half of survey respondents felt that peer support services were easy to access (56%), a significant decrease from last year's survey results in which 83% of the respondents indicated that the services were easy to access. 11% 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 five years, peer support services were perceived as the easiest of all the priority services to access.

17% of survey respondents felt that family support services were difficult to access or that no access was available while 39% of the respondents indicated that family support services were easy to access. The remaining 44% of respondents rated access to family support services as "fair".

Overall, respondents felt that accessing peer support and family support services was more difficult during CY 2018 when compared to CY 2017.



Factors that Hinder Access

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

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

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

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

Efficient Utilization

In terms of service utilization, 91% of the responses indicated that peer support services were being utilized efficiently or were utilized efficiently most of the time. 9% of respondents indicated that the peer support services were not utilized efficiently.

86% of the responses indicated that family support services were being utilized effectively or were utilized efficiently most of the time.

Alternatively, 14% 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 and 94% during CY 2017.
- 81% of the survey respondents reported that **family support services** could be **accessed within 30 days** of the identification of service need. This finding compares to 33% during CY 2013, 69% during CY 2014, 74% during CY 2015, 79% during CY 2016 and 80% during CY 2017.
- 0% reported it taking **four to six weeks to access peer support services** following the identification of need (20% – CY 2013; 13% – CY 2014; 15% - CY 2015; 13% - CY 2016; 0% - CY 2017).
- 19% percent reported it taking **four to six weeks to access family support services** following the identification of need (44% – CY 2013; 8% – CY 2014; 13% – CY 2015; 13% – CY 2016; 13% – CY 2017).
- 0% of the survey respondents reported that it would take an average of **six weeks or longer to access peer support services** (10% – CY 2013; 13% – CY 2014; 7% – CY 2015; 4% – CY 2016; 6% – CY 2017).
- 0% of the survey respondents reported that it would take an average of **six weeks or longer to access family support services** (22% – CY 2013; 23% – CY 2014; 13% – CY 2015; 8% – CY 2016; 7% – CY 2017).

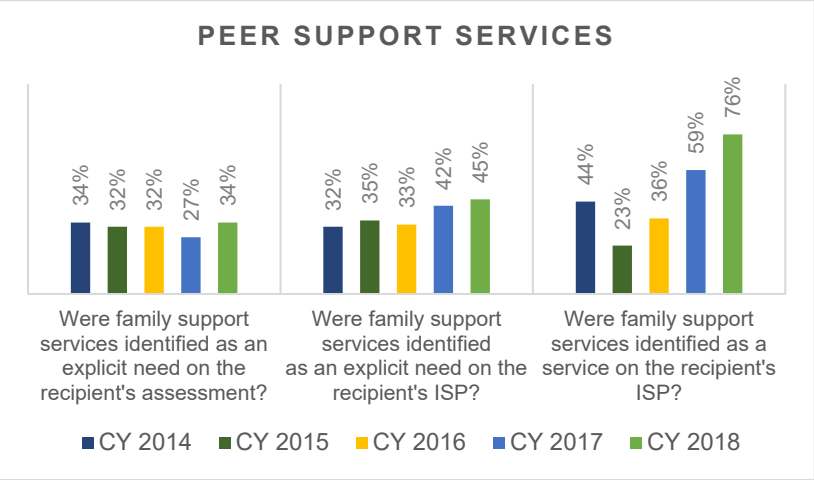
Medical Record Reviews

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

Peer Support Services

76% of the ISPs included peer support services when assessed as a need; a significant improvement over the past two years.

Almost half, (47%) of the recipients included in the sample received at least one unit of peer support during CY 2018 based on a review of service utilization data.



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

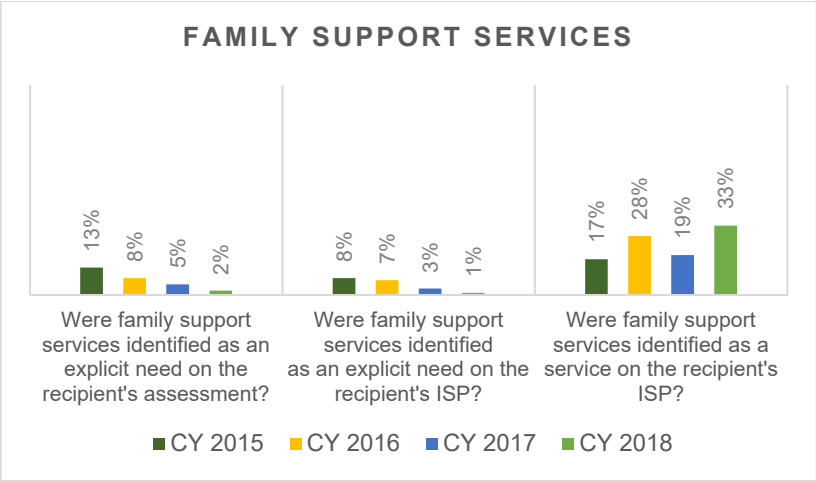
- The clinical team did not follow up with initiating a referral for the service; and
- The member declined to attend the service.

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.

33% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP.

4% of the recipients included in the sample received at least one unit of family support during CY 2018 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.

In 2 cases, the person was unable to access family support services after the service was recommended by the clinical team. Reviewers were able to review progress notes and determined that there was no documentation that the clinical team initiated a referral for the service.

Service Utilization Data — Peer Support Services

During the time period of October 1, 2017 through June 30, 2018; 28,210 unique users were represented in the service utilization data file. Of those, 91% were Medicaid eligible and 9% were non-Title XIX eligible.

- Overall, 37% of the recipients received at least one unit of peer support services during the time period (the same finding as last year).

Access to the service was similar between Title XIX (37%) and non-Title XIX groups (33%).

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

- Slightly less than half of the members who received at least one unit of peer support during the review period accessed the service during a single month.
- Over 69% of all members who received at least one unit of peer support during the review period accessed the service for one or two months. Peer support services are widely accessible across the system and members may have multiple opportunities to attend a clinic-based peer support group and/or receive peer support services within or outside their assigned direct care clinic. The nature of the service lends to episodic participation and less dependent on sustained participation to be an effective support and intervention.

PERSISTENCE IN PEER SUPPORT SERVICES OCTOBER 2017 — JUNE 2018			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
1	48.5%	56.2%	49.1%
2	20.2%	18.8%	20.1%
3–4	15.9%	17.8%	16.0%
5–6	7.0%	4.5%	6.8%
7–8	3.1%	1.5%	3.0%
9+	5.2%	1.2%	4.9%
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, 2.6% of the recipients received at least one unit of family support services during the time period (2.0% over a comparable time period last year). Over the six years that the service capacity assessment has been conducted, family support service utilization rates have been consistently at 2% to 4%. A number of factors may be influencing these results including the absence of supportive family members, member choice to not include family members in their treatment, and a lack of understanding by clinical teams regarding the appropriate application of the service.

Access to the service was split between Title XIX (2.7%) and non-Title XIX groups (1.8%).

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

- 76.8% 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 80% last year.
- Over 87% of all members who received at least one unit of family support during the review period accessed the service for one or two months.

**PERSISTENCE IN FAMILY SUPPORT SERVICES
OCTOBER 2017 — JUNE 2018**

Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	76.8%	68.9%	76.3%
2	10.5%	20.0%	11.1%
3–4	6.3%	4.4%	6.2%
5–6	2.9%	0.0%	2.7%
7–8	1.5%	2.2%	1.5%
9+	2.0%	4.4%	2.2%

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, 2017 through December 31, 2018, 36% of all members with an SMI received at least one unit of peer support. During the prior year, 37% of members received peer support services. (2013 – 38%; 2014 – 31%; 2015 – 29%; 2016 – 38%).

- Participants in the adult member focus group reported that peer support services are one of the most valuable services provided in the behavioral health system and would like to see peers included in all aspects of the system.
- Participants in the case manager group feel that after-hour availability of peer and family support specialists would be beneficial to members. After-hour access to peer support is not currently available unless a member is assigned to an ACT team.
- More than half of the survey respondents felt that peer support services were easy to access (56%), a significant decrease from last year's survey results in which 83% of the respondents indicated that the services were easy to access. Despite this finding, 100% of the survey respondents reported that peer support services could be accessed within 30 days of the identification of the service need and peer support services were perceived as the easiest of all the priority services to access.
- 34% of the sample of medical record assessments identified peer support as a need. When assessed as a need, peer support services were identified on the recipient's ISP 76% of the time – a considerable improvement over the three prior years.
- Maricopa County has strong access to peer support services and, based on Mercer's national penetration and prevalence analysis, utilization is at a level that could be considered a best practice benchmark.
- Over 30% of all members who received at least one unit of peer support during the review period accessed the service for more than one or two consecutive months – a similar finding derived from the 2018 service capacity assessment.

Findings: Family Support

- Service utilization data shows a modest increase in the percentage of members who received at least one unit of family support services during 2018 when compared to prior years (2013 – 2%; 2014 – 3%; 2015 – 2%; 2016 – 2%; 2017 – 2%; **2018 – 4%**).

- For most of the assessments reviewed, the clinical teams regularly identify and document natural and family supports that are important to the member. Despite clinical team's identification of natural and family supports, individual service plans infrequently included family support services (33%) when identified as a need.

- Almost 20% of the key informant survey respondents indicated that it would take four to six weeks to access family support services following the identification of need (highest percent since 2013).

- Family members, individuals receiving services and case managers all agree that family members would benefit from a service delivery system navigational guide and/or a compendium of available supports and resources.

Recommendations: Peer Support

- Consider performing a peer support workforce assessment that analyzes access to flexible working hours, availability of workplace supports, and a review of the competitiveness of pay rates.

Recommendations: Family Support

- Ensure through training and ongoing supervision that direct care clinical team members, including case managers and clinical supervisors, understand the appropriate application of family support services.

- Provide additional training and supervision to recognize the value of family support services as effective service plan intervention.

MULTI-EVALUATION COMPONENT ANALYSIS — SUPPORTED EMPLOYMENT

Service Description

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

Focus Groups

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

- Most adult member and family member participants reported they are pleased with the supported employment services they have received from the rehabilitation specialists at direct care clinics and supported employment providers. Members stated that staff have helped them to develop resumes, conduct online searches for jobs, provide coaching on how to interview, provided tips to be successful on the job and onsite job coaching. One member shared, “The services helped with my self-confidence so I could handle a job.”

- Similar to last year, participants in the adult member, case manager and family member focus groups reported varied success in obtaining employment as a result of encouragement provided by VR. While there is noted variation in the timely access to VR services across service sites, participants expressed that the increased availability of VR specialists continues to be a positive change.

- Similar to last year, participants in the family member, provider and case manager focus groups reported that the positive “philosophical shift” regarding employment continues to prevail. This has resulted in a perceived reduction in clinical teams simply assessing a member’s readiness for employment to more substantive engagement with individuals regarding work interests, work history and conveying the inherent value that employment can bear for individuals advancing their personal recovery. One adult member stated, “My clinic is always bringing up employment with me.”

- Similar to the last two years, participants in the provider and case manager focus groups stated that members are encouraged to pursue a wider variety of employment opportunities outside of peer support specialist training and employment. Provider organizations are now

co-located at the clinics leading to more diverse opportunities for members. Case manager participants also reported that they continue to observe an increase in the number of employers who are willing to hire individuals with SMI diagnoses.

- Adult member and family member participants shared concerns that access to supported employment services can be dependent on the knowledge level of the assigned case manager. In these situations, members and family members are not sure how to address concerns or identify options that may be available to them.

- Similar to the last two years, provider and case manager focus group participants report that benefit specialists are available in most clinics; however, the technical knowledge of the benefit specialists can vary. Not all are familiar with Disability 101 training or do not appear able to explain the impact of employment on benefits. Participants in all four focus groups reported that some members and family members remain concerned about the potential loss of health and welfare benefits due to income generated from employment. Provider focus group participants recommended that peer support specialists receive cross-training on Disability 101 to help members and family members navigate this complex topic.

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

19% of survey respondents felt that supported employment services were difficult to access, comparable to last year (17%) and significantly less than CY 2013 and CY 2014 (75% – CY 2013; 33% – CY 2014). 89% of respondents indicated that supported employment services were easy to access or having “fair” access, an increase from CY 2017 (83%) and significantly higher than CY 2014 (66%).

Factors that Hinder Access

Factors that negatively impact accessing supported employment services included:

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

Efficient Utilization

75% of the responses indicated that supported employment services were being utilized efficiently or were utilized efficiently most of the time, down slightly from 78% last year. 25% of respondents indicated that supported employment services were not utilized efficiently.

Timeliness

79% of the survey respondents reported that supported employment services could be **accessed within 30 days** of the identification of the service need. This compares to 79% during CY 2017, 73% during CY 2016, 70% during CY 2015, 60% during CY 2014 and 22% during CY 2013. 5% 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 demonstrated that supported employment services were identified as a need on either the recipient's assessment and/or ISP in 59% of the cases reviewed, the same finding as last year. Supported employment services were identified as a service on the recipient's ISP in 75% of the cases reviewed when assessed as a need. (CY 2013 – 13%; CY 2014 – 26%; CY 2015 – 22%; CY 2016 – 53%; CY 2017 – 82%).

41% of the recipients included in the sample received at least one unit of supported employment during CY 2018 based on a review of the service utilization data.

In 65 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 78% of those cases in which the person did not access the service despite an identified need – almost two times the rate identified during CY 2017.

Building on a trend established over the past few years, the review team noted that in some cases the clinical team identifies supported employment services on the member's individual service plan in the absence of, or even contrary to, the member's assessed needs.

The review of medical records reveals several issues that were also identified during last year's service capacity assessment:

- Assessed needs and corresponding individual service plan interventions are commonly misaligned and suggest that some clinical teams responsible for developing the service plan in coordination with the member do not fully understand the appropriate application of supported employment services.
  - In one example, within the learning/working domain of an ISP, the stated objective read: "Member needs to explore work/volunteer opportunities in the community." The service category identified to support this objective was documented as "cognitive rehabilitation", with a corresponding service code of "H0004" (behavioral health counseling and therapy). The member in this case was a young adult (21 years-old) with an assessed need for supported employment services. The clinical team's misalignment of the recommended service category and service code reflects a general and pervasive lack of understanding of the appropriate application of covered behavioral health services, and, in this example, supported employment services. Despite the service identified on the ISP, the member ultimately received a supported employment service rendered by the rehabilitation specialist assigned to the direct care clinic.

- Individual service plans are not always based on the member's assessed needs and can include generic language that does not differentiate each member's unique circumstances and needs. Mercer reviewed numerous records that indiscriminately identified supported employment services as a recommended service in the absence of an assessed need.

Service Utilization Data

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

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

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

Services which prepare a person to engage in meaningful work-related activities may include but are not limited to the following: career/educational counseling, job shadowing, job training, including Work Adjustment Training; assistance in the use of educational resources necessary to obtain employment; attendance to RSA/VR 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.

For the time period October 1, 2017 through June 30, 2018, H2027 (pre-job training and development) accounts for 93% of the total supported employment services (a slight decrease from CY 2017 – 94%). H2025 (ongoing support to maintain employment/15-minute billing unit) represents 7% of the supported employment utilization (CY 2017 – 6%). H2026 (ongoing support to maintain employment/per diem billing unit) accounted for less than 1% of the overall supported employment utilization.

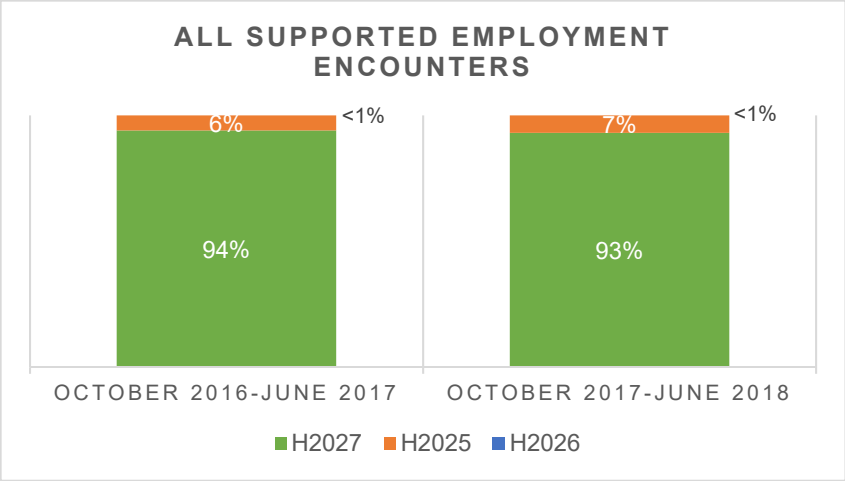
A billing modifier (i.e., SE) is applied in conjunction with billing code H2027. The intended use of the modifier is to track members who are engaged in rapid job search with an expected outcome of securing employment within 45 days of engaging in supported employment services. Mercer analyzed the presence of this code and modifier within the service utilization data file (see graphic below). H2027 SE represents 9% (CY 2017 – 9%) of the overall supported employment utilization.

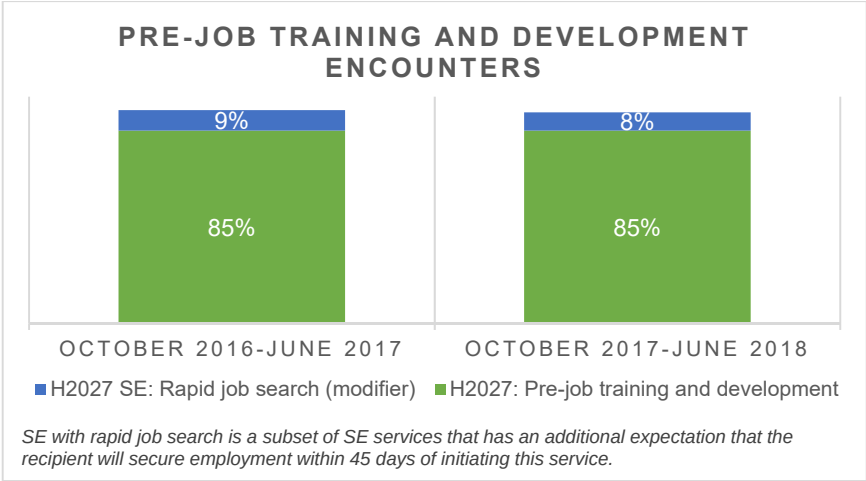
Challenges related to providing ongoing support to maintain employment (H2025) include members opting out of supported employment services once competitively employed or the member's inability to attend meetings with job coaches due to commitments related to full-time employment. Until recently, billing procedures prohibited the application of the service telephonically. Beginning in July 2017, the *AHCCCS Covered Behavioral Health Services Guide* was revised to allow H2025 to be encountered with place of service code (POS) 02 and be conducted with the member telephonically. Data acquired through a review of service utilization encounters demonstrated that 463 unduplicated members during CY 2018 were affiliated with telephonic ongoing support to maintain employment services.

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

- Overall, 26% of the recipients received at least one unit of supported employment during the review period, the same finding identified during CY 2017.

- Access to the service was unevenly split between Title XIX (27%) and non-Title XIX groups (21%).





To increase access to supported employment services, supported employment providers, the Maricopa County RBHA and the PNOs/administrative entities have partnered to co-locate supported employment specialists and job developers in many of the direct care clinics. The clinical teams and the supported employment specialists meet regularly to integrate and coordinate services for members interested in obtaining and/or maintaining employment. The meetings provide a forum for the supported employment specialist to share the current caseload of members engaged in supported employment services, support outreach efforts and to review the member's clinical status.

The supported employment specialists and rehabilitation specialists assigned to the clinics also coordinate closely with staff employed with the Arizona Department of Economic Security/Rehabilitation Services Administration (DES/RSA). Twenty-five full-time DES/RSA Counselors are dedicated to persons with SMI, co-located and represented at all the direct care clinic locations. Staff turnover in these positions has

recently stabilized and vacancies are less prevalent. As of May 15, 2019, three VR Counselor vacant positions are reportedly "on hold"[53]. VR counselors meet regularly with direct care clinic rehabilitation specialists and contracted supported employment providers and work in coordination to meet member's supported employment needs.

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

- Members referred to RSA/VR – 2,215 (January 1, 2018 – November 30, 2018)
- Members served in the VR program – 1,764 (quarter ending December 31, 2018)
- Members open in the VR program – 1,433 (quarter ending December 31, 2018)
- Members in service plan status with VR – 873 (quarter ending December 31, 2018)

As reported by a key informant knowledgeable of supported employment services offered at direct care clinic locations, rehabilitation specialists assigned to clinical teams are perceived to be increasingly effective at actively engaging members regarding employment related goals. Rehabilitation specialist vacancies identified during the CY 2017 service capacity assessment have been largely resolved and the positions are credited with making a significant difference for members seeking support in pursuit of employment opportunities. While significant progress has been made over the past year with hiring and clarifying the roles of the rehabilitation specialists, added emphasis, and perhaps additional training, is needed across all direct care staff to effectively convey to members why pursuing skills development, education, and/or employment opportunities is so critical to advancing a person's overall recovery goals. A key informant shared that the

[53] Telephonic interview with the Arizona Rehabilitation Services Administration, Statewide Behavioral Health Coordinator, May 15, 2019.

system could improve by promoting and sharing success stories and illustrating how employment has contributed to successful outcomes for individuals.

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 2017 — JUNE 2018**

Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	52.8%	60.1%	53.3%
2	18.2%	18.9%	18.2%
3–4	14.8%	12.6%	14.7%
5–6	5.9%	4.3%	5.8%
7–8	2.7%	2.0%	2.6%
9+	5.6%	2.0%	5.3%

- Over 53% percent of the recipients who received at least one unit of supported employment services during the review period accessed the service during a single month;
- Nearly 15% of the recipients received supported employment services for three to four consecutive months during the review period; and
- 5% of the recipients received the service for at least nine consecutive months.

Key Findings and Recommendations

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

Findings: Supported Employment

- Service utilization data demonstrates 29% of members received at least one unit of supported employment during CY 2018, an increase of 3% from last year. (CY 2013 – 39%; CY 2014 – 20%; CY 2015 – 17%; CY 2016 – 26%; CY 2017 – 26%).

- 19% of survey respondents felt that supported employment services were difficult to access, comparable to last year (17%) and significantly less than CY 2013 and CY 2014 (75% – CY 2013; 33% – CY 2014). 89% of respondents indicated that supported employment services were easy to access or having “fair” access, an increase from CY 2017 (83%) and significantly higher than CY 2014 (66%).

- Similar to last year, participants in the family member, provider and case manager focus groups reported that the positive “philosophical shift” regarding employment continues to prevail. This has resulted in a perceived reduction in clinical teams simply assessing a member’s readiness for employment to more substantive engagement with individuals regarding work interests, work history and conveying the inherent value that employment can bear for individuals advancing their personal recovery.

- Per the focus group participants, not all benefit specialists appear to be familiar with Disability 101 training or are unable to explain the impact of employment on benefits. Participants in all four focus groups reported that some members and family members remain concerned about the potential loss of health and welfare benefits due to income generated from employment, which can impact a member’s decision to pursue employment related goals.

- In 65 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 78% of those cases in which the person did not access the service despite an identified need – almost two times the rate identified during CY 2017.

- Assessed needs and corresponding individual service plan interventions are commonly misaligned and suggest that some clinical teams responsible for developing the service plan in coordination with the member do not fully understand the appropriate application of supported employment services.

- Individual service plans are not always based on the member's assessed needs and can include generic language that does not differentiate each member's unique circumstances and needs. Mercer reviewed numerous records that indiscriminately identified supported employment services as a recommended service in the absence of an assessed need.

- Consistent with patterns noted over the past five years, the service utilization data set demonstrates proportional variation in the volume of encountered service codes for supported employment. For the time period October 1, 2017 through June 30, 2018, H2027 (pre-job training and development) accounts for 93% of the total supported employment services (slight decrease from CY 2017 – 94%).

Recommendations: Supported Employment

- Through training and supervision, ensure that clinical team members understand the appropriate application of covered services designed to meet a person's objective and goal of securing and/or maintaining employment.

- Track employment tenure and assess if the presence of ongoing support to maintain employment influenced the duration of members' employment episodes. Leverage these trended data to establish predictive algorithms that may help identify the most appropriate candidates to target for the provision of ongoing support to maintain employment.

- Establish regular monitoring and performance improvement activities to address instances in which the clinical team identifies supported employment services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services.

- Monitor (and take actions as appropriate) the observed practice of indiscriminately documenting supported employment services on members' individual service plans without evidence of an assessed need for the service.
- Create educational materials, available in the lobbies of the clinics, which describe basic information about employment and its impact on member health and welfare benefits. Explore opportunities to refocus the roles of benefit specialists who primarily assist members to determine eligibility for benefits towards an orientation that explores opportunities for individuals to earn income and reduce reliance on public assistance programs.

MULTI-EVALUATION COMPONENT ANALYSIS — SUPPORTED HOUSING

Service Description

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

Focus Groups

Key themes related to supported housing services included:

- Participants in the adult member group reported satisfaction with supported housing services. One member stated, “They helped me to achieve independent living.” Participants in the provider focus group shared that housing supports help to address issues before they escalate. In turn, this helps reduce the risk of evictions.
- Adult members shared that the move-in assistance provided by MMIC is very helpful. One member stated, “It’s working well for people who don’t have the fees and move-in deposits needed.”
- Similar to last year, case manager and adult member focus group participants shared that the expanded recruitment of housing navigators has been a positive change. Housing navigators are peers who help members to access housing start-up kits, research housing options, help members navigate through the leasing process and apply for move-in and moving assistance if needed.
- Case managers and providers expressed concern about the use of the vulnerability index used to assess priority for housing. These participants feel the tool is primarily an administrative task which does not result in accurately prioritizing members for housing, unless they are being discharged from a hospital.

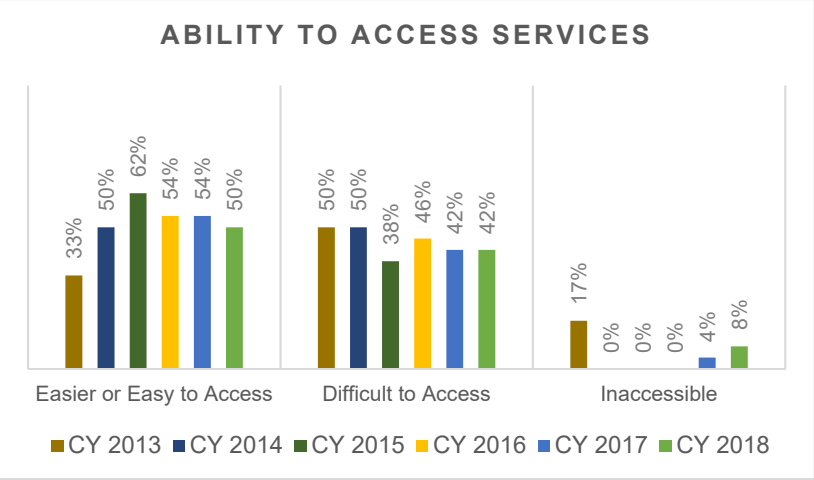
- Similar to the last three years, the insufficient capacity of available, affordable and safe housing units, including transitional housing, remains a primary concern of all focus group participants. It remains a particular challenge to locate housing for members with records of multiple evictions or prior felony convictions.
- All focus group participants expressed concerns about increasing prices in market rent which contributes to the lack of capacity. Many apartment complexes are being renovated, resulting in an increase in rent and a reduction in lease renewals. Some adult members shared that their leases recently expired and their landlords are not willing to renew them. Finding a comparable apartment in a safe neighborhood is proving to be very challenging. Vouchers are available to members, but landlords are not always willing to accept the vouchers. Additionally, case managers and adult members reported that many landlords will not rent to individuals with mental illness due to stigma.
- Case managers, family members and adult members reported that the waiting list for housing is too long. Similar to previous years, case managers expressed difficulty obtaining information about a member's status on the list.
- Similar to last year, some family members and adult members report that they do not know who to speak to about supported housing resources and are not aware of the options available to them.
- Similar to last year, participants expressed a need for additional assisted living housing that will support the needs of aging and elderly members. Additionally, participants in all focus groups shared that there is a need for assisted living for those individuals who are not able to live independently but who no longer meet criteria for residential settings. Family member and adult members expressed concerns that individuals are not assessed adequately and are not able to live independently.
- Case manager participants also reported a need to provide housing support services to individuals who are transitioning out of incarcerated settings by providing services to them prior to discharge.

Key Informant Survey Data

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

Level of Accessibility

42% of the survey respondents felt that supported housing services were difficult to access; a finding consistent with CY 2017. Two (8%) respondents indicated that supported housing services were inaccessible, a significant improvement from CY 2013 when 17% of the key informants felt that the services were inaccessible.



50% of respondents indicated that supported housing services had “fair access” or were easy to access.

Factors that Hinder Access

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

- 50% of the responses indicated that a wait list exists for the service; (25% during CY 2013; 63% during CY 2014; 59% during CY 2015; 45% during CY 2016; 28% during CY 2017);
- 43% of the responses were directed to a lack of capacity/no service provider available (31% during CY 2013; 50% during CY 2014; 38% during CY 2015; 37% during CY 2016; 22% during CY 2017); and
- 14% percent indicated that admission criteria for services were too restrictive (25% during CY 2013; 31% during CY 2014; 26% during CY 2015; 20% during CY 2016; 15% during CY 2017).

Efficient Utilization

In terms of service utilization:

- 32% of the responses indicated that the services were being utilized efficiently (10% during CY 2013; 25% during CY 2014; 31% during CY 2015; 33% during CY 2016; 26% during CY 2017);
- 23% responded that the services were utilized efficiently most of the time (30% during CY 2013; 50% during CY 2014; 38% during CY 2015; 42% during CY 2016; 52% during CY 2017); and
- 46% of the respondents indicated that supported housing services were not utilized efficiently (60% during CY 2013; 25% during CY 2014; 26% during CY 2015; 24% during CY 2016; 22% during CY 2017).

Timeliness

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

12% of the respondents indicated that the service could be **accessed on average within four to six weeks** (22% during CY 2013; 0% during CY 2014; 4% during CY 2015; 11% during CY 2016; 30% during CY 2017).

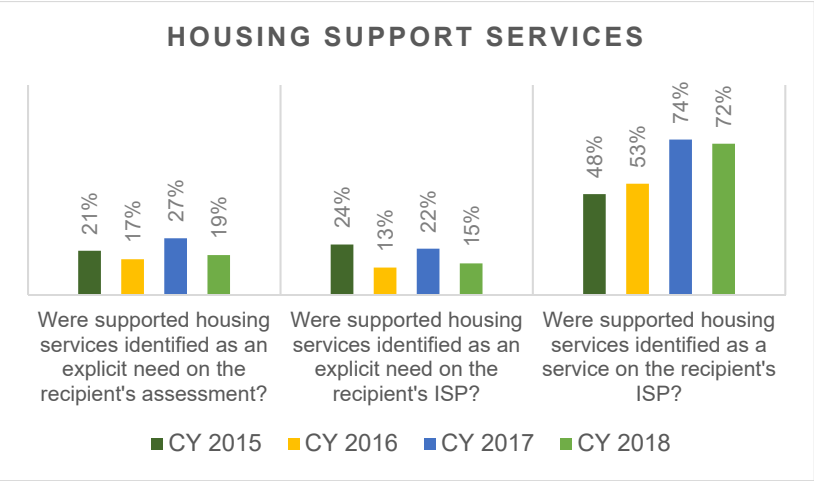
47% of the survey respondents reported that it would take an **average of six weeks or longer to access** supported housing services (67% during CY 2013; 92% during CY 2014; 78% during CY 2015; 68% during CY 2016; 50% during CY 2017).

Medical Record Review

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

- Supported housing services were identified as a need on either the recipient's assessment and/or recipient's ISP in 20% of the cases reviewed.
- Supported housing was identified as a service on the recipient's ISP in 72% of the cases when identified as a need. (slightly down from last year when 74% of the ISPs with a documented need included supported housing).

15% of the recipients included in the sample received a unit of supported housing during CY 2018.



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

In some cases, Mercer's review team noted that the clinical team assessed a need for supported housing, but the corresponding individual service plan did not include a supported housing service or intervention (n=10 cases or 26% of the cases in which there was an assessed need for supported housing).

Service Utilization Data

Permanent supported housing utilization includes skills training and development services to help members obtain and maintain community-based independent living arrangements. In addition to these services, targeted services for contracted permanent supported housing

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

As indicated within the service utilization data file, 3,868 Title XIX eligible (Medicaid) recipients were affiliated with the service during the time period of October 1, 2017 – December 31, 2018 and 278 non-Title XIX recipients received the service from a total population of 28,210 (15%)[54].

Key Findings and Recommendations

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

Findings: Supported Housing

- Service utilization data reveals that 15% of members received at least one unit of supported housing during the review period.
- Participants in the adult member group reported satisfaction with supported housing services. One member stated, “They helped me to achieve independent living.” Participants in the provider focus group shared that housing supports help to address issues before they escalate. In turn, this helps reduce the risk of evictions.
- Similar to the last three years, the insufficient capacity of available, affordable and safe housing units, including transitional housing, remains a primary concern of all focus group participants. It remains a particular challenge to locate housing for members with records of multiple evictions or prior felony convictions.

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

- 42% of the survey respondents felt that supported housing services were difficult to access; a result consistent with CY 2017. Two (8%) respondents indicated that supported housing services were inaccessible, a significant improvement from CY 2013 when 17% of the key informants felt that the services were inaccessible.

- When asked about the factors that negatively impact accessing supported housing services, 43% of the responses were directed to a lack of capacity/no service provider available (31% during CY 2013; 50% during CY 2014; 38% during CY 2015; 37% during CY 2016; 22% during CY 2017).

- Medical record review results demonstrated that 26% of cases with an assessed need for supported housing did not include an ISP intervention to address the need.

Recommendations: Supported Housing

- Promote more robust clinical supervision and oversight of case managers and other direct care clinic team members that ensures regular and timely consultation to address the ongoing supported housing needs of members. When supported housing needs are identified, prioritize service interventions to address and stabilize immediate housing needs prior to engaging the member in less urgent services (e.g., clinic-based health promotion groups).

- Assess the capacity of the system to respond to unexpected and immediate supported housing needs (e.g., transitional housing and supports) to offer critical temporary support to members transitioning from supervised clinical settings to the community.

- Consider a formal assessment to confirm the utility and applicability of the vulnerability index used to assess priority for housing.

MULTI-EVALUATION COMPONENT ANALYSIS — ASSERTIVE COMMUNITY TREATMENT

Service Description:

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

Focus Groups

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

- Adult members reported that ACT teams are very active and help members stay in the community, including accompanying members during behavioral health and physical health appointments.
- One adult member did report that his ACT team was not available after 6pm and that he was unaware of the procedure to contact the team at night and on weekends.
- Participants in the provider focus group reported that the ACT model is effective as an evidenced-based practice, but only when fidelity to the model is maintained.
- Family member participants and family mentors agreed that ACT teams would benefit from adding a family mentor to the team composition.
- Some family members reported that they are not aware of ACT team services or how to access them.
- Similar to the last two years, participants in the case manager focus group reported that criteria for ACT admissions remains unclear and reasons for non-acceptance of ACT team services are not always provided. Case managers added that a large percentage of referrals are denied and there appears to be a difference between admissions criteria set by the RBHA and those set by the individual clinics.

- Similar to last year, provider focus group participants shared that case managers do not seem to understand which members are appropriate for ACT and recommend training to support appropriate identification and referral. Additionally, provider representatives reported there is a need for community-wide education regarding ACT services and appropriateness of referrals, particularly for hospital systems.
- Similar to the last three years, participants in the provider focus group reported that not all clinics have an ACT team or an ACT team in close proximity to the clinic. ACT teams may be assigned members from all over Maricopa County which results in significant travel time in lieu of providing direct services.
- Similar to last year, participants in the case manager and provider focus groups stated that ACT teams are frequently at capacity and there is a need for more specialty ACT teams such as medical and forensic ACT teams.
- Similar to the last two years, some ACT teams are fully staffed while others experience higher attrition rates and frequent staff vacancies (particularly for peer support specialist positions).

Key Informant Survey Data

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

Level of Accessibility

24% 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) and zero respondents indicated that the service was inaccessible (18%

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

Factors that Hinder Access

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

- 57% indicated that the member declines service (20% – CY 2013; 50% – CY 2014; 41% – CY 2015; 43% – CY 2016; 32% – CY 2017).
- 43% of the responses identified clinical team unable to engage/contact member (27% during CY 2013; 32% during CY 2014; 45% – CY 2015; 41% – CY 2016; 27% – CY 2017);
- 29% selected staffing turnover (CY 2014 – 32%; CY 2015 – 41%; CY 2016 – 35%; CY 2017 – 18%).

Efficient Utilization

In terms of the efficiency of service utilization:

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

Timeliness

81% of the survey respondents reported that ACT team services could be **accessed within 30 days** of the identification of the service need (CY 2013 – 60%; CY 2014 – 58%; CY 2015 – 77%; CY 2016 – 75%; CY 2017 – 94%).

19% indicated that the service could be **accessed on average, within four to six weeks** (20% – CY 2013; 6% – CY 2014; 5% – CY 2015; 8% – CY 2016; 0% – CY 2017).

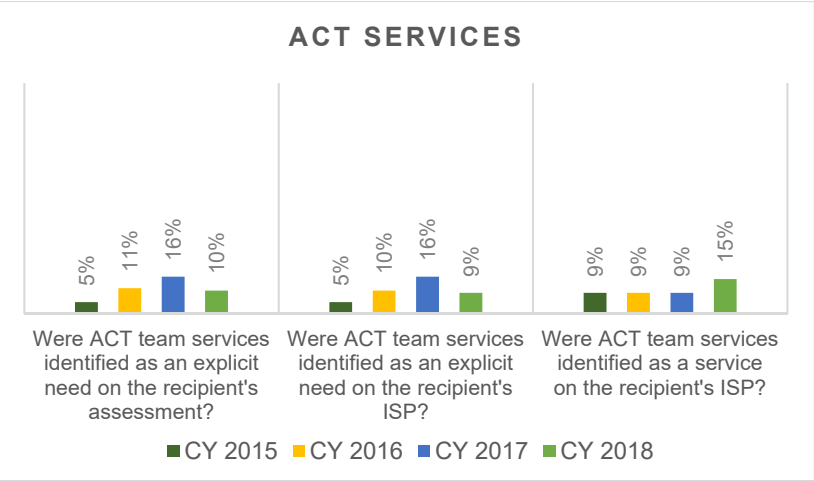
Zero respondents reported that it would take an **average of six weeks or longer to access** ACT team services (20% – CY 2013; 33% – CY 2014; 18% – CY 2015; 17% – CY 2016; 6% – CY 2017).

Medical Record Review

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

In twenty cases, ACT team services were identified as a need on recipients' assessments and/or ISPs. Three of these cases identified "ACT team services" on the ISP. In most of the remaining cases, ISPs would identify case management services as the intervention to meet an assessed need for ACT.

10% of the recipients included in the sample were assigned to an ACT team.



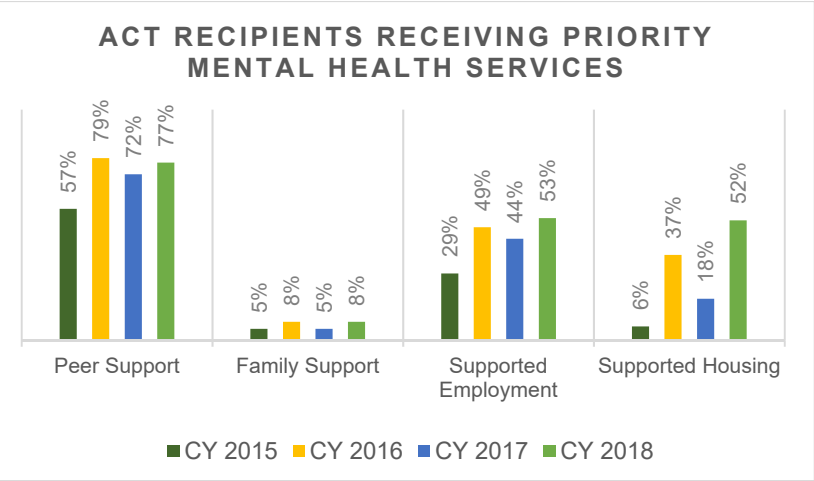
Service Utilization Data

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 2018 service utilization profiles for 2,175 ACT team members who received a behavioral health service were analyzed.

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

The analysis found that 77% of the ACT team members received peer support services during the review period. ACT recipients who received supported employment services was determined to be 53%. Utilization of supported housing services was found to be 52% across the identified ACT team members.



Key Findings and Recommendations

Findings: ACT Team Services

- As a percentage of the total SMI population, 6.5% of all members are assigned to an ACT team. This is a similar finding observed during CY 2015, CY 2016, and CY 2017.

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

- 24% 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) and zero respondents indicated that the service was inaccessible (18% perceived the services inaccessible during CY 2013). 81% of the survey respondents reported that ACT team services could be

accessed within 30 days of the identification of the service need (CY 2013 – 60%; CY 2014 – 58%; CY 2015 – 77%; CY 2016 – 75%; CY 2017 – 94%).

- An analysis of service utilization data found that 77% of the ACT team members received peer support services during the review period. ACT recipients who received supported employment services was determined to be 53%. Utilization of supported housing services was found to be 52% across the identified ACT team members.

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

- A review of 100 SMI members that represent the highest aggregate behavioral health service costs during CY 2018 was conducted. It was determined that 29% 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 and 26% during CY 2017. Of the 29 members assigned to ACT and included on the list of the top 100 members with the highest behavioral health service costs; 17 (59%) also resided in supervised behavioral health residential settings. During times of transition (admission or discharge from ACT team services), it may be appropriate to temporarily have a member assigned to ACT and placed in a supervised setting, but this should be time-limited due to the duplicative nature of the services. Overall, 46 of the 100 (46%) members resided in a supervised behavioral health residential setting, which may contribute to higher service costs for those members and may discourage clinical teams from considering or referring a member to an ACT team. If members placed in a supervised behavioral health residential setting (and not currently assigned to an ACT team) are excluded from the analysis, then 42% of the highest cost utilizers are assigned to an ACT team.

- An analysis of jail booking data was completed to identify members that have had multiple jail bookings over a defined period (i.e., eleven months—January 2018 through November 2018) and determine if the member was subsequently referred and assigned to an ACT team, including one of the three forensic specialty ACT teams. The analysis found:

- 426 members experienced at least two jail bookings during the period under review (391 for same time period in CY 2017; 467 for same time period in CY 2016; 408 for same time period in CY 2015).
- Of these 426 members, 93 (22%) were assigned to an ACT team (CY 2017 – 16%; CY 2016 – 25%; CY 2015 – 23%) during the review period.
- Of the 93 members assigned to an ACT team, 26 (28%) are assigned to a forensic specialty ACT team (CY 2017 – 29%; CY 2016 – 22%; CY 2015 – 20%).
- 29 members receiving ACT team services have three or more incarcerations over the review period, but are not assigned to one of the three available forensic specialty ACT teams.

Recommendations: ACT Team Services

- Continue efforts to actively facilitate the identification of appropriate candidates for ACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns and adverse incidents involving SMI recipients.
- Consider expanding referral sources that can identify and recommend members to forensic ACT teams and utilize available data to inform decision making. For example, utilize cost and criminal justice recidivism data to identify potential candidates for these specialty ACT teams.
- As part of the annual assessment update, intentionally review the member's assigned level of case management (i.e., connective, supportive, ACT) and determine if the member is assigned to the appropriate level of case management. As part of the annual assessment update, document that this review occurred.

- Clinical teams should regularly evaluate opportunities for current ACT team members to step down to a lower level of care as clinically appropriate and document when these reviews occur as part of the member's medical record.
- Establish triggers (e.g., length of stay) that would necessitate a review of the ongoing appropriateness of ACT team services and determine if a member could be transitioned to a less intensive level of case management.
- Provide education to system stakeholders (e.g., direct care clinic staff, providers, referral sources) regarding the ACT team admission criteria to help ensure appropriate identification and referral of ACT team candidates.

Outcomes Data Analysis

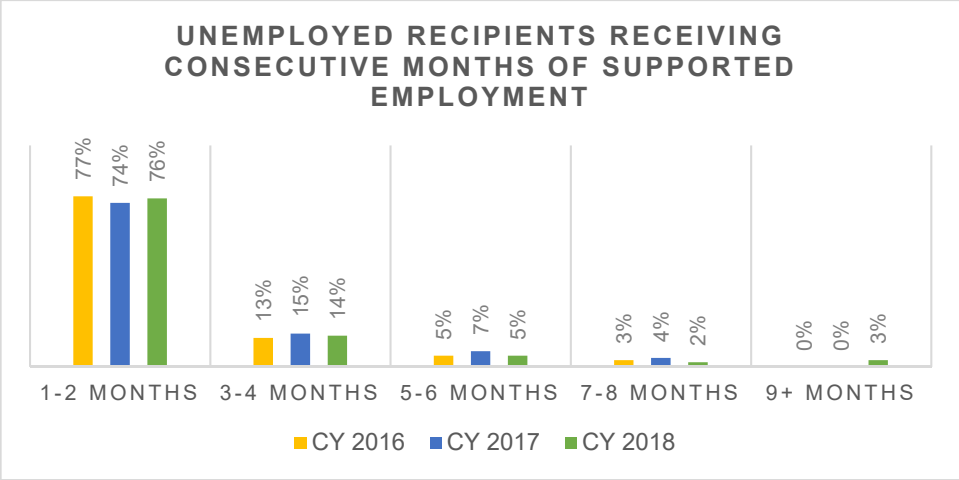
The service capacity assessment included an analysis of recipient outcome data in an attempt to link receipt of one or more of the priority mental health services with improved functional outcomes. The relationships between outcomes and service utilization trends may be identified, but those relationships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

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

During CY 2018, an analysis was completed that compared recipients' persistence with receiving supported employment services and peer support services for each of the outcome indicators selected. Overall, there are strong relationships between receipt of the priority services and improved outcomes related to incarcerations, living situation and employment status. The relationship is further strengthened when the recipient sustains consistent participation in the priority service over an extended period of time.

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

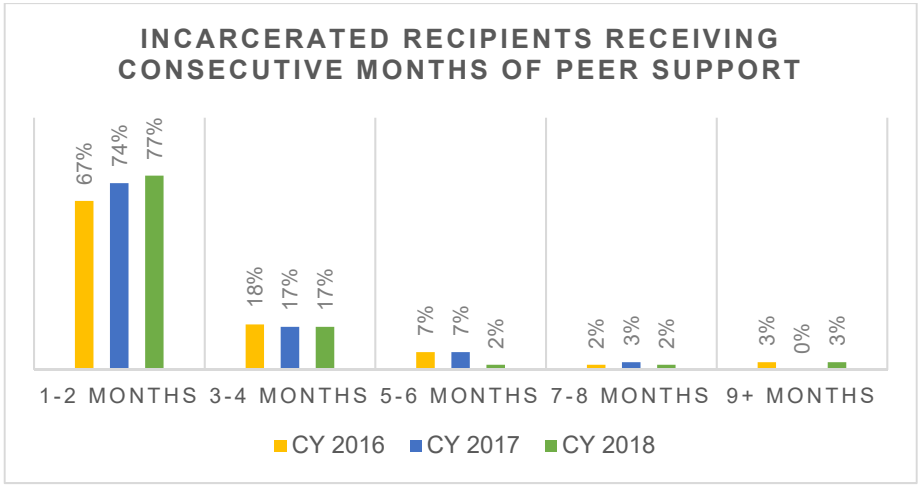
- Similar to CY 2017 results, the percentage of recipients identified as unemployed decreases as the duration with supported employment services increases. 76% of recipients identified as unemployed are associated with two or less consecutive months of supported employment services. Alternatively, recipients who experienced five or more consecutive months of supported employment services constituted only 10% of the total unemployed group.



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

- Of the group of recipients who were incarcerated during the review period, only 2% received seven to eight consecutive months of peer support services. 77% of recipients who had experienced an incarceration received peer support services during a single month or during two consecutive months during the review period.

- Nearly half (47%) of members noted to be homeless or residing in a boarding home, crisis shelter, hotel, or behavioral health treatment setting received peer support services during the review period.
- Longer periods of consecutive peer support services are also associated with lower unemployment rates. 72% of the recipients identified as unemployed received one or two months of peer support services; the percentage of unemployed recipients who received peer support services for seven or eight consecutive months was determined to be 3%.



APPENDIX A

FOCUS GROUP INVITATION

MERCER
MAKE TOMORROW, TODAY

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

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

Focus groups will be held at the following location:
The Burton Barr Library
1221 N. Central Ave, Phoenix, AZ 85004

Stakeholder Group One	Stakeholder Group Two
Adults receiving at least one SMI Priority Mental Health Service **Tuesday, January 29, 2019** **10:00 am–12:00 pm** **Meeting Room B (First Floor)**	*Direct Care Clinic Case Managers* involved in providing Priority Mental Health Services to Adults with SMI **Tuesday, January 29, 2019** **2:00 pm–4:00 pm** **Meeting Room A (First Floor)**
Stakeholder Group Three	**Stakeholder Group Four**
Providers of ACT, SH, SE, Peer and Family Support Services to adults receiving SMI Priority Mental Health Services **Wednesday, January 30, 2019** **2:00 pm–4:00 pm**	*Family Members of Adults with SMI* Receiving at least one Priority Mental Health Service **Wednesday, January 30, 2019** **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 Wednesday, January 23, 2019 to Laura Henry at laura.henry@mercer.com or 602-522-8556.

MARSH & McLENNAN COMPANIES

APPENDIX B

KEY INFORMANT SURVEY

Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2019

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

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

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

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

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

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

If you checked other above (please specify)

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

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

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

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

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

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

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

* 8. What is your job role/title?

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

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

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

APPENDIX C

GROUP 2 — MEDICAL RECORD REVIEW TOOL

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

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

APPENDIX D

SUMMARY OF RECOMMENDATIONS

Service	Recommendations
Peer Support Services (PSS)	PSS 1: Consider performing a peer support workforce assessment that analyzes access to flexible working hours, availability of workplace supports, and a review of the competitiveness of pay rates.
Family Support Services (FSS)	FSS 1: Ensure through training and ongoing supervision that direct care clinical team members, including case managers and clinical supervisors, understand the appropriate application of covered behavioral health services, including family support. FSS 2: Provide additional training and supervision to recognize the value of family support services as effective service plan intervention.

Service	Recommendations
Supported Employment Services (SES)	SES 1: Through training and supervision, ensure that clinical team members understand the appropriate application of covered services designed to meet a person's objective and goal of securing and/or maintaining employment. SES 2: Track employment tenure and assess if the presence of ongoing support to maintain employment influenced the duration of members' employment episodes. Leverage these trended data to establish predictive algorithms that may help identify the most appropriate candidates to target for the provision of ongoing support to maintain employment. SES 3: Establish regular monitoring and performance improvement activities to address instances in which the clinical team identifies supported employment services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services. SES 4: Monitor (and take actions as appropriate) the observed practice of indiscriminately documenting supported employment services on members' individual service plans without evidence of an assessed need for the service. SES 5: Create educational materials, available in the lobbies of the clinics, which describe basic information about employment and its impact on member health and welfare benefits. Explore opportunities to refocus the roles of benefit specialists who primarily assist members to determine eligibility for benefits towards an orientation that explores opportunities for individuals to earn income and reduce reliance on public assistance programs.

Service	Recommendations
Supported Housing Services (SHS)	SHS: 1 Promote more robust clinical supervision and oversight of case managers and other direct care clinic team members that ensures regular and timely consultation to address the ongoing supported housing needs of members. When supported housing needs are identified, prioritize service interventions to address and stabilize immediate housing needs prior to engaging the member in less urgent services (e.g., clinic-based health promotion groups). SHS 2: Assess the capacity of the system to respond to unexpected and immediate supported housing needs (e.g., transitional housing and supports) to offer critical temporary support to members transitioning from supervised clinical settings to the community. SHS 3: Consider a formal assessment to confirm the utility and applicability of the vulnerability index used to assess priority for housing.

Service	Recommendations
Assertive Community Treatment (ACT)	ACT 1: Continue efforts to actively facilitate the identification of appropriate candidates for ACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns and adverse incidents involving SMI recipients. ACT 2: Consider expanding referral sources that can identify and recommend members to forensic ACT teams and utilize available data to inform decision making. For example, utilize cost and criminal justice recidivism data to identify potential candidates for these specialty ACT teams. ACT 3: As part of the annual assessment update, intentionally review the member's assigned level of case management (i.e., connective, supportive, ACT) and determine if the member is assigned to the appropriate level of case management. As part of the annual assessment update, document that this review occurred. ACT 4: 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 5: Establish triggers (e.g., length of stay) that would necessitate a review of the ongoing appropriateness of ACT team services and determine if a member could be transitioned to a less intensive level of case management. ACT 6: Provide education to system stakeholders (e.g., direct care clinic staff, providers, referral sources) regarding the ACT team admission criteria to help ensure appropriate identification and referral of ACT team candidates.

Service	Recommendations
General Recommendations	GR 1: Continue efforts to ensure that annual assessment updates and ISPs are current for all active members. GR 2: Consider initiating all identified service referrals at the time that the individual service plan is reviewed, endorsed and signed by the member. This practice will help ensure that all relevant services on the ISP are timely referred in coordination with the development of the individual's service plan.

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