Mercer

Government Human Services Consulting

Service Capacity Assessment 2024

Priority Mental Health Services

Arizona Health Care Cost Containment System

July 31, 2024

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Contents

Section 1

Executive Summary

The Arizona Health Care Cost Containment System, Arizona's Medicaid Agency (hereafter referred to as Arizona or State), engaged Mercer Government Human Services Consulting (Mercer) to implement a network sufficiency evaluation of four prioritized mental health services available to persons living with a serious mental illness (SMI) in Maricopa County, Arizona. This report represents the eleventh in a series of annual service capacity assessments.

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

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

Overview of Findings and Recommendations

See Table 1 for a service utilization summary of the priority mental health services during the review period. The current review period primarily targets calendar year (CY) 2023, although for some units of analysis that rely on service utilization data, the timeframe was adjusted to account for potential lags in processing administrative claims data.

Service Capacity Assessment Conclusions

Mercer's service capacity assessment found decreases in the percentage of members using the priority mental health services during CY 2023 when compared to CY 2022 and CY 2021 as depicted in the following tables. Some of percentage reductions may be attributed to an increase of almost 2,000 members between CY 2023 and CY 2022. As such, caution should be applied when comparing year-to-year results.

Table 1 — Summary of Priority Mental Health Services Utilization, CY[1] 2023, CY 2022, and CY 2021

CY 2023 Service Capacity Assessment Time Period — Utilization

Data Source	Number of Recipients	Peer Support		Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	39,046	29%		3%	26%	14%	5.3%[2]

CY 2022 Service Capacity Assessment Time Period — Utilization

Data Source	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	37,107	31%	3%	30%	17%	5.7%

[1] Calendar year (CY) referenced in this context refers to the time period October 1, 2022 through December 31, 2023.

[2] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 5.3% of all active SMI recipients are assigned to ACT teams.

CY 2021 Service Capacity Assessment Time Period — Utilization

Data Source	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	36,718	37%	4%	32%	22%	6.2%

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

Consumer-Operated Services (Peer Support and Family Support)

Twenty-nine percent (29%) of all members living with a SMI received at least one unit of peer support during the period of October 1, 2022 through December 31, 2023; a decrease from the prior review period, in which 31% of members received peer support services. Peer support specialists are available within the health home clinics, through multi-disciplinary teams providing ACT team services, via participation in an expansive array of clinic-based education and support groups, and/or within the community by attending available consumer-operated peer support programs.

Service utilization data demonstrates that 3% of members received at least one unit of family support services during 2023; the same finding as last year. There appears to be an opportunity to educate members, family members, and health home clinical teams about the availability and benefit of family support services. Some case manager representatives were able to describe the role of a family support specialist, but others could not describe how to identify when the service may be beneficial to a member. Most case managers reported they receive a general overview of the service when first hired but no other formal training on how to engage with natural supports and facilitate assess to the service.

Supported Employment

Service utilization data demonstrates 26% of members received at least one unit of supported employment during CY 2023, a decrease of 4% from last year, continuing a trend of year-to-year decreases in utilization. 1,445 fewer members received supported employment when comparing CY 2023 to CY 2021. However, there were an additional 160,654 units of the service delivered during this same period.

Most case managers and provider participants shared positive feedback regarding co-located employment providers who are active at the clinics. Some providers would like more time at the clinics, an increase in dedicated and allocated space to conduct work, and additional opportunities for further collaboration with the clinical teams.

The review team noted inconsistencies across the integrated health homes regarding listing supported employment services on members' ISPs to reflect a one-time annual vocational activity profile (VAP) through the health home's assigned rehabilitation specialist (this activity is typically identified as "pre-job development and training" and commonly includes pre-job development and ongoing support to maintain employment billing codes). Some health homes include this intervention on virtually all ISPs; other clinics do not necessarily follow this approach. The contracted managed care organization has promulgated expectations to the health homes that an assessment of vocational interests and capabilities occur during the member's annual assessment update and ISP development process. Several cases in the medical record review sample did not include evidence that the member received a VAP after the clinical team identified the activity as an intervention on the member's ISP. The contracted managed care organization does not currently monitor or track the completion of annual vocational-related assessments.

Supportive Housing

Service utilization data reveals that 14% of members received at least one unit of supportive housing during the review period, a decrease when compared to the last two years. Over 2,500 (2,546) less members received supportive housing between CY 2021 and CY 2023. There was a 31.5% reduction in the number supportive housing units during this same period.

Sixty percent (60%) of the survey respondents reported that it would take an average of six weeks or longer to access supportive housing services (63% in CY 2022). When asked about the factors that negatively impact accessing supportive housing services, the most predominant responses include:

- Wait list exists for services (21 responses)
- Lack of capacity/no service provider available (18 responses)
- Staffing turnover (12 responses)

Provider and adult member focus group participants shared that there are not enough step-down or transitional housing options for members who need to move gradually to more independent settings. Adult and family members cited a particular need for those members being discharged from hospitals. For some family members, their adult children have become homeless following hospitalizations due to the lack of step-down options.

Assertive Community Treatment

As a percentage of the total population with SMI, 5.3% of all members are assigned to an ACT team. There are 57 fewer members assigned to an ACT team when comparing CY 2023 to CY 2022. There has been a reduction of 262 ACT team members between CY 2021 and CY 2023, a 12.7% decrease.

In the provider focus group, ACT team staff members demonstrated passion and commitment to the members on their teams. They described ACT as a “great program when members are appropriately referred” and “so beneficial when the members want to be there.”

ACT team providers and case managers shared that turnover remains high among ACT staff. Case managers stated that ACT specialties are not practiced due to the turnover rates. Providers from peer-run organizations noted that they have not encountered a peer support specialist on an ACT team, that they have a difficult time engaging with ACT teams about their members, and it is “rare” to get a call back.

General Findings and Recommendations

Mercer also noted additional findings and recommendations to improve the appropriate identification and, when indicated, the provision of the priority mental health services members who may benefit from the services. Opportunities identified this year include:

- Perform an assessment of the workflows at the integrated health homes that focuses on the implementation of members’ ISP interventions, with the goal of ensuring that clinical teams initiate timely referrals for needed services. Health home progress note templates may restate ISP objectives and goals, but there continues to be multiple examples of clinical teams failing to get recommended ISP services in place on behalf of members.
- Continue efforts to monitor the timely completion of annual member assessments and ISPs. When compiling the sample for medical record reviews, 14% of the cases (from a sample of 200) did not include current assessments or ISPs.
- Ensure that new employee orientation materials and ongoing training curricula for health home clinical team members (including case managers and clinical supervisors) address the appropriate application of the priority mental health services and how to assist members with accessing the services when medically necessary.
- Continue efforts to address workforce challenges, including the recruitment and retention of peer support specialists, family mentors, and case managers across the system of care.

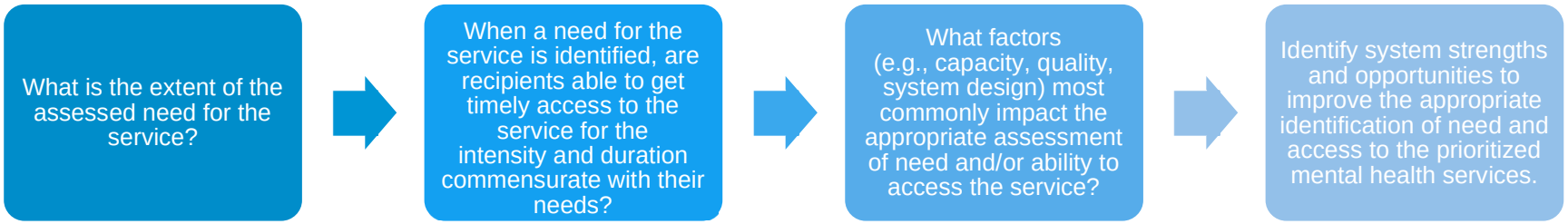
Additional and more detailed findings and recommendations for each of the priority services can be found in *Section 5, Findings and Recommendations.*

Section 2
Overview

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

Goals and Objectives of Analyses

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



Limitations and Conditions

Mercer did not independently verify the accuracy and completeness of service utilization data, outcomes data, and other primary source information collected from AHCCCS and AHCCCS' contracted managed care organization. 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

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

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.

Section 3
Background

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

History of Arnold v. Sarn

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

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

On January 8, 2014, a final agreement was reached in the Arnold v. Sarn case. The final settlement extends access to community-based services and programs agreed upon by the State and plaintiffs, including crisis services, supported employment and supportive 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 persons with SMI.

Service Delivery System

AHCCCS contracts with managed care organizations to deliver integrated physical health and behavioral health services in three geographic service areas (GSAs) across Arizona. Each contractor (also known as a managed care contractor) must manage a network of providers to deliver all covered physical health and behavioral health services to Medicaid-eligible persons determined to

have a SMI. The managed care organizations contract with behavioral health providers to provide the full array of covered physical health and behavioral health services, including the prioritized mental health services that are the focus of this assessment. In addition to Medicaid-eligible members, system administrators must 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 persons living with a SMI.

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

Table 2 — Maricopa County Health Homes

Provider	Health Home	Provider	Health Home
Alium	Ironwood	**Intensive Treatment Systems**	West Clinic Access Point
		Lifewell Behavioral Wellness	Desert Cove
Chicano Por La Causa	Centro Esperanza		Oak
Community 43	16th Street		South Mountain
Community Bridges, Inc.	Mesa Heritage		Windsor
Community Partners Integrated Healthcare, Inc.	Osborn		
Copa Health	Arrowhead Campus	**Resilient Health**	Higley
	East Valley Campus		1st Street
	Gateway Campus	**Southwest Behavioral and Health Services**	Buckeye Outpatient
	Hassayampa Campus		
	Metro Campus	**Southwest Network**	Estrella Vista
	West Valley Campus		Northern Star
			Saguaro

Provider	Health Home	Provider	Health Home
			San Tan
Horizon Health and Wellness	Plaza	**Spectrum**	Anywhere Care
Jewish Family and Children Services	Queen Creek		
	Michael R. Zent Healthcare Clinic	**Terros**	Priest 23rd Avenue 51st Avenue
	East Valley Health Center		
La Frontera/EMPACT	Apache Junction		
	Comunidad		
	San Tan		
	Tempe		
Valleywise	First Episode Center	**Valle Del Sol**	Red Mountain
	Mesa Behavioral Health Specialty Clinic		

Section 4

Service Capacity

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

Table 3: Consumer-Operated Services (Peer Support and Family Support)

Number of Unique Providers	Number of Provider Locations	Contracted Capacity
32	68	2,815

Table 4: Supported Employment

Number of Unique Providers	Number of Provider Locations	Co-Located Health Homes	Contracted Capacity
7	30	18	770

Table 5: Supportive Housing (Scattered Site and Community-Based Permanent Supportive Housing)

Number of Unique Providers	Number of Provider Locations	Contracted Capacity
11	11	1,025

Table 5a: Supportive Housing (Temporary Housing Assistance Program)

Number of Unique Providers	Number of Provider Locations	Contracted Capacity
2	2	300

[4] As reported by the Maricopa County Regional Behavioral Health Authority administering the AHCCCS contract in December 2023. Additional capacity exists across the system of care for most of the prioritized mental health services and is not reflected as contracted capacity.

Table 6: ACT Teams (23 teams serving 2,060 recipients)[5]

Health Home Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Community Bridges: 99th Avenue	Primary care provider (PCP) partnership	100	78	22%
Community Bridges: Avondale	PCP partnership	100	86	14%
Community Bridges: Forensic Assertive Community Treatment (FACT) Team 1	Forensic team and PCP partnership	100	83	17%
Community Bridges: FACT Team 2	Forensic team and PCP partnership	100	74	26%
Community Bridges: Mesa Heritage	PCP partnership	100	86	14%
La Frontera/EMPACT: Tempe	PCP partnership	100	80	20%
La Frontera/EMPACT: Capitol Center	PCP partnership	100	92	8%
La Frontera/EMPACT: Comunidad	PCP partnership	100	86	14%
Lifewell Behavioral Wellness: Desert Cove	PCP partnership	100	89	11%
Lifewell Behavioral Wellness: South Mountain	PCP partnership	100	93	7%
Copa Health: Gateway	PCP partnership	100	87	13%
Copa Health: Metro Campus — Omega Team	PCP partnership	100	95	5%
Copa Health: Metro Campus — Varsity Team	PCP partnership	100	92	8%
Copa Health: West Valley	Medical team	100	94	6%
Copa Health: West Valley Campus	PCP partnership	100	92	8%
Southwest Network: Northern Star	PCP partnership	100	100	0%

[5] As of December 1, 2023.

Health Home Clinic	Specialty	Capacity	Number of Recipients	% Below Full Capacity
Southwest Network: Saguaro	PCP partnership	100	91	9%
Southwest Network: San Tan	PCP partnership	100	92	8%
Terros: 51st Avenue	PCP partnership	100	92	8%
Terros: Priest		100	92	8%
Terros: 23rd Avenue Recovery Center ACT 1 (Formerly Townley 1)	PCP partnership	100	99	1%
Terros: 23rd Avenue Recovery Center ACT 2 (Formerly Townley 2)		100	93	7%
Valleywise: Mesa Riverview	PCP partnership	100	94	6%
Totals		**2,300**	**2,060**	**10.5%**

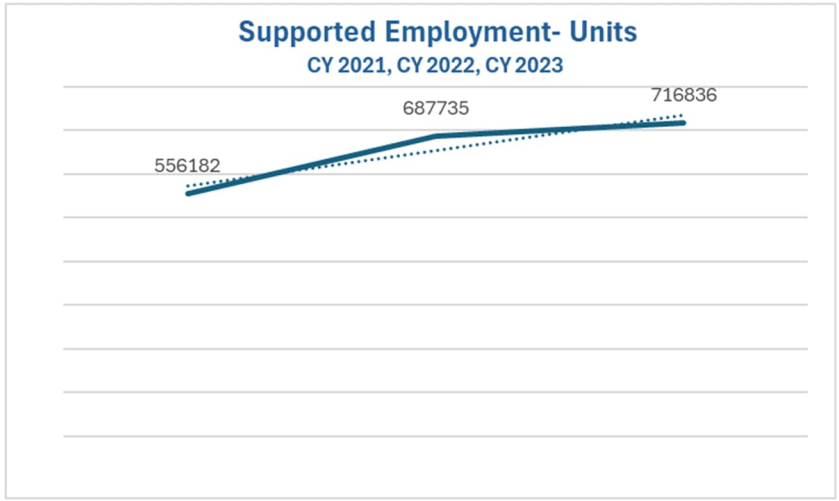
Service Utilization

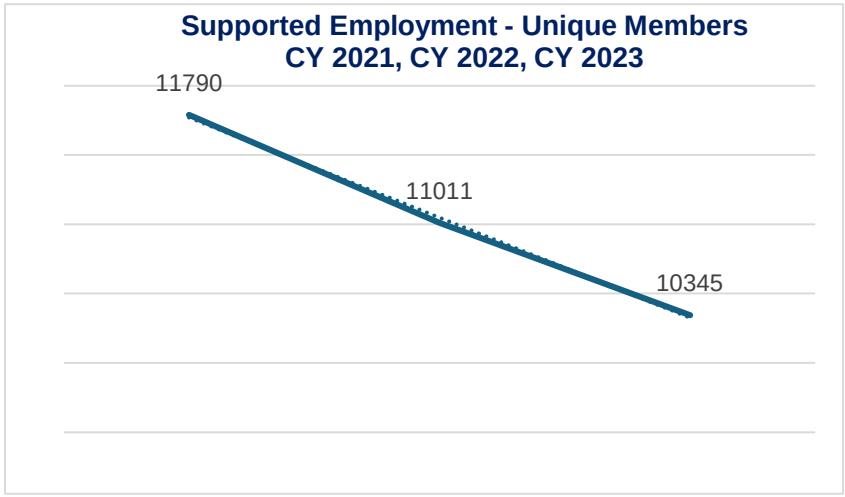
Service utilization data is presented below to identify the volume of units and unique members affiliated with each priority mental health service over the most recent three years.

Table 7: Supported Employment

CY 2023		CY 2022		CY 2021	
Members	**Units**	**Members**	**Units**	**Members**	**Units**
10,345	716,836	11,011	687,735	11,790	556,182

CY = calendar year

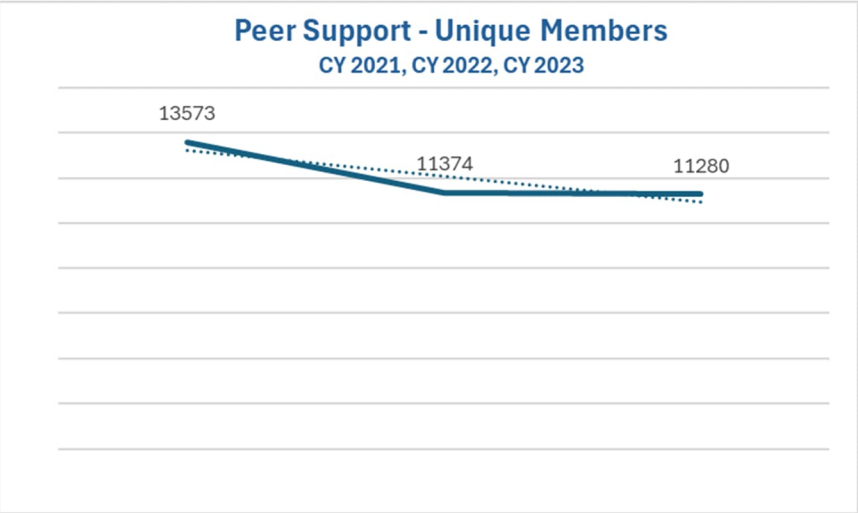


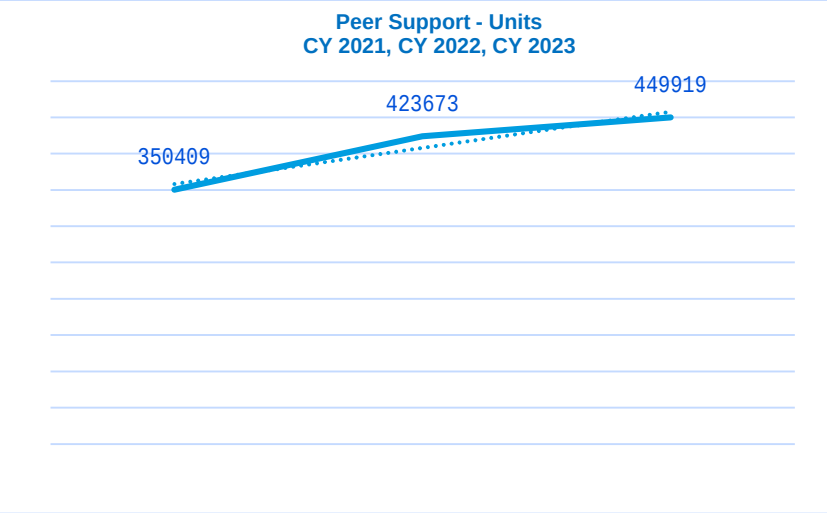


1,445 fewer members received supported employment when comparing CY 2023 to CY 2021. However, there were an additional 160,654 units of the service delivered during this same period.

Table 8: Peer Support

CY 2023		CY 2022		CY 2021	
Members	Units	Members	Units	Members	Units
11,280	449,919	11,374	423,673	13,573	350,409

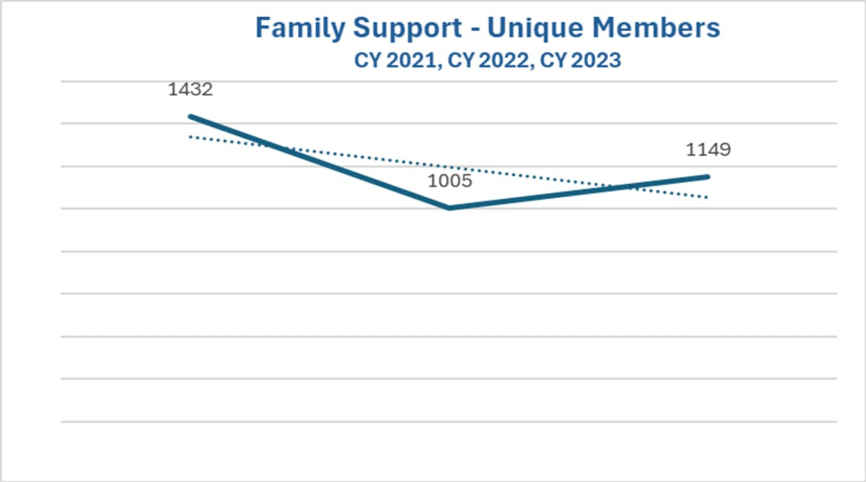


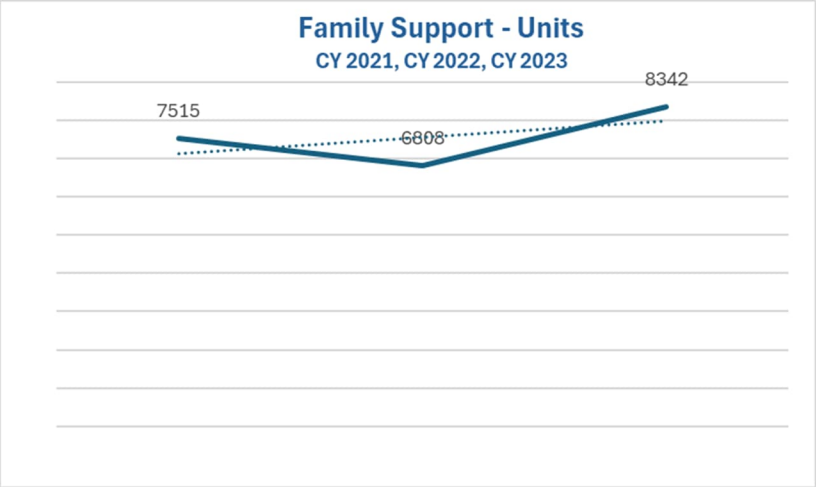


Almost 100,000 (99,510) more units of peer support were delivered in CY 2023 when compared to CY 2021. However, 2,293 less members received peer support during this same period.

Table 9: Family Support

CY 2023		CY 2022		CY 2021	
Members	Units	Members	Units	Members	Units
1,149	8,342	1,005	6,808	1,432	7,515

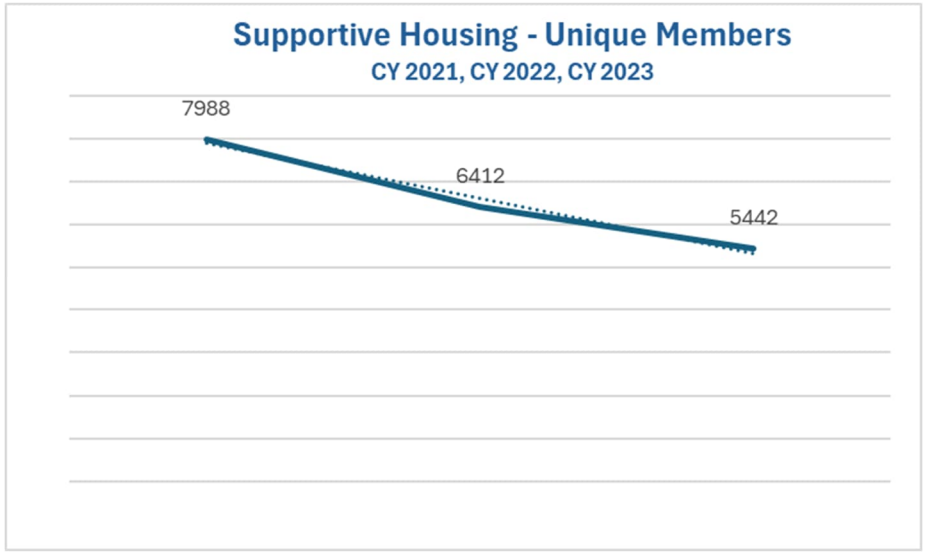


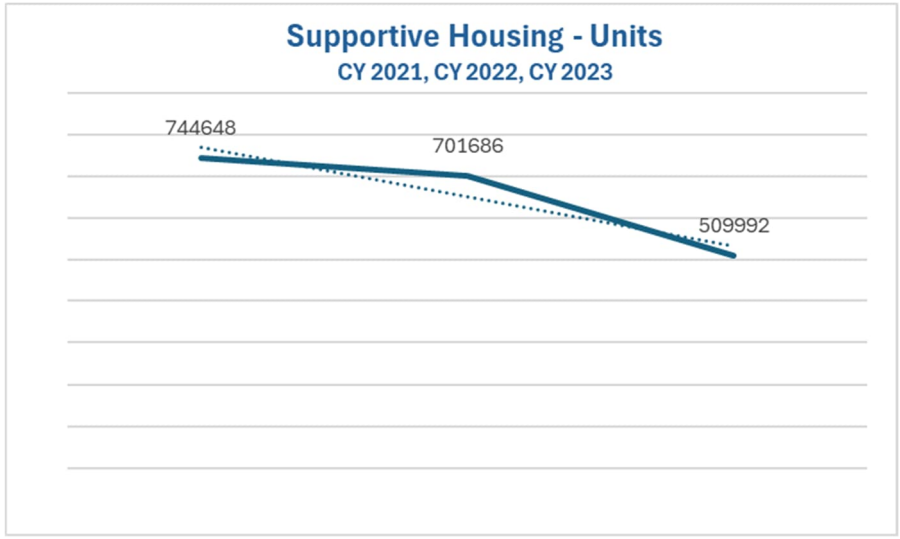


144 more members received family support services during CY 2023 when compared to CY 2022. There was almost a 10% increase in the number of family support units between CY 2023 and CY 2021.

Table 10: Supportive Housing[6]

CY 2023		CY 2022		CY 2021	
Members	Units	Members	Units	Members	Units
5,442	509,992	6,412	701,686	7,988	744,648



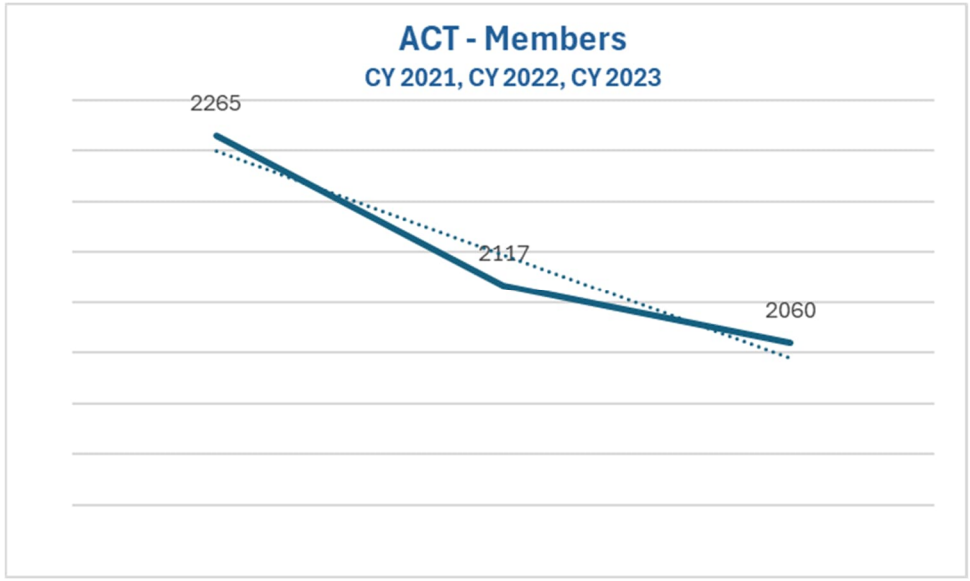


Over 2,500 (2,546) fewer members received supportive housing between CY 2021 and CY 2023. There was a 31.5% reduction in the number supportive housing units during this same period.

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

Table 11: ACT Services

CY 2023	CY 2022	CY 2021
Members	Members	Members
2,060	2,117	2,265



There are 57 fewer members assigned to an ACT team when comparing CY 2023 to CY 2022. There has been a reduction of 262 ACT team members between CY 2021 and CY 2023, which is a 12.7% decrease.

Methodology

Mercer uses the following methods to perform a service capacity assessment of the priority mental health services:

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

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

Focus Groups

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

Participation in the focus groups was solicited by an invitation created by Mercer, which was reviewed and approved by AHCCCS.[7]

Notification of the annual service capacity assessment focus groups was communicated to key stakeholders in the community. This included email communications and electronic invitations sent to the administrative entities, providers of the priority mental health services, and to family and peer-run organizations. Mercer distributed the invitation multiple times to each set of key stakeholders to increase participant registration rates.

The focus groups targeted the following participants:

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

A total of 31 stakeholders participated in the four two-hour focus groups conducted on January 30, 2024, and January 31, 2024. All four focus groups were held in-person at the Burton Barr Library in Central Phoenix, Arizona. Invitations to voluntarily participate in the focus groups were distributed to a defined list of stakeholders, and the actual number of participants does not represent a statistically significant sample. As such, focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants.

The methodology included the following approach:

- Definitions of each of the priority mental health services were communicated to each group of participants at the onset of the focus groups.
- Participants were prompted to discuss experiences related to accessing each of the priority services, including perceived system strengths and barriers.

[7] See Appendix A: Focus Group Invitation.

- 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. To meet this objective, a key informant survey was created using Qualtrics®. The survey tool includes questions with rating assignments related to accessing the priority mental health services, including the ease of access and timeliness of access to the services.[8]

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

The survey was disseminated to key system stakeholders (e.g., service providers, administrators of health homes, etc.) via email, with a hyperlink to the online survey. A total of 33 respondents completed the survey tool.

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

Medical Record Reviews

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

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

- The recipient was identified with a SMI and received a covered behavioral health service during October 1, 2022 and December 31, 2023.

[8] See Appendix B: Key Informant Survey.

- The recipient had an assessment and ISP date between January 1, 2023 and November 15, 2023.[9]

The medical record review seeks 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?
- 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. Accessing current assessments and ISPs has been a longstanding challenge in performing medical record reviews, as the audit methodology requires access to an assessment and ISP within the designated review period. During CY 2023, 14% of the initially requested cases did not include current assessments and/or ISPs.

Three licensed behavioral health professionals review medical record documentation and record results in a data collection tool to complete the medical record audit. As applicable, additional comments may be added to the tool to clarify scoring and findings. Reviewer training, inter-rater reliability testing, and scoring guidelines help to ensure that each reviewer consistently applies the review tool.

Analysis of Service Utilization Data

Mercer initiated a request to AHCCCS for a comprehensive service utilization data file. The service utilization data file includes all adjudicated service encounters for any person designated as SMI and assigned to the Maricopa County GSA, with dates of service between October 1, 2022 and December 31, 2023.

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

Specific queries identify the utilization of each prioritized mental health service. The analysis evaluates the volume of unique users, billing units, and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, Mercer performs an analysis of recipients who sustained consistent participation in each of the prioritized services, including recipients who only received the service in a single month versus those who continued participation in the service over consecutive months (i.e., two to three months, three to four months, five to six months, seven to eight months, and nine months).

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

The service utilization data file supports the medical record review sample extraction. It also allows for an analysis of the service utilization profile for each selected recipient and supports an aggregated view of service utilization for the sample group.

Sample characteristics for CY 2021–CY 2023 of the service capacity assessment are illustrated in the following tables and are compared to the characteristics of the total population of active users.

CY 2023 Service Capacity Assessment Time Period — Utilization

	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample Group	200	37%	1%	27%	22%	7%
Service Utilization Data	39,046	29%	3%	26%	14%	5.3%[10]

CY 2022 Service Capacity Assessment Time Period — Utilization

	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample Group	200	37%	4%	46%	26%	8%
Service Utilization Data	37,107	31%	3%	30%	17%	5.7%[11]

[10] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 5.3% of all active SMI recipients are assigned to ACT teams.

[11] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 5.7% of all active recipients with SMI are assigned to ACT teams.

CY 2021 Service Capacity Assessment Time Period — Utilization

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

Analysis of Outcomes Data

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

- Employment data
- Criminal justice involvement
- Grievance data
- Emergency room utilization

Penetration and Prevalence Analysis

As part of the service capacity assessment, a review of utilization and penetration rates of the prioritized mental health services (ACT, supported employment, supportive housing, and peer support[12]) was conducted. Penetration rates were compared to benchmarks, as described below.

The following review process was completed by Mercer:

- Review of select academic publications
- Consultation with national experts regarding the prioritized services and benchmarks for numbers served

[12] Peer support services are not currently reported on the Substance Abuse and Mental Health Services Administration's National Outcome Measures (NOMS) interview tool.

- Review of data from the Substance Abuse and Mental Health Services Administration on evidence-based practice (EBP) penetration rates at the state and national level

The intent in reviewing these sources was to identify average and best practice benchmarks for EBP penetration. *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 in a study.

Please note that data for Maricopa County included in this report generally covers CY 2022. Although Mercer uses the most recently available data it has for comparison (including CY 2023), some of the comparison states and communities have not updated their publicly available data sets since 2020 because of the public health emergency.

Section 5

Findings and Recommendations

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

The service capacity assessment includes the following distinct evaluation components:

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

Serious Mental Illness Prevalence and Penetration — Overview of Findings

Service system penetration represents the percentage of people who received services among the estimated number of people considered eligible for services during a specified period. As detailed in Table 12, the publicly funded system served 24% of the estimated adults living with SMI in Maricopa County in 2023. This penetration rate is lower than the national (publicly funded) penetration rate of 28%; however, it is higher than some statewide rates and is comparable to rates of communities of a similar size. Within the Maricopa County Medicaid system, the penetration rate (36%) exceeds the national average (28%) and the rates of similarly sized regions in Texas (i.e., Harris County [Houston] and Bexar County [San Antonio], which both have penetration rates of 28%). Thus, Maricopa County's lower overall penetration rate appears to result from the low penetration rate among people without Medicaid coverage (7%). During the COVID-19 public health emergency, many states (including Arizona) expanded their Medicaid-eligible populations.

The Maricopa County system's utilization rates excel for certain EBPs. For example, supportive housing and supported employment are more available in Maricopa County (especially for Medicaid recipients) than for people living with SMI nationally. Maricopa County also provides access to peer support services in what could be considered a best practice benchmark. In addition, Maricopa County provides ACT to a more significant percentage of the eligible population than most comparison communities included in this analysis. In Maricopa County, ACT teams serve 2,060 individuals as of December 1, 2023. A study by ACT researchers estimated that 4.3% of adults with SMI served in a mental health system need an ACT level of care. [13] Few of the identified comparison communities provide ACT to 4.3% or more of their adults living with SMI, but 5.3% of adults with SMI residing in Maricopa County received ACT in 2023. However, because many people receiving ACT-level of care in Maricopa County receive it from a forensic ACT team (FACT), 5.3% does not represent an over-use of ACT.

Maricopa County has 23 ACT teams[14], including specialty ACT teams that partner with PCPs, medical specialty, and forensic teams. Some people in need of ACT-level services also live with chronic (and sometimes acute) physical health conditions. Maricopa County has 21 ACT teams that integrate medical professionals (Medical ACT) or partner with PCPs (PCP Partnership ACT Teams). Two FACT teams serve adults living with SMI who have a history of high utilization of the criminal justice system (the FACT teams include PCP partnerships). This allocation of resources for justice-involved people reflects responsiveness to the stated concerns of many system stakeholders to address the needs of people living with SMI with histories of criminal justice system involvement. Maricopa County's array of ACT and FACT offerings is very comprehensive compared to other large counties nationally.

[13] Cuddeback, G. S., Morrissey, J. P., Cusack, K. J. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803–1806. The estimate of 4.3% was based on findings from an analysis of data of the services for people living with SMI in Portland, Oregon.

[14] During the review period, one ACT team was dissolved. However, a new ACT team has been implemented in 2024.

Table 12 — Service System Penetration Rates for Individuals with SMI

Penetration Rates					
Region	**Adult Population (≥ 18 Years Old)[15]**	**Estimated Rate of SMI in the Adult Population[16]**	**Estimated Number of Adults with SMI in the Population[17]**	**Number of Adults with SMI Served[18]**	**Penetration Rate Among Adults with SMI[19]**
United States	262,083,034	5.9%	15,354,982	4,264,663	28%
Arizona:	5,848,310	5.6%	330,314	131,014	40%
Maricopa County:[20]	3,532,288	4.6%	161,528	39,046	24%
Adults with Medicaid	791,205	10.3%	81,494	29,645	36%
Non-Medicaid Adults	2,741,083	4.5%	125,993	9,401	7%
Texas:	22,942,176	5.4%	1,243,548	325,172	26%
Harris County (Houston)	3,550,425	3.4%	119,429	33,840	28%
Bexar County (San Antonio)	1,553,113	3.5%	53,925	14,884	28%
New York:	15,611,308	5.0%	788,332	593,555	75%

[15] All state-level population estimates are based on the US Census Bureau, Population Division. *Estimates of the total resident population and resident population age 18 years and older for the United States, States, and Puerto Rico: July 1, 2023*.

[16] National and state-level SMI estimates: Substance Abuse and Mental Health Services Administration. (2023). *2021–2022 National Survey on Drug Use and Health: Model-based prevalence estimates (50 states and the District of Columbia)*. Available at: https://www.samhsa.gov/data/report/2021-2022-nsduh-state-prevalence-estimates

County-level SMI estimates: Substance Abuse and Mental Health Services Administration. (2022). *2016–2018 NSDUH substate region estimates – tables.* Available at: https://www.samhsa.gov/data/report/2016-2018-nsduh-substate-region-estimates-tables

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

[18] The national and state-level percentages of people with SMI served were obtained from Substance Abuse and Mental Health Services Administration. (2024). *2022 Uniform Reporting System (URS) output tables*. Available at: https://www.samhsa.gov/data/report/2022-uniform-reporting-system-urs-output-tables

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

[20] The number of people with SMI served in Maricopa County is based on Arizona Health Care Cost Containment System's 2023 service utilization data file.

Penetration Rates					
Region	**Adult Population (≥ 18 Years Old)[15]**	**Estimated Rate of SMI in the Adult Population[16]**	**Estimated Number of Adults with SMI in the Population[17]**	**Number of Adults with SMI Served[18]**	**Penetration Rate Among Adults with SMI[19]**
New York County (New York City)[21]	1,381,874	3.9%	52,911	91,191	172%
Colorado:	4,662,926	6.9%	322,574	70,744	22%
Denver City/County[22]	584,904	5.9%	34,418	19,829	58%
Nebraska	1,497,381	7.5%	112,641	9,702	9%
California	30,519,524	5.7%	1,726,513	382,616	22%
Illinois	9,844,167	5.1%	501,246	16,403	3%
Kansas	2,246,209	6.6%	147,790	11,371	8%
Minnesota	4,436,981	5.5%	245,776	167,563	68%
Wisconsin	4,661,826	5.9%	274,521	29,420	11%
Tennessee	5,555,761	6.9%	380,825	203,423	53%
Indiana	5,274,945	6.4%	336,938	86,941	26%
Delaware	819,952	5.4%	43,891	7,093	16%
New Hampshire	1,150,004	5.9%	67,532	12,920	19%
North Carolina	8,498,868	5.8%	492,297	65,227	13%

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

[22] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with Clinical/Administrative Director, Kim Foust, and her staff at the Mental Health Center of Denver, March 11, 2024.

Overview of EBP Utilization Benchmark Analyses

Table 13 — EBP Utilization Rates Among People with SMI Who Were Served in the System[23]

EBP Utilization Rates						
Region	ACT		Supported Employment		Supportive Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
United States	71,243	1.7%	62,679	1.5%	96,893	2.3%
Arizona:	1,782	1.4%	12,914	9.9%	1,073	0.8%
Maricopa County (2023)[24,25]	2,060	5.3%	10,345	26.5%	5,442	13.9%
Maricopa County — Medicaid	1,597	5.4%	8,076	27.2%	4,436	15.0%
Maricopa Co. — non-Medicaid	463	4.9%	2,269	24.1%	1,006	10.7%
Maricopa County (Supported Employment Ongoing)[26]	*Not Applicable*	*Not Applicable*	2,250	5.8%	*Not Applicable*	*Not Applicable*
Texas:	7,851	2.4%	7,161	2.2%	7,743	2.4%
Harris County (Houston)	1,178	3.5%	3,327	9.8%	1,063	3.1%
Bexar County (San Antonio)	186	1.2%	275	1.8%	1,048	7.0%
New York:	8,071	1.4%	800	0.1%	25,554	4.3%

[23] National and state-level data on the number of people using EBPs was obtained from Substance Abuse and Mental Health Services Administration. (2024). *2022 Uniform Reporting System (URS) output tables*. Available at: https://www.samhsa.gov/data/report/2022-uniform-reporting-system-urs-output-tables

[24] Supported employment services in Maricopa County are associated with seven billing codes: H2025, H2025 HQ, H2025 SE, H2026, H2027, H2027 HQ, and H2027 SE. Codes H2025 through H2026 are labeled as ongoing support to maintain employment. H2027, H2027 HQ, and H2027 SE are labeled as psychoeducational services (pre-job training and development). For this analysis, Mercer reports both the unduplicated number of people who received any service associated with supported employment and separately those who received "ongoing" supported employment. The ongoing billing codes are most likely to indicate high-fidelity supported employment. Mercer also does not know the extent to which the figures from other regions and states represent actual, evidence-based supported employment.

[25] The number served in Maricopa County with evidence-based services is based on AHCCCS's 2023 service utilization data file.

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

EBP Utilization Rates						
New York County (New York City)[27]	1,218	1.3%	Not Available	Not Available	4,717	5.2%
Colorado:	1,240	1.8%	820	1.2%	248	0.4%
Denver City/County (MHCD)[28]	570	1.7%	404	1.2%	1,667	4.8%
Nebraska	67	0.7%	625	6.4%	810	8.3%
California	5,850	1.5%	342	0.1%	812	0.2%
Illinois	592	3.6%	1,286	7.8%	Not Available	Not Available
Kansas	Not Available	Not Available	648	5.7%	1,913	16.8%
Minnesota	1,924	1.1%	1,703	1.0%	1,903	1.1%
Wisconsin	Not Available	Not Available	1,327	4.5%	591	2.0%
Tennessee	303	0.1%	838	0.4%	917	0.5%
Indiana	1,088	1.3%	1,079	1.2%	3,138	3.6%
Delaware	413	5.8%	6	0.1%	32	0.5%
New Hampshire	779	6.0%	3,292	25.5%	Not Available	Not Available
North Carolina	4,079	6.3%	Not Available	Not Available	Not Available	Not Available

Table 13 depicts utilization rates of ACT, supported employment, and supportive housing among adults with SMI served in the Maricopa County behavioral health system. Maricopa County has an ACT utilization rate of 5.3%, which exceeds researchers' best estimate of the percentage of people with SMI who need ACT (4.3%). The county's utilization rates for supportive housing and supported employment services also exceed the national average benchmarks. Maricopa County's supported employment utilization rate of 26.5% and ongoing supported employment utilization rate of 5.8% (considered closer to high-fidelity supported employment than the other supported employment codes) are among the highest in this benchmark analysis. For example, the national utilization rate for supported employment is less than 2%. Given that most people living with SMI served in the public system are unemployed, supported employment is a vital EBP underutilized nationwide. The utilization rate for supportive housing (13.9%) in Maricopa County

[27] Utilization data originally was obtained for a previous year's analysis from Marleen Radigan, Dr.PH, MPH, MS, Research Scientist VI and Director in the Office of Performance Measurement and Evaluation within the New York State Office of Mental Health, May 2019. No update is available since the COVID-19 pandemic began in 2020.

[28] Data is from the Mental Health Center of Denver (MHCD), the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with Clinical/Administrative Director, Kim Foust, and her staff at the Mental Health Center of Denver, March 11, 2024.

is also much higher than the national average (2.3%) and of the utilization rates of all other regions in the analysis. The availability of supportive housing is essential in preventing chronic homelessness among the population of people living with SMI.

Changes in EBP Utilization from 2013 through 2023

Table 14 compares the utilization of ACT, supported employment, and supportive housing in Maricopa County from 2013 through 2023. The following are highlighted findings of the analysis comparing utilization/penetration rates across those years:

- **ACT:** Between 2013 and 2020, Maricopa County experienced a steady increase each year in the total number of adults with SMI who received ACT services, consistently achieving penetration rates that ranged from 6.4% to 7.0%, which exceeded the benchmark penetration rate for ACT services (4.3%). The ACT penetration rate decreased in 2021 and 2022 to 6.2% and 5.7%, with the 24 ACT teams serving 2,117 people as of December 1, 2022. In 2023, there are 23 ACT teams serving 2,060 members for a penetration rate of 5.3%.[29] However, these decreases do not necessarily represent a decrease in the quality of care, as they indicate a penetration rate that is closer to the best estimate that Mercer currently has of the percentage of people with SMI served in a publicly funded system who need ACT.
- **Supported Employment*:*** From 2022 to 2023, there were decreases in the overall penetration rate for supported employment (29.7% to 26.5%) and ongoing supported employment (6.5% to 5.8%). In 2020, the overall penetration rate for supported employment reached its highest since 2013. The number of individuals who received *ongoing* supported employment during 2020 exceeded 3,200 unique individuals; this decreased to just over 2,400 in 2022 and 2,250 in 2023. However, the penetration rate for ongoing supported employment services in 2023 is nearly double that in 2013 (5.8% versus 2.5%). Regardless, although the penetration rate for supported employment in Maricopa County is high relative to most states, it is well below the level of need for supported employment, as is true nationally.
- **Supportive Housing:** A single supportive housing billing code (H0043) informed the initial years of the penetration rate analysis. Supportive housing providers infrequently utilized this code. As a result, Mercer could not accurately estimate supportive housing utilization between 2013 and 2014. In recognition that supportive housing services can incorporate many interventions and activities, an additional billing code (H2014: Skills Training and Development) was added in 2016 to capture the provision of supportive housing services more accurately by contracted supportive housing providers. With the addition of the H2014 code, the supportive housing penetration rate increased from 3.7% in 2015 to 4.6% in 2016 and 6.6% in 2017. The following year (2018), Mercer expanded the analysis to include additional service codes (T1019 and T1020: Personal Care Services; and H2017: Psychosocial Rehabilitation Services) when contracted supportive housing providers rendered the services. As a result,

[29] During the review period, one ACT team was dissolved. However, a new ACT team has been implemented in 2024.

the penetration rate for supportive housing more than doubled to 15.1% in 2018, and the total number of people served with supportive housing also increased significantly. The penetration rate for supportive housing increased substantially between 2019 (14.9%) and 2021 (21.8%) but decreased in 2022 to 17.3% (6,412 served), then reduced again to 13.9% (5,442 served) in 2023.

Table 14 — Maricopa County EBP Utilization Rates: 2013 through 2023

Maricopa County EBP Utilization Rates Among People with SMI Served in the System							
Year	Number of Adults with SMI Served	ACT		Supported Employment (SE)		Supportive Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[30]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2023)	39,046	2,060	5.3%	10,345	26.5%	5,442	13.9%
SE Ongoing	-	-	-	2,250	5.8%	-	-
Maricopa County (2022)	37,107	2,117	5.7%	11,011	29.7%	6,412	17.3%
SE Ongoing	-	-	-	2,423	6.5%	-	-
Maricopa County (2021)	36,718	2,265	6.2%	11,790	32.1%	7,988	21.8%
SE Ongoing	-	-	-	2,567	7.0%	-	-
Maricopa County (2020)	35,114	2,317	6.6%	11,890	33.8%	7,558	21.5%
SE Ongoing	-	-	-	3,265	9.2%	-	-

[30] For additional information regarding ongoing supported employment, see footnotes 14 and 16.

Maricopa County EBP Utilization Rates Among People with SMI Served in the System							
Year	Number of Adults with SMI Served	ACT		Supported Employment (SE)		Supportive Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[30]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2019)	34,451	2,278	6.6%	10,615	30.8%	5,149	14.9%
SE Ongoing	-	-	-	2,436	7.1%	-	-
Maricopa County (2018)	34,264	2,241	6.5%	9,861	28.8%	5,160	15.1%
SE Ongoing	-	-	-	2,376	6.9%	-	-
Maricopa County (2017)	31,712	2,233	7.0%	8,168	25.8%	2,098	6.6%
SE Ongoing	-	-	-	1,708	5.4%	-	-
Maricopa County (2016)	30,440	2,093	6.9%	7,930	26.1%	1,408	4.6%
SE Ongoing	-	-	-	1,544	5.1%	-	-
Maricopa County (2015)	24,608	1,693	6.9%	4,230	17.2%	902	3.7%
SE Ongoing	-	-	-	725	3.0%	-	-
Maricopa County (2014)	23,977	1,526	6.4%	5,634	23.4%	793	3.3%
SE Ongoing	-	-	-	657	2.7%	-	-

Maricopa County EBP Utilization Rates Among People with SMI Served in the System							
Year	Number of Adults with SMI Served	ACT		Supported Employment (SE)		Supportive Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[30]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2013)	20,291	1,361	6.7%	7,366	36.3%	Not Available	Not Available
SE Ongoing	-	-	-	515	2.5%	-	-

Chart 1 — Maricopa County ACT Utilization Rates: 2013 through 2023

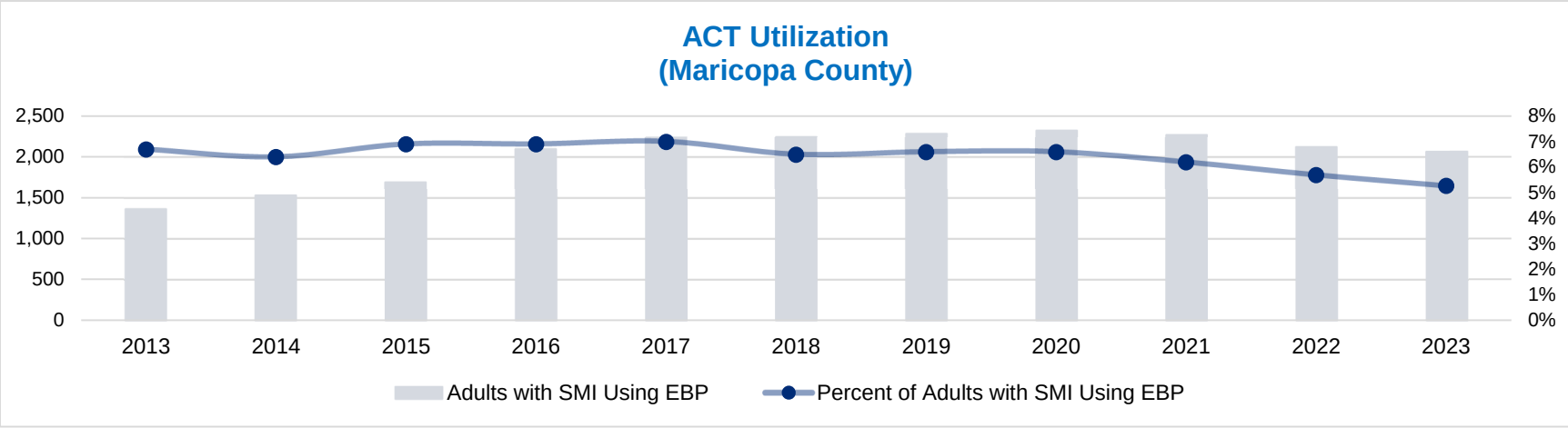


Chart 2 — Maricopa County Supported Employment Utilization Rates: 2013 through 2023

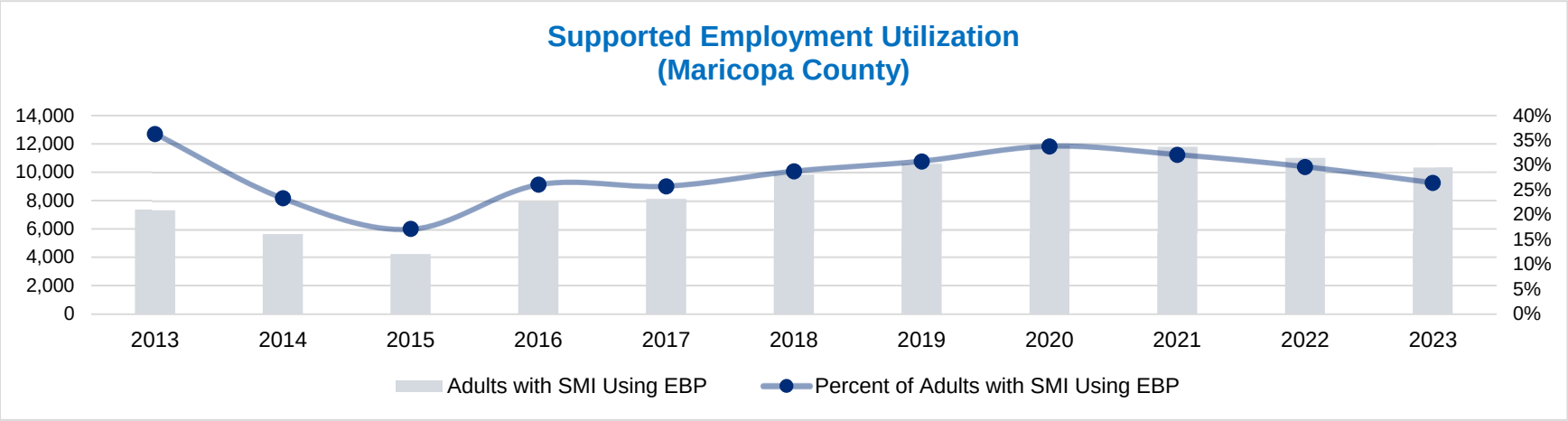


Chart 3 — Maricopa County Ongoing Supported Employment Utilization Rates: 2013 through 2023

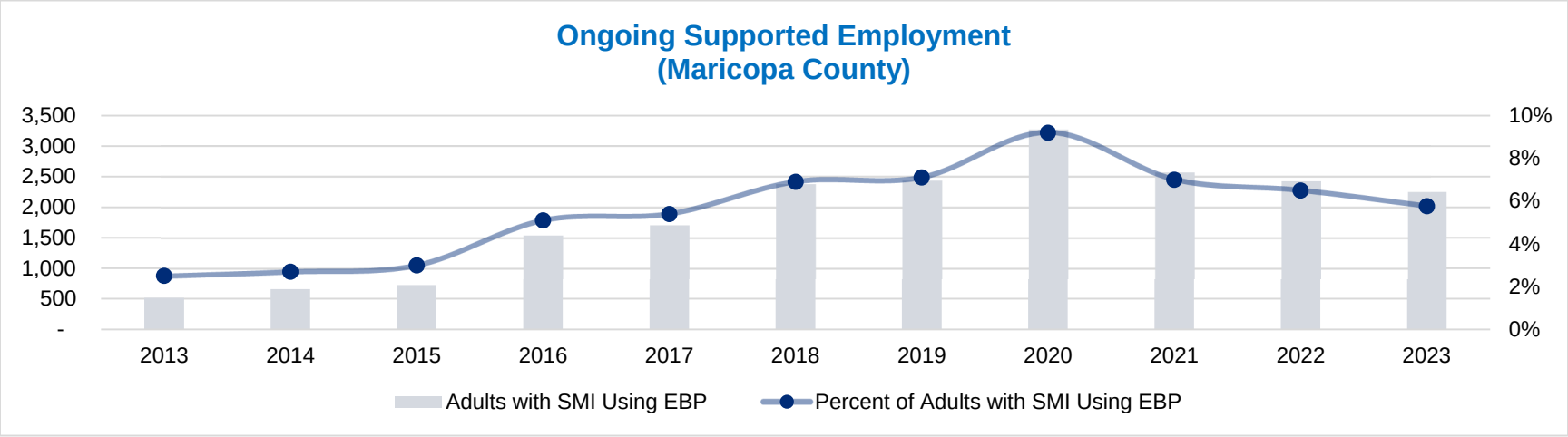
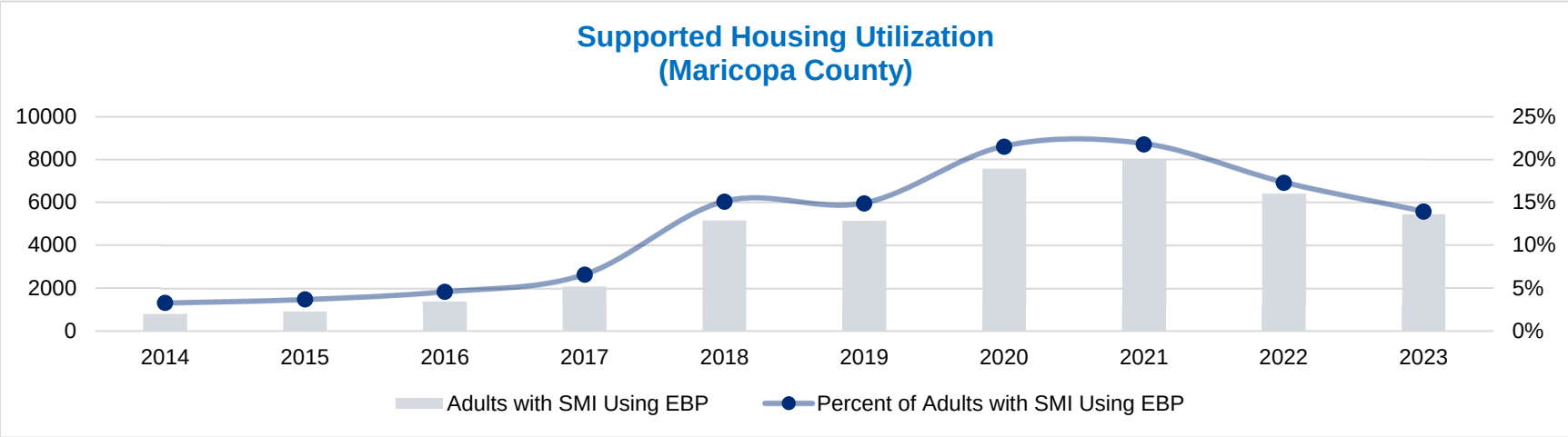


Chart 4 — Maricopa Supportive Housing Utilization Rates: 2014 through 2023



ACT Benchmarks

In an influential 2006 study, Cuddeback, Morrissey, and Meyer estimated that over 12 months, 4.3% of adults with SMI in an urban mental health system needed an ACT level of care. The Maricopa County ACT penetration rate is presented in Table 15 relative to all people with SMI served in the system (as well as relative to the 4.3% estimate provided by Cuddeback et al.).[31]

Over the years, Maricopa County has made significant strides in bolstering its capacity to offer ACT services to individuals with SMI. The ACT penetration rate, standing at 5.3%, surpasses the benchmark set by the Cuddeback et al study (4.3%). This achievement not only holds up well against other communities nationwide but also sets a high standard, particularly when considering that Maricopa County a) incorporates FACT teams to cater to the needs of adults with SMI who have a history of involvement with the criminal justice system, and b) integrates physical health care into most of its teams.

[31] Some readers might conclude from this analysis that Maricopa County provides ACT to too many people with SMI, given that its penetration rate of 5.3% exceeds the estimated percentage of people living with SMI needing ACT (4.3%). However, it is important to note that the 4.3% estimate Mercer uses in this analysis was derived from a study conducted in Portland, Oregon almost 15 years ago. That study is the only United States-based study of its kind that Mercer could find that would be pertinent to Maricopa County, and it did use well-accepted criteria concerning the number of psychiatric hospitalizations that would indicate that a given person needs ACT. However, since the Cuddeback et al study, ACT has been extended to people living with SMI who have recurring involvement in the criminal justice system and who may or may not have enough hospitalizations to qualify for ACT. Maricopa County has extended ACT to these clients, and the overall penetration rate for ACT is likely very close to the actual level of need. A more in-depth study would be needed to verify that conclusion. However, the overall finding is that Maricopa County delivers a robust level of ACT and varying types of ACT to its clients who need that level of care.

Table 15 — ACT Utilization Relative to Estimated Need among People with SMI

Region	Number of Adults with SMI Served in Public System	Number of Adults Estimated to Need ACT	Number of Adults Who Received ACT	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
Ideal Benchmark[32]	-	-	-	*4.3%*	*100%*
United States	4,264,663	183,381	71,243	1.7%	39%
Arizona:	131,014	5,634	1,782	1.4%	32%
Maricopa Co.	39,046	1,679	2,060	5.3%	123%
Maricopa Co. — Medicaid	29,645	1,275	1,597	5.4%	125%
Maricopa Co. — non-Medicaid	9,401	404	463	4.9%	115%
Texas:	325,172	13,982	7,851	2.4%	56%
Harris County (Houston)	33,840	1,455	1,178	3.5%	81%
Bexar County (San Antonio)	14,884	640	186	1.2%	29%
New York:	593,555	25,523	8,071	1.4%	32%
New York County (New York City)[33]	91,191	3,921	1,218	1.3%	31%
Colorado:	70,744	3,042	1,240	1.8%	41%
Denver County (MHCD)[34]	19,829	853	570	2.9%	67%
Washington	95,392	4,102	973	1.0%	24%
Nebraska	9,702	417	67	0.7%	16%
California	382,616	16,452	5,850	1.5%	36%
Illinois	16,403	705	592	3.6%	84%
Minnesota	167,563	7,205	1,924	1.1%	27%

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

[33] Utilization data was obtained by Marleen Radigan, D.Ph., MPH, MS, Research Scientist VI and Director in the Office of Performance Measurement and Evaluation within the New York State Office of Mental Health.

[34] Data is from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with Clinical/Administrative Director, Kim Foust, and her staff at the Mental Health Center of Denver, March 11, 2024.

Region	Number of Adults with SMI Served in Public System	Number of Adults Estimated to Need ACT	Number of Adults Who Received ACT	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
Wisconsin	29,420	1,265	N/A	N/A	N/A
Tennessee	203,423	8,747	303	0.1%	3%
Indiana	86,941	3,738	1,088	1.3%	29%
Delaware	7,093	305	413	5.8%	135%
New Hampshire	12,920	556	779	6.0%	140%
North Carolina	65,227	2,805	4,079	6.3%	145%

Supported Employment Benchmarks

Maricopa County provides aspects of supported employment to a high percentage of those with an estimated need for this EBP: 26.5% of people with SMI in the public mental health system received at least one vocational assessment or other type of pre-vocational service. However, the best estimate of the percentage of individuals who received high-fidelity supported employment in Maricopa County are those who received ongoing support to maintain employment (5.8%).

Table 16 — Supported Employment Utilization Relative to Estimated Need among People with SMI

Supported Employment Utilization					
Region	Number of Adults with SMI Served in System[35]	Number of Adults in Need of SE[36]	Number of Adults Who Received SE[37]	SE Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
Ideal Benchmark	-	-	-	*45.0%*	*100%*
United States	4,264,663	1,919,098	62,679	1.5%	3%
Arizona:[38]	131,014	58,956	12,914	9.9%	22%
Maricopa Co. — Total Served	39,046	17,571	10,345	26.5%	59%
SE Ongoing	39,046	17,571	2,250	5.8%	13%
Maricopa Co. — Medicaid	29,645	13,340	1,475	5.0%	11%
SE Ongoing	29,645	13,340	1,710	5.8%	13%
Maricopa Co. — non-Medicaid	9,401	4,230	2,269	24.1%	54%
SE Ongoing	9,401	4,230	540	5.7%	13%
Texas:	325,172	146,327	7,161	2.2%	5%
Harris County (Houston)	33,840	15,228	3,327	9.8%	22%
Bexar County (San Antonio)	14,884	6,698	275	1.8%	4%

[35] The number of people with SMI served at the national and state-level was obtained from the Substance Abuse and Mental Health Services Administration. (2024). 2022 Uniform Reporting System (URS) output tables. Available at: Uniform Reporting System (samhsa.gov)

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

[37] The number of people who received supported employment at the national and state levels were obtained from the Substance Abuse and Mental Health Services Administration. (2024). 2022 Uniform Reporting System (URS) output tables. Available at: Uniform Reporting System (samhsa.gov)

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

Supported Employment Utilization					
Region	Number of Adults with SMI Served in System[35]	Number of Adults in Need of SE[36]	Number of Adults Who Received SE[37]	SE Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
New York	593,555	267,100	800	0.1%	0.3%
Colorado:	70,744	31,835	820	1.2%	3%
Denver County (MHCD)[39]	19,829	8,923	404	2.0%	5%
Nebraska	9,702	4,366	625	6.4%	14%
California	382,616	172,177	342	0.1%	0.2%
Illinois	16,403	7,381	1,286	7.8%	17%
Kansas	11,371	5,117	648	5.7%	13%
Wisconsin	29,420	13,239	1,327	4.5%	10%
Tennessee	203,423	91,540	838	0.4%	1%
Indiana	86,941	39,123	1,079	1.2%	3%
Delaware	7,093	3,192	6	0.1%	0.2%
New Hampshire	12,920	5,814	3,292	25.5%	57%

[39] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with Clinical/Administrative Director, Kim Foust, and her staff at the Mental Health Center of Denver, March 11, 2024.

Peer Support Benchmarks

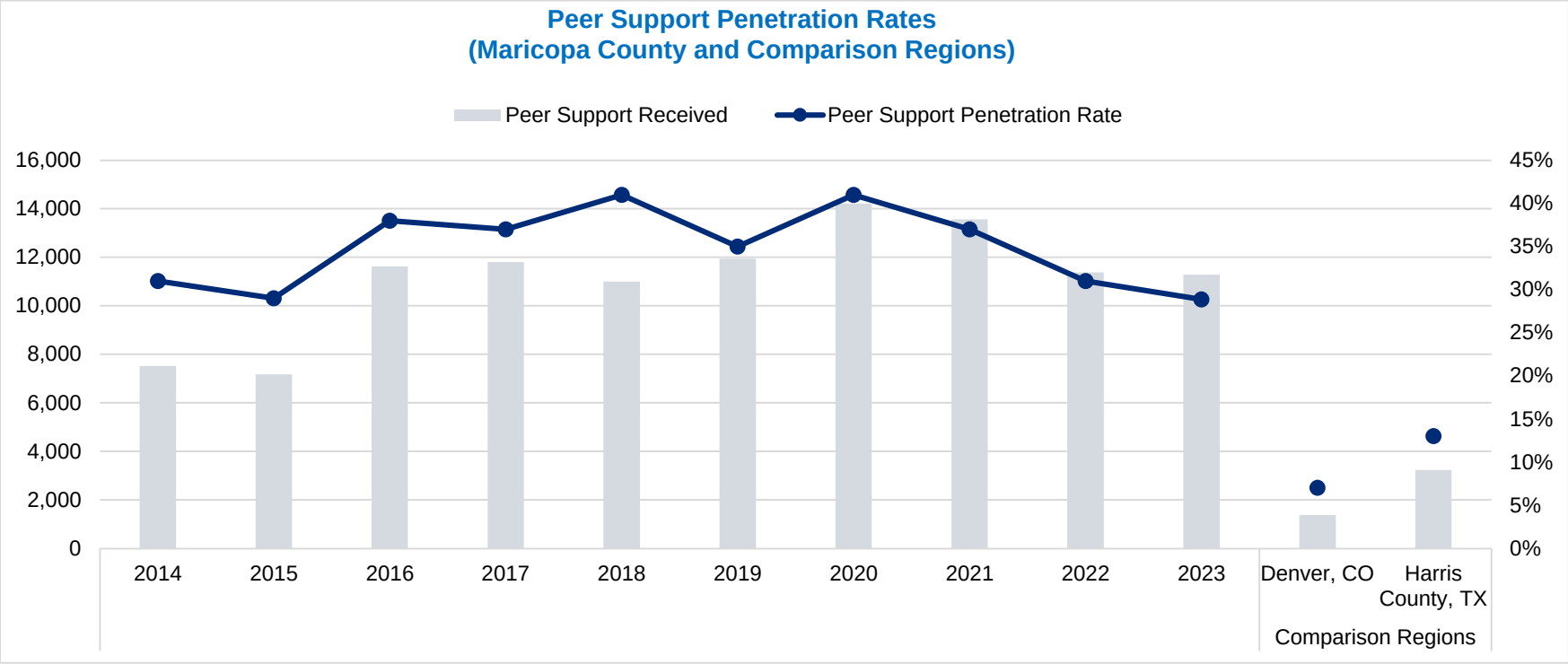
Maricopa County excels in making peer support services available to people in need. Its penetration rates for 2013–2023 are high and likely represent a best practice benchmark regarding access to peer support (see Table 17).

Table 17 — Peer Support Penetration Rates

Peer Support		
Region	**Peer Support Received**	**Peer Support Penetration Rate**
Arizona:		
Maricopa County (Total) — 2023	11,280	29%
Maricopa County (Total) — 2022	11,374	31%
Maricopa County (Total) — 2021	13,573	37%
Maricopa County (Total) — 2020	14,224	41%
Maricopa County (Total) — 2019	11,943	35%
Maricopa County (Total) — 2018	11,001	41%
Maricopa County (Total) — 2017	11,803	37%
Maricopa County (Total) — 2016	11,629	38%
Maricopa County (Total) — 2015	7,173	29%
Maricopa County (Total) — 2014	7,522	31%
Maricopa County (Total) — 2013	8,385	41%
Texas:		
Harris County	3,238	13%
Colorado:		

Peer Support		
Region	**Peer Support Received**	**Peer Support Penetration Rate**
Denver City/County[40] (2023)	1,292	7%

Chart 5 — Peer Support Penetration Rates



[40] Data are from the Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with Clinical/Administrative Director, Kim Foust, and her staff at the Mental Health Center of Denver, March 11, 2024. The Mental Health Center of Denver peer support services for adults with SMI using peer mentors and 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[41]

Peer support services are delivered in individual and group settings by individuals who have personal experience with mental illness, substance use disorder, 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 available ongoing community-based services.

Focus Groups

Mercer facilitated four focus groups with key system stakeholders as part of the service capacity assessment of the four priority behavioral health services in Maricopa County. Mercer convened the focus groups to facilitate discussion with participants with direct experience with priority mental health services. Readers should review focus group results in the context of qualitative and supplemental data and not interpret the feedback as representative of the total population of potential focus group participants.

Key findings derived from the focus groups regarding the delivery system's capacity to deliver peer support and family support services included:

- Most focus group participants view peer support services as a valuable service. Members reported: "Peer support specialists are someone to count on"; "My peer support specialist was willing to talk and listen"; and "Peer support works!" Family members reported that a "peer is someone who a member will trust quickly" and "they can speak in ways" that may be more receptive to members. Family members also view peer support as a "good first steppingstone" for members in their recovery. One case manager stated, "My peer support specialist is the best. He really gets to embody his role."
- Some family members expressed concerns that peer support is not always appropriate for members with "severe psychosis," and one parent thought peer support "has done far more harm than good." Another family member shared that peer support has been "dangerous and disruptive" for their adult child who is on a court order. The family member reported the peer support specialist

[41] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation,* which may not reflect the terminology used to currently describe these services.

told her adult child “You don’t need to be on these medications forever and just move out if you don’t like living in your group home.”

- Integrated health homes have largely moved back to in-person delivery of peer support services, although virtual delivery remains available on a limited basis depending on the health home. Participants in all focus groups continue to advocate for options to promote accessibility to the service, and the preservation of virtual delivery of peer support services was an important theme across all focus groups.
- Participants in all focus groups reported that there are still not enough peer support specialists in the system, particularly at the health homes. There were varying reports of the number of peer support specialists at the health homes (between one and three). It is reportedly commonplace for peer support specialists to serve multiple teams. A case manager noted they only have one peer support specialist who serves all five teams at their health home.
- Despite the demand for peer support specialists, case manager participants shared that their sites are not recruiting or budgeting for additional positions. Provider and case manager participants reported that many members become certified but cannot find a peer support job. Although a lack of available positions contributes to this, perceived job requirements, such as having a car and requiring full-time status, are also contributing factors.
- Participants indicated that turnover rates remain high among peer support specialists at the health homes. Turnover rates were reported to be lower at peer-run organizations. Primary contributors to turnover continue to include low pay, despite educational and past work experience, the demands/stress of the position (notetaking and billing requirements), transitions to other positions, a lack of on-the-job training, and a lack of respect for the role. One member stated that he “was offered six different peer support specialists in the last year due to the constant turnover.” Another member stated, “Turnover happens so quickly that I cannot build relationships.”
- Case managers expressed concern that sometimes peers are seen as “taking the side of the member,” which can be looked down upon by other treatment team members. This can lead to a lack of respect for their input, leaving peer support specialists to feel like they “don’t matter as much as the rest of the team.”
- Participants across all focus groups noted that peer support specialists are often asked to take on duties outside of their roles due to the turnover among other health home positions (most notably, case managers). This “becomes too much for the person” who has specifically chosen a peer role due to their lived experience. Participants thought that management at the health homes still does not consistently understand the unique role of a peer support specialist, which can contribute to role-blurring, and ultimately, may result in higher rates of burnout and turnover in the role.

- Family members thought that the “role-blurring” also posed safety risks for peer support specialists who are being asked to take on responsibilities of “trained professionals.” Family members expressed that peer support specialists are not trained to understand medications and court orders and are not equipped to engage with members who may be in crisis. One family member shared that a peer support specialist was sent out to the lobby of her adult child’s health home to “evaluate” the member whose symptomology made him too acute for a behavioral health residential facility.
- Participants agreed that peer support specialists would benefit from more on-the-job support related to both the mechanics of their role and their own mental health. One former peer support specialist in the member focus group reported, “I had a lot of trauma related to employment and getting fired, so I never lasted too long in the role. I needed more support.” Another former peer specialist shared, “I had a hard time with taking the job home with me,” and there “needs to be more sensitivity to people who have trauma and take on these roles.”
- To address turnover, participants suggested offering higher salaries, performance-based incentive pay, sign-on and retention bonuses, administrative support for note entry, and to build confidence, offering more training before becoming fully deployed in the role. One health home holds monthly meetings for peer support specialists across their health home. The meetings are led by a peer, and they are viewed as a supportive practice for peer support specialists.
- It was reported that there are barriers to initiating peer support at a peer-run organization. Case managers reported that some peer-run organizations are “picky” about what should be on the ISP (i.e., use of specific codes and the provider’s name). Each time a change is requested, this delays the service start date. Participants in all focus groups expressed an understanding that members may self-refer for services, but ultimately, all paperwork must be received from the member’s assigned health home before services can begin.
- There were varying responses regarding the length of time it takes for peer support services to be initiated. Case manager participants reported that in-house referrals are processed within hours to three days; it takes about a week for the services to begin at a peer-run organization. For members, the wait time can be weeks “depending on case manager responsiveness.” Another member shared that his case manager has been the Blue Dot since COVID, which “translates to not having time to make the referral and complete the paperwork.”
- Case managers and providers shared that peer-run organizations have become more creative with peer services and are offering weekend groups, evening hours, and different social activities and outings such as camping trips.
- As reported in prior years, there continues to be a lack of information about the availability and benefit of family support services. One adult member stated that he “had never heard of family support services,” and none had received the service. There were varied responses about how often members are asked if they are interested in the service (monthly, annually, or every few years), with most feeling that it was asked in a “checking boxes kind of way” and it did not feel “genuine.” Most family members

were not aware of the service, and one reported receiving it at one time until it “disappeared.” Family members thought families would benefit more from legal advocacy and help navigating the system.

- Adult members shared it would be beneficial to market family support services to demonstrate how they can play a supportive service to families and members. Family members and providers thought the service would be most beneficial to families whose loved ones were experiencing a first episode or were new to the system. Providers also thought it would be beneficial to provide more training to members and their families about the services that can be provided by the health homes.
- In past years, it was reported that some health homes offered group sessions for family members (some monthly) that were facilitated by family support specialists. This year, case manager and provider participants reported they are aware of some group sessions, but it varies from agency to agency. Case managers thought there had been a reduction in the number of groups as family support specialist roles diminished and the remaining ones were encouraged to bill more individual codes. Both adult members and providers thought these sessions were beneficial for family members as they provide general information about behavioral health that does not require a Release of Information (ROI) to be signed.
- Some case manager representatives were able to describe the role of a family support specialist, but others could not describe how to identify when the service may be beneficial to a member. Most case managers reported they receive a general overview of the service when first hired but receive no other formal training on how to engage with natural supports and facilitate access to the service.
- Participants in all focus groups agree that there are not enough family support specialists in the system. One case manager reported only having one for their entire company and others reported having none employed at their organization. One case manager refers families to the National Alliance on Mental Illness due to the lack of internal resources. An adult member participant shared that his clinic “hasn’t had one for three years.” A provider representative stated, “Even though this is a best practice, family support services are not on the radar for most clinics — too many other priorities.” Another provider stated, “If the service were more accessible, this would encourage members to pursue it more,” and noted that it is “rarely” available in the clinics anymore.
- When turnover occurs for family support positions, the health homes either elect not to re-hire for the position or struggle to find applicants. Low pay continues to be a contributing factor to high turnover rates of family support specialists, along with high rates of burnout, caseload sizes, billing and documentation requirements, and inadequate supervision and support from leadership. Additionally, case managers expressed that family support specialists often have “blurry roles,” with unclear expectations about the position. Providers thought this contributed to challenges with maintaining boundaries, which also contributes to burnout and turnover.

- Case managers and providers noted that members commonly decline to have family members involved in their treatment, and family members do not always understand the member's rights to choose whether they want others involved in their treatment. Additionally, this year, some adult members shared their reluctance to involve family members in their care. One member reported that he wants to keep his services separate from his family due to the stigma of mental health. Others shared feeling nervous about their families learning everything about their lives, but simultaneously, wanting their involvement. This caused them to decline signing ROIs for their family members.

Key Informant Survey Data

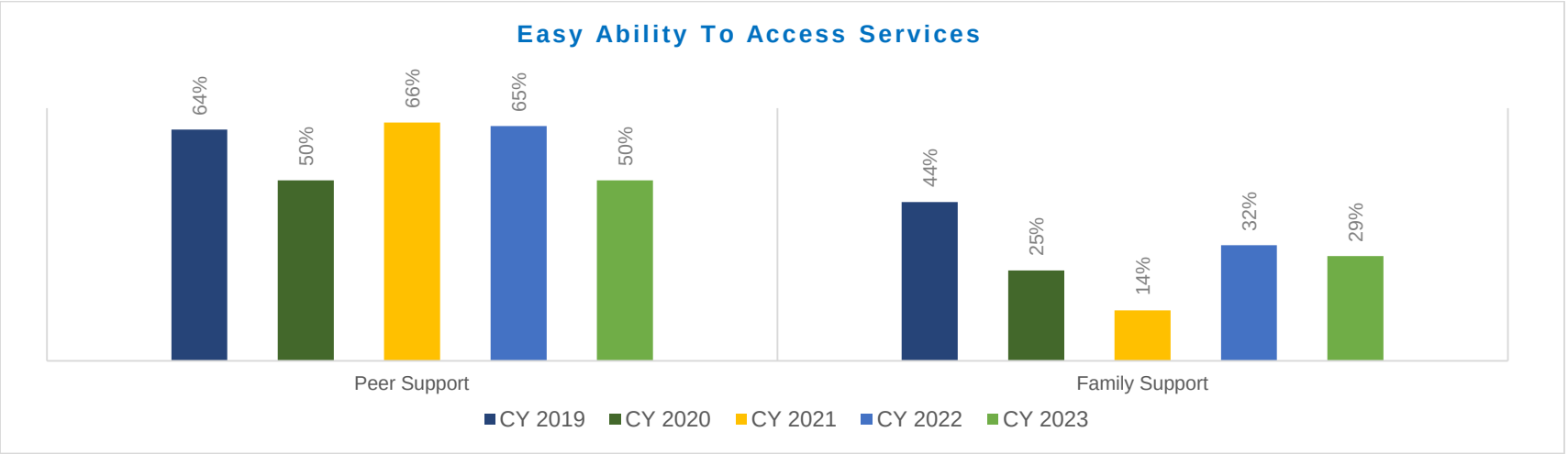
As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to the priority services, Mercer administered a key informant survey. The survey tool included questions and rating assignments related to the priority mental health services. The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

Level of Accessibility

Fifty percent (50%) of survey respondents thought that peer support services were easy to access, a decrease compared to last year's findings (65%). Thirteen percent (13%) of survey respondents indicated that peer support services were difficult to access or believed that the services were inaccessible. Consistent with the last ten years, peer support services were perceived as the easiest of all the priority services to access.

Twenty-one percent (21%) of survey respondents thought that family support services were difficult to access, while 29% of the respondents indicated that family support services were easy to access. Fifty percent (50%) of respondents rated access to family support services as "fair."

Overall, respondents thought that the ability to access peer support and family support services was more difficult during CY 2023 when compared to CY 2022.



Factors that Influence Access

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

- Staff turnover
- Member declines service

Efficient Utilization

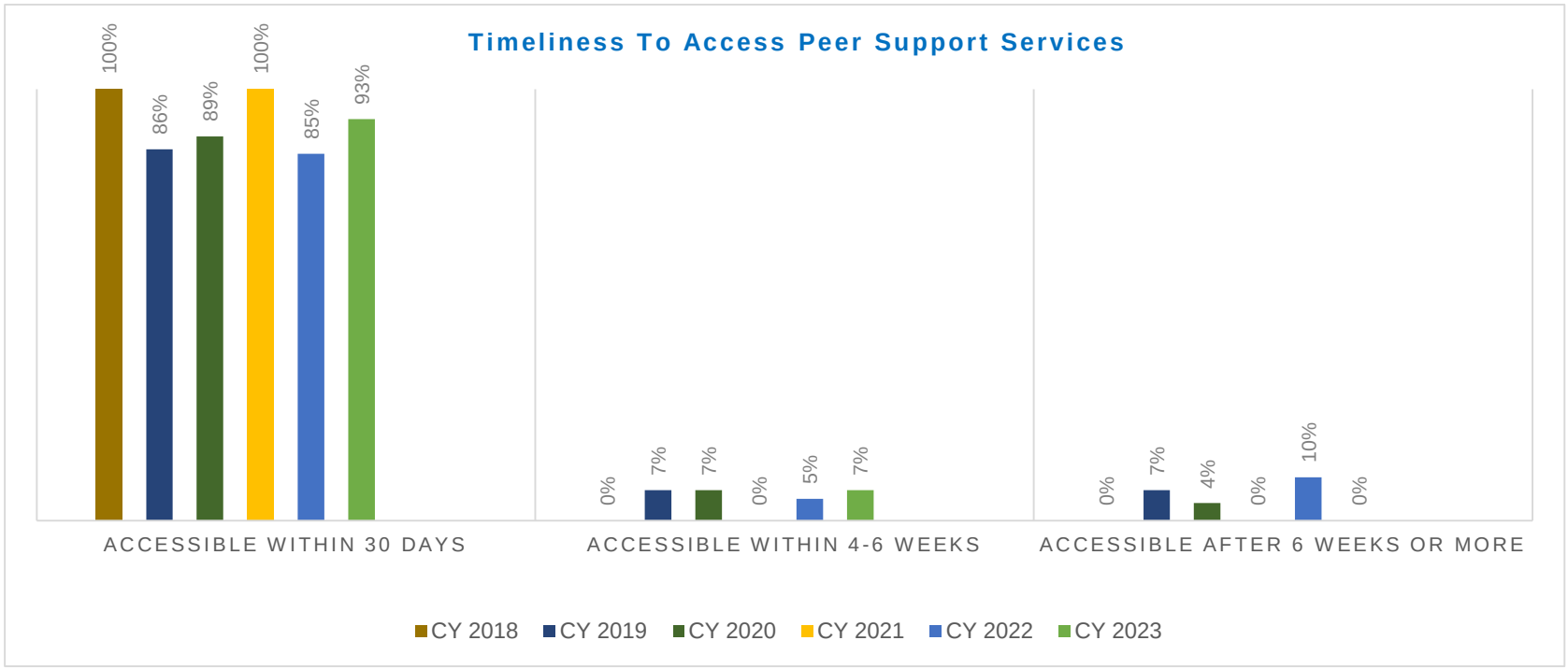
In terms of service utilization, 93% of the responses indicated that peer support services were being used efficiently or were utilized efficiently most of the time. Seven percent (7%) of respondents indicated that the peer support services were not utilized efficiently.

Sixty-nine percent (69%) of the respondents indicated that family support services were being utilized effectively or were utilized efficiently most of the time. Thirty-one percent (31%) of the respondents indicated that family support services were not utilized efficiently.

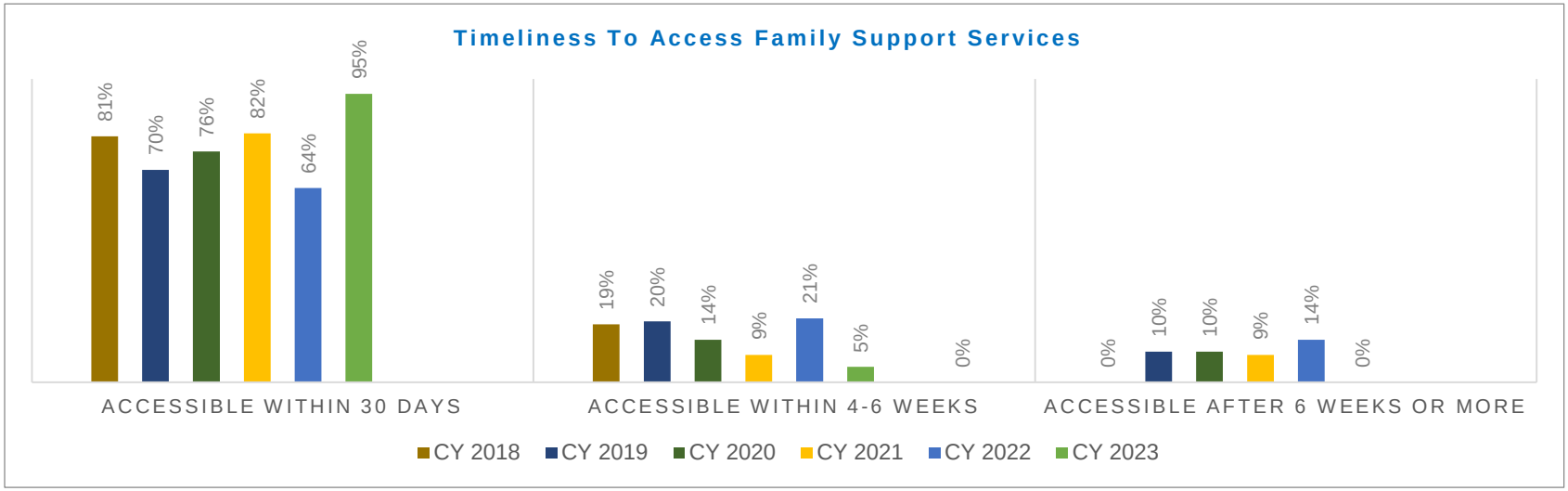
Timeliness

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

- Ninety-three percent (93%) 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 85% during CY 2022.
- Seven percent (7%) reported it taking four to six weeks to access peer support services following the identification of need.
- None (0%) of the survey respondents reported that it would take an average of six weeks or longer to access peer support services.



- Ninety-five percent (95%) of the survey respondents reported that family support services could be accessed within 30 days of the identification of a service need. This finding compares to 64% during CY 2022.
- Five percent (5%) reported it taking four to six weeks to access family support services following the identification of need.
- None (0%) of the survey respondents reported that it would take an average of six weeks or longer to access family support services.

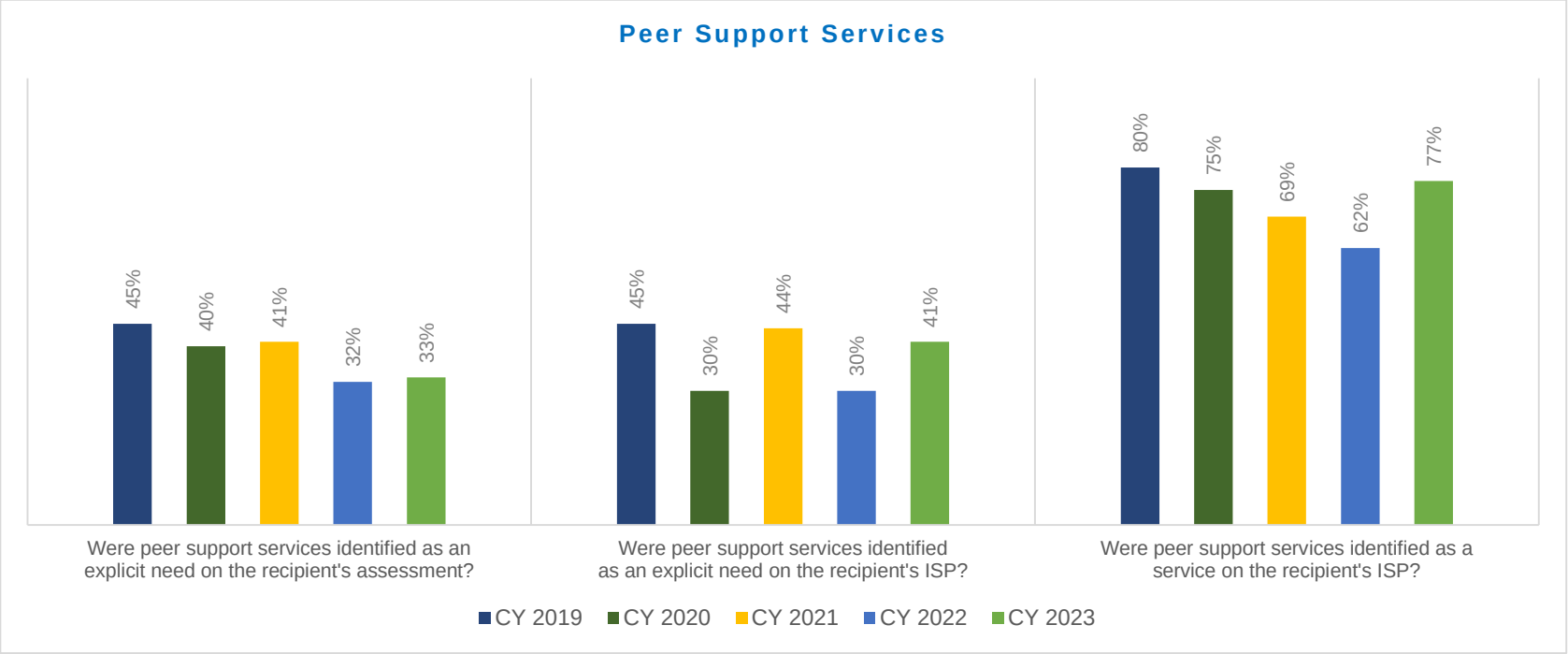


Medical Record Reviews

Mercer reviewed a random sample of 200 recipients' medical record documentation to evaluate 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, included as part of the ISP, and, when applicable, accessed promptly by the member.

Peer Support Services

- Seventy-seven percent (77%) of the ISPs included peer support services when assessed as a need; an increase when compared to CY 2022 (62%).
- Thirty-seven percent (37%) of the recipients included in the sample received at least one unit of peer support during CY 2023.



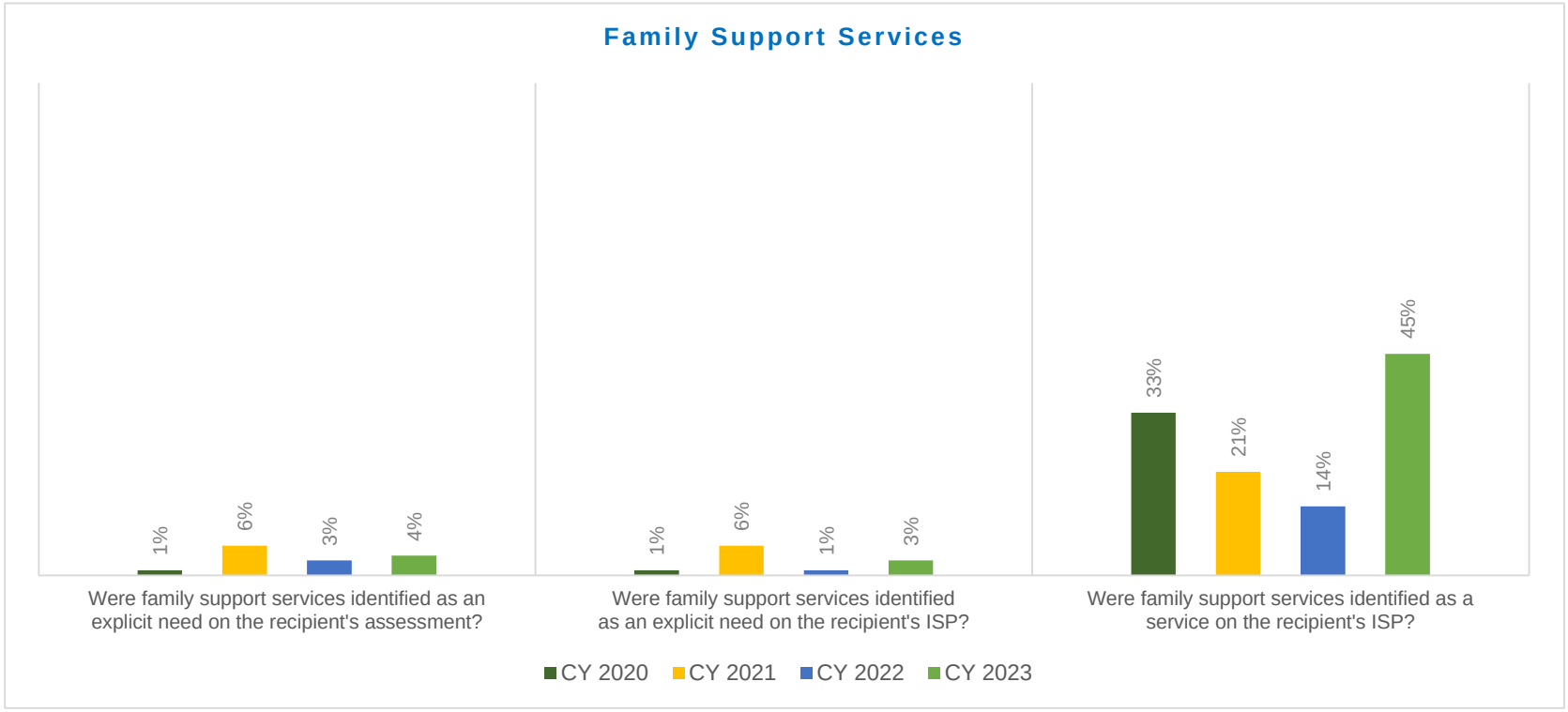
Reviewers could review progress notes and record the documented reasons that the person could not access peer support services when recommended by the clinical team. The most common finding is that the clinical team did not initiate a referral for the service.

Family Support Services

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

Six percent (6%) of the cases included an assessed need for family support services. Of these cases, 45% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP.

One percent (1%) of the recipients included in the sample received at least one unit of family support during CY 2023 based on a review of service utilization data.



Assessments and ISPs rarely identify family support services as a need, a trend that continued during CY 2023. Of the eleven cases in the sample that included an assessed need for family support services, five ISPs included family support services to address the need.

Service Utilization Data — Peer Support Services

Peer support services (i.e., self-help/peer services) are designated by two unique billing codes (H0038 – 15-minute billing unit and H2016 – per diem). During the period of October 1, 2022 through June 30, 2023; there were 37,879 unique users represented in the service utilization data file. Of those, 76% were Medicaid eligible (i.e., Title XIX) and 24% were Non-Title XIX eligible.

- Overall, 23% of the recipients received at least one unit of peer support services during the period (a decrease from last year, when 26% of recipients received peer support over a comparable period).
- Access to the service favored Title XIX eligible members (24%) over the Non-Title XIX population (21%).

Persistence in Services

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

- Overall, 54% of members who received at least one unit of peer support during the review period accessed the service during a single month, a slight decrease when compared to CY 2022 (55%).
- Seventy-two percent (72%) of all members who received at least one peer support unit during the review period accessed the service for one or two months. During CY 2022, this result was 73%. Peer support services are widely accessible across the system. Members may have multiple opportunities to attend a clinic-based peer support group or receive peer support services within or outside their assigned health home. The nature of the service can lead to episodic participation and is less dependent on sustained participation to provide adequate support and intervention.

Persistence in Peer Support Services October 2022–June 2023			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
1	52.8%	58.8%	54.0%
2	18.5%	16.1%	17.9%
3–4	14.9%	12.2%	14.3%
5–6	6.7%	5.3%	6.4%
7–8	2.9%	3.1%	2.9%
9+	4.3%	4.6%	4.4%

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

Targeted Interview — Peer Support Provider

Mercer facilitated an interview with a representative from a contracted peer support provider to gain additional insight about system strengths, challenges, and opportunities related to the availability and provision of peer support services. The provider's program offers options for in-person 1:1 peer support in member's homes and at multiple integrated health homes as well as group peer support. Some of the health homes staff one peer support specialist per clinical team (the provider's health homes have four to five clinical teams each). The provider representative acknowledged ongoing challenges with retaining and recruiting peer support specialists. The position vacancy rate can be as high as 60%, and most peer support specialists transition out of the position within a year.

In addition to the peer support specialists assigned to the clinical teams, the provider has dedicated three full-time peer navigators to focus on the provider's assigned panel of members designated to the "navigator program." Members get assigned to "navigator status" following eight consecutive weeks of unsuccessful outreach and engagement, and thereafter, receive infrequent contact from the provider. A member may stay on navigator status indefinitely, unless a significant event occurs such as an exasperation of mental health symptoms, loss of Medicaid eligibility, commitment to the Department of Corrections, or transition to the Arizona Long-Term Care System. The number of members assigned to the provider's navigator panel is substantial and was reported to exceed 1,000 individuals. Newly assigned members to the navigator panel come to the provider without clinical information that could be useful in effectively supporting the person. The peer navigators struggle to perform the required outreach, and a percentage of members (estimated to be upwards of 5% to 10%) may decompensate and require behavioral health crisis services, which requires reengagement with the clinical team and additional resources to manage the member's care. The managed care contractor reports that the navigator program is being "revamped" and hopes to make positive changes in the future.

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, 1.8% of the recipients received at least one unit of family support services during the review period (2.2% over a comparable review period last year). The utilization of family support has consistently been between 2% to 5% since the inception of the service capacity assessment. Several factors may influence these results, including the absence of supportive family members, the choice to exclude family members from their treatment, and a need for more understanding by clinical teams regarding the appropriate application and potential benefits of the service.

Access to the service was shared between Title XIX (1.9%) and non-Title XIX groups (1.6%).

Persistence in Services

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

- Seventy-five percent (75%) of the members who received at least one unit of family support during the review period accessed the service during a single month, an increase from last year when 73% of the members accessed the service during a single month.
- Eighty-eight percent (88%) of all members who received at least one unit of family support during the review period accessed the service for one or two months, the same finding during CY 2022.

Persistence in Family Support Services October 2022–June 2023			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
1	75.4%	75.3%	75.4%
2	13.1%	13.0%	13.0%
3–4	7.6%	8.2%	7.8%
5–6	2.2%	1.4%	2.1%
7–8	<1.0%	<1.0%	<1.0%
9+	<1.0%	1.4%	1.0%

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

Key Findings and Recommendations

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

Key Findings: Peer Support

- Service utilization data reveals the volume of peer support services accessed during a defined review period. For the period of October 1, 2022 through December 31, 2023, 29% of all members living with SMI received at least one unit of peer support. During the prior year, 31% of members received peer support services.
- Almost 100,000 (99,510) more units of peer support were delivered in CY 2023 compared to CY 2021. However, 2,293 less members received peer support during this same period.
- Most focus group participants view peer support services as a valuable service. Family members reported that a “peer is someone who a member will trust quickly” and “they can speak in ways” that may be more receptive to members. Family members also view peer support as a “good first steppingstone” for members in their recovery. One case manager stated, “My peer support specialist is the best. He really gets to embody his role.” Members reported “Peer support specialists are someone to count on,” “My peer support specialist was willing to talk and listen,” and “Peer support works!”
- Participants indicated that turnover rates remain high among peer support specialists at the health homes. Turnover rates were reported to be lower at peer-run organizations. Primary contributors to turnover continue to include low pay despite educational and past work experience, the demands/stress of the position (notetaking and billing requirements), transitions to other positions, a lack of on-the-job training, and a lack of respect for the role. One member stated that he “was offered six different peer support specialists in the last year due to the constant turnover.” Another member stated, “Turnover happens so quickly that I cannot build relationships.”
- It was reported that there are barriers to initiating peer support at a peer-run organization. Case managers reported that some peer-run organizations are “picky” about what should be on the ISP (i.e., use of specific codes and the provider’s name). Each time a change is requested, this delays the service start date. Participants in all focus groups expressed an understanding that members may self-refer for services, but ultimately, all paperwork must be received from the member’s assigned health home before services can begin.
- Fifty percent (50%) of survey respondents thought that peer support services were easy to access, a decrease compared to last year’s findings (65%). Thirteen percent (13%) of survey respondents indicated that peer support services were difficult to access

or believed that the services were inaccessible. Consistent with the last 10 years, peer support services were perceived as the easiest of all the priority services to access.

- When evaluating a sample of medical record documentation, 77% of the ISPs included peer support services when assessed as a need; an increase when compared to CY 2022 (62%).
- Overall, Maricopa County excels in making peer support services available to people in need. Its penetration rates for 2013–2023 are high and likely represent a best practice benchmark regarding access to peer support.

Key Findings: Family Support

- Service utilization data demonstrates that 3% of members received at least one unit of family support services during 2023, the same finding as last year.
- 144 more members received family support services during CY 2023 compared to CY 2022. There was almost a 10% increase in the number of family support units between CY 2023 and CY 2021.
- Six percent (6%) of the cases included an assessed need for family support services. Of these cases, 45% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP.
- Twenty-one percent (21%) of survey respondents thought that family support services were difficult to access while 29% of the respondents indicated that family support services were easy to access.
- Some case manager representatives were able to describe the role of a family support specialist, but others could not describe how to identify when the service may be beneficial to a member. Most case managers reported they receive a general overview of the service when first hired but receive no other formal training on how to engage with natural supports and facilitate assess to the service.
- Participants in all focus groups agree that there are not enough family support specialists in the system. One case manager reported only having one for their entire company and others reported having none employed at their organization. One case manager refers families to the National Alliance on Mental Illness due to the lack of internal resources. An adult member participant shared that his clinic "hasn't had one for three years." A provider representative stated, "Even though this is a best practice, family support services are not on the radar for most clinics — too many other priorities." Another provider stated, "If the service were more accessible, this would encourage members to pursue it more," and noted that it is "rarely" available in the clinics anymore.

Recommendations: Peer Support

- Examine factors contributing to high turnover and vacancies across peer support specialists operating within the service delivery system and take actions to address recruitment and retention.
- Continue efforts to implement improvements to the contracted managed care organizations navigator program, and ensure that contracted providers are equipped with data and resources to manage their assigned navigator panels efficiently and effectively.
- Analyze the system of care to ensure peer support services can be readily accessed when members desire and need the services, and implement strategies to enhance the availability of this critical service.

Recommendations: Family Support

- Continue efforts to provide training, supervision, and written materials to help ensure that health home clinical team members understand the appropriate application of family support services and to recognize the value of family support services as an effective service plan intervention.

Multi-Evaluation Component Analysis — Supported Employment

Service Description[42]

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

Mercer facilitated focus groups to promote discussion with participants with direct experience with priority mental health services. Readers should review focus group results in the context of qualitative and supplemental data and not interpret the feedback as representative of all system stakeholders.

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

[42] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation,* which may not reflect the terminology utilized to currently describe these services.

- Across all focus groups, attendees agreed that the impact of COVID on supported employment services has dissipated, and member interest in employment, volunteerism, and pursuit of daily meaningful activities has returned to pre-pandemic levels.
- Members and case manager participants reported that some members (particularly aging adults) must now consider employment due to the increase in housing costs.
- Co-located vocational rehabilitation counselors continue to be available on a part-time basis at most health homes (one to two days per week), and each serves multiple clinics. Vocational rehabilitation orientation sessions are offered both virtually and in-person. Some vocational rehabilitation counselors attend morning meeting huddles, when available, and/or are invited by the clinical teams.
- Adult members shared that their case managers mention employment at different frequencies. Some case managers broach the subject annually during the ISP process while others bring it up “regularly” to assess the members’ interest. This aligned with case managers who reported that employment discussions are usually held during ISP sessions, while other case managers try to raise this topic more regularly. Some family members were not aware that this service was available for their adult child.
- Provider and case manager attendees shared that there has been a positive push from the managed care contractor to engage more members in vocational rehabilitation and supported employment services and likewise, a push to hire more rehabilitation specialists at the health homes.
- Some adult members who had received supported employment services, including vocational rehabilitation services, did not feel that the employment options offered matched their interests, skillsets, and goals. One member shared that he “was discouraged from pursuing jobs outside of high-school jobs or basic simple jobs.” This same member thought there were “very limited employment options” offered through the health homes, and he thought there should be more focus on “nurturing dreams.” Another shared that he was “funneled down to a menial, redundant job (that was) not meaningful or fulfilling.” Another member wanted to go back to school but was told no by his vocational rehabilitation counselor. “It’s hard for me to advocate for myself with authority figures. I just tuck my tail between my legs.” This member reported taking a job at a laundry facility.
- Per case manager participants, members' interests and skill sets are considered when considering employment activities. The case managers identified job options such as delivery roles (e.g., Amazon, food delivery), call centers, and temporary agency roles. Some supported employment providers noted that they still have difficulty securing "long-term and part-time options for members." At the same time, it's not "always possible" to match jobs to a member's interests.
- One member reported positive experiences with his supported employment services. He shared that the wait time was short for the services to begin. He explained that it gave him a “sense of purpose in life” and “where everyone can learn basic skills to be successful in a work environment.” Some family members reported their adult children also had positive experiences with

supported employment services, including vocational rehabilitation services. One parent shared that her adult child's vocational rehabilitation counselor was "amazing and understood my child well."

- Adult member participants shared that there needs to be more support to help people maintain employment, not to just obtain it. They advocated for more on-the-job job coaching and a greater focus on how trauma impacts a person's ability to be successful in employment.
- Most members, case managers, and providers indicated that referrals to supported employment providers are usually processed within a week, and services begin about a week later. "The process is very simple and easy." The barrier to expediency was typically caused by a delay in obtaining a referral from a case manager or the lack of a rehabilitation specialist at a health home. Referrals for vocational rehabilitation services are typically processed by the counselor within 30 days.
- Most case managers and provider participants shared positive feedback about co-located employment providers who are active at the clinics. Some providers would like more time at the clinics, an increase in dedicated and allocated space to conduct work, and additional opportunities to further collaborate with the clinical teams.
- Case managers, providers, and adult members all reported that members remain fearful of the impact of working on their benefits. One member stated, "If I crash and burn at any time, I will not qualify for SSI or SSDI — I will have nothing. There is no support for people who have ebbs and flows" with their mental health. Family members agreed that this is a significant concern for them as well, particularly if their adult child loses Medicaid eligibility. Several family members shared experiences of their adult children receiving letters from the Social Security Administration within weeks of starting employment about reassessment eligibility for benefits such as SSI and SNAP.
- Providers, case managers, and adult members all reported they are aware of Disability 101 (DB101), and some members reported that their vocational rehabilitation counselors helped them to navigate the website. However, although case managers are familiar with DB101 as a resource for members, they do not receive training on how to use DB101, and typically, only the rehabilitation specialists receive this training. Only one family member was familiar with DB101 as a resource.
- Providers and case managers agreed that there are not enough rehabilitation specialists at the clinics, despite a reported push to hire more within the health homes. Both sets of attendees reported a blurring of roles as rehabilitation specialists assume case manager duties due to case manager vacancies. One health home was without a rehabilitation specialist for a full year. Another rehabilitation specialist covered the role, but this meant splitting their time between multiple sites.
- Case managers shared concerns that being a rehabilitation specialist used to be considered a promotional opportunity accompanied by a merit increase. However, when a person accepts this role, it appears to be a lateral move fiscally despite the

specific skill set required. Case managers view a rehabilitation specialist as a “key role” in the health home and one where the person is “familiar with a whole other network” compared to case managers.

- One rehabilitation specialist shared that she is the only one at her clinic, and she serves five clinical teams. A case manager supervisor noted that their clinic had four, but three resigned at the same time. High workloads and productivity requirements were cited as the leading causes of turnover.
- Participants discussed the low availability of clinic-based benefit specialists. Member, case manager, and provider participants shared that benefit specialists are only available on a part-time basis at some health homes, and most no longer assist with SSI and SSDI benefits. Their work remains limited to assisting with benefits such as SNAP and AHCCCS eligibility. Some health homes do not have any benefit specialists available for their members, and case managers see a growing need for this supportive role. Some family members were familiar with the benefit specialist role but did not find them to be helpful since they mostly need assistance with applying for SSI or SSDI.
- Case manager and provider participants shared that training on supported employment services is limited to rehabilitation specialists. In turn, some rehabilitation specialists will provide training to other members of the clinical team and, for some sites, will attend morning meetings to discuss the needs of members. Some health homes provide training on supported employment during new employee onboarding training while others could not recall whether this training was provided for new hires.

Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to supported employment services, Mercer administered a key informant survey. The survey distribution process targeted a defined list of system stakeholders, and responses to the survey did not represent a statistically significant sample of all potential informants. Readers should review survey results in the context of qualitative and supplemental data and avoid interpreting results to be representative of the total population of system stakeholders.

Level of Accessibility

Thirteen percent (13%) of survey respondents believed that supported employment services were difficult to access, the same finding as last year. One respondent (3%) indicated that the service was not available. Eighty-four percent (84%) of respondents indicated that supported employment services were easy to access or had “fair” access, slightly higher than CY 2022 (83%).

Factors that Influence Access

Factors that negatively impact accessing supported employment services include:

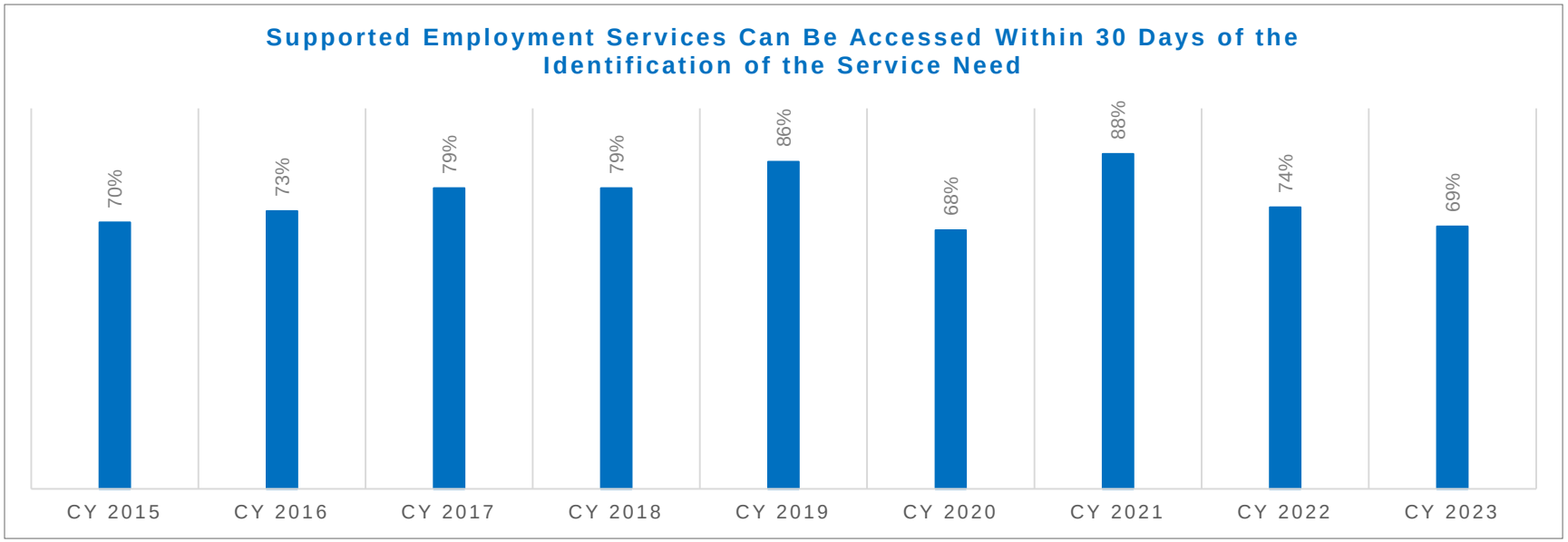
- Member declines services
- Transportation barriers
- Staff turnover
- Clinical team unable to engage/contact member

Efficient Utilization

Seventy-seven percent (77%) of the responses indicated that supported employment services were being used efficiently or were utilized efficiently most of the time, less than last year (86%). Twenty-three percent (23%) of respondents indicated that supported employment services were not utilized efficiently.

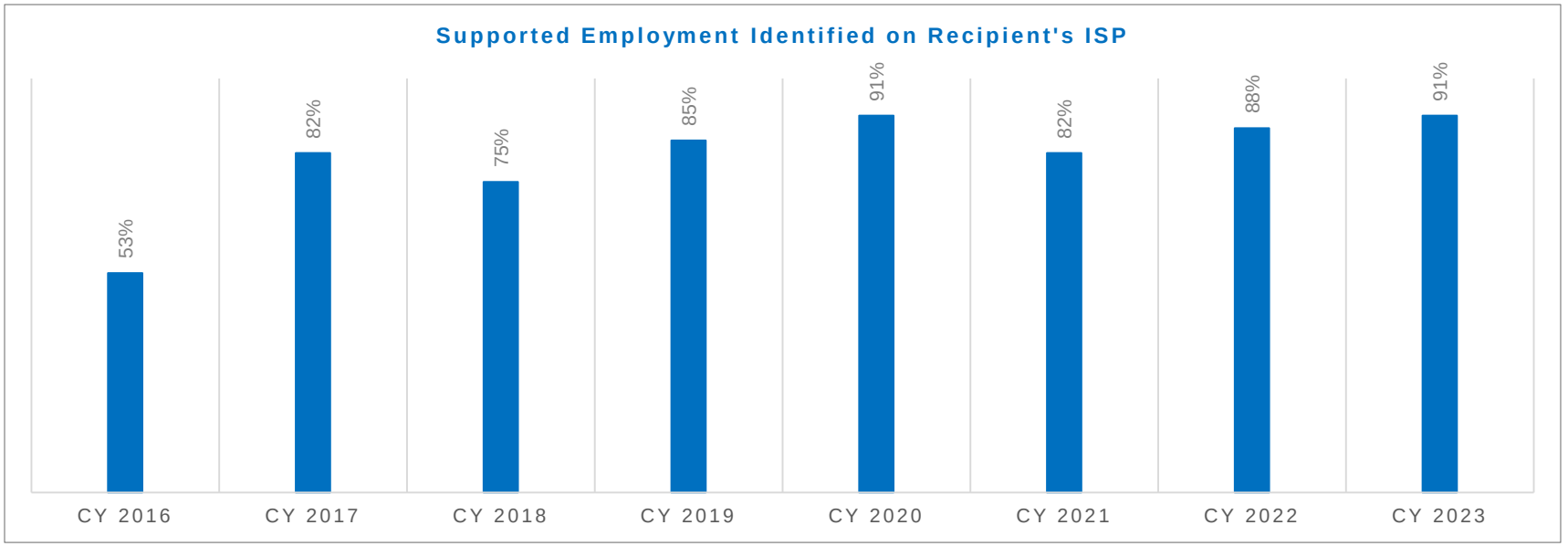
Timeliness

Sixty-nine percent (69%) of the survey respondents report that supported employment services can be accessed within 30 days of the identification of the service need. This compares to 74% during CY 2022. Seventeen percent (17%) of the survey respondents reported that it would take an average of six weeks or longer to access supported employment services.



Medical Record Review

The results of the medical record review demonstrate that supported employment services are identified as a need on either the recipient's assessment and/or ISP in 64% of the cases reviewed, four percentage points higher than last year (60%). Supported employment services were identified as a service on the recipient's ISP in 91% of the cases reviewed when assessed as a need (88% in CY 2022).



Twenty-seven percent (27%) of the recipients included in the medical record review sample received at least one unit of supported employment during CY 2023 based on a review of service utilization data.

In 89 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 almost half (49%) of the cases in which the person did not access the service despite an identified need — higher than the rate identified during CY 2022 (46%).

The review team noted inconsistencies across the integrated health homes regarding listing supported employment services on members' ISPs to reflect a one-time annual vocational activity profile (VAP) through the health home's assigned rehabilitation specialist (this activity is typically identified as "pre-job development and training" and commonly includes pre-job development and ongoing support to maintain employment billing codes). Some health homes include this intervention on virtually all ISPs; other clinics do not necessarily follow this approach. The contracted managed care organization has promulgated expectations to the health homes that an assessment of vocational interests and capabilities occur during the member's annual assessment update and ISP development process. Several cases in the medical record review sample did not include evidence that the member received a

VAP after the clinical team identified the activity as an intervention on the member's ISP. The contracted managed care organization does not currently monitor or track the completion of annual vocational-related assessments.

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 that 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, assistance in the use of educational resources necessary to obtain employment; attendance to Vocational Rehabilitation/Rehabilitation Services Administration (VR/RSA) information sessions; attendance to job fairs; training in resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), work activities, professional decorum, time management, and assistance in finding employment.

H2025 — Ongoing Support to Maintain Employment

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

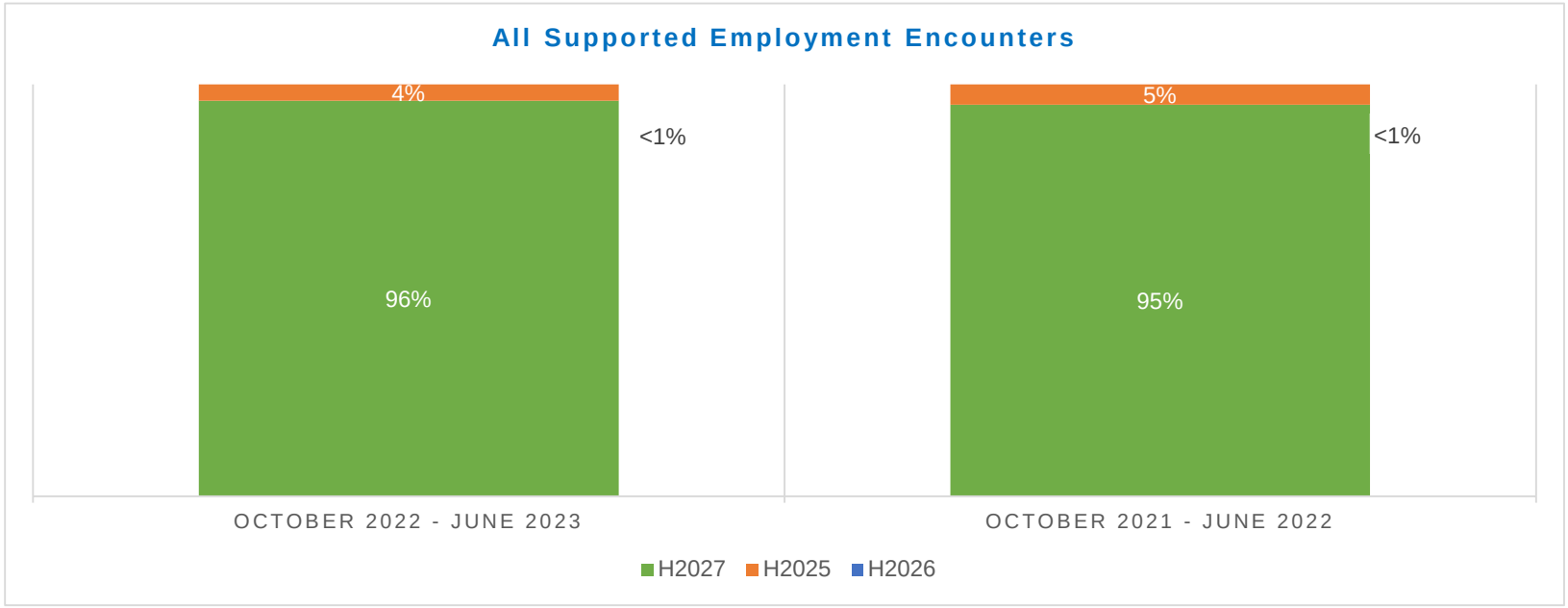
H2026 — Ongoing Support to Maintain Employment (per Diem)

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

Service Utilization Trends

For the period October 1, 2022 through June 30, 2023, H2027 (pre-job training and development) accounts for 96% of the total supported employment services. H2025 (ongoing support to maintain employment/15-minute billing unit) represents 4% of the

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



Challenges with providing ongoing support to maintain employment (H2025) include members opting out of supported employment services once competitively employed or the member's inability to attend meetings with job coaches due to commitments related to full-time employment. However, supported employment providers now offer virtual meetings, texting, and telephonic support in lieu of in-person meetings.

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

- Overall, 20% of the recipients received at least one unit of supported employment during the review period, ten percentage points less than CY 2022 (30%).
- Access to the service was split between Title XIX (21%) and Non-Title XIX groups (18%).

Persistence in Services

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

Persistence in Supported Employment Services October 2022–June 2023			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
1	57.7%	64.1%	59.1%
2	14.8%	12.8%	14.3%
3–4	13.5%	11.8%	13.1%
5–6	6.1%	4.7%	5.8%
7–8	2.7%	1.9%	2.6%
9+	5.1%	4.6%	5.0%

- Fifty-nine percent (59%) of the recipients who received at least one unit of supported employment services during the review period accessed the service during a single month. This finding aligns with low utilization of ongoing support to maintain employment, a supported employment service, and support that lends to consistent participation over a series of months.
- Thirteen percent (13%) of the recipients received supported employment services for three to four consecutive months during the review period.
- Five percent (5%) of the recipients received the service for at least nine consecutive months.

Coordinating With VR/RSA

The supported employment specialists associated with contracted supported employment providers and health home rehabilitation specialists coordinate closely with staff employed with the Arizona Department of Economic Security (DES)/ RSA (aka “Vocational Rehabilitation”). One supported employment provider reported that coordination with DES/RSA can be challenging due to inefficient workflows and delays in supporting prospective job candidates. The provider reports that alternative funding sources, such as grants, are being pursued to supplement untimely services and supports through DES/RSA. The contracted managed care organization meets with DES/RSA each quarter and is familiar with the current challenges. The parties are working to improve member’s experience with the agency.

Twenty-seven full-time DES/RSA counselors are dedicated to persons with SMI and co-located at several health home clinic locations. Six vacancies were reported as of December 2023. VR counselors meet regularly with health home clinic rehabilitation

specialists and contracted supported employment providers and work in coordination to meet member's supported employment needs.

The VR program for persons with SMI is tracking targeted outcomes. Overall, there have been decreases across most metrics when compared to CY 2022. DES/RSA data secured from the contracted managed care organization include the following:

- Members referred to VR/RSA — 1,287 between October 1, 2022 and September 30, 2023
- Members served in the VR program — 1,320 between January 1, 2023 and September 30, 2023
- Members open in the VR program — 1,095 between January 1, 2023 and September 30, 2023
- Members in service plan status with VR — 256 between January 1, 2023 and September 30, 2023

Key Findings and Recommendations

The most significant findings regarding the need for 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 26% of members received at least one unit of supported employment during CY 2023, a decrease of 4% from last year and continuing a trend of year-to-year decreases in utilization (32% in CY 2021).
- There were 860 more members who received supported employment when comparing CY 2023 to CY 2021, and there were an additional 160,654 units of the service delivered during this same period.
- Thirteen percent (13%) of survey respondents believed that supported employment services were difficult to access, the same finding as last year. One respondent (3%) indicated that the service was not available. Eighty-four percent (84%) of respondents indicated that supported employment services were easy to access or had "fair" access, slightly higher than CY 2022 (83%).
- Most case managers and provider participants shared positive feedback about co-located employment providers who are active at the clinics. Some providers would like more time at the clinics, an increase in dedicated and allocated space to conduct work, and additional opportunities to further collaboration with the clinical teams.
- During a focus group session, one member reported positive experiences with his supported employment services. He shared that the wait time was short for the services to begin, and he views the Club House model as beneficial. He explained that it gave

him a “sense of purpose in life” and “where everyone can learn basic skills to be successful in a work environment.” Some family members reported their adult children also had positive experiences with supported employment services, including VR services. One parent shared that her adult child’s VR counselor was “amazing and understand my child well.”

- Case manager and provider focus group participants shared that training on supported employment services is limited to rehabilitation specialists. In turn, some rehabilitation specialists will provide training to other members of the clinical team and, for some sites, will attend morning meetings to discuss the needs of members. Some health homes provide training on supported employment during new employee onboarding training while others could not recall if this training was provided for new hires.
- Supported employment services were identified as a service on the recipient’s ISP in 91% of the cases reviewed when assessed as a need (CY 2022 — 88%).
- In 89 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 almost half (49%) of the cases in which the person did not access the service despite an identified need — higher than the rate identified during CY 2022 (46%).
- Several cases in the medical record review sample did not include evidence that the member received a VAP after the clinical team identified the activity as an intervention on the member's ISP. The contracted managed care organization does not currently monitor or track the completion of annual vocational-related assessments.
- One supported employment provider reported that coordination with DES/RSA can be challenging due to inefficient workflows and delays in supporting prospective job candidates.

Recommendations: Supported Employment

- Continue efforts to coordinate with DES/RSA, and work to address potential delays in supporting members who have expressed a desire to engage in vocational activities and job searches.
- Ensure that integrated health homes are performing required vocational assessments during the annual assessment and ISP update process, and monitor and track that recommended services on member’s ISPs are delivered, including VAPs.
- Continue to monitor and address the practice of documenting supported employment services on members’ ISPs without evidence of an assessed need for the service. Train clinical teams to develop ISPs that are individualized and reflect the member’s unique circumstances and needs.

- Designate staffing resources to serve in the role of benefit specialists (use of peer support specialists, case managers, etc.) to address ongoing member concerns about securing employment, without jeopardizing eligibility for public assistance programs (e.g., AHCCCS eligibility, SSDI).

Multi-Evaluation Component Analysis — Supportive Housing

Service Description[43]

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

Focus Groups

Mercer facilitated focus groups to promote discussion with participants with direct experience with priority mental health services. Readers should review focus group results in the context of qualitative and supplemental data and not interpret the feedback as representative of all system stakeholders.

Findings collected from focus group participants regarding supportive housing services included the following:

- There was consensus across all focus groups that there are not enough stable, safe, and affordable housing options in Maricopa County. Additionally, there are still not sufficient subsidized vouchers available, waitlists remain excessively long, and finding landlords willing to accept vouchers at fair market value remains increasingly difficult. Providers noted that there are no new vouchers available, and they haven't seen any distributed since the summer of 2023. Providers have been told there is no average wait time for a voucher as the system is "on hold." Adult members expressed that when housing is available, it is often far from their service areas and transportation becomes an issue.

- Provider representatives noted that a common barrier to obtaining housing is having the required documentation ready and easily accessible once housing is available (i.e., identification, income statements, updated ISPs, and assessments). This is challenging for members who may be experiencing homelessness and/or may have more acute needs. They noted that some housing

[43] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation,* which may not reflect the terminology utilized to currently describe these services.

providers have become “very specific” about the documentation required, and there is not enough staff at the health homes who can assist with completing the process. Providers also noted that there are some housing providers with units open for months because of pending documentation. Participants believed this became a more significant issue when AHCCCS moved to a single contracted housing administrator.

- One adult member shared that he works full time and does not qualify for Medicaid. Housing is unaffordable for him and due to his Medicaid eligibility status, he “cannot get assistance” from his health home for housing. He expressed a “feeling of hopelessness” that he is “stuck” in his current living situation that does not support his recovery. Family members echoed this same concern for their adult children who do not qualify for Medicaid and the limited housing options available for them.

- Case managers shared that for those who can obtain housing, there is a lack of supports to help those individuals to maintain the housing on a long-term basis. They cited examples of individuals who exhibit hoarding behaviors and supports for individuals who were formerly homeless and have lost the skills needed to maintain a home. These issues often lead to failed inspections, lease violations, and ultimately, evictions.

- Case managers also shared that moving assistance has been eliminated (previously covered under flex funds) and obtaining a starter box is particularly challenging. They describe starter boxes as a “one and done” and as a vital resource for individuals to get settled into their homes. Most members move in with little to no household goods, and starter boxes were viewed as a critical resource.

- Case manager participants reported there are ongoing challenges in working with the AHCCCS-contracted housing administrator. Although the referral process is easy to navigate, they find it challenging to obtain any information or speak to a live person after a referral is submitted. Emails are responded to with a generic email response, and there is no way to determine a member’s status on the waitlist. Case managers are only able to speak to a live person once a member is awarded a voucher and is assigned to a housing specialist. Case managers also shared that they cannot determine how members get through the waitlist. “Some members have been on the waitlist for years while others get housing within six months.”

- Provider and adult member participants shared that there are not enough step-down or transitional housing options for members who need to move gradually to more independent settings. Adult and family members cited a particular need for those members being discharged from hospitals. For family members, their adult children have become homeless following hospitalizations due to the lack of step-down options.

- Providers, adult members, and case managers agreed that there are not enough clinic-based housing specialists. Some health homes do not have any, and many clinics only have one for the entire site. In some health homes, housing specialists cover

multiple clinics. One adult member shared that it took over six weeks for the clinic-based housing specialist to call him back. They informed him that there were no housing options available to him and he should remain in his group home.

- Case managers shared positive feedback about community-based supportive housing providers and described them as “very responsive” to referrals (approximately one week for services to begin). Providers indicated they can start services as quickly as within two business days, and the goal is to initiate services within 10 days at most.

- Case managers would like to see an increase in the availability of community-based supportive housing services as some providers experience waitlists for their services. Providers expressed a desire for housing providers to share their capacity levels with other providers to reduce waitlist times.

- Some health homes provide an overview of supportive housing services during new employee onboarding training, but most case managers shared they are not trained on the full continuum of supportive housing services and how to access them. Providers shared they have seen a slight improvement at the health homes regarding their knowledge of supported housing services. Although some training is available to health home staff, due to the high rate of turnover, it is difficult to keep the teams informed.

- Most of the adult member participants and all the family members were not familiar with the full cadre of supported housing services and could only identify vouchers as a service under supportive housing. When the full-service definition was provided to the participants, attendees agreed that those services would be helpful to members.

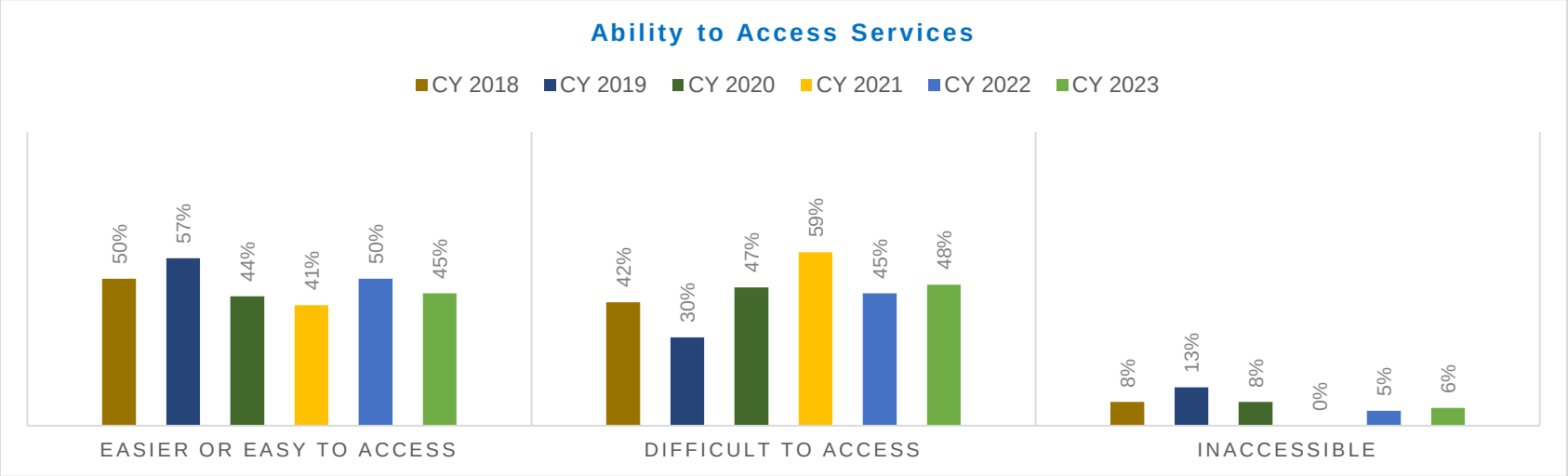
- Adult members shared varying responses when asked if their case managers discuss the status of their housing with them. Some are asked regularly, others shared that it appears these are “check box” questions, and others could not recall ever being asked if their housing was stable, safe, or at risk of being lost.

Key Informant Survey Data

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

Level of Accessibility

Forty-eight percent (48%) of the survey respondents believed that supportive housing services were difficult to access (45% in CY 2022). Two respondents (6%) indicated that supportive housing services were inaccessible.

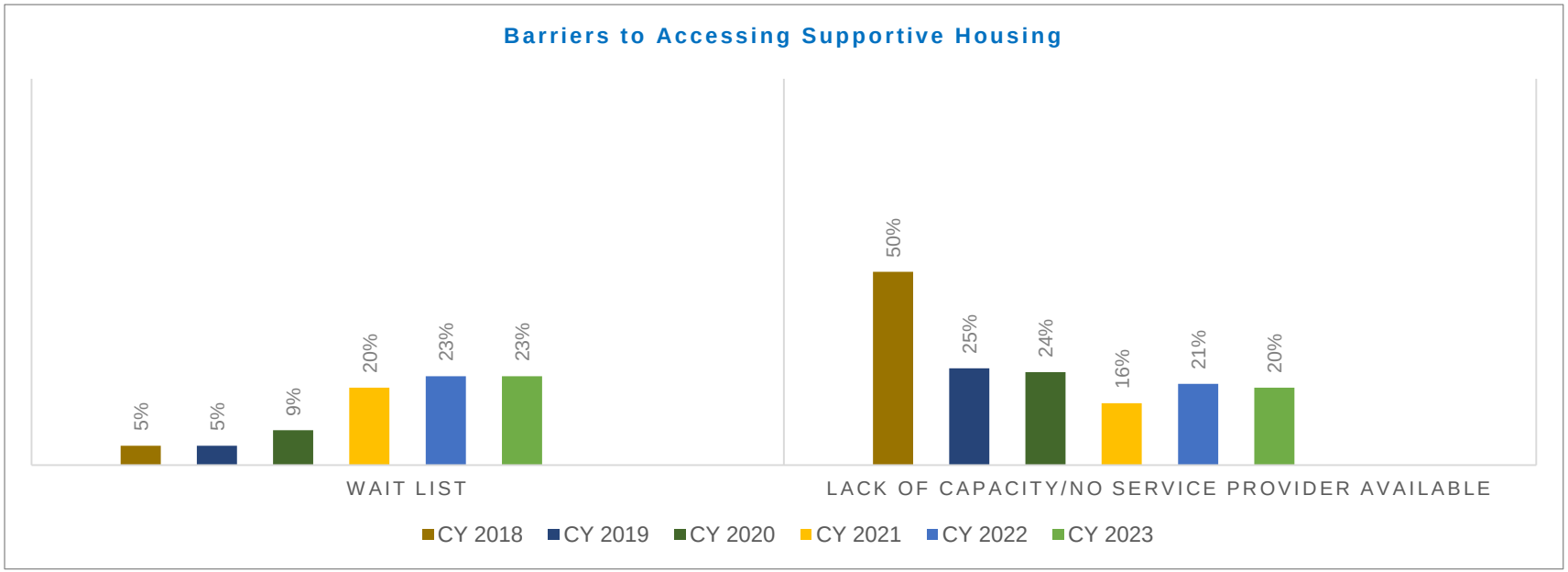


Forty-five percent (45%) of respondents indicated that supportive housing services had “fair access” or were easy to access; a decrease from CY 2022 (50%).

Factors that Influence Access

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

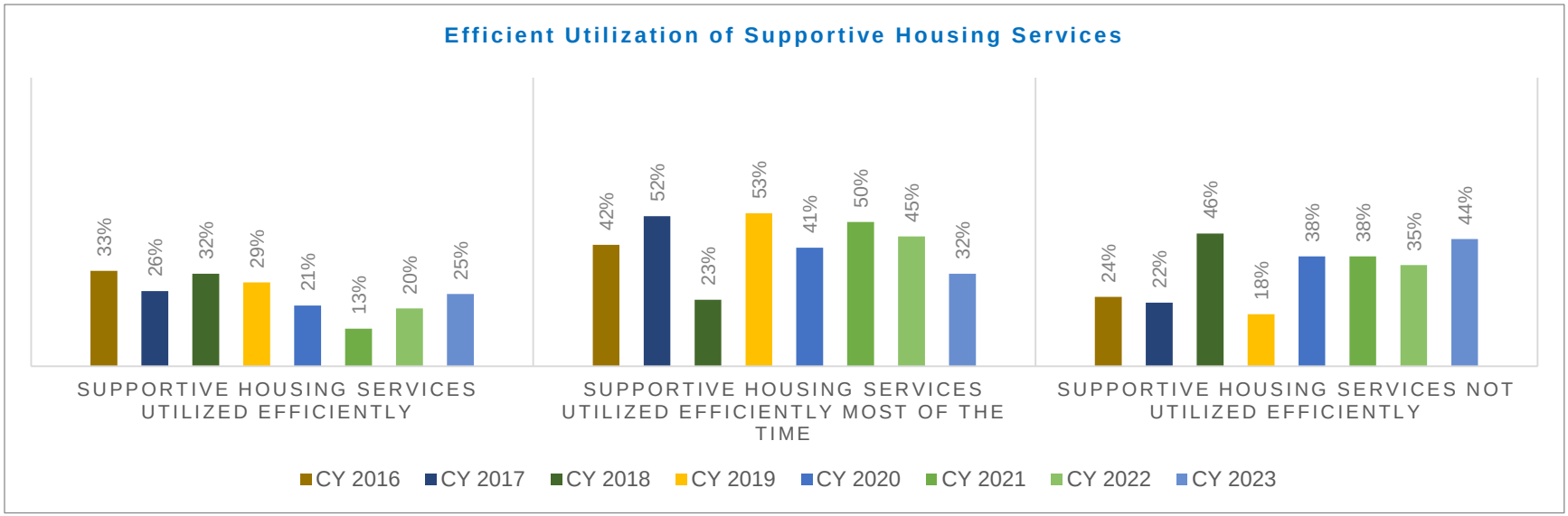
- Wait list exists for services (21 responses)
- Lack of capacity/no service provider available (18 responses)
- Staffing turnover (12 responses)



Efficient Utilization

In terms of efficient utilization of supportive housing services:

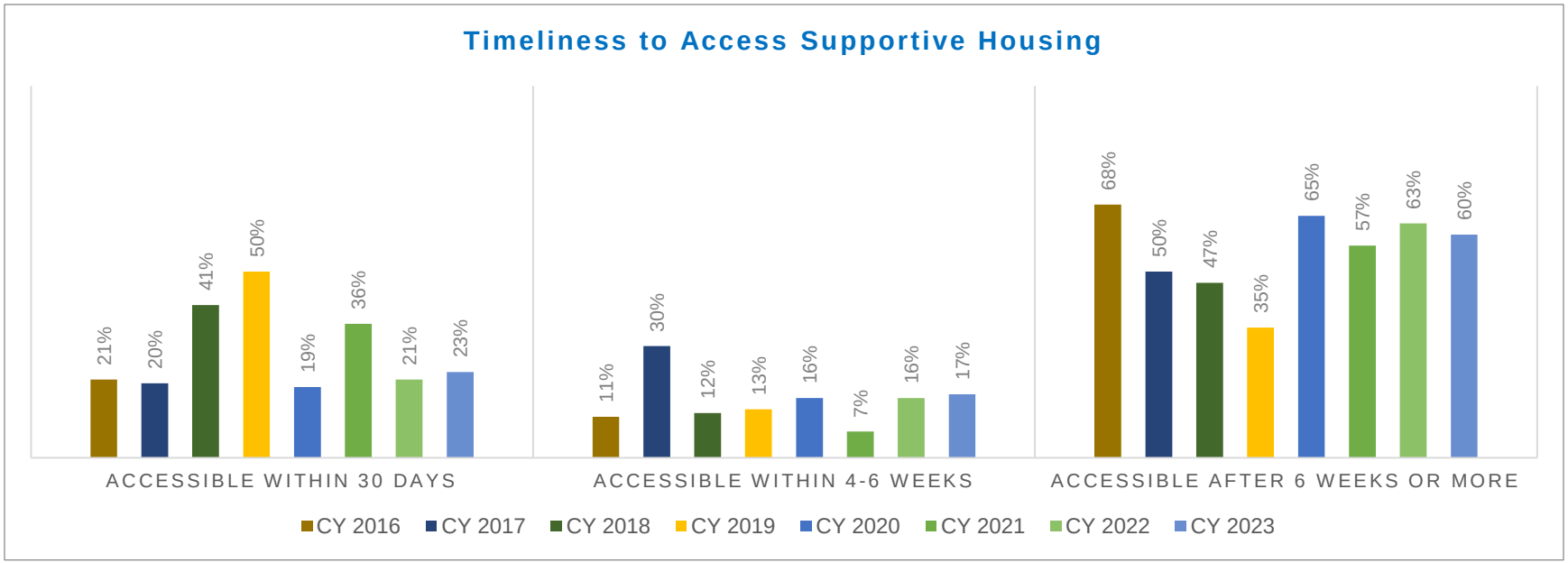
- Twenty-five percent (25%) of the responses indicated that the services were being utilized efficiently (20% in CY 2022).
- Thirty-two percent (32%) responded that the services were utilized efficiently most of the time (45% in CY 2022).
- Forty-four percent (44%) of the respondents indicated that supportive housing services were not utilized efficiently (35% in CY 2022)



Timeliness

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

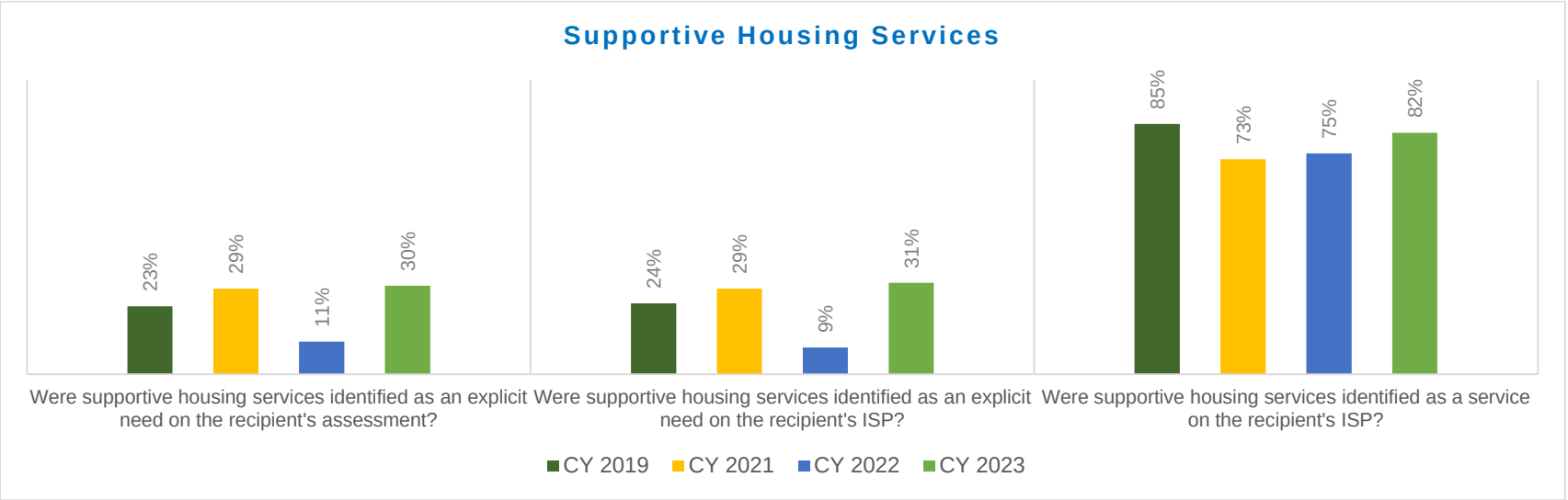
- Twenty-three percent (23%) of the survey respondents reported that supportive housing services could be accessed within 30 days of the identification of the service need (21% in CY 2022).
- Seventeen percent (17%) of the respondents indicated that the service could be accessed on average within four to six weeks (16% in CY 2022).
- Sixty percent (60%) of the survey respondents reported that it would take an average of six weeks or longer to access supportive housing services (63% in CY 2022).



Medical Record Review

The clinical teams at the integrated health homes consistently assess and document each recipient's living situation in the health home medical records.

- Supportive housing services were identified as a need on either the recipient's assessment or recipient's ISP in 36% of the cases reviewed, substantially more than last year's finding (12%).
- Supportive housing was identified as a service on the recipient's ISP in 82% of the cases when identified as a need. An increase from last year when 75% of the ISPs with a documented need included supportive housing.
- Twenty-two percent (22%) of the recipients included in the medical record review sample received a unit of supportive housing during CY 2023.



In 35 cases, reviewers were able to review progress notes and record the reasons that the person was unable to access supportive housing services after housing-related assistance was included on the person's ISP. The most common reason was that there was a lack of evidence that the clinical team followed up with initiating a referral for the service.

Service Utilization Data

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

Mercer utilizes a subset of these services to capture supportive housing services when rendered by a contracted permanent supportive housing provider.[44] The contracted managed care organization tracks supportive housing utilization through a roster of

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

members that are affiliated with one of ten contracted supportive housing providers. During the period of January 1, 2023–November 30, 2023, the roster of members receiving permanent supportive housing totaled 1,303.

As indicated within the service utilization data file, 4,436 (compared to 5,525 last review cycle) Title XIX eligible (Medicaid) recipients and 1,006 (compared to 887 last review cycle) Non-Title XIX recipients were affiliated with the service during the period of October 1, 2022–December 31, 2023, from a total population of 39,046.

Key Findings and Recommendations

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

Findings: Supportive Housing

- Service utilization data reveals that 14% of members received at least one unit of supportive housing during the review period, contributing to a downward trend over the past three years. Over 2,500 (2,546) less members received supportive housing between CY 2021 and CY 2023.
- Provider and adult member participants shared that there are not enough step-down or transitional housing options for members who need to move gradually to more independent settings. Adult and family members cited a particular need for those members being discharged from hospitals. For family members, their adult children have become homeless following hospitalizations due to the lack of step-down options.
- Case managers shared positive feedback about community-based supportive housing providers and described them as “very responsive” to referrals (approximately one week for services to begin). Providers indicated they can start services as quickly as within two business days, and the goal is to initiate services within 10 days at the most.
- Some health homes provide an overview of supportive housing services during new employee onboarding training, but most case managers shared they are not trained on the full continuum of supportive housing services and how to access them. Providers shared they have seen a slight improvement at the health homes regarding their knowledge of supported housing services. Although some training is available to health home staff, due to the high rate of turnover, it is difficult to keep the teams informed.
- Forty-eight percent (48%) of the survey respondents believed that supportive housing services were difficult to access (45% in CY 2022). Two respondents (6%) indicated that supportive housing services were inaccessible.
- Sixty percent (60%) of the survey respondents reported that it would take an average of six weeks or longer to access supportive housing services (63% in CY 2022).

- Supportive housing was identified as a service on the recipient's ISP in 82% of the cases when identified as a need. An increase from last year when 75% of the ISPs with a documented need included supportive housing.

Recommendations: Supportive Housing

- Promote and expand transitional housing offerings to support members who require temporary housing to help maintain stability and successfully integrate back to the community following discharge from a hospital or crisis stabilization unit.
- Continue efforts to identify safe and affordable housing options for persons living with SMI through collaboration with other community stakeholders, the AHCCCS contracted housing administrator, and permanent supportive housing providers.
- Examine causal factors that may be contributing to trends of reduced utilization of permanent supportive housing services, including but not limited to, service capacity and workflows to access the services.

Multi-Evaluation Component Analysis — Assertive Community Treatment

Service Description[45]

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

Focus Groups

Mercer facilitated focus groups to promote discussion with participants with direct experience with priority mental health services. Readers should review focus group results in the context of qualitative and supplemental data and not interpret the feedback as representative of all system stakeholders.

Findings collected from focus group participants regarding ACT services included the following:

[45] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation,* which may not reflect the terminology utilized to currently describe these services.

- In the provider focus group, ACT team members again demonstrated passion and commitment to the members on their teams. They described ACT as a "great program when members are appropriately referred" and "so beneficial when the members want to be there."
- Some adult members shared they were previously on ACT teams. One member believed his ACT team focused too much on taking medications, that he was visited daily, and he felt "very controlled." Another member shared that he was on ACT for eight years before going to prison and did not feel that he got "better." A few other adult members were aware of ACT and shared varying opinions of the service. One member stated that members get to "have a great team with a caseload of 100," while another member stated that "members on ACT teams need dedicated support and don't know what to ask for." He further explained that he has "known people to get zero services from their ACT team because they didn't know what to ask for" and he thought "ACT teams should be doing more than providing case management and crisis services."
- Some family member attendees were personally familiar with ACT due to their adult children receiving the service and shared varying views about the service. One family member was pleased that her daughter was going to receive ACT services once she was admitted to a behavioral health residential facility. Other family members shared they were told they could not consent to ACT services by their children's clinical teams despite holding guardianships. Another family member reported that the on-call service was non-responsive and did not believe it was a "true 24-hour service."
- Case manager participants expressed that there are still not enough ACT teams available, and they would like to see more FACT teams. An ACT provider shared that one FACT team was recently eliminated.
- Providers and case managers reported that not all ACT teams are operating at full capacity. An ACT provider shared they are not permitted to step down more than five to six members per month, but they assess regularly to determine whether members are ready for a discharge. Case managers were unaware of the discharge criteria for ACT and reported that members can remain on ACT "for years."
- In prior years, case managers reported they were aware of existing admission criteria for ACT, but none had seen or received training on formal admission criteria. This year, all case manager participants reported the admission criteria are readily available for review, and they expressed a stronger understanding of the criteria.
- Case managers reported that processing time for clinic-based referrals range from three to six months, but are much more rapid when a person is in an inpatient setting. A FACT provider reported they can process referrals within 24 hours if the paperwork and release of information are up to date.
- ACT team providers and case managers shared that turnover remains high among ACT staff. Case managers stated that ACT specialties are not practiced due to the turnover rates. Providers from peer-run organizations noted that they have not

encountered a peer support specialist on an ACT team, they have a difficult time engaging with ACT teams about their members, and it is “rare” to get a call back.

- ACT providers did not feel that pay contributes to the turnover among ACT staff. Rather they emphasized the demand of the work, including being on call regularly and high productivity expectations. One provider shared that the biggest challenge is “finding the right staffing fit who really want to work with and understand the population.”
- One ACT provider reported they utilize administrative support for progress notes and encourage staff to use an app in the field to generate notes. They identified these as supportive strategies for ACT team members.

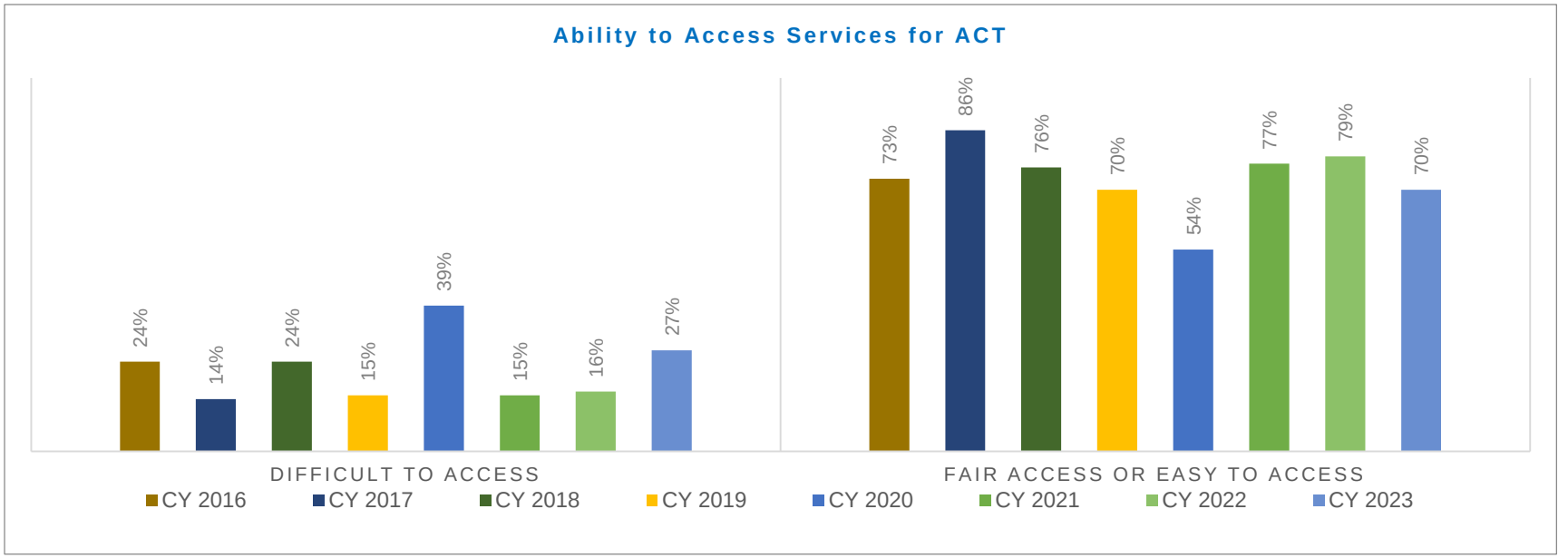
Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to ACT team services, Mercer administered a key informant survey. The survey tool included questions and rating assignments related to the priority mental health services. The survey distribution process targeted a defined list of system stakeholders, and responses to the survey did not represent a statistically significant sample of all potential informants. Readers should review survey results in the context of qualitative and supplemental data and avoid interpreting results to be representative of the total population of system stakeholders.

Level of Accessibility

Twenty-seven percent (27%) of survey respondents reported that ACT team services were difficult to access (16% in CY 2022). One respondent indicated that the service was unavailable.

Seventy percent (70%) of respondents indicated that ACT team services had “fair access” or were easy to access (79% in CY 2022).



Factors that Influence Access

When asked about the factors that negatively impact accessing ACT team services, the CY 2023 responses are as follows:

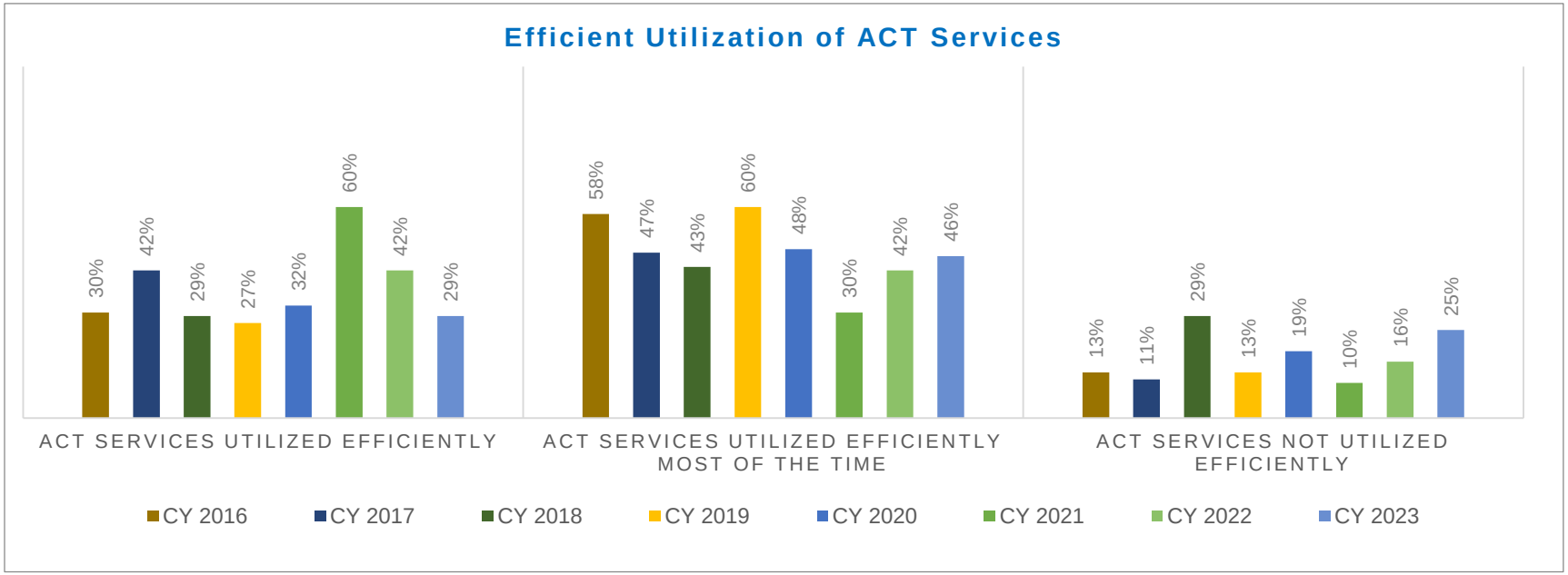
- Staff turnover (17)
- Clinical team unable to engage/contact member (17)
- Member declines services (16)

Efficient Utilization

In terms of the efficiency of service utilization in CY 2023:

- Twenty-nine percent (29%) of the responses indicated that the services were being utilized efficiently (42% in CY 2022).

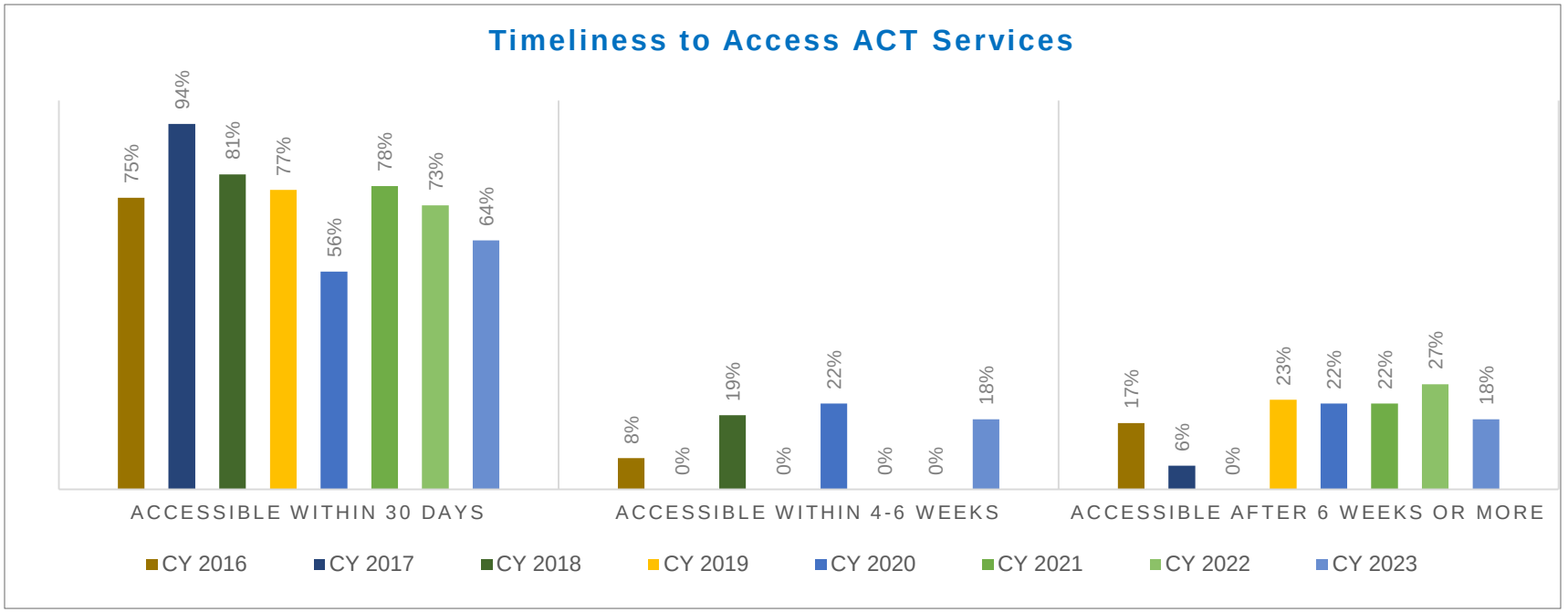
- Forty-six percent (46%) responded that the services were utilized efficiently most of the time (42% in CY 2022).
- Twenty-five percent (25%) of the respondents indicated that ACT team services were not utilized efficiently (16% in CY 2022).



Timeliness

In terms of the amount of time to access ACT team services in CY 2023:

- Sixty-four percent (64%) of the survey respondents reported that ACT team services could be accessed within 30 days of the identification of the service need (73% in CY 2022).
- Eighteen percent (18%) of the survey respondents indicated that the service could be accessed on average, within four to six weeks (0% in CY 2022).
- Eighteen percent (18%) of survey respondents reported that it would take an average of six weeks or longer to access ACT team services (27% in CY 2022).

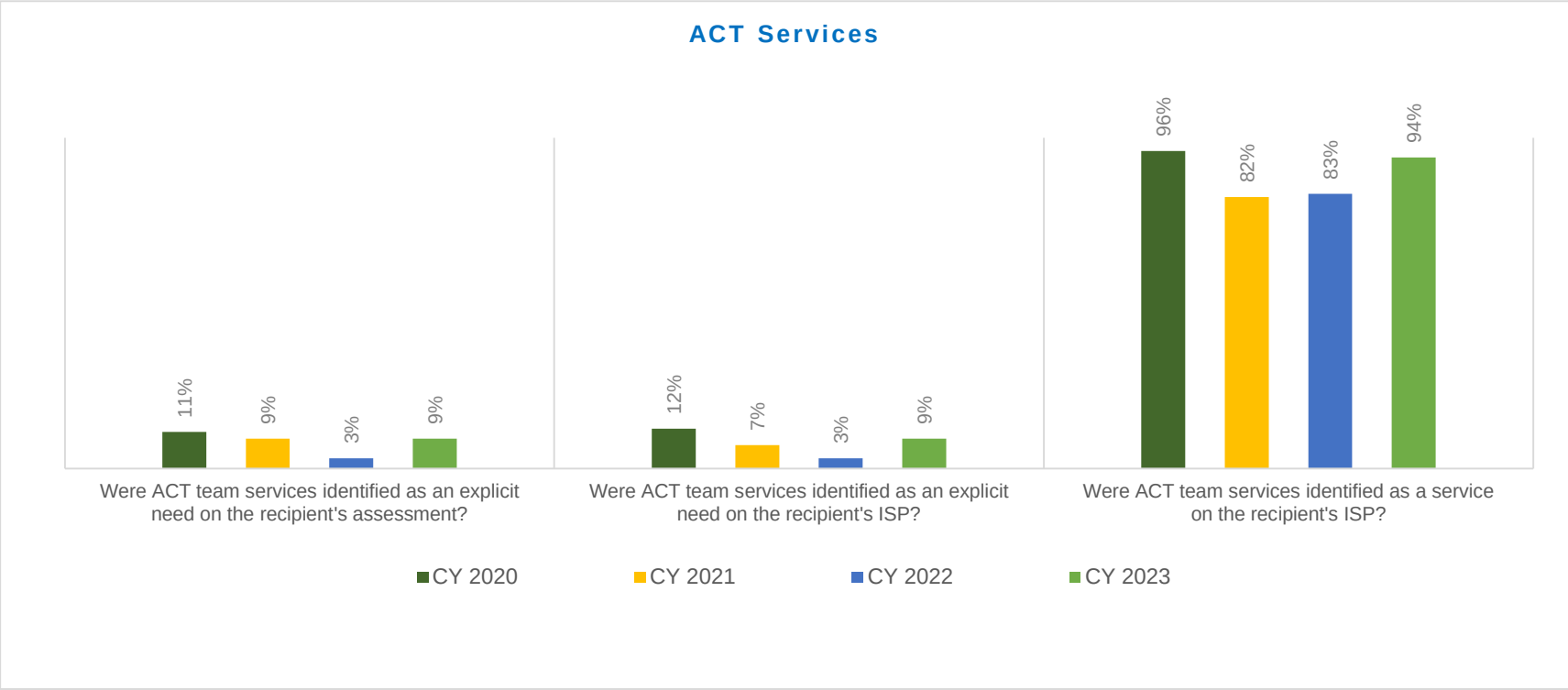


Medical Record Review

Mercer reviewed a random sample of 200 recipients' medical record documentation to evaluate the consistency in which ACT team services were assessed by the clinical team, identified as a needed service to support the recipient, included as part of the ISP, and, when applicable, accessed timely by the member.

In eighteen cases (9%), ACT team services were identified as a need on recipients' assessments or ISPs. Ninety-four percent (94%) of the cases with an assessed need for ACT included ACT or case management services on the ISP.

Seven percent (7%) of the recipients included in the sample were assigned to an ACT team.

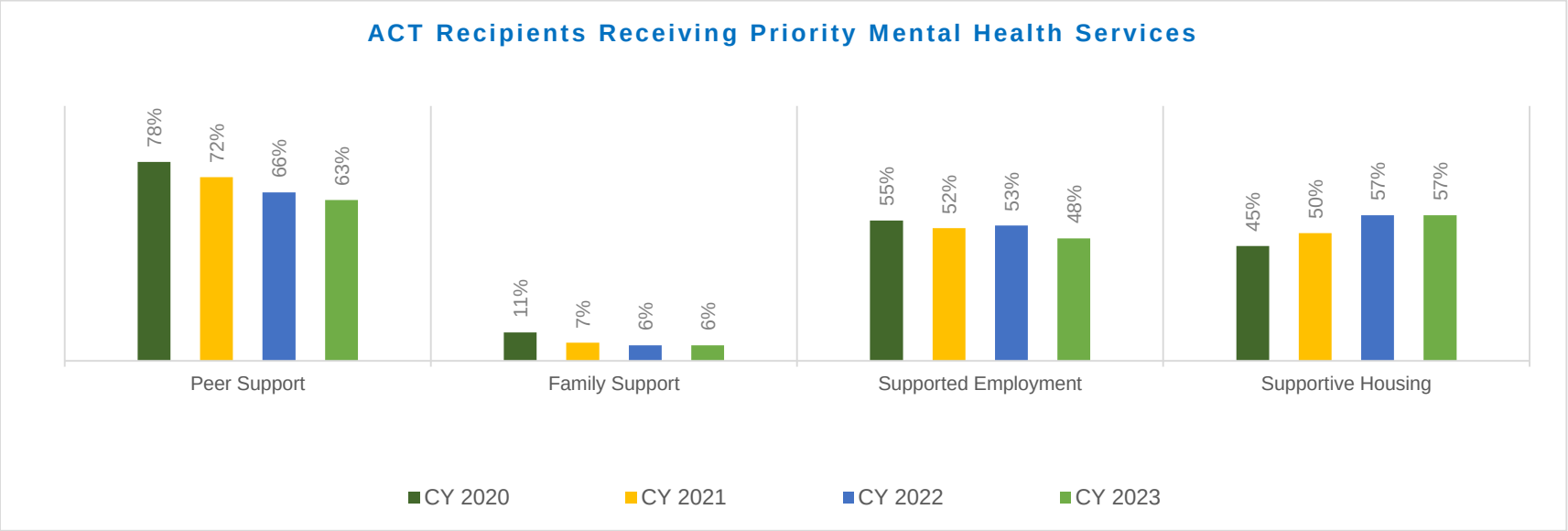


Service Utilization Data

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 2023 service utilization profiles for 2,042 ACT team members who received a behavioral health service were analyzed. The analysis sought to identify the utilization of one or more of the priority services (supported employment, supportive housing, peer support services, and/or family support services).

The analysis found:

- Sixty-three percent (63%) of the ACT team members received peer support services during the review period.
- Six percent (6%) of the ACT team members received family support services.
- Forty-eight percent (48%) of ACT recipients received supported employment services.
- Fifty-seven percent (57%) of ACT recipients received supportive housing services.



Analysis of Cost Data

To ensure the appropriate utilization of ACT services, entities involved in the clinical management of persons living with SMI should actively monitor and identify candidates for ACT team services by regularly analyzing relevant data sources. Examples include, but are not limited to, service utilization trends, service expenditures, the review of jail booking data, quality of care concerns, and adverse incidents involving members living with SMI.

Mercer assessed 100 members living with SMI associated with the highest aggregate behavioral health service costs during CY 2023. The analysis found that 19% of the members are assigned to an ACT team. This is the same percentage when the analysis was completed during CY 2022.

Of the 19 members assigned to ACT and included on the list of the top 100 members with the highest behavioral health service costs,15 (79%) also reside in supervised behavioral health residential settings. During times of transition (admission or discharge from ACT team services), it may be appropriate to temporarily have a member assigned to ACT and placed in a supervised setting, but this should be time-limited due to the duplicative nature of the services. In other cases, placement in a supervised behavioral health residential setting and assignment to ACT may be appropriate for some high acuity members (e.g., medical co-morbidities, challenging behaviors).

Overall, 75% of the 100 members reside in a supervised behavioral health residential setting, which can contribute to higher service costs for those members and may dissuade clinical teams from considering or referring a member to an ACT team. When members placed in a supervised behavioral health residential setting are excluded from the analysis, 21 out of 25 (84%) members could benefit from assignment to an ACT team if determined clinically appropriate.

Key Findings and Recommendations

Findings: ACT Team Services

- As a percentage of the total population with SMI, 5.3% of all members are assigned to an ACT team. There were 57 less members assigned to an ACT team when comparing CY 2023 to CY 2022. There has been a reduction of 262 ACT team members between CY 2021 and CY 2023, a 12.7% decrease.
- In the provider focus group, ACT team members again demonstrated passion and commitment to the members on their teams. They described ACT as a “great program when members are appropriately referred” and “so beneficial when the members want to be there.”
- ACT team providers and case managers shared turnover remains high among ACT staff. Case managers stated that ACT specialties are not practiced due to the turnover rates. Providers from peer-run organizations noted that they have not encountered a peer support specialist on an ACT team, they have a difficult time engaging with ACT teams about their members, and it is “rare” to get a call back.
- Providers and case managers reported that not all ACT teams are operating at full capacity. An ACT provider shared they are not permitted to step down more than five to six members per month, but they assess regularly to determine whether members are

ready for a discharge. Case managers were unaware of the discharge criteria for ACT and reported that members can remain on ACT “for years.”

- Twenty-seven percent (27%) of survey respondents reported that ACT team services were difficult to access (16% in CY 2022). One respondent indicated that the service was unavailable.
- Sixty-three percent (63%) of the ACT team members received peer support services, 48% received supported employment services, and 57% received supportive housing services during the review period.

Recommendations: ACT Team Services

- To address available capacity on many ACT teams, continue efforts to identify candidates for ACT and FACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns, and adverse incidents involving members living with SMI.
- Examine causal factors that may be contributing to trends of reduced utilization of ACT team services, including admission criteria and workflows to access the services.
- Continue efforts to address workforce challenges, to assist with recruitment and retention of ACT team staff members. Consider offering flexible work schedules, incentives, and other innovative approaches to support workers and improve job satisfaction and retention.
- Provide training, supervision, and written materials to help ensure that health home clinical team members understand how to identify ACT team candidates and procedures to refer a member to an ACT team.
- Similar to activities performed by the contracted managed care organization to engage clinical teams when a member is hospitalized to treat behavioral health conditions, proactively outreach clinical teams when key metrics suggest a member may be appropriate for transition to an ACT team.

Section 6

Outcomes Data Analysis

The service capacity assessment included an analysis of recipient outcome data to link receiving one or more priority mental health services with improved functional outcomes. Relationships between outcomes and service utilization trends do not necessarily reflect causal effects. As such, observed outcomes may be contingent on several variables unrelated to the receipt of one or more of the priority mental health services.

Mercer reviewed the following data sources:

- Employment status
- Criminal justice involvement
- Emergency room utilization
- Grievance data

Employment Status

Employment stimulates self-reliance and leads to other valued outcomes, including self-confidence, respect for others, personal income, and community integration. It is not only an effective short-term treatment but also one of the only interventions that lessens dependence on the mental health system over time.[46]

The contracted managed care organization contracts with seven specialty employment providers to implement evidence-based supported employment services. The provider network includes various provider types, including outpatient providers, peer-run organizations, and community service agencies. These providers may offer psychoeducational services, pre-job training and development, and ongoing support to maintain employment. A billing code modifier (H2027 SE) tracks employment services provided to members with an expressed interest and goal of obtaining employment in the next 45 days or are currently engaged in an active job search with a contracted supported employment provider. Services provided using H2027 SE are directly related to obtaining

[46] Robert E. Drake and Michael A. Wallach. Employment is a Critical Mental Health Intervention. *Epidemiology and Psychiatric Services*, November 5, 2020.

employment. From January 1, 2023 through December 31, 2023, 1,869 persons living with SMI in Maricopa County received at least one unit of H2027 SE.

For persons living with SMI, the following counts of employment are noted as of December 1, 2023:

- 3,153 persons competitively employed full-time
- 3,062 persons competitively employed part-time
- 1,290 persons with other employment

Criminal Justice Involvement

Mercer analyzed jail booking data to identify members that have had multiple jail bookings over a defined period (i.e., 11 months — January 2023 through November 2023). Members with multiple incarcerations are then compared to ACT and FACT rosters to determine the percentage accessing the evidence-based practice.

- 1,257 unique members were incarcerated during the review period. The number of incarcerations per member ranged from one to eight.
- 428 members experienced at least two jail bookings during the period under review (464 in CY 2022).
- Of these 428 members, 57 (13%) were assigned to an ACT team during the review period (11% in CY 2022).
- Of the 57 members assigned to an ACT team, 12 (21%) are assigned to a forensic specialty ACT team (22% in CY 2022).
- 17 members receiving ACT team services have three or more incarcerations over the review period but are not assigned to one of the two available forensic specialty ACT teams, an increase of three members when compared to last year.
- 163 members were incarcerated three or more times but are not assigned to an ACT or forensic specialty ACT team.

Emergency Room Utilization[47]

Mercer analyzed emergency room utilization for members living with SMI in Maricopa County over the period of October 1, 2022–December 31, 2023. A summary of findings is presented below:

- Over the reporting period, there were 94,587 emergency department visits involving 14,184 unique members or 36% of the total population (39,047).
- 8,798 (23%) members experienced three or more emergency room visits during the reporting period.
- For persons assigned to an ACT team, there were 8,818 emergency room visits involving 918 unique members or 45% of the ACT team population (2,060).
- 591 (29%) ACT team members experienced three or more emergency room visits during the reporting period.

Grievance Data

Mercer reviewed summarized grievance data collected by the contracted managed care organization over the following period: January 1, 2023–November 2023. Below is an overview of the types of complaints related to members living with SMI in Maricopa County.

A total of 2,318 complaints were recorded over the reporting period.

2,041 complaints were noted as “closed” at the time of the report, with nearly 40% of those cases involving issues that were found to be substantiated.

The tables below summarize counts by complaint category and sub-category:

Category	Count
Access to care	26
Attitude and service	2,045
Billing and fnancial issues	50

[47] Mercer did not have access to diagnostic codes for members presenting to the emergency room and, therefore, cannot verify that the visits involved assessment/treatment for behavioral health conditions.

Category	Count
Quality of care	195
Quality of practitioner office site	2
TOTAL	**2,318**

Subcategory — Access to Care	Count
Access to care	6
Contractor service	2
Medical service provision	13
Transportation	2

An additional three cases were categorized as “not otherwise specified”

Appendix A

Focus Group Invitation

Are you looking for a way to provide feedback about the behavioral health system in Maricopa County ***and*****,** you are:

- An ***adult with a serious mental illness*** (SMI) living in Maricopa County and receiving services from the behavioral health system.
- A ***family member of an adult with SMI*** living in Maricopa County who is receiving services from the behavioral health system.
- A ***direct care clinic case manager*** providing services for adults with SMI in Maricopa County.
- Or a ***provider of a priority mental health service (PMHS)*** in Maricopa County. PMHS include Assertive Community Treatment (ACT), Supportive Housing or Permanent Supportive Housing (SH), Supported Employment (SE), or Peer and Family Support Services.

If so, consider registering for <u>one</u> of the stakeholder sessions below. *Attendees may only attend one session that best matches their role in the behavioral health system.*

<u>Stakeholder Group One</u>: For ***Adults with SMI*** receiving at least one PMHS Tuesday, January 30, 2024 10:00 am–12:00 pm	**<u>Stakeholder Group Two</u>**: For ***Direct Care Clinic Case Managers*** providing PMHS to adults with SMI Tuesday, January 30, 2024 2:00 pm–4:00 pm

Stakeholder Group Three: For ***Providers of ACT, SH, SE, Peer and Family Support Services***

Wednesday, January 31, 2024
10:00 am–12:00 pm

Stakeholder Group Four: For ***Family Members of Adults with SMI*** receiving at least one PMHS

Wednesday, January 31, 2024
2:00 pm–4:00 pm

All sessions will be held *in person* at the following location:

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

RSVP with the name of the stakeholder group you want to attend (for example, Group One) by January 26, 2024, to Liza Auterino at liza.auterino@mercer.com or via phone at +1 480 238 9161.
Space is available for 15 participants per stakeholder group. All RSVPs will be confirmed by email.
Once capacity is reached, interested participants will be placed on a waiting list.

Si el Espanol es su idioma de preferencia y desea dar comentarios, por favor enviar correo a liza.auterino@mercer.com y nosotros agendaremos una llamada con un intérprete.

Information gathered in these stakeholder sessions will be provided to the Arizona Health Care Cost Containment System (AHCCCS) as part of the annual Service Capacity Assessment of PMHS in Maricopa County. Information gathered helps to expand access to recovery-oriented services. Please note that all attendee names and information shared will be kept confidential.

Priority Mental Health Services – Definitions

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

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

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

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

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

Appendix B

Key Informant Survey

Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2024

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

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

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

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

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

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

Q4. If you checked other above, please specify:

_____

Q5. Are the priority services below being utilized efficiently?

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

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

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

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

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

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

_____

Q9. What is your job role/title?

- O CEO (1)
- O Executive Management (2)
- O Clinical Leadership (behavioral health) (3)
- O Clinical Leadership (medical) (4)
- O Specialty Case Manager (5)
- O Direct Services Staff (BHP/BHT) (6)
- O Other (please specify) (7) _____

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

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

Appendix C

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, 2023 – December 31, 2023*

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

Appendix D

Summary of Recommendations

Service	Recommendations
Peer Support Services (PSS)	PSS 1: Examine factors contributing to high turnover and vacancies across peer support specialists operating within the service delivery system, and take actions to address recruitment and retention. PSS 2: Continue efforts to implement improvements to the contracted managed care organizations Navigator program, and ensure that contracted providers are equipped with data and resources to manage their assigned navigator panels efficiently and effectively. PSS 3: Analyze the system of care to ensure peer support services can be readily accessed when members desire and need the services, and implement strategies to enhance the availability of this critical service.
Family Support Services (FSS)	FSS 1: Continue efforts to provide training, supervision, and written materials to help ensure that health home clinical team members understand the appropriate application of family support services and to recognize the value of family support services as an effective service plan intervention.
Supported Employment Services (SES)	SES 1: Continue efforts to coordinate with DES/RSA, and work to address potential delays in supporting members who have expressed a desire to engage in vocational activities and job searches. SES 2: Ensure that integrated health homes are performing required vocational assessments during the annual assessment and ISP update process, and monitor and track that recommended services on member's ISPs are delivered, including VAPs. SES 3: Continue to monitor and address the practice of documenting supported employment services on members' ISPs without evidence of an assessed need for the service. Train clinical teams to develop ISPs that are individualized and reflect the member's unique circumstances and needs. SES 4: Designate staffing resources to serve in the role of benefit specialists (use of peer support specialists, case managers, etc.) to address ongoing member concerns about securing employment,

Service	Recommendations
	without jeopardizing eligibility for public assistance programs (e.g., AHCCCS eligibility, SSDI).
Supportive Housing Services (SH)	SH 1: Promote and expand transitional housing offerings to support members who require temporary housing to help maintain stability and successfully integrate back to the community following discharge from a hospital or crisis stabilization unit. SH 2: Continue efforts to identify safe and affordable housing options for persons living with SMI through collaboration with other community stakeholders, the AHCCCS contracted housing administrator, and permanent supportive housing providers. SH 3: Examine causal factors that may be contributing to trends of reduced utilization of permanent supportive housing services, including but not limited to, service capacity and workflows to access the services.
Assertive Community Treatment (ACT)	ACT 1: To address available capacity on many ACT teams, continue efforts to identify candidates for ACT and FACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns, and adverse incidents involving members living with SMI. ACT 2: Examine causal factors that may be contributing to trends of reduced utilization of ACT team services, including admission criteria and workflows to access the services. ACT 3: Continue efforts to address workforce challenges to assist with recruitment and retention of ACT team staff members. Consider offering flexible work schedules, incentives, and other innovative approaches to support workers and improve job satisfaction and retention. ACT 4: Provide training, supervision, and written materials to help ensure that health home clinical team members understand how to identify ACT team candidates and procedures to refer a member to an ACT team. ACT 5: Similar to activities performed by the contracted managed care organization to engage clinical teams when a member is hospitalized to treat behavioral health conditions, proactively outreach clinical teams when key metrics suggest a member may be appropriate for transition to an ACT team.
General Recommendations (GR)	GR 1: Perform an assessment of the workflows at the integrated health homes that focuses on the implementation of members' ISP interventions, with the goal of ensuring that clinical teams initiate

Service	Recommendations
	timely referrals for needed services. Health home progress note templates may restate ISP objectives and goals, but there continues to be multiple examples of clinical teams failing to get recommended ISP services in place on behalf of members. GR 2: Continue efforts to monitor the timely completion of annual member assessments and ISPs. When compiling the sample for medical record reviews, 14% of the cases (from a sample of 200) did not include current assessments or ISPs. GR 3: Ensure that new employee orientation materials and ongoing training curricula for health home clinical team members (including case managers and clinical supervisors) address the appropriate application of the priority mental health services and how to assist members with accessing the services when medically necessary. GR 4: Continue efforts to address workforce challenges, including the recruitment and retention of peer support specialists, family mentors, and case managers across the system of care.

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