CONTENTS

1 Executive Summary .................................................................................................................................................................................. 1
   • Overview of Findings and Recommendations .................................................................................................................................... 3
   • Service Capacity Assessment Conclusions ........................................................................................................................................ 4

2 Overview ................................................................................................................................................................................................... 6
   • Goals and Objectives of Analyses ...................................................................................................................................................... 6
   • Limitations and Conditions ................................................................................................................................................................. 6
   • Contributors to Project ....................................................................................................................................................................... 6
   • Acknowledgments .............................................................................................................................................................................. 8

3 Background ............................................................................................................................................................................................... 9
   • History of Arnold v. Sarn .................................................................................................................................................................... 9
   • SMI Service Delivery System in Maricopa County .............................................................................................................................. 9
   • Current Service Capacity ................................................................................................................................................................. 11

4 Methodology............................................................................................................................................................................................ 16
   • Focus Groups .................................................................................................................................................................................. 16
   • Key Informant Interviews ................................................................................................................................................................. 17
   • Medical Record Reviews (Group 1 and Group 2) ............................................................................................................................. 18
   • Analysis of Service Utilization Data .................................................................................................................................................. 20
   • Analysis of Outcomes Data .............................................................................................................................................................. 22
   • Penetration and Prevalence Analysis ............................................................................................................................................... 24
   • Service Expansions — Comparison of Select States ....................................................................................................................... 24

5 Findings and Recommendations ............................................................................................................................................................. 25
   • Penetration and Prevalence Analysis ............................................................................................................................................... 25
- Service Expansions — Comparison of Select States ....................................................................................................................... 30
- Multi-Evaluation Component Analysis .............................................................................................................................................. 34
  - Priority Service: Consumer Operated Services ........................................................................................................................... 34
  - Priority Service: Supported Employment .................................................................................................................................... 45
  - Priority Service: Supported Housing ........................................................................................................................................... 55
  - Priority Service: Assertive Community Treatment Teams ........................................................................................................... 62
- Outcomes Data Analysis .................................................................................................................................................................. 68

Appendix A: Focus Group Invitation ............................................................................................................................................................ 70
Appendix B: Key Informant Survey ............................................................................................................................................................ 71
Appendix C: Assessment Verification Interview Tool ................................................................................................................................... 75
Appendix D: Group 2 Medical Record Review Tool ..................................................................................................................................... 77
Appendix E: List of Peer-Directed Groups ................................................................................................................................................... 80
Appendix F: Summary of Recommendations .............................................................................................................................................. 81
Executive Summary

The Arizona Department of Health Services/Division of Behavioral Health Services engaged Mercer Government Human Services Consulting (Mercer) to design and implement a network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI). The service capacity assessment included a need allocation evaluation of supported housing, supported employment, consumer operated services (peer support services and family support services), and assertive community treatment (ACT). Research was conducted by reviewing other states that have settled similar litigation related to persons with SMI to determine the approach and methodology utilized to assess the sufficiency of comparable covered services. Research sought to determine how network sufficiency was defined in these states and how a system capacity analysis was beneficial if performed. Mercer adopted and modified methods performed under nationally recognized system capacity analyses and performed a service capacity assessment of the priority mental health services to assess unmet needs utilizing the following methods:

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

A formal evaluation of practice fidelity of each priority service was beyond the scope of Mercer’s project. When observed through one or more of the evaluation components, information is included in the report regarding the appropriate delivery of each service based on knowledge of nationally accepted fidelity standards and best practices.

For example, the following observations were noted by the review team:

- Rarely did the planning of peer support and the documentation of peer support services include awareness of the main tenet of peer support, namely, coaching and modeling recovery-oriented attitudes, beliefs, motivations, and behaviors. This may be due in large part to the fact that peer support rarely is described in the direct care clinic clinical documentation as coaching and mentoring for recovery. Instead, it is more often utilized as an ancillary service that may help people find more opportunities for recreation and socialization. While these activities are important, peer support also can help people develop recovery-oriented attitudes, beliefs, and behaviors, as peer support specialists share their hard-fought-and-won insights on how they have prevailed over mental illness. Peer support should result in people developing better illness self-management, greater involvement in community settings of their choice (versus simply becoming more involved in programs for people with mental illness), and greater engagement in work and school.

- At times, supported employment services consisted of a visit from the rehabilitation specialist who made an inquiry into the recipient’s vocational interests or referred the recipient to an employment program or opportunity, but it was uncommon in the record reviews to find examples of evidence-based supported employment (e.g., thorough, formal vocational assessment; rapid job search, job development with employers, job coaching, etc.) Some recipients did appear to be receiving services through an external vocational rehabilitation program, but the actual services received were not documented in the direct care clinic clinical record. As noted in the sample of medical record reviews, most of what constitutes “pre-job training and development” includes activities that are not considered evidence-based supported employment (assessing a person’s readiness) or an interview to assess a person’s interest in working (versus a thorough/formal vocational assessment).

- It was noted during record reviews that the day-to-day functions of the ACT team staff members are primarily oriented towards monitoring and surveillance of the recipient’s living quarters (e.g., adequate food, appearance of living space, appropriate room temperature) and ensuring that observations are completed and documented regarding the recipient’s adherence to taking prescribed medications. In addition, some teams appeared to lack all recommended staffing designations and the roles across team members were noted to be overly generic. While it is preferred that ACT team staff members step in and assist recipients whenever needs present, the roles appeared diluted and staff member’s unique specialization was rarely applied. In the few ACT team cases reviewed, recipients assigned to ACT teams rarely received specialized services related to substance abuse, supported employment, or other recovery-oriented supports and services.

It should be noted that the review team did not apply fidelity review instruments as part of the service capacity assessment. However, fidelity evaluations are an important consideration when assessing the current utilization and availability of each priority service. Reported rates of utilization of each priority service should be viewed in the context of how much of the delivered service actually meets established fidelity standards.
Overview of Findings and Recommendations
Select findings and recommendations regarding the accessibility and provision of the priority services are summarized below. At times, multiple evaluation components revealed similar or identical outcomes lending additional relevance to the finding.

**Consumer Operated Services (Peer Support Services and Family Support Services)**
- Maricopa County is one of the leaders nationally in engaging peers in the system. There are numerous opportunities for people to receive training in peer support, and compared to other systems, a high percentage of people with SMI receive peer support services.
- Improvements could include continuing to target approaches to leveraging peer support. The system should continue efforts to increase the use of peer support services as a follow-up to crisis services; utilize peers as part of hospital discharge planning and supportive engagement; using peers to help ensure timely ambulatory care follow up after hospitalization; helping recipients to get incorporated into traditional physical healthcare pathways (integrated care) and deploy peer support specialists to assist recipients who are experiencing significant life challenges (e.g., incarcerations).
- It appears that the formal assessment and ISP development process is inconsistently targeting peer support as a specific clinical intervention; more recipients end up using peer support than have peer support identified as a planned intervention in their ISPs.
- Clinical teams are doing an effective job of identifying and documenting family supports that are available to the recipient. Also, there is documentation of the recipient’s preferences regarding family involvement in service planning. However, very few cases reviewed indicated that the clinical team actually helped connect family members and natural support system members to family support. Missed opportunities to leverage family members to support the recipient’s achievement of ISP goals were a common observation.

**Supported Employment Services**
- Supported employment opportunities available at community providers sometimes focus on skill development and job preparation for work within the behavioral health system, such as employment training to become a peer support specialist. The review team observed fewer examples of community providers supporting persons with employment opportunities outside of the behavioral health system.
- Billing code H2026 (ongoing support to maintain employment/per diem billing unit) represents less than 1% of the utilization of supported employment. This finding illustrates that the emphasis with the delivery of supported employment is directed to pre-job training and development and that very few individuals receive ongoing support to maintain employment, such as connections to employment/job coaches. This finding also suggests that there may be a paucity of available providers and/or programs that deliver supported employment programming designed to engage recipients in intensive supports throughout the work day (per diem code) to ensure skill mastery and job retention.
- According to Mental Health National Outcome Measures data, Arizona currently has the highest percentage of recipients served with supported employment than any other state with data: 23.7% of all recipients received supported employment in 2012. The Arizona estimate is considerably higher than the national rate of 1.7% and Arizona’s 23.7% estimate indicates a “best practice benchmark”.
- Supported employment services sometimes consisted of a visit from the rehabilitation specialist who made an inquiry into the person’s vocational interests or referred the person to an employment program or opportunity, but it was uncommon in the record reviews to find examples of evidence-based supported employment (e.g., thorough, formal vocational assessment; rapid job search; job development with employers; job coaching.)
Supported Housing Services

- Half of the survey respondents identified “a lack of capacity/no service provider available” as the most prevalent factor negatively impacting access to housing support services. In addition, over two-thirds of key informants believed that it would take six weeks or longer on average to access housing support services once identified as a need.
- The review team discovered opportunities to transition current residents placed in residential placements. In addition, moving recipients from residential settings to independent community living placements with supports may only represent modest cost increases for the system. Fair market rent calculated for Maricopa County indicated that it would cost $748 per month for a one bedroom apartment. Current fee-for-service rates for State-funded room and board services in residential settings are reported to be $21.28 per day or approximately $638 per month. When clinically appropriate and with the provision of wraparound services, it may be preferable to assist a significant percentage of recipients currently in residential facilities to live in independent living arrangements.
- A means of tracking the provision of supported housing services should be developed. This should include training clinical teams in differentiating between case management, other services, and supported housing.

ACT Team Services

- Opportunities may exist to ensure consistent implementation of established ACT admission criteria across all provider network organizations, enhance monitoring and oversight of the process by the regional behavioral health authority, and routinely assess cost and utilization data to support the appropriate identification of candidates for ACT teams. It was found that 80% of the highest cost SMI utilizers are not assigned to an ACT team, which may represent a missed opportunity while recognizing that some recipients may not be clinically appropriate, not in the community (jail, residential) or may decline ACT team services.
- Thirteen of the fifteen existing ACT teams are at least 5% or more below capacity (capacity of each team = 100 recipients). In fact, five of the fifteen teams are 10% or more below capacity and three of the fifteen teams are 15% or below capacity, meaning that over half the available teams are 10% or more below capacity. While the expectation is that ACT teams will not always work at full capacity, ACT teams should only fluctuate between slightly under capacity and slightly over capacity.
- Focus group data suggested that more ACT resources need to be devoted to recipients with criminal justice system involvement. These recipients are viewed as challenging to serve and more ACT teams need to have forensic expertise. Many systems utilize forensic ACT teams, as has Maricopa County, and as new ACT teams are planned for implementation, special consideration should be given to ensuring additional teams serve the forensic population.

Service Capacity Assessment Conclusions

- The plan for added capacity (1,500 class members) for consumer operated services (peer support services and family support services) appears appropriate based on the service capacity analysis, though of all the priority mental health services, peer support services seem to be sufficiently available. There should be an emphasis on more appropriate application of the services and an overall promotion of family support services.

---

The service capacity assessment validated that the system is in need of the 1,250 new supported employment slots that will be implemented by fiscal year (FY) 2017. In fact, because there appears to be a greater need for supported employment services than for ACT team services, the system should consider reallocating some of the resources that are planned to be directed to adding 13 new ACT teams into expanding the number of supported employment offerings. As of December 13, 2013, only 13% of Maricopa County’s SMI population was reported as competitively employed (part-time or full-time) and the review team believes that the demand for supported employment services may extend beyond the planned allocation of additional service capacity.

Plans to add supported housing services capable of serving 1,500 additional class members by FY 2017 are substantiated based on the service capacity assessment. There is a perceived and documented need for the provision of more supported housing services. Service utilization data revealed that only five unique recipients received a supported housing (H0043) code during the 15 month review period, which clearly does not represent the extent of available supported housing services and resources. Development and implementation of a standardized mechanism to better track and quantify supported housing services and expenditures within the behavioral health system is needed.

The review team was unable to substantiate a clear need for the planned addition of 13 ACT teams by FY 2017. At the time of the review, many of the current ACT teams were not at full capacity. The under capacity of ACT teams in Maricopa County may suggest that teams are not actively recruiting appropriate new participants (a fidelity issue), or that there is not a sufficient need for ACT team services to warrant a near doubling of the number of teams available in the system by FY 2017. In addition, it is possible that many of the ACT teams are not adequately transitioning recipients to lower levels of care when the recipient’s recovery warrants such a transition. Despite these issues, Maricopa County’s current ACT team representation of less than 6% of the total active SMI population does likely necessitate some additional capacity. However, the review team recommends that most resources be initially devoted to ensuring that the existing teams are performing at acceptable fidelity, including the appropriate identification, recruitment, and transitioning of recipients to less intensive levels of care when clinically indicated.

Additional findings and recommendations for each of the priority services can be found in Section 5, Findings and Recommendations.
Overview
The Arizona Department of Health Services (ADHS)/Division of Behavioral Health Services (DBHS) engaged Mercer Government Human Services Consulting (Mercer) to design and implement a network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI). Mercer’s evaluation included the initial design of a service capacity assessment; an analysis of unmet needs related to the prioritized services in Maricopa County, Arizona; and the development of an approach to support ongoing year-to-year network capacity evaluations. The service capacity assessment included a need allocation evaluation of supported housing, supported employment, consumer operated services (peer support services and family support services), and assertive community treatment (ACT).

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

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

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

Contributors to Project
The review team consisted of the following personnel.

---

2 The determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis.
Core Team
Daniel Wendt, Senior Associate
Daniel is a Senior Associate at Mercer and performs clinical and behavioral health consulting. Daniel possesses over 25 years of experience with Medicaid managed care programs and clinical service delivery systems. Daniel has a clinical background and is experienced in quality performance improvement concepts and approaches.

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

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

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

Other Project Team Members
Jeanie Aspiras
Josh Compton
Dillon Davis
Doug Shannon
Katherine Sternbach
Timothy Dittmer (TriWest Group)
Andy Keller (TriWest Group)
Jesse Seiger-Walls (TriWest Group)
Bill Wilson (TriWest Group)
Acknowledgments
Mercer would like to thank the following ADHS/DBHS staff: Cory Nelson, Deputy Director, Kelli Donley, Project Manager, and Michael Sheldon, Bureau Chief, for assistance with project coordination and responding to multiple data requests.

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

Mercer also expresses gratitude to the focus group participants and the key informants who provided valuable insight, completed survey tools, and granted interviews.
Background
The ADHS/DBHS serves as the single State authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health system. ADHS/DBHS contracts with community-based organizations, known as regional behavioral health authorities (RBHAs), to administer behavioral health services throughout the State of Arizona.

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

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

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

SMI Service Delivery System in Maricopa County
ADHS/DBHS contracts with RBHAs to deliver behavioral health services across six geographic service areas (GSAs) throughout Arizona. Each RBHA must manage a network of providers to deliver all covered behavioral health services. RBHAs contract with behavioral health providers to provide the full array of covered behavioral health services, including the four prioritized services that are the focus of this assessment.
For persons determined to have a SMI in Maricopa County, the RBHA has contracted with four adult provider network organizations (PNOs) that operate direct care clinics throughout the county. The PNOs include Choices Network, People of Color Network, Partners in Recovery Network, and Southwest Network. The table below identifies the four adult PNOs and affiliated direct care clinics.

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

The direct care clinics provide a range of recovery focused services to SMI recipients such as medication services, medical management, case management, transportation, peer support services, family support services, and health and wellness groups. ACT teams are available at 13 different direct care clinic locations. Access to other covered behavioral health services, including supported employment and supported housing is primarily accessible to SMI recipients through RBHA contracted community-based providers.
Current Service Capacity
The information presented below reflects the contracted capacity for each of the prioritized services during the period under review.\(^3\)

**ACT Teams (15 teams serving 1,361 recipients)\(^4\)**

<table>
<thead>
<tr>
<th>PNO/Direct Care Clinic</th>
<th>Specialty</th>
<th>Capacity</th>
<th>Number of Recipients</th>
<th>% Below Full Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southwest Network: San Tan</td>
<td></td>
<td>100</td>
<td>100</td>
<td>0%</td>
</tr>
<tr>
<td>Southwest Network: Hampton</td>
<td></td>
<td>100</td>
<td>100</td>
<td>0%</td>
</tr>
<tr>
<td>Southwest Network: Osborn</td>
<td></td>
<td>100</td>
<td>95</td>
<td>5%</td>
</tr>
<tr>
<td>Southwest Network: Bethany Village</td>
<td>Young Adult Team</td>
<td>100</td>
<td>89</td>
<td>11%</td>
</tr>
<tr>
<td>Choices: Enclave</td>
<td></td>
<td>100</td>
<td>87</td>
<td>13%</td>
</tr>
<tr>
<td>Choices: South Central</td>
<td></td>
<td>100</td>
<td>84</td>
<td>16%</td>
</tr>
<tr>
<td>Choices: Townley Center</td>
<td></td>
<td>100</td>
<td>86</td>
<td>14%</td>
</tr>
<tr>
<td>Choices: West McDowell</td>
<td></td>
<td>100</td>
<td>84</td>
<td>16%</td>
</tr>
<tr>
<td>People of Color Network: Centro Esperanza</td>
<td></td>
<td>100</td>
<td>86</td>
<td>14%</td>
</tr>
<tr>
<td>People of Color Network: Comunidad — Team 1</td>
<td>Forensic Team</td>
<td>100</td>
<td>90</td>
<td>10%</td>
</tr>
<tr>
<td>People of Color Network: Comunidad — Team 2</td>
<td></td>
<td>100</td>
<td>93</td>
<td>7%</td>
</tr>
<tr>
<td>People of Color Network: Capitol Center</td>
<td></td>
<td>100</td>
<td>92</td>
<td>8%</td>
</tr>
<tr>
<td>Partners in Recovery: Metro Center Campus — Team 1</td>
<td></td>
<td>100</td>
<td>99</td>
<td>1%</td>
</tr>
<tr>
<td>Partners in Recovery: Metro Center Campus — Team 2</td>
<td></td>
<td>100</td>
<td>93</td>
<td>7%</td>
</tr>
<tr>
<td>Partners in Recovery: West Valley Campus</td>
<td></td>
<td>100</td>
<td>83</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td><strong>1,500</strong></td>
<td><strong>1,361</strong></td>
<td><strong>9%</strong></td>
</tr>
</tbody>
</table>

\(^3\) As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in January 2014.

\(^4\) As of February 14, 2014.
A presentation of service utilization data was completed to identify the volume of units and unique members affiliated with each provider. The review is intended to identify the most prevalent providers of selected priority services. The analysis was completed for the following priority mental health services: peer support, family support, and supported employment. Contracted supported housing providers are also identified.

**Consumer Operated Services (peer support and family support)**

- CHEEERS
- REN
- STAR
- Visions of Hope
- Vive La Esperanza/Hope Lives

---

5 As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in January 2014.
Top family support providers, by members served

Number of members

Provider

PARTNERS IN RECOVERY
SOUTHWEST NETWORK
TERROS
VISIONS OF HOPE ARIZONA
CHILD & SUPPORT SERVICES
RECOVERY INNOVATIONS
STAR
LIFEWELL BEHAVIORAL WELLNESS

Top family support providers, by units

Number of units

Provider

PARTNERS IN RECOVERY
RECOVERY INNOVATIONS
VISIONS OF HOPE ARIZONA
CHILD & SUPPORT SERVICES
TERROS
SOUTHWEST NETWORK
EMPACT SUICIDE PREVENTION
SOUTHWEST BEHAVIORAL HEALTH
PSA BEHAVIORAL HEALTH
Supported Employment Providers

- Arizona Foundation for the Handicapped.
- Beacon Group (TETRA).
- Career Advisors.
- Catholic Community Services.
- Central Arizona Council on Developmental Disabilities.
- Chandler/Gilbert ARC.
- Desert Winds Employment Consultants.
- DK Advocates.
- Elite Community Services.
- Focus Employment Services.
- Gompers Habilitation Center.
- Goodwill Industries of Central Arizona.
- GS Consulting Group.
- Lifewell Behavioral Wellness.
- Marc Community Resources.
- Odyssey Services Corp.
- Scottsdale Training and Rehab Services.
- Southwest Autism Research and Resource.
- The Centers for Habilitation.
- Turning Point Assistance and Development.
- Valleylife.
- Wedco Employment Center.

---

6 As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in January 2014.
Supported Housing Providers\textsuperscript{7,8}

- ABC Housing.
- Biltmore Properties.
- City of Phoenix.
- City of Tempe.
- Desert Leaf.
- Lifewell.
- Native American Connections.
- ProMarc.
- RIAZ.
- Save the Family.
- Superstition Mountain Mental Health Center/Mountain Health and Wellness.
- UMOM.

\textsuperscript{7} As reported by the Maricopa County RBHA administering the ADHS/DBHS contract in January 2014.
\textsuperscript{8} Supported housing services were not significantly represented within the service utilization data file.
Methodology
Research was conducted by reviewing other states that have settled similar litigation related to persons with SMI to determine the approach and methodology utilized to assess the sufficiency of comparable covered services. Research sought to determine how network sufficiency was defined in these states and how a system capacity analysis was beneficial if performed. Mercer adopted and modified methods performed under nationally recognized system capacity analyses and performed a service capacity assessment of the priority mental health services to assess unmet needs utilizing the following methods:

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

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

**Focus Groups**
As part of the service capacity assessment of the four priority behavioral health services in Maricopa County, four focus groups were conducted with key informants. The focus groups were organized and managed to facilitate discussion with participants who have direct experience with the four priority mental health services. Participation in the focus groups was solicited by an invitation created by Mercer,
which was reviewed and approved by the ADHS/DBHS Office of Family Affairs\(^9\). The focus groups were also communicated to key stakeholders in the community, a notice was sent to the four Adult PNOs, and an electronic invitation was sent out by People of Color Network through their Community News bulletin.

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

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

A total of 30 stakeholders participated in the four two-hour focus groups conducted on February 19, 2014 and February 20, 2014 at Quality Care Network’s administrative offices in Phoenix, Arizona. A total of seven providers, six family members, ten adult recipients, and seven peer support specialists participated.

The methodology included two steps. First, participants were asked several questions related to the priority mental health services:

- How did they define ACT services, supported housing services, supported employment services, and peer support services?
- Did they think that the priority services were sufficiently available within the service delivery network?
- Did they think any of the services were underutilized?
- What were the issues that were impacting the utilization of the services?
- Did they have any recommendations to improve the service delivery of the priority mental health services?

The participants were also asked to prioritize the top three to four areas as the most important issues regarding the priority mental health services.

**Key Informant Interviews**

One objective of the service capacity assessment was to obtain comprehensive stakeholder input. As a result, a key informant survey was created using Survey Monkey\(^\circ\). The survey tool included 10 questions with rating assignments related to accessing the priority mental health services, including the ease of access and timeliness of access to the services.\(^{10}\)

The survey was disseminated to key system stakeholders via email with a hyperlink to the online survey. The survey remained accessible for two and half weeks during March and April 2014. Identified key stakeholders included the following: CEOs of the four adult PNOs; CEOs

---

\(^9\) See Appendix A, Focus Group Invitation.

\(^{10}\) See Appendix B, Key Informant Survey.
of supported housing services, supported employment services and peer support services; as well as an emergency department physician, the CEO of National Alliance for the Mentally Ill Phoenix, Arizona Health Care Cost Containment System behavioral health coordinators, and providers of substance abuse services and crisis services.

A total of 13 respondents completed the survey. While the final number of respondents to the survey was relatively low, the informed perspective that these key individuals possess should not be underestimated. The key informants who were asked to complete the survey include individuals who have decades of experience with Arizona’s public behavioral health system. These system experts can uniquely appreciate the system’s strengths and opportunities. The individuals that participated offered relevant insight regarding the availability of the priority services and other related issues.

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

Group 1
The Group 1 sample included 122 randomly selected cases, identified using the following criteria:

- The recipient was identified as SMI, assigned to GSA-6 and received a covered behavioral health service during October 1, 2012 and December 31, 2013; and
- The recipient was affiliated with an assessment code (H0031)\(^{11}\) with a date of service during October, November, or December 2013.

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

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

\(^{11}\) Cases for Group 1 were purposely selected to ensure that a recent assessment and ISP were completed to support the recipient’s recall regarding the needs and available services discussed with the clinical team.
Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient’s current annual assessment update or initial assessment, a current psychiatric evaluation, and the recipient’s current ISP.

Mercer developed an interview guide\(^{12}\) to support the assessment of the recipient’s perception regarding the need for one or more of the priority services. Mercer’s review team conducted an orientation and review of the interview tool to help ensure consistent application of the guide across reviewers.

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

Forty-one out of one hundred twenty-two recipients (34%) completed the interviews. Some participants declined to participate, other recipients did not show for scheduled appointments, and some recipients were unable to be contacted during the designated interview period (March 2014). In a small number of cases and at the request of the recipient, the interviews were completed over the telephone or at the person’s private residence.

Group 1 medical record documentation for the sample (n=122) was reviewed by a behavioral health professional and recorded in a data collection tool. Documentation regarding the priority mental health services was analyzed and recorded by reviewing assessments and ISPs. Additional comments were included to further clarify findings. Findings from the recipient interviews were added to the data collection tool to support a comparative analysis between the medical record documentation findings and the recipient’s recorded responses to the interview questions.

Group 2
For Group 2, the final sample included 198 randomly selected cases, selected using the following criteria:

- The recipient was identified as SMI and received a covered behavioral health service during October 1, 2012 and December 31, 2013.\(^{13}\)
- The recipient was affiliated with an assessment date between April and August 2013.\(^{14}\)

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

\(^{12}\) See Appendix C, Assessment Verification Interview Tool.
\(^{13}\) Total population of unique SMI recipients = 23,512.
\(^{14}\) Cases for Group 2 were selected to ensure that sufficient time had elapsed to reasonably expect the delivery of recommended services following the completion of the recipient’s assessment and ISP.
Is there evidence that the need for each of the priority mental health services was assessed by the clinical team?
When assessed as a need, was the priority mental health service(s) identified on the recipient’s ISP?
When identified as a need and listed on the recipient’s ISP, is there evidence that the recipient accessed the service consistent with the prescribed frequency and duration and within a reasonable time period?
If the recipient was unable to access the recommended priority service, what were the reasons that the service(s) was not delivered?

Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient’s current annual assessment update or initial assessment, a current psychiatric evaluation (if available), the recipient’s current ISP, and all clinical team progress notes dated April 1, 2013 through December 31, 2013.\textsuperscript{15}

Group 2 medical record documentation for the sample (n=198) was reviewed by four licensed clinicians and recorded in a data collection tool.\textsuperscript{16} The data collection tool was pre-loaded to include recipient identifying information and each recipient’s unique service utilization profile. Additional comments were recorded to further clarify findings. Prior to conducting the medical record reviews, inter-rater reliability testing was completed with each reviewer on actual cases to ensure at least 90% agreement on ratings. When 90% agreement between raters was not achieved, ratings were carefully reviewed to promote clarification of rating decision rules.

**Analysis of Service Utilization Data**

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

The specified time frame for the file included dates of service between October 1, 2012 and December 31, 2013. In consultation with ADHS/DBHS, it was determined that encounter submission lag times can impact the completeness of the data set. Estimates of completion rates and time periods are presented below:

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Estimated % of Completeness</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2012 — June 30, 2013</td>
<td>99%</td>
</tr>
<tr>
<td>July 1, 2013 — September 30, 2013</td>
<td>90%</td>
</tr>
<tr>
<td>October 1, 2013 — December 31, 2013</td>
<td>50%</td>
</tr>
</tbody>
</table>

\textsuperscript{15} In a few cases, the date range for progress notes was amended to correspond with the development of the recipient’s assessment and ISP. For example, one recipient in the sample participated in the development of an assessment and ISP during February 2013. Subsequently, progress notes were requested with a start date of February 2013 so that service delivery could be assessed concurrent with the recipient’s updated assessment and service plan.

\textsuperscript{16} See Appendix D, Group 2 Medical Record Review Tool.
Therefore, analysis of the service utilization data was substantially targeted to the October 1, 2012 — June 30, 2013 time frame. Exceptions were noted when analyzing service utilization data in the context of the medical record review sample period, which spanned calendar year (CY) 2013. It should be noted that utilization of the priority mental health services would be expected to be under-reported when reviewing the last two calendar quarters of 2013.

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

The service utilization data file also supported the extraction of the Group 1 and Group 2 medical record samples and allowed for an analysis of the service utilization profile for each recipient selected, as well as supporting an aggregated view of service utilization for each sample group (total sample size across Group 1 and Group 2 = 320). Group 1 and Group 2 sample characteristics are illustrated in the table below and compared to the overall sampling frame or population characteristics.

<table>
<thead>
<tr>
<th>Sample Group</th>
<th>Number of Recipients</th>
<th>Peer Support</th>
<th>Family Support</th>
<th>Supported Employment</th>
<th>Supported Housing</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>122</td>
<td>36%</td>
<td>2%</td>
<td>39%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Group 2</td>
<td>198</td>
<td>40%</td>
<td>3%</td>
<td>32%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Service utilization data</td>
<td>23,512</td>
<td>38%</td>
<td>2%</td>
<td>39%</td>
<td>0.02%</td>
<td>6%</td>
</tr>
</tbody>
</table>

---

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

18 ACT services were not included as part of the service utilization database, but based on the current ACT roster, 6% of all SMI recipients are assigned to ACT teams.
Analysis of Outcomes Data
The service capacity assessment utilized an analysis of recipient outcome data in an attempt to correlate receipt of one or more of the priority mental health services with improved functional outcomes. Based on the available data, the review team selected the following outcome indicators to support the analysis:

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

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

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

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

The outcomes data was provided by ADHS/DBHS as part of the service utilization data file request. For each recipient included in the service utilization file, ADHS/DBHS provided abstracts of the most recent demographic data record. ADHS/DBHS regularly monitors the RBHAs to ensure that each active recipient has an associated data demographic file with current assessment and outcomes data. As of January 2014, ADHS/DBHS reported that 87.6% of all active SMI recipients assigned to the Maricopa County RBHA had current information in the system.

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

**Number of Arrests**
The outcome indicator records the number of times that the recipient has been arrested within the past 30 days. A valid entry is the number of times (between 0 and 31).
**Primary Residence**
The outcome indicator is described as the place where the recipient has spent most of his/her time in the past 30 days prior to the assessment. Valid values include:

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

**Employment Status**
The outcome indicator records the recipient’s current employment status. Valid values include:

- Unemployed.
- Volunteer.
- Unpaid rehabilitation activities.
- Homemaker.
- Student.
- Retired.
- Disabled.
- Inmate of institution.
- Competitive employment full-time.
- Competitive employment part-time.
- Work adjustment training.
- Transitional employment placement.
- Unknown.
Penetration and Prevalence Analysis
As part of the service capacity assessment, a review of the utilization and penetration rates of the priority mental health services (ACT, supported employment, supported housing, and peer support\(^{19}\)) was performed. Penetration rates were compared to benchmarks, as described below.

The following review process was completed:

- Select academic publications were reviewed and Mercer corresponded with national experts regarding the prioritized services.
- Review of national data from SAMHSA on EBP penetration rates at the State level; and
- Interviews with experts in psychiatric rehabilitation and community mental health from Denver, Colorado, a large western city which had been involved in the implementation of a lawsuit settlement agreement (i.e., Goebel Settlement Agreement).

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

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

\(^{19}\) Peer support services are not currently reported on the SAMHSA 2012 Mental Health National Outcome Measures (NOMS) report.
Findings and Recommendations
In this section, findings associated with each of the priority mental health services are presented. Key information is summarized for each evaluation component that was applied to support the service capacity assessment. As part of each summary, key findings and recommendations are identified to address how effectively the overall service delivery system is performing to identify and meet recipient needs through the provision of the priority services.

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

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

Penetration and Prevalence Analysis
The following table illustrates State-level EBP penetration rates and utilization figures in the United States as well as in selected regions that have comparable populations to Arizona or to Maricopa County. Benchmarking data was more accessible at the State level than at the county level; however, penetration estimates from Denver, Colorado were applied, based on similar experiences with the Goebel Settlement Agreement and the focus on ACT team services, supported employment services, and supported housing services. Although State-level comparisons reach beyond Maricopa County, it was assumed that Maricopa County contributes substantially to State-level penetration rates. In addition, the table displays the authorized EBP service, by state, as identified in SAMHSA’s 2012 NOMS report. The states selected for benchmarking had comparable adult populations to Arizona and data was available.

---

20 SAHMSA. (2012). 2012 Mental Health NOMS: Central Mental Health Service Uniform Reporting System. Retrieved from http://www.samhsa.gov/dataoutcomes/urs/urs2012.aspx. Data show the number and percentage of people with SMI who received each EBP. Data on peer support were not available. Peer support services were not reported in the 2012 Mental Health NOMS.
Overall Mental Health Service Penetration Rates

The table below summarizes the total penetration rates among adults living with a SMI in the US.\(^{21}\) Using SAMHSA state-level estimates for SMI, penetration rates are summarized below for the total adult population and total adult population with SMI. Utilizing Arizona Medicaid data, penetration rates for Maricopa County were estimated.\(^{22}\) Among adult Medicaid recipients (in the month of September 2013), Maricopa County’s penetration rate (5.4%) was more than twice the national average (2.1%). Despite the fact that SMI estimates are much higher among Medicaid enrollees than non-Medicaid enrollees (11.7% and 4.62%, respectively), the finding could suggest that among the Medicaid population, Maricopa County behavioral health services utilization may exceed national benchmarks in overall service penetration. Statewide, Arizona has fairly comparable penetration rates compared to the national average (1.8% and 2.1% total population).

### EBP Utilization Rates\(^{23}\)

<table>
<thead>
<tr>
<th>Region</th>
<th>ACT (N=40 states)</th>
<th>Supported Housing (N=38 states)</th>
<th>Supported Employment (N=42 states)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Percent of Consumers Utilizing EBP</td>
<td>Count</td>
</tr>
<tr>
<td>US</td>
<td>65,383</td>
<td>2.0%</td>
<td>73,212</td>
</tr>
<tr>
<td>Arizona</td>
<td>(No Data)(^{24})</td>
<td>(No Data)</td>
<td>1,584</td>
</tr>
<tr>
<td>Colorado</td>
<td>3,182</td>
<td>6.2%</td>
<td>420</td>
</tr>
<tr>
<td>Denver Metro(^{25})</td>
<td>1,100</td>
<td>(No Data)</td>
<td>(No Data)</td>
</tr>
<tr>
<td>Denver City-County(^{26})</td>
<td>800</td>
<td>10.0%</td>
<td>1,650</td>
</tr>
<tr>
<td>Maricopa County(^{27})</td>
<td>1,361</td>
<td>6.0%</td>
<td>(No Data)</td>
</tr>
<tr>
<td>Kansas</td>
<td>(No Data)</td>
<td>(No Data)</td>
<td>3,895</td>
</tr>
<tr>
<td>Minnesota</td>
<td>2,233</td>
<td>2.0%</td>
<td>718</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>3,802</td>
<td>9.0%</td>
<td>864</td>
</tr>
<tr>
<td>Tennessee</td>
<td>417</td>
<td>1.1%</td>
<td>697</td>
</tr>
<tr>
<td>Indiana</td>
<td>1,143</td>
<td>1.6%</td>
<td>2,367</td>
</tr>
</tbody>
</table>

\(^{21}\) Accounts for any persons who have received state authorized mental health services (of any type), including services authorized and funded through Medicaid.

\(^{22}\) Medicaid figures were based on the *Magellan Enrolled Episode of Care Penetration Report* for the month of September 2013. Annual data was not available at the time of this review.

\(^{23}\) Reported EBP data is based on state authorized mental health services including Medicaid enrollees.

\(^{24}\) The table contains instances where ‘no data’ is indicated. This does not mean that EBP services were not provided in the state; only that *state authorized EBP services* were not reported in the SAMHSA’s NOMS system.


\(^{26}\) *Ibid.*

\(^{27}\) ACT data for Maricopa County was derived from an ACT team recipient roster dated February 14, 2014. Data for supported employment was informed through an analysis of service utilization data for dates of service October 1, 2012 through June 30, 2013.

\(^{28}\) The 32.5% may overestimate the percentage of recipients with SMI who actually received evidence-based supported employment.
### Penetration Rates

<table>
<thead>
<tr>
<th>Region</th>
<th>Adult Population ≥18 years old</th>
<th>Est. SMI Rate</th>
<th>Est. Adults with SMI</th>
<th>Total Adult Penetration Count ≥18 years old</th>
<th>Penetration Rate</th>
<th>Penetration Rate Among Persons with SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>240,113,369</td>
<td>4.62%</td>
<td>11,093,238</td>
<td>5,155,740</td>
<td>2.1%</td>
<td>46.5%</td>
</tr>
<tr>
<td>Arizona</td>
<td>4,933,015</td>
<td>4.22%</td>
<td>208,173</td>
<td>90,372</td>
<td>1.8%</td>
<td>43.4%</td>
</tr>
<tr>
<td>Maricopa County</td>
<td>2,961,170 (Total)</td>
<td>4.22%</td>
<td>124,961</td>
<td>20,291</td>
<td>0.7%</td>
<td>16.2%</td>
</tr>
<tr>
<td></td>
<td>259,028 (Medicaid)</td>
<td>11.70%</td>
<td>30,306</td>
<td>14,022</td>
<td>5.4%</td>
<td>46.3%</td>
</tr>
<tr>
<td></td>
<td>2,702,142 (Non-Medicaid)</td>
<td>4.22%</td>
<td>94,655</td>
<td>6,269</td>
<td>0.2%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Colorado</td>
<td>3,959,556</td>
<td>5.19%</td>
<td>205,501</td>
<td>61,184</td>
<td>1.5%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Denver Mental Health Center of Denver (MHCD)</td>
<td>471,019</td>
<td>5.19%</td>
<td>24,446</td>
<td>8,000</td>
<td>1.7%</td>
<td>32.7%</td>
</tr>
<tr>
<td>Kansas</td>
<td>2,161,163</td>
<td>4.46%</td>
<td>96,388</td>
<td>90,373</td>
<td>4.2%</td>
<td>93.8%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>4,104,670</td>
<td>5.31%</td>
<td>217,958</td>
<td>161857</td>
<td>3.9%</td>
<td>74.3%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>4,407,907</td>
<td>4.91%</td>
<td>216,428</td>
<td>80846</td>
<td>1.8%</td>
<td>37.4%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>4,963,829</td>
<td>5.01%</td>
<td>248,688</td>
<td>158951</td>
<td>3.2%</td>
<td>63.9%</td>
</tr>
<tr>
<td>Indiana</td>
<td>4,949,101</td>
<td>5.89%</td>
<td>291,502</td>
<td>71589</td>
<td>1.4%</td>
<td>24.6%</td>
</tr>
</tbody>
</table>

**Notes:**

29 Adult population figures are based on US Census Bureau 2012 estimates for person 18 years of age and older.
31 Estimated SMI rate multiplied by adult population.
32 2012 Mental Health NOMS: Central Mental Health Service Uniform Reporting System (full reference above), persons 18 year of age or older, with exception to Maricopa County and Denver MHCD.
33 Penetration rate is calculated by the total adult penetration count over the total adult population in each region, respectively.
34 Penetration among persons with SMI is calculated by dividing the total adult penetration count by the estimated adults with SMI.
35 Maricopa County figures are based on a single month of service: September 2013. Annual unduplicated figures were not available at the time of this report.
ACT Penetration Rate Benchmarks

Benchmarks from State Level NOMS Data
It should be noted that there was no State level ACT data reported to the SAMHSA 2012 NOMs; however, SAMHSA acknowledges that there is no standard way for reporting eligibility for and use of ACT. With those constraints in mind, it appears that a best practice benchmark comes from the State of Colorado, which according to NOMS data, provides ACT to over 6% of adult consumers receiving mental health services.

An interview was conducted with Adult Recovery Services Director, Kristi Mock, at MHCD. Eight hundred consumers with SMI are served by ACT teams at community behavioral health centers, within the Denver metro area of the city and it was further noted that MCHD has a number of community treatment teams (CTT) that represent a level of care between ACT and Maricopa County’s supportive level of case management. CTT in Denver serves an additional 14% of the SMI population at MHCD.

If Denver’s ACT penetration among adults with SMI (10%) were applied to Maricopa County, then 2,029 of the service recipients with SMI in Maricopa County would be served by ACT teams, suggesting that approximately 20 ACT teams in Maricopa County would be needed in order to match the penetration rate in Denver. Denver may represent a potential “best practice” benchmark for Maricopa County.

Supported Housing Penetration Rate Benchmarks

Benchmarks from State Level NOMS Data
Arizona has a higher rate of supported housing penetration (3.7%) than the national average (2.6%). Kansas, although a smaller state, could provide a best practice benchmark; based on the 2012 NOMS data, Kansas provides supported housing to more than twice as many people as Arizona.

If the national average penetration rate for supported housing were to be applied as a benchmark for Maricopa County, then 528 people would receive supported housing in Maricopa County. This represents a potential “average benchmark” for Maricopa County.

However, nationally and in most states, access to affordable housing for people with SMI is a serious challenge. Therefore, an even better comparison for Maricopa County is with the city and county of Denver, which has a reported penetration rate of 20% for supported housing. In implementing the Goebel Agreement, Denver allocated considerable resources into housing and likely represents a “best practice benchmark” in this area. A comparable supported housing penetration rate in Maricopa County would suggest that just over 4,000 Maricopa County recipients with SMI would receive supported housing. Maricopa County has agreed to add an additional 1,500 supported housing units to existing capacity by fiscal year (FY) 2017.

Supported Employment Penetration Rate Benchmarks

Benchmarks from State Level NOMS Data
The NOMS data cited above indicated that nationally, 1.7% of people with SMI received supported employment in 2012. Another potential “average benchmark” comes from a study of Medicaid beneficiaries and service claims, in which less than 1% of Medicaid beneficiaries with
schizophrenia or bi-polar disorder were identified as seeking a claim for supported employment services. In an analysis of US Veterans, a slightly higher percent (2.2%) of the 75,000 veterans with mental illness included in the study received supported employment services in 2008–2009. Data from these three sources represent potential “average benchmarks”.

According to Mental Health NOMS data, Arizona currently has the highest percentage of recipients served with supported employment than any other state with data: 23.7% received supported employment in 2012. Obviously, the Arizona estimate is considerably higher than the national rate of 1.7% and indicates a “best practice benchmark”.

In an interview with Roy Starks, Director of Rehabilitation Services (Denver, CO), it was revealed that MHCD maintains capacity to serve 250 consumers with supported employment at any point in time. Over the course of a 12-month period, approximately 550 consumers received services. In addition to the 550, MHCD also serves another 130 in evidence-based supported education within its vocational rehabilitation program (for purposes of benchmarking, the 130 are included in the supported employment total for a combined total of 680). The annual percentage of adults with SMI in Denver served in supported employment over the course of a 12-month period is 8.5%, given that MHCD serves 8,000 adults with SMI annually.

Denver is considered a high-performing city in the area of supported employment, with its penetration rate much higher than the national average found in the NOMS state-level data, but much lower than Arizona’s reported rate (23.7%) or the state of Kansas’ reported rate (16.9%) as depicted in the 2012 NOMS data.

**Peer Support Services Penetration Rate Benchmarks**

Terminology and definitions of peer support services can vary widely from state to state, as can the professional certification standards used and the degree to which peer support is integrated into other available services. Currently peer support service penetration rates are not available nationally.

Although some states have established professional certification for peer specialists, this does not always reflect the capacity in which peer support specialists are actually working. In Illinois, quantitative aspects of peer support services are difficult to track because certified recovery support specialists are allowed to bill for most covered services and as well as peer support, which is not tracked in the state data systems. In Denver, MHCD employs many peers as case managers, in psychiatric rehabilitation services, and in other roles that are not traditionally designated for peers. However, the director of recovery services at MHCD reported it has official capacity to serve an estimated 150 persons annually in peer support services, which is less than 2% of consumers with SMI. This number is much lower than the number reportedly served through peer support in Maricopa County (32.7%).
Service Expansions — Comparison of Select States
A comparative analysis was performed with selected states and included a review of negotiated agreements to increase capacity and services to populations of persons identified to have serious and persistent mental illness. Each state reviewed has proposed service expansions for one or more of the prioritized services. The review supports a comparison of other states with Maricopa County’s agreement to expand service capacity. States reviewed included Delaware, New Hampshire, and North Carolina as each state has recently negotiated settlements that include many of the same priority services for comparable disability populations.

The analysis sought to answer the following question:
How does Maricopa County’s agreement to expand service capacity compare to other states that have negotiated similar agreements for comparable populations?

ACT Team Services
When fully implemented, Maricopa County will have 28 ACT teams capable of serving 2,800 recipients by FY 2017. Based on current enrollment, 13.8% of recipients will be engaged with ACT team services. This rate compares to 13.3% in Delaware; 12.5% in North Carolina, and 10.1% in New Hampshire at the time each respective agreement is finalized.37

Supported Housing Services
Maricopa County will expand supportive housing services to serve an additional 1,500 recipients by FY 2017. The increase represents added capacity of 7.4% when based on the current enrolled population. In comparison, Delaware’s agreement calls for added capacity of 7.8% (by 2015); North Carolina will add capacity of 7.5% based on the reported enrolled population (by 2020); and New Hampshire will add capacity of 4%.

Supported Employment Services
Maricopa County will expand supported employment services to 1,250 additional recipients by FY 2017. The increase represents added capacity of 6.1% based on the current enrolled population. In comparison, Delaware’s agreement calls for added capacity of 4.8%; North Carolina’s agreement will result in increased capacity of 6.2%; and New Hampshire will increase capacity of supported employment services resulting in an overall penetration rate of 18.6%.

Peer Support Services and Family Support Services
Maricopa County’s agreement calls for increases of 7.4% in peer and family support service capacity; Delaware is committing to an increased capacity of 12.1%; North Carolina’s and New Hampshire’s agreements do not specify how much peer and family support services capacity will be added.

37 These penetration rate estimates were not included in the benchmarking analysis because they represent future, projected penetration rates.
Based on the comparative analysis, Maricopa County’s plan for expanded services appears to be consistent with the selected states reviewed. See the table below for a summary of each state’s plan to expand services.

<table>
<thead>
<tr>
<th>State</th>
<th>Enrollment</th>
<th>Timelines</th>
<th>ACT</th>
<th>Support Housing</th>
<th>Supported Employment</th>
<th>Peer and Family Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arizona</strong></td>
<td></td>
<td></td>
<td>8 Teams (Some Specialty)</td>
<td>Services for 1,200 Class Members</td>
<td>Services for 750 Class Members</td>
<td>Services for 1,500 Class Members</td>
</tr>
<tr>
<td></td>
<td>20,207</td>
<td>FYs 2015 and 2016 (2014–2016)</td>
<td>5 Teams (Some Specialty)</td>
<td>Services for 300 Class Members</td>
<td>Services for 500 Class Members</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Delaware</strong></td>
<td>8,254</td>
<td>2012 Expand 8 ACT Teams</td>
<td>2011 Vouchers/Subsidies/ Bridge Funding to 150 Individuals</td>
<td>Supported Employment Up to 100 Individuals/Year</td>
<td>Provide Family or Peer Support to 250 Individuals/Year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2013 Add 1 Additional Team</td>
<td>Vouchers/Subsidies/Bridge Funding to 450 Individuals</td>
<td>Supported Employment Up to Additional 300 Individuals/Year</td>
<td>Provide Family or Peer Support to 250 Additional Individuals/Year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2014 Add 1 Additional Team</td>
<td>Vouchers/Subsidies/Bridge Funding to 550 Individuals</td>
<td>Supported Employment Up to Additional 300 Individuals/Year</td>
<td>Provide Family or Peer Support to 250 Additional Individuals/Year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015 Add 1 Additional Team</td>
<td>Vouchers/Subsidies/Bridge Funding to 650 Individuals</td>
<td>Supported Employment Up to Additional 400 Individuals/Year</td>
<td>Provide Family or Peer Support to 250 Additional Individuals/Year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 NA</td>
<td>State Will Provide Vouchers/Subsidies/Bridge Funding to Anyone in the Target Population Who Needs this Support</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

---

38 Stipulation agreement January 8, 2014.
40 Settlement agreement July 6, 2011.
<table>
<thead>
<tr>
<th>State</th>
<th>Enrollment</th>
<th>Timelines</th>
<th>ACT</th>
<th>Support Housing</th>
<th>Supported Employment</th>
<th>Peer and Family Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Hampshire</td>
<td>14,721[^42]</td>
<td>June 2014</td>
<td>Each Mental Health Region has an ACT Team</td>
<td>240 Supported Housing Units</td>
<td>Increase Penetration Rate by 2% over 2012 Penetration Rate of 12.1 to 14.1%</td>
<td>Maintain Family Support Services Consistent with the Agreement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Penetration Rate of 12.1 to 14.1%</td>
<td>Have a System of Peer Support Services Offered Through Peer Support Centers Open a Minimum of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8 Hours Per Day for 5.5 Days Per Week in Each Mental Health Region of the State</td>
</tr>
<tr>
<td></td>
<td></td>
<td>October 2014</td>
<td>All 11 ACT Teams Operate Within the Standards of the Settlement</td>
<td>December 2014 Additional 50 Housing Units Total = 290</td>
<td>All Individuals Receiving ACT will have Access to Supported Employment from Employment Specialist on their ACT Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>June 2015</td>
<td>Serve at Least 1,300 of the Target Population</td>
<td>50 Additional for a Total of 340</td>
<td>Increase Penetration to 2% to 16.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>June 2016</td>
<td>Serve Additional 200 People for Capacity to 1,500</td>
<td>Additional 110 Total of 450</td>
<td>Increase 2% to 18.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>June 2017</td>
<td>Maintain a List of all Individuals Admitted to or Risk Admission to New Hampshire Hospital/ or Glencliff who Need ACT but are Not Available</td>
<td>Additional 150 for a Total of 600</td>
<td>Increase 5% to 18.6% Maintain a List of Individuals with SMI who Would Benefit from Supported Employment Services but for Whom it is Not Available</td>
<td></td>
</tr>
</tbody>
</table>

[^42]: Settlement Agreement December 19, 2013.

## State Enrollment Timelines ACT Support Housing Supported Employment Peer and Family Support Services

<table>
<thead>
<tr>
<th>State</th>
<th>Enrollment</th>
<th>Timelines</th>
<th>ACT</th>
<th>Support Housing</th>
<th>Supported Employment</th>
<th>Peer and Family Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>39,800</td>
<td>July 2013</td>
<td>All Individuals Receiving ACT Will Receive Services From an Employment Specialist on their ACT Team Increase to 33 Teams Serving 3,225 Individuals</td>
<td>At Least 100 up to 300</td>
<td>Supported Employment Provided to a Total of 100 Individuals</td>
<td>Not Specified</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>July 2014 Increase to 34 Teams Serving 3,467 Individuals</td>
<td>150 Additional</td>
<td>Provide Supported Employment to Total of 250 Individuals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>July 2015 Increase to 37 Teams Serving 3,727 Individuals</td>
<td>At Least 708 Individuals</td>
<td>Provide Supported Employment to a Total of 708 Individuals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>July 2016 Increase to 40 Teams Serving 4,006 Individuals</td>
<td>At Least 1,166 Individuals</td>
<td>Provide Supported Employment to a Total of 1,166 Individuals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>July 2017 Increase to 43 Teams Serving 4,307 Individuals</td>
<td>At Least 1,624 Individuals</td>
<td>Provide Supported Employment to a Total of 1,624 Individuals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>July 2018 Increase to 46 Teams Serving 4,630 Individuals</td>
<td>At Least 2,082 Individuals</td>
<td>Provide Supported Employment to a Total of 2,082 Individuals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>July 2019 Increase to 50 Teams Serving 5,000 Individuals</td>
<td>At Least 2,541 Individuals</td>
<td>Provide Supported Employment to a Total of 2,500 Individuals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 2020 NA</td>
<td>At Least 3,000 Individuals</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

---

44 Settlement Agreement July 28, 2011.
**Consumer Operated Services**

Multi-Evaluation Component Analysis

**Priority Service: Consumer Operated Services (Peer Support Services and Family Support Services)**

**Service Descriptions**

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

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

**Focus Groups**

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

- Systemwide, there has been a great effort to employ peers and it was observed that many peer support specialists and peers working in other roles have been added to the system in recent years.
- Participants did not feel that this was an underutilized service across the service delivery system. However, there are not enough peer support specialists and family mentors assigned and available at all the direct care clinic locations. While many peers are employed in the system, the distribution is uneven. For example, one peer worker indicated that she was the only peer support specialist located in her assigned direct care clinic. Other direct care clinics have greater numbers of peers employed, which contributes to a sense of collective strength.
- Clinical teams need to refer recipients to peer support services more often and in particular, there often is a need for clinical team members and programs to understand more precisely what peer support is and how it can help recipients in recovery. Sometimes “peer support” is simply thought of as a group, class, or social activity that happens to be led by a peer, even if there is no recovery-oriented coaching or modeling.
- A few peer support workers did not feel valued or supported in their places of work and often felt isolated. However, one peer support worker assigned to an ACT team indicated that he had been fully embraced as a member of the team. There was some variation in the extent to which peer support workers received support, which was perceived as vital to their effectiveness in meeting recipient’s needs.
**Consumer Operated Services**

- It may appear that more peer support is accessible than is actually available due to peer support workers activities being directed to fulfill other roles, which has pulled them away from delivering the kind of unique peer support services that they are most qualified to deliver.

Family support services were not evaluated as a distinct service during the focus groups. However, various comments during the focus groups indicated that it is often difficult to engage family and natural supports system members in family support services, even when family support workers have experience and skill. New models of engaging family members may need to be tried.

**Key Informant Survey Data**

One objective of the service capacity assessment was to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to the priority services. As a result, a key informant survey was administered. The survey tool included questions and rating assignments related to the priority mental health services.

Most respondents felt that peer support services were easier or easy to access (73%) as opposed to difficult to access or having no ability to access (27%). Of all the priority services, peer support services were perceived as the easiest to access.

Almost two-thirds of survey respondents felt that family support services were difficult to access or were inaccessible while only a little more than a third of the respondents indicated that family support services were easier to access or easy to access.

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

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

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

- Language or cultural barriers.
- Clinical team unable to engage/contact member.
- Lack of capacity/no service provider available.
- Transportation barriers.
In terms of service utilization, almost two-thirds of the responses indicated that peer support services were being utilized effectively or were utilized effectively most of the time. Slightly more than a third of respondents indicated that the peer support services were not utilized effectively.

Half of the responses indicated that family support services were being utilized effectively or were utilized effectively most of the time. Alternatively, half of the responses indicated that family support services were not utilized effectively.

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

- Seventy percent of the survey respondents perceived that peer support services could be accessed within 30 days of the identification of the service need.
- One third of the survey respondents perceived that family support services could be accessed within 30 days of the identification of service need.
- Twenty percent reported it taking four to six weeks to access peer support services following the identification of need.
- Forty-four percent reported it taking four to six weeks to access family support services following the identification of need.
- Ten percent of the survey respondents reported that it would take an average of six weeks or longer to access peer support services.
- Twenty-two percent of the survey respondents reported that it would take an average of six weeks or longer to access family support services.

**Medical Record Reviews Group 1**

A random sample of 122 recipients was identified to support an analysis of assessment and service planning documentation. The reviewed evaluated how well the clinical teams were identifying needs for peer support services and family support services. When identified as needed service to benefit the recipient, information was reviewed to determine if the need was translated to the recipient’s ISP and identified as a specific intervention. A subgroup of the sample was subsequently interviewed to collect information regarding their perceived needs for the same services.

A review of medical record documentation revealed that the clinical teams are routinely (88% of the time) assessing the recipient’s social and community integration. This represents a strength in the current system and establishes the ability to identify opportunities to apply targeted interventions to address identified needs, such as peer support services.

At times, peer support services can be an appropriate response to address community and social integration needs, but only 21% of the cases identified peer support as a need. Further, even when assessed as a need, peer support services were identified on the recipient’s ISP only 23% of the time.
Consumer Operated Services

Often, the clinical team would subsequently list an alternative service on the ISP to meet an assessed need for peer support. Examples of alternative services included case management, day programs, health promotion and outside services. In nearly half (46%) of the assessments that included an identified need for peer support, the ISP did not include any services to meet the specified need. When needs are identified through the assessment process, there should be a specific intervention identified on the ISP to address those needs.

Despite the challenges noted, 36% of the Group 1 recipients received at least one unit of peer support services during CY 2013.

Interviews

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

The interview asked the following:

- Did the clinical team assess the recipient’s need for peer support services? Over half of the respondents indicated that the clinical team had discussed peer support service opportunities.

- Sixteen of the forty-one (39%) recipients interviewed expressed a desire or need to access peer support services.

- Is the clinical team’s assessment consistent with the recipient’s perception regarding the need for one or more of the priority mental health services? In a majority of the cases, the clinical team and the recipient concurred that peer support services would be a beneficial service.
**Consumer Operated Services**

**Family Support Services**

The clinical teams are routinely identifying and documenting natural and family supports that are important to the recipient. Eighty-four percent of the records found evidence that natural and family supports were assessed by the clinical team. Family support services can be an appropriate service for family members to develop skills to effectively interact and care for the person in the home and community. However, in most cases, the ISPs did not include explicit references to family support services.

While the review team recognizes that family support services may not always be an appropriate intervention when family members are identified as supportive, the low percentage of cases in which family support services were identified as an ISP service suggests that opportunities are likely being missed. Fifty-one of the one hundred twenty-two cases (42%) included assessment documentation identifying family members described by the recipient as supportive. Opportunities exist to leverage family support services when the recipient is noted to be difficult to engage and is not consistently following through with ISP recommendations. In these cases, family members may be uniquely positioned to have a positive impact with the recipient. On occasion, the clinical team would identify other services or supports as alternatives to family support services. Examples of alternative services included “natural supports” and prevention services.

In 69% of the assessments that identified available supportive family members, the ISP did not include any services to address the opportunity. Only 2% of the Group 1 recipients received at least one unit of family support services during CY 2013.

**Interviews**

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

The interview asked the following:

- Did the clinical team assess the recipient’s and family’s need for family support services? Less than half of the respondents recalled discussing the service with the clinical team.
- Seven of the forty-one recipients interviewed expressed a desire or need for family members to access family support services.
- Is the clinical team’s assessment consistent with the recipient’s perception regarding the need for one or more of the priority mental health services? When the clinical team identified a need for family support services, a majority of recipients interviewed concurred with the assessment.

However, as indicated above, most recipients did not actually receive family support services.
Medical Record Reviews: Group 2
A random sample of 198 SMI recipients’ medical record documentation was reviewed to assess the consistency in which peer support services and family support services were assessed by the clinical team, identified as a needed service to support the recipient, and included as part of the ISP.

Overall, the recognition that a recipient may benefit from peer support services as a specific clinical intervention was noted to be an inconsistent component of the formal clinical assessment and service planning process.

Seventy-two percent of the ISPs included peer support services when assessed as a need as part of the recipient’s assessment. Documentation in some of these cases identified needs for the recipient to engage or attend community-based consumer operated programs or direct care clinic peer led groups. In these instances, the review team determined that a need for peer support services was present. However, ISPs would often identify alternative services such as case management services or natural supports to meet an identified need for peer support services.

However, regardless of the identification of the need for peer support services as part of the assessment and service planning process; 40% of the recipients included in the sample received at least one unit of peer support during CY 2013. Essentially, many recipients who had needs for socialization, whether formally assessed or not, were referred to peer-led socialization and recreational activities. Rarely did the planning of peer support and the documentation of peer support services include awareness of coaching and modeling recovery-oriented attitudes, beliefs, motivations, and behaviors.
Consumer Operated Services

In 23 cases, reviewers were able to review progress notes and record the documented reasons that the person was unable to access peer support services when recommended by the clinical team. The most common findings included the following:

- Billing/service description errors (medical record documentation described alternative services such as case management services, health promotion, or day treatment programs);
- The recipient declined to attend the service; and
- The clinical team did not follow up with initiating a referral for the service.

To a lesser degree, the following additional reasons were noted: client moved/transferred and client was hospitalized.

Family Support Services

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

Two-thirds of the ISPs included family support services when identified as a need as part of the recipient’s assessment. Examples in which the review team determined that a need for family support services existed included circumstances in which the recipient had explicitly expressed a desire for a family member to be involved in treatment and/or clinical team documentation was present that identified a need for the recipient to seek support and/or engage with involved family members.

At times, ISPs would identify “natural supports” to meet an identified need for family support, which in some cases may be an appropriate intervention. However, clinical team members should strive to more actively assess the family member’s readiness and capability to provide support to the recipient. When needed, family support services can assist family members to be more effective by teaching families skills and strategies for better supporting their family member’s treatment and recovery.
**Consumer Operated Services**

As evident through the assessment and service planning process, only 3% of the recipients included in the sample received at least one unit of family support during CY 2013.

In six cases, reviewers were able to review progress notes and record the reasons that the person was unable to access family support services after the service was recommended by the clinical team. Findings included:

- Billing/service description errors (e.g., medical record documentation appeared to describe alternative services, such as case management services);
- Recipient was hospitalized; and
- The clinical team did not follow up with initiating a referral for the service.

**Service Utilization Data**

During the time period of October 1, 2012 through June 30, 2013, 22,597 unique users were represented in the service utilization data file. Of those, 73% were Medicaid eligible and 27% were non-Title XIX eligible.

- Overall, 33% of the recipients received at least one unit of peer support services during the time period.

Access to the service was evenly split between Title XIX (32%) and non-Title XIX groups (34%). Many of the PNOs have adopted administrative policies that result in the assignment of a peer support specialist (in lieu of a case manager) to a non-Title XIX eligible recipient who is assigned to a connective level of case management. This policy may explain, in part, the relatively equal access to peer support services across eligibility groups.

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

- Fifty percent of recipients who received at least one unit of peer support during the review period accessed the service during a single month.
- Thirteen percent of recipients received peer support services for three to four consecutive months during the review period and 8% received the service for nine consecutive months.

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

### Persistence in Peer Support Services

<table>
<thead>
<tr>
<th>Consecutive months of service</th>
<th>Medicaid recipients</th>
<th>Non-Medicaid recipients</th>
<th>All recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>46.5%</td>
<td>59.8%</td>
<td>50.1%</td>
</tr>
<tr>
<td>2</td>
<td>16.8%</td>
<td>19.6%</td>
<td>17.6%</td>
</tr>
<tr>
<td>3–4</td>
<td>14.2%</td>
<td>11.0%</td>
<td>13.4%</td>
</tr>
<tr>
<td>5–6</td>
<td>7.6%</td>
<td>4.3%</td>
<td>6.7%</td>
</tr>
<tr>
<td>7–8</td>
<td>4.5%</td>
<td>2.2%</td>
<td>4.0%</td>
</tr>
<tr>
<td>9</td>
<td>10.0%</td>
<td>2.8%</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

*Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.*
Overall, only 1.4% of the recipients received at least one unit of family support services during the time period. Access to the service was unevenly split between Title XIX (1.7%) and non-Title XIX groups (0.6%).

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

- Over two thirds (67.2%) of the recipients who received at least one unit of family support during the review period accessed the service during a single month.
- 9.6% of the recipients received family support services for three to four consecutive months during the review period and 3.2% received the service for seven to eight consecutive months.
- Only six individuals received the service during nine consecutive months.

### Key Findings and Recommendations

The most significant findings regarding the demand and provision of peer support and family support services, sometimes reinforced by integrating the results of multiple evaluation components, are presented below. Recommendations are included that should be considered as follow up activities to address select findings.

### Findings: Peer Support

- Peer support services are relatively accessible through a variety of opportunities. Of all the priority services, peer support services were perceived to be the easiest to access. One third of all recipients received some peer support services during the review period. This penetration rate is considered high and may represent a “best practice benchmark”.
- Compared to other state public behavioral health delivery systems, Maricopa County has developed a robust system of peer support opportunities, including vocational tracks to assist behavioral health recipients with training to become peer support specialists.
- Many recipients are offered support and wellness groups and opportunities to socialize with peers appear to be abundant, both within the direct care clinic setting and via community providers.
- There is wide promotion of peer-directed groups evident at all of the direct care clinic sites and community-based providers.
- It appears that the formal assessment and ISP development process is not consistently targeting peer support services as a specific clinical intervention.

---

46 See example of peer-directed groups available at one community-based provider, Appendix E.
**Consumer Operated Services**

- A more strategic approach to identifying candidates that would benefit from peer support services would better address the clinical needs of recipients.
- Peer support specialists are not consistently leveraged by the clinical team to assist in the service planning process.
- Peer support specialists are not always valued by professionals as members of the clinical team.
- ACT team peer support specialists do not always offer their specialized perspective and often engage in case management activities, which sometimes makes their role difficult to distinguish from other ACT team members.
- Billing for peer support services appears inconsistent; sometimes activities are billed as peer support, other times similar activities are coded as case management.

**Findings: Family Support**

- Clinical teams are doing a good job of identifying and documenting family supports that are available to the recipient. Also, there is documentation of the recipient’s preferences regarding family involvement in service planning. However, very few cases reviewed indicated that the clinical team contemplated the use of family support services during the service planning process. Missed opportunities to leverage family members to support the recipient’s achievement of ISP goals were a common observation.
- Very few ISPs included family support services (i.e., Home Care Training Family) as a distinct service. The identification of available family supports does not usually lead to recommendations to better prepare involved family members as part of the recipient’s recovery plan. When provided, family support services rarely included developing skills to effectively interact with or guide the recipient.
- Few families are engaged in family support, despite the fact that family support mentors exist in the system. One knowledgeable and apparently capable family support mentor reported great difficulty in eliciting family members’ engagement in family support opportunities.

**Recommendations: Peer Support**

- Assess the availability of peer support specialists at each direct care clinic and add additional staff when gaps or insufficient resources are identified.
- Through training and supervision, ensure that professionals understand and value the unique contributions that peer support workers can offer. Peer support workers are not ancillary contributors to clinical programs, but, rather, have a unique role to play in helping people adopt recovery-oriented beliefs (recovery is attainable), attitudes (hope for my future) and behaviors (illness self-management, participation in work and community). Therefore, peer support workers should: a) be included in assessment and treatment planning activities, and b) should not be assigned to tasks that other clinicians prefer not to do and that unnecessarily divert them from their primary purposes and most significant contributions to promoting recovery outcomes.
- All peer support workers should be trained regarding how to document peer support services in the medical record. While ADHS/DBHS has developed written policy expectations for this training, the review team did not find consistent evidence that the medical record documentation met standards. It is important that assessment of and progress on recovery-oriented needs and goals is documented in the record.
**Consumer Operated Services**

- Provide additional training and supervision to recognize the value of peer support services and family support services as effective clinical interventions.
- The system should continue efforts to target and increase the use of peer support services as a follow up to crisis services; utilize peers as part of hospital discharge planning and supportive engagement; use peers to help ensure timely ambulatory care follow up after hospitalization; help recipients to get incorporated into traditional physical healthcare pathways (supporting integrated care) and deploy peer support specialists to assist recipients who are experiencing significant life challenges (e.g., incarcerations).
- Most peer support provided within the direct care clinics appears to occur within the context of group settings; attempts should be made to balance the delivery with individualized peer support (current approach within the direct care clinics does not consistently promote individual relationship and trust building).

**Recommendations: Family Support**

- The system should examine the possibility of adopting evidence-based family support tools that have shown good outcomes. Many different family education/support programs have been developed that improve family communication and result in better outcomes. ADHS/DBHS plans to work with the current GSA-6 contractor to implement the SAMHSA family support fidelity tool in the near future.
- Consider developing more formal arrangements with external family advocacy and support organizations, such as local National Alliance for the Mentally Ill chapters, which often have the capability of providing evidence-based family education and support programs. Families may appreciate the mutual-help nature of these external programs.
- Rather than just identifying family supports available to the recipient, incorporate family members into treatment plans. Establish annual training for staff and supervisors that goes beyond understanding at a conceptual level to focus on specific strategies to actively promote the availability and use of family support services.
Supported Employment

Priority Service: Supported Employment

Service Description

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

Focus Groups

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

- Some participants indicated that the current system offers little opportunity or encouragement to seek alternative options outside of training for peer support employment. The system is doing a good job of hiring people into peer support roles, but it is not doing a good job of helping people who do not have a vocational goal of working in peer support. Participants variously had talents and trainings in areas such as journalism and education, but were not always being assisted in making vocational advancements in their chosen field.
- Long wait lists were reported for vocational rehabilitation services, with some recipients waiting six to eight months to access supported employment.
- Vocational rehabilitation with training in supported employment is available onsite at some direct care clinics, but not all. Rehabilitation specialists located at the direct care clinics do not necessarily provide supported employment services.
- Supported employment needs more development and resources; including the development of additional employment opportunities for recipients.
- Many of the direct care clinic rehabilitation specialist positions are reported to be vacant.
- It was noted that some ACT teams include a rehabilitation specialist and an employment specialist.
- Many more recipients would want to work if they understood that employment does not have to jeopardize their benefits. Participants reported that there were not enough experts in the system that were helping people understand the possibilities of working and maintaining one’s access to treatment.
- Participants believed that many clinicians in the system do not appreciate the importance of work as much as people who have lived experience with recovery appreciate it. Many said that working actually improved their mental health (one reported that she thought it kept her out of the hospital a few times), whereas many mental health workers think that work endangers one’s mental health. These beliefs of mental health workers limit the number of referrals they make to supported employment. One focus group participant commented, “Clinics need to help us with our vocational dreams”.
- Participants identified several employment programs, including vocational rehabilitation programs to which people could be referred to more often.

"Clinics need to help us with our vocational dreams."
**Supported Employment**

- Focus group participants indicated that it was important for the system to do a better job of assessing an individual’s employment goals and to individualize employment supports for people, rather than simply attempting to plug them into group employment opportunities involving set-aside jobs for people with SMI.
- There was an overall sense across the focus groups that not enough was being done to help people attain employment. There was strong sentiment expressed in the group that employment was a primary outcome of concern and, despite the existence of several programs, there is not enough supported employment services in the system.
- Barriers to securing employment for recipients include co-occurring substance use disorders that can result in failed pre-employment drug screens, criminal records, and stigma regarding mental illness.
- One group identified the need for additional employment coaches/job coaches that can facilitate communication and problem solve issues between the recipient and the employer. This is a standard feature of evidence-based supported employment.

**Key Informant Survey Data**

Seventy-five percent of survey respondents felt that supported employment services were difficult to access or were inaccessible, the highest rate of response in this domain for any of the prioritized services. Twenty-five percent of respondents indicated that supported employment services were easier to access, with none of the survey respondents indicating that the service was easy to access.

When asked about the factors that negatively impact accessing supported employment services, almost half (47%) of the responses were directed to a lack of capacity/no service provider available. Other factors impacting access included:

- Clinical team unable to engage/contact member;
- Wait list exists for service; and
- Admission criteria for services too restrictive.

Only 30% of the responses indicated that supported employment services were being utilized effectively or were utilized effectively most of the time. Alternatively, 70% of respondents indicated that supported employment services were not utilized effectively.

Only about one in five (22%) of the survey respondents perceived that supported employment services could be accessed within 30 days of the identification of the service need. The remaining 78% of the survey respondents reported that it would take an average of six weeks or longer to access supported employment services.

One survey respondent offered the following comment, “Supported employment does not currently exist per the SAMHSA fidelity model within a single provider agency or network.”

One respondent offered the following comment: “Supported employment does not currently exist per the SAMHSA fidelity model within a single provider agency or network.”
Supported Employment

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

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

Findings specific to supported employment services are presented below.

The medical record review uncovered evidence that 87% of recipients’ learning and working life domains were assessed by the clinical team.

Is there evidence that recipients' learning and working life domains were assessed by the clinical team?

- Yes, 87%
- No, 13%

Supported employment services can be an appropriate response to address work goals, but in most cases the ISPs did not include explicit references to supported employment services. In fact, the record review found that when a work-related goal was assessed as a need, supported employment services (i.e., psychoeducational services and ongoing support to maintain employment) were only identified on the recipient’s ISP 20% of the time.

When assessed as a need, are supported employment services identified on the recipient’s ISP?

- Yes, 20%
- No, 80%

Fifty of the one hundred twenty-two cases (41%) indicated that support with employment goals were identified as a need by the clinical team. Often times to meet this identified need; the clinical team would list an alternative service on the ISP to address assessed needs for supported employment. Examples of alternative services included:

- Skills training and development and psychosocial rehabilitation
  living skills training.
- Cognitive rehabilitation.
- Outside services.
- Case management.
**Supported Employment**

For 34% of the assessments that included an identified need for supported employment, the ISP did not include *any* services to meet the specified need. In many cases reviewed, the clinical team would assume a passive role in assisting the person with employment-related supports and services, even after the recipient explicitly expressed a desire to find a job. A common progress note, often repeated in multiple entries for the same recipient, stated: “Rehabilitation specialist to be available at any time to provide resources to case manager or behavioral health recipient if/when ready to pursue employment.” While the recipient shares responsibility to take a primary role in recovery-related activities, this approach by the clinical team is void of active support and engagement, which can be critical elements to achieving successful outcomes for recipients.

Despite challenges with the appropriate identification of need and inclusion of the service as part of the recipient’s ISP, 39% of the Group 1 recipients who received a service in CY 2013 did receive at least one unit of supported employment services.

**Interviews**

The interview revealed the following findings:

- A majority (87%) of the interview respondents concurred that there was an assessment regarding supported employment needs and available services.
- Fifteen of the 41 (37%) recipients interviewed expressed a desire or need to access supported employment services.
- In most (73%) of the cases, the clinical team’s assessment of need for supported employment services was consistent with the recipient’s perception.

**Medical Record Reviews: Group 2**

The recognition that a recipient may benefit from establishing goals related to work and/or education was noted to be a consistent component of the formal assessment and treatment planning process. The consistent use of a standardized assessment and service plan template assured that working goals were addressed for most recipients included in the sample. Still, some individuals declined to establish employment goals or desired to pursue other interests such as education or therapy services.

The results of the medical record review for Group 2 showed that supported employment services were identified as an explicit need on either the recipient’s assessment or ISP in slightly more than half the cases reviewed. However, supported employment services were rarely identified as a service on the recipient’s ISP (13%).

Very few ISPs included supported employment services when a work-related goal was identified as a need as part of the recipient’s assessment. Often ISPs would identify alternative services or activities ostensibly to meet an identified need for supported employment services. Frequent alternative services to address assessed supported employment needs and listed on the ISP included skills training and development and psychosocial rehabilitation living skills training; self-help/peer support; health promotion; case management services and referrals to the rehabilitation specialist located at the recipient’s assigned direct care clinic.
Supported Employment

Regardless of the identification of the need for supported employment services as part of the assessment and service planning process; 32% of the recipients included in the sample received at least one unit of supported employment during CY 2013.

In 30 cases, reviewers were able to review progress notes and record the reasons that the person was unable to access supported employment services after a work-related need was identified by the clinical team. The most common reasons were:

- The client decided that he/she was not ready for employment activities due to unmanaged behavioral health symptoms; and
- The clinical team did not follow up with initiating a referral for the service.

Service Utilization Data

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

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

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

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

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

**H2026 — Ongoing Support to Maintain Employment (per diem)**

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

The service utilization data set demonstrates significant variation in the volume of the three available service codes for supported employment. For the time period October 1, 2012 through June 30, 2013, H2027 (pre-job training and development) accounts for 93% of the total supported employment services. H2025 (ongoing support to maintain employment/15 minute billing unit) represents slightly less than 7% of the supported employment utilization. Finally, H2026 (ongoing support to maintain employment/per diem billing unit) represents less than 1% of the utilization of supported employment. This finding illustrates that the emphasis with the delivery of supported employment is directed to pre-job training and development and that very few individuals receive ongoing support to maintain employment, such as connections to employment/job coaches. This finding also suggests that there may be a paucity of available providers and/or programs that deliver supported employment programming designed to engage recipients in intensive supports throughout the work day (per diem code) to ensure skill mastery and job retention.
Additional findings from the service utilization data set are as follows:

- Overall, 33% of the recipients received at least one unit of supported employment during the time period.
- Access to the service was unevenly split between Title XIX (42%) and non-Title XIX groups (8%).

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

- Sixty percent of the recipients who received at least one unit of supported employment during the review period accessed the service during a single month (this finding also reflects the disproportionate utilization of pre-job training and development);
- Eleven percent of the recipients received supported employment services for three to four consecutive months during the review period; and
- Six percent of the recipients received the service for nine consecutive months.

### Key Findings and Recommendations

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

#### Findings: Supported Employment

- The standardized assessment template includes prompts regarding the recipient’s employment goals. As such, employment is a domain that is almost always explored as part of the person’s assessed needs, a strength of the system.
- While the standardized assessment format affords some degree of assurance that critical life domains such as employment and living situation will be addressed, the rigid approach to completing the template compromises the relevancy of the information collected, including:
  - The assessment of need is not always individualized to the recipient’s unique circumstances;
  - The assessment occurs in a point in time and is typically not revisited by the clinical team following the formal annual assessment update process; and
  - Identified needs are sometimes not addressed through the development of service plan interventions.

- Recipients can initially and often refuse to establish employment goals. Common reasons that recipients defer employment goals are:
Supported Employment

— The person receives Social Security Disability Income/Social Security Income and perceives that additional income may jeopardize their entitlements/Medicaid eligibility;
— The person identifies as retired;
— The person does not perceive to be psychiatrically stable enough to work at the time of the assessment; or
— The clinical team does not perceive the recipient to be capable of employment at the time of the assessment.

• When the recipient declines employment, the clinical team rarely establishes and implements a formal strategy to periodically re-engage the recipient regarding readiness for employment. A common statement found on several of the ISPs reviewed to illustrate this finding is as follows:

  — “Meet annually with rehabilitation specialist to address working goals.”

• Once employment is assessed and identified as a goal or need, the clinical team usually does not take an active role with assisting the recipient to assess and formulate work interests, leverage prior work history, offer assistance to the recipient to determine job readiness and prepare for employment opportunities, or assist with finding compatible jobs.
• In a number of the cases reviewed, the recipient secured employment independent of the clinical team’s involvement (and sometimes knowledge) and despite overcoming significant challenges inherent with their disabilities.
• Once working, supported employment is rarely contemplated as an important support/service to assist the person sustain employment and problem solve issues that may arise.
• Vocational rehabilitation specialists are co-located onsite at select direct care clinics while some individuals are referred out to community providers to access supported employment services.
• Supported employment opportunities available at community providers sometimes focus on skill development and job preparation for work within the behavioral health system, such as employment training to become a peer support specialist. The review team observed fewer examples of community providers supporting persons with employment opportunities outside of the behavioral health system.
• Results of key informant survey findings suggest that insufficient capacity may exist for supported employment services:

  — Seventy-five percent of survey respondents felt that supported employment services were difficult to access or were inaccessible, the highest rate of response for this domain across all the prioritized services. In addition, none of the survey respondents believed that supported employment services were easy to access.
  — Almost half of the survey respondents associated “a lack of capacity or no service provider available” with supported employment services.
  — Seventy-eight percent of the survey responses indicated that it would take six weeks or longer to access supported employment services once a need was identified.
**Supported Employment**

**Recommendations: Supported Employment**

- Continue efforts with the Rehabilitative Services Administration to develop additional supported employment opportunities outside the behavioral health system that address recipient’s vocational preferences, talents and experiences.
- Explore opportunities to expand the presence of vocational rehabilitation specialists at the direct care clinics.
- Clarify and define the roles of rehabilitation specialists assigned to the direct care clinics (including distinctions between rehabilitation specialists and employment specialists assigned to ACT teams). Once determined, increase oversight and supervision of these responsibilities and fill vacant positions.
- Continue efforts through Disability Benefits 101-Arizona to meet workforce development needs, link recipients to resources knowledgeable regarding accessing public assistance (e.g., disability compensation, health insurance) and review potential implications of additional income related to employment. Examine the feasibility of utilizing peer support specialists in these roles.
- Through training and supervision, ensure that clinical team members recognize the value of supported employment services in meeting a recipient’s employment related goals. Ensure that supported employment services are included as an intervention on the ISP in these circumstances.
- Supported employment for ongoing support service encounters are disproportionately less than pre-job training and development. Assess the sufficiency of contracted providers to support the provision of ongoing support to maintain employment services.
- Ensure that clinical team members actively and continuously engage recipients regarding opportunities to participate in employment related supports and services. Promote awareness and skill development through training and monitor expectations via ongoing supervision.
- Consider developing Individual Placement and Support (IPS) supported employment teams to provide supported employment services. IPS has been extensively researched and proven to be effective.  
  
- Adequate training in IPS should be ensured. This training should be provided by experts in the IPS model. In addition, because agency support for supported employment is one of the aspects of fidelity that is specified by the IPS model, all direct care clinic supervisors should receive a basic introduction to the IPS model, which should include guidance on how to ensure that all clinical programs are supportive of the philosophy, principles, and practices of IPS supported employment.
**Case In Point:** Seeking opportunities to encourage and support recipients in fulfilling meaningful goals can make a significant difference in the person's life.

An adult male assigned to an ACT team communicated his desire to return to work. He had previously enjoyed a successful career as a commercial truck driver. Despite multiple emergency room visits and hospitalizations due to anxiety and suicidal ideations, the recipient located a local trucking company that was hiring, successfully interviewed for a position, and was invited to a training program to secure his commercial driver's license. The training program required him to leave Arizona and travel to another state for a two week period. Early on, the recipient was able to focus and maintain attendance during the day time training program, but his anxiety symptoms escalated at night in his motel room. Ultimately, he was forced to withdraw from the program and returned to Arizona.

When expressing his desire to apply and interview with the trucking company, ACT team staff members documented his statements, but there was little indication in the medical record that the team supported the recipient, either verbally or through the provision of services. Documented ACT team interventions were limited to regular home visits in which safety issues were reviewed and medication observations were recorded.
Supported Housing

Priority Service: Supported Housing

Service Description

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

Focus Groups

Key themes related to supported housing services included:

- All of the groups acknowledged the need for more housing and independent living opportunities and the need for more supported housing opportunities.
- Findings included limited capacity for ACT housing and an insufficient number of housing vouchers to meet demand.
- Only one community-based provider was perceived to be available to support recipients experiencing extended periods of homelessness.
- Participants observed that non-Title XIX eligible recipients are placed on long housing wait lists and that there is insufficient capacity for housing supports. Other unmet needs identified included assistance with tenant/landlord relationships, increased capacity for transitional housing to meet needs of recipients discharged from inpatient settings, and additional capacity of wraparound services and supports.
- It was reported that some recipients have been on wait lists to receive housing vouchers for eight months or longer.
- Housing supports are available, and there are community providers that specialize in supported housing and whose programs are effective. However, the number of programs is insufficient to meet the demand.
- Community providers that specialize in supported housing are available and the programs are perceived to be effective. There is a more significant issue with availability of housing vouchers and associated wait lists.
**Supported Housing**

**Key Informant Survey Data**
Fifty percent of survey respondents felt that supported housing services were difficult to access and 17% indicated that the services were inaccessible. The remaining 33% of respondents indicated that supported housing services were easier to access or easy to access.

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

- Thirty-one percent of the responses were directed to a lack of capacity/no service provider available;
- Twenty-five percent indicated wait list exists for service; and
- Twenty-five percent selected admission criteria for services too restrictive.

In terms of service utilization:

- Ten percent of the responses indicated that the services were being utilized effectively;
- Thirty percent responded that the services were utilized effectively most of the time; and
- Sixty percent of the respondents indicated that supported housing services were not utilized effectively.

Only 11% of the survey respondents perceived that supported housing services could be accessed within 30 days of the identification of the service need. Twenty-two percent indicated that the service could be accessed on average within four to six weeks. The remaining 67% of the survey respondents reported that it would take an average of six weeks or longer to access supported housing services.

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

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

Findings specific to supported housing services are presented below.

- The medical record review looked for evidence that the recipient’s living situation was assessed by the clinical team. Virtually all the assessments reviewed (96%) assessed the recipient’s current living situation and documented any unmet needs in this area.

Supported housing services can be an appropriate response to address needs for recipients seeking assistance with establishing or maintaining community-based independent living situations. Most of the ISPs reviewed did not include explicit references to supported housing services.

- When assessed as a need, supported housing services were identified on the recipient’s ISP in 20%* of the records. *Only one recipient’s ISP included supported housing as a distinct service. The remaining ISPs included subsidized living arrangements and flex funds.

Forty-nine of the one hundred twenty-two cases (40%) assessed the need for services and supports related to housing. Often times, the clinical team would list an alternative service on the ISP to address assessed needs for supported housing. Examples of alternative services included:

- Natural supports;
- Outside services; and
- Case management.

For 59% of the assessments that included an identified need for supported housing, the ISP did not include any services to meet the specified need. None of the Group 1 recipients received any units of supported housing (H0043) services during CY 2013.

**Interviews**

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

The interview revealed the following:

- A majority (65%) of the recipients interviewed reported that the clinical team did discuss housing related needs and services.
- Twenty-two of the forty-one recipients (61%) interviewed expressed a desire or need to access supported housing services.
- There was not always agreement between the clinical team’s identification of need and the recipient’s perception of need for supported housing services. Disagreement between the clinical team’s assessment and the recipient’s perception of need was found in 41% of the cases reviewed.
Supported Housing

Medical Record Reviews: Group 2

In all cases reviewed, the recipient’s living situation was assessed and documented and, in most cases, included the recipient’s expressed preferences related to housing.

- Supported housing services were not identified as a need on either the recipient’s assessment or recipient’s ISP about two-thirds of the time.
- Supported housing was rarely identified as a service on the recipient’s ISP; only 6% of cases included supported housing on the ISP.

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

Often ISPs would identify alternative services or activities to address housing-related needs. Examples included:

- Skills training and development and psychosocial rehabilitation living skills training;
- Personal care services;
- Case management (including an ACT housing specialist); and
- Natural supports.

None of the recipients included in the sample received a unit of supported housing (as evidenced by the presence of billing code H0043) during CY 2013.

In 13 cases, reviewers were able to review progress notes and record the reasons that the person was unable to access supported housing services after housing-related assistance was identified as a need by the clinical team. The most common reasons were:

- The clinical team did not follow up with initiating a referral for the service;
- The recipient was hospitalized or incarcerated; and
- The recipient was placed on a wait list for the service.
**Supported Housing**

**Service Utilization Data**

The data set demonstrates that the supported housing billing code is rarely utilized. As indicated within the service utilization data file, no Title XIX eligible (Medicaid) recipients were affiliated with the service during the entire time period. Only three distinct users (non-Title XIX) received the service from a total population of 22,597 (.013%) between October 1, 2012 — June 30, 2013. During October 1, 2012 through December 31, 2013; five unduplicated recipients were associated with the supported housing billing code. All five of the recipients were non-Title XIX eligible.

Three different contracted supported housing providers submitted the supported housing service encounters. As previously noted, most available funding for supported housing originates outside of the publicly funded behavioral health system and subsequently is not recorded through the processing of service encounters. Future analyses may require an assessment of RBHA financial statements and supported housing provider billing invoices to more fully quantify utilization and assess capacity for supported housing services. However, because myriad of federal, state, county, and city housing funds are directed to supported housing and available to SMI persons in Maricopa County, it may be challenging to compile a comprehensive analysis of supported housing expenditures. In addition, since ADHS/DBHS and SAMHSA service descriptions state that supported housing services are provided to assist individuals to maintain housing and help people keep housing, any number of covered behavioral health services, community resources, and natural supports could be construed to help a person remain stable and successfully housed in an independent community living situation, further complicating a direct assessment of available service capacity and utilization.

**Key Findings and Recommendations**

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

**Findings: Supported Housing**

- There appears to be an overemphasis on maintaining psychiatric stability as an intervention to obtain or maintain the recipient’s independent living objectives. For example, it is common for the clinical team to document “needs to maintain stability of symptoms” as the primary means to address the person’s identified goal for living independently.
- The medical record reviews demonstrated little support with living skills training, budgeting, or other skill development activities to assist persons to achieve and maintain independent living. There was evidence of frequent home visits documented in the medical record in which these opportunities for supported housing services could have been delivered, but the visits typically focus on safety assessments.
- Service utilization data revealed that only five unique members received a supported housing (H0043) code during the fifteen month review period. One key informant interviewed identified that most housing supports are not billed or encountered, but that housing program providers submit detailed invoices to the Maricopa County RBHA to account for housing support expenditures. Most housing support funding (which is a combination of federal, state, county, and city funding) available to SMI recipients in Maricopa County does not originate or traverse through ADHS/DBHS.
- Non-Title 19 eligible persons may not have access to the full extent of supported housing services.
Supported Housing

- The Maricopa County RBHA maintains a housing wait list that includes designations of homeless or chronic homelessness and community living. As of March 17, 2014, the wait list included 494 homeless or chronic homeless persons and 680 persons waiting for community living housing, with some individuals waiting for over two years. The number of SMI recipients receiving some kind of rental subsidy in Maricopa County is reportedly not tracked.
- Approximately 700 SMI recipients are placed in residential settings. Many of these recipients possess the potential to secure independent living through community housing with housing supports. One key informant interviewed estimated that 80% of the recipients currently placed in a residential setting could be successfully transitioned to community housing with supports.
- The current capacity for community living placements is reported to be approximately 1,000 (with turnover of 10–20 individuals per month). Moving recipients from residential settings to independent community living placements with supports may only represent modest cost increases for the system. Fair market rent calculated for Maricopa County indicated that it would cost $748 per month\(^{48}\) for a one bedroom apartment. Current fee-for-service rates for state-funded room and board services in residential settings are reported to be $21.28 per day or approximately $638 per month. When clinically appropriate and with the provision of wraparound services, it may be preferable to assist a significant percentage of recipients currently in residential facilities to live in independent living arrangements.

Recommendations: Supported Housing

- Develop and implement a standardized mechanism to track and quantify supported housing services and expenditures within the behavioral health system. As part of the development, examine why the supported housing services billing code is underutilized and clearly define the services and supports that constitute supported housing services.
- Continue efforts to partner with local municipalities and other community stakeholders to identify and deliver additional housing support capacity.
- Examine opportunities to transition recipients placed in residential settings to community living arrangements with wraparound supports.
- Assess the current wait lists for homeless and community living placements. Ensure the relevancy of the information (e.g., Do all the identified recipients still have needs?) and establish an algorithm to prioritize recipients who will access future openings.

\(^{48}\) Source: www.huduser.org FY 2013 Fair Market Rent Documentation System.
Case In Point: Proactively anticipating needs may help recipients achieve positive outcomes.

A recipient with reoccurring substance use issues was seeking a stable living situation. The recipient had been intermittently residing in a half-way house, his parent’s home, and was homeless for a period of time. The assigned direct care clinic case manager was very diligent in contacting the recipient and checking on his status. Medical record documentation was detailed and described ongoing struggles and attempts to engage the recipient in substance use treatment services. Eventually, the recipient was unable to be located for several months. Late in the review period, the recipient contacted the case manager and requested to transfer to another direct care clinic. During a documented telephone conversation between the case manager and the recipient, the recipient stated that when he gets to his new clinic he is going to ask the clinical team to apply for housing for him. The case manager stated that she would have done that for him if he would have told her.
Assertive Community Treatment Teams

Priority Service: Assertive Community Treatment Teams

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

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

- Participants identified a need for more ACT teams. However, each of the groups indicated that there needed to be more specialized ACT teams including forensic teams, teams designated to address dual diagnosis, and transition age youth teams.
- Focus group participants indicated a need for more consistency in transitioning or graduating ACT recipients to lower levels of care.
- It was noted that not all of the PNOs have access to specialty teams and that referrals are not always directed to a specialty team when the recipient may be in need of a specialty team.
- It was believed that some direct care clinics decline recipients who may benefit from an ACT team due to high acuity and challenging behaviors.
- The housing specialist and rehabilitation specialist assigned to the ACT teams often function primarily as case managers and do not always focus on their specialized area.
- Generally, people did not perceive that ACT team services were difficult to access when needed. However, there was reported variation around the county regarding the availability of ACT teams.
- There appears to be many people with SMI in Maricopa County who become involved with the criminal justice system. ACT teams need to develop greater capacity to meet the needs of people with SMI who have criminal justice system involvement.

Key Informant Survey Data
Forty-six percent of survey respondents felt that ACT team services were difficult to access and 18% indicated that the service was inaccessible. The remaining 36% of respondents indicated that ACT team services were easier to access or easy to access.

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

- Twenty-seven percent of the responses identified clinical team unable to engage/contact member;
- Twenty percent indicated member declines service; and
- Twenty percent of the responses identified admission criteria for services too restrictive.
Assertive Community Treatment Teams

In terms of the effectiveness of service utilization:

- Twenty-seven percent of the responses indicated that the services were being utilized effectively;
- Eighteen percent responded that the services were utilized effectively most of the time; and
- Fifty-five percent of the respondents indicated that ACT team services were not utilized effectively.

Sixty percent of the survey respondents perceived that ACT team services could be accessed within 30 days of the identification of the service need. Twenty percent indicated that the service could be accessed on average, within four to six weeks. The remaining 20% of the survey respondents reported that it would take an average of six weeks or longer to access ACT team services.

Medical Record Reviews: Group 1

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

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

Findings specific to ACT team services are presented below. The standardized assessment template does not currently include explicit prompts to address a recipient’s assigned level of case management. As such, it was typically not apparent that the clinical team considered the appropriateness of ACT team services as a component of the documented annual assessment update activity.

However, the ISP template does include a prompt to document the level of case management (i.e., level of care) and the field was populated in all of the ISPs reviewed (two recipients in the sample did not have current ISPs).

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

Eight of the one hundred twenty-two cases (7%) included recipients assigned to an ACT team.

Interviews

Forty-one Group 1 recipients agreed to and participated in an interview regarding the prioritized mental health services.
**Assertive Community Treatment Teams**

The interview disclosed the following:

- Most the recipients (82%) agreed that the clinical team reviewed the level of case management during the assessment and service planning process and assessed the recipient’s need for ACT team services.
- Only two of the forty-one (5%) recipients interviewed expressed a need to access ACT team services. One of the recipients stated that the clinical team had not followed up with the referral for ACT team services. The other recipient was assigned to an ACT team.

**Medical Record Reviews: Group 2**

ACT team services were not noted to be a documented component of the formal assessment and treatment planning process. While each ISP template includes the recipient’s currently assigned level of case management (i.e., assertive, supportive, connective), in most cases reviewed, there was little to no documented evidence that the clinical team was contemplating or recommending a change in the level of case management, including referring a person to an ACT team or stepping down a recipient assigned to an ACT team to a less intensive level of case management.

In almost every case in which ACT team services were identified as an explicit need on recipients’ assessments and/or ISPs, ACT team services were also identified as a service on the ISP.

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

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

**Service Utilization Data**

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

However, Mercer did complete an analysis of service utilization for recipients that were assigned to an ACT team. CY 2013 service utilization profiles for 1,286 ACT recipients who received a behavioral health service were analyzed.

The analysis sought to identify the utilization of one or more of the priority services (supported employment, supported housing, peer support services, family support services) as well as the proportion of case management services provided as compared to overall
Assertive Community Treatment Teams

service utilization for ACT team recipients. Case management is a critical supportive service inherent to the ACT team model and will vary in intensity and frequency to meet the individualized and ongoing clinical needs of each recipient. However, data collected as part of the medical record reviews and themes elicited via the focus groups suggested that there may be an over-reliance on case management services within the ACT teams.

The analysis found:

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

The following percentages of ACT team recipients received priority mental health services during CY 2013:

- Peer Support Services (60%);
- Family Support Services (4%);
- Supported Employment Services (53%).

The analysis does not include supported housing services due to the low occurrence of supported housing service encounters and the lack of standardized mechanism to track the provision of supported housing services.
Assertive Community Treatment Teams

Key Findings and Recommendations

Findings: ACT Team Services

- One thousand three hundred sixty-one recipients were assigned to 15 ACT teams as of February 14, 2014.
- Thirteen of the fifteen teams are at least 5% or more below capacity (capacity of each team = 100 recipients). In fact, five of the 15 teams are 10% or more below capacity and half the available teams are 10% or more below capacity. While the expectation is that ACT teams will not always work at full capacity, ACT teams should only fluctuate between slightly under capacity and slightly over capacity.
- It appears that each of the PNOs have established ACT team admission and exit criteria, but it is unclear how and to what degree the Maricopa County RBHA conducts oversight of the ACT team determinations. Upon review, the ACT team admission criteria may preclude the appropriate identification of candidates and result in delayed referrals of recipients who need ACT team services. For example, one policy reviewed states: “Person must have at least a 90 day trial with a supportive team that was unsuccessful prior to transfer to the ACT team.” It is standard practice to identify recipients with the highest needs for assertive community supports and get them into ACT team services as soon as possible.
- Mercer reviewed a list of the top 100 SMI utilizers in Maricopa County (in terms of total service expenditures) to ascertain how many of the recipients were actively assigned to one of the 15 ACT Teams. The results of the analysis found that only 20% of these recipients were assigned to an ACT Team.
- While the scope of the service capacity assessment did not include fidelity assessments of the ACT delivery model, it was noted during record reviews that the day-to-day functions of the ACT team often appeared to over-emphasize monitoring and surveillance of the recipient’s living quarters (e.g., adequate food, appearance of living space, appropriate room temperature) and ensuring that observations are completed and documented regarding the recipient’s adherence to taking prescribed medications. In addition, some teams appeared to lack some recommended staffing designations and the functions across staff members were noted to be overly generic. While it is preferred that ACT team staff members step in and assist the member whenever needs present, the roles appeared so diluted that the staff member’s unique specialization was rarely applied. For example, multiple progress notes demonstrated that home visits were interchangeably occurring by the substance abuse specialist, the peer support specialist or the employment specialist, but the documented activities performed by these team members in the context of the home visit were non-distinguishable. In the cases reviewed, recipients assigned to ACT teams rarely received specialized services related to substance abuse, supported employment, or other recovery-oriented supports and services.
- In terms of accessing ACT team services, the most significant barriers appear to be at entry or admission to the service (identification, engagement and admission criteria).
### Assertive Community Treatment Teams

**Recommendations: ACT Team Services**

- Ensure ongoing monitoring and actions to address current ACT team recipient vacancies. Ensure adherence to the established 5% vacancy threshold that, when met or exceeded, necessitates additional follow-up actions by the contractor.
- Ensure the consistent implementation of established ACT team admission and exit criteria.
- Ensure adherence to referral pathways for ACT team admissions that facilitate identification of appropriate candidates for ACT team services. Active identification of ACT team candidates should occur through the regular analysis of service utilization trends, service expenditures, and the review of quality of care concerns and adverse incidents involving SMI recipients.
- Develop written procedures to refer to and access specialty ACT teams when needed. When adding additional ACT team capacity, consider the expansion of specialty teams to meet the unique needs of recipients (e.g., forensics, transition age youth, co-occurring conditions).
- Focus group data suggested that more ACT resources need to be devoted to recipients with criminal justice system involvement. These recipients are seen as difficult to serve and more ACT teams need to have forensic expertise. Many systems utilize forensic ACT teams, as has Maricopa County, and as new ACT teams are planned for implementation, special consideration should be given to ensuring that some of the teams serve the forensic population.
- Consider sponsoring an annual conference on ACT that would offer opportunities for booster training in various aspects of ACT implementation. A mix of Maricopa County’s own experts and outside experts could provide various breakout sessions on different aspects of ACT. For example, an ACT psychiatrist in Maricopa County that participated in one of the focus groups uses a graduation/transition to lower level services approach that is consistent with recognized guidelines and best practice. The psychiatrist could be enlisted to provide a workshop on how to effectuate transition to lower level services. This idea could be expanded to an annual EBPs conference that would also incorporate IPS supported employment, peer support, supported housing and other models, thereby engaging a wider array of providers, both within the behavioral health system and from allied systems.
Outcomes Data Analysis

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

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

During CY 2013, an analysis was completed that compared recipients’ persistence with receiving supported employment services and peer support services for each of the outcome indicators selected. Overall, there are strong correlations between receipt of the priority services and improved outcomes related to incarcerations, living situation and employment status. The relationship is further strengthened when the recipient sustains consistent participation in the priority service over an extended period of time.

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

- The greater number of consecutive months of supported employment services was associated with recipients who resided in independent living arrangements.
- A majority of recipients who have only received one or two consecutive months of supported employment is correlated with a higher percentage of recipients residing in a boarding home, crisis shelter, hotel, homelessness, and behavioral health treatment settings. A smaller percentage of recipients (11%) in these living arrangements were found to have achieved long-term persistence in supported employment services.
- The percentage of recipients identified as “unemployed” significantly decreases as the duration with supported employment services increases. For example, 81% of recipients identified as “unemployed” are associated with two or less consecutive months of supported employment services. Alternatively, recipients who experienced five or more consecutive months of supported employment services contributed to only 9% of the total “unemployed” group.
- Of the relatively small proportion of recipients incarcerated, only 6% were recipients affiliated with seven or more consecutive months of supported employment services.

---

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

51 Long-term persistence in this example is defined as seven or more consecutive months of receiving supported employment.
The following outcomes were noted when reviewing the selected outcomes for recipients who had received peer support services during the review period:

- Only 12% of recipients noted to be homeless or residing in a boarding home, crisis shelter, hotel, or behavioral health treatment setting received peer support services during the review period. Alternatively, recipients who received seven or more consecutive months of peer support were less likely to reside in these types of settings (17%).
- Of the group of recipients who were incarcerated during the review period, only 3% received nine consecutive months of peer support services. However, 68% of incarcerated recipients had only received peer support services during a single month or during two consecutive months during the review period.
- Longer periods of consecutive peer support services are associated with lower unemployment rates. For example, 71% of the recipients identified as unemployed received one or two months of peer support services; the percentage of unemployed recipients who received peer support services for seven or more consecutive months was determined to be only 7%.

**Case In Point:** Establishing individualized goals, and active engagement and ongoing support by the clinical team can result in positive outcomes for recipients.

A single 47 year-old male expressed his desire to find full-time employment. His goal for work was documented on his ISP. At the time, he was unemployed, parenting his teenage daughter, and providing care to his mother. Shortly after completing his annual ISP review, with assistance from his clinical team, he enrolled in a real estate agent training program. By the end of the review period, he had completed the real estate training program, passed his licensing exam, and begun practicing as a real estate agent in the Phoenix area. His clinical team provided frequent encouragement and support, as indicated in the medical record progress notes.
## Focus Group Invitation

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

The goal is to collect information for an ADHS/DBHS evaluation of the behavioral health service delivery system for adults with a serious mental illness (SMI), specific to Assertive Community Treatment (ACT), Supported Housing (SH), Supported Employment (SE) and Peer support services, including current system strengths, challenges, barriers, and concerns related to these priority behavioral health services. This information will be used to inform strategies to help the adult system of care in Maricopa County move toward an enhanced, recovery-oriented service delivery system.

All focus groups will be held at the following location:

**Quality Care Network**  
5328 E. Washington, Bldg. B  
Phoenix, AZ 85034

<table>
<thead>
<tr>
<th>Focus Group One</th>
<th>Focus Group Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults receiving behavioral health services</td>
<td>Family Members of Adults receiving behavioral health services</td>
</tr>
<tr>
<td>February 20, 2014 9:00 am–11:00 am</td>
<td>February 20, 2014 1:00 pm–3:00 pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus Group Three</th>
<th>Focus Group Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Support Specialist providing behavioral health services to adult consumers</td>
<td>Providers of ACT, SH, SE, to adults receiving behavioral health services</td>
</tr>
<tr>
<td>February 20, 2014 5:00 pm–7:00 pm</td>
<td>February 19, 2014 5:00 pm–7:00 pm</td>
</tr>
</tbody>
</table>

Space is available for 10 participants per focus group. Once capacity is reached, interested participants will be placed on a waiting list.

RSVP by Thursday, February 14, 2014 to Stacia Ortega at stacia.ortega@mercerc.com

Refreshments will be provided.
APPENDIX B

Key Informant Survey

1. What is your job role?
   - CEO
   - Executive Management
   - Clinical Leadership (behavioral health)
   - Clinical Leadership (medical)
   - Specialty Case Manager
   - Direct Services Staff (BHP/BHT)
   - Other (please specify)

2. From the list below, please select which best describes your organization
   - Consumer Operated Agency
   - Behavioral health provider for Adults with a SMI only
   - Behavioral health provider for Adults with a SMI, children, GMH/SA
   - Provider Network Organization within the Maricopa County RBHA system
   - Hospital
   - Crisis Provider
   - Housing Supports
   - Employment Supports
   - Family and Peer Support Services
   - Other (please specify)

3. How many people, with a serious mental illness are currently served by your organization?

4. What is your payer mix (this may be an estimate)?
   - Medicaid
   - Medicare
   - Dual eligibles
   - Non-Title 19
   - Uninsured
   - Private
   - Commercial
### 5. Please indicate if you provide the following behavioral health services to Adults with a serious mental illness

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Support Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Support Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment Activities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 6. Please describe your organization's activities related to the provision of the following services:

- Supportive Housing
- Supported Employment
- Peer Support Services
- Family Support Services
- ACT
- Employment Activities

### 7. In providing services to adults with a serious mental illness, how would you rate the following services in terms of quality (1=poor, 5=Excellent)

<table>
<thead>
<tr>
<th>Service</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported Housing Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**8. In providing services to adults with a serious mental illness, how would you rate the following services in terms of their access to these services (1=no access/service not available, 2=difficult to access, 3=easier to access, 4=easy to access)?**

<table>
<thead>
<tr>
<th>Service</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education support services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment support services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing support services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer support services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify)

**9. What are the top three services, from the list below, that you believe need the more attention from the behavioral health system?**

- [ ] Education Support Services
- [ ] Employment Support Services
- [ ] Housing
- [ ] Housing Support Services
- [ ] Peer Support Services
- [ ] Family Support Services
- [ ] ACT

**10. Of the three services you identified as needing more system attention, please briefly describe what the increased attention would entail:**

1. 
2. 
3. 
11. Please select from the list below the factors that you feel negatively impact the service delivery system for you as a provider

<table>
<thead>
<tr>
<th>Factor</th>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>lack of capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>do not have clinical/employment/housing expertise to provide services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>do not have peer/family support services expertise</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>insufficient number of ACT teams</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>staffing capacity to meet fidelity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>staffing turnover</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>payer issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Yes</th>
<th>Most of the Time</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including supported employment)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing (including supported housing)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. What would you say is the most significant service delivery issue for the persons you serve with a serious mental illness?

* Asterisks designate questions that must be answered.
APPENDIX C

Assessment Verification Interview Tool

ASSESSMENT VERIFICATION INTERVIEW

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

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

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

   ___ Supported Employment
      Supported employment helps you get a job or other meaningful community activity (i.e., volunteer work) that you are interested in. It can involve helping you think about what job you want, reviewing your job skills and needs for training, finding jobs you might want, preparing for interviewing or applying for a job, and supporting you once you have a job.

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

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

   ___ Family Support Services
      Family support services help your family be better at understanding and helping you. It may be provided by a family mentor at your clinic.
2. Are any of these services in your most recent individual service plan?
   ___ Yes  ___ No

3. Do you think that you need any of these services?
   ___ Yes
      ___ Assertive Community Treatment
      ___ Supported Employment
      ___ Supported Housing
      ___ Peer Support Services
      ___ Family Support Services
   ___ No
# Group 2 Medical Record Review Tool

## Mercer

### Network sufficiency record review tool—Group Two

**Log-in screen**

<table>
<thead>
<tr>
<th>Reviewer name</th>
<th>Consumer ID</th>
<th>DOB <em><strong>/</strong></em>/___</th>
<th>Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] Useable for Chart Review
- [ ] Not Useable  If not usable, reason: 

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Date of most recent assessment ___/___/___
- Date of most recent ISP ___/___/___
- Sample period: January 1, 2013 – December 31, 2013

### Chart review

<table>
<thead>
<tr>
<th></th>
<th>Functional Assessment Need¹</th>
<th>ISP Goals Need²</th>
<th>ISP Services³</th>
<th>Claims</th>
<th>ISP/Claims Difference</th>
<th>Reason Claims &lt; ISP (1)</th>
<th>Reason Claims &gt; ISP (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ From Part E: Assessment, Functional Assessment, Needs: Living Situation = Supported Housing; Learning/Working = Supported Employment; Social/Community Integration = ACT, PSS, FSS. In addition to reported need, include any current services (i.e., the member is already receiving rent subsidies, so may not be in the Recommendation field). Mark “yes” if present, “no” if not present.

² From Part D: ISP, Goals, Need. Mark “yes” if present, “no” if not present.

³ From Part D: ISP, Services. Give frequency as prescribed, i.e., 1X/quarter, 15 units/week.
<table>
<thead>
<tr>
<th>Legend Claims&lt;ISP</th>
<th>Legend Claims&gt;ISP</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Client declined services</td>
<td>a. Client requested additional services</td>
</tr>
<tr>
<td>b. Wait list for prescribed service</td>
<td>b. Provider requested additional services</td>
</tr>
<tr>
<td>c. No service provider available</td>
<td>c. Family requested additional services</td>
</tr>
<tr>
<td>d. Hospitalization</td>
<td>d. Other, please specify</td>
</tr>
<tr>
<td>e. Incarceration</td>
<td></td>
</tr>
<tr>
<td>f. Client moved, transferred</td>
<td></td>
</tr>
<tr>
<td>g. Death of Client</td>
<td></td>
</tr>
<tr>
<td>h. Client was refused for service for behavior reasons</td>
<td></td>
</tr>
<tr>
<td>i. Language or cultural barriers</td>
<td></td>
</tr>
<tr>
<td>j. Family/other request to reduce services</td>
<td></td>
</tr>
<tr>
<td>k. Clinician decided services not needed</td>
<td></td>
</tr>
<tr>
<td>l. Transportation barriers</td>
<td></td>
</tr>
<tr>
<td>m. Billing/service description errors</td>
<td></td>
</tr>
<tr>
<td>n. Case closed due to inability to contact client</td>
<td></td>
</tr>
<tr>
<td>o. Other, please specify</td>
<td></td>
</tr>
</tbody>
</table>
List of Peer-Directed Groups

VISIONS OF HOPE

ACTING CLASS – From Improv to movie scenes, this class dives deep into the heart of acting.

ADVENTURING IN ART – Explore recovery through various forms and types of art, art appreciation and crafts.

A LIFEWORTH LIVING – This group provides support and education for the purpose of suicide prevention.

ART EXPRESSION – Structured art

ARTS AND CRAFTS – Let your imagination grow by creating fun arts and craft projects to take home or share with others.

BON APPETIT – Enjoy great meal ideas by our nutritionist. Get nutritional and education sessions on how to craft a nutritious meal and you get to eat it!

CINEMATOGRAPHY – Want to be the next Spielberg? Well here is your chance to get some hands on experience using a camera, and learn the basics of movie making.

CREATIVE EXPRESSIONS – Work together using the creative process to develop group murals & individual projects.

CREATIVE WRITING WORKSHOP – Membership examples of their writing and peers have 1 week to work on and critical these submissions and then discuss them with their authors and their peers.

CURRENT EVENTS – Local and world news discussion, and will discuss how we fit.

FILM APPRAISAL – Weekly viewing of fun learning about history, science, current events, and other topics followed by discussion.

FINANCES – Learn and explore your finances, budgeting.

FINDING YOUR PURPOSE – Do you ever wonder what to do with your life or wish you had more success with your daily tasks? Here is a class to create supportive friendships and confidence in your life’s purpose.

GET UP N’ GO – We will get your bodies moving, whether or not you have moved in a long time, you can sit and do everything everyone else is doing.

H.O.P.E – Helping Our Peers – This is a mini-topic based group where members can discuss anything that is on their minds.

INDIVIDUAL GED TUTORING – by apt at Huber: See Jennifer Kizer.

INTERACTIVE MEDIA – This class will introduce members to computers, games, and software.

KARAOKE – Sing a tune and sing some of your favorite songs.

Laughing and chewing is encouraged.

LGBTQ & YOU – This group addresses the concerns and issues for people who self-identify as lesbian, gay, bisexual, transgender, or questioning.

LIVING SAFELY – Learning to navigate in new ways safely.

MEMBER GATHERING – An opportunity for members to socialize and practice interaction while discussing ideas that they would like to see implemented for future activities.

MEMBER LEADERSHIP – Members learn to create and present a recovery based 1-day class around a recovery oriented topic of their choice. Members learn about recovery principles while discovering more about their own recovery.

MEN’S GROUP – Share your experiences are a man, while learning and supporting one another.

NUTRITION CONSULTATION/EDUCATION – Private, one-on-one sessions with a traditional and holistic nutritionist. Come be inspired by creating goals that work for you!

NUTRITION FOR MIND, BODY & SOUL – Incorporation of overall health, from food to self-esteem, to positivity in body image.

OPEN ART STUDIO – This time to let yourself be free. Here you will have freedom of choice to work on a project of your desire while working with your peers.

OPEN UP TO ART – Learn how to express yourself through various art exercises and projects.

POSITIVE AFFIRMATIONS – Come be a part of an encouraging class that helps to promote positivity in your everyday life. Learn coping skills and how to love yourself for who you are.

PROBLEM SOLVING FOR FAMILIES – Helps families and their loved ones define and address challenges they are facing. Provides an opportunity to learn from each other’s experiences and enhance network of support. For families enrolled in Family Support.

RECOVERY AGENT – Learn to express anger in a healthy way.

RECOVERY BINGO – BINGO! Join us for a game of bingo with health-related themes. Each week someone wins a prize.

RECOVERY EDUCATION – This group focuses on skills that will be helpful in living in the larger community and improving quality of life.

ROLE PLAYING – Come participate in a tabletop role-playing system that enjoys mythical times and teaches decision-making and problem-solving skills.

SELF-ESTEEM – Learn effective ways to build your self-esteem by recognizing your strengths in a non-threatening environment.

SIT AND BE FIT – Exercises that you can do at home.

This class is recommended for individuals who want to exercise at home and need help creating a program.

SIT AND STRETCH – Move and stretch while sitting in a chair in this fun and engaging class. This class is recommended for individuals who may be confined to a wheelchair, who have physical limitations, new to exercises, or anyone looking to increase their flexibility.

SPANISH BINGO – Socialization activity where members practice reading, pronouncing, and translating Spanish descriptions and vocabulary as they play bingo for donated items.

STAYING CONNECTED – Stay connected with current events and discuss popular topics.

STRENGTH BODIES – Challenge yourself to build a strong body by exercising to music from the exercise tapes recommended for those with minimal physical restrictions.

TALKING WITH HAND – Introduction of techniques for communicating with deaf people using American Sign Language (ASL).

THE EMOTIONS – Express your emotions and feelings freely.

THOUGHTS FOR THE DAY – Would you like to feel more relaxed, less stressed and have more clarity? That’s what our members say they experience with this class.

TRANSFORMATIONS – Even when change is not our choice, it is necessary to individual recovery. Learn how to accept and make changes to fit your role.

VISIONS FOOD SERVICE PROGRAM – Learn the skills needed to get your food handler’s certification.

VISIONS SHOP – Spend your hard earned Visions Bucks on donated goods from the Visions Shop. New items every week!

WOMEN’S SUPPORT GROUP – Do you like making your own recipes and sharing them with the world! The VOA YouTube Channel brings out your creative side through movies showing art, life and recovery.

WELLNESS WALK – Walk for health, walk for life. Let’s get walking.

WILDERNESS/URBAN SURVIVAL – Learn bus routes, laced tying, orienteering, emergency plans and everything in between to help keep you and others safe.

WOMEN’S GROUP – Share your experiences as a woman while listening and supporting other women.

STRETCH AND BREATHE – The class offers a time to rest and relax one’s body through stretches, poses and deep breathing exercises.

YOUNG ADULTS’ SUPPORT GROUP – Support Group for families for children and adults (18-21 yrs.).

YOUR INNER PATH – Follow your inner path by finding your individual spirituality to understand your illness and better manage symptoms.

YOUR LIFE FROM A TO Z – Learn how personal hygiene and healthy lifestyles to keep you well.
## Summary of Recommendations

<table>
<thead>
<tr>
<th>Service</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Support Services (PSS)</td>
<td>PSS1. Assess the availability of peer support specialists at each direct care clinic and add additional staff when gaps or insufficient resources are identified.</td>
</tr>
<tr>
<td></td>
<td>PSS2. Through training and supervision, ensure that professionals understand and value the unique contributions that peer support workers can offer. Peer support workers are not ancillary contributors to clinical programs, but, rather, have a unique role to play in helping people adopt recovery-oriented beliefs (recovery is attainable), attitudes (hope for my future) and behaviors (illness self-management, participation in work and community). Therefore, peer support workers should: a) be included in assessment and treatment planning activities, and b) should not be assigned to tasks that other clinicians prefer not to do and that unnecessarily divert them from their primary purposes and most significant contributions to promoting recovery outcomes.</td>
</tr>
<tr>
<td></td>
<td>PSS3. All peer support workers should be trained regarding how to document peer support services in the medical record. While ADHS/DBHS has developed written policy expectations for this training, the review team did not find consistent evidence that the medical record documentation met standards. It is important that assessment of and progress on recovery-oriented needs and goals is documented in the record.</td>
</tr>
<tr>
<td></td>
<td>PSS4. Provide additional training and supervision to recognize the value of peer support services and family support services as effective clinical interventions.</td>
</tr>
<tr>
<td></td>
<td>PSS5. The system should continue efforts to target and increase the use of peer support services as a follow up to crisis services; utilize peers as part of hospital discharge planning and supportive engagement; use peers to help ensure timely ambulatory care follow-up after hospitalization; helping recipients to get incorporated into traditional physical healthcare pathways (supporting integrated care) and deploy peer support specialists to assist recipients who are experiencing significant life challenges (e.g., incarcerations).</td>
</tr>
<tr>
<td></td>
<td>PSS6. Most peer support provided within the direct care clinics appears to occur within the context of group settings; attempts should be made to balance the delivery with individualized peer support (current approach within the direct care clinics does not consistently promote individual relationship and trust building).</td>
</tr>
<tr>
<td>Service</td>
<td>Recommendations</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Family Support Services (FSS) | FSS1. The system should examine the possibility of adopting evidence-based family support tools that have shown good outcomes. Many different family education/support programs have been developed that improve family communication and result in better outcomes. ADHS/DBHS plans to work with the current GSA-6 contractor to implement the SAMHSA family support fidelity tool in the near future.  
FSS2. Consider developing more formal arrangements with external family advocacy and support organizations, such as local National Alliance for the Mentally Ill chapters, which often have the capability of providing evidence-based family education and support programs. Families may appreciate the mutual-help nature of these external programs.  
FSS3. Rather than just identifying family supports available to the recipient, incorporate family members into treatment plans. Establish annual training for staff and supervisors that goes beyond understanding at a conceptual level to focus on specific strategies to actively promote the availability and use of family support services. |
<table>
<thead>
<tr>
<th>Service</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Employment</td>
<td>SE1. Continue efforts with the Rehabilitative Services Administration to develop additional supported employment opportunities outside the behavioral health system that address recipient’s vocational preferences, talents and experiences.</td>
</tr>
<tr>
<td></td>
<td>SE2. Explore opportunities to expand the presence of vocational rehabilitation specialists at the direct care clinics.</td>
</tr>
<tr>
<td></td>
<td>SE3. Clarify and define the roles of rehabilitation specialists assigned to the direct care clinics (including distinctions between rehabilitation specialists and employment specialists assigned to ACT teams). Once determined, increase oversight and supervision of these responsibilities and fill vacant positions.</td>
</tr>
<tr>
<td></td>
<td>SE4. Continue efforts through Disability Benefits 101-Arizona to meet workforce development needs, link recipients to resources knowledgeable regarding accessing public assistance (e.g., disability compensation, health insurance) and review potential implications of additional income related to employment. Examine the feasibility of utilizing peer support specialists in these roles.</td>
</tr>
<tr>
<td></td>
<td>SE5. Through training and supervision, ensure that clinical team members recognize the value of supported employment services in meeting a recipient’s employment related goals. Ensure that supported employment services are included as an intervention on the ISP in these circumstances.</td>
</tr>
<tr>
<td></td>
<td>SE6. Supported employment for ongoing support service encounters are disproportionately less than pre-job training and development. Assess the sufficiency of contracted providers to support the provision of ongoing support to maintain employment services.</td>
</tr>
<tr>
<td></td>
<td>SE7. Ensure that clinical team members actively and continuously engage recipients regarding opportunities to participate in employment related supports and services. Promote awareness and skill development through training and monitor expectations via ongoing supervision.</td>
</tr>
<tr>
<td></td>
<td>SE8. Consider developing Individual Placement and Support (IPS) supported employment teams to provide supported employment services. IPS has been extensively researched and proven to be effective.</td>
</tr>
<tr>
<td></td>
<td>SE9. Adequate training in IPS should be ensured. This training should be provided by experts in the IPS model. In addition, because agency support for supported employment is one of the aspects of fidelity that is specified by the IPS model, all direct care clinic supervisors should receive a basic introduction to the IPS model, which should include guidance on how to ensure that all clinical programs are supportive of the philosophy, principles, and practices of IPS supported employment.</td>
</tr>
<tr>
<td>Service</td>
<td>Recommendations</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Supported Housing</td>
<td><strong>SH1.</strong> Develop and implement a standardized mechanism to track and quantify supported housing services and expenditures within the behavioral health system. As part of the development, examine why the supported housing services billing code is underutilized and clearly define the services and supports that constitute supported housing services.</td>
</tr>
<tr>
<td></td>
<td><strong>SH2.</strong> Continue efforts to partner with local municipalities and other community stakeholders to identify and deliver additional housing support capacity.</td>
</tr>
<tr>
<td></td>
<td><strong>SH3.</strong> Examine opportunities to transition recipients placed in residential settings to community living arrangements with wrap-around supports.</td>
</tr>
<tr>
<td></td>
<td><strong>SH4.</strong> Assess the current wait lists for homeless and community living placements. Ensure the relevancy of the information (e.g., Do all the identified recipients still have needs?) and establish an algorithm to prioritize recipients who will access future openings.</td>
</tr>
<tr>
<td>Service</td>
<td>Recommendations</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>ACT Team Services</td>
<td>ACT1. Ensure ongoing monitoring and actions to address current ACT team recipient vacancies. Ensure adherence to the established 5% vacancy threshold that, when met or exceeded, necessitates additional follow-up actions by the contractor.</td>
</tr>
<tr>
<td>(ACT)</td>
<td>ACT2. Ensure the consistent implementation of established ACT team admission and exit criteria.</td>
</tr>
<tr>
<td></td>
<td>ACT3. Ensure adherence to referral pathways for ACT team admissions that facilitate identification of appropriate candidates for ACT team services. Active identification of ACT team candidates should occur through the regular analysis of service utilization trends, service expenditures, and the review of quality of care concerns and adverse incidents involving SMI recipients.</td>
</tr>
<tr>
<td></td>
<td>ACT4. Develop written procedures to refer to and access specialty ACT teams when needed. When adding additional ACT team capacity, consider the expansion of specialty teams to meet the unique needs of recipients (e.g., forensics, transition age youth, co-occurring conditions).</td>
</tr>
<tr>
<td></td>
<td>ACT5. Focus group data suggested that more ACT resources need to be devoted to recipients with criminal justice system involvement. These recipients are seen as difficult to serve and more ACT teams need to have forensic expertise. Many systems utilize forensic ACT teams, as has Maricopa County, and as new ACT teams are planned for implementation, special consideration should be given to ensuring that some of the teams serve the forensic population.</td>
</tr>
<tr>
<td></td>
<td>ACT6. Consider sponsoring an annual conference on ACT that would offer opportunities for booster training in various aspects of ACT implementation. A mix of Maricopa County’s own experts and outside experts could provide various breakout sessions on different aspects of ACT. For example, an ACT psychiatrist in Maricopa County that participated in one of the focus groups uses a graduation/transition to lower level services approach that is consistent with recognized guidelines and best practice. The psychiatrist could be enlisted to provide a workshop on how to effectuate transition to lower level services. This idea could be expanded to an annual EBPs conference that would also incorporate IPS supported employment, peer support, supported housing and other models, thereby engaging a wider array of providers, both within the behavioral health system and from allied systems.</td>
</tr>
</tbody>
</table>