

CASE STUDY

Supportive Service Expansion for Individuals with Serious Mental Illness: A Case Study of Mercy Maricopa Integrated Care

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Executive Summary

NORC at the University of Chicago developed this case study of supportive service expansion for individuals with serious mental illness enrolled in the Mercy Maricopa Integrated Care (Mercy Maricopa) Medicaid managed care plan in Maricopa and Pinal County, Arizona, through a series of structured interviews with stakeholders ranging from service providers to member advocates. This case study provides background and historical information on Mercy Maricopa and the population it serves and examines the 1) policy drivers, 2) partnerships, and 3) organizational decisions and staffing alignment that have influenced Mercy Maricopa's implementation of expanded support services, including employment and housing supports. The case study also explores the successes and challenges identified by stakeholders.

Lessons Learned

Through this work, NORC identified lessons that other states or health care systems may consider as they undertake the expansion of services to the SMI population or determine how to prioritize populations for specific services.

- **Establish a Member-Centered Framework:** Mercy Maricopa takes a member-centric approach, focused on ensuring that members have maximized choice in obtaining and directing their services and supports. Clearly linking program outcomes to member success and actively including member participation in that process helps to orient the organization toward a member-centered framework.
- **Strengthen and Maintain Stakeholder Partnerships:** Mercy Maricopa leadership was deliberate about connecting with the local network of organizations working with individuals with serious mental illness, enabling it to unify its service delivery approach by ensuring that strong connections with providers led to consistent and best practices across clinics.
- **Nurture and Sustain Good Communication:** Mercy Maricopa has worked closely with providers to help clearly communicate expectations, focus on improvement, and enhance relationships, promoting substantial growth and flexibility. A foundation of clear communication, strong partnerships, and accessible leadership can assist organizations in traversing substantial growth and changes.
- **Be Strategic with Resources:** Strong partnerships with robust communication also enabled Mercy Maricopa to identify strategic uses for limited resources.

Policy Drivers

Several key policy and legal drivers played a significant role in the implementation and expansion of supportive services for individuals diagnosed with a serious mental illness (SMI) in Maricopa County, specifically the Regional Behavioral Health Authority transition and the *Arnold v. Sarn* court decision.

- **Successes:** Mercy Maricopa has exceeded the capacity requirements of the *Arnold v. Sarn* settlement and leveraged opportunities to expand services to an increasing number of members. By exceeding these mandated targets, Mercy Maricopa and its partners showed a commitment to prioritizing member needs and a dedication to working with community stakeholders to ensure those needs were identified and addressed appropriately.
- **Challenges:** Limited housing stock and easy access to public transportation have hindered members' access to permanent housing and employment, despite the housing and employment support services and the transportation resources provided by Mercy Maricopa.

Partnerships

Mercy Maricopa's efforts to build partnerships with government officials, providers, and stakeholders has been an important part of the design, implementation, and expansion of its care model. This has enabled Mercy Maricopa to create a system of care that anticipates the needs of its members, and Mercy Maricopa has developed tools in response to issues raised through stakeholder relationships.

- **Successes:** Mercy Maricopa's deep partnerships with state, county, and city government, as well as its strong network with community stakeholders and providers has enabled it to more effectively identify and address the needs of members.
- **Challenges:** Challenges in communicating services and policies have arisen across Mercy Maricopa's provider and stakeholder network, leading to gaps in member and family awareness of available services. To remedy these challenges, Mercy Maricopa created educational resource guides for providers and hosts community forums and annual conferences with providers, members, and families to highlight new programs and address concerns.

Organizational Decisions and Staffing Alignment

Mercy Maricopa has made several strategic network and staffing decisions that have played important roles in the implementation of Mercy Maricopa's expanded housing and employment support services program for individuals with serious mental illness. For example, Mercy Maricopa developed a Systems

of Care division, which includes the housing, employment, and court services programs with the goal of further coordinating the full spectrum of supportive services throughout the 24 SMI clinics.

- **Successes:** The expertise of Mercy Maricopa’s staff has strengthened institutional knowledge of member needs, services, and opportunities for expansion. Mercy Maricopa recognized the need to build a robust and experienced team and hired individuals who had been involved in the systems of care for many years.
- **Challenges:** Case management staff turnover at clinics has exacerbated communication challenges and reduced stability for members and families. Challenges with staff retention have caused delays in care and reduced efforts in building relationships between clinical staff and members. Concerns with HIPAA regulations have also caused challenges in sharing member data across providers, slowing the continuity of care. Lastly, alignment of services across domains of the health system necessitates a robust process for data sharing; this proved difficult during Mercy Maricopa’s initial implementation and continues to challenge clinics today.

Introduction

NORC at the University of Chicago (NORC) developed this case study of supportive service expansion for individuals with serious mental illness (SMI) enrolled in the Mercy Maricopa Integrated Care Medicaid managed care plan in Maricopa County, Arizona, through a series of structured interviews with stakeholders ranging from service providers to member advocates. Through interviews with Mercy Maricopa Integrated Care (Mercy Maricopa) staff, service providers, and community advocates, we identified three major categories of factors that have shaped the design and implementation of expanded support services under Mercy Maricopa. This case study provides background information on Mercy Maricopa, as well as examines the 1) policy drivers, 2) partnerships, and 3) organizational decisions and staffing alignment that have influenced the impact of Mercy Maricopa's implementation of expanded support services, including employment and housing supports. This case study does not specifically examine the impact or effectiveness of the associated interventions. NORC is also conducting a separate mixed-methods study examining the impact of the supportive services expansion on cost, utilization, and member health care experience.

Case Study Background

In recent years, concerns about the health and well-being of individuals have expanded to include a focus on how personal, interpersonal, community, and systemic factors play an important role in individuals' physical and mental health. Evidence has demonstrated that interventions that target these factors, such as stable housing and employment, can have far-reaching impacts that extend beyond reducing homelessness and unemployment alone, to areas of health such as chronic disease management, mental health stabilization, and substance use treatment¹. Studies have shown that investments in these interventions may improve health outcomes, and can subsequently reduce costs by decreasing hospitalizations, admissions for psychiatric care, and length of hospital stays, particularly for high-risk populations such as individuals with SMI.^{2,3,4,5,6,7,8,9,10,11,12,13,14}

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines SMI as “having, at any time during the past year, a diagnosable mental, behavioral, or emotional disorder that causes functional impairment that substantially interferes with or limits one or more major life activities.”¹⁵ Individuals living with SMI are more likely to face unemployment, arrests, and homelessness compared to those without mental illness.¹⁶ Research estimates that approximately 26 percent of adults who are homeless and staying in shelters live with an SMI, and approximately 24 percent of state prisoners have “a recent history of a mental health condition.”^{17,18} Individuals with SMI also face an increased risk of

having chronic medical conditions, and, as a result, these individuals on average die 25 years earlier than the general population, largely due to treatable medical conditions.^{19,20} It is estimated that, altogether, SMI costs the United States nearly \$200 billion in lost earnings every year.²¹

Mercy Maricopa, an integrated physical and behavioral health Medicaid managed care plan, primarily serves members in Maricopa County, Arizona (including Phoenix). Mercy Maricopa is a local not-for-profit health plan sponsored by Mercy Care Plan (MCP) and Maricopa Integrated Health Systems. MCP is an Arizona nonprofit with a 28-year history of providing Medicaid managed care administration and is sponsored by Dignity Health and Carondelet Health Network. Both Mercy Maricopa and MCP are administered by Aetna Medicaid Administrations LLC. In March 2013, Mercy Maricopa was awarded the Regional Behavioral Health Authority (RBHA) contract for Maricopa County by the Arizona Department of Health Services (ADHS), now managed by the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency.²² As such, Mercy Maricopa currently has a contract through AHCCCS to provide behavioral health services to Medicaid eligible children and adults in the General Mental Health and Substance Abuse population (GMHSA), integrated behavioral health and physical health services to Medicaid eligible adults with SMI, and crisis services, as well as a range of state-funded behavioral health services for individuals not eligible for Medicaid. Individuals in the GMHSA population are those with general mental health and substance abuse issues who are eligible for Medicaid but do not have an SMI diagnosis.

RBHAs operating in different parts of the state have historically administered the behavioral health and substance abuse services carve-out for AHCCCS members, but Mercy Maricopa was the first RBHA to cover integrated physical and behavioral health services for Medicaid eligible individuals with an SMI, of which there are approximately 20,000 people in Maricopa County.²³ Additionally, Mercy Maricopa focuses on SMI populations who also experience homelessness, which includes more than 5,000 such individuals in Maricopa County.²⁴ In addition to the behavioral health and substance abuse services it provides to the Medicaid and non-Medicaid SMI populations, Mercy Maricopa also contracts for other supportive services, including housing and employment supports as required by the *Arnold v. Sarn*²⁵ court ruling. These services are funded through a mix of state appropriations, federal Medicaid matching funds, and in the case of housing vouchers, various federal housing subsidies, including U.S. Department of Housing and Urban Development (HUD) Section 8. For the purposes of this case study, we focus primarily on housing and employment supports, as those are the services that had the largest expansion from the *Arnold v. Sarn* agreement.

Arnold v. Sarn was a class action suit filed against the state in 1981 alleging that ADHS and Maricopa County did not fulfill their statutory obligations to provide a comprehensive community mental health system.²⁶ Under a judgment reached in 1986 and affirmed by the State Supreme Court in 1991, the state was required to provide a combination of supportive housing, supported employment, assertive community treatment, and peer and family services to individuals with SMI in Maricopa County.²⁷ In January 2014, the parties reached a settlement to the lawsuit, which included specific requirements to increase the number of individuals served by the employment, housing, and peer support services and to implement ongoing evaluation tools in line with the SAMHSA Fidelity Model. The SAMHSA Fidelity Model is used to examine whether a program is implemented as the developer intended and consequently whether it follows evidence-based best practice.²⁸ Following the settlement, AHCCCS expanded the available services that Mercy Maricopa administers to include supportive housing and supported employment, and Mercy Maricopa continued to expand these services to additional members, beyond those required by the settlement. As a result of the lawsuit and service expansion, Arizona's Medicaid covered services also expanded among the GMHSA population. For example, Arizona is one of 14 states that provides Medicaid reimbursement for supported employment services and one of 18 that provides reimbursement for peer support services (as of 2015).²⁹ Supported employment and peer support services add to the robust set of covered behavioral health services that also include skills training, personal care assistance, family support, and case management. See Exhibit 1 for examples of Mercy Maricopa's supportive services.

Exhibit 1. Examples of Mercy Maricopa Supportive Services



Supportive Housing ³⁰

Mercy Maricopa offers housing vouchers that enable members who are homeless with an SMI and who qualify through the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) evaluation to choose from one of Mercy Maricopa’s permanent supportive housing options. Under Mercy Maricopa’s permanent supportive housing program, members sign a lease and pay 30 percent of their income towards rent, and housing vouchers pay the remainder. Housing includes optional supportive housing services up to 24 hours per day (described below) and members may choose from the following housing options, depending on their needs:

- Community housing: Members can choose to live in a house or apartment within Mercy Maricopa’s housing network.
- Scattered Site housing: Members select their own house or apartment in the community.
- Bridge to Permanency: Members choose a house or apartment in the community. The goal of this program is to transition a member from a Mercy Maricopa subsidy to a Housing Choice Voucher/Section 8.

Mercy Maricopa also offers supportive housing services to all members with an SMI to help members retain their existing or new housing. These services include: assistance with activities of daily living, skills training and development, transportation, health education, conflict resolution, crisis response, and assistance with socialization and seeking employment.



Supported Employment ³¹

Supported employment is a set of services designed to assist members in obtaining and holding competitive employment. Services may fall into one of three categories:

- Skills training and development provides education in areas such as: self-care, household management, social skills, budgeting, and using community resources.
- Pre-job training and development helps members prepare to enter the workforce through career and educational counseling, job shadowing and resume writing, interview and study skills, professional behavior and dress, and time management.
- Ongoing support enables members to maintain employment through on-the-job coaching and supervision, counseling, and support-network development.

Purpose and Methods

Aetna, Inc. contracted with NORC to conduct a case study to:

- Examine the history of how Mercy Maricopa developed and implemented its integrated care model with a focus on housing and employment supports
- Highlight the complexities, challenges, and lessons learned associated with implementing and managing Mercy Maricopa's integrated care model
- Explore Mercy Maricopa's "systems of care" model as a framework for approaching integration on this scale

NORC researchers conducted a site visit in Maricopa County, Arizona, in May 2017 and led 20 interviews with 35 individuals, including state and local government officials, Mercy Maricopa leadership and staff, clinical providers, advocates, and other stakeholders. NORC conducted an additional interview with a stakeholder organization over the phone on May 12, 2017, and followed up via email with individual organizations and Mercy Maricopa staff with additional questions as needed. NORC staff began each interview by providing background and a description of the case study, as well as the overarching research questions. Interviewees were guided through the consent process, and verbal consent was obtained to record each interview. Study interviewees were told they would not be identified by name, and therefore all quotations included in this study are anonymous. Transcripts of each interview were coded and analyzed for themes in response to each of the research questions through NVivo 10 software.

Specifically, we examined the following: the factors that led to the focus on the employment and housing supports for the SMI population, including any specific considerations or data/information used, the stakeholders involved in the programs' development and expansion, and the challenges and successes related to implementation and sustainability of the programs.

The case study presents the findings of these interviews, highlighting the factors that impacted the implementation and expansion of the housing and employment supportive services programs under Mercy Maricopa, the successes of the implementation strategy, the challenges that arose, and lessons learned from the program.

Policy Drivers

Mercy Maricopa leadership and staff, as well as other stakeholders, identified several external factors that played a role in the implementation and expansion of supportive services for the SMI and GMHSA populations in Maricopa County. These factors were largely a byproduct of earlier developments in supportive service models and policy, legislative, or legal decisions as discussed above. Primary policy drivers of supportive services implementation included the RBHA transition to Mercy Maricopa and the *Arnold v. Sarn* court decision.

Regional Behavioral Health Authority Transition

Mercy Maricopa followed Magellan (2007-2014)—and before them, Value Options (1999-2007)—as the RBHA for Maricopa County and parts of Pinal County. Under the Mercy Maricopa contract, the role of the RBHA in Maricopa County changed in several ways. The first was the relationship between the RBHA and the SMI clinics. Value Options owned several clinics, which Magellan inherited when it became the RBHA in 2007, blurring the distinction between provider and managed care organization.

A stakeholder who held a similar role throughout the tenure of all three RBHAs remarked that the relationship between the previous RBHAs at the clinics impacted their roles as managed care providers. Since Mercy Maricopa was not tasked with managing the clinics, it has been able to remain focused on the broader management and provision of integrated physical, behavioral, and supportive services for its members.

“The mindsets of [the prior RBHAs] were really that of treatment providers, because they were treatment providers.”

—Provider

Furthermore, since the RBHA has monitoring responsibilities for the services it provides, there was concern about the responsibility to evaluate clinical outcomes of an owned provided in an unbiased manner. The previous RBHA transferred several clinics into private ownership over the first two years of its tenure as part of a systemic transformation initiated by ADHS. Consequently, Mercy Maricopa’s responsibilities have been entirely independent of clinic management and have enabled the organization to focus on monitoring, innovation, and member experience. The importance of this restructuring was especially salient during the first few Fidelity evaluations³²—a requirement of the *Arnold v. Sarn* settlement. Clinics initially struggled to achieve high Fidelity scores as the expectations and directives

related to the Housing First model^{i,33} and Zero Exclusion employment model^{ii,34} butted against years of standard practice. Before the implementation of these models, many clinics had focused primarily on provider-determined services, whereas now providers were asked to prioritize member choice in accessing the services that the member wants on the member's timeframe. The RBHA's position, independent of the clinics, enabled it to reinforce the Fidelity criteria and also recommend strategies that would encourage the clinics' alignment with the Fidelity framework, and Mercy Maricopa led significant efforts to educate and support providers in this transition.

In addition to the transition of the clinics away from ownership by the RBHAs, Mercy Maricopa was the first RBHA to offer integrated medical and behavioral health services for the SMI population. A 2006 report by the National Association of State Mental Health program directors identified Arizona as the state with the greatest average lifespan disparity (31.8 years) between individuals with SMI and the general population.³⁵ This was a motivating factor in prioritizing SMI populations for an integrated care model and was included in Arizona's Health Improvement Plan with a goal of integrating care by 2015.³⁶

Similarly, earlier forays into co-location models—where supportive service providers are physically located within clinics—as well as the data demonstrating significant disparity in lifespan for individuals with SMI pushed the state towards integrated managed care for this population. Although the scope of services under the RBHA has shifted and expanded in recent years, Mercy Maricopa inherited a legacy that included employment and housing initiatives from the earlier RBHAs. Additionally, while the earlier RBHAs introduced the concept of co-location through various pilot programs, these were not widely implemented until Mercy Maricopa's term as the RBHA.

ⁱ Housing First is an approach to reducing homelessness that prioritizes housing above other less critical factors such as obtaining employment or maintaining sobriety. The Housing First model does not require individuals to address their behavioral health or substance use problems before being accepted.

ⁱⁱ Zero Exclusion is a model where any individual who is interested in pursuing supported employment is able to do so without considerations that might otherwise bar them, such as perceived job readiness, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment of non-adherence, or personal presentation.

Arnold v. Sarn

As noted above, the *Arnold v. Sarn* lawsuit had been ongoing in Maricopa County from 1981 until a settlement was reached in 2014. Over the 33 years of the ongoing lawsuit, several directives on the provision of services were initiated, though none were as expansive as the settlement reached in 2014. For example, providers who had worked under multiple RBHAs throughout the duration of the lawsuit noted that the lawsuit drove certain clinical regulations (e.g., staff ratios, case management plan mandates, face-to-face contact with members) and piecemeal service growth, but did not broadly expand services across the board until the settlement in 2014. The settlement ultimately helped to highlight employment, housing, and peer and family support services by mandating minimum levels of services for each of the aforementioned areas.

“Because we’ve been under a lawsuit for 30-some odd years, there’s a lot of variety of services. It’s very robust, and there’s a lot of funding [and]...services that other states just don’t have. It’s been put in place over a long period of time.”

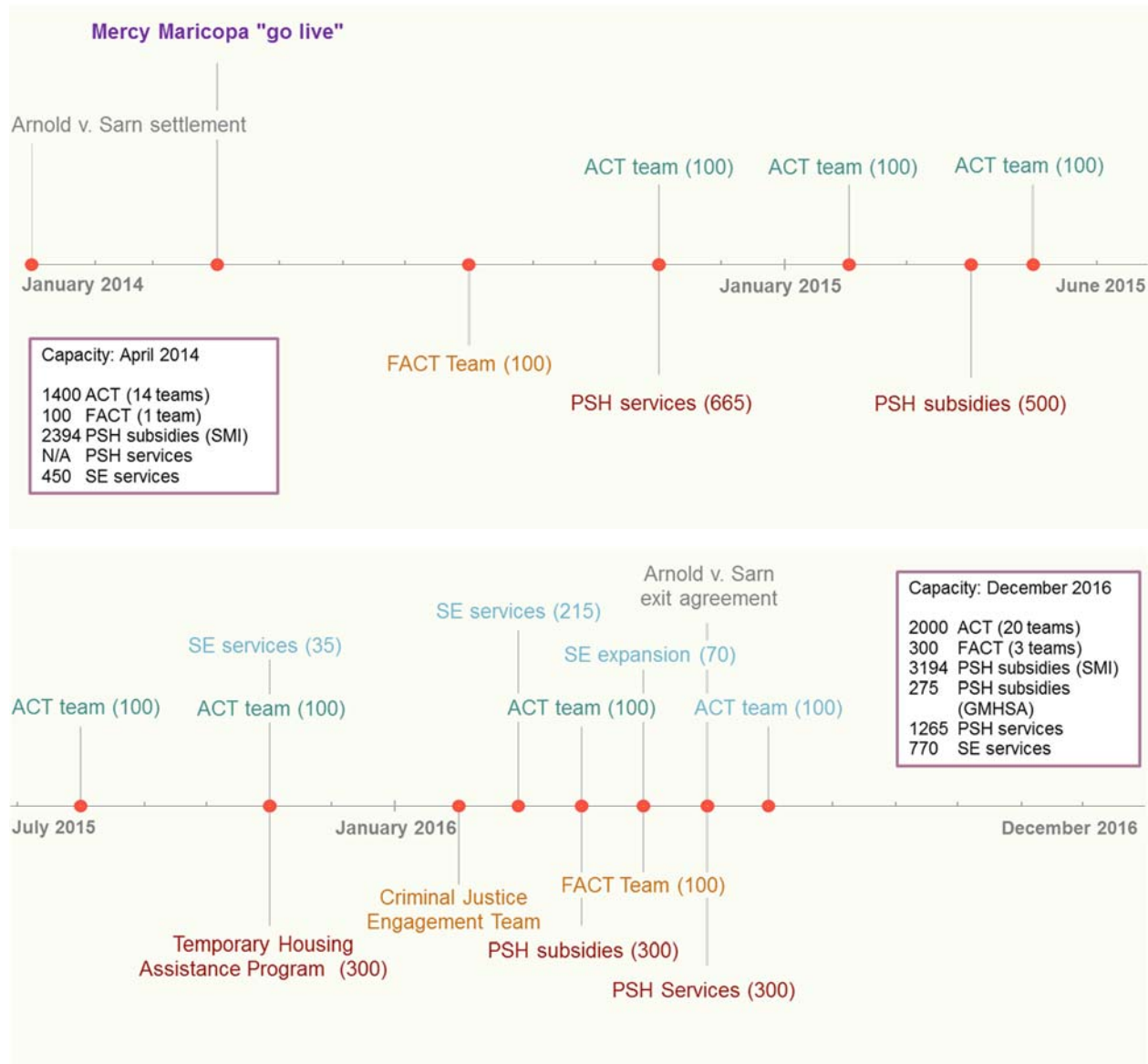
—Provider

The *Arnold v. Sarn* settlement impacted the organization and expansion of services at multiple levels. The settlement stipulated that the RBHA expand housing supports to an additional 1,200 members, the employment supports to an additional 750 members, peer and family support services to an additional 1,500 members and their families, and that it increase the number of Assertive Community Treatment (ACT)ⁱⁱⁱ teams from 15 to 23.^{37, 38} These criteria necessitated substantial broadening of services and coverage. As the settlement was implemented, officials identified several factors specific to Maricopa County that presented challenges to implementing the agreement. Specifically, Maricopa County—as with the whole western United States—had an expanding homeless population. AHCCCS noted that the magnitude of homelessness in some major metropolitan areas, such as Los Angeles County (reported at 57,794 homeless individuals in 2017³⁹), was a concern that could be curtailed in Maricopa County by making housing a priority. Mercy Maricopa noted that they were startled when they received a lengthy list of individuals with SMI who were experiencing homelessness. Since the supportive housing services that *Arnold v. Sarn* required must be provided to those who already have housing, it became clear that a large number of individuals needed to not only receive the supportive services, but also the housing itself. In response to the data and in recognition of members’ needs Mercy Maricopa went beyond the lawsuit requirements to expand the housing options available to its members.

ⁱⁱⁱ ACT provides 24/7, team-based “multidisciplinary, flexible treatment” to support people with mental illness. ACT teams assist with all aspects of life, including medication, housing, employment, and other social supports.

The timeline on the following page (Exhibit 2) illustrates the expansion of services as a result of the lawsuit, as well as additional expansions above and beyond those mandated by the lawsuit that Mercy Maricopa has initiated, with the support of AHCCCS and other stakeholders, since 2014.

Exhibit 2. Mercy Maricopa Service and Capacity Expansion, January 2014 through December 2016



Source: Mercy Maricopa interviews and documents

Note: Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), General Mental Health and Substance Abuse (GMHSA), Permanent Supportive Housing (PSH), Supportive Employment (SE). All expansions refer to the SMI population except for the most recent PSH expansion, which was specific to the GMHSA population.

Successes

Mercy Maricopa has adhered to the *Arnold v. Sarn* settlement and met all of the expansion targets stipulated in the lawsuit for expanding network capacity for housing and employment support services, and has also exceeded these targets in several cases. For example, the settlement stipulated that Mercy Maricopa expand housing supports to an additional 1,200 members; by December of 2016, Mercy Maricopa had expanded permanent support housing service capacity by 1,265 individuals. Additional details of Mercy Maricopa’s expansion can be seen in the timeline in Exhibit 2 (above) and in Table 1 (below). *Arnold v. Sarn* served as a catalyst for Mercy Maricopa and other behavioral health stakeholders throughout Arizona to expand services in an unprecedented way.

Table 1. Capacity for Member Services

Service	Arnold requirement	Mercy Maricopa member capacity
Supportive Housing Services	1200	1265
Supportive Housing Vouchers	N/A	3194
Supportive Employment Services	750	770
Peer and Family Support services	1500	2215
ACT teams	2300	2300

In addition to meeting the support service expansion thresholds mandated by *Arnold v. Sarn*, it is important to note that Mercy Maricopa, with the support of stakeholders, took the opportunity to leverage the work they were doing to not just meet the expansion requirements, but to also push beyond them to meet member needs. By exceeding these mandated targets, Mercy Maricopa and its partners showed a commitment to prioritizing member needs and a dedication to working with community stakeholders to ensure those needs were identified and addressed appropriately.

Challenges

Throughout the process of designing, implementing, and maintaining an integrated approach to healthcare and supportive services for individuals with SMI, stakeholders and Mercy Maricopa staff identified both

“[Finding housing has] taken longer than it may have if we didn’t have such a tight market...our vacancy rates here in Maricopa County are a lot lower than they ever have been. More people are renting than buying, we have a lot of population growth going on, and at the same time our rents are skyrocketing....the average rates are going above and beyond [our voucher caps] for decent housing.”

—Provider

limited housing and transportation to places of employment in Maricopa County as ongoing challenges that placed external pressures on Mercy Maricopa.

Resource Limitations: Constraints on resources, especially in the areas of housing and transportation, limited Mercy Maricopa’s ability to consistently provide the full scope of services to all members. Although Mercy Maricopa has responded to market increases in rent prices by approving higher rents through reasonable accommodations requests, increasing its subsidies, and partnering with housing providers to increase available housing options, housing limitations remain. Housing shortages and rapidly increasing rents mean that dollars allocated

for housing are unable to go as far. Members who receive vouchers are also not as competitive as privately paying renters, as their voucher allocation does not meet market-rate rental prices and landlords are hesitant to rent to individuals with vouchers, especially those who may have unstable rental histories. Members are finding that it takes longer to obtain housing, even once they have a voucher in hand, and apartments that are available at their price-point are unsuitable for issues related to safety and location. Furthermore, crime-free housing initiatives, which are an increasing priority in the Maricopa County region, shut out many SMI individuals with any criminal background, further restricting available housing.

Although Mercy Maricopa and its partners are working to educate landlords about the benefits of housing members with SMI who are supported in maintaining their tenancy, it continues to be difficult to access housing for this population. A review of the literature surrounding similar social service integration programs revealed that programs that incorporate housing services often acknowledged the widespread shortages in available, affordable housing.⁴⁰ This issue is a common obstacle faced by programs serving large numbers of high-risk, high-need individuals in need of housing.

On the employment side, despite Mercy Maricopa’s transportation services, local transportation options limit the employment opportunities that members are able to access. Specifically, employment support providers face limitations in connecting members to job interviews or actual employment due to the

unavailability and accessibility of public transportation. Although employment support providers noted that they will drive members to interviews themselves, that option is not tenable for regular employment. As a result, members may receive job offers but be unable to accept them due to the distance from their home, complex or non-existent bus and light-rail routes, or off-hours bus schedules for night shifts.

Partnerships

Building partnerships with government officials, providers, and stakeholders involved with the SMI community has been an important part of Mercy Maricopa’s process when designing, implementing, and expanding its care model. These partnerships have enabled Mercy Maricopa to create a system of care that is responsive to and anticipates the needs of its members.

Strategic Government Partnerships

With the increase in homelessness driving the need to expand housing opportunities for its members, Mercy Maricopa, in partnership with other stakeholders, recognized that the resources to provide housing needed to be dramatically increased beyond the *Arnold v. Sarn* requirements in order to address member needs. AHCCCS, the state Medicaid agency, had engaged with RBHAs over the course of the lawsuit and noted that working with the RBHAs over time was a critical and necessary part of identifying the needs of the SMI population, finding pathways for funding the increased service scope required, and expanding the available network of housing providers.

AHCCCS has been an important source of financial support for Mercy Maricopa’s housing programs. Since state appropriations for the SMI population have not been subject to cuts, AHCCCS and Mercy Maricopa have been able to be strategic with their partnerships and spending in order to cover more services and supports with available funding. For example, Mercy Maricopa collaborated with AHCCCS, HUD, and other governmental entities that provide housing vouchers, as well as other community partners, to advocate for more state funding for housing resources for members, which led to an expansion of supportive housing services and housing vouchers for the SMI population.

“It became very clear that we had to figure out funding for the increase in [supportive housing] capacity..., [Mercy Maricopa] had to figure out how they were going to pay for everything once they made a commitment to it.”

—Government official

The support that Mercy Maricopa received from AHCCCS extended to state support for supportive employment services as well. AHCCCS has demonstrated a willingness to invest state funding in the employment program, using state resources—which are matched by federal Medicaid dollars—to fund vocational rehab, vocational positions, and employment support services.

Local government agencies also emphasized that they recognize that a strong partnership with Mercy Maricopa is necessary to enable better support and treatment for the homeless and SMI population in the county. Maricopa County had joined a funders' collaborative, which studied the service utilization and needs of homeless individuals. The outcomes of the study highlighted that the behavioral health needs of a significant proportion of homeless individuals were not being met. There was, “a deep, deep need for strengthening the relationship and accountability across [the homeless and behavioral health services] systems of care,” which was a need Mercy Maricopa stepped up to fill. Similarly, the City of Phoenix worked with Mercy Maricopa to establish funding partnerships; Mercy Maricopa provides Medicaid funds for housing support services to the city, and the city is then able to pair those services with the housing vouchers they provide to the homeless, maximizing dollars allocated for the vouchers, which were previously underutilized due to lack of corresponding supportive services. Alongside the state, city, and county in these partnerships was Valley of the Sun United Way (United Way), a non-profit organization that has done significant work around ending homelessness in Maricopa County. State government officials described United Way as both a funding and leadership resource, citing the Supportive Housing Institute course that United Way puts on for those involved in the housing system. This course brings together housing stakeholders for an eight-week long curriculum focused on technical assistance around topics such as financing and service delivery of supportive housing. It was through partnerships such as these that Mercy Maricopa was able to build and maintain the robust set of services it offers to the SMI community.

Provider and Community Outreach

In addition to governmental partnerships, Mercy Maricopa proactively outreaches to providers and the community to develop professional relationships and establish mutual understanding around service options and the supportive house and supported employment models. After being awarded the RBHA contract, Mercy Maricopa focused on both transitioning the existing provider network established by the prior RBHAs to its own network, as well as expanding the provider and community networks to meet the needs of the population it was charged with serving.

As Mercy Maricopa took over the RBHA role, its staff conducted extensive outreach with stakeholders and the broader community to build needed relationships and strengthen its ability to provide relevant services to members. For example, in order to build a comprehensive network, Mercy Maricopa reached out to and expanded contracts with local housing and employment providers, such as the Arizona Behavioral Health Corporation and Marc Community Resources. The new contracts clearly delineated the anticipated scope of work for various providers in its network, and began allocating funding for these types of supportive services. One fundamental player involved in this process was the Corporation for Supportive Housing (CSH). Mercy Maricopa engaged CSH to facilitate the development of contracts with housing providers and to assist Mercy Maricopa in navigating these new provider relationships. Mercy Maricopa also engaged with the Human Services Campus,⁴¹ which includes the local homeless shelter that provides wrap-around services for homeless adults, and has behavioral health providers located at the campus to support their work and engage members. In addition, Mercy Maricopa staff described that before contracting with clinics and rolling out changes to existing contracts with the prior RBHA, staff visited each clinic to introduce themselves, discuss the SAMHSA model of care that was being implemented, and obtain feedback from the clinics about how to best serve members and their families. By actively engaging with these housing, employment, and clinic providers, Mercy Maricopa staff sought to ensure providers had a thorough understanding of the RBHA's role within the continuum of care, and understood the scope of work of the *Arnold v. Sarn* settlement. Staff also wanted to receive feedback from providers about how to best serve the SMI population, given their long history of serving them. In our interviews, providers cited Mercy Maricopa's outreach as pivotal in their transition to and acceptance of the integrated model of care.

Mercy Maricopa also began meeting with community advocates for the SMI population, as well as members and their families. Staff held multiple forums throughout Maricopa County in order to introduce themselves, present Mercy Maricopa's vision for integrating physical and behavioral health care for the SMI population, and receive feedback from those most affected by the system—families, caregivers and clients. Furthermore, Mercy Maricopa staff joined community committees such as the Continuum of Care Committee,⁴ which is comprised of advocacy organizations, government representatives, providers, and members. The Continuum of Care Committee's focus on leveraging partnerships to end homelessness helped Mercy Maricopa connect with organizations working with similar populations, and identify community needs for the homeless population in the state. Mercy Maricopa staff used the feedback they

⁴ A committee with the aim of developing regional solutions to end homelessness. (see <http://azmag.gov/Committees/Technical-Committees/Maricopa-Regional-Continuum-of-Care-Committee>)

received through their involvement on various community-based committees and other community and provider outreach efforts to develop and implement the housing, employment, and court services programs, and continue to leverage these community connections today. For example, Mercy Maricopa has used the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) as a method for prioritizing the most vulnerable individuals on whom to spend scarce housing dollars. Staff explained that it was through meetings with housing stakeholders that the VI-SPDAT was identified as an important tool that could be used by Mercy Maricopa. Government officials noted that using the VI-SPDAT to prioritize highest-need individuals for housing helped cut the housing waitlist from nearly 1,600 individuals to 180, and enabled Mercy Maricopa to focus its efforts on providing housing vouchers and support services to the most vulnerable and chronically homeless individuals in the county.

Recognizing these community contributions as integral to their organizational structure, Mercy Maricopa described how they continue to look for various opportunities to seek and utilize community input throughout the organization. For example, Mercy Maricopa has established 16 committees to address various operational and policy issues that guide its programs for the SMI population. Of these, 10 committees include membership representing members, themselves, and their families.

“I can go to any community meeting now and everyone will say it’s a complete 180° and that the relationship with MMIC and having MMIC at the table is probably one of the best changes in our community that we’ve had in the last couple of years.”

—Government official

In the three years since Mercy Maricopa became the RBHA for Maricopa County, their commitment to the integrated care model and the members they serve has driven them to expand their supportive services beyond what was offered under previous RBHAs and stipulated in the *Arnold v. Sarn* settlement. On the housing side, though the settlement focused solely on providing support services, Mercy Maricopa recognized the need for additional housing stock and began working to find additional funding for more housing. In order to

“It’s that attitude of aligning with the community priorities that in the past we never saw.”

—Provider

accomplish this, Mercy Maricopa reached out to county, city, and state officials, leveraging the partnerships they had built over time, to secure additional funding for housing services. This enabled Mercy Maricopa to expand housing options such as scattered site housing, which grew from just over 100 subsidies to more than 1,200 today. Stakeholders cited this growth as one of the key accomplishments of Mercy Maricopa’s tenure and the adoption of the physical and behavioral health integrated care model.

Successes

A common theme throughout the interviews was the significance and importance of the partnerships Mercy Maricopa forged among various providers and stakeholders, including: between Mercy Maricopa and providers; between Mercy Maricopa and the city, county, and state; and between Mercy Maricopa and the local shelter system. Literature on the integrated physical and behavioral health programs for the SMI population in other states highlights the importance of facilitating partnerships between behavioral health and housing providers, as well as other community partners, and of ensuring communication across all participating entities as essential in serving the SMI population.^{42,43} In establishing the program in Maricopa County, there were informal and formal relationships that Mercy Maricopa helped establish, and Mercy Maricopa staff made a clear and concerted effort to establish themselves as a key entity in Maricopa County that was going to actively participate in developing strategies to serve the SMI population.

State, county, and city staff noted the importance of Mercy Maricopa's participation in many different forums and coalitions as essential to enhancing its strong working relationship with government entities. The partnership with the city includes a deliberate sharing of resources so that housing vouchers, which the city held and were unused in the absence of housing support services, could be matched with the support services provided by Mercy Maricopa; this now allows city vouchers to be more fully utilized to provide housing for Mercy Maricopa members. Mercy Maricopa's connection with the county facilitated Mercy Maricopa's investment and support of the coordinated entry system, which uses the VI-SPDAT across intake agencies to systematically identify the housing needs of individuals and prioritize those who are highly vulnerable. Additionally, the ongoing relationship between Mercy Maricopa and AHCCCS helps to match additional financial support from the state for vouchers with the supportive services offered through the RBHA.

Mercy Maricopa continues provider outreach efforts through its provider staff liaisons and by expanding the regular meetings it holds with providers. Mercy Maricopa wants to ensure that providers have the resources they need to implement best practices within the services they provide and uphold Fidelity standards required under their contracts. Mercy Maricopa housing and employment provider staff liaisons are responsible for coordinating communication between Mercy Maricopa and providers, as well as offering technical assistance to them. Mercy Maricopa also facilitates and participates in information sharing activities across stakeholders, including monthly and quarterly meetings for subsets of providers, such as vocational rehabilitation counselors and specialists, and employment specialists to learn about and discuss policy or protocol changes; periodic provider CEO meetings where Mercy Maricopa describes priority issues and relevant legislative policies; and inter-agency meetings with Mercy Maricopa,

AHCCCS, and other providers. These opportunities for communication enhance the relationship between the Mercy Maricopa and service providers and funders.

Providers noted how these relationships have strengthened the fabric of Maricopa County’s safety net for the SMI population and resulted in the more effective and strategic allocation of resources, pairing funding across sources to multiply their impact. These relationships have provided Mercy Maricopa with needed flexibility to directly address gaps in services noted by partners by providing necessary resources. Providers noted that Mercy Maricopa has invested in higher-cost strategies, such as integrated clinical care programs, based on the recommendation of clinics as a way to strengthen the care provided to SMI clients. Other gap-filling strategies adopted by Mercy Maricopa include providing housing support services to the scattered site housing facilities, dedicating a transitional care facility to the reentry population, and directing Community Reinvestment Funds to housing, where 5 percent of Mercy Maricopa’s profits are reinvested in infrastructure and other community supports. Mercy Maricopa’s flexibility and its responsiveness to partner concerns and recommendations have resulted in programs that are increasingly responsive to the needs of Maricopa County’s SMI population and the overall aims of the initiative. Mercy Maricopa has created major shifts in the role and scope of the RBHA in Maricopa County and has utilized the function of partnerships to achieve many of these advances.

Challenges

Building a strong network of partnerships with stakeholders and members has not been without its challenges. One of the most challenging aspects is facilitating and encouraging communication across the many stakeholders serving the SMI population.

Communication: Although Mercy Maricopa has implemented initiatives that are responsive to the needs of providers, members, and families, there have been some challenges that may have restrained how rapidly the expansion and utilization of the new opportunities inherent in the integrated physical and behavioral health services model have taken place. A common theme in this area was a general lack of awareness of available resources that are now offered as part of Mercy Maricopa’s integrated model of care, among members, families, and providers. This seems to stem from the problem of staff turnover coupled with the difficulty of keeping up with the evolving nature of the programs and services provided through Mercy Maricopa as its offerings evolve. As a result, Mercy Maricopa leadership recognized that not only is there a need for continuous education

“We just felt like, ‘Well, why aren’t they communicating with us?’ You know, whenever there is change, everyone is heightened and sensitive to everything... So there was a lot of concern, a lot of fear, fear of the unknown.”

—Provider

and communication about changes or additions to programs, services, and operational policies with providers and other stakeholders, but also among its own staff. Mercy Maricopa addressed this issue internally among its medical management staff who were housed in hospitals. Staff needed to more fully understand the complete array of supportive services available to members upon discharge in order to ensure that members received the needed services available to them in the community. To remedy this situation, Mercy Maricopa created educational toolkits, known as Placemats or decision trees, to demonstrate how the post-hospital discharge referral process works and who is involved throughout. In addition, Mercy Maricopa hosts community forums with providers, members, and families to highlight new programs and address concerns, and recently held their third annual “connections conference” focused on increasing knowledge of and connections to resources.

The lack of clear communication between Mercy Maricopa and service providers at the onset of the transition also left some providers feeling confused about their role in the RBHA and uncertain about their jobs. To address these and related concerns, Mercy Maricopa staff continue to build these relationships and adopt strategies to improve communication to meet this challenge.

Organizational Decisions and Staffing Alignment

Through our interviews with stakeholders and Mercy Maricopa staff, we identified key organizational and structural factors that played important roles in the implementation of Mercy Maricopa’s expanded housing and employment support services program for the SMI population.

Organizational Structural Decisions

Mercy Maricopa’s organizational structure and staffing reflects its aim of placing the member at the center of a comprehensive care system. For example, Mercy Maricopa staff members hold deep connections with a number of external entities in the housing and employment sphere and participate in a broad array of state-wide coalitions, strengthening relationships with other RBHAs, universities, AHCCCS, providers, and advocates. When structuring the organization, Mercy Maricopa intentionally established staff positions with job descriptions focused on facilitating partnerships with providers and members and have several provider liaison staff members that connect Mercy Maricopa to employment and housing support service providers. For example, certain staff members within the ACT (2 positions), employment (6 positions), and housing (5 positions) teams serve as liaisons to connect Mercy Maricopa to service providers. These liaisons regularly meet with providers and communicate the needs and concerns of providers to Mercy Maricopa, and convey best practices approaches, technical assistance, and

any strategic or policy shifts from Mercy Maricopa back to the providers. Additionally, Mercy Maricopa has established an Office of Individual and Family Affairs with dedicated staff that harness the experience and input of members, families, and other natural supports as programs are designed and redesigned, as policy is developed or modified, and as services are evaluated. This office within Mercy Maricopa ensures that members’ voices are included across various committees within Mercy Maricopa, as well as provides training and technical assistance to the contracted peer-run organizations, including through regular community forums.⁴⁴

Additionally, Mercy Maricopa’s organizational structure and staffing reflects its desire to support relationships external to Mercy Maricopa and the broader network of service entities across the county. Mercy Maricopa co-locates housing support specialists in clinics, which was noted by providers as an important step to increase the cohesion of these specialists with clinical staff and ensure better continuity of services across providers for a member. The co-location has enabled clinical staff to provide direct referrals to support staff, often in the same member visit, which prevents member attrition.

When developing and training its workforce, Mercy Maricopa charged staff to adopt a mindset of comprehensively addressing the needs of the SMI population with specific emphasis on the social determinants of health. Mercy Maricopa leadership noted that they work internally—with key departments such as medical management and quality management—as well as externally—with housing, employment, and clinic providers—to ensure a continued focus on programs that target not only a provider’s particular focus area but the full spectrum of social determinants of health. In addition, Mercy Maricopa developed a new arm of its organization, called Systems of Care, led by the Chief Clinical Officer, which oversees among other areas, housing, employment, and court services, with the goal of further coordinating the full spectrum of supportive services that address the social determinants of health throughout the organization’s 24 SMI clinics. Mercy Maricopa noted the role the Systems of Care division plays in bringing organizational attention to the importance of social supportive services that go beyond the traditional menu of services provided by health plans. The creation of this new division and Mercy Maricopa’s intentional self-identification as a comprehensive and integrated physical and behavioral health care plan has emphasized the important role that supportive services play in addressing member health care, including the social determinants of health.

“By [creating the Systems of Care department], it really focused efforts around the importance of these [social supports], and ultimately put, at the time, the Chief Clinical Officer role in a position to really focus efforts significantly around these areas.”

—Mercy Maricopa staff

Service and Staffing Alignment

Through application of the SAMHSA model of care, Mercy Maricopa has aligned providers along the framework of Housing First and Zero Exclusion as well as standardize services. When assuming the role of the RBHA, Mercy Maricopa was required and became committed to implement the SAMHSA Fidelity model of service delivery as part of the *Arnold v. Sarn* settlement. Specifically, Mercy Maricopa identified the Housing First and Zero Exclusion models, which demonstrated their commitment to implement evidence-based interventions. Prior to the Fidelity model, many providers operated under the pretext that housing was a privilege to be earned once a member had fulfilled certain standards such as sobriety or attendance of doctors' appointments. The Housing First and Zero Exclusion employment models shifted that mentality away from provider-directed services by placing the member at the center of care. The Housing First model embraces the idea that housing is the cornerstone to building and maintaining health. Members are able to determine when they would like housing and associated supportive services. Housing is therefore used as a tool for treatment rather than an incentive. Similarly, the Fidelity-based Zero Exclusion employment model empowers members to identify when they feel ready for employment rather than through the determination of a behavioral or other provider. Mercy Maricopa staff noted that initially providers were helping people obtain employment, but not fully adhering to the core principals of Zero Exclusion, which, ultimately, prevented some members from achieving employment when they felt ready. In the years since it first implemented the new model, Mercy Maricopa has seen Fidelity scores increase dramatically, thanks in large part to their commitment to technical assistance and to providers' willingness to buy into the Fidelity model to transform their service delivery.

In addition to the shifts in service framework that were instituted through the Fidelity model, clinic-staffing structure shifted as well. Under Mercy Maricopa, the housing and employment specialists are co-located in clinics, consistent with its pursuit of a comprehensive model of care. Apart from limited pilots, broader co-location did not occur until Mercy Maricopa took over as the RBHA. Under Mercy Maricopa, these entities became integrated, and staff from each service domain are assigned to specific clinics and share office space, clients, and, in most clinics, medical records. Providers have noted that the co-location has brought more attention to supportive services that supplement the general physical and behavioral services in the clinic, including peer support, family support, employment services, and mentorship. In

“I would say the change has been an increased focus on employment services and peer services and supportive type services that are not just the nuts and bolts of clinics, like medication, and housing crisis.”

—Provider

addition, the co-location creates a “one stop shop” for members, facilitating access to these additional services and reducing any lags in care.

Successes

Staffing with Experts: Mercy Maricopa and other stakeholders stressed the importance of having a dedicated and experienced staff during and following implementation.

After Mercy Maricopa was awarded the contract in March of 2013, and before they officially opened their doors to members in April of 2014, they set out to assemble a team of individuals who would advance the goals of integrated care and improve the health and well-being of the SMI population. Mercy Maricopa’s leadership recognized gaps in their own experience related to housing and employment services and identified and hired staff with a thorough understanding of the social services they were now responsible for administering. Staff noted that there was a large amount of money to allocate towards a system they were not fully immersed in; it was important to learn about the existing funding streams as well as other opportunities and to hire staff that had experience in those areas. Mercy Maricopa recognized the need to build a robust and experienced team,

“[We] had to learn housing very, very quickly because there were millions of dollars that needed to be allocated... there was a learning process that many of us had to go through to learn about vouchers, and also learn about the other funding streams that were not even a part of the housing community.”

—Mercy Maricopa staff

“The housing administrator that we had hired on at the time had substantial experience with [housing] efforts, and had gone through specific training around housing... so she was actually one of the first ones that I had hired, who wasn’t even going to be reporting to me, but I felt the need to really bring on someone that could, you know, really speak very well internally to housing and what it needed to look like.”

—Mercy Maricopa staff

and it began to hire individuals who had been involved in these systems of care for many years. The staff members, who had held positions within health plans, advocacy organizations, housing providers, and employment providers, and even some of whom were parents of individuals in the system, brought with them substantial expertise in the areas of health, housing, employment, and justice, as well as a strong commitment to serving the population. In order to assist Mercy Maricopa in selecting the appropriate staff, especially as it pertained to housing positions, Mercy Maricopa brought on consultants from CSH. The experienced staff that Mercy Maricopa leadership hired, as well as the support they received from CSH, enabled Mercy Maricopa to develop a robust understanding of the services it was administering, and a dedicated workforce ready to administer them.

Challenges

The decisions Mercy Maricopa has made in staffing and structuring their organization have enabled Mercy Maricopa to provide a robust set of services tailored to the SMI population, but these decisions have not been without challenges. Two significant challenges have been the large turnover experienced by case managers in the clinics and the barriers that exist in sharing data and information across providers.

Staff Retention: Despite progress in communication among Mercy Maricopa staff and contracted providers, communication challenges between providers and members were also highlighted in the interviews; at times these gaps were driven by the frequent turnover of clinic staff. High turnover among case managers is rampant throughout the mental health field and Mercy Maricopa’s network of providers is no exception.⁴⁵ The frequency of turnover may prevent clients from developing deeper relationships with their clinical team or from understanding the full array of services (including housing and employment services). Since staff turnover is so frequent and rapid, it is difficult to ensure that providers, and therefore members, are aware of all of the available and newest opportunities to leverage. Additionally, there is a lack of efficient communication channels between clinics, which adds barriers to ensuring continuity of care across service providers and can lead to lapses in providing a service. Providers also described that delays due to a slow receipt of referral packets have hindered timely care—an issue that can also be attributed in part to case manager turnover. Furthermore, these frequent staffing shifts may have a negative impact on members’ stability. Members are less likely to trust their recovery team if there are frequent fluctuations in staff, and members are more likely to be overlooked or accidentally dropped with changes to their assigned case manager. Integrated teams may offer a buffer to this effect as overlapping staff provide additional points of contact with each member. However, it continues to prove challenging that the staff role most responsible for tracking and coordinating service delivery experiences frequent turnover.

“The case managers of the clinics often have high caseloads and there is a lot of turnover, and so you can have somebody that’s never met their case manager, and it’s hard to keep somebody stable in supportive housing when they have complex behavioral health needs but no service person that’s actually talking to them and working with them.”

—Program provider

Mercy Maricopa staff acknowledges case manager turnover as a challenge to the success of the organization and, more importantly, its members, and is actively working to address the issue among its providers. Mercy Maricopa staff have asked all providers to identify their case management vacancy rates and enact a plan to improve employee retention. Mercy Maricopa leadership is also formulating its own

proposed changes to remedy the high turnover rate. Such proposed solutions include promoting a clinical mentorship program to provide ongoing coaching to case managers and returning to a more traditional model of clinical work in which case managers have more frequent contact with supervisors. Moreover, Mercy Maricopa staff highlighted the importance of securing peer support services for members in their service plan so that members can access these services immediately, thereby relieving some burden from case managers. Lastly, Mercy Maricopa staff have been leveraging their relationship to its parent organization, Mercy Care Plan, and its Arizona Long Term Care System, to determine the mechanisms used that have been successful in promoting staff retention.

Data Sharing and Reporting: As housing and employment specialists have co-located in clinics in pursuit of a comprehensive model of care, they have faced a variety of challenges in sharing data and member information. Employment providers described facing resistance when joining clinics' morning meetings, meetings that serve as a discussion of each member's status and ongoing needs. One provider noted that these meetings were largely crisis-driven in the past, and thus clinical staff had to adjust to incorporating the new focus on supportive services. Supportive service providers had to continue reminding clinical staff of the importance of these services in preventing crises and stabilizing members. While progress has been made in fostering cooperation among all providers involved in a member's care, providers continued to experience challenges in obtaining pertinent information about the health needs of members or services received through another service provider—a likely byproduct of HIPAA regulations and data sharing. According to the literature, the difficulty of sharing data, especially as it pertains to the exchange of beneficiaries' health data, is seen across programs integrating physical and behavioral health services as well as social support services.⁴⁶ Alignment of services across domains of the health system necessitates a robust system of data sharing, something that has proven difficult during Mercy Maricopa's program implementation and continues to cause trouble across clinics today. Many stakeholders, government officials and service providers alike, see room for improving the data sharing system and reporting on outcome measures across systems of care, as well.

Adopting new models of care. As Mercy Maricopa introduced SAMHSA's Fidelity model, alignment with these requirements proved especially challenging for service providers that may have been using a different model for many years. With the implementation of Housing First and supported employment outlined in the *Arnold v. Sarn* settlement, providers had to adjust to a new organizational structure and a new way of thinking about these supportive services. Providers described having to reorganize their ACT teams, given the new standards surrounding licensing and educational background, forcing some staff into lower-level positions, or out of a job altogether. Providers not only described experiencing these types of structural changes as a result of implementing the Fidelity model, but also described philosophical shifts

as well. For instance, one provider recalled being “blown away” by the Housing First model when it was first introduced, and the initial struggle in reorienting the clinic and staff to that framework. Mercy Maricopa staff also remembered difficult conversations with employment providers when the idea of supported employment and Zero Exclusion were first implemented. Many prominent employment providers in the community had been basing their offer of employment services from their own perceptions of a client’s readiness to work, and were reluctant to recommend and deliver services that they felt were premature to the perceived readiness of the member. As noted above, initial Fidelity scores reflected this tension and led Mercy Maricopa to invest in robust educational efforts to shift providers’ perspectives towards the unconditional model of connecting members to services

Lessons Learned

It is important to note that due to the significant and far-reaching impact of the *Arnold v. Sarn* lawsuit, the specific climate and set of circumstances in place in Maricopa County that resulted in how and what services were expanded is unique and is unlikely to apply precisely to other states. However, due in large part to Mercy Maricopa’s efforts, there are lessons that other states or health care systems may consider as they undertake the expansion of services to the SMI population or determine how to prioritize populations for specific services. The lessons learned addressed below are based on key observations made in interviews with Mercy Maricopa staff, providers, and advocates. These lessons learned include a basis in member service, strong connections to stakeholders, strategies around resource allocation, and sensitivity to provider and systemic needs during major shifts.

Establish a Member-Centered Framework

Mercy Maricopa staff frequently describe their approach and the services they provide as “member-and family centric.” The organization’s strategies, informed by the SAMHSA Fidelity Model, are focused on ensuring that members have maximized agency in obtaining and directing their services and supports. From this point of view, Mercy Maricopa developed its internal structures—expanding staff in the Office of Individual and Family Affairs, bolstering its external relationships, and working with providers on best practices that follow the Fidelity model—to support the member first. Clearly linking program outcomes to member success and actively including member participation in that process helps to orient the organization toward a member-centered framework.

Strengthen and Maintain Stakeholder Partnerships

Mercy Maricopa leadership was deliberate about incorporating itself into the local network of organizations working with individuals with SMI. This enabled it to unify its service delivery approach by ensuring that strong connections with providers led to consistent and best practices across clinics. Additionally, the diversity of partnerships improved the scope of services by allowing differing perspectives and experiences to inform the service delivery system. Including a variety of stakeholders, from local and state-level government, providers and agencies, and importantly, from members, direct beneficiaries, and their families can facilitate service expansion.

Nurture and Sustain Good Communication

No system is able to undergo such significant growth without challenges and growing pains. Mercy Maricopa experienced this directly when providers received their initial Fidelity reviews, underscoring areas where expectations and best practices were not communicated clearly between the RBHA and providers. Mercy Maricopa worked with providers through liaisons and regular meetings to convey important messages about the protocol and to enhance relationships that communicate in both directions. A foundation of clear communication, strong partnerships, and accessible leadership can assist organizations in traversing substantial growth and changes.

Be Strategic with Resources

The strong partnerships mentioned above also permitted Mercy Maricopa to identify strategic approaches to maximizing limited resources. A cornerstone of the expansion was the connection between the RBHA and the state and local governments. For example, the City of Phoenix partnered with Mercy Maricopa to provide housing support services under Medicaid, freeing up funds for the city to provide vouchers for brick-and-mortar housing. Without clear communication, trust, and a spirit of collaboration, smart allocations of resources such as these could not be made. Resources otherwise hidden may sometimes only be unveiled through collaborations, proactive communication, or extensive network development.

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