

**Meet Me Where I Am Campaign**  
**2009 Statewide Practice Reviews**  
**Summary Report and Recommendations**

**Submitted to: Arizona Department of Health Services, Division of Behavioral Health Services**

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The Meet Me Where I Am (MMWIA) Campaign originated in the early months of 2007, under the direction of the Arizona Department of Health Services Division of Behavioral Health Services (ADHS/DBHS). The primary goals of the campaign included the following:

- Increase awareness and utilization of the Support and Rehabilitation Services listed in the ADHS/DBHS Covered Services Guide.
- Create a flexible, community-based workforce that is able to be molded by Child and Family Teams (CFTs) to help accomplish the work designed by CFTs without programmatic limitations.
- Support youth and families with the most complex needs in order to help them live together in the community successfully and avoid out-of-home placements. This assumes the ability of providers to work with youth with extremely complex behavioral needs, including handling dangerous behavior when it occurs.
- Help integrate youth and families with the communities in which they live. This requires providers to conduct activities in the community and to provide transportation to, during and from support activities as well as to support youth with any assistance with the self-administration of medication that may be needed in order to participate in community activities.

ADHS/DBHS allocated new funding, based on CAP Rate increases, to each Regional Behavioral Health Authority (RBHA) specifically for MMWIA and required each Geographic Service Area (GSA) within each RBHA to develop a MMWIA Design Team to help plan, implement and oversee MMWIA. In addition, a variety of outreach and training events were provided by ADHS/DBHS, including a Stakeholder Input Day in March of 2007, GSA-Specific MMWIA Kickoff Events, CFT Coordination Workshops, Provider Development Workshops and nine training modules for MMWIA. A Practice Protocol on Support and Rehabilitation Services was also created and distributed, as were several guidance letters from DBHS, to fully describe the initiative and its associated expectations.

RBHAs were provided several guidelines from ADHS/DBHS in September 2007 regarding the development of MMWIA services, which included the following:

- 1) Focus was to be on the Support and Rehabilitation Services codes from the ADHS/DBHS Covered Services Guide.
- 2) Services were to be provided in the home and community, rather than in the office or an out-of-home placement location.
- 3) Services were to be delivered individually, rather than in group settings.
- 4) A RBHA Design Team was to be created to oversee MMWIA Development and was to include a parent as co-chair and have at least 25% representation from family members.
- 5) Generalist Support and Rehabilitation Services was to be the focus of the campaign, and this was defined in the ADHS/DBHS Practice Protocol on Support and Rehabilitation Services. Providers were to tailor their services to the requests of CFTs without placing programmatic limitations on the services.

- 6) RBHAs were to contract with Generalist Providers, to be identified as MMWIA Demonstration or Expansion Sites, that have a strong desire to provide Generalist-type services and that are prepared to work with youth with the most complex needs.
- 7) Creativity was to be encouraged at the Design Team and Demonstration Site Provider levels, and they were to report back to the ADHS/DBHS MMWIA Steering Committee on a regular basis regarding successes, challenges and ideas that have been tested at the Demonstration Sites and within the Design Teams.
- 8) Services were to be delivered using a Positive Behavior Support (PBS) approach.

## **Purpose of the Practice Reviews**

At the two-year mark of the MMWIA campaign, ADHS/DBHS desired to obtain information about the progress of MMWIA in meeting the goals identified above. Therefore, a state-wide review of MMWIA practice at the Demonstration Site and RBHA levels was designed and implemented. While some RBHAs were already conducting practice reviews using tools designed at the RBHA Design Team level, no state-wide review of practice had been conducted since the inception of the campaign.

This author was retained to help design the practice review tools and conduct a state-wide review of MMWIA practice with the following goals:

- Gather information regarding ideas that have been piloted around the state in relation to MMWIA, sharing what has worked well and what has been challenging.
- Review whether MMWIA services have been developed in congruence with the original goals and instructions established by ADHS/DBHS.
- Use the review process as a form of technical assistance for the agencies being reviewed, as well as for those participating on the Review Teams.
- Provide recommendations regarding next steps involved with MMWIA so that the practice of Generalist Support and Rehabilitation Services can be further improved.

## Practice Review Design

Eighteen MMWIA Generalist Demonstration Sites were identified for participation in this review:

RBHA	GSA	Demonstration Site Provider(s)
NARBHA	1	Arizona’s Children Association (AZCA)—Flagstaff
NARBHA	1	Child & Family Support Services(CFSS)—Northern Arizona
Cenpatico	2	Arizona Counseling and Treatment Services (ACTS) – Yuma/ La Paz
Cenpatico	2	Community Integration Associates (CIA) – Yuma/La Paz
CPSA	3	Southeastern Arizona Behavioral Health Services (SEABHS)
Cenpatico	4	Superstition Mountain Mental Health Center (SMMHC)
Cenpatico	4	Horizon Human Services
Cenpatico	4	Arizona’s Children Association (AZCA) – Pinal/Gila
CPSA	5	Providence
CPSA	5	La Frontera Center/ La Paloma Family Services
CPSA	5	Intermountain Centers for Human Development
CPSA	5	Arizona’s Children Association (AZCA) – Tucson
Magellan	6	Arizona Youth and Family Services (AYFS)
Magellan	6	Youth Evaluation and Treatment Centers (YETC)
Magellan	6	Child & Family Support Services (CFSS) – Phoenix
Magellan	6	Touchstone
Magellan	6	People of Color Network (POCN)
Magellan	6	A New Leaf (ANL)

Each provider identified above participated in a one-day MMWIA practice review in the summer of 2009. Reviews were conducted by a MMWIA Review team which consisted of the following individuals:

- a) A lead reviewer (Tim Penrod, Marcia Pinter or ADHS/DBHS, depending on the review);
- b) A RBHA or Provider Network representative;
- c) A peer reviewer (meaning an employee from another MMWIA Demonstration Site), when available;
- d) A family member reviewer, when available;
- e) An ADHS/DBHS representative, when available.

The tool used in the practice reviews was developed using two primary sources: The ADHS/DBHS Support and Rehabilitation Services Practice Protocol and a document distributed through the ADHS/DBHS MMWIA Steering Committee entitled “Recommendations for Cultivating and Fortifying Generalist Direct Support.” A draft provider review tool was developed and circulated among the ADHS/DBHS MMWIA Steering Committee members and RBHA Design Team members for feedback. Adjustments to the tool were made based on the feedback received, and the review tool was finalized.

The provider reviews focused on capturing demographic information about the provider, information about what the provider is doing well and recommendations from the Review Team to help the provider improve practice. A typical review consisted of three parts: 1) Interviews with the provider's management team, 2) Interviews with frontline staff members and supervisors, and 3) a clinical record review.

Provider reviews focused on measuring adherence to the standards set for Generalist Support and Rehabilitation Services providers in the documents referenced above and did not include an attempt to gather or measure clinical outcomes. The review tools were not scored. The number of recommendations provided by the Review Teams for a specific provider was not necessarily indicative of the relative strength of the program. Recommendations were provided to afford the agency opportunities for improvements and were not tied to official performance improvement requirements. Therefore, the information from each provider review, together with the corresponding recommendations from the Review Team, should be considered as individualized to the provider, rather than as an effort to produce comparative evaluations with high inter-rater reliability.

In addition to the 18 provider reviews, each RBHA/GSA participated in a review of practice at the RBHA level. These reviews were smaller in scope, with review team representation typically consisting of the lead reviewer and, when available, a representative from ADHS/DBHS. The RBHA review tool was constructed using the same two documents as the provider review tool and went through a similar feedback and revision process. An important part of the RBHA review process was the use of two separate online surveys, one for RBHA MMWIA Design Team members and the other for family members who have been involved with MMWIA. In these surveys, Design Team members and family members were able to share their opinions regarding how well the Design Teams are functioning and how well family input has been integrated into MMWIA. The results of these surveys are found in the corresponding RBHA Review summary packets.

## Innovative Examples

The following are a few highlights of innovative Generalist Support and Rehabilitation Services practice discovered during the various Provider and RBHA reviews:

- La Frontera Center in Tucson uses a creative approach to managing contract capacity for Generalist Support and Rehabilitation Services. As the provider of other types of outpatient services for enrolled members, La Frontera maintains a team of Generalist Support and Rehabilitation Services workers that are available to CFTs. In addition, they subcontract with La Paloma Family Services to provide a significant amount of additional capacity for Generalist Support and Rehabilitation Services. This approach allows La Frontera to use greater flexibility in meeting the needs of families by drawing on the resources of La Frontera, La Paloma or both agencies combined. In addition, if the demand for Support and Rehabilitation Services increases, La Frontera is able to draw on the resources of its regular outpatient contract, if needed, to increase the amount of Generalist Support and Rehabilitation Services contracted through La Paloma, adding increased flexibility to the arrangement.
- While many children's system Support and Rehabilitation Services providers hesitate to use the covered service Peer Support, Arizona Counseling and Treatment Services (ACTS) in Yuma uses the provision in the Covered Services Guide that allows Peer Support to be provided by a Behavioral Health Technician to deliver a variety of Peer Support Services. ACTS reports enjoying the flexibility associated with the Peer Support code as it lends itself better to a mentoring-type role than some of the other Support and Rehabilitation Services.
- Cenpatico, the RBHA for GSA 4 and GSA 2, has developed a variety of promotional tools for MMWIA that have been very successful. The RBHA has generated a variety of brochures and newsletters that feature MMWIA and developed the popular "Cause for Celebration" (C4C) form that many providers are using around the state to capture success stories within MMWIA. In addition, Cenpatico has also hosted several "Cause for Celebration" events in local communities that focus on outreach for MMWIA services and celebrate successes of youth and families. Cenpatico is also recognized for developing "Ask Me about MMWIA" buttons to promote the MMWIA Campaign.
- Magellan, the RBHA for Maricopa County, developed an extensive performance review process that includes provider staff member interviews, clinical record reviews, assessment of congruence with a Generalist approach, implementation of PBS, training plan reviews, training record reviews, family satisfaction and perception of functional outcomes surveys, case manager satisfaction and perception of functional outcomes surveys, and other elements. Magellan includes family members as part of the review teams. In a few instances, providers attributed improvement of performance within Generalist Support and Rehabilitation Services to the feedback received from these reviews.

- Several Generalist provider agencies made significant enhancements to their programs over the past year as a result of working with consultants to help them make targeted improvements or in response to technical assistance provided by the RBHA. Examples include the following agencies: Southeastern Arizona Behavioral Health Services, Arizona’s Children Association – Flagstaff location, People of Color Network, A New Leaf, and Touchstone.
- Touchstone has developed a comprehensive training and mentoring program for Support and Rehabilitation Services staff members that lasts for the first six months of employment and covers a variety of topics, including an extensive focus on providing employees with a variety of tools to provide effective Support and Rehabilitation Services.
- Youth Evaluation and Treatment Centers (YETC) recently negotiated with their liability insurance carrier to allow them to provide transportation for friends of youth as long as they are connected to the CFT plan. They initiated the change in order to increase the flexibility with which they provide Generalist MMWIA services.
- NARBHA, the RBHA for GSA 1, developed several tracking tools that have assisted in the effective management of Support and Rehabilitation Services. One tool was a “ME” modifier that has been added as a suffix to MMWIA Claims since the inception of the campaign. Another tool is the Weekly MMWIA Capacity report discussed in the subsection on Tracking and Publicizing Available Capacity in this report.
- CPSA, the RBHA for GSA 3 and GSA 5, expanded their GSA 5 MMWIA Design Team to rotate hosting duties between Generalist provider sites and to include invitations to all families receiving services from the Generalist provider hosting the meeting. This provides an opportunity to include family members and to receive input about how MMWIA is going from those directly receiving services.
- Arizona’s Children Association in Pinal and Gila Counties has provided Generalist Support and Rehabilitation Services on the San Carlos Apache Indian Reservation, where staff members report the services have been very much needed, well received and effective.
- Other excellent examples of innovation are found within the individual provider review documents.

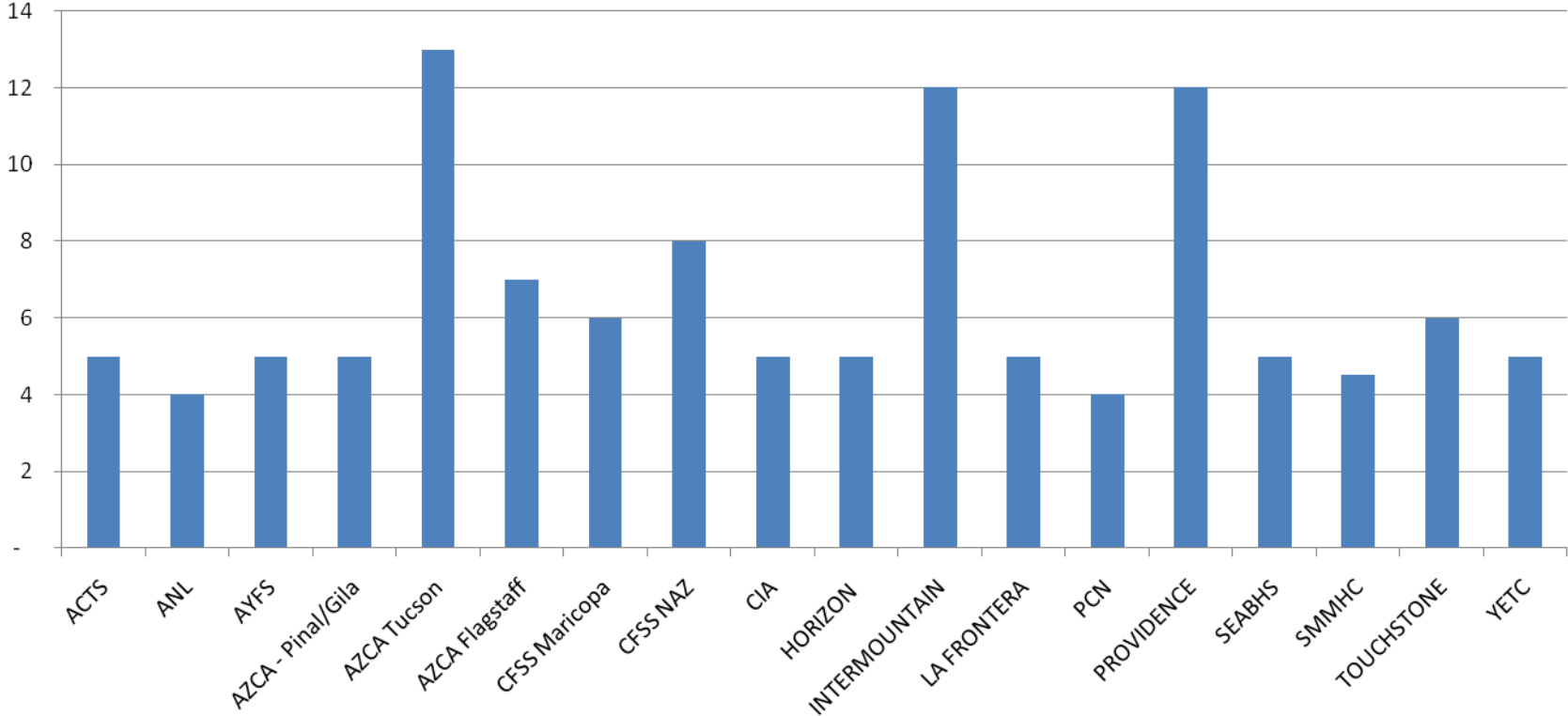
## Demographic Information

This section provides a snapshot of some of the demographic information collected on the provider and RBHA review tools. Collecting uniform demographic information proved to be very challenging. Some of the difficulties included the following:

- Some providers were not able to include Case Management data in their reports, as requested on the provider review tool, because their computer systems would not pair the case management data with Support and Rehabilitation Services codes.
- Some providers included HCTC , crisis and transportation data, while others did not.
- Some providers simply provided estimates, while others used actual claims data.
- Providers that provide other outpatient services in addition to their MMWIA program were sometimes not able to identify which services were provided by MMWIA program staff members and/or to MMWIA-enrolled children. Therefore, the information received from some providers reflects all Support and Rehabilitation Services provided by the agency rather than just within the MMWIA program. The new ADHS/DBHS claims modifier for MMWIA should help with this challenge in the future.
- Support and Rehabilitation Services provided in MMWIA programs tended to change throughout the year. Some providers found it difficult to report data that they felt accurately reflected a typical distribution of services.
- Some demographic information provided as estimates by providers did not match the mathematical averages calculated from the data. For example, a provider may have reported that they provide 800 hours of Support and Rehabilitation Services in their MMWIA program each week and that they have 10 FTE MMWIA staff members. Mathematically, this would mean that each FTE provides 80 hours of Support and Rehabilitation Services per week on average, which is highly improbable. Another example is a provider that reported 300 program hours per week with 100 enrolled members in MMWIA, yet estimated that each enrolled member receives 10 hours per week of Support and Rehabilitation Services (rather than an average of 3 hours per week, as the math would suggest). When mathematical calculations did not match the other information reported, the mathematical averages were used to produce the data contained in the charts in the demographics section of this report.

The next several pages of this section provide charts and tables displaying some of the demographic information collected during the provider reviews.

### Number of Employees per Supervisor



Note: When a demonstration site program had more than one location or used more than one provider, the supervisor-to-employee ratios were averaged for that demonstration site’s entire operations, including that of any subcontracted providers.

### Emergency Safety Response Information

Provider	Is the provider able to use Emergency Safety Responses?
ACTS	No
ANL	✓
AYFS	No
AZCA - Pinal/Gila	No
AZCA Tucson	No
AZCA Flagstaff	No
CFSS Maricopa	✓
CFSS NAZ	✓
CIA	No
HORIZON	✓
INTERMOUNTAIN	No
LA FRONTERA	No
POCN	No
PROVIDENCE	No
SEABHS	No
SMMHC	✓
TOUCHSTONE	✓
YETC	✓

**Assistance with the Self-Administration of Medication Information**

<b>Provider</b>	<b>Does the provider provide assistance with the Self-Administration of Medication?</b>
ACTS	No
ANL	No
AYFS	No
AZCA - Pinal/Gila	No
AZCA Tucson	No
AZCA Flagstaff	No
CFSS Maricopa	✓
CFSS NAZ	✓
CIA	No
HORIZON	✓
INTERMOUNTAIN	No
LA FRONTERA	No
POCN	No
PROVIDENCE	No
SEABHS	✓
SMMHC	✓
TOUCHSTONE	✓
YETC	✓

## Breakout of Codes Frequently Billed by Generalist Support and Rehabilitation Services Providers (Averaged/Estimated):

	ACTS	ANL	AYFS	AZCA - Pinal/Gila	AZCA TUCSON	AZCA Flagstaff	CFSS Maricopa	CFSS NAZ	CIA	HORIZON	INTERMOUNTAIN	LA FRONTERA	POCN	PROVIDENCE	SEABHS	SMMHC	TOUCHSTONE	YETC
Skills Training		20%	80%		10%	19%	74%	69%	20%	40%	16%	52%	90%	7%	60%	28%	50%	70%
Case Management	30%	10%	10%	15%	15%	40%	14%	9%	10%		36%	32%	4%	75%	20%		8%	13%
Family Support	15%	70%	10%	18%	22%	25%	4%	7%	20%	11%	23%	11%	2%	1%	10%	1%	30%	11%
Respite				40%	39%	7%			20%	35%	25%			13%		38%	4%	1%
Personal Care					9%		7%	3%	20%				4%			8%	7%	
Peer Support	30%													2%		16%		
Group Skills Training	20%			18%								3%						
Other	1%				5%	1%	1%	0%		11%							1%	1%
Health Promotion									5%	3%				2%	10%			
Individual Skills Training	4%			9%														
Psychosocial Rehab								10%								9%		
Transportation						4%		3%										4%
Job Training									5%									
Crisis Services						4%												
Interpretive Services												2%						
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

### Notes:

- Some providers did not prepare data that included case management figures
- Some providers were not able to separate out case management provided by non-MMWIA staff members from their totals
- Some providers were not able to separate out Support and Rehabilitation Services provided by non-MMWIA staff members at their clinic
- Not all providers separated out group Support and Rehabilitation Services codes from individual codes when providing this data. For the most accurate information, consult the full demographic information in the provider review tool for each provider
- Not all providers included information regarding transportation in their data
- This data was self-reported by providers and may not match the aggregate data provided in the RBHA code distribution reports

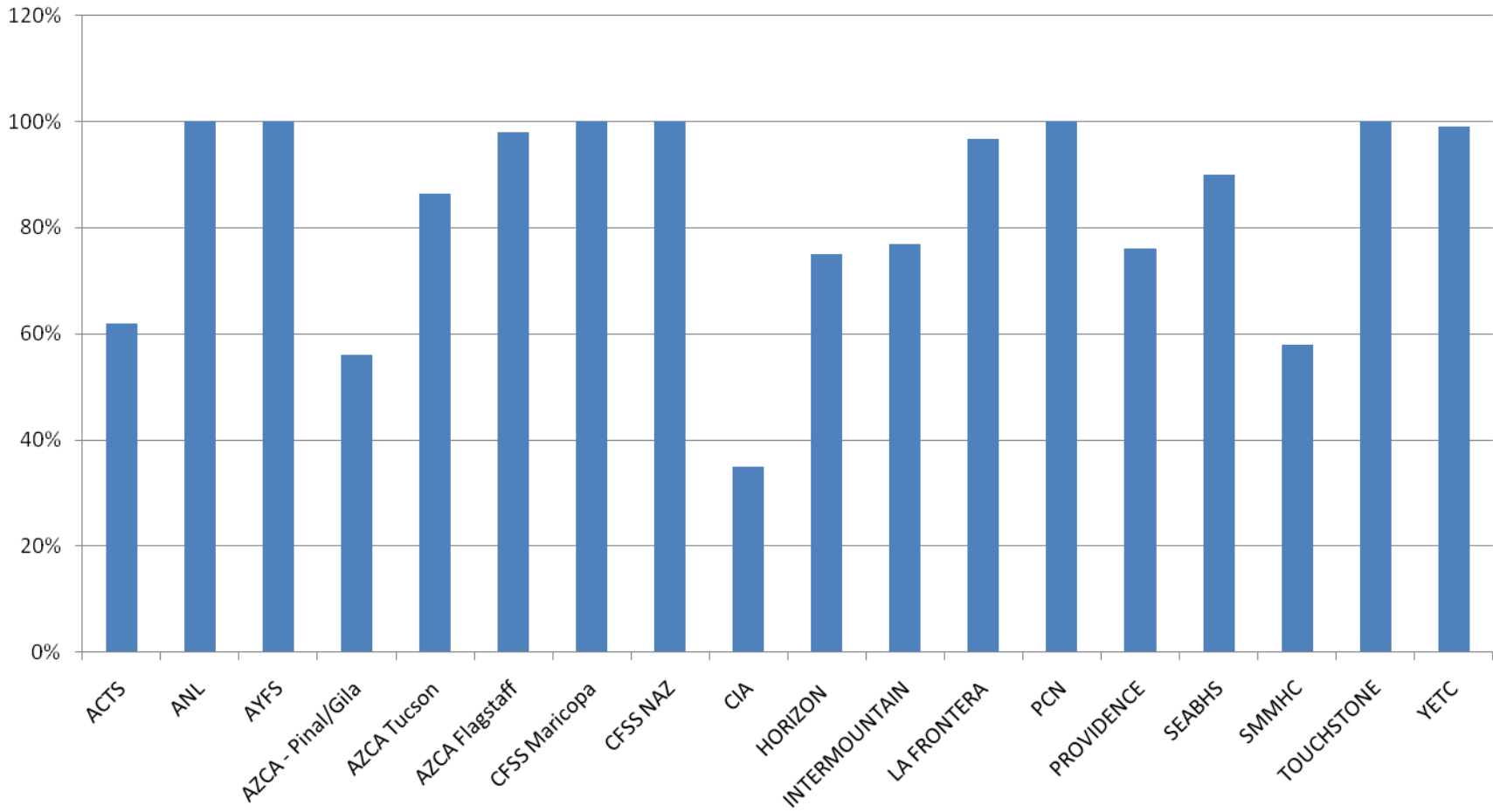
## Respite Services through MMWIA

<b>Provider</b>	<b>% Respite Provided at Home (12)</b>	<b>% Respite Provided at Office (11)</b>	<b>% Respite Provided in Place of Service Other (99)</b>	<b>% Respite Provided in a Group Setting</b>
AZCA - Pinal/Gila	5%	0%	95%	95%
AZCA Tucson	20%	0%	80%	35%
AZCA Flagstaff	100%	0%	0%	0%
CIA	5%	0%	95%	95%
HORIZON	3%	0%	97%	88%
PROVIDENCE	68%	0%	32%	32%
SMMHC	0%	0%	100%	99%
TOUCHSTONE	70%	0%	30%	0%
YETC	0%	0%	100%	100%

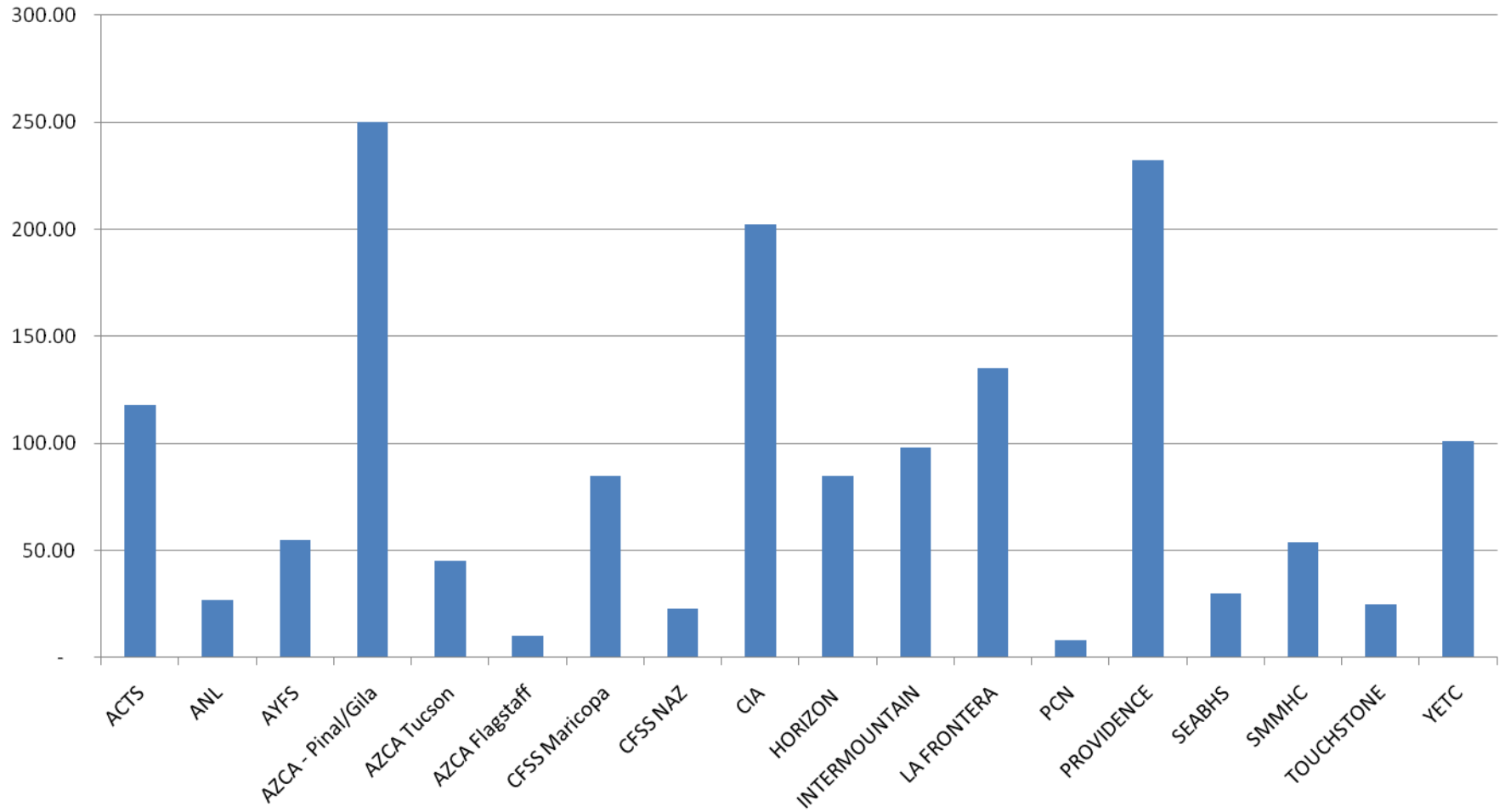
Notes:

- The data above only includes providers that self-reported providing respite services representing at least 1% of their total MMWIA services and were able to identify the place of service tied to the respite services.
- This data may differ from the aggregate data provided by RBHAS during the RBHA reviews. For example, although no providers above reported providing any office-based respite services, data provided by some RBHAs indicated that some respite is provided in-office. However, the data provided by some RBHAs includes non-MMWIA providers/staff members in addition to MMWIA providers/staff members. Please refer to the RBHA practice review documents for more information.

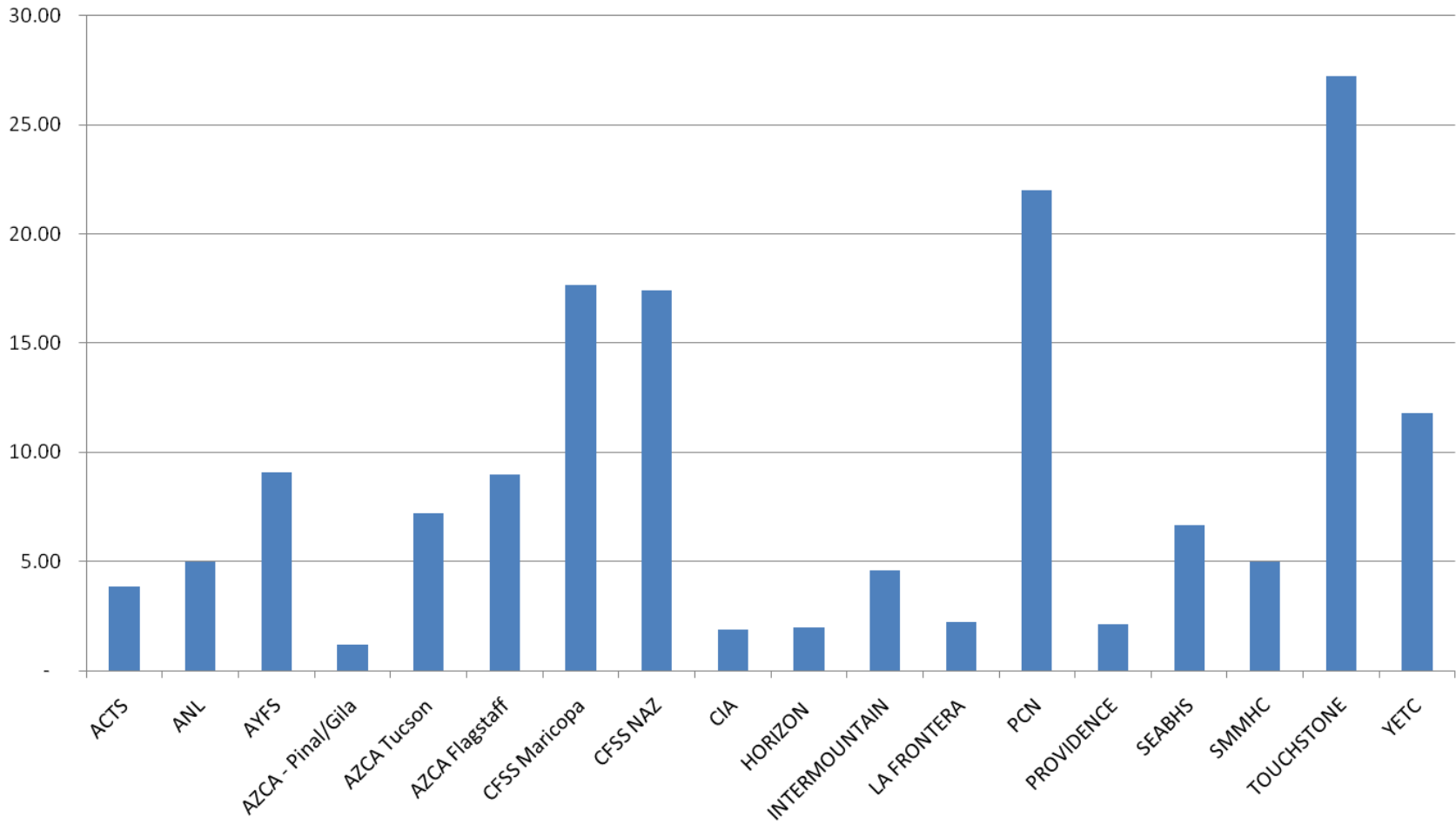
### % of SRS Services Provided Individually (rather than Group Settings)



## Number of Individuals Enrolled in MMWIA



**Average Number of Hours per Child Enrolled in MMWIA per Week**



Provider	Able to work alone with youth?	Able to play/participate in recreational activities?	Able to go swimming with youth?	Able to work any time of day or night, including overnight?	Able to work in certain parts of a home (kitchen, bedroom)?	Able to work with youth of the opposite sex?
ACTS	✓	✓	✓	✓	✓	✓
ANL	✓	✓	☰	✓	✓	✓
AYFS	✓	✓	☰	✓	✓	☒
AZCA - Pinal/Gila	✓	✓	No	✓	●	✓
AZCA Tucson	✓	☐	No	✓	✓	✓
AZCA Flagstaff	✓	✓	☰	✓	✓	✓
CFSS Maricopa	✓	✓	✓	✓	✓	✓
CFSS NAZ	✓	✓	✓	✓	✓	✓
CIA	✓	✓	✓	✓	●	✓
HORIZON	✓	✓	✓	✓	✓	✓
INTERMOUNTAIN	✓	✓	✓	✓	✓	✓
LA FRONTERA	✓	✓	✓	✓	●	✓
POCN	✓	✓	☰	✓	✓	✓
PROVIDENCE	✓	✓	✓	✓	📁	✓
SEABHS	✓	✓	✓	✓	●	☒
SMMHC	No	✓	✓	✓	✓	✓
TOUCHSTONE	✓	✓	✓	✓	●	✓
YETC	✓	✓	☰	✓	✓	✓

☐ = Does not permit swimming or horseback riding

☰ = With certain restrictions, such as having a life guard present, the family present or two staff members

☒ = Male staff members are not permitted to work with and/or transport female members

● = Staff members may not work with a youth at home unless a parent/guardian is present

📁 = Working in the bedrooms of members is not permitted

## **Specific Topics Related to Generalist Services**

### ***Increased Awareness and Acceptance of Support and Rehabilitation Services***

The knowledge and use of Support and Rehabilitation Services across the state has improved significantly, both within MMWIA itself as well as generally within non-MMWIA programs. This has been an important benefit of the MMWIA campaign in all parts of the state. The Support and Rehabilitation Services codes appear to have risen from relative obscurity to now representing a significant portion of all covered services claims within each RBHA.

MMWIA Generalist Support and Rehabilitation Services have been well-received in all parts of the state and are much-desired services. The information dissemination and expansion strategies associated with MMWIA have been very successful. Most GSAs report an enormous demand for services, and all GSAs report increasing familiarity, acceptance and requests for Support and Rehabilitation Services by stakeholders and families. Some providers reported that Juvenile Court judges have requested the use of Support and Rehabilitation Services through MMWIA to help keep youth living at home.

### ***Family Involvement***

Family involvement is a critical part of MMWIA on several levels. The ADHS/DBHS MMWIA steering committee is co-chaired by a family member and has representation of at least 25% family members. Similarly, RBHA Design Teams have a family member co-chair and a requirement of at least 25% family member participation. Some RBHAs have been successful in meeting this requirement while others have struggled (see individual RBHA Review summary reports for details). In addition, several RBHAs and providers collect feedback from family members regarding their satisfaction with MMWIA services and use this information to help shape the delivery of services. Family members played an important role on the Review Teams for the MMWIA Provider Review process, and several RBHAs use or have plans to use family members to help administer RBHA-specific performance measurement tools for MMWIA.

As with other initiatives, MMWIA runs the risk of not relying on family member input to the fullest extent when designing, delivering, evaluating and adjusting approaches. Several RBHAs commented during the RBHA reviews that they are having difficulty arranging family member participation on the RBHA Design Teams. The family member survey regarding MMWIA that accompanied the current review yielded mixed input from family members, with some indicating that family members are an important part of driving MMWIA practice while others offered comments that family members feel like “token” members of Design Teams and other workgroups.

Even the design of the current evaluation process for MMWIA providers and RBHA reviews would have benefitted from more family member involvement in its conceptualization and implementation. It is recommended that each RBHA, RBHA Design Team and the Statewide MMWIA Steering Committee consider seriously the degree to which family involvement is currently affecting the

design, delivery, evaluation and adjustment of MMWIA services and take steps to integrate family involvement to a greater degree.

### ***Helping Avoid Out-of-Home Placement***

When used effectively, Generalist Support and Rehabilitation Services help avoid out-of-home placements and help bring youth back to home-based settings following out-of-home placements. This was a primary focus of the MMWIA campaign. Unfortunately, there are a number of current challenges to using Generalist Support and Rehabilitation Services to support home-based placement. Some of the more common findings from the practice reviews include the following:

- 1) Not all programs funded through MMWIA use their entire MMWIA workforce to focus on youth with the most complex needs, such as those currently residing in or at risk of out-of-home placement. It is not uncommon in some areas to find a MMWIA program serving many families with less complex needs while simultaneously having many youth in the GSA in out-of-home care that are not, and never have been, connected to MMWIA.
- 2) Billing code conflicts partially affect the ability of Support and Rehabilitation Services providers to work with youth in some out-of-home settings. See the section below on billing code conflicts for more information.
- 3) Not all CFTs appear to have an awareness of how to best use Generalist Support and Rehabilitation Services to help a youth avoid or return from an out-of-home placement. For example, a team may be familiar with a traditional behavior coaching or 1:1 model where support is provided only a few hours per week. Such teams, due to their limited view or understanding of these services, may have difficulty determining how best to use the Generalist Support and Rehabilitation Services providers to help return a youth to a home-based setting, including struggling to understand how to configure the support hours and activities required to help achieve this goal.
- 4) Some individuals conceptualize Support and Rehabilitation Services as being lower-intensity services compared with other clinical services and may not believe that they are an effective method to work with youth who have the most complex needs.
- 5) Many other factors related to MMWIA implementation, as mentioned in the remainder of this report, affect the ability of providers to help keep youth from experiencing out-of-home placements. For example, the availability of at least one provider in the area that is able to use Emergency Safety Responses, flexible agency policy and procedure, and the degree to which a provider functions as a Generalist all influence the effectiveness of services.

It is recommended that all youth experiencing current out of home placement be connected with MMWIA Generalist Support and Rehabilitation Services in an effort to help return them from out-of-home care.

### ***Youth with the Most Complex Needs***

Every provider interviewed expressed a belief that they worked with the most complex youth in their area. Many shared experiences related to working with youth with very challenging circumstances and many of the clinical records reviewed involved youth with multi-system involvement and complex needs. However, while the majority of youth enrolled with some providers appear to be those with the most complex needs, at other providers, youth with the most complex needs appear to represent only a small subset of the total MMWIA enrollment.

Some providers classify a subset of their MMWIA-enrolled youth as having the most complex needs. Others similarly classify youth based on complexity of need, but they serve those with less complex needs through non-MMWIA Support and Rehabilitation Services. It is recommended that MMWIA funds be prioritized for serving youth with the most complex needs and that providers desiring to provide Support and Rehabilitation Services for youth with less complex needs do so using non-MMWIA funding sources.

### ***Emergency Safety Responses***

Perhaps no topic involves more controversy than that of Emergency Safety Responses (ESRs). ESRs involve physically holding a person, when there is a danger to self or others, using a nationally-accepted model of non-violent crisis intervention. In order to use ESRs, the provider must make an election in their OBHL Program Description and comply with several requirements including training, reporting and reviews of all ESRs performed.

Some individuals are opposed to ESRs because they may be dangerous for youth or staff members. Others oppose them because they do not believe that children should ever be held against their will. Still others believe that ESRs may serve to reinforce negative behavior and only make the challenges worse.

Many individuals who believe ESRs should be provided during times of safety risk believe that, without community-based providers being able to provide ESRs, some youth would never be able to transition home successfully from residential settings where they have become accustomed to being restrained. In addition, without ESRs, some may not feel that it is possible to avoid out-of-home placement when significant safety issues are involved. Others believe providers that do not use ESRs are more likely to call the police for help when situations become challenging, which may reinforce negative behavior more than would using an ESR. In addition, calls to the police often do not provide a response that is suitable for youth receiving behavioral health services and may help develop a criminal record for youth with challenges that could have been handled in another way.

Several providers that do not permit the use of ESRs indicated that the need has never come up during the time they have operated as a Generalist provider or that their staff members' skills were so exceptional that they were always able to de-escalate a situation. However, experience has shown for many providers that, eventually, when working with high-needs youth, dangerous situations will present themselves, often without warning, and de-escalation efforts will sometimes be unsuccessful. In these

circumstances, each Generalist Support and Rehabilitation Services provider must help staff members be aware of the expected procedures. A lack of a contingency plan due to confidence that a situation will never arise is a risky scenario.

Perhaps one of the greatest concerns noted regarding the topic of ESRs involved some providers who indicated that they have a hands-off policy and therefore do not train their staff members on the hold portions of ESRs. When asked what they would do in dangerous circumstances if de-escalation techniques did not work, some of these providers indicated that they would hold the youth as a last resort (not all 'hands-off' providers responded this way – others taught defensive blocking maneuvers or instructed staff members to leave the environment). There is tremendous risk of harm associated with staff members holding a youth as a last resort without proper training. Therefore, these providers might consider training that involves the use of ESRs for these worst-case scenarios, particularly because those are the very circumstances in which ESRs are intended to be used.

Because Generalist Support and Rehabilitation Services are intended for youth with the most complex behavior, families may express a desire to have access to providers that are able to provide ESRs when needed. For this reason, it is recommended that families have a choice of at least one Generalist Support and Rehabilitation Services provider in each geographic area that is able to provide ESRs if needed.

### ***Assistance with the Self-Administration of Medication***

Most providers were unaware of the OBHL license type dealing with Assistance with the Self-Administration of Medication. The review teams encouraged providers to explore this license type if their staff members are ever involved with any of the activities covered by this license type (prompting to take medication, observing someone taking medication, opening a medication container for someone, etc.). Some Generalist Support and Rehabilitation Services providers conduct such activities at the request of CFTs without realizing that these types of activities are regulated by a type of OBHL licensure. These activities are most likely to be requested of providers that spend several hours per day with youth as often occurs when working with youth with the most complex needs. It is recommended that each Generalist Support and Rehabilitation Services provider examine whether adding the license type of Assistance with the Self-Administration of Medication would be applicable and beneficial for their program.

### ***Basic Principles of Wraparound, CFT Practice and the 12 Principles of the Arizona Vision***

The basic values of CFT practice, wraparound and the Arizona 12 Principles are an important foundation for Generalist Support and Rehabilitation Services. Most Generalist providers are doing an excellent job providing services that align well with these principles and values. However, review teams did encounter several examples of Generalist providers appearing not to adhere to even some of the most basic of these principles, such as the following:

- Respecting families as experts on their own lives

- Creating a partnership with families on an equal level
- Avoiding blaming or shaming youth, parents and families
- Strengths-based assessment
- Needs-based planning rather than deficit-based planning
- Basing interventions off of strengths and utilizing positive behavior support strategies

Particularly concerning is the fact that in several examples, the Generalist provider did not notice these types of statements being made. Because these principles are a core upon which all other elements of Generalist practice are built, it is recommended that RBHAs and Design Teams do all in their power to help ensure that Generalist Support and Rehabilitation Services are delivered by providers that align well with these values and principles.

### ***Attending CFT Meetings***

Most providers do an excellent job ensuring that Support and Rehabilitation Services staff members, or their supervisors, attend CFT meetings. The most common finding was that Support and Rehabilitation Services staff members attend CFTs regularly and that supervisors attend as needed. However, a few agencies typically send supervisor-level staff rather than frontline staff to CFTs. Other agencies try to send both a supervisor and a frontline staff member to all CFTs. One or two agencies stated they attend CFTs when they can but that it is impractical to have someone from the Generalist provider attend all CFT meetings. It is recommended that Generalist Support and Rehabilitation Services providers have at least one staff member in attendance at all CFT meetings.

### ***“What Families Want”***

Review teams encountered several examples of providers explaining that families have expressed that they do not want certain aspects of Generalist services and that they honor those requests. Examples included the following:

- Families do not want us around their homes in the evenings, on weekends or on holidays because they want the time for themselves.
- Families do not want us to work with them for more than a couple of hours per week because it takes up too much of their family time.

While it is certainly expected that providers tailor their approaches to the individual needs and preferences of families, the data gathered across the state overwhelmingly suggests that families with the most complex needs typically value the added support offered through Support and Rehabilitation Services over privacy during times of significant distress. Support and Rehabilitation Services can be invasive services in the sense that they are normally delivered in homes and in the community during times that youth and families are home. Statements that families do not want Support and Rehabilitation Services more than a few hours per week or during the times of the week that the child is

more typically home may indicate that the family may not be experiencing needs as intense as the majority of families receiving Generalist Support and Rehabilitation Services. It is recommended that RBHAs closely examine the practice of any Generalist agency claiming that families do not want certain aspects of Generalist services to assure that the agency is working with youth with most complex needs and that any deviation from Generalist practice is truly a result of the expressed desires of families with the most complex needs rather than out of convenience for the provider.

### ***“What Is Best for Families”***

Most Generalist providers explained decisions they make regarding the way their programs are structured as being “what is best for families.” However, these determinations did not always reflect input from families, and sometimes these decisions were contrary to requirements of operating as a Generalist Support and Rehabilitation Services provider. Examples included the following:

- “We do not want to make families dependent on our services, so we only provide them for a limited duration.”
- “It is best that families not become dependent on professionals for services, therefore our program limits the frequency of the service—the amount of time provided to each family each week.”
- “In order to keep families from becoming dependent on transportation, we sometimes do not provide it when requested by the team.”
- “We do not believe the family could sustain what was requested of us as a provider, so we declined to provide the type of activity requested.”

In order for Generalist Support and Rehabilitation Services to be successful, Generalist providers must work well with the referring CFT and trust that the requests of the team are in the best interests of families. In CFT practice, individual professionals do not decide what they think families need. Instead, the entire team, including the family, discusses needs and options and develops a plan to be carried out. Sometimes that plan is successful, even when it may seem less than logical by one individual. At other times, the plan is not successful and needs to be modified. It is important, however, that Generalist Support and Rehabilitation Services providers work with CFTs to carry out the type of work requested so that the best efforts of the team may be devoted to making future adjustments to the plan. It is recommended that Generalist providers that have concerns about requests made by a CFT discuss those concerns within the CFT so that the team can make an informed decision. Once a decision has been made by the CFT, it is recommended that the Generalist provider carry out their part of the plan as designed by the team without independently modifying the plan based on what the Generalist provider individually believes to be best for the family.

### ***Scheduling Flexibility***

Flexibility of schedule was an area of excellence with most Generalist providers reviewed. The culture that has been established at most Generalist agencies is one centered on a flexible workforce. Several examples were encountered of program managers, supervisors and frontline Support and Rehabilitation Services staff members appearing to thrive on the very nature of flexible service delivery. For example, the following statements were noted by the Review Teams:

- “Our motto is, ‘there are no evenings, weekends or holidays in Generalist Direct Support...every day is a work day’.”
- “I receive calls from the families I work with at all hours of the evening and on weekends.”
- “We do whatever it takes to configure our services to meet the needs of families. Often that means that families needs come first and the needs of staff members come second.”
- “I often work a ‘split schedule day’ where I go support a family from 7 am to 9 am, have a break for several hours, and then return to provide support from 4 pm to 9 pm.”
- “Any of my workers are willing to go out whenever they are needed, whether pre-planned or not.”
- “We have developed interview questions that screen out individuals who do not want to work flexible schedules. Lack of flexibility is a deal breaker in our interviews.”

### ***Frequency of Service***

Frequencies of Support and Rehabilitation Services provided, measured for this review in terms of the average number of hours of Generalist Support and Rehabilitation Services per week each child receives, varied widely among providers, as indicated in the demographics section of this report. Some averaged one hour per week of Support and Rehabilitation Services on the low side of the scale to more than 25 hours per week on the high end of the scale. One thing each provider seemed to share in common, however, was a perception that the amount of service provided by their agency on average each week was about the right amount for families, whether their program averaged one hour per week, 25 hours per week or somewhere in-between.

There are two important trends to examine when considering the frequency of Support and Rehabilitation Services provided by Generalist providers:

- 1) When the frequency varies from family to family, based on the needs defined by the CFT, this tends to indicate that the frequencies are likely being driven by CFT planning rather than by programmatic patterns.
- 2) When the average, midpoint and mode of the frequencies provided to families within a program indicate that the frequencies involve a relatively-high number of hours per week, this tends to indicate the provider may be working with youth that have a high complexity of needs.

These two areas represent opportunities for ongoing technical assistance, performance measurement and discussion. It is relatively-tempting for a program to develop a pattern of providing the same amount of service per week for most families, such as one visit per week for two hours. It is also common for a provider that averages a low number of hours per week to be proud of the efficient work they do while feeling those that provide more hours per week on average perhaps give families more help than needed, or at least provide the services inefficiently. On the other hand, others may argue that programs averaging lower numbers of hours per week per family may not be working with youth that have the most complex needs or may not be fully meeting the Support and Rehabilitation Services needs of families.

### ***Duration of Service***

Most Generalist providers are doing an excellent job using the CFT to define the duration of services. Examples shared during staff member interviews as well as those discovered documentation reviews indicated that there was a wide variety of service durations based on the needs of families, with only a few exceptions statewide. Those agencies that struggled to use CFTs to individualize the duration of services appeared to do so out of a desire to preserve the resources for other families in need or to avoid dependence on the services.

Some types of comments that may be indicators that a provider is struggling with CFT-driven durations include the following:

- “Once a family has been involved for about six months, we really start taking a close look at whether services are still appropriate.”
- “We have a one-month program where we get families in, stabilize things, and move on to the next family.”

While these comments may represent quality Specialist Direct Support programming, they are not appropriate for Generalist Support and Rehabilitation Services. In these instances, it is recommended that RBHAs and Design Teams help providers understand that Generalist Support and Rehabilitation Services rely on CFT-driven durations rather than on program-driven durations.

Comparing data for durations and frequencies is challenging. Using the average (mean) duration or frequency as an indicator may not accurately reflect the most common experiences of families. Better indicators for future reviews would be the midpoint and the mode.

### ***Avoiding Restrictions by Age, Gender, Population, and Other Factors***

The provider reviews demonstrated that most providers avoid restricting access to Generalist Support and Rehabilitation Services because of age, gender or population. In fact, all individually-delivered Support and Rehabilitation Services appeared to work with a wide variety of ages, genders, and with individuals with a variety of diagnoses and other needs. The one exception is providers that include group services in their MMWIA service delivery, which are not typically considered to be an appropriate Generalist type of service due to these restrictions.

## **Group Services**

Several providers included group Support and Rehabilitation Services as part of their MMWIA service delivery mix. Group services, by their nature, often restrict participation by age, gender or need. For example, a provider may offer a transitional living group that is geared specifically toward teenagers, a girl's empowerment group, or an anger management group. Each of these groups is intended for a specific age range, gender or type of need. In addition, group services are often office-based and rarely represent the individualized services needed by youth with the most complex needs to assist in avoiding out-of-home care. Please refer to the demographics section of this report for information about the prevalence of group services currently delivered as part of MMWIA.

While group Support and Rehabilitation Services may play an important role in the mix of outpatient services available to families, it is recommended that MMWIA funds not be used for group Support and Rehabilitation Services so the funding may be preserved for Generalist Support and Rehabilitation Services.

## **Accepting All Referrals vs. Establishing Referral Criteria**

Some MMWIA providers accept all referrals to MMWIA without the use of referral criteria. These providers often serve many more individuals than providers that use referral criteria. Several providers that accept all referrals expressed a desire to continue to do so, because they believe that the ability to provide Support and Rehabilitation Services for all youth, regardless of complexity of need, is important in helping keep those that are currently doing well from having greater challenges in the future. Others express that they want to be sure to provide Support and Rehabilitation Services to all families because Support and Rehabilitation Services are an important part of the covered services mix.

MMWIA Generalist Support and Rehabilitation Services are a limited resource, specifically funded by ADHS/DBHS to provide services for CFTs of youth with the most complex needs. Although it is true that Support and Rehabilitation Services are an important part of the service mix for all families and may help those with less-complex needs keep from evolving to higher levels of need, MMWIA was intended for those with the most complex needs. RBHAs currently using MMWIA funding for Support and Rehabilitation Services for those with less-complex needs may consider reserving the MMWIA-funded portion of their Support and Rehabilitation Services capacity to work with youth with the most complex needs.

It is recommended that referral criteria be used for MMWIA referrals and that RBHA Design Teams help define the level of intensity required for use of MMWIA services. For example, some providers have used one or more of the following criteria:

- CASII score of 3 or above.
- Involvement of multiple stakeholder systems (CPS, Juvenile Probation, Special Education, Department of Juvenile Corrections, Developmental Disabilities, etc.).

- Current out-of-home placement or threatened out-of-home placement due to behavioral or emotional complexity.
- Assignment to a Dedicated Case Manager.

It is also recommended that GSAs requesting to use a portion of their MMWIA funds to work with those with less-complex needs first be required to ensure that all youth with the most complex needs are receiving access to Generalist Support and Rehabilitation Services (for example, that all youth placed out of home, including those out of state, are involved with Support and Rehabilitation Services).

This is an area about which many providers feel strongly. One provider commented to the Review Team, “Please do not take away our ability to serve all children through MMWIA.” Families also commented on the MMWIA Survey administered in early 2009 that MMWIA services should be available for all children in the system.

### ***Accepting All Referrals vs. Establishing Capacity Limits***

Some providers work with all MMWIA referrals presented to them without setting any capacity limitations on services. Others have established capacity limitations tied to the number of staff members employed in the program. Both approaches have potential downsides:

- Providers that do not set capacity limits are often forced to manage the number of hours provided on average to each family by lowering the amount of services provided to other families or by finding additional funding to hire more staff members.
- Providers that do set capacity limits are often “at capacity” and must turn down referrals for new program participants. However, they may be able to dedicate larger amounts of Support and Rehabilitation Services for youth with the most complex needs.

The issue of setting capacity limits varies by RBHA. Magellan and NARBHA Generalist providers currently set capacity limits (although NARBHA providers have not yet had to use these limits). Cenpatico and CPSA Generalist providers generally do not currently set capacity limits. Generalist Support and Rehabilitation Services are different than other types of clinical services in terms of program capacity because families typically are receiving a specific number of hours of support per week from their Generalist Support and Rehabilitation Services provider. Each Fulltime Equivalent (FTE) position at a Generalist provider typically provides between 20 and 30 encounterable hours of service per week. Therefore, accepting a single new referral requesting 30 hours of support per week may equal the cost of adding an entire FTE to the provider’s workforce. When compared with the demand of conducting one additional intake into the system, the resource requirements for providing Support and Rehabilitation Services with no capacity limitations are significant. It is recommended that RBHAs encourage Generalist providers to establish capacity limitations in order to preserve MMWIA’s resources in sufficient quantity to serve youth with the most complex needs.

### ***Working in the Community vs. Home***

The majority of Generalist Support and Rehabilitation Services reviewed took place primarily in homes and the community rather than in an outpatient clinic office. However, while most providers worked with families both in the home and in the community, a few providers only work in homes and do not often go into the community with youth and families. In order to provide the full extent of PBS-type services and to integrate youth into the community more fully, it is recommended that all providers consider activities that involve a balance of home-based and community-based activities.

### ***Respite***

As indicated in the charts in the Demographics section of this report, some MMWIA providers commonly provide respite more than others. Some providers provide very little respite in their MMWIA program for reasons such as the following:

- The RBHA has a pool of respite-only Specialty Support and Rehabilitation Services providers that are available to families.
- The intensity and type of services requested by CFTs is often different than what would be considered “unskilled respite.”

Many MMWIA providers that commonly provide respite often do so in a group setting. This presents some challenges for data collection as respite codes do not have a group modifier. Therefore, the only way to project the amount of respite billed in group settings is to understand the way the agency structures its respite services.

While no respite services were reported by providers as being delivered in office-based settings, there are several challenges associated with the concepts of home-based and community-based respite:

- Few providers allow their workers to provide respite services in the home of the family while the parents are gone. Few, if any, providers allow their workers to provide respite from their own homes. Therefore, the extent of home-based respite delivered in MMWIA programs appears to be limited to conducting activities with the child while the parent is in another part of the home doing something else.
- It is difficult to differentiate between respite services delivered in a community office building from those taking place at a variety of community locations, such as zoos and parks. Because most agencies appear to code each of these types of respite as place of service “99” (“other”), the claims data appears identical for youth who spend a day receiving respite in a building (because it is not the actual licensed clinic office location, it is often coded as “other” rather than as “office”) and those that spend the day participating in events out in the community.
- Several providers offer weekend respite. Transportation is typically offered by the provider and activities vary from facility-centered activities to activities in the community.

- Some providers spend a large portion of their MMWIA funds on respite services.

It is recommended that respite provided using MMWIA funding focus on home-based and individual community-based (rather than group community-based) types of respite.

### ***Evidence-Based Programs and Specialized Support and Rehabilitation Services***

A few providers expressed concern that they feel a responsibility to provide a nationally-recognized evidence-based program through their Generalist MMWIA contract. Generalist Support and Rehabilitation Services rely upon the CFT to design the types of interventions desired, including the frequency, duration and other elements of service delivery. This process places trust in the CFT process and the team, rather than solely in the provider, as experts on the type of support that will be most beneficial for families. One example is the use of programmatic structure similar to that of Family Preservation, where staffing patterns (Masters-Bachelor pairs), frequency and duration may be determined by the program design rather than by the CFT. Providers that desire to deliver stand-alone evidence-based programs that are not configured by the CFT may find that they are more satisfied delivering the specific evidence-based practice rather than Generalist Support and Rehabilitation Services. It is recommended that each RBHA carefully review the practice of each Generalist provider and determine whether its current operations are best suited for Generalist Support and Rehabilitation Services practice or whether the program is prescribing to a specific evidence based practice model.

### ***Policy Restrictions and Risk Management***

During the practice reviews, management at the provider agency was asked to respond to a series of questions regarding agency policy and procedure related to several common types of activities requested by CFTs. Because each agency has the responsibility to manage the risk associated with providing community-based services, there were no correct or incorrect answers to the policy-related questions. The data regarding some of the answers to these policy-related questions is shared in the Demographics section of this report.

Most providers appeared to have policies and procedures that allow them to flexibly respond to the requests of CFTs within the context of clinical judgment and reasonable safety precautions. The following are some of the highlights:

- Most providers allow their staff to work alone with children. Some require a parent or another adult to be present if the services are being provided in the home. Some require two adults to be present when providing transportation, and others do not allow male staff members to work alone with female youth.
- Most providers allow their staff members, with reasonable clinical judgment and safety precautions, to work in kitchens with youth and to work in bedrooms of youth if needed.
- Some providers had restrictions on recreational activities such as swimming.

It is recommended that RBHA MMWIA Design Teams closely monitor the degree to which Generalist provider policies and procedures allow them the flexibility to carry out the requests made by CFTs.

### ***Travel***

Most providers expressed that traveling long distances is part of the challenge of providing Generalist Support and Rehabilitation Services. No providers indicated that there were any restrictions on where they were willing to travel within the geographic boundaries of their service area. It appears that travel is a struggle for providers regardless of location. For example, some providers cited the difficulties of having to drive 15-20 miles down small, winding dirt roads between appointments, while others drive 60 to 90 minutes between every appointment in rural parts of state. Others report getting stuck in traffic of large urban areas for several hours at a time. Most providers, however, appear able to manage their workforce and their contracts despite the challenges presented by travel.

### ***Transportation***

Nearly every Generalist provider builds transportation to, during and from Support and Rehabilitation Services activities into their program, and those that do not appear to experience frequent complaints about this aspect of their programs. Most providers also reported being able to provide transportation for parents of enrolled members. Several are able to provide transportation for non-enrolled siblings and relatives. Very few reported being able to provide transportation for non-enrolled friends of youth, although the reasons cited varied from HIPAA concerns to liability challenges to not being sure why they were unable to provide this type of transportation. One provider pointed out that the ADHS/DBHS Covered Services Guide defines family members as individuals with a close connection to the enrolled member, regardless of blood relation. In this spirit, a few providers did offer transportation to friends of enrolled members when those friends were connected to the service plan through the CFT process and were an important part of the service delivery. It is recommended that transportation of youth and their family to, during and from Generalist Support and Rehabilitation Services activities be considered an important and expected part of service delivery.

### ***Crisis Response by Support and Rehabilitation Services Providers***

Most Generalist providers make their Support and Rehabilitation Services staff members accessible to families outside of scheduled Support and Rehabilitation Services activities. Several providers indicated that their frontline Support and Rehabilitation Services staff members keep their phones on at all times and take calls from families whenever needed. Other providers utilized a Generalist program on-call rotation to take calls from families outside of schedule hours, and these on-call personnel (sometimes supervisors and sometimes a rotation of frontline staff members) could either provide support needed by families directly (by phone or in person) or could contact and dispatch the regular Support and Rehabilitation Services workers tied to the family when needed. Many providers described this availability of Support and Rehabilitation Services workers outside of regularly-scheduled support as a way to successfully avoid the need to use the formal crisis system, such as police departments or mobile crisis teams. It is recommended that Generalist Support and Rehabilitation

Services providers make their staff members available as designed by CFTs to assist in preventing and/or responding to crisis-related needs, including the ability to respond outside of pre-scheduled hours when needed.

### ***Supervision***

Most providers reported having MMWIA program supervisors who have previously provided Generalist types of direct support. Often, these supervisors worked their way into a supervisory position within the provider agency by starting out as a frontline support worker. Many supervisors reported that they currently provide Generalist Support and Rehabilitation Services as part of their current job description, either to help with workload demands, fill-in for their frontline staff members, provide extra support when needed by families, or to become more familiar with the families with whom their employees work.

Many supervisors reported that they provide field-based supervision, such as observing or working along-side the frontline Support and Rehabilitation Services staff members while they work with families. Several also reported providing individual supervision in the community, such as at a coffee shop, obviously taking the necessary precautions to protect the privacy of their supervision conversations. Most frontline Support and Rehabilitation Services workers interviewed felt supported by their direct supervisor and stated they felt that they received the support they need to handle the administrative and clinical complexities often present in Generalist Support and Rehabilitation Services.

### ***Working with the Child vs. Family***

While most Generalist providers report working with both the child and the family, a few providers have employees who specialize by position type in working with one or the other. A handful of programs appeared to work almost exclusively with the child. Others had entire segments of their Generalist workforce that work only with the child.

One area that appears to be a source of confusion in some parts of the state is the subject of Family Support Partners. In some areas, Family Support Partners work with the parents and family while the Support and Rehabilitation Services workers work with the children. This may be an area requiring ongoing clarification.

One trend noted was the more a provider or a position type within a provider focused their work exclusively on children, the more frequently comments were heard during the review about the challenges of working with parents. One potential explanation for this observation is staff members may begin to identify more with those with whom they work. Therefore, when they work exclusively with children, they may be less sensitive to the needs and viewpoints of the parents. In general, it is recommended that Generalist Support and Rehabilitation Services providers are able to work with both the youth alone and the entire family as directed by the CFT.

### ***Behavior Modification vs. Positive Behavior Support***

Traditional behavior modification systems involve the use of incentive systems, point charts, behavior tracking tools, and involve efforts to deal with antecedents, behavior and consequences to shape behavior. Positive Behavior Support (PBS) may involve the use of these types of activities. However, PBS also includes elements not always found in pure behavior analysis, such as a focus on expanding choices, enhancing quality of life, participation in enjoyable activities, developing a respected role within the community, avoiding the use of coercion, and focusing on strengths to develop positive behavior.

Because traditional behavior analysis may be better known by providers and therefore may be more comfortable, it is often employed as the default approach. Some providers may even speak of using PBS approaches when in reality they are using very traditional behavior modification approaches. Many providers, although excited about the ideas involved with PBS, are admittedly in the beginning stages of fully understanding and/or using PBS approaches. For this reason, the provider review tool contained several pages of material with examples of PBS approaches that could be found in staff member interviews and clinical documentation.

Many providers are doing an excellent job integrating PBS-type approaches more fully into their practice. Others are struggling to move beyond traditional behavior modification and appear to focus primarily on trying to stop bad behavior.

Training and supervision on PBS comes with a few risks, including the following:

- 1) Focusing exclusively on behavior analysis or modification and its accompanying tools while forgetting the positive elements mentioned above that are fundamental to PBS.
- 2) Conducting a variety of fun activities without a clear purpose. For example, a provider may take a youth fishing or to the zoo, but may struggle to explain (or document effectively) the clinical reasons for providing the activity.

There are a variety of excellent resources locally and nationally on PBS. MMWIA Design Teams, RBHA-level reviews, and Generalist providers would likely benefit from ongoing efforts to improve PBS-related practice in the system. PBS needs to be an ongoing area of training, supervision, evaluation, and technical assistance across the state for the next several years as it becomes more of a natural way to work with people.

### ***Behavior Coaches vs. Mentors***

Although not specifically listed on the Provider Review Tool, frontline staff members at several Generalist agencies were asked whether they view their role more as a mentor to youth or more as a behavior coach. Programs that have infused a culture centered on Positive Behavior Support were more likely to have staff members that viewed themselves as mentors to youth, while those still struggling to develop PBS approaches were more likely to view their roles as behavior modifiers or behavior coaches. While all programs appeared to be clear that their services were medically necessary behavioral health

services, those that viewed their role more as mentoring tended to describe an equal relationship with families and youth more than those that viewed their role as behavior coaches. And those that viewed their role as behavior coaches more than mentors tended to view themselves as experts that youth and families needed to respect and follow. This dynamic was sometimes unrelated to position titles used for Support and Rehabilitation Services workers. For example, one agency titled their positions “Behavior Coaches”, but the staff members clearly aligned more with a mentoring type of approach.

### ***Functional Behavior Assessment***

Functional Behavior Assessment or Analysis in some form is a foundation for high-quality Support and Rehabilitation Services. This appeared to be one of the areas with the greatest diversity of approaches by Generalist providers. The majority of Generalist providers appear to be in the early-implementation stage in their understanding and development of Functional Behavior Assessment (FBA). Many have attended some form of training or have developed internal tools to use in conducting FBAs. Most providers have provided few, if any, formal FBAs. There are a few Generalist providers, however, who have a wealth of internal expertise on FBA.

A variety of questions and concerns regarding FBA were raised during the practice reviews, including the following:

- Does one need to be board certified in order to provide an FBA?
- Is there a required format for FBA at a RBHA or state level? Will there be one in the future?
- Does an FBA need to be lengthy in order to be of high quality? Are there downsides to being too lengthy or too detailed?
- Does every child need a formal FBA?
- Does an FBA need to be formal or written in an evaluation format in order to be effective?
- Must FBAs be accompanied by a behavior plan, and how does the behavior plan differ from the CFT plan or service plan?
- Are FBAs and behavior plans intended as instructions for family members in how to better parent their children?
- Do FBAs need to include quality of life measures and recommendations in order to be effective?
- Do FBAs tend to drive the system too far toward a pure behavior analysis approach rather than a well-rounded PBS approach?
- Should FBAs be conducted by individuals familiar with the youth and family or by someone completely unfamiliar with the family so that they can be objective?
- Should FBAs be conducted by Support and Rehabilitation Services frontline staff members, by program supervisors, by Case Managers, by trained clinicians, or by all of the above?
- Are FBAs a required part of being a Generalist provider?
- Is there any harm in a provider contracting out FBAs as a specialized service rather than attempting to train staff members internally to conduct them?

Rather than attempting to answer each of the questions above in this report, it is recommended that answers to these questions may be explored by the ADHS/DBHS MMWIA Steering Committee and/or RBHA Design Teams.

### ***Comprehensive Outpatient Clinic vs. Stand-Alone Support and Rehabilitation Services Provider***

All 18 MMWIA programs are provided by OBHL-licensed outpatient clinics; no demonstration sites are classified as Community Service Agencies. Some of these outpatient clinics are also responsible for providing all of the outpatient services needed by a family as part of their service plan (for example, intake assessments, counseling, medical services, etc.). Others are stand-alone clinics that specialize exclusively in providing Generalist Support and Rehabilitation Services. The current variety of MMWIA program designs offer a variety of provider configurations and highlight some of the advantages and challenges associated with the various provider types. Examples include the following:

- Clinics that provide all of the services families need in addition to the MMWIA services are more likely to more effectively integrate with CFT practice and other clinical services, share needed clinical documentation, and coordinate care. These clinics may also struggle to differentiate between Generalist Support and Rehabilitation Services and other types of services and therefore hamper the culture of Generalist services to flourish independently.
- Stand-alone Generalist Support and Rehabilitation Services providers may be more likely to dedicate resources specifically to cultivating quality Support and Rehabilitation Services, including recruiting, hiring, training, and supervising Support and Rehabilitation Services. In addition, they may be better-able to allow the culture of Generalist Support and Rehabilitation Services and PBS to be the focal point of the agency. However, they may struggle to coordinate effectively with the CFT, obtain necessary documentation, and work congruently with other clinical services.
- A few agencies appear to have maximized the benefits of both the comprehensive outpatient clinic and the stand-alone Support and Rehabilitation Services agency by maintaining a distinct, separate program for Support and Rehabilitation Services that offers services not only to children served by their own clinic but by any other clinic in the geographic area. A key to this success appears to be the degree to which the Generalist MMWIA program is able to maintain its own unique identity and culture within the structure of the agency.

### ***Difficulties with Data***

Many providers struggled to identify data associated with MMWIA services, particularly when the agency also provided the other outpatient services needed by the family. For example, some providers were unable to separate out the case management services provided by their Dedicated Case Manager or Clinical Liaison from that provided by their MMWIA Support and Rehabilitation Services worker. As a result, it was very difficult to determine how much case management was provided as part of the MMWIA services at these providers. Other providers were able to group all of the data for

Support and Rehabilitation Services together, but were unable to determine which were provided by their MMWIA-dedicated staff members and which were provided by others within their clinic.

It is anticipated that the new claims modifier for MMWIA will help with some of these challenges. However, even with the claims modifier in place, it is recommended that Generalist providers and RBHAs more regularly examine the types of data that was requested in the MMWIA provider and RBHA reviews.

### ***Billing Code Myths and Questions***

A number of myths and questions regarding covered Support and Rehabilitation Services were identified during the provider reviews. Providers often indicated they had been told one of the following items by a data validation auditor, another RBHA employee, a trainer or some other person they trusted. It is recommended that accurate information regarding the following items be determined and communicated to Generalist Support and Rehabilitation Services providers as soon as possible.

- Myth 1: Only individuals with the title Family Support Partner are able to bill the code “Family Support”
- Myth 2: Because only a person who has directly received services in the behavioral health system or who is roughly the same age as the recipient can deliver Peer Support services, Peer Support cannot be provided in the children’s system.  
(Note: there is a provision in the covered services guide that indicates a BHT can provide Peer Support services, and a provider in Yuma has experience billing this service).
- Myth 3: The code “supported housing” involves providing a service related to helping an individual locate housing.
- Myth 4: Psychosocial Rehabilitation is a service that is fundamentally different from Skills Training.  
(Note: Psychosocial Rehabilitation is what Skills Training becomes after 8 hours of Skills Training has been billed in a single day by a provider for one enrolled member).
- Question 1: Can an individual who provides respite simultaneously for four youth for one hour bill one hour of time for each youth since respite does not have a group modifier?
- Question 2: If a provider is involved with transporting a youth to an activity and provides a Support and Rehabilitation Service while driving (such as a conversation that involves skills training), how should the provider appropriately handle the billing? Some providers have been told that Support and Rehabilitation Services can never be billed while a youth is in a vehicle (because only transportation can be billed). Others have been told that the provider is able to choose whether to bill transportation or the appropriate Support and Rehabilitation Service, as long as the provider does not bill both of them for the same unit of time. Others report that they have been told it is fine to bill a Support and Rehabilitation Service, such as Personal Care, simultaneously while billing transportation.

- Question 3: Can a behavioral health provider bill covered Support and Rehabilitation Services for primarily monitoring the safety of an enrolled member, such as when a CFT requests Support and Rehabilitation Services in order to help keep a youth safe who experiences danger-to-self or danger-to-others types of risks?

### ***Billing Code Conflicts***

Billing code conflicts were frequently cited as a reason it is difficult for Generalist providers to work with youth having the most complex needs. Many providers indicate that the majority of their youth reside in Level II placements, and Level II and Level III placements currently conflict with most Support and Rehabilitation Services billing codes.

While an override process is in place for Level I and HCTC placements to allow Support and Rehabilitation Services to be provided in support of a transition out of these placements, several providers noted that the process is cumbersome administratively and therefore is a deterrent for some providers. Other providers mentioned that they are nervous about relying on a code override process, feeling that the use of overrides might place their agency in jeopardy during individual agency audits from the Office of the Inspector General, even if the state plan allows for such overrides.

### ***Billing Code Differentiation***

Differentiation between Support and Rehabilitation Services billing codes is a struggle for many Generalist Support and Rehabilitation Services providers as several of the codes have potentially-overlapping definitions. Module 1 of the ADHS/DBHS MMWIA modules contains valuable information about Support and Rehabilitation Services billing code differentiation. Many providers have found it useful to invest significant time in developing tools and providing training for employees to help them differentiate between the various Support and Rehabilitation Services codes.

### ***System Structures for Generalist Support and Rehabilitation Services***

In a letter dated September 2007, Dr. Laura Nelson of ADHS/DBHS instructed RBHAs to develop MMWIA Design Teams and to use those Design Teams to help decide how Support and Rehabilitation Services would be provided in the RBHA area, including how the MMWIA funding would be spent. According to the RBHA reviews, it appears that few Design Teams played this type of role. And in the survey feedback obtained from Design Team members, few appear to feel empowered with this type of responsibility at the Design Team level.

Module 9 of the ADHS/DBHS MMWIA modules presents several System Models for structuring Support and Rehabilitation Services in a RBHA system and considers the pros and cons associated with each type. Choosing the wrong system structure for the needs of the region can place unneeded barriers in the way of families and CFTs in accessing Generalist services. It is recommended that each RBHA Design Team review these structures and empower their Design Teams with a voice concerning the way Support and Rehabilitation Services are set up in the RBHA system. Family voice is particularly important in this area.

## ***Training***

The ADHS/DBHS MMWIA Training Modules appear to be used in each RBHA area and by every provider. Some providers use these modules as the exclusive training content for Support and Rehabilitation Services employees, while others add content to their training program. Several programs involve an element of field-based shadowing prior to having new employees begin providing services alone.

## ***Sharing Clinical Documentation***

When a Generalist Support and Rehabilitation Services provider is different from the agency providing the other outpatient services for a family, it is important that the Generalist provider is given updated copies of key clinical documents such as the ADHS/DBHS Service Plan, Core Assessment, Assessment Addenda, Psychiatric medication reviews, and others. In all areas other than Maricopa County, this process appears to be going smoothly. Maricopa County providers continue to struggle significantly with this issue and Magellan is working to find a solution that is helpful in resolving the matter. The documents are not only important for coordinating care, provider Data Validation audits will result in claims being marked in error if the Generalist provider does not have the most accurate, current paperwork in their file.

## ***Tracking and Publicizing Available Capacity***

A common challenge for Generalist Support and Rehabilitation Services is the constantly-changing program hours. Providers often struggle when youth who receive a large amount of support hours each week have sudden scheduling changes. For example, if a program is able to provide 250 hours of support each week and a particular youth receives 50 of those hours (25 hours per week from two different Support and Rehabilitation Services staff members), the program faces some difficult decisions if that youth runs away, goes into the hospital, goes to detention or experiences some other similar change in availability. The program suddenly has 50 free hours that week and two staff members with no scheduled work. Often, however, the program is unsure whether it should immediately accept and/or assign new work to those support workers with open availability, or whether the youth's circumstances will suddenly change again in the near future, requiring the full attention of the two support staff members once again. Such is the nature of managing Generalist Support and Rehabilitation Services programs.

Capacity management in Generalist Support and Rehabilitation Services is most accurately measured in hours per week of service provided rather than in terms of traditional caseload assignments. For example, a program may have 10 FTE Support and Rehabilitation Services positions, and each position may provide 25 direct hours per week of Support and Rehabilitation Services on average. This program would have a weekly program capacity of 250 hours. Whether those 250 hours would provide services for 20 individuals or 5 individuals depends entirely upon the ways in which CFTs configure the support services. When providers attempt to use a caseload assignment method for Generalist Support and Rehabilitation Services, they often run into challenges. For example, if the same program mentioned above with the 10 FTE decides that each of its employees will work with 10 youth,

an inherent frequency limitation is created. If each employee provides 25 direct service hours per week, he or she can only spend an average of 2.5 hours with each assigned youth.

A challenge for Case Managers/CFT Facilitators seeking Generalist Support and Rehabilitation Services is finding out whether a provider has current open availability to provide the amount of Support and Rehabilitation Services requested by the CFT. Because this information may change on a daily basis, it is difficult for RBHAs and Provider Networks (when applicable) to make accurate information available in real-time. In the past, some RBHAs have published weekly capacity reports, but they are often outdated within a few minutes of being distributed. Others have considered creating real-time electronic referral systems that display current accurate capacity information for Generalist providers similar to an online ticket vendor system. However, to date, such a system has not been created.

As discussed in another section of this report, some areas of the state do not struggle with knowing whether Generalist providers have open capacity in their systems because Generalist providers in those areas always accept all new referrals. These systems also may experience challenges because the amount of total support available per enrolled youth is inherently limited in this type of structure.

NARBHA has created an innovative approach to sharing information on a weekly basis regarding capacity of Generalist providers. Each Generalist provider sends a weekly report to NARBHA, which is distributed to the referring CFT agencies, showing the amount of support provided the past week by the provider in relation to their weekly contract capacity. For example, a provider that is funded to provide 250 hours of support each week may report that last week they only provided 220 hours of support. The most current information regarding the amount of hours committed for the present week is also reported, helping referring agencies become aware of the potential open capacity of the Generalist provider. Perhaps the most innovative part of the weekly report, however, is a section that projects through the end of the fiscal year the amount of capacity per week the Generalist provider can provide to be on target for the contracted amounts of service. This information may help the RBHA manage the total capacity of Generalist Support and Rehabilitation Services within the RBHA service area.

### ***Administrative Complexities***

Several other sections of this report mention complexities of operating a successful Generalist Support and Rehabilitation Services program. While most providers seemed to enjoy the challenges associated with Generalist work, several expressed being challenged by the complexity involved with Generalist provider operations.

Several providers expressed a need for internal support from their provider organization to provide the tools needed to do the work effectively (such as access to petty cash, vehicles or mileage reimbursement for transportation, cell phones and other technology, etc.). Others expressed concern about RBHA-level operations that make the work of a Generalist provider more complex, such as the need to manage multiple contracts, multiple funding sources, and participate in regular intensive practice reviews in addition to meeting other standard provider requirements. It is recommended that ADHS/DBHS and RBHAs work together to ensure that administrative burdens be made as simple as

possible for Generalist providers, especially in the infancy of their programs, so that they may focus their efforts upon quality service delivery, rather than managing complex administrative operations.

### ***Case Management***

Case management services are a necessary part of operations as a Generalist provider, even though the case management billing code may not specifically be a targeted Support or Rehabilitation Service. Case management allows Generalist providers to coordinate with CFTs, stakeholders and families. However, there is also a risk that Generalist providers may rely heavily on case management services, rather than providing a balanced range of Support and Rehabilitation Services. Such practice becomes evident in medical record reviews in that the most frequently-encountered services delivered by Generalist providers become “check-in” visits billed as case management rather than actual support activities. It is recommended that each RBHA and RBHA Design Team monitor the use of case management by each Generalist provider to help recognize and avoid this pattern.

### ***Quality of CFT Facilitation***

The success of Generalist Support and Rehabilitation Services correlates strongly with the quality of CFT facilitation. Several Generalist providers mentioned challenges with the quality of CFT facilitation and its negative effect on Support and Rehabilitation Services design, delivery, monitoring and adjustment. As outlined in Module 4 of the ADHS/DBHS MMWIA modules and in the ADHS/DBHS Practice Protocol on Support and Rehabilitation Services, CFTs help select and commission Generalist Support and Rehabilitation Services providers. In order to do so, CFT facilitators must possess strong facilitation skills and have sufficient knowledge and experience with Support and Rehabilitation Services to know the resources available to the team and how to use them effectively.

Considerable resources have been dedicated to enhancing CFT practice over the past few years. Practice protocols, training, and coaching for CFT facilitators have been provided by ADHS/DBHS, RBHAs and individual provider agencies. Generalist Support and Rehabilitation Services were developed specifically as a tool for CFTs and are intricately connected to the success of the CFT process. Yet, by the report of many Generalist providers, CFT facilitation continues to be challenging. The following examples of challenges with CFT practice were noted during the practice reviews:

- Many CFTs are not aware of how to conceptualize the use of Support and Rehabilitation Services, especially for use in helping youth with complex needs avoid and/or return home from out-of-home placements. Module 4 of the ADHS/DBHS MMWIA modules may be helpful as a technical assistance/training resource in this area.
- Generalist Support and Rehabilitation Services providers and their supervisors, when associated with an agency different from that of the case management agency, often report ending up with a closer working relationship to the youth and family than does the CFT facilitator.

- Duplication of efforts may exist between the Support and Rehabilitation Services staff members and the Case Managers in the system in meeting the complex needs of youth and families, particularly when CFTs are not well-coordinated.
- Some Generalist agencies feel that case management responsibilities are sometimes abdicated to them by CFT facilitators.
- Several Support and Rehabilitation Service providers expressed frustration that many of the CFTs they attend do not even attempt to follow some of the basic structures associated with CFT practice, such as exploration of strengths, needs and creative options.
- There is a risk of providers using Support and Rehabilitation Services categorically rather than individualizing them to the needs of the family unless CFTs operate with a high level of skill.

Rather than simply expending more of the same types of resources on the enhancement of CFT facilitation, it is recommended that ADHS/DBHS and RBHAs explore innovative approaches to improving CFT practice that may not have been considered in the past. The large amount of Support and Rehabilitation Services providers in the system is a relatively new feature that may not have existed when many of the current system structures were designed. These providers may be a helpful source of information and resources in identifying and implementing creative new approaches to address CFT facilitation challenges.

### ***Petty Cash***

Several providers mentioned the importance of having access to some petty cash funds to support the types of community-based activities common with Generalist Support and Rehabilitation Services. Some agencies that do not currently provide access to petty cash for this purpose mentioned this as a challenge that they face.

### ***Ongoing RBHA-Level Reviews***

Two RBHAs, Magellan and Cenpatico, conduct RBHA-level practice reviews with MMWIA providers on a regular basis. Magellan uses a team of reviewers, including a family member, to review providers on a semiannual basis. In addition, Magellan collects feedback from family members receiving services and from CFT facilitators regarding their perceptions of MMWIA services and the functional outcomes they report, connected to receiving services. Cenpatico conducts quarterly reviews in a variety of areas affecting performance as a Generalist provider. Several RBHAs and providers also conduct family satisfaction inventories or use internal measures of performance.

The effects of RBHA –level reviews in both the Magellan and Cenpatico areas was evident in helping shape the expectations and practices of some Generalist providers. Several providers shared examples of changing practice significantly over the past year in response to RBHA-level reviews, including focusing more on youth with the most complex needs, making services available on weekends, and integrating Positive Behavior Support into their approaches.

### ***Funding Levels by GSA***

Most GSAs reported that Generalist Support and Rehabilitation Services are in high demand and that they feel a strong desire to obtain additional funding to expand Generalist services. The one exception was the Tucson area (GSA 5), where the RBHA reported being very satisfied with the amount of funding allocated for MMWIA and the current capacity of Support and Rehabilitation Services that have been developed.

### ***Shifting Funding to Support Increased Generalist Support and Rehabilitation Services Capacity***

RBHAs have been encouraged to find ways to shift funding over time from other sources to support the development of Generalist Support and Rehabilitation Services beyond the specific allocations for MMWIA provided by ADHS/DBHS. One example would be shifting funds previously used for out-of-home care to be used instead to support further development of Support and Rehabilitation Services. While some RBHAs have begun to shift funding beyond the specific ADHS/DBHS MMWIA allocations to support further Generalist Support and Rehabilitation Services development, it is recommended that this area continue to be monitored and encouraged by ADHS/DBHS.

## Key Findings and Recommendations

The RBHA and Provider reviews provided a wealth of information, much of which is summarized throughout this report. The following is a summary of several key findings as well as a collection of recommendations presented within the report.

- 1) There is a tremendous diversity in the way in which MMWIA Support and Rehabilitation Services have been implemented across the state. Significant differences exist in the way the work is carried out within each geographic region (GSA), as well as between providers within a GSA. This is an area of strength that should be recognized, and there are tremendous opportunities to learn from the creative ideas providers and RBHAs have implemented, some of which are highlighted in this report.
- 2) The knowledge and use of Support and Rehabilitation Services across the state has improved significantly, both within MMWIA itself as generally within non-MMWIA programs. This has been a success of MMWIA in all parts of the state. The Support and Rehabilitation Services codes appear to have risen from relative obscurity to now representing a significant portion of all covered services claims within each RBHA.
- 3) MMWIA Generalist Support and Rehabilitation Services have been well-received in all parts of the state and are a much-desired set of covered services. The education/information strategies associated with MMWIA have been very successful. Most GSAs report a huge demand for services, and all areas report increasing familiarity, acceptance and requests for Support and Rehabilitation Services by stakeholders and families.
- 4) Opportunities to capture clinical outcomes associated with Support and Rehabilitation Services are something requested frequently by MMWIA providers. Some providers and some RBHA Design Teams are implementing outcome measures; however, there appears to be a desire in most parts of the state to find ways to quantify the many success stories being experienced.
- 5) Many MMWIA Design Teams need clearer direction and purpose, as shown in the survey responses from Design Team members and comments shared by several MMWIA Generalist Providers. The connection between the Statewide MMWIA Steering Committee and the MMWIA Design Teams needs strengthening in order to gather information needed to manage MMWIA, help resolve challenges, and share specific strategies for success associated with Generalist Support and Rehabilitation Services.
- 6) Many Generalist Support and Rehabilitation Services providers expressed a desire for a forum to network with other Generalist providers and to share ideas and brainstorm solutions to challenges facing Generalist practice.
- 7) The ADHS/DBHS Practice Protocol on Support and Rehabilitation Services appears to be current and applicable. Neither all MMWIA RBHA leaders nor all Generalist providers appeared to be familiar with all of the content in the Practice Protocol document. Additionally, the individual

reviews of RBHA and Generalist providers indicated that both RBHAs and Generalist providers have a number of areas in which to improve in order to be in compliance with the ADHS/DBHS Support and Rehabilitation Services Practice Protocol. It is recommended that ADHS/DBHS implement steps to ensure RBHAs meet the requirements of the protocol more fully and that RBHAs integrate reviews of key elements of the Practice Protocol in RBHA-level practice reviews.

- 8) Nearly unanimously, MMWIA programs and services were described by providers and RBHAs as invigorating, refreshing and energizing. All providers report experiencing tremendous success with the services and appear to enjoy the elements that make Generalist Support and Rehabilitation Services unique. Many providers shared success stories relating to helping youth live successfully at home and in the community when prior interventions had not worked.
- 9) It is recommended that each RBHA, RBHA Design Team and the Statewide MMWIA Steering Committee consider seriously the degree to which family involvement is currently affecting the design, delivery, evaluation and adjustment of MMWIA services and take steps to integrate family involvement to a greater degree.
- 10) It is recommended that all youth experiencing current out of home placement be connected with MMWIA Generalist Support and Rehabilitation Services in an effort to help return them from out-of-home care.
- 11) It is recommended that MMWIA funds be prioritized for serving youth with the most complex needs and that providers desiring to provide Support and Rehabilitation Services for youth with less complex needs do so using non-MMWIA funding sources.
- 12) It is recommended that families have a choice of at least one Generalist Support and Rehabilitation Services provider in each geographic service area that is able to provide ESRs if needed.
- 13) It is recommended that each Generalist Support and Rehabilitation Services provider examine whether adding the license type of Assistance with the Self-Administration of Medication would be applicable and beneficial for their program.
- 14) Because the Arizona's 12 Principles and the basic principles of wraparound are a core upon which all other elements of Generalist practice are built, it is recommended that RBHAs and Design Teams do all in their power to help ensure that Generalist Support and Rehabilitation Services are delivered by providers that align well with these values and principles.
- 15) It is recommended that Generalist Support and Rehabilitation Services providers have at least one staff member in attendance at all CFT meetings.
- 16) It is recommended that RBHAs closely examine the practice of any Generalist agency claiming that families do not want certain aspects of Generalist services to assure that the agency is working with youth with most complex needs and that any deviation from Generalist practice is

truly a result of the expressed desires of families with the most complex needs rather than out of convenience for the provider.

- 17) It is recommended that Generalist providers that have concerns about requests made by a CFT discuss those concerns within the CFT so that the team can make an informed decision. Once a decision has been made by the CFT, it is recommended that the Generalist provider carry out their part of the plan as designed by the team without independently modifying the plan based on what the Generalist provider individually believes to be best for the family.
- 18) It is recommended that RBHAs and Design Teams help providers understand that Generalist Support and Rehabilitation Services rely on CFT-driven durations rather than on program-driven durations.
- 19) While group Support and Rehabilitation Services may play an important role in the mix of outpatient services available to families, it is recommended that MMWIA funds not be used for group Support and Rehabilitation Services so the funding may be preserved for Generalist Support and Rehabilitation Services.
- 20) It is recommended that referral criteria be used for MMWIA referrals and that RBHA Design Teams help define the level of intensity required for use of MMWIA services.
- 21) It is also recommended that GSAs requesting to use a portion of their MMWIA funds to work with those with less-complex needs first be required to ensure that all youth with the most complex needs are currently receiving access to Generalist Support and Rehabilitation Services (for example, that all youth placed out of home, including those out of state, are involved with Support and Rehabilitation Services).
- 22) It is recommended that RBHAs encourage Generalist providers to establish capacity limitations in order to preserve MMWIA's resources in sufficient quantity to serve youth with the most complex needs.
- 23) In order to provide the full extent of PBS-type services and to integrate youth into the community more fully, it is recommended that all providers consider activities that involve a balance of home-based and community-based activities
- 24) It is recommended that respite provided using MMWIA funding focus on home-based and individual community-based (rather than group community-based) types of respite.
- 25) It is recommended that each RBHA carefully review the practice of each Generalist provider and determine whether its current operations are best suited for Generalist Support and Rehabilitation Services practice or whether the program is prescribing to a specific evidence based practice model.

- 26) It is recommended that RBHA MMWIA Design Teams closely monitor the degree to which Generalist provider policies and procedures allow them the flexibility to carry out the requests made by CFTs.
- 27) It is recommended that transportation of youth and their family to, during and from Generalist Support and Rehabilitation Services activities be considered an important and expected part of service delivery.
- 28) It is recommended that Generalist Support and Rehabilitation Services providers make their staff members available as designed by CFTs to assist in preventing and/or responding to crisis-related needs, including the ability to respond outside of pre-scheduled hours when needed.
- 29) In general, it is recommended that Generalist Support and Rehabilitation Services providers are able to work with both the youth alone and the entire family as directed by the CFT.
- 30) Providers' understanding and implementation of Positive Behavior Support (PBS) has improved since the time it was introduced during the MMWIA training workshops and MMWIA training modules. However, many providers admittedly have a long way to go in more fully understanding and implementing PBS- types of approaches and may need ongoing technical assistance and support in this area. PBS needs to be an ongoing area of training, supervision, evaluation, and technical assistance across the state for the next several years as it becomes more of a natural way to work with people.
- 31) It is recommended that answers to the questions listed in the section on Functional Behavior Assessment be explored by the ADHS/DBHS MMWIA Steering Committee and/or RBHA Design Teams.
- 32) It is recommended that Generalist providers and RBHAs more regularly examine the types of data that was requested in the MMWIA provider and RBHA reviews.
- 33) It is recommended that accurate information be provided to Generalist Support and Rehabilitation Services providers regarding the questions and concerns outlined above in the subsection entitled "Billing Code Myths and Questions."
- 34) It is recommended that each RBHA Design Team review these structures and empower their Design Teams with a voice concerning the way Support and Rehabilitation Services are set up in the RBHA system. Family voice is particularly important in this area.
- 35) It is recommended that ADHS/DBHS and RBHAs work together to ensure that administrative burdens be made as simple as possible for Generalist providers, especially in the infancy of their programs, so that they may focus their efforts upon quality service delivery, rather than managing complex administrative operations.
- 36) There is a risk that Generalist providers may rely heavily on case management services, rather than providing a balanced range of Support and Rehabilitation Services. Such practice becomes

evident in medical record reviews in that the most frequently-encountered services delivered by Generalist providers become “check-in” visits billed as case management rather than actual support activities. It is recommended that each RBHA and RBHA Design Team monitor the use of case management by each Generalist provider to help recognize and avoid this pattern.

37) It is recommended that ADHS/DBHS and RBHAs explore innovative approaches to improving CFT facilitation and practice as described in the subsection of this report entitled “Quality of CFT Facilitation.”

38) A system priority should be further increasing the capacity of Generalist Support and Rehabilitation Services. Survey results and provider reviews show that, with the possible exception of the Tucson area, all parts of the state are in need of significant increases in Generalist Support and Rehabilitation Services capacity. Capacity increases may be accomplished through allocation of additional future capitation rate increases. However, the type of systemic movement required to create enough capacity for Generalist Support and Rehabilitation Services will likely require shifting funds from other sources, preferably from those involving lower utilization patterns as community-based services increase in availability and effectiveness in the system. While some RBHAs have begun to shift funding beyond the specific ADHS/DBHS MMWIA allocations to support further Generalist Support and Rehabilitation Services development, it is recommended that this are continue to be monitored and encouraged by ADHS/DBHS.