

Arizona Department of Health Services
Division of Behavioral Health Services
Prescribing Clinician Network Sufficiency Analysis
May 2006
(Revised 5/15/06)

In order to determine statewide Prescribing Clinician sufficiency¹, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) recognizes the need to have a standardized process for all T/RBHAs. Collaboratively DBHS and the T/RBHAs created the following logic model.

Assumptions:

- The average time for a psychiatric evaluation is 60-90 minutes annually for each adult individual on medications and 90-120 minutes for each child/adolescent on medications.
- The average time needed for medication monitoring is 30 minutes per session, which includes time needed for documentation and coordination of care.
- The average number of medication monitoring visits per year is 5-6 visits per each adult individual on medications and 6-8 visits for each child/adolescent on medications.
- The total average of Prescriber Clinician time needed for each individual on medications per year, therefore, is 4 hours for adults and 5 hours for children/adolescents. This takes into account that higher-needs, complex consumers may require more frequent visits or longer visits, while some consumers will require less frequent contact with their prescriber. It is also acknowledged that nursing personnel can address some consumer needs, thus decreasing overall demand on the prescriber.
- The prescribing clinician is also expected to perform numerous other duties as necessary, including participation on a Child and Family Team or Adult Clinical Team, contact with family members, return telephone calls, review medical records/lab work, coordinate care with other medical providers, participate in clinic staffings, etc. One FTE equals 40 hours per week x 52 weeks = 2080 hours per year (maximum hours available). However, it is estimated that prescribers spend 10 hours/week conducting the other duties outlined above. This equates to 30 hours/week of actual face-to-face time with patients (75% of an FTE). If 4 weeks of vacation are added in, a prescriber is estimated to have 1440 hours/prescriber/year of actual face-to-face time with patients.
- 100% of enrolled adults with SMI should be evaluated and followed by prescribing clinicians, even though they may not be taking medications.

¹ DBHS contract does not define “sufficiency;” however contractors are held to specified timeline standards for appointments, including appointments for medication evaluation. “Sufficient” would mean that contractors are able to comply with these appointment standards $\geq 85\%$ of the time.

- 40% of enrolled adults with GMH/SA are on medications. (TXIX/XXI only are included here, since non-TXIX/XXI do not have medication benefits.)
- 35% of enrolled children/adolescents are on medications.
- All Level I facilities have prescriber capacity expectations determined per OBHL rules. Therefore, they will be excluded from prescriber capacity calculations..
- All specialty licensed methadone clinics are excluded from prescriber capacity counts as well, because, by virtue of their OBHL license, they must have adequate prescriber staff to provide the medication and monitoring services. All other outpatient clinics are included.
- Prescriber losses in remote, rural areas can have a significant, negative impact on an individual's ability to see a prescriber in a timely manner, therefore must be tracked carefully.

Process:

Geo Mapping² is necessary in order to account for rural and urban variances and to confirm that prescribers are located within close proximity of consumers.

- T/RBHAs are asked to Geo Map the location of consumers by population (Adult SMI, Adult GMH/SA, Child) based on their residence zip code. One map for Adult SMI, one map for Adult GMH/SA, and one map for children should be created.
- Different colors should be used for census of enrolled members³:
 - color a = <10 enrolled members in the identified zip code
 - color b = 11-25 enrolled members
 - color c = 26-50 enrolled members
 - color d = 51-100
 - color e = 101-200
 - color f = 201-300
 - color g = 301- 400
 - color h = >400
- T/RBHAs are asked to separately Geo Map the location of contracted prescribers (Do not include locum tenens or Single Case Agreements here) by population they treat (Adult SMI, Adult GMH/SA, Child/Adolescent) based on their clinic zip code. This ensures that Child/Adolescent prescribers are available to that sub-population. This process also allows for better analysis when prescriber gains or losses are reported. If a prescriber is an FTE, but splits time between two separate clinical sites or two separate populations (i.e. sees both adults and children or both SMI and GMH/SA), the prescriber should be noted for both. Prescribers should be mapped individually and color-coded based on their employment status (FTE = 40hrs/wk):

² Contractors without Geo mapping technology may use a modified process in which the above information is presented in a table format. Contractors should have capability to use zip code information to assess population and prescriber capacity.

³ Each T/RBHA can identify their own T/RBHA-specific stratification schedule for color coding using "Natural Breaks" classification if the suggested methodology above is not effective.

- color a = 1 FTE
- color b = 0.75-0.99 FTE
- color c = 0.5-0.74 FTE
- color d = 0.25-0.49 FTE
- color e = <0.25 FTE
- color f = >1-3 FTE
- color g = >3-5 FTE
- color h = >5 FTE
- These maps are compared to ensure prescribers are located within close proximity of consumers. Consumers in rural areas should not have to travel more than 1-1.5 hours for a prescriber...that equates to 50-75 miles, and allows for consideration that some people choose to live in hard-to-reach areas.
- T/RBHAs are asked to separately list locum tenen prescribers (zip code location and FTE status) if needed to ensure adequate capacity.

Each T/RBHA is expected to have the minimum number of FTE to serve the identified population for each GSA. Each T/RBHA meeting the minimum expectations should strive for the Goal number of prescribers. Each T/RBHA meeting the goal expectations is encouraged to strive for the Benchmark number of prescribers.

Each quarter, in addition to submitting a Prescriber Gains and Losses report, each T/RBHA will recalculate the minimum number of FTE prescribers needed for each GSA. This process will trigger the need to increase the number of FTE based on population growth/enrollment increases. If additional FTE are needed, the T/RBHA will outline how this gap will be filled immediately with existing prescribers. In most cases, this is accomplished with increasing hours of currently contracted prescribers. In addition the T/RBHA will outline how it plans to fill needed FTE positions permanently, including timelines, and keep DBHS updated on progress.

Each **GSA** will complete the following table of information:

Population	Number of eligible consumers	Number of enrolled consumers (N)	Number of enrolled consumers on meds (N x 1, 0.4, or 0.35 = M)	Number of prescriber hours needed per year (M x 4 or 5 = H)	Minimum number of FTE prescribers needed (H ÷ 2080)	Goal: number of FTE prescribers needed: (H ÷ 1760)	Benchmark: number of FTE prescribers needed: (H ÷ 1440)
Example population: children/adolescents	100,000 eligible	10,000 enrolled	4,000 on medications	20,000 hours needed per year	10 FTE needed	12 FTE needed	14 FTE needed
Children/Adolescents							
Adult GMH/SA							
Adult SMI							
Total							