1. Prescriber Sufficiency

During the RBHA Medical Director's Meeting in January 2008 concerns were raised surrounding the Prescriber Gains and Losses report. The medical directors indicated that since the report is a snapshot look at capacity that it does not adequately reflect the actual system due to staff turnover along with other factors. The attendees agreed that the quarterly Prescriber Sufficiency analysis accurately tracks sufficiency for prescriber capacity.

ADHS/DBHS submitted a letter to AHCCCS on January 28, 2008 requesting that the Prescriber Gains and Losses report be eliminated. On March 11, 2008 AHCCCS responded to the ADHS/DBHS request by approving the elimination of the report contingent upon the addition of an analysis of findings from complaint data related to prescriber accessibility quarterly.

On May 8, 2008 formal letters were sent to each RBHA indicating that the Quarterly Prescriber Loss and Gains Report is no longer required and that there are additional analysis needed within the Prescriber Sufficiency Analysis. The letter indicates that the new reporting requirements will be required with the Quarter 4 submissions due to ADHS/DBHS on July 15, 2008.

Statewide Overview

In order to determine statewide Prescribing Clinician sufficiency, ADHS/DBHS developed a Prescriber Sufficiency Model in collaboration with the RBHAs. For the FY08 Annual Plan and on a quarterly basis throughout the year, each RBHA was required to provide the following analysis of prescriber sufficiency:

a) Complete an analysis of FTE prescribers needs (outpatient services only) using the Prescriber Capacity Sufficiency Model.
b) Analyze the geographic availability of prescribers compared with the geographic location of enrolled members.
c) Identify any coverage gaps or excesses

For the FY08 4th Quarter Reports, the format was changed once more to reflect that the Prescriber Sufficiency Analysis replaced the current format and includes in the analysis a summary comparison of the prescriber sufficiency and findings from complaint data for the respective quarter related to accessibility (i.e. member complaints regarding availability of prescribers).

RBHA Descriptions

Northern Arizona Regional Behavioral Health Authority

During FY08 NARBHA has demonstrated that they are consistently above the goal number of prescribers needed. A review of complaint data identified five complaints regarding Clinical Decisions Related to Service, or Access to Services. NARBHA's Medical Systems Analyst reviewed the five complaints at the end of Quarter 4. NARBHA determined that each of the providers took appropriate action once they became aware of the complaint and that the complaints did not indicate prescriber capacity issues.

Of the five complaints, 60% (3/5) were complaints that the member was about to run out of medications and needed to be seen by a medical practitioner or get an immediate refill. The RA's were notified of complaints and refill prescriptions were given. Two complaints were resolved

satisfactorily. One complaint was closed without merit as the legal guardian had resolved the issue to which the non-custodial parent was making complaint about.

Of the five complaints, 20% (1/5) or one was a complaint that the member could not be seen in a timely manner for a psychiatric evaluation. The RA was notified of the complaint and the member was scheduled for the psychiatric evaluation in accordance with the time frame requirements. The complaint was resolved satisfactorily.

Finally, of the five complaints, 20% (1/5) or one was a complaint that the member was not told that her doctor was no longer working at the RA. The physician left with short notice and the member has been assigned to a new doctor with an appointment scheduled in two weeks. The complaint was resolved satisfactorily.

Table 1.1 NARBHA Prescriber Sufficiency

Population	Number of Enrolled Consumers	Number of Enrolled Consumers on Meds (N x 1.04 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 Prescriber Needed (H/1760)	Benchmark : Number of FTE Presriber Needed (H/1440)	Current Number
Children/ Adolescents	4119	1442	7210	5.15	6.01	7.21	**8.16**
Adult GMH/SA	6661	2661	10,644	6.41	7.5	9.08	**9.8**
Adult SMI	4122	4122	16,488	9.89	11.6	13.8	**14.11**
Total	10783	6783	33,915	16.3	19.1	22.88	**23.91**

Prescriber Capacity Based upon June 30, 2008 Data

Cenpatico Behavioral Health – GSA 2

As of June 30, 2006, the prescriber network in GSA 02 is above standard for all populations according to the Prescriber Sufficiency Model developed by DBHS. An examination of complaint data from April 1 thru June 30, 2008 revealed two complaints relating to prescriber availability. Both complaints were for children and both were filed against Excel.

The first complaint filed in April indicated the child had not had a medication appointment in approximately 8 months (according to caller). When the appointment was scheduled, Excel cancelled for the prescriber was no longer seeing children. An appointment was finally able to be scheduled with a nurse practitioner who needed additional time to review the chart. This was referred to Cenpatico QM team as a Quality of Care issue.

The second complaint referred to an issue related to scheduling appointments while the prescribing clinician was unavailable (out of office, vacation, etc…) Cenpatico is working with Excel to ensure that participants see no interruption in services, especially for medication while the prescriber is out of office.

Table 1.2 Cenpatico GSA 2 Prescriber Sufficiency

Population	Number of enrolled participants (N)	Number of enrolled participants on meds (N x 1, 0.4, or 0.35 = M)	Number of prescriber hours needed per year (M x 4 or 5 = H)	Below Standard: (H ÷ 1400)	Standard: (H ÷ 1200)	Above Standard: (H ÷ 1000)	Cenpatico Number of FTE Prescribers
Children/ Adolescents	1349	472.15	2360.75	1.69	1.97	2.36	**5.75**
Adult GMH/SA	2172	868.8	3475.2	2.48	2.9	3.48	**5.26**
Adult SMI	971	971	3884	2.77	3.24	3.88	**4.32**
Total	4492	2311.95	9719.95	6.94	8.10	9.72	**15.33**

* *Prescriber Capacity Based upon June 30, 2008 Data*

Cenpatico Behavioral Health – GSA 4

Cenpatico GSA 4 is above the standard for all populations. No complaints were received during this period relating to prescriber sufficiency or availability.

Table 1.3 Cenpatcio GSA 4 Prescriber Sufficiency
* *Prescriber Capacity Based upon June 30, 2008 Data*

Population	Number of enrolled participants (N)	Number of enrolled participants on meds (N x 1, 0.4, or 0.35 = M)	Number of prescriber hours needed per year (M x 4 or 5 = H)	Below Standard: (H ÷ 1400)	Standard: (H÷ 1200)	Above Standard: (H ÷ 1000)	Cenpatico Number of FTE Prescribers
Children/ Adolescents	2916	1020.6	5103	3.65	4.25	5.10	**6.66**
Adult GMH/SA	3536	1414.4	5657.6	4.04	4.71	5.66	**6.09**
Adult SMI	1454	1454	5816	4.15	4.85	5.82	**6.12**
Total	7906	3889	16576.6	11.84	13.81	16.58	**18.87**

Community Partnership of Southern Arizona – GSA 3

For children and adolescents, the current CPSA GSA 3 network capacity of prescribing clinicians of 1.5 FTEs falls slightly below the ADHS/DBHS category "Below Standard" of 1.7 FTEs. There was a net loss of 0.7 FTEs from the previous quarter, while enrollment also dropped slightly. In discussion with SEABHS, the loss of hours is attributed to one physician who is contracted to SEABHS for a total of 32 hours/week. He sees both adults and children and his time is not allocated on a fixed basis to either population; rather, he sees members as scheduling needs demand, so that some weeks will see more children than adults. During other weeks, he may see more adults than children based on the service needs of members at the sites he serves. Thus, the total hours available fluctuate. If he sees all children then the total hours available for children/week increase to 32 for a total of 2.05 FTEs above the standard of 2.0 FTE. That would also decrease available adult hours to 284 hours/week or 7.10 FTEs which would meet the

standard for adult hours. The hours reported in the above table are based on the encountered services delivered by the physician and thus reflect the average use of his hours during the quarter. Sufficiency of prescribers for youth continues to be a focus of the RBHA system of Care Network Development Plan and continued recruitment efforts are underway. In the interim, the current staff is working additional hours to assure that youth are seen according to timeline requirements.

For adults, the current CPSA network capacity of prescribing clinicians of 7.7 FTEs is 1.2 FTEs above the ADHS/DBHS category "Standard" for CPSA GSA3, and 0.1 FTE below the ADHS/DBHS category "Above Standard." There was a net gain of 0.2 FTEs for the adult population, while enrollment dropped slightly.

There were no complaints to CPSA Member Services about lack of availability or accessibility to Behavioral Health Medical Practitioners in GSA-3.

SEABHS and CPSA continue to recruit Behavioral Health Medical Professionals. SEABHS has implemented telemedicine through a subcontract with FasPsych from Phoenix. This has helped increase availability and accessibility, especially for persons who are unwilling or unable to wait for available psychiatric appointments and for persons who need appointments sooner than routine appointments.

Table 1.4 CPSA GSA 3 Prescriber Sufficiency

Population	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)	Below Standard: (H ÷ 1400)	Standard: (H ÷ 1200)	Above Standard: (H ÷ 1000)	Actual T/RBHA Result (3-31-08)
Children/ Adolescents	1,338	468	2,342	1.7 FTE	2.0 FTE	2.3 FTE	**1.5 FTE** (Below Standard)
Adult GMH/SA	2,323	929	3,717	2.7 FTE	3.1 FTE	3.7 FTE	**7.7 FTE** (Within Standard)
Adult SMI	1,028	1028	4,112	2.9 FTE	3.4 FTE	4.1 FTE	
Total	4,689	2426	10,170	7.3 FTE	8.5 FTE	10.2 FTE	**9.2 FTE** (Within Standard)

* *Prescriber Capacity Based upon June 30, 2008 Data*

Community Partnership of Southern Arizona – GSA 5

For children, the current CPSA GSA 5 network capacity of 14.2 FTEs is 0.1 FTEs above the previous quarter, and exceeds the ADHS/DBHS category "Standard" of 10.7 FTEs by 3.5 FTEs, and exceeds the ADHS/DBHS category "Above Standard" of 12.8 FTEs by 1.4 FTEs.

For adults, the current CPSA GSA 5 capacity of 38.7 FTEs is 2.7 FTEs below the previous quarter, and falls slightly below the ADHS/DBHS category "Standard" of 39.1 FTEs by 0.4 FTEs. One adult network had a net loss of 26 hours or 4.5 FTE. The other two adult networks each had net gains in FTEs.

Review of complaint data from Member Services did show an increase in complaints related to access and availability of Behavioral Health Medical Professionals in the adult system of care in

GSA 5. In April there were four complaints; in May, there were seven; and in June, there were thirteen. The majority of these complaints did not come from the network with the net loss in hours, but was equally distributed between the remaining two despite net increases (three complaints each). Of the total 23 complaints, 17 were related to timeliness. This may be due more to the ongoing dynamic of changes in and movement of staff over the quarter not reflected in the FTEs counted at the end of the quarter. One adult serving network moved two large service sites; some BHMP staff members changed locations in the process and this may have added to the delay. Of note is that Member Services has resolved all of these complaints.

CPSA will continue to work with the GSA 5 Networks that serve adults to maintain and further improve the current capacity of general psychiatrists and other Medical Behavioral Health Professionals with prescriptive privileges. CPSA will recalculate minimum network standards for each network utilizing the DBHS formula for the RBHA sufficiency. This will assist CPSA and the networks to better align minimum standards with DBHS requirements.

CPSA provides each network with a summary and detail of complaints. CPSA Collaborative Technical Assistance teams will review with each network the complaints related to access and availability of BHMPs.

Table 1.5 CPSA GSA 5 Prescriber Sufficiency

Population	**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)**	**Below Standard: (H ÷ 1400)**	**Standard: (H ÷ 1200)**	**Above Standard: (H ÷ 1000)**	**Actual T/RBHA Result (12-31-07)**
Children/ Adolescents	7,320	2562	12,810	9.2 FTE	10.7 FTE	12.8 FTE	**14.2 FTE** (Above Standard)
Adult GMH/SA	8,659	3464	13,854	9.9 FTE	11.5 FTE	13.9 FTE	**38.7 FTE** (Below Standard)
Adult SMI	8,273	8273	33,092	23.6 FTE	27.6 FTE	33.1 FTE	
Total	24,252	14299	59,756	42.7 FTE	49.8 FTE	59.8 FTE	**52.8 FTE** (Within Standard)

** Prescriber Capacity Based upon June 30, 2008 Data*

Magellan Health Services

For SMI, based upon the Prescribing Clinician Matrix updated with prescriber FTE's from the Annual Network Inventory, Magellan Health Services prescribing FTE's are now above the standard. Based on these results no plan to address deficiencies is needed. Magellan Health Services will continue to aggressively monitor prescriber sufficiency through Staff Roster Updates and complaint data. Locum Tenens were not used in the count of the total.

For General Mental Health/Substance Abuse adults, based upon the Prescribing Clinician Matrix updated with prescriber FTE's from the Annual Network Inventory, Magellan Health Services prescribing FTE's now meet the standard. Based on these results no plan to address deficiencies is needed. Magellan Health Services will continue to aggressively monitor prescriber sufficiency through Staff Roster Updates and complaint data. Locum Tenens were not used in the count of the total.

Based upon the Prescribing Clinician Matrix updated with prescriber FTE's from the Annual Network Inventory, Magellan Health Services prescribing FTE's for children and adolescents, now meet the standard. Magellan Health Services will continue to aggressively monitor prescriber sufficiency through Staff Roster Updates and complaint data. Locum Tenens were not used in the count of the total.

A review of complaint data for this review period shows five complaints related to prescriber availability. Of the five complaints, one was for the Child/Adolescent population and four were for the SMI population. The complaint reasons were Specialty Treatment-Suboxone (one) and Lack of Staff (four).

For the issue related to Suboxone, the member was given a Single Case Agreement to go outside the network to get her medication. For the issues related to lack of staff the Customer Service Representative worked with the members to ensure services were scheduled and completed, as appropriate. Magellan Health Services will continue to monitor complaints related to prescriber availability on a monthly basis and address any emerging trends indicating sufficiency issues.

Table 1.6 Magellan Health Services Prescriber Sufficiency

Population	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)	Below Standard: (14 and under would be below standard) (H ÷ 1400)	Standard: (15-19 would be standard) (H ÷ 1200)	Above Standard: (20 and above would be above standard) (H ÷ 1000)	Actual T/RBHA Result
Children/ Adolescents	17,231	6,031	30,155	21.5	25.1	30.1	25.905
Adult GMH/SA	22,731	9,092	36,368	26	30.3	36.4	31.18
Adult SMI	11,068	11,068	44,272	32	37	44.3	108.07
Total	51,030	25,361	110,795	79.5	92.4	110.8	131.61

** Prescriber Capacity Based upon June 30, 2008 Data*

2. FY09 Adult SMI and GMH/SA System of Care Summary

The purpose of the System of Care Network Development Plan is to identify the current status of the system of care at all levels to identify network development and/or enhancement needs for the upcoming Fiscal Year and to identify goals, objectives and tasks needed to effectively address those needs. The identification of development needs is based on assessing network sufficiency, capacity, change initiatives and minimum network standards. The plan provides clear objectives tied to goals, with tasks to map progress along the way. Tasks clearly state what is to be done, who is the responsible person, have a clear target completion date and identification of a deliverable to measure completion.

Goal 1: Expansion of Adult Support and Counseling Services

Objective 1.1: Expand/Enhance the availability and accessibility of Housing Services (must include 18-21 young adult specific tasks)

Objective 1.2: Expand/Enhance the availability of routine/non-emergent transportation

services

Objective 1.3: T/RBHAs will make training resources for the Meet Me Where I Am Campaign available to providers within the adult system

Objective 1.4: Enhance service availability and coordination of services for individuals 18-21

Objective 1.5: Increase capacity for respite services

Objective 1.6: T/RBHAs will expand and enhance the availability and accessibility of counseling services

Goal 2: Expansion of Adult Psychosocial Rehabilitation Services

Objective 2.1: Expand Employment Services and ongoing support to maintain employment

Objective 2.2: Expand the number employment providers who are mutually contracted by both the T/RBHA and ADES/RSA

Objective 2.3 Increase service utilization of the following covered services: Psycho educational Services (H2027) and Ongoing Support to Maintain Employment (H2025)

Objective 2.4: T/RBHAs to enhance service coordination with ADES/RSA

Objective 2.5: T/RBHAs will train provider network staff in psychosocial rehabilitation approaches

Goal 3: Develop and Enhance Adult Specialty Services

Objective 3.1: T/RBHAs will develop and/or expand treatment services for sexual offenders

Objective 3.2: T/RBHAs will develop and/or expand services for victims of sexual abuse trauma

Objective 3.3: T/RBHAs will provide appropriate and clinically sound services to individuals with developmental disabilities

Objective 3.4: Enhance behavioral health services delivery for older adults in accordance to best practices and DBHS Protocol

Objective 3.5: Increase availability of telemedicine

Objective 3.6: Increase Consumer and Stakeholder Awareness of Specialty Services

Objective 3.7: Increase the availability of Dialectic Behavioral Therapy(DBT)

Objective 3.8: T/RBHAs will provide community education/training for adults regarding their influence on underage drinking

Goal 4: Increase the Utilization of Peer and Family Supports within the Adult System of Care

Objective 4.1: T/RBHAs will train provider network staff on the role of peer and family support within the Adult System of Care

Objective 4.2: Increase the number and percentage of behavioral health recipients delivering Peer Support Services

Objective 4.3: Increase the number and percentage of family members of behavioral health recipients delivering Peer/Family Support Services

Goal 5: Expand and Enhance Substance Abuse Services

Objective 5.1: T/RBHAs will ensure that individuals with substance use challenges have access to, and receive, appropriate services.

Objective 5.2: T/RBHAs will ensure that appropriate service recipients have access to Buprenorphine

Objective 5.3: T/RBHAs will analyze their provider network’s ability to meet the needs of individuals with co-occurring issues and provide the data to DBHS

Objective 5.4: T/RBHAs will ensure that Substance Abuse Prevention and Treatment funding is expended in accordance with priorities outlined in the grant and

ADHS/DBHS Provider Manual

Goal 6: Enhance Training and Supervision of Direct Care Staff

Objective 6.1: All direct care staff will be trained in the Recovery Principles and strategies to incorporate them into service planning

Objective 6.2: T/RBHAs will monitor the types, frequency, and content of supervision required and provided by Providers to direct care staff

Magellan Only Goals

Goal 7: Expand psychiatric recovery center and detoxification services

Objective 7.1: Initiate process for the addition of two additional psychiatric recovery centers

Objective 7.2: Initiate process for expansion of detoxification services capacity

Goal 8: Incorporate elements of MHA Village model concepts and practices into service delivery

Objective 8.1: Implement MHA Village Model at DCC sites

Goal 9: Enhance ability to collect preferred language data

Objective 9.1: Capture preferred language data for individuals currently enrolled in RBHA services

3. FY09 Children's System of Care Summary

The purpose of the System of Care Network Development Plan is to identify the current status of the system of care at all levels to identify network development and/or enhancement needs for the upcoming Fiscal Year and to identify goals, objectives and tasks needed to effectively address those needs. The identification of development needs is based on assessing network sufficiency, capacity, change initiatives and minimum network standards. The plan provides clear objectives tied to goals, with tasks to map progress along the way. Tasks clearly state what is to be done, who is the responsible person, identifies a clear target completion date and describes the deliverable to measure completion.

The Goals and Objectives outlined in this Title XIX Children's System of Care Network Development Plan identifies network development and enhancement activities for the contract year based on the assessment of the current status of the network and multiple sources of information about current and projected network needs. The plan also represents activities that ADHS/DBHS will undertake to further meet Settlement Agreement obligations and system changes that keep the Children's System of Care current with ongoing improvements in overall behavioral health treatment practice from a national perspective.

This plan includes input from various stakeholders, including T/RBHAs, providers, and families. ADHS/DBHS has met with the leadership of the T/RBHAs, associated local service providers, and family member representatives at each Geographical Service Area (GSA) to review with them the details of this Children's System of Care Network Development Plan and the expectations for the upcoming year. Each T/RBHA has developed and is implementing its own Geographic Service Area (GSA)-specific work plan incorporating local service providers with relevant provider-specific objectives. ADHS/DBHS will monitor progress on the T/RBHA level plans throughout the coming year.

ADHS/DBHS is committed to the successful implementation of the goals and objectives described in this Plan and strongly believe that the direction outlined for the coming year is vital to the continued development of a sustainable high-quality children's behavioral health system. While unanticipated issues may periodically arise, requiring adjustments or modifications to particular plan tasks or objectives, ADHS/DBHS is committed to completion of the Goals/Objectives/Tasks set forth in this Children's System of Care Network Development Plan within the timeframes indicated.

The five goal areas for the plan and respective objectives include:

Goal 1: Develop a statewide quality management system for children's services that strengthens practice according to the Arizona 12 Principles

Objective 1.1: Implement an in-depth, statewide tool and process that reviews practice and adherence to the Child and family Team Practice and 12 Principles.

Objective 1.2: Promote adherence to the Arizona 12 Principles and Child and Family Team practice through the use of Quality Management measures at the ADHS, T/RBHA, and Provider levels.

Objective 1.3: Publish and disseminate practice review findings and quality management information.

Goal 2: Implement a children's statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team practice.

Objective 2.1: Conduct ongoing network analysis of case manager capacity in order to provide case managers for all children with complex behavioral needs.

Objective 2.2: Expand the capacity and quality of Support and Rehabilitation Services, and of specialty Clinical Services.

Objective 2.3: Expand capacity in Substance Abuse Services and incorporate goals into the System of Care development planning process.

Objective 2.4: Implement the revised intake, assessment, and service planning process and adjust current policy and practice related to this process.

Objective 2.5: Implement T/RBHA Child and Family Team expansion plans to serve all enrolled children and families through the Child and Family Team practice.

Objective 2.6: Promote the use of Functional Behavioral Assessment/Analysis and Positive Behavioral Support strategies using existing covered behavioral health services.

Objective 2.7: Enhance service delivery, for young adults ages 18-21, in accordance with the Arizona 12 Principles.

Objective 2.8: Enhance Home Care Training to Home Care Client (HCTC) services for children, adolescents and young adults

Objective 2.9: Enhance behavioral health services for children, birth to five.

Objective 2.10: Implement the Child and Adolescent Service Intensity Instrument (CASII).

Goal 3: Develop strong technical assistance initiatives to strengthen Child and Family Team Practice in accordance with the Arizona 12 Principles

Objective 3.1: Enhance clinical supervision and coaching to promote the development of practice improvement strategies.

Objective 3.2: Enhance training to develop and strengthen the behavioral health workforce.

Objective 3.3: Enhance monitoring to ensure appropriate implementation and utilization of ADHS practice protocols, technical assistance, training, and supervision requirements.

Objective 3.4: Improve access of quality behavioral health services to diverse populations by promoting, developing, and maintaining a culturally and linguistically competent children's behavioral health system.

Goal 4: Involve youth and families in improving the behavioral health system.

Objective 4.1: The Family Committee, consisting of family representatives from across the state, will continue to review quality management data, gather feedback from their local communities, and make recommendations to ADHS for system improvement.

Objective 4.2: Strengthen family involvement in an effort to enhance positive outcomes for children and families.

Objective 4.3: Strengthen youth involvement to enhance positive outcomes for children and families.