Arizona Behavioral Health Payment Reform Toolkit Provider Readiness Assessment Results

Summary

Things are moving quickly in your environment! You have a new governor, DBHS and AHCCCS are merging, and you are facing a rapid ramp up of the new integrated care RBHA structure. This is a time of great opportunities and some potential threats for the behavioral health delivery system

This report has been organized to get you the key information about what you reported, drawing primarily on responses to the "AZ Provider Readiness Self-Assessment," completed in Survey Monkey. We have also woven in the responses to the real-time polling surveys conducted during the two "Arizona Behavioral Health Payment Reform Toolkit Provider Readiness Assessment Results" webinars, conducted on April 13-14th. We have taken the survey results and organized the responses into two categories:

- Collectively, you report that you're good at this, based on "Yes", "Almost Always" or "Completed" responses for a significant majority of the 47 provider organizations that participated in the survey
- More than a few of you might need to work on this, based on "No", "Rarely or Never", "Sometimes", "In Process" or "Not Yet" responses for a significant number of organizations

It's important to note that the summary results describe the complete set of respondents. When we conclude "Good at This" or "Needs Work", we are commenting on the collective state of affairs for the provider network. For each area and question, organizations span the range of possible responses.

One of the benefits of this at-a-glance view is to identify areas where groups of providers might come together to share the costs of a performance improvement project, like you did with your Open Access consultation a few years ago.

For the fifteen major areas of the Assessment we concluded the following:

Area	Good At This	Needs Work	Comment
1. Level of Care (LOC)		X	
2. Open Access and No Show Tracking	X		But might need some work
3. Evidence-Based Practices Use	X		
4. Outcome-Based Care		X	But making progress
5. Clinical Improvement Tools in Use	X		
6. Individual and Population Health Management		X	This is a new area of focus
7. Primary Care/Behavioral Health Integration		X	But making progress
8. Health Indicators		X	This is a new area of focus
9. Care Coordination		X	
10. Peer Supports		X	
11. Third Party Billing and Collections		X	
12. Cost Accounting		X	
13. New Payment Models		X	This is a new area of focus
14. Quality Improvement		X	
15. Compliance	X		
16. Electronic Health Record Software in Use		X	

The remainder of this report describes who participated and offers more detailed information about the results. There's a lot of information here. Feel free to selectively read the detail and skip what's less important to you.

If you have any questions, please contact us via email at John@djconsult.net.

Readiness Assessment Overview and General Information

47 Agencies participated in the Assessment, encompassing 8,900 Full Time Equivalent (FTEs) staff and 309,000 clients served annually (duplicated). The following table provides an overview of the respondents. Agencies are categorized by small, medium and large, with each category comprising one third of the agencies responding, grouped by total numbers of full time equivalent (FTE) employees. It is important to note that a third of the agencies participating are serving more than two thirds of the clients.

	Large	**Med.**	**Small**	**Total/ Overall**
# of Agencies	16	16	15	47
Total Number of FTEs	6,611	1,951	400	8,962
Median FTEs/ Agency	287	117.5	32	120
Number of Direct Service BH Clinician FTEs (non-Medical):	3,222	1,173	199	4,594
Number of Direct Service Medical FTEs:	590	51	15	656
Total Clients Served	212,603	86,840	10,132	309,575
Median Clients/ Agency	7000	2900	460	2,500
% of Total Clients Served By All Agencies	69%	28%	3%	100%

Based on polling conducted during the two readiness assessment review webinars, 46% of the participating agencies contract with Mercy-Maricopa, 34% with Cenpatico, and 20% with Health Choice Integrated Care.

1. Client Needs, Levels of Care, and Caseload Management

77% of agencies estimate the behavioral health need of clients. Respondents identified the following average breakdown between behavioral and physical health complexity:

- 19% Low Behavioral Health/Low Physical Health Complexity, Risk, and Needs
- 42% High Behavioral Health/Low Physical Health Complexity, Risk, and Needs
- 11% Low Behavioral Health/High Physical Health Complexity, Risk, and Needs
- 29% High Behavioral Health/High Physical Health Complexity, Risk, and Needs

As illustrated by the table below, responses were reasonably consistent across all sizes of agencies.

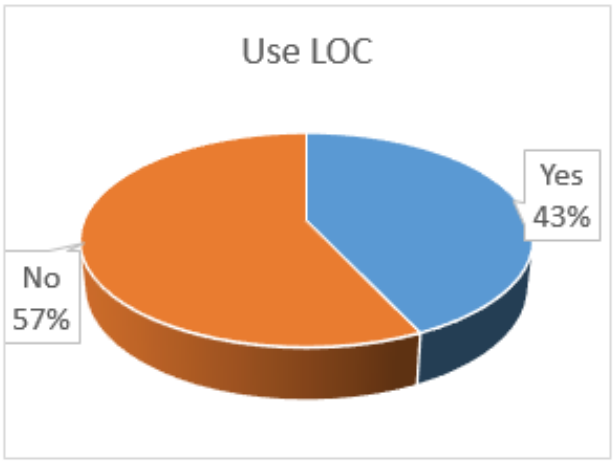
Complexity	Large	Med.	Small	Overall
Average % Low Behavioral Health/Low Physical Health Complexity, Risk, and Needs	16%	18%	22%	19%
Average % High Behavioral Health/Low Physical Health Complexity, Risk, and Needs	32%	49%	44%	42%
Average % Low Behavioral Health/High Physical Health Complexity, Risk, and Needs	16%	8%	7%	11%
Average % High Behavioral Health/High Physical Health Complexity, Risk, and Needs	35%	25%	26%	29%
Estimate BH Need	69%	81%	80%	77%

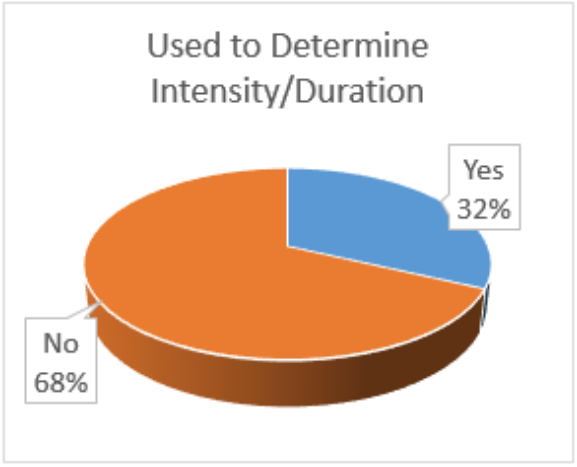
Level of Care (LOC)

You might need to work on this

Under half of the agencies use a Level of Care (LOC) System as a standard tool and about one third of the agencies use LOC to determine the duration and intensity of care. During the assessment review webinars, 71% of the participants thought that having a LOC System might be important to their RBHA; 44% thought they should wait to hear what their RBHA thinks before doing more work; and 40% thought they should begin working on Level of Care as soon as possible.

It is important to note the gap differences between the responses of the large agencies and





those of the small and medium ones, illustrated by the table below, with the largest agencies indicating much more robust use of levels of care.

Level of Care Utilization	Large	Med.	Small	Overall
Use LOC	75%	31%	20%	43%
Supervisors trained on LOC	69%	31%	20%	40%
Direct service clinicians trained on LOC	56%	31%	20%	36%
Clients assigned LOC	69%	31%	20%	40%
LOC used by clinicians to determine duration and intensity of care?	63%	19%	13%	32%
Reports provided to clinicians & supervisors on actual services provided, sorted by LOC	19%	13%	0%	11%
LOC information used in clinical supervision to identify utilization and quality problems and support client-level problem solving	31%	13%	0%	15%
LOC data aggregated at department and organization level and used on a regular basis for quality improvement	38%	6%	0%	15%

2. Access, Scheduling, and Engagement

Open Access and No Show Tracking

You report that you're good at this . . . but, you might need to work on this

Rapid Access to Care is one of the core elements of a Behavioral Health Center of Excellence and is widely recognized as a key performance indicator (KPI). This is because delays in access can result in no care, high no show rates, more acute care, higher cost care, and even higher prevalence of behavioral health disorders.

Clients, the general community, and partner organizations such as primary care clinics, hospitals, managed care plans and social service agencies have extremely positive opinions of organizations that are welcoming and able to see a new client/family with same day or next day access. This positive regard is further enhanced when the client/family is able to receive follow up care when they need it.

Without Rapid Access to Care, it will be extremely difficult to succeed in a value-based purchasing environment.

We know the use of Open Access and robust No Show Tracking are important measures for the RBHAs, so it is encouraging to see that a majority of all organizations, and particularly the larger ones, indicate they have implemented these practices, as reflected in the following table.

Access and Engagement	Large	Med.	Small	Overall
Use open access	75%	69%	60%	68%
Track no shows for individual services?	75%	50%	60%	62%
Track no shows for group services?	44%	44%	60%	49%
Track the number of no shows for each clinician/direct care staff?	56%	56%	40%	51%
Have a specific no show appointment policy and procedure?	69%	63%	53%	62%
Actively involve consumers in the development and on-going management of a self care plan?	81%	94%	93%	89%
Have a specific transfer/discharge protocol for cases that are not actively engaged in treatment?	94%	63%	73%	77%
Do you understand the reasons (root causes) for no shows?	88%	63%	60%	70%
Have you implemented strategies to reduce no show rates?	81%	69%	80%	77%
Do you routinely measure consumer satisfaction?	94%	94%	73%	87%
Does your organization use engagement strategies to support no-show reduction, medication adherence and retention in services?	94%	75%	87%	85%

While respondents report using Open Access, as the following table shows, very few agencies are able to accommodate clients within 48 hours for in-person assessments, appointments to develop the treatment plan following the intake/assessment, and appointments with a prescriber following the intake/assessment (totals do not add to 100% due to variance in responses).

	Days to Assessment	Days to Tx Plan	Days to Seeing a Prescriber
0 Days	11%	19%	9%
1 Day	9%	19%	9%
2-3 Days	13%	6%	9%
4-6 Days	6%	2%	0%
7-7.5 Days	28%	21%	4%
10-15 Days	4%	2%	0%
15+	4%	6%	26%

3. Evidence-Based Practices Use

You report that you're good at this

A Behavioral Health Center of Excellence is known for providing care that works. This success is based on:

1) doing a great job identifying client/family needs;
2) knowing the evidence base of what works;
3) engaging the client in care planning;
4) ensuring that all of the client's care is coordinated;
5) regularly monitoring progress with validated outcomes measurement tools; and
6) changing the care plan if the desired progress isn't occurring.

An organization that is able to provide this type of care has higher client/family success rates and will thrive in a value-based purchasing environment.

Fully 98% (all but one) of the agencies report using evidence-based practices (EBPs). 85% of agencies provide ongoing training and supervision in the use of EBPs and 81% routinely screen/assess for trauma.

Evidence-Based Practices Use	Large	Med.	Small	Overall
Provide on-going training and supervision in the use of evidence-based practices?	75%	88%	93%	85%
Routinely screen and assess clients for trauma?	88%	81%	73%	81%
Offer trauma-informed EBP and best practice treatments?	75%	81%	80%	79%
Provide treatment for co-occurring mental health and substance use disorders?	94%	88%	80%	87%

Below is a listing of the EBPs reported to be in use:

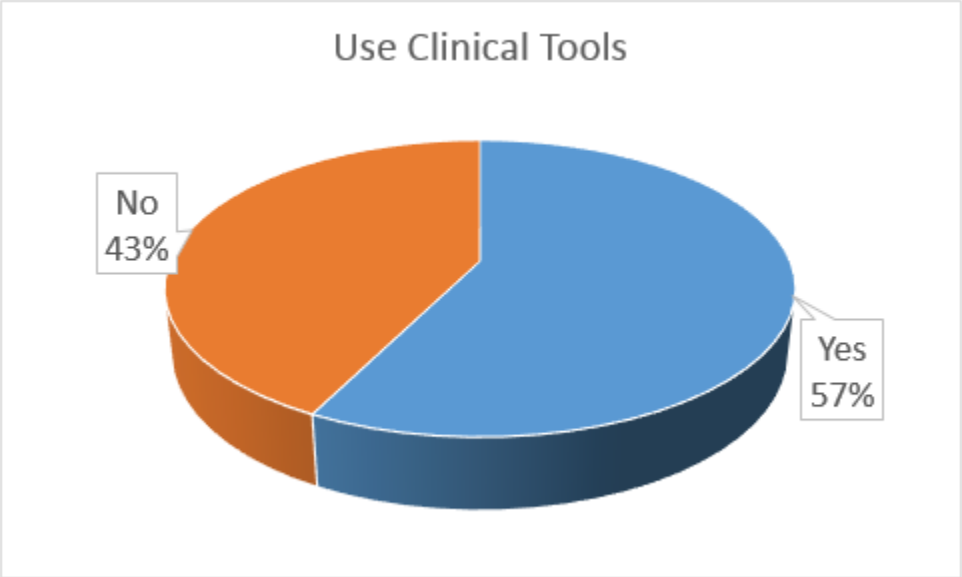
- Acceptance & Commitment Therapy
- A-CRA
- ACT
- Art Therapy
- Brief Solution Focused
- CBT
- CDSMA
- Child & Family Team Process
- Child Parent Psychotherapy
- DBT
- EFT
- Mindfulness
- Motivational Interviewing
- Nurturing Parent
- Peer Support
- Play Therapy
- Relapse Prevention Therapy
- Seeking Safety
- Stages of Change
- Structured Family Therapy
- Supportive Housing
- TF-CBT

- EMDR
- Forensic ACT
- Hazelden Living in Balance
- Matrix Model
- Medication Assisted Treatment
- Trauma Informed Care
- Triple P Parenting Program
- WHODAS
- WRAP

4. Outcome-Based Care

You might need to work on this, but you are making progress

As documented in the table below, 57% of organizations report that they use clinical tools to routinely measure effectiveness of care and client improvement. 81% of agencies develop care plans that include measurable targets (e.g., PHQ-9) and reported they adjust the care plan if goals are not being met. It is notable that just 44% of the largest agencies use clinical tools to routinely measure effectiveness of care and client improvement.



Outcome Measurement	Large	Med.	Small	Overall
Develop care plans that include measurable targets (e.g., PHQ-9) and adjust the care plan if goals are not being met?	69%	94%	80%	81%
Does your organization use clinical tools to routinely measure effectiveness of care and client improvement?	44%	63%	67%	57%

There is clearly progress underway in this area. However, because this is such a central component of payment reform, there is definitely room for improvement in getting all agencies to a standard of care where they are routinely using evidence-based clinical tools to measure improvement and effectiveness of care. Based on conversations during

the February 2015 Boot Camp, we think that the provider network can benefit from taking this work to the next level, reaching Treat to Target Fidelity as defined below.

Treat to Target Fidelity

1. A **multidisciplinary care team** works with an individual with behavioral health disorders to complete a multi-dimensional assessment;
2. The assessment is used to identify **specific and measurable goals** for the individual including at least one clinical goal and one personal goal;
3. The client and their team develop a **professional care plan** and **self-care plan** that includes setting targets related to the goals, utilizing validated tools to measure improvement;

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

4. The team supports **client engagement** throughout the process, engaging the client in all aspects of the care planning and treatment, understanding how the client is progressing through the stages of change, and providing high-touch care management;
5. The client and team **monitor progress** in a persistent and individualized way to determine whether the care is working, using the clinical measurement tools to determine whether the targets are being reached; this includes measuring progress at every visit for some of the tools;
6. There are **regular case reviews** with the team and with the client to determine whether the care plan is working or needs adjusting; if targets are not being met, care plans are changed;
7. **Electronically shared information** is available to all members of the care team, ideally through the use of a patient registry, including the care plans, medication list, and results from the outcomes tracking tools

Depending on the approach of each RBHA, providers will need to decide when to focus on this effort. 45% of webinar survey respondents think working on Treat to Target "Is

critical and we better get rolling ASAP." 38% of respondents think it "Is important, but I want to wait to hear what my RBHA thinks."

5. Clinical Improvement Tools in Use

You report that you're good at this

Respondents indicated that the clinical improvement tools listed below were in use.

- ASAM
- ASQ
- ASQS
- Beck
- BERS
- BMI
- BP
- CASII
- CASIJ
- CBCL
- Duke Profile
- EDI-3
- GAD-7
- GAF
- M3
- MHSIP
- ORS/SRA
- PAWS
- SASSI
- SBIRT PHQ-9
- SEARS-P
- Triple P
- WI-QOL

6. Individual and Population Health Management

You might need to work on this

Agencies generally report they have adequate capacity to measure individual and population health measures. Utilization of high cost services is an area of noted deficit with just 47% of agencies able to measure this for individuals, and 43% for clinic populations. This issue will need to be addressed to be successful as payment reform unfolds. The following table indicates agency responses related to their capacity to measure improvement in the following areas for individual and clinic population health management.

All agencies appear to need work to effectively measure utilization of high cost services for individuals and clinic populations (though mid-sized agencies may have a good start on this). Additional, the smaller agencies indicate gaps in their abilities to measure functioning (for clinic populations), the ability to self-manage or consistently use supports to manage chronic conditions (populations and individuals), and linkage to primary care services (populations and individuals).

% of Agencies that Measure	Lrg Ind	Lrg Pop	Med Ind	Med Pop	Sm Ind	Sm Pop	Overall Ind	Overall Pop
Functioning	75%	69%	69%	75%	60%	47%	68%	64%
Utilization of high cost services	44%	38%	50%	56%	47%	33%	47%	43%
Ability to self-manage or consistent use supports to manage chronic conditions	63%	50%	63%	56%	33%	20%	53%	43%

% of Agencies that Measure	Lrg Ind	Lrg Pop	Med Ind	Med Pop	Sm Ind	Sm Pop	Overall Ind	Overall Pop
Linkage to primary care services	69%	63%	75%	63%	47%	40%	64%	55%
Improved change in work, independent living, or social support status	81%	81%	63%	50%	67%	33%	70%	55%
Client satisfaction	88%	81%	88%	81%	87%	67%	87%	77%

7. Primary Care/Behavioral Health Integration

You might need to work on this, but you are making progress

Respondents indicate that primary care/behavioral health integration is well on its way in Arizona. 64% of organizations are fully integrated, co-located, or in a structured or unstructured partnership to work collaboratively to address the whole health needs of patients/clients. The table below summarizes respondents' approaches to integration.

Integration With Primary Care	Large	Med.	Small	Overall
Structured Partnership	13%	31%	27%	23%
Integrated	19%	19%	13%	17%
Co-located/integrated	25%	13%	7%	15%
Unstructured Partnership	0%	6%	20%	9%
Total Some Form of Defined Integration	**57%**	**69%**	**67%**	**64%**
Other	38%	6%	0%	15%
No Integration/Separate Treatment	6%	25%	33%	21%

As Arizona moves in the direction of full integration of behavioral health and primary care, these numbers will need to rise, particularly for the large organizations that serve the most clients.

8. Health Indicators

You might need to work on this

When asked to indicate which preventative health services or screenings their organization provides, respondents indicated that they are strongest in measuring/providing Health Education (72%), Blood Pressure (72%), and Body Mass Index (BMI - 68%). Fewer organizations are providing Weight Loss Management (43%), Tobacco Cessation (49%), or Chronic Disease Self-Management (49%).

The following table shows the preventative health services or screenings agencies provide. While all large agencies are providing at least some preventative health services or screenings, one in five of the mid-sized agencies and one in three small agencies provide NONE of the listed services/screenings.

Preventative Health Services Or Screenings	Large	Med.	Small	Overall
Measurement of height and weight (calculation of BMI)	94%	63%	47%	68%
Blood pressure	94%	75%	47%	72%
Heart rate and pulse	88%	75%	33%	66%
Tobacco cessation	69%	50%	27%	49%
Weight loss/management	56%	44%	27%	43%
Chronic disease self-management	75%	50%	20%	49%
Health education	94%	75%	47%	72%
Health risk assessment	81%	56%	40%	60%
None	0%	19%	33%	17%

The importance of work in these areas is underscored by webinar survey respondents – 57% think there is an extremely high likelihood that their RBHA will require tracking health indicators for all clients taking psychotropic meds.

9. Care Coordination

You might need to work on this

The purpose of care coordination activities is to ensure patients'/clients' needs are being met while avoiding fragmentation or duplication of services. Patients/clients with or at risk of developing complex, chronic conditions may need referrals to medical providers (within or outside the organization). Providers were asked about the extent to which their organizations coordinate care with other organizations. While 68% of respondents

indicate they are tracking referrals and sending information to the referral source, as the following table shows, a majority of small and about half of medium sized agencies report limited data tracking for most of the care coordination activities.

Care Coordination	Large	Med.	Small	Overall
Lab and test tracking	75%	44%	20%	47%
Referral tracking	69%	69%	67%	68%
Medication reconciliation	94%	50%	13%	53%
Service utilization and outcome data	31%	50%	33%	38%
Transitions between levels of care	69%	75%	20%	55%
Informal coordination occurs but is not tracked	56%	50%	7%	38%
Assist with accessing medical providers that take insurance/payer status of patient	69%	50%	33%	51%
Conduct appointment scheduling	56%	44%	7%	36%
Arrange/confirm patient has reliable transportation	63%	56%	27%	49%
Send necessary information to the referral source to ensure continuity of care (including reason for referral and relevant data/information)	81%	75%	47%	68%
Follow up with the patient and referral source that appointment was completed	44%	56%	20%	40%
Track results and follow up needs	25%	44%	20%	30%
Develop and enact appropriate response and follow up based on results of the referral(s)	25%	31%	20%	26%

10. Peer Supports

You might need to work on this

Individuals with the lived experience of patients/clients served by organizations can be extremely beneficial in providing services, such as wellness coaching, health education, outreach, benefits management, navigation. The following table illustrates the extent to which agencies use peer supports. While nearly all of the large agencies use some form of peer support, 38% of the mid-sized agencies and 47% of small have not begun this important work.

Peer Support	Large	Med.	Small	Overall
Our organization does not use peer supports/peer providers	6%	38%	47%	30%

Peer Support	Large	Med.	Small	Overall
Peer support personnel are members of the care team and participate in various team activities (treatment team meetings, communications, treatment plan development and support, document interactions in the health record)	88%	63%	47%	66%
Peers receive training in the conditions, approaches, treatments, side effects, and interactions among mental health, substance related and other health conditions	81%	50%	33%	55%
Peers receive regular supervision	81%	56%	47%	62%
Peers are employed commensurate with their skills, abilities and education	88%	56%	47%	64%

11. Third Party Billing and Collections

You might need to work on this

The following table provides a summary of the respondents who indicated they had "Completed" the respective activities related to third party billing and collections. Third party billing and collections is an area that will need improvement across all agencies to operate effectively under payment reform in the new integrated care RBHA structure.

Third Party Billing and Collections	Large	Med.	Small	Overall
We have strong processes in place to collect billing information for new clients and update that information regularly.	38%	56%	60%	51%
We have contractual relationships with all of the major payors that serve our clients.	56%	44%	73%	57%
We are effective at obtaining pre-authorizations and re-authorizations from our clients payors.	44%	56%	67%	55%
We bill all services within seven days of our cut-off date (weekly, semi-monthly or monthly).	63%	63%	27%	51%
We follow-up on unpaid and partially paid claims from insurance companies on a regular basis.	50%	56%	67%	57%
We use a sliding scale and effectively bill clients who are privately insured or self-insured.	38%	38%	20%	32%
All employees participate and have clear roles in supporting our billing and collection efforts.	25%	50%	53%	43%

12. Cost Accounting

You might need to work on this

The following table provides a summary of the respondents who indicated they had "Completed" the respective activities related to cost accounting. These responses indicate that this is an area where nearly all providers could benefit from focused technical assistance.

Cost Accounting	Large	Med.	Small	Overall
We have developed a way to use cost data from our general ledger to calculate the cost of every service provided by our organization.	13%	19%	33%	21%
We are able to use this per service cost data to summarize costs by client, clinician, team, program, and other relevant groupings.	6%	19%	27%	17%
We use this cost information to make internal resource allocation decisions, develop proposals for new programs, and determine where our organization is making and losing money.	25%	13%	40%	26%

During the assessment review webinars, more than 85% of responding participants indicated they would be interested in a 90 minute Technical Assistance Webinar devoted to Cost Accounting.

13. New Payment Models

You might need to work on this

The following table provides a summary of the respondents who indicated they had "Completed" the respective activities related to new payment models. These responses indicate that this is an area where providers could benefit from focused technical assistance.

New Payment Models	Large	Med.	Small	Overall
We have utilization management guidelines in place that provide guidance to clinicians on the range of service that should generally be provided to clients at each level of care.	31%	25%	7%	21%
We regularly report on how much service clients are receiving at each level of care and how this compares to our utilization management guidelines.	19%	6%	7%	11%

New Payment Models	Large	Med.	Small	Overall
Clinicians and supervisors use the utilization management guidelines and actual service utilization during clinical supervision.	13%	6%	0%	6%
We could use utilization and cost data to price out what it costs the average client at each level of care and then use this information to develop case rates for payors.	13%	6%	0%	6%

14. Quality Improvement

You might need to work on this

The following table provides a summary of the respondents who indicated they had "Completed" the respective activities related to quality improvement. These responses indicate that this is an area where providers could benefit from focused technical assistance.

Quality Improvement	Large	Med.	Small	Overall
We have a well-developed quality management process with an annual quality plan.	81%	56%	27%	55%
Our clinical staff are trained in quality improvement and use these skills on a regular basis to make improvements in how the system of care operates.	38%	25%	13%	26%
Our clinical support staff are trained in quality improvement and use these skills on a regular basis to make improvements in how the clients experience care.	38%	25%	13%	26%
Our administrative staff are trained in quality improvement and use these skills on a regular basis to make improvements in how they do their work.	38%	25%	13%	26%

15. Compliance

You report that you're good at this

The following table provides a summary of the respondents who indicated they had "Completed" the respective activities related to compliance.

Compliance	Large	Med.	Small	Overall
We have a designated compliance officer who monitors compliance efforts and leads problem solving efforts.	81%	81%	53%	72%
We have implemented compliance and practice standards through the development of written standards and procedures.	69%	88%	40%	66%
We conduct internal monitoring and auditing through the performance of periodic compliance audits.	88%	81%	53%	74%
We conduct appropriate training and education on compliance-related practice standards and procedures.	75%	50%	40%	55%
We respond appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities.	100%	100%	87%	96%
We have developed open lines of communication with staff to keep them updated regarding compliance issues and activities.	75%	56%	73%	68%
We regularly enforce disciplinary standards through well-publicized guidelines and practices.	63%	50%	40%	51%

16. Electronic Health Record Software in Use

You might need to work on this

Most agencies are using EMR/software products for: progress notes, client assessments, treatment plans, medication management (these are most likely acting as an 'electronic' file cabinet). **Fewer** agencies use EMR software for: appointment scheduling, crisis plans, wellness and recovery plans. There is **very low use** of software to track: labs, clinical outcome measures, clinical and quality reporting.

The following electronic health record software is reported to be in use (in order of usage):

1. NextGen
2. Credible
3. Netsmart
4. HMS
5. Custom
6. Claimtrak
7. Unicare
8. Welligent
9. SalesForce
10. Valant

During the webinars, 24% of the survey respondents indicate their organization has already signed up for The Behavioral Health Information Network of Arizona HIE, and another 35% indicated they are very likely to sign up.

Provider Perspectives on Current Reporting Requirements

Behavioral health providers across the state were asked to share their thoughts on state- and RBHA-level reporting requirements and regulations that create undue administrative burden and do not bring added value to service delivery practices and overall clinical care.

The majority of providers stated that most of the mandated reporting focuses on "process" rather than care and client recovery outcomes. Providers also stated that too many administrative resources were spent reporting compliance-related data requirements, such as demographics, service encounters, provider rosters, training lists, and requirements.

Another frequently cited administrative burden was the variability of reporting requirements across RBHAs and the lack of coordination between entities that mandate and request reports, and perform audits (e.g., RBHA, state, licensing board, Office of Human Rights). In addition, several mandated reporting requirements were reported as "excessive" in terms of the length of time required to complete, scope and appropriateness based on provider type, and frequency of reporting.

Finally, providers report that the data sharing and reporting process flows primarily in one direction – with a significant amount of data flowing to RBHAs and the state to meet compliance requirements, but limited information flowing back to the providers. Many providers indicated that they received data that are very important to clinical service delivery and care coordination (e.g., ED, inpatient hospitalization and pharmacy utilization data), however, these data are not reported consistently within or across RBHAs.

Appendix: Provider Perspectives on Current Reporting Requirements

1. Areas and Types of Process and Compliance Reporting Requirements Identified as Burdensome and Of Limited Clinical Utility

- Assessment & service plan timeframes
- Client Lists
- Demographics/Episode of Care
- Documentation for non-emergency transportation
- Licensed BHP review/signature within 48-72 hours on assessments and treatment plans
- Monthly Flex Fund Report
- Monthly Provider/Staff Roster
- Resubmitting new treatment plans for each new diagnosis
- Rules regulating case manager caseloads for high needs individuals
- Training Lists
- Training Requirements (not position relevant)

2. Regulatory, Reporting and Reimbursement Barriers and Challenges that Impact Service Delivery

a. Training and Credentialing Requirements

- Training requirements for staff are often not relevant to the position (e.g., Administrative Billing Staff with no patient interaction are required to take clinically-oriented courses; clinical providers are required to participate in trainings on billing procedures)
- Credentialing requirements for CEO, COO and other executive level staff who have no client interaction
- Variation across insurance companies regarding credentialing requirements
- Lack of reciprocity re: professional licenses, and State licensure reciprocity delays, results in shortages of licensed staff and impedes the ability to recruit outside of Arizona

b. State Agency Policies and Reimbursement Requirements

- Low provider reimbursement rates
- Arizona Board of Behavioral Health Examiners restricts the number of licensed professionals in the state when there are major shortages
- Encountering 100% of Crisis Based Services where we should be reimbursed for availability
- AHCCCS rule that requires clients to renew AHCCCS every six months, which leads clients to cycle on and off with frequent need to close and re-enroll
- Lack of funding for mandated positions
- Uncoordinated audits by multiple entities (RBHA, state, licensing, special offices such as human rights)
- Translating all service plan documentation into English for non-English speaking families, simply for auditing purposes.
- Perceived excessive intake requirements to open an episode of care and excessive discharge requirements to close an episode of care.
- Licensed BHP must see clients within 7 and 30 days
- Requirement to ensure residents have access to prescribed medications at all times, including when insurance does not cover the medication or the resident cannot cover required co-payment. This has become an additional financial burden on some providers.
- Funding cuts to translation services

- Court Ordered Evaluation: Requirement that a patient on COE must receive two separate psychiatric evaluations from two different psychiatrists significantly slows down the process.
- State Hospital: The state hospital has a self-imposed static population cap of 50 that has not changed despite the significant increase in the general population and a recognition that some people truly require that level of care and cannot live safely in the community.
- Housing: Rule of 8% limits apartment complexes from renting more than 8% of their housing to patients; this reduces available housing options in the community
- Federal 42 CFR restrictions impacts health information exchange and consent process

c. RBHA Authorization and Reporting Requirements

- Complex form to document psychotropic medication consent for outpatient clients.
- Poly-pharmacy pre-authorization rules and process, which can delay clients getting their medications.
- Frequent re-authorization required for residential placements.
- RBHA's determining/requiring exactly how many FTE's of certain positions a provider should have
- Rules regulating case manager caseloads for high needs individuals
- Assessment/service plan timeframes
- Each provider involved in care must maintain a full record including assessments, treatment plans, progress summaries, etc. instead of sharing via EHR.
- Most administrative tasks are non-billable.
- Update assessment & treatment plan to provide a bus pass.
- Financial reporting that changes format with each new RBHA.
- Pre-planned menu requirements, pushes agencies towards frozen, more processed foods, restricts fresh choices and what is in season or at the market or on sale, because you must stick with the pre-planned menu.
- Auto-enrollment policies make providers financially responsible for consumers they haven't even met.
- Physician service mandates that require 20-30 minute appointments for a routine medication management visit
- Due to the requirements of past MCOs it is now a common practice for a clinical team to amend a Court Ordered Treatment if a patient no-shows for an appointment, misses an appointment or is arrested. This is not a recovery-oriented approach to treatment and places a heavy burden on the crisis system and law enforcement community.

3. Volume of and Timelines for Requested Reports

- Number of reports in general - example: COT contact; HEA; Referrals and Transfers; Referrals to other agencies; SMI reconciliation; ACT capacity; Special Assistance; etc. (*See sample list of reports below*)
- Weekly requests for ad hoc reports with very little time to complete the reports. We have to drop everything to get the reports in.
- Length of Intake and Annual Assessment process (3 hours, including SCND/CASII).
- AHCCCS eligibility, CASII every 6 months
- Updating all annual requirements for youth on medication only services

4. Duplication of Effort and Lack of Coordination:

- Duplicative reporting to RBHA, DBHS, AHCCCS
- Lack of coordination and standardization across the RBHAs creates excessive burden on statewide providers.
- No standardization across the RBHAS for:
    - Financial reporting purposes

    - Claims processing
    - Data validation
    - Clinical data reviews
    - Deliverables are not consistent across all RBHA's
    - Release of Information/Client Consent
- Delays in attaining hospital D/C summaries and aftercare instructions

5. Examples of the Range of Required Data Reporting from Different Service Providers

- Contract compliance deliverables, Network Staffing Inventory, demographics reports, TPL information, Training Compliance Reports, plans (Compliance, QM, UM, BC, Pandemic, Cultural Competency, etc.), CPSA Supplemental Schedule
- Child Dedicated Recovery Coach Inventories; PCP transition logs; 7 day access to care report; Monthly Success Stories; Medical Integration Work Plan; Staffing lists; HEA Screening Reports; Access to Care reports; birth to 5 competency; IAD's
- Daily Patient Census; Hospital Hold Start/Stop Times; Patient Discharge Data; Incident Accident Death; Seclusion and Restraint; Enrollment and Encounters
- PASRR Report, Medical Care Evaluation Study Results, SSI-MAO Renewals, Quarterly Prevention Reports, Clinical Incidents, Seclusion/ Restraint Summaries, Sentinel Events, SMI Determinations, Corporate Compliance
- Caseload ratios; Member eligibility status; Census of members; ACT outcomes, staffing and caseloads; Incident Reports; Performance Improvement Plans; Discharge planning; monthly tracking; vacancy report; psych evaluations; psych rehab; incident/accident/death; Transitioning age youth; ISP percentage

6. What data do RBHAs report back to providers?

Compliance Related Data	**Adjudicated Claims Data**
• Claim Denials • EOBs • External Audit Results • Member Roster Reconciliation • Grievances Filed • AOE reports • Dashboards • LAG reports • Eligibility and Due for Renewals • Overdue Demographics	• ED • Inpatient hospitalizations • Pharmacy (however, not reported back consistently by RBHAs).