**FY 2015 Provider Network Development
and Management Plan**

Updated submission March 23, 2015

State of Arizona
Department of Health Services
Division of Behavioral Health Services
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I.   Introduction

Purpose:
The Provider Network Development and Management Plan's purpose is to align the Division of Behavioral Health Services' vision with oversight and monitoring of the Regional Behavioral Health Authorities, Integrated Regional Behavioral Health Authority, and Tribal Regional Behavioral Health Authorities provider networks, utilizing a foundation that supports an individual's needs.

Goals:
The Provider Network Development and Management Plan ensures the following:

- That covered services are as accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those services are to non-AHCCCS persons within the same service area;

- That covered services are provided promptly and are reasonably accessible in terms of location and hours of operation; and

- That there are sufficient personnel for the provision of all covered services, including available emergency care on a 24-hour a day, 7 days a week basis.

Service Delivery Structure
The Division of Behavioral Health Services, DBHS hereafter, contracts with Regional Behavioral Health Authorities (RBHAs), an Integrated Regional Behavioral Health Authority, and Tribal Regional Behavioral Health Authorities (TRBHAs), to administer managed care delivery services in six distinct geographic service areas (GSAs) throughout the State. This regionalized system allows local communities to provide services in a manner appropriate to meet the unique needs of individuals and families. DBHS requires the T/RBHAs to maintain a comprehensive network of behavioral health providers that deliver prevention, intervention, treatment and rehabilitative services to a variety of populations, including:

- Children and Adolescents
- Adults Diagnosed with a Serious Mental Illness (SMI)
- Adults Diagnosed with General Mental Health Disorders (GMH)
- Adults Diagnosed with Substance Use Disorders (SUD/SA)

As the first integrated RBHA, Mercy Maricopa Integrated Care began providing whole-healthcare for approximately 18,000 members diagnosed with a serious mental illness (SMI) in April 2014. In addition, services were provided for 700,000 other adult, child and adolescent members with general mental health and substance abuse services, most of whom are Medicaid or Medicare eligible in GSA 6. Mercy Maricopa contracts with a wide, community-based network of behavioral and physical health-care providers to deliver services to eligible members. This integrated care model will transform service delivery and yield better health outcomes, lower costs, improve population health and promote system reform from a payment and delivery perspective. A public, integrated, managed-care system of this scale is unique in the nation, and Arizona is leading the way.

The RBHAs
Similar to health plan network structures, each RBHA contracts with service providers to deliver a range of behavioral health care services. Arizona is divided into six GSAs served by the RBHAs:

- Mercy Maricopa Integrated Care serves Maricopa County and parts of Pinal County
- Community Partnership of Southern Arizona (CPSA) serves Pima County

- Northern Arizona Behavioral Health Authority (NARBHA) serves Mohave, Coconino, Apache, Navajo, and Yavapai Counties
- Cenpatico Behavioral Health of Arizona serves La Paz, Yuma, Greenlee, Graham, Cochise, Santa Cruz, Gila, and most of Pinal Counties

The Tribal RBHAs

In addition to RBHAs, DBHS has Intergovernmental Agreements (IGAs) with five of Arizona's Native American Tribes to deliver behavioral health services to persons living on Tribal reservations. The IGAs for Gila River Indian Community, Navajo Nation, Pascua Yaqui Tribe and the White Mountain Apache Tribe require provision of both Medicaid and state-subsidized services. The Colorado River Tribe IGA requires provision of only state-subsidized services. Services to other Tribes are provided and covered by the RBHA serving the geographic area. Tribal members will continue to have the choice of receiving their care through their Tribal Regional Behavioral Health Authority, tribally-operated behavioral health program or Indian Health Services.

Arizona Regional Behavioral Health Authorities
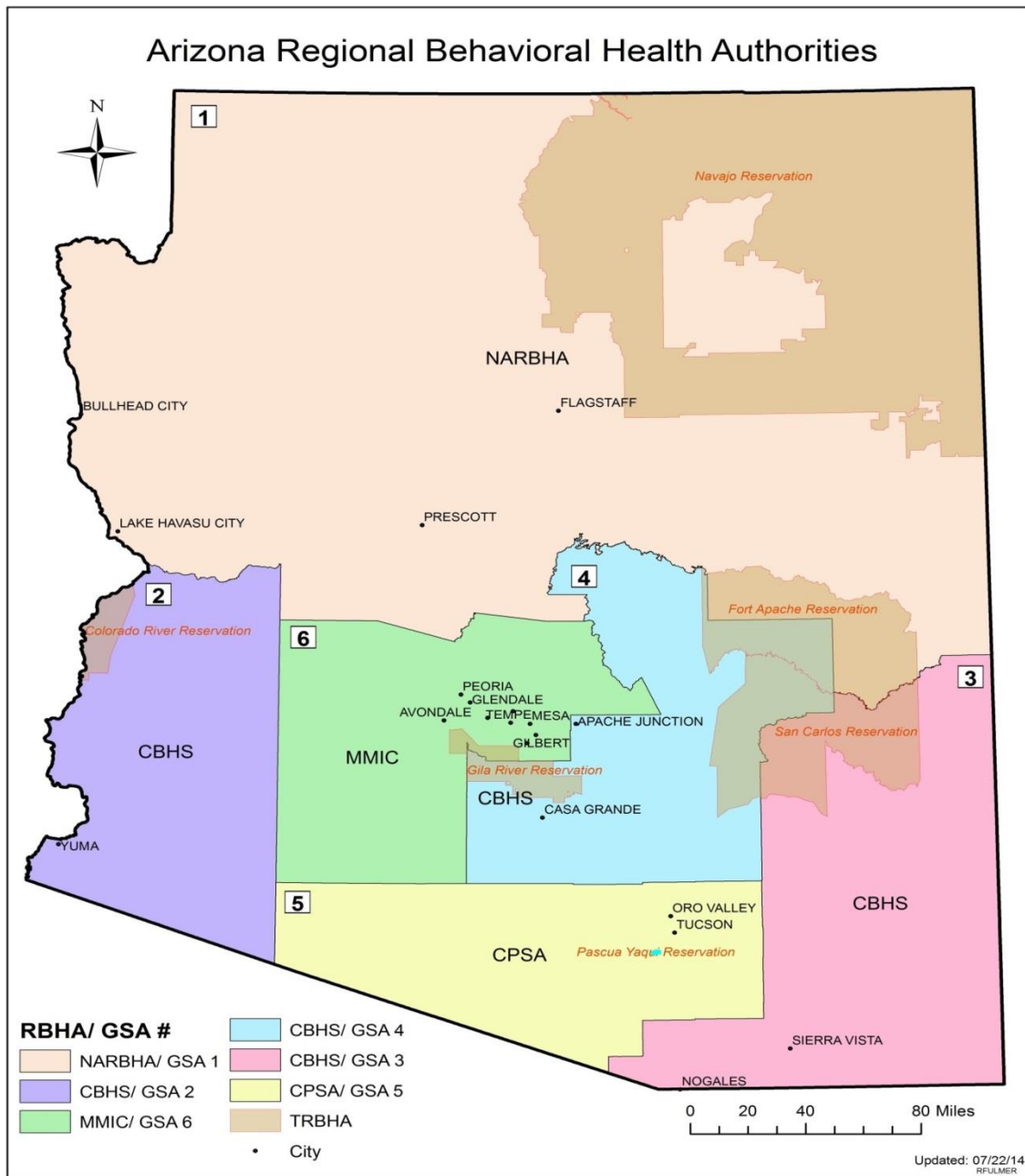
II.   Evaluation of Prior Year Plan

The FY14 plan implemented the geographic information system (GIS) minimum network standards for the continuum of care in the provider network. After careful evaluation, ADHS has determined that the originally set minimum network standards required modification to ensure members have appropriate access to the continuum of care. Inpatient and Subacute service types were combined due to like service array and the unique opportunity for rural areas to have sufficient access to Subacute without requiring hospital infrastructure. Behavioral Health Therapeutic Home and Community Service Agency standards were removed due to insufficient need to require geographical access to these specialized provider types. Additionally, integrated network standards for PCP and Dental Services were added for this year's evaluation as well as the change from 95% eligible members to 90% eligible members to align with medical management integrated minimum performance measures.

Geographic access requirements also required revision for urban and rural standards. ADHS requires all RBHAs to submit Provider Affiliation Transmissions; a network inventory method applied to increase process accuracy and efficiency. The chart below displays the change in mileage modifications for this year's report:

Behavioral Health Minimum Network Standards			
Service Type	Provider Billing Type	Geographic Access Requirement	
		Urban*	Rural*
Inpatient (with organized psych unit) & Subacute	02, 71, A6, B5, B3	decreased by 15 miles	decreased by 65 miles
Level I Residential Facility	78, B1, B2, B3	decreased by 40 miles	decreased by 55 miles
Behavioral Health Residential Facility	74, A2, B8	remained the same	decreased by 60 miles
Behavioral Health Therapeutic Home	A5	Standard removed	Standard removed
Behavioral Health Outpatient Clinic	77	remained the same	decreased by 25 miles
Community Service Agency	A3	Standard removed	Standard removed
Pharmacy	3	remained the same	decreased by 25 miles
* Urban includes GSA 5 & 6, Rural includes GSA 1-4			

All the modifications except for the three that remained the same for urban access provide improvement to the provider network. As eligibility and population changes, ADHS will be revising minimum network standards to meet the needs. This year by requiring the RBHAs to have compliance to lower distances, ADHS has observed several changes to the provider network.

A. Significant Provider Network Changes

NARBHA

Northern Arizona University based Behavioral Consultation Services of Northern Arizona (BCSNA), partnered with the Navajo Nation and DDD. BCSNA has a Navajo-speaking Behavioral Analyst placed on the Navajo Nation and dually enrolled members and their families are now being served through NARBHA's network. Peer and family support services were expanded this past year as well. This included Hope Lives, a forensic peer-run organization in Flagstaff; NAZCARE a peer-run Wellness Center in Winslow, and Family Involvement Center is a family-run organization developing additional family support services in NARBHA's network. The addition of Verde Valley Medical Center, a level I hospital located in Cottonwood was a significant change to Northern Arizona. This addition has lowered costs for transportation and provided family members with a greater opportunity to be involved. A behavioral health out-patient treatment center operated by the West Yavapai Guidance Center opened in Chino Valley in the spring of 2014. This center has established greater access to services and lower transportation costs in the sprawling suburbs of Prescott.

Cenpatico

Yuma Regional Medical Center opened a new Outpatient Clinic in July 2014 to expand service capacity for SMI and GMH/SA population in the Yuma area. Cenpatico added Caring Connections for Special Needs in Sierra Vista and Douglas. This addition has provided an expanded range of services provided to children with high needs. Oro Valley Hospital added an inpatient geriatric psychiatric program for ages 65 and older. This unit adds services for SMI and GMH/SA geriatric population within the Cenpatico network.

CPSA

Recovery Innovations/Recovery Opportunity Center in Tucson became a newly contracted provider for the RSSI Institute to provide additional Peer Support Employment Training. Sonora Behavioral Health Hospital adjusted their bed capacity for children and adults. They reduced the children's beds by 12 and increased the adult beds by 12. This change will provide additional beds needed for the adult population. CPSA added Bernalillo Academy in Albuquerque, New Mexico to their network in order to increase RTC Bed Capacity. Though it is out-of-state, it provides a placement option for children with cognitive delays who exhibit extremely aggressive behavior and who have not been able to successfully engage in outpatient treatment services in their community. Devereux of Arizona opened a 10-bed level I secure residential treatment center for adolescents this year. This addition has provides local options when an RTC is needed within CPSA's network.

MMIC

Visions of Hope, an outpatient clinic providing peer support, rehabilitation services, and homecare training services closed their doors in May 2014. Though this was an unexpected closure, other providers within the MMIC network assumed the services for the members that were impacted.   To assure all members successfully transitioned, MMIC provided Transition Grids showing the progression of the transition. MMIC is the first RBHA to advance an integrated network of behavioral health and acute care providers throughout central Arizona to meet the unique whole health needs of the populations they are contracted to serve since going live on April 1, 2014.

B. ADHS System of Care Plan

The Arizona Department of Health Services/Division of Behavioral Health Services FY2014 System of Care Plan looked at the four overarching goals:

- Goal 1: Promote a Recovery-oriented system of care that maximizes resiliency and independence for members and families;
- Goal 2: Improve the quality of behavioral health interventions;
- Goal 3: Reduce negative health impact due to abuse of alcohol and other substances among enrolled behavioral health members and non-enrolled citizens of Arizona; *and*
- Goal 4: Reduce the Arizona age-adjusted suicide rate from 17.2 to 15.0 per 100,000 by 2018.

Over the course of the year, the four Regional Behavioral Health Authorities (RBHAs) and three Tribal Regional Behavioral Health Authorities (TRBHAs) provided quarterly updates regarding steps taken to achieve the goals. System improvement was seen in all of the goals with marked progress evident around the promotion of a recovery oriented system of care.

Network Management utilizes the annual System of Care plan as one of the avenues to monitor network adequacy and sufficiency. Each RBHA utilizes the plan created by DBHS and individualizes their approach to meet the specific network needs of their network. Quarterly updates on their progress in meeting the goal and objectives are provide by each RBHA. Some of the highlights for last years' plan include RBHA specific approaches to the goals and objectives. Technical assistance and trainings have been provided on healthcare integration. Cenpatico incorporated *Coordinating Primary Care Needs of Clients for Paraprofessionals* curriculum into their workforce development offerings to advance workforce (1) understanding of four common chronic conditions, (2) recognition of warning signs that a member needs help to obtain medical treatment, and (3) insight into health risk and opportunities to educate members regarding

health issues / resources. Cenpatico is continuing to identify other trainings to complete their evolving integrated service curriculum. CPSA's provider network of CSPs now provides some form of chronic disease self-management groups for members in addition to resources and information. NARBHA created "A Whole Health Library" on their website to provide resources, clinical trials, blogs, supports and advocacy links to members, clinical teams, and the community.

NARBHA and CPSA implemented the Assertive Community Treatment (ACT) team pilot in their networks while Cenpatico is also incorporating ACT into each of their three GSAs this year. NARBHA's team will be located in Mohave County and they are in the process of hiring the team. CPSA's Clinical Network Management will continue to establish benchmarks for team ratios and service utilization, and will monitor to ensure member improvement and recovery.

The Children's System of Care Practice Reviews (SOCPR) continued this past year in all RBHAs. The results continue to provide valuable feedback in the planning and development of the next year's System of Care Plan at DBHS. The finalized system report and individual provider feedback sessions include discussion of any gaps in services and provides individualized feedback that the RBHAs can utilized for improvement at the provider level.

Another area was the monitoring of case management capacity. Cenpatico monitored capacity through the requirement that all High Need Recovery Centers provide their caseload numbers and inventories each month. All ratios related to members with Low to Moderate needs are monitored monthly to ensure the ratios are within expectations. CPSA Network Management continues to monitor the CSPs through Comprehensive and TXIX audits. Another example of monitoring caseload sizes is the inclusion of site level reporting of all caseloads in GSA 6's SMI system of care through the Quarterly Performance Improvement Plan.

III.   Current Network Status by Service Type

The provider network currently offers a broad range of covered services that support prevention, intervention and recovery focused activities. Through these services, members in Arizona are experiencing recovery, leading productive and fulfilling lives in the community, and are reaching out to others as peer and family support specialists. Qualified providers within each GSA deliver covered behavioral health services per contractual obligations. The table below provides an overview of service type availability by GSA. Mercy Maricopa Integrated Care is the only integrated plan that requires a contracted network for PCP, Dental and Specialist as an acute and behavioral health benefit.

Service Type	Provider Billing Type	GSA 1	GSA 2	GSA 3	GSA 4	GSA 5	GSA 6	Total # of Contracted Providers
Inpatient (w/organized psych unit) & Subacute	02, 71, A6, B5	23	14	1	3	33	89	*122
Level I Residential Facility	78, B1, B2, B3	6	4	0*	1	7	9	*12
Behavioral Health Residential Facility	74, A2, B8	52	19	4	9	68	146	*298
Behavioral Health Outpatient Facility	77	99	66	31	40	191	354	*618
Pharmacy	3	1178	999	32	49	1091	1125	*1237
PCP (Integrated RBHA only)							2264	*2264
Dental Services (Integrated RBHA only)							280	*280

Non-duplicative Providers Numbers

*Note GSA 3 does not have any physically located level I facilities, compared to the other two GSAs for Cenpatico, GSA 03 historically has had lower populations of members falling within the minimum network standards for Geographic Access. Not only is this GSA rural in nature, but it also has a large population of members in a higher income bracket thus decreasing the population of Medicaid recipients who access behavioral healthcare. The need for inpatient and

residential facilities is much lower in this GSA, resulting in a lower population of members meeting the network standards. When a member does require inpatient services, Cenpatico assures that these needs are accommodated through transportation services and other means such as tele-health when appropriate.

A. How Members Access the System

Acceptance of New Members
All RBHAs and their contracted intake providers are currently accepting new Title XIX and Title XXI members. Any AHCCCS eligible resident of Arizona can seek services from the delegated RBHA based on zip code of residence. DBHS publishes RBHA contact phone numbers via the ADHS website. The RBHAs continuously monitor the flow of new Title XIX and Title XXI members entering the behavioral health system. This monitoring focuses on the equitable distribution of new members to various providers and ensures access to all covered behavioral health services and members' ability to choose their service provider. Members can also access the system from the Emergency Departments (EDs) and Hospitals through a crisis mobile team. After the crisis has abated, the member is offered services through an intake agency. The RBHAs take multiple elements into consideration when monitoring network capacity; including appointment availability, timeliness of services, availability of funding, current utilization, staffing patterns, length of stay, referral patterns, number of active enrollments and member choice

Provider Choice
The RBHAs are contractually required to provide behavioral health recipients with a selection of providers. RBHAs are required to ensure that members are free to exercise their right to receive services from an alternative in network provider at any time. The RBHAs structure their provider networks in order to offer members choices of behavioral health services and qualified providers pursuant to 42 CFR § 438.6(m). The service array ranges from inpatient settings to community-based services which maximize member independence. Members are also provided with options when selecting case managers, medical practitioners, individual clinicians, and service locations. The Integrated RBHA is required to maintain Arizona licensed PCPs as allopathic or osteopathic physicians in its Provider Network that generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; certified nurse practitioners or certified nurse midwives; or physician's assistants (42 CFR 438.206(b)(2)). Mercy Maricopa Integrated Care continues to offer members freedom of choice in selecting a PCP within the network (42 CFR438.6(m) and may not restrict PCP choice unless the member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. Table 3 (below) depicts PCP choice for the SMI population in GSA 6. As of 9/30/14 enrolled SMY members in GSA 6 was 18,689. Thus all of these members have two (2) PCP choices fewer than two (2) miles and five (5) minutes from their place of residence.

TABLE 3

MMIC (GSA 6) SMI Member PCP Access		
MMIC SMI Members: 18,689	Miles	Mins
First Choice Average	1.37	3.5
Second Choice Average	1.84	4.57

Transportation Structure
Transportation is a key component of ensuring that members have access to medically necessary behavioral health services. The RBHAs and sub-contracted providers offer non-emergency and emergency transportation to members and/or families to help them receive and benefit from these services and facilitate achievement of their recovery goals. The RBHAs utilize provider-maintained vehicles, subcontract with dedicated transportation providers, provide bus or taxi vouchers, and gas vouchers. RBHAs must offer transportation services to support access to covered services. Emergency transportation providers are utilized when a member requires a higher level of transport. Additionally, the integrated RBHA provides transportation to all Medicaid eligible members for covered services including SMI members receiving physical health care services who have specialized health care needs such as dialysis, radiation and chemotherapy; ensuring that the member arrives no sooner than one (1) hour before the appointment and does not have to wait for more than one (1) hour after the conclusion of the appointment for return transportation. The Division uses information gathered during the annual Administrative Review as well as utilization complaint data to monitor RBHA compliance with transportation expectations.

Telemedicine Infrastructure

Telemedicine is generally described as the use of communication equipment to link health care practitioners and patients in different locations. DBHS recognizes the complexities of service provision within its rural communities; specifically in regards to obtaining qualified physicians who specialize in behavioral health care. The RBHAs have implemented telemedicine programs with several contracted service providers in order to provide better access to services. Telemedicine systems have enhanced the increasing cost efficiency, reducing transportation expenses, improving access to behavioral health providers and specialists, enhancing quality of care, and better communication among providers. Through telemedicine, members are able to access psychiatrists or psychiatric nurse practitioners in their own communities instead of having to travel. Services provided by physicians and nurse practitioners through telemedicine include diagnostic consultation and assessment (psychiatric diagnosis interview/examination and office/other outpatient visit for the evaluation/management of a new patient), psychotropic-medication adjustment and monitoring (pharmacologic management), and individual and family counseling (individual psychotherapy). Telemedicine is available in a majority of rural communities and is used in conjunction with face to face service delivery.

B. Relationships between Various Network Partners

DBHS requires that RBHAs ensure the timely response and provision of needed covered behavioral health services to members based on their individual clinical needs. This includes the provision of immediate behavioral health services. Immediate services are provided within a timeframe indicated by a member's behavioral health condition but no later than 2 hours from the identification of need or as quickly as possible when a response within 2 hours is geographically impractical. To meet this expectation, the RBHAs shape service accessibility and service delivery through various contractual and purchasing strategies; including block purchase contracts, funding pools, urgent care availability and contract/reimbursement incentives. Other methods to reduce emergency room utilization include:

- Availability of crisis appointments with medical practitioners at provider agencies to ensure that new enrollees and members do not run out of medication, that persons who requiring follow-up after inpatient or crisis services receive timely care, and that medication side effects are evaluated and attended to prior to the member's next scheduled appointment.

- Availability of on-call medical practitioners –providing telephonic consultation to determine appropriate interventions and access to medications as needed.

- Utilization of Telemedicine for medical practitioner interventions.

- Requiring medical practitioner clearance prior to emergency room referral.

- Telephone and mobile crisis triage availability 24 hours/day, 7 days/week.

- Development of comprehensive crisis plans to assist members in the event of a behavioral health-related crisis, individualized to the member's needs and detail how to access services during regular business hours, evenings and on weekends, as well as how to utilize natural supports.

- Utilization of Sub-acute and respite providers for crisis services.

- Direct admittance to psychiatric hospitals (Level I) when this level of care is required.

- Availability of generalist and rehabilitation services to assist with stabilization and support.

C. Availability of Methadone and Buprenorphine Provider Sites by GSA

GSA 1

A couple years ago NARBHA re-bid its opiate-replacement services and selected Southwest Behavioral Health (SBH) as the provider of opiate replacement services. SBH takes a holistic approach to opiate replacement services and has sites in Flagstaff, Bullhead City and Prescott Valley. NARBHA currently has nine medical practitioners who are certified to prescribe buprenorphine across northern Arizona.

GSA 2, 3, 4

IV Drug Users are served by all Cenpatico intake agencies and referrals are made to Methadone Specialty providers for those needing methadone treatment. Cenpatico intake providers are required to have Buprenorphine treatment available throughout GSAs 02, 03, and 04. The Yuma Treatment Center provides methadone treatment in GSA 02. In GSA 04, New Hope offers methadone treatment and in GSA 03 New Hope and La Frontera are the specialist agencies providing methadone dispensing peer support, employment, and living skills' training; enhancing treatment for IV drug users at all intake agencies. GSA 03 and 04 provide a smaller scope of service delivery for methadone in comparison to Yuma. All agencies have adequate capacity to serve IV drug users at this time.

GSA 5

CPSA, by contract, requires all CSPs to employ or subcontract with psychiatrists or physicians, waivered by the federal government, to prescribe methadone and/or buprenorphine to persons with substance-use disorders. CPSA's network includes three methadone sites and five doctors waivered to prescribe buprenorphine to adults; including three waivered to prescribe buprenorphine to youth. All are accepting new members and available to members throughout GSA 5.

GSA 6

Mercy Maricopa contracts with five (5) methadone providers and six (6) buprenorphine providers in their GSA and all are accepting new patients.

IV.   Current Network Gaps

Various methodologies are implemented to evaluate current network gaps. The analysis minimally includes RBHA compliance to minimum network standards for geographical access, single case agreement (letter of agreement) utilization, out of state placements, ADHS enforced corrective action plans, ADHS compliance to ACOM 436 minimum Network Standards and ADHS compliance to ACOM 417 Appointment Availability report.

A. Geographic Information Systems (GIS)

Ensuring accessible provider services is paramount to delivering the highest quality of care to AHCCCS eligible members. To ensure medical and behavioral health services are easily accessible by members, ADHS conducts in depth GIS analysis to determine acceptable geographical access limits to providers. This analysis can be used to highlight current access gaps as well as prediction aids for member eligibility changes. The regional behavioral health authorities (RBHA) are contractually required to submit a quarterly Provider Affiliation Transmission (PAT) file. The PAT file format and submission standards are developed and maintained by the Arizona Health Care Cost Containment System (AHCCCS). PAT file contents are loaded into the Client Information System (CIS) and used to conduct GIS analysis in conjunction with member enrollment databases. Both elements, the PAT file and member database, are geocoded to allow analysis within the GIS application. Geocoding the street address provided within each database results in a latitude and longitude ensuring the most accurate placement plotting to conduct analysis. Based on current and projected enrollment numbers, ADHS sets the minimum geographical access standards as follows for FY15:

Behavioral Health Minimum Network Standards				
Service Type	Provider Billing Type	Population Served	Geographic Access Requirement	
			Urban*	Rural*
Inpatient (with organized psych unit) & Subacute	02, 71, A6, B5, B6	Adults and Children	Max. distance does not exceed 10 miles for 90%eligible members	Max. distance does not exceed 60 miles for 90%eligible members
Level I Residential Facility	78, B1, B2, B3	Children only	Max. distance does not exceed 10 miles for 90%eligible members	Max. distance does not exceed 100 miles for 90% of eligible members
Behavioral Health Residential Facility	74, A2, B8	Adults and Children	Max. distance does not exceed 10 miles for 90%eligible members	Max. distance does not exceed 30 miles for 90% of eligible members
Behavioral Health Outpatient Clinic	77	Adults and Children	Max. distance does not exceed 10 miles for 90%eligible members	Max. distance does not exceed 10 miles for 90%eligible members

Pharmacy	3	Adults and Children	Max. distance does not exceed 10 miles for 90%eligible members	Max. distance does not exceed 10 miles for 90%eligible members
PCP (integrated RBHA only)		Adults	Max. distance does not exceed 10 miles for 90%eligible members	N/A
Dental Services (integrated RBHA only)		18-21 yr olds only	Max. distance does not exceed 10 miles for 90%eligible members	N/A
* Urban includes GSA 5 & 6, Rural includes GSA 1-4				

Based upon the ADHS/DBHS new Minimum Network Standards, as measured by the PAT file standards showing geographic access, NARBHA is meeting all standards. Despite NARBHA's vast geographic service area and the additional cost to establish clinics in small towns that do not have the member volume to achieve economies of scale, NARBHA continues to prioritize convenient access to covered behavioral health services. This focus on service accessibility is also reflected in the input NARBHA receives from members. Specifically, in NARBHA's 2013 Consumer Satisfaction Survey, 92% of children/youth/families indicated satisfaction with service accessibility and 85% of adults indicated satisfaction with service accessibility.

Cenpatico providers in GSA 02 utilize home-based treatment to ensure adequate access to services in outlying areas, such as Dateland (Yuma County) and Salome (La Paz County). Clinicians travel from Yuma to work with behavioral health members in outlying areas of Yuma County. Providers in La Paz County work in multiple locations and provide services outside of the clinic to ensure the population of La Paz County receives the care expected from the Cenpatico Provider Network. No action is needed due to accessibility of home-based services for persons in frontier areas. In GSA 02, over 91% of Cenpatico members fall within the minimum network standards in all categories excluding level one residential treatment centers (RTCs). While only 1.1% of children fall within the minimum performance standard for RTCs, Cenpatico prides itself on engaging community-based wrap-around support services in lieu of RTCs; offering high quality care in the least restrictive environment. Very few children are placed in RTCs annually; however, when it is deemed necessary, children are placed in RTCs and accommodations are made for families to stay connected to children placed a distance away from their homes. Cenpatico accommodates these needs through transportation services and other means.

In GSA 04, 77-94.8% of Cenpatico members fall within the minimum network standards across all categories. GSA 04, like the other two Cenpatico GSAs, is currently working with providers to increase peer and family run services and include more PFRO's in the network. Over the last year, there has been an increase in these services and Cenpatico will continue to pay particular attention to GSA 04 in an attempt to add more of these providers to the network in order to meet network standards.

CPSA ensures that a full array of services is available to all enrolled members regardless of site location by requiring contractors to provide services to members in their homes and communities as necessary. Additionally, CPSA continues to engage in development activities to enhance the system of care and increase service accessibility. With the opening of new development projects in 2013 and 2014, CPSA meets three (3) of the six (6) new minimum network standards. In regard to requirements not met, CPSA continues to expand access to inpatient beds through contracts with local hospitals. As soon as contracts are executed with Oro Valley Hospital and Carondelet, all inpatient facilities within GSA 5 will be contracted with CPSA. The lack of additional inpatient resources will make it difficult to achieve minimum-standard geographic access to this provider type, and CPSA will continue to address this gap through other methods of treatment and/or transportation to facilities in need. With the inability to develop a sub-acute facility for children due to the lack of adequate facilities in GSA 5, CPSA will continue to exceed the 10-mile requirement for this service type. Although, CPSA recently opened its first Level I Residential Treatment Center (RTC) for children to address this gap of service type. This has improved compliance with minimum network standards in this area for this service. All efforts are made to keep members in the least-restrictive environment possible, and utilization data show a lack of need for an adult RTC.

Based on the GIS analysis, there is one "non-compliant" measure for GSA 6; being the standard of accessibility measuring access to Level 1 facilities for members <18 y.o. The standard is 90% of members within 10 miles; ADHS

analysis indicates this to be 11 miles; one mile beyond the measure of compliance. This could be attributed to a statistical margin of error (+/- 1 mile) which should be taken into account for poor member and provider location reporting. The other "non-compliant" measure is for GSA 5 which is also the measure for access to Level 1 facilities. The "non-compliant" measure for Level 1 facilities in GSA 5 can be attributed to a large rural population within a urban designation for measuring access within GSA 5. Transportation services can be used to minimize the impact the additional distance may have on a member who is beyond the urban areas of Pima County (GSA 5).

Behavioral Health Minimum Network Standards								
Service Type	Provider Billing Type	Population Served	Average Distance for 90% of Population					
			GSA 1	GSA 2	GSA 3	GSA 4	GSA 5	GSA 6
Inpatient (with organized psych unit) & Subacute	02, 71, A6, B5, B3	Adults and Children	17	9	36	16	15	6
Level I Residential Facility	78, B1, B2, B3	Children only	77	66	82	26	16	11
Behavioral Health Residential Facility	74, A2, B8	Adults and Children	25	11	18	9	9	3
Behavioral Health Outpatient Clinic	77, IC	Adults and Children	4	4	2	2	7	4
Pharmacy	3	Adults and Children	2	2	2	3	3	1
PCP (integrated RBHA only)		Adults	NA	NA	NA	NA	NA	2
Dental Services (integrated RBHA only)		18-21 yr olds only	NA	NA	NA	NA	NA	4
* Urban includes GSA 5 & 6, Rural includes GSA 1-4								

B. Single Case Agreements

Letters of intent (LOIs) and/or single-case agreements (SCAs) are utilized when a member receives or is in need of a service from a provider outside the network. Execution of such agreements brings the provider into the network; eliminating any repeated use of providers without a written agreement and reducing the prevalence of any member receiving services "out of network." For FY14 there were a total of 756 single case agreements for GSAs 1, 2, 3, 4, and 5 with the most frequently used is provider type 78 being level I psychiatric hospital. More specifically, based on the data from all RBHAs on SCA utilization, hospitals are frequently used as SCA when the member experiences a clinical need in a different city than their place of residence. Although each RBHA has a sufficient network of hospitals that are physically located within their geographical limits, not all behavioral health needs occur in the member's home region.

NARBHA's utilization of single case agreements indicates that there is a shortage of respite providers, a need to contract for more in-state inpatient resources for children who are dually enrolled (DD/BH) and behavioral health residential services for members living with SMI. In the coming year, NARBHA will be expanding respite capacity; developing intensive in-home Behavioral Analysis for dually enrolled members and their families and a residential facility for adults with SMI in Navajo County. Cenpatico's SCA were done for members who were currently outside of their home geographic service area. In FY2013, approximately 70% of the SCAs were for Level I facilities that have declined contracting with Cenpatico, or were emergent one time admissions. In FY2014, this trend continued with approximately 60% of the SCAs representing Level I facilities that declined contracting with Cenpatico or were emergent on time admissions. CPSA children are the highest utilizers of LOI services; accounting for 95% of all LOI encounters, 88% of which are Title XIX. Over 83% of LOI encounters were for children's out-of-region residential services. The adult population makes up only 5% of all services encountered by providers under an LOI. All adult utilization occurred in hospitals, special hospitals and/or behavioral health inpatient facilities. MMIC did not have any SCAs to report as the integrated contract that began 4/1/14 as all relinquishing RBHA providers were authorized payment for six months post implementation. The physical health network for the integrated

RBHA is robust and comprehensive that to date that no SCA's have been executed as all providers accept AHCCCS rates. The below table presents the SCA statewide data for FY14 yet captures SCA's for MMIC March 2015:

Provider Name	Provider Type	NARBHA GSA 1	Cenpatico GSA 2	Cenpatico GSA 3	Cenpatico GSA 4	CPSA GSA 5	MMIC GSA 6	Total
Abrio	39	16						16
Arise, Inc.	39						2	2
Arizona Center For Change	77						2	2
Arizona Counseling & Treatment	77						1	1
Ascend Bhvrl Hlth Gambit House	B8						19	19
Aurora Behavioral Health	71	4	15	7	67	30		123
AZ Behavioral Care Homes	B8						41	41
AZ Mentor Jasmine House	B8						13	13
Banner Behavioral Health Hospital	71	5	3	2	34	29	1	74
Banner Good Samaritan Hospital	71		4	1	12			17
Banner Thunderbird Hospital	71				1			1
Bentley's Transitional Living	B8						17	17
Bernalillo Academy	B1	5				1		6
Bescare Homes	B8						4	4
Better Horizons Behavioral Health	B8	4					13	17
Burkeshire	49						1	1
Carollo, Paul	87						2	2
Carondelet St Joseph Hospital	71		1	15	1			17
Cedar Sanctuary	B8						3	3
Center For Discovery	78						2	2
Change Academy At Lake Ozark	B3					1		1
Child & Family Support Services	77				4		7	11
Community Counseling Center	77			1	10			11
Compass Behavioral Health	71			3	1			4
Cope Inc	77			15				15
Copper Hills Youth Center	B1					3	12	15
Cottonwood Treatment Center	B3	9						9
Crossroads	B8						5	5
Davis Hospital And Medical Ctr.	B5					1		1
Desert Rain	77						1	1
Desert Vista	71				4			4
Devereux Florida	02						5	5
Devereux Georgia	B1						1	1
Devereux Texas	71					3		3
Dr. Fernando Armendariz	11		18					18
Dr. Renee Roberts	11			5				5
Dr. Shannon Biggins	11			3				3
Edalatian, Neshat	87						1	1
Emmarie Behavioral Health	B8	2					20	22

Provider	Code						Total
Encourage Empowerment	77			3			3
Eureka Imperial Residence	B8					1	1
Exempla Lutheran Medical Center	2				1		1
Family First Counseling	77			42			42
Flagstaff Medical Center	71		2		1		3
Florence Crittenton	74			2			2
Fresno Community Hospital	2				1		1
Friend, Susan	85					3	3
Gentry, Joseph	11					1	1
Grossman & Grossman	77					14	14
Grossmont Hospital	71		1				1
H.O.P.E. Inc	77					1	1
Haven Senior Horizon	71					14	14
Healthy Futures	77					15	15
Hope Group Dba Highland Behavioral	77					5	5
Horizon Human Services	77	3				4	7
House of Hope	A2			9			9
Human Resource Training	77					2	2
Human Service Consultants	77					1	1
Institute For Child And Family	77					1	1
Intensive Treatment Systems	77			1			1
Jersey Shore Univ. Medical Center	2				1		1
Jesa Homes	B8	6				1	7
JFM Inspirations Counsellng	B8					22	22
Popkey, Kimberly	87					1	1
LAMAC House	B8	3					3
Lateef Behavioral Care Home, LLC	B8	2	7	4		3	16
Lewis, Alan	11					6	6
Lifewell	77			2			2
Little Colorado Behavioral Health	77			6			6
Luminaria Group Home	74		2	1	1		4
Marisol	B8					2	2
Mark Allen Foundation	B8					28	28
Marsh, LPC Julie	87					21	21
Massachusetts General Hospital	71			1			1
McCoy, LPC, Jay R.	87					1	1
MIHS	71		1	2	9		12
Mirasol, Inc.	B8				6		6
Mohave Mental Health Clinic	77					1	1
Montevista Hospital, Psychiatric	71	17	1				18
Mountain Top Behavioral - Fraktur	B8					5	5
New Vision Behavioral Health & Wellness	B8					1	1

Provider	Code							Total
Newman, LPC, Gail	87						5	5
Northland Family Help Center	B8	5						5
Ohm, Tammy	87						2	2
Orion Homes LLC	B8						1	1
Pettitt, Deborah	77						1	1
Phoenix Children's Hospital	2	2						2
Phoenix Children's Hospital	71				10			10
Pineview Hospital	71		1		1			2
Pioneer Valley Hospital	2					1		1
Presidio Counseling	77			4				4
Providence	77						1	1
Rodrigues, Shawn / The Heart Of The Matter	87						6	6
Rosewood Ranch	B5	2				3	24	29
Salomon, Felix	11						1	1
San Marcos Treatment Center	78	1		6	9	3	33	52
Schulte, Robert	08						1	1
Sequel Care - Mingus Mountain	B8						1	1
Smilth, Laura	77						1	1
Sonora Behavioral Health	71						1	1
Spring Mountain Sahara Tx Center	78	10						10
Spring Mountain Sahara Tx Center	71		2		1			3
St. Luke's Behavioral Health	71					15		15
Successful Journeys	B8	8						8
Sugar, LCSW, Sue	85						1	1
Sunrise Behavioral Health	B8	5						5
SWBH-Prescott	77						2	2
Texas Neurorehab Center	71	1				1	2	4
Texidor, PhD Alberto J.	11						1	1
The Eagle Watch	B8						1	1
The Guidance Center	77				2			2
The Resolution Group	77						1	1
University Physician Hospital	71			11	5			16
Uph Kino Hospital	71		3	19	7			29
Valley Center For The Deaf	39						2	2
Valley Hospital-Phoenix	71	6	24	24	62	5		121
West Yavapai Guidance	71		1		10		2	13
Windhaven Psychiatric Hospital	71				2	1		3
Wooten, PhD, Buffy Terry	11						2	2
Wright, Kimberly	11						1	1
Youth Development Institute	B1				5			5
Zaccari, LCSW, Annette	85						2	2
TOTALS		**116**	**86**	**125**	**323**	**106**	**422**	**1178**

The yellow highlighted providers indicate out of state providers, based on this data the table below represents the percent of which single case agreements are with out of state providers:

GSA #	GSA 1	GSA 2	GSA 3	GSA 4	GSA 5	GSA 6	Total
Total # SCA	116	86	125	323	106	422	**1178**
Total # of Out of State SCA	33	1	6	9	11	55	**115**
% Out of State	28.45%	1.16%	4.80%	2.79%	10.38%	13.03%	**9.76%**

Process on those providers for who Single Case Agreements have been utilized multiple times to gain them in the network.

GSA 1
On an annual basis, NARBHA's Provider Services Department conducts utilization analysis of single case agreement providers. If a Single Case Agreement provider has delivered more than 25 services in the past year and is expected to deliver more than 25 services in the upcoming year then discussions are initiated to bring the single case agreement provider into the network.

GSA 2,3,4
Providers who have been issued multiple SCAs are submitted to a Potential Provider Committee meeting by the Contracts Department to explore adding them to the network. All providers who have been issued 20 or more SCAs are reviewed by the Committee. Once the agency has been approved by the Potential Provider Committee, the contracts department outreaches the provider to discuss contracting. If the provider agrees to pursue a contract, the contracts department helps potential providers through the credentialing and contracting process until a contract is executed. The agency is then invited to a monthly onboarding or orientation to answer their questions and orient them to the Network and contract requirements.

GSA 5
CPSA does not utilize single-case agreements (SCAs), but instead executes letters of intent (LOIs) when a member receives, or is in need of, a service from a provider outside the CPSA care system/network. Both CPSA and its CSPs may execute LOIs to ensure continuity and availability of care for members. Execution of such agreements brings the provider into the CPSA network, eliminating any repeated use of providers without a written agreement and reducing the prevalence of any member receiving services "out of network."

GSA 6
MMIC's contracts department conducts utilization analysis of single case agreement providers. If a Single Case Agreement provider has delivered more than 25 services in the past year and is expected to deliver more than 25 services in the upcoming year then discussions are initiated to bring the single case agreement provider into the network.

C. Out of State Placements

Members who require out-of-state placement are identified by their Child and Family Team (CFT) or Adult Recovery Team (ART) when it is determined:
- A child or young adult needs specialized programming not currently available in Arizona to effectively treat a specified behavioral health condition;
- An out-of-state placement's approach to treatment incorporates and supports the child's or young adult's unique cultural heritage;
- There is a lack of current in-state bed capacity; *and/or*

- Geographic proximity encourages support and facilitates family involvement in the person's treatment.

Decisions to place children or young adults in out-of-state placements for behavioral health care and treatment are examined closely and made after the CFT or ART have attempted and submitted information to review for all other in-state options. Other options may include single case agreements with in-state providers that would allow enhanced programming or staffing to meet the specific needs of the person or the development of an Individual Service Plan (ISP) that incorporates a combination of support services and clinical interventions and takes advantage of the full extent of all available covered services to meet the clinically identified needs of the child or young adult. In addition to exhausting all in-state treatment options, the following coordination efforts/processes are made:
- The CFT or ART has been involved in the service planning process and is in agreement with the out-of-state placement;
- The CFT and ART has determined how they will remain active and involved in service planning once the out-of-state placement has occurred;
- A proposed ISP that includes a discharge plan has been developed that addresses the needs and strengths of the person;
- All applicable prior authorizations requirements have been met;
- The Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the Arizona Department of Education Academic Standards and the specific educational needs of the member;
- Coordination has occurred with other state agencies involved with the person, including notification to the DDD Medical Director when the member is enrolled in this funding category;
- The member's AHCCCS Health Plan Behavioral Health Coordinator or health care provider has been contacted and a plan for the provision of any necessary non-emergency medical care has been established and is included in the comprehensive clinical record. T/RBHAs must clarify for providers in their policies and procedures who is responsible for this activity;
- Cultural considerations have been explored and incorporated into the ISP; *and*
- In the event that a member has been placed out-of-state secondary to an emergency situation or unforeseen event, the T/RBHA must address all above conditions as soon as notification of the out-of-state placement is received.

An analysis of network gaps resulting in out-of-state placements revealed a need for treatment for sexual offending and sexually maladaptive behavior, autism spectrum disorder, extreme aggression, and behavioral health treatment for members with cognitive delays. Plans to develop and increase the number of acute, sub-acute, and residential facilities have been discussed as a strategy for expanding in-state services to minimize or alleviate the need for out-of-state placements. In the meantime, T/RBHAs have sought to contract with existing providers credentialed to address the aforementioned network gaps. For example, effective October 1, 2014, CPSA added Bernalillo Academy to their provider network. Bernalillo Academy specializes in the treatment of children with cognitive delays, who exhibit extremely aggressive behavior. While Bernalillo Academy is an out-of-state provider (New Mexico), it allows for a placement option and increases bed availability for Residential Treatment Centers (RTCs).
Several supportive services are in place to manage continued in-state progress. Identified supportive services currently in place for members upon their return include intensive outpatient treatment, peer and family support services. Intensive outpatient treatment offers an array of services such as medication management along with individual and group therapy. Support services such as Meet Me Where I AM (MMWIA) is focused on meeting children and families where they are in the community and in their recovery. Family support services are available statewide to ensure the member's family is supported in its efforts to maintain the member in the home and community. Specialty providers are also available to help meet the needs of members with special needs such as members with sexually maladaptive behaviors or members in the DDD system.

Strategy for expanding in-state services to minimize or alleviate the need for out of state placements for programs to address eating disorders:

GSA 1

NARBHA currently contracts with Rosewood Hospital in Wickenburg for inpatient services for members with eating disorders. In the past year Rosewood has served four NARBHA members. For out-patient services, NARBHA contracts with psychologist Laura Lynn, based in Flagstaff, for members who need specialized therapy for eating disorder issues. Dr. Lynn served five members in FY14. NARBHA has not referred members for out-of-state services for eating disorders in the past year.

GSA 2,3,4

Currently Cenpatico has no out of state placements and has never placed a member out of state for eating disorder treatment. Cenpatico provides high touch care management when a member is identified as having a severe eating disorder. Outpatient treatment teams are developed to include a nutritionist, the member's PCP, a psychiatrist, a therapist, the member's Recovery coach (Case Manager) and home-based support services. Additional team members may be added dependent upon the member's needs. In rare situations, short term residential services are provided through a Tucson-based specialty agency. This approach has met the needs of their members to date.

GSA 5

In FY15, CPSA again placed less than 1% of its total population out-of-state. Placements continue to be limited to unique situations in which specialized providers are required to meet a member's specific needs. These unique situations often include a need for treatment for sexually maladaptive behavior, extreme aggression, symptoms related to autism and hospitalization for crisis episodes that occurred when a member was out of state. CPSA has utilized a local provider to offer eating disorder treatment to both adults and adolescents, as needed. Other in-state residential facilities have been identified as able to address eating disorders as well. Upon identification of member need, CPSA would establish a letter of intent (LOI) with any one of these providers to offer eating disorder treatment to an enrolled member. In FY15, no out of state placements have been authorized to treat eating disorders.

GSA 6

Mercy Maricopa is in the process of exploring a contract with an outpatient provider who specializes in eating disorders which is located in the North Phoenix area. Mercy Maricopa also reviews prospective provider applications for the presence of this specialty so that they may conduct site visits to assess their expertise and use as necessary. MMIC is currently contracted with two providers that specialize in eating disorders both with an expansive continuum of care. Community Connections is an in-network residential eating disorder provider who also has intensive outpatient services. Mercy Maricopa also holds single case agreements with Rosewood Treatment Center, an inpatient eating disorder provider that has had a long-standing relationship with the Maricopa County Regional Behavioral Health Authority (RBHA). Rosewood also has a broad array of services and levels of care. Rosewood has been approached many times to contract with the RBHAs, but has declined to date. These two providers are both located in Arizona and assist in keeping members treatment local.

Specific services and available providers as it applies to identification of supportive services in place to manage continued in-state progress by GSA:

GSA 1

NARBHA continues to expand support services to reduce out-of-state placements. To provide families with rest and relief, NARBHA has eight BH Respite Homes through West Yavapai Guidance Center that are in the process of getting licensed – the first such homes in the state. NARBHA is also working with MIKID and Mohave Mental Health to expand respite services in Mohave County. To expand services, NARBHA is in discussion with Intermountain Centers for Human Development to expand HCTC and related support services in northern Arizona. To support dually enrolled members (DD/BH), NARBHA has expanded the contract with Behavioral Consultation Services of Northern Arizona (BCSNA) for the delivery of parent education and intensive in-home services for families who are struggling and may be at-risk of a member needing out-of-home or out-of-state placement.

GSA 2,3,4

Cenpatico has no children in out-of-state placements and has only had three in the last 10 years. This was achieved through the development of High Need Recovery Centers to focus attention on serving persons with High Needs, the

consistent adherence to the Arizona Vision and 12 Principles, and the careful execution of Meet Me Where I Am (MMWIA). The use of 24/7 Support and Rehabilitation services is a key component to their MMWIA programming. The services provided include but are not limited to:

- Access to services outside normal business hours and on the weekends to accommodate members' needs;
- Respite for family relief to avoid escalation of behaviors;
- Family support services to help parents and caretakers obtain support;
- Skills training to ready youth for independent living;
- Parent training and Functional Behavioral Assessments to help caretakers respond effectively to childhood behaviors;
- Personal care services including teaching members how to maintain their own living space;
- HCTC if a placement is needed short term outside of a biological or foster home;
- Flex funds for sports dues or uniforms, art class fees, etc. ;
- Low Recovery Coach to member ratios for members with High Needs with no more than 20 members per Dedicated Recovery Coach;
- Child and Family teams led by trained and certified facilitators;
- Community Based Crisis Services; including our Brief Intervention Program and the Assessment and Intervention Center.

GSA 5

Comprehensive Service Providers (CSPs) and other contracted specialty agencies offer an array of support services to ensure appropriate treatment for members residing in-state. Each member's needs are reviewed, and support services are implemented on an individualized basis. While a full array of services are offered to members, providers frequently encounter support and rehabilitation services to ensure continued progress in treatment. Members with specialized needs who may otherwise need out-of-state placement are often offered therapeutic residential placement (with or without one-to-one staff authorization) or intensive in-home services, medication management, individual and/or family therapy, vocational training, skills training, family support and case management.

GSA 6

Mercy Maricopa maintains a sufficient provider network of in-state providers that provide the full complement of supportive services for C/A, GMH/SA and SMI as outlined in the ADHS/DBHS Covered Services Guide. Members receive these services as clinically indicated and can access them at a variety of provider types including, outpatient, residential and inpatient settings. If a service were to be unavailable in their network, they would enter into an in-state single case agreement with an out of network provider, and focus on bringing up network sufficiency in that identified area. To date, no member has been referred out of state in order to obtain a support service.

Presented below is the total number of out of state placements by RBHA, population type and location.

FY14 Out-of-State Placements					
RBHA	Total # of Out-of-State Placements	DDD	CMDP	Out-of-State Providers Used by RBHAs	
				Name and Location	Population Served
Cenpatico	3	0	1	San Marco Center, TX	San Marco specializes in children between the ages 8-18 with IQs of 50 and above with developmental delays and sexual behavior problems.
CPSA	9	4	3	Bernalillo Academy, NM	Bernalillo Academy specializes in working with children between the ages of 5-17 with a diagnosis of Autism Spectrum Disorder, Developmental Delays, Neurobehavioral Challenges and Neurodevelopmental Disorders.

				Copper Hills Youth Center, UT	Copper Hills specializes in working with adolescents aged 12-17. Copper Hills offers a programs for autism spectrum disorder , sexual misconduct, and substance abuse therapy
				Devereux, TX	Devereux (TX) specializes in working with children and adolescents who have moderate to severe behavioral problems.
				San Marco Center, TX	See above for services offered
MMIC	22	14	2	Devereux, FL	Devereux specializes in working with members diagnosed with Autism who have moderate to severe behavioral challenges and/or significant deficits in adaptive skills.
				Texas NeuroRehab Center	Texas NeuroRehab Center works with member between the ages of 8-17 with IQs that fall between 40-90. The member may be facing a combination of complex medical, behavioral, social and learning difficulties.
				Copper Hills Youth Center, UT	See above for services offered
				San Marco Center, TX	See above for services offered
NARBHA	20	2	5	Cottonwood Treatment Center, UT	Specializes in working with adolescents and young adults aged 12-21. Cottonwood offers specialized treatments such as: Dialectical Behavioral Therapy (DBT) and Neurofeedback Therapy.
				Montevista Hospital, NV	Montevista is a chemical dependency hospital that specializes in children and young adults aged 12-21
				Bernalillo Academy, NM	See above for services offered

D. Corrective Action Plans

Corrective Action Plans (CAP) are a method of enforcement ADHS uses to ensure contractual requirements are being executed by contractors. Historically, when a CAP is imposed the RBHA must submit a plan for ADHS approval with requested deliverables to ensure milestones are met to obtain full compliance with the specific issue. Provider Network Issues that occurred over the prior year that required ADHS intervention are as follows:

RBHA	Type	Description
Cenpatico	Corrective Action Plan	Behavioral Health Service Provision for Adults
Cenpatico	Corrective Action Plan	SMI Edibility Determination
Cenpatico	Corrective Action Plan	UM Data Validation
CPSA	Corrective Action Plan	Access to Care
CPSA	Corrective Action Plan	Behavioral Health Service Provision Corrective Action Plan
Magellan	Corrective Action Plan	Behavioral Health Service Provision Corrective Action Plan
Magellan	Corrective Action Plan	CMDP - Behavioral Health Service Delivery
Magellan	Corrective Action Plan	Coordination of Care
Magellan	Corrective Action Plan	Notice of Action Requirements - NOA
Magellan	Corrective Action Plan	Provider Oversight and Monitoring - Network Sufficiency (UPC)
Magellan	Corrective Action Plan	Recovery Response Center - RIAZ
MMIC	Corrective Action Plan	Pharmacy Prior Authorization and Organizational Staff Changes
MMIC	Notice to Cure	Telephone Performance Standards - Call Center Statistics

MMIC	Corrective Action Plan	Timely Notification to Members and Timely Submission to ADHS
NARBHA	Corrective Action Plan	Appropriateness of Services, Access to Care
NARBHA	Corrective Action Plan	Behavioral Health Service Provision Corrective Action Plan
NARBHA	Corrective Action Plan	Court Ordered Treatment, Length of Stay, Prior Authorizations & SMI Determinations
NARBHA	Corrective Action Plan	Provider Oversight - West Yavapai Guidance Clinic - WYGC

Of the above ADHS enforcement actions all items are closed at present time except Pharmacy Prior Authorization and Organizational Staff Changes and Timely Notification to Members and Timely Submission to ADHS for Mercy Maricopa Integrated Care. ADHS Medical Management and network management is currently monitoring this corrective action plan on a monthly basis.

E. ACOM 436 Network Standards

Mercy Maricopa Integrated Care, GSA 6, is contractually required to meet the standards set forth in the ACOM 436 policy. Since April 1st 2014 transition, MMIC has been compliant with all standards for this policy. DBHS included PCP, Dental and Pharmacy time and distance standards in GIS analysis, where all RBHAs are required to have a contracted pharmacy within 10 miles. PCP and Dental providers are only required for the GSA 6 contract at this time. Maps are included in appendix.

- 99.2% of Maricopa County members served through subcontractors live within 15 minutes or 10 miles from an in-network PCP
- 99.6% of Maricopa County members served through subcontractors live within 15 minutes or 10 miles from an in-network Pharmacy
- 98.2% of Maricopa County members served through subcontractors live within 15 minutes or 10 miles from an in-network Dentist

Mercy Maricopa Integrated Care is also complaint with contracting with Maricopa County Hospitals. MMIC is contracted with all hospitals in districts 2, 3, 4, 5, 6, 7, 9. Therefore no gaps identified through compliance to ACOM 436 network standards.

F. ACOM 417 Appointment Availability

G. Appointment Availability (DDD & CMDP Included)				
RBHA	Provider Type	Routine Appointment Compliance Percentage	Urgent Appointment Compliance Percentage	Emergent Appointment Compliance Percentage
NARBHA (GSA 1)	BH Provider (Initial Assessment)	78%	82%	95%
	BH Provider (Ongoing Appointment)	82%	82%	82%
Cenpatico (GSA 2, 3 & 4)	BH Provider (Initial Assessment)	100%	91%	100%
	BH Provider (Ongoing Appointment)	93%	93%	93%
CPSA (GSA 5)	BH Provider (Initial Assessment)	91%	59%	74%
	BH Provider (Ongoing Appointment)	72%	N/A	N/A
MMIC (GSA 6)	PCP	100%	100%	100%

	Specialist	95%	94%	93%
	Dental	100%	100%	100%
	BH Provider (Initial Assessment)	100%	100%	86%
	BH Provider (Ongoing Appointment)	97%	100%	73%

The first submittal of data for ACOM 417 (Appointment Availability) was provided to ADHS/DBHS on October 2014. Therefore, the statistical data presented in the above chart is representative of the 4th quarter of FY14 (July 1, 2014 through September 30, 2014).

To monitor appointment availability standards, T/RBHAs utilize various methods which include requiring providers to submit monthly tracking logs of referrals received. The information received via the tracking logs allows the T/RBHA's Quality Management Department to conduct an analysis to determine compliance with the Appointment Availability policy. The Appointment Availability policy states that members should receive an initial assessment within seven (7) days and subsequent services within 23 days of the initial assessment.   In addition, RBHAs require Providers to submit monthly reports regarding CMDP members to ensure that children removed from their home by DCS/Department of Child Safety are receiving an assessment and intervention within 72 hours.

Methodologies used by the RBHAs to conduct provider surveys/audits include: chart audits, annual medical record audits, member satisfaction surveys, automated surveys, fidelity audits, and annual administrative audits. Additionally, a review of member services complaints and review of appointment availability outcomes are conducted by Advisory Committees to identify and address possible compliance violations.

Each RBHA utilized several methods to capture the data presented in the chart above. Secret shopper phone calls were utilized to ensure appointments are offered within seven days to a person requesting an intake. Mailing customer satisfaction surveys to respective members to determine if members received required and quality services is another method used by RBHAs to audit providers. If members are unresponsive to the mailed surveys, RBHAs do their due diligence by following up with the member by attempting to make contact telephonically. Chart audits are conducted either face-to-face or remotely via online access for providers who maintain electronic health records. Face-to-face audits are also conducted with providers in an attempt to proactively eliminate areas of concern and implement a written plan of action. These various methods of conducting surveys/audits are coordinated and the results of the audits are reviewed by the RBHA's Quality Management Department.

Each RBHA requires their providers to submit reports containing statistical analysis regarding compliance with wait time standards. If providers are not in compliance with wait time standards, RBHA's offer technical assistance to resolve the issue. In the event that Providers consistently fail to comply with wait time standards, subsequent action could include placing the provider on a Corrective Action Plan (CAP).

Analysis of the Appointment Availability Reports to assist with identification of potential gaps by RBHA

To be in compliance with Appointment Availability standards, RBHAs must ensure members seeking behavioral health treatment receive an initial assessment within seven days of referral and ongoing services must be provided within 23 days of initial assessment. The minimal performance standards (MPS) for accessing a behavioral health provider within seven days and receiving ongoing services within 23 days of initial assessment are 75% and 90% respectively. The goal is for AHCCCS members to receive an initial behavioral health assessment at an 85 percentile rate; and have access to a follow-up visit with a behavioral health professional (BHP) within 23 days of the initial visit at a 95 percentile rate. To be in compliance with Appointment Availability standards, the Integrated RBHA must ensure members seeking physical health treatment have appointment access to PCPs in 21 days while the standards for Specialists and Dental appointments are 45 days. In addition, RBHAs must ensure that the waiting time for a scheduled appointment at the PCP's or specialist's office is no more than 45 minutes, except when the provider is unavailable due an emergency.

GSA 1
The appointment availability reports help with identifying gaps in the number of available appointments with their providers, and the timeliness of appointments. Network staff receives the appointment availability reports quarterly from their Quality Management department. These quarterly appointment availability reports are taken to NARBHAs Quality Management Committee, which Network Staff are members of, to review compliance and discuss further action if a provider is not meeting compliance. This could be in the form of a Letter of Concern or a Corrective Action. Network staff monitor appointment availability compliance by provider and by NARBHA overall. For FY15 Q1 Appointment Availability Reports, NARBHA was compliant or passed for Emergent Appointments at 97.4%, Urgent Appointments at 89.01% and Routine Appointments at 92.83%. The 45 minute wait time measure also passed at 99.28%. NARBHA feels at this time, there are no network gaps.

GSA 2, 3, 4
Information obtained through the Appointment Availability reports are analyzed by the Network Development team monthly and reported to the Network Sufficiency Committee quarterly. For the last two quarters, the network has met the appointment availability standards at an 85% level or higher in all areas. Cenpatico is in the process of increasing provider accountability by distributing trending data at the provider level with Intake and Care Coordination Agencies at the monthly CEO meetings.

GSA 5
CPSA monitors appointment availability through the "Referral Exception Report" for all populations, as follows:

- Crisis – within 2 hours of referral;
- Urgent/Emergent – within 24 hours of referral;
- CMDP/DCS – no later than 72 hours after notification by the Department of Child Safety (DCS) that a child has been or will be removed from their home, and;
- Routine – within 7 days of referral;

Information is collected from providers on a quarterly basis with a focus on efforts to meet referral requirements as stated above. Providers have established processes to meet the demands by engaging an array of specialized activities, which are reported to CPSA. An analysis of data derived from the Referral Exception Report paired with the qualitative information provided by the agencies (above), CPSA finds there to be no gaps or network insufficiencies related to appointment availability.

GSA 6
Provider Relations collects the data (Apt Availability Report) and the Network Management team reviews the results to identify fail/pass survey compliance.

Tribes
Under the current IGA the TRBHAs are not required to submit the appointment availability deliverable; however, they do provide oversight and monitoring of appointment availability standards. The TRBHAs review both member quality of care concerns and member complaints through their Quality Improvement Committee and would address concerns about appointment availability through this channel. Gila River for example, for the past three fiscal years has exceeded their 90% threshold rate as it relates to members accessing ongoing services.

V. Interventions to Fill Network Gaps and Barriers

The purpose of network analysis is to identify current gaps within the System of Care and develop network interventions for the upcoming Fiscal Year. DBHS deploys an annual System of Care Plan, which requires each RBHA to submit quarterly updates, identifying goals, objectives and tasks needed to effectively address network gaps. The identification of development needs is based on assessing network capacity, change initiatives and minimum network standards. To maintain an adequate system of care, ongoing improvements must be identified and implemented to ensure that children, families and adult populations continue to receive quality behavioral health services that are accessible and recovery-focused.

DBHS has implemented a variety of mechanisms to address network gaps; the Bureau of Network Management addresses all issues of network sufficiency. The Bureau was created April 2014 and currently employs three (3) network coordinators and a Bureau Chief. This group meets regularly with representation from Child/Adult psychiatrists, Medical Management, Program Operations, Individual and Family Affairs, Business Operations, Customer Service and ADHS leadership risk team to discuss provider network related concerns.. The Bureau is appraised of modifications in the system through the Notification of Change process. The Network Coordinators inform the group of changes for discussion and determination of whether they would potentially result in an insufficient provider network. If an insufficiency/gap is determined, the most appropriate program area, including Compliance if necessary, takes the lead in creating a monitoring plan to address it. DBHS utilizes Fidelity Audits, Letters of Concern (LOC), Technical Assistance Meetings, Corrective Action Plans (CAPs) and sanctions, when appropriate, to ensure accountability for system changes, network management, new program development and ensure network gaps do not occur.

ADHS partners with its contractors to ensure projects move forward, which often involves solving problems and working around or with obstacles. In 2013, a number of systemic changes created new challenges for project development. Many state-level changes in FY 2013 brought new staff, systems and interpretations of licensing and regulation rules to the forefront. These changes created a number of challenges for projects being developed. Wait times for applications increased and technical assistance answers were clarified in a few instances. While these challenges did not stop project development, they did delay completion of multiple projects.

VI.   Immediate Short-Term Interventions

DBHS monitors immediate gaps when they occur through material change notifications, monthly DLS (Division of Licensing Services) Substantiated Violation Reports, monthly Crisis Response data, hospital hold data, and site visits. The expedited/temporary credentialing process requires the T/RBHAs to render a decision regarding temporary or provisional credentialing within 14 calendar days from receipt of a completed application. Once provisional/temporary credentialing is approved, provider information must be entered into the T/RBHA's information system to allow payment to the provider effective as of the date the provisional credentialing is approved. Providers working in Federally Qualified Health Centers (FQHCs) and FQHC Look-alike Centers, as well as hospital-employed physicians (when appropriate), must be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional. If an expedited or temporary credentialing process is utilized, the following minimum requirements must be met:

- A provider must complete a signed application that includes the following items:
  - Reasons for inability to perform any essential functions of the position, with or without accommodation; evidence of lack of present illegal drug use history of loss of license and/or felony convictions history of loss or limitation of privileges or disciplinary action, current malpractice insurance coverage; and attestation by the applicant of the correctness and completeness of the application.
- In addition, the applicant must furnish the following information:
  - Minimum five-year (5) work history or total work history if less than five (5) years, and Current Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate, as applicable.
- T/RBHAs must conduct primary source verification of the following:
  - Licensure or certification (a signed statement from the medical or nursing board of examiners stating they perform primary verification of education and internship/residency as part of the licensing process is acceptable), board certification, if applicable, or the highest level of credential attained, and National Practitioner Data Bank (NPDB) query, or ;
- In lieu of NPDB query, all of the following: minimum five-year (5) history of professional liability claims resulting in a judgment or settlement, disciplinary status with regulatory board or agency; and Medicare/Medicaid sanctions.
- Each T/RBHA's Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and committee review, as outlined in this section, should be completed.
- T/RBHAs must ensure compliance with all applicable credentialing requirements within six months following the granting of temporary credentials. If the provider has not been credentialed during this six-month time period,

then the T/RBHA may issue a second temporary credential. All credentialing processes must be completed by the end of the second six-month (6) period.

VII.   Outcome Measures and Evaluations

DBHS continues to monitor several performance measures that assure members are receiving timely and effective behavioral health services. The performance measure for Access to Care (ATC) was adjusted from contract year 2013 to contract year 2014. The performance measure for contract year 2014 is now looking at Access to Behavioral Health Provider within 7 and 23 days as two (2) separate measures. The new measure was included in the March 2014 revision to the 2014 DBHS Bureau of Quality & Integration Specifications Manual with an implementation date of April 2014 and again, with minor revisions to the methodology, in the 2015 edition of the Specifications Manual. Both the 2014 and 2015 manuals were sent to all T/RBHA's. This performance measure is quarterly and captures the following data elements; Month, GSA, Behavioral Health Category (Child, SMI, GMH/SA), Age (0-17, 18-21, 21+, and Eligibility (T19, T21, DDD, CMDP, NT19). The performance measure is further defined and seeks the following information;

1. Follow up service will be determined as any service included in Attachment B3b. Access to Behavioral Health Provider Numerator Service Codes.
2. The following variables will be calculated:
    a. Number of members who received a follow up service within 7 days
    b. Number of members who received a follow up service within 23 days

Due to the change in measure from one contract year to another DBHS is providing information in this area from the final quarter of the 2013 contract which is Quarter 5. An annual update for contract year for 2014 will be completed at the next submission of the Annual Network Plan to reflect the updated changes to the measure. Below is the Quarter 5 update following the historical measure. Additionally the Minimum Performance Standards (MPS) have changed for the 2014 contract period. The 7 day MPS is 75% and the 23 day MPS is 90%.

Annual Access to Care 23 day Performance Rates						
Adult	FY13 Annual including Q5			Child	FY13 Annual including Q5		
	Num	Denom	%		Num	Denom	%
GSA 1 - NARBHA	3675	4208	87.3	GSA 1 - NARBHA	3465	3947	87.7
GSA 2 - Cenpatico 2	899	961	93.5	GSA 2 - Cenpatico 2	1262	1336	94.4
GSA 3 - CPSA 3/Cen 3	1009	1071	94.2	GSA 3 - CPSA 3/Cen 3	1428	1473	96.9
GSA 4 - Cenpatico 4	1730	1794	96.4	GSA 4 - Cenpatico 4	2174	2235	97.2
GSA 5 - CPSA 5	3968	4554	87.1	GSA 5 - CPSA 5	5728	6450	88.8
GSA 6 - Magellan	15197	16401	92.6	GSA 6 - Magellan	21764	24138	90.1
Statewide	26478	28989	91.3	*Statewide*	35821	39579	90.5

Annual Access to Care 23 day Performance Rates						
Adult	FY13 Q5 only			Child	FY13 Q5 only		
	Num	Denom	%		Num	Denom	%
GSA 1 - NARBHA	584	728	80.2	GSA 1 - NARBHA	602	725	83.0
GSA 2 - Cenpatico 2	170	183	92.9	GSA 2 - Cenpatico 2	189	199	95.0
GSA 3 - CPSA 3/Cen 3	199	210	94.8	GSA 3 - CPSA 3/Cen 3	283	292	96.9
GSA 4 - Cenpatico 4	331	345	95.9	GSA 4 - Cenpatico 4	381	397	96.0
GSA 5 - CPSA 5	765	847	90.3	GSA 5 - CPSA 5	734	791	92.8
GSA 6 - Magellan	3014	3278	91.9	GSA 6 - Magellan	4398	4904	89.7
Statewide	5,063	5,591	90.6	*Statewide*	6,587	7,308	90.1

A. Complaint Data

Complaints can be filed by members or any party on behalf of members receiving behavioral health services. They can reflect any expression of dissatisfaction about the delivery of behavioral health services and can be filed directly with service providers, with the RBHAs, or with ADHS/DBHS. Each RBHA is contractually required to maintain a complaint process that is easily accessible to behavioral health members, providers, and other stakeholders. They are further required to examine and assess their complaint data on a quarterly basis to identify trends and outliers to assist in identifying the need for and development of improvement strategies in the State's service delivery system. Complaints referenced in this report are those that are reported to DBHS via RBHA-submitted monthly complaint logs. Complaint data are reviewed in QM Committee meetings on a regular basis.

Complaint Category	Complaints reported by adult members	Complaints reported by child members	Total complaints
Access to Services	525	111	636
Client Rights	151	16	167
Clinical Decisions	975	149	1124
Coordination of Care	239	39	278
Customer Service	1477	176	1653
Financial	116	11	127
Information Sharing	25	3	28

B. Consumer Survey

DBHS conducts two annual consumer surveys; an Adult Consumer Survey, and a Youth Survey, based on the SAMHSA Mental Health Statistics Improvement Program (MHSIP) surveys. The surveys request independent feedback from Title XIX/XXI adults and families of youth receiving services through Arizona's publicly funded behavioral health system. The surveys measure consumer(s') perceptions of behavioral health services in relation to the following domains:

- General Satisfaction
- Access to Services
- Service Quality/Appropriateness
- Participation in Treatment Planning
- Outcomes
- Cultural Sensitivity
- Improved Functioning
- Social Connectedness

The results are then presented to the DBHS Quality Management Committee. T/RBHA performance on outcome domains is used to measure their eligibility for a financial incentive. Member satisfaction with *Access to Service* and *Participating in Treatment Planning* are two main indicators in the DBHS Performance Framework and Dashboard. T/RBHAs scoring low in domains are required to develop a CAP addressing actions to be taken to increase and sustain satisfaction scores. Due to feedback from the T/RBHAs regarding low participation rates of their members' in the Consumer Survey, a work group was developed to address their concerns. Some of the issues raised by the T/RBHA include; the need to develop a culturally competent survey, the time of year that the survey is administered, and alternative methods of completing the survey such as talking circles. The domains are reviewed based upon an MPS of this measure:

Access to Behavioral Health Provider (encounter for a visit) within 7 days of being designated as "active care" for an initial visit
AHCCCS MPS: 75%
AHCCCS Goal: 90%

Access to Behavioral Health Provider (encounter for a visit) within 23 days of being designated as "active care" for an initial visit
AHCCCS MPS: 90%
AHCCCS Goal: 95%

DBHS has reviewed the consumer survey data and identified some measures saw a change towards a 5% increase while others showed a decrease. Going forward DBHS will monitor survey results based upon the domains and MPS identified above and results will be reflected in the Annual Network Plan and the Annual QM plan.

C. Independent Case Review

The ICR this year focused on the adequacy and appropriateness of screening, assessment and treatment for our members. As a follow-up to the ICR, System of Care conducted site visits to 17 prevention coalitions and outpatient treatment facilities, in addition to 5 follow-up meetings with the T/RBHAs. The site visits followed a 3-tier process in assessing service provision via interviews with the providers, chart reviews, and follow-up meetings with the RBHAs. Overall, there was an improvement in findings from the site visits last year. However, the following were found to be areas of concern:

- Potential Network Gaps affecting transportation, detox, and access to MAT services
- Inconsistency among providers regarding ASAM and LOC, and determining criteria for discharge
- General lack of outcome monitoring
- ISP process as a barrier
- Billing issues for Traditional Healing services and Peer Support
- Prevention coalition gaps – please see attached document for specific concerns. (Note, this was the first year prevention coalitions were included in the site visits.)

The following recommendations were identified as likely avenues in alleviating areas of concern and improving service provision:

- Collaborate with networks to identify network gaps contributing to high utilization of transportation in some areas (particularly for MAT services), and utilization of hospitals as an alternative to detox
- Recommendation to verify if the LOC assessed using the ASAM matches the LOC provided through an in-depth chart review
- Discuss ways to provide RBHAs and providers with more guidance on defining/criteria for "discharge"
- Discuss methods that adequately monitor for fidelity
- Discuss ways to provide more guidance on measuring outcomes
- Discuss with RBHAs how to implement TB screening documentation in order to provide evidence of TB screening
- Further investigation of billing process for traditional healing is needed (in order to ensure traditional healing services are being utilized and properly reimbursed, and to ensure peer support is being properly billed)
- Follow-up by prevention staff with prevention administrators at each RBHA

VIII.   Ongoing Network Development Activities
Network Development continues to support the T/RBHAs in expanding and/or enhancing their provider networks. Division staff continues to participate on T/RBHA teams, establishing network expansion targets and providing T/RBHA-specific technical assistance on a quarterly basis. DBHS has established a network management process that identifies network needs and evaluates network success through utilization of Minimum Network Standards. DBHS partners with internal departments through meetings and various reports. This includes Licensing, Compliance and Medical Management/Utilization Management, and System of Care Departments to name a few. This provides another avenue to identify network sufficiency and potential service gaps. The System of Care Plan goals and objectives provide an excellent way to see what each T/RBHA is doing throughout the year as they are required to submit quarterly reports on their progress in meeting the goals and objectives outlined below.

A. System of Care Plan

For FY2015 the goals and objectives established for the upcoming year are as follows:

- **Goal 1 - Promote a Recovery-oriented system of care that maximizes resilience and independence for members and families.**
    - o **Objective 1.1 –** Advance health and wellness initiatives within the behavioral health system
    - o **Objective 1.2 –** Establish ratios of case managers to members sufficient for both children with complex needs and adults with serious mental illness
    - o **Objective 1.3 –** Promote the Office of Individual and Family Affairs
    - o **Objective 1.4 –** Develop sufficient availability of generalist direct support providers and specialty providers to deliver flexible, in-home, community based support and rehabilitation services
    - o **Objective 1.5 -** Increase opportunities for members to engage in informed decision making regarding employment opportunities.
    - o **Objective 1.6 –** Increase the number of youth who successfully transition to adulthood
- **Goal 2 - Improve the quality of behavioral health interventions**
    - o **Objective 2.1** - Expand the use of best practices to improve outcomes
    - o **Objective 2.2** - Improve Access to Care
    - o **Objective 2.3** - Improve the quality of services to Children age 0-5
    - o **Objective 2.4** - Enhance Substance Abuse Services

B. Planned Acquisitions for FY15

- Sierra Vista Regional Hospital is planning to open a psychiatric wing in May 2015. Although we are concerned they may not have the volume of referrals to fully support the unit, we welcome the addition of the facility to the community. It should help that they will be able to accept Medicare patients as well. The facility will be able to accommodate court ordered treatments (COTs) as well.
- YUMA HHS/MHW is developing a second sub-acute to provide 23 hour crisis stabilization services, to be open by May 2015.
- Yuma Regional Medical Center is adding a medical/psych unit to serve persons with both BH and PH chronic conditions. This facility should be operational by July 2015.
- Community Bridges is transitioning their Level IV Rural Substance Abuse Transition Agency in Holbrook to a Chemical Dependence Residential Facility. The Holbrook CD residential facility will have a sweat lodge and access to Traditional Healers and other American Indian healing ways. This is slated to be completed in January 2015.
- Southwest Behavioral Health Services (SBH) and the Bullhead City Alano Club to develop Chemical Dependence Residential Treatment. This facility will be on the property of the local Alano Club in Bullhead City and members will be connected to natural supports and hope through this innovative partnership.

IX. Coordination between Internal Departments

ADHS recognizes the importance of the coordination of care process between the RBHAs and AHCCCS contractors as well as with outside organizations that affect the delivery of behavioral health agencies. In an effort to improve consumer outcomes through cross-system coordination, communication, process improvement and building and maintaining AHCCCS contractor and stakeholder relationships, DBHS created the Office of Interagency Services and incorporated specific AHCCCS contractor coordination requirements into the ADHS/DBHS-RBHA contracts and Provider Manual. In addition, DBHS provides oversight, technical assistance, coordination and monitoring activities to address coordination of care between T/RBHAs and AHCCCS contractors. Additionally, the Bureau Network Management participates in the following committees on an ongoing basis to facilitate internal department communication and collaboration:

- **Internal Quality Management Meeting**
    Attendees Include: Chief Medical Officer, Deputy Chief Medical Officer , Assistant Director of Quality and Integration, Assistant Director of Operations, Assistant Director of Compliance & Consumer Rights, Office of Performance Improvement, Bureau of Compliance, Business/Finance, Business Information Systems, Office of

Information Management, Office of Quality of Care, Office of Medical Management, Bureau of Program Operations, Bureau of Network Management, Office of Individual & Family Affairs, and Office of Customer Service.

- **Internal Compliance Meeting**
  Attendees Include: Chief Medical Officer, Assistant Director of Quality and Integration, Assistant Director of Operations, Assistant Director of Compliance & Consumer Rights, Office of Performance Improvement, Bureau of Compliance, Business/Finance, Business Information Systems, Office of Information Management, Office of Quality of Care, Office of Medical Management, Bureau of Program Operations, Bureau of Network Management, Office of Individual & Family Affairs, and Office of Customer Service.

- **Policy Committee Meeting**
  Attendees Include: Chief Medical Officer, Assistant Director of Quality and Integration, Assistant Director of Operations, Assistant Director of Compliance & Consumer Rights, Office of Performance Improvement, Bureau of Compliance, Business/Finance, Business Information Systems, Office of Information Management, Office of Quality of Care, Office of Medical Management, Bureau of Program Operations, Bureau of Network Management, Office of Individual & Family Affairs, Office of Customer Service, and Community Stakeholders.

- **DDD Quarterly Collaboration Meeting**
  These meetings are conducted by each RBHA. Within each RBHA meeting **Attendees Include:** RBHA DD Liaison, RBHA Medical Director(s), RBHA Children and Adult System of Care Representatives, DDD Statewide Behavioral Health Manager, DDD District Managers, DBHS System of Care, DBHS Network Management

- **Internal Housing Review Committee**
  Attendees Include: Chief Financial Officer, Housing and Employment Administrator, Network Management, Business and Finance, System of Care, Senior Grants Coordinator

- **Internal Substance Abuse Meeting**
  Attendees Include: Chief Medical Officer, Deputy Chief Medical Officer, Assistant Director of Quality and Integration, Assistant Director of Operations**,** Bureau of Program Operations, Finance, and Bureau of Network Management.

- **Medical Director Weekly Briefing**
  Attendees Include: Chief Medical Officer, Deputy Chief Medical Officer, Assistant Director of Quality and Integration, Office of Performance Improvement, Office of Medical Management, Office of Quality of Care, Bureau of Program Operations, Bureau of Network Management, Office of Individual & Family Affairs, and Office of Customer Service.

- **ASAP Program Inventory Workgroup**
  Attendees Include: Governor's Office for Children, Youth and Families, DBHS Bureau of Program Operations, DBHS Bureau of Network Management, Division of Licensing, AHCCCS, and Borad of Behavioral Health Examiners.

- **CABHP Citizen Review Panel Members**
  Attendees Include: ASU Center for Applied Behavioral Health Policy, DBHS Bureau of Network Management, Division of Child Safety, other community stakeholders.

X.   Coordination with Outside Organizations
GSA 1
NARBHA regularly facilitates meetings among community stakeholders and also contractually requires Responsible Agencies (RAs) to conduct regular collaborative meetings at the local level with system partners. Regional meetings that

NARBHA facilitates include: the Recovery Action Committee, the Northern Arizona Children's Council, meetings with DES/DDD and Navajo/DDD, RSA quarterly meetings, Integrated Care, BH Medical Practitioners, Inpatient Work Group, and the RA CEO and Clinical Directors meetings, among others. NARBHA also participates, either regularly or by invitation, on numerous state and local committees, work groups, and Task Forces that are facilitated by other organizations. Input from providers and other stakeholders are key to both network development planning and implementation. In the past year NARBHA continued to collaborate with DES/DDD and the Navajo Nation to expand the Positive Behavioral Support program for Navajo DD members.

NARBHA's Recovery Action Committee and Northern Arizona Children's Coordination Council are avenues for input from peers and family members. Peers and family members serve on NARBHA's Board of Directors and on committees. NARBHA also has regular communication and collaboration with NAMI and the Flagstaff NAMI President sits on NARBHA's Board of Directors.

GSA 2, 3, 4
Cenpatico has developed collaborative meetings throughout all GSAs to encourage purposeful partnership and collaboration with various stated agencies which includes; Department of Developmental Disabilities (DDD) and Department of Child Safety (DCS), Adult Protective Services (APO), Juvenile and Adult Probation (JPO/APO), AZ Dept. of Juvenile Courts and AZ Adult Dept. of Courts ADJC/ADOC, Administrative Office of the Court (AOC). The goal of these meetings is to facilitate effective coordination of behavioral health services. Meetings are held quarterly, sometimes semi-annually and ad hoc meetings are scheduled as needed. Cenpatico also works very closely with law enforcement agencies in every county and community they serve. Specifically, they work with the local police and sheriff to ensure they are aware how to access services, handing out crisis cards, flyers and speaking at meetings.

Cenpatico solicits input from Youth, Adults, Peers and Families by hosting Peer and Family Advisory Councils throughout each of the counties served. Fourteen different areas were established to ease the burden of travel on the members. There are two (2) in GSA 02, eight (8) in GSA 03, and four (4) in GSA 04. Cenpatico established an overall Member and Family Advisory Board. Their roles and responsibilities include addressing systemic issues and serving as a resource to the Quality Management Department, Clinical Operations Department and Executive Management Team for developing new programs, testing ideas and completing projects such as helping select member satisfaction surveys. Board members also offer assistance in the evaluation, design and implementation of behavioral health services. Youth Advisory Councils are established each GSA providing youth an avenue for their voices to be heard. Cenpatico offers stipends to youth participating as an incentive. The minutes and feedback from these meetings are provided to the Interagency Coordinating Council (ICC) contacts that are a part of the larger Transition Age Youth Project.

The CEO of Cenpatico hosts a Provider CEO Roundtable to work with provider agencies to build a collaborative system. Cenpatico has invited representatives from each GSA to be a committee member of the Network Adequacy, Efficiency and Barriers Committee to ensure that providers are involved in the Network Development Process.

Community Forums are held annually in all major communities to provide information and solicit feedback from all parties involved in the System of Care. In addition, Cenpatico holds Community Forums. The information and feedback gathered is provided to the Executive Management Team at Cenpatico. The Executive Management Team then discusses any projects that need to be developed in order to resolve any known issue(s) in the communities they serve.

GSA 5
CPSA is dedicated to maintaining a productive and cooperative working relationship with system partners, stakeholders and providers. To ensure frequent communication, CPSA hosts many collaborative forums for collecting input from outside organizations. Recurrent meetings are held with the Pima County Dept. of Child Safety (DCS) program director, assistant program managers (APMs) and mental health specialists to provide updated information on systems, address challenges and barriers, and identify practice-improvement projects. In addition, CPSA's facilitates quarterly meetings with DCS APMs and comprehensive service provider (CSP) clinical directors and meetings between DCS staff, CSP clinical directors and urgent-response providers. Having a co-located CPSA liaison at Pima County Juvenile Court Center (CJCC) has provided a collaborative way to connect with the court's child and family services team, which includes dependency

specialists, the Family Drug Court team, CASAs and mediators. CPSA meets regularly with the Juvenile Probation Team, Family Drug Court and Youth Recovery Court to assist with system challenges and share updates on projects. CPSA works in partnership with the AOC/Adult Probation and Parole, Arizona Department of Corrections and Re-Entry. CPSA's Criminal Justice Team (CJT) utilizes member involvement with the criminal justice system as an opportunity for intervention and recovery. The CJT also performs cross-system collaboration efforts with criminal justice, first responders and community stakeholders, including CPSA's Board of Directors Policy and Program Development subcommittee, to provide regular, up-to-date trainings on behavioral health and its intersection with criminal justice. This includes the Southern Arizona Crisis Intervention Team (CIT) Training, co-facilitated with Tucson Police Department and Pima County Sheriff's Department two to three times each year.

CPSA works closely with Division of Developmental Disabilities (DDD) members receive services in a system of care designed to meet their unique needs. Monthly collaborative meetings are held to bring partners together and address system issues and provide feedback. CPSA collaborates with the Pima County educational system attending monthly meetings with five school districts. The Pima County School Superintendent's Office is an active participant and collaborates with CPSA to ensure availability and accessibility of behavioral health services to school-age children. Presentations and question-and-answer sessions with educational entities including Transition Consortium and Professional Developers are conducted quarterly.

CPSA collaborates closely with the Pima County Peer and Family Support Coalition to enhance and improve the behavioral health system through peer and family involvement. In addition, CPSA contributes to planning and organization of the Recovery & Wellness Community Forum, an annual event for members and family members in the behavioral health system. The community forum offers members and family members an opportunity to learn about recovery and wellness and to provide feedback on the behavioral health system. The event includes keynote-speaker presentations, workshops, a resource fair and a wellness clinic. CPSA has sponsored this event for 14 years. Free and open to the community, the forum hosts about 300 participants each year. The planning committee comprises representatives from CPSA, CSPs and community service agencies (CSAs), along with CPSA members and families.

GSA 6

Coordination with outside organizations including the extent in which the Integrated RBHA (MMIC) has periodically met with a broad spectrum of behavioral and physical health providers to improve service delivery. The Chief Innovation Officer has oversight into the strategy and business development aspects of the organization.   On a consistent basis, the Chief Innovation Officer meets with new and existing providers to discuss expansion opportunities.   The Continuous Innovation Committee is an avenue to discuss business development, possible pilots and new ideas. Mercy Maricopa is continuing to introduce and another and collaboration efforts are planned to be continued to provide additional support as the network continues to grow and evolve. In addition, Mercy Maricopa providers and stakeholders meet during regular meetings and Committee meetings. During these meetings they are given the opportunity to review and provide input about the current status of the Network and/or current network development issues. Mercy Maricopa Governance Board meets to solicit and provide information on updates to the system and review progress. The Board includes Mercy Maricopa staff, providers, members and stakeholders. These members provide Mercy Maricopa with input about the status and performance of the Network to improve service delivery.

XI.   Network Design by GSA

GSA 1

NARBHA's Geographic Service Area (GSA) consists of 61,436 square miles, or approximately half of the geographic land mass of Arizona, and includes the counties of Mohave, Yavapai, Coconino, Navajo, and Apache. All Navajo and White Mountain Apache tribal land also falls within the geographic boundaries of GSA 1; however, these tribal members are served by a Tribal Regional Behavioral Health Authority (TRBHA). NARBHA has established, and continues to expand and enhance a full continuum of covered behavioral health services to meet members' needs. Services in GSA 1 are accessible, offer choice to members, are recovery-oriented, are provided in or near the member's home and

community, incorporate family and consumer voice, are culturally relevant, and are increasingly integrated with physical health care services. NARBHA currently serves approximately 18,000 members who receive publicly-funded behavioral health services throughout northern Arizona. Approximately 73% of these members are adults and 27% are children. Through a provider network made up of almost 600 separately-registered AHCCCS providers contained in 62 provider contracts, NARBHA's provider network is able to capably deliver the full continuum of covered behavioral health services that are consistent with best practices and the child and adult principles.

A. How members access the system

Members in need of behavioral health services may access the NARBHA System of Care through numerous different paths. NARBHA's ten Responsible Agencies operate 38 clinics in Northern Arizona – most of which provide integrated care. Members may also go to one of NARBHA's nine peer-run Wellness/Recovery Centers or access the peer-run Warm Line in northern Arizona where enrollment and services will be coordinated with the RAs. The PATH Team does outreach to homeless members and the RAs coordinate and communicate with local first responders, CPS, DDD, and RSA to ensure that members and families who need behavioral health services have easy access to those services. Members in crisis are able to immediately access services through NARBHA's Crisis Hotline, mobile crisis services and through NARBHA's four substance abuse stabilization facilities, or through NARBHA's four inpatient hospital/subacute facilities. NARBHA and its Responsible Agencies also have a regular presence at local health fairs and at community events such as Pride in the Pines, Veterans Stand Down and Project Connect.

Description of how the RBHA assesses the medical and social needs of new members to determine how the RBHA may assist the member in navigating the network more efficiently:

NARBHA provides 24/7 coverage to meet the medical and social needs of new members in the following ways:

- During the work week Monday through Friday, NARBHA is available by phone through their Member Services department to answer any and all questions that new members may have in navigating the NARBHA network. This department employs a Manager and three full time Member Services representatives.
- The Member Services Representatives can refer clinical teams to the NARBHA's Care Management Team for subject matter expertise for members who are at risk and/or have complex care needs.
- NARBHA requires the RA's develop a 12 month calendar for member's to sign up and participate in Stanford's Chronic Disease Self-Management Program (CDSMP).
- NARBHA maintains the NARBHA website, http://www.narbha.org, which describes in detail the Integrated Care Programs available to their members, including information on SBIRT, Trauma Informed Care (TIC), CDSMP, and Recovery through whole health videos. NARBHA maintains a crisis hotline with Protocol which is available 24/7 for members who are in crisis.

Description of what assistance is provided to members with a high severity of illness or higher utilization to better navigate the provider network:

Based on a data sharing agreement with Health Choice, NARBHA notifies the RA's on a weekly basis when a shared Health Choice member is admitted to an acute medical facility to provide behavioral health outreach and engagement post discharge. Based on the member's diagnosis the NARBHA Integrated Care Project Manager and the NARBHA Medical Directors may make recommendations for added BH services such as peer support, medication review, or referral to the RA Integrated Care Clinics. If the member readmits to the same or a higher level of care within 30 days of the original admission to a level of care the NARBHA Care Management team will follow the member for 30 days post discharge to insure RA follow up and member compliance with the discharge plan.

Based on an agreement with Flagstaff Medical Center (FMC), NARBHA has helped to engineer and engage in the FMC Pilot Program to prevent Hospital ER and inpatient admissions/readmissions for members with Heart Failure, Chronic Obstructive Pulmonary Disease/Asthma, Diabetes, Unintentional overdose, and high risk maternity members. Members are followed by NARBHA's Integrated Care Project Manager for 30 days post discharge from FMC to assist the member in follow up for medical and behavioral health goals.

Members with a previous hospitalization within a 12 month period, who meet specific admission criteria (i.e. homeless, suicide attempt, prolonged detox, or diagnosed with schizophrenia are placed on NARBHA's "Spotlight" protocol. NARBHA's In-network hospitals are required to meet with the member prior to discharge to discuss services that would be beneficial and possibly reduce the probability of a readmission.

Each member is assigned a NARBHA Clinical Care Manger who works with the outpatient provider to ensure services identified and requested by the member are received. Members in out of state treatment facilities are assigned to a NARBHA clinical care specialist to facilitate coordination between Health Plan and stakeholders.

Description of how members with chronic medical conditions are identified by the RBHA including a description of how placement options are coordinated with/communicated to Contractors providing Acute Care services:

Through partnerships with Health Plans, NARBHA is merging health data on their common members. Using physical health data, behavioral health data, and demographics, NARBHA is able to identify NARBHA-served AHCCCS members who have high needs, may be under-served, or are at risk for hospitalization or other negative outcomes. By prospectively identifying high-risk or high-need members, focused culturally appropriate outreach, access and interventions may occur to improve overall health and wellness.

Health Plans participating with NARBHA send a data file every two-four weeks to NARBHA for merger with NARBHA demographics and behavioral health data. NARBHA then runs a combined data set through ACG-PM and develops a table which meets the Health Plans' requests for information. Data includes inpatient hospitalizations, ED visits, diagnoses, medications, fill dates, PCP, all specialty providers, claims paid, outpatient services and chronic conditions, predictive risks for inpatient hospitalization, high costs, etc. The merged data tables are sent back to the Health Plans and to the NARBHA Responsible Agencies to do targeted outreach and care management.

Member profiles are developed for high-risk members, including children, youth, general mental health, substance abuse and SMI. High risk is classified by NARBHA as having four or more chronic conditions, which include medical conditions such as congestive heart failure, COPD, diabetes and hypertension. These profiles are used by NARBHA care managers to identify needs and member-specific interventions.

NARBHA shares opiate and benzodiazepine pharmacy data with the Health Plans on the AHCCCS PIP on Coordination of Care for Benzodiazepines and Opiates in order to merge the data sets into a standardized risk algorithm for diazepam-equivalents and morphine-equivalents. These high risk members receive more focused care management from NARBHA and Health Plans, including invitation from their physicians to participate in Project ECHO.

Methodology(ies) the RBHA uses to collect and analyze member, provider, staff and other stakeholder feedback about the network's design and performance. When specific issues are identified, the protocols for handling those issues.

NARBHA ensures stakeholder feedback is collected and analyzed continuously, both internally and externally and at all levels of the organization and community. Methodologies NARBHA utilizes to collect such input include: regular bi-monthly meetings with stakeholders; monthly provider meetings; committee meetings with member and family participation; QM and MM meetings which have both provider and member/family participation. NARBHA also holds Community forums and regularly meets with NAMI and other advocacy organizations to receive input from community members. In addition to feedback received through meetings, NARBHA also receives and analyzes other sources of feedback collected through member complaints, grievances and appeals, member and family satisfaction surveys, and provider issue tracking.

Depending upon the type of feedback received, NARBHA follows different processes, policies and protocols. If NARBHA received feedback about a provider's performance, NARBHA may implement Quality of Care Concern protocols/policies. Provider Improvement protocols could include formal corrective actions that are developed, monitored and tracked. If

the feedback that NARBHA receives is based upon a gap in the provider network, NARBHA may follow its single case agreement policies/protocols for temporary network expansion. Another option NARBHA utilizes in the event that feedback is received relating to a gap in the provider network is to follow network development policies/protocols which guide provider recruitment. Network development is multi-faceted and dependent upon System values, collaboration with the community and system partners, funding, and evidence-based practices.

NARBHA considers stakeholder feedback to be a critical component toward network development. Examples of how stakeholder feedback has shaped NARBHA's network development include, but not limited to:

- The recruitment of a forensic peer-run organization (Hope Lives);
- The recruitment of the Family Involvement Center to Northern Arizona;
- The development of Homestead, which offers stabilization services for dually enrolled (DD/BH) adolescents; and
- The development of capitated contracts for Functional Behavioral Assessments and behavioral analysis for dually enrolled services

Description of the most significant barriers to efficient network deployment within the RBHA's service area.

The most significant barrier to efficient network deployment with NARBHA's service area has been related to funding. Members in the Substance Abuse population were disproportionately represented among members who were no longer AHCCCS eligible and consequently there was not sufficient funding to develop substance abuse residential treatment which was identified as a need/gap in two communities in the GSA. To address this barrier (insufficient funds) NARBHA worked closely with its provider network and other stakeholders to enroll members into AHCCCS once Medicaid eligibility was restored. NARBHA also made substantial preparations to renovate an existing facility in Navajo County and identified another facility in Bullhead City (Mohave County) to be ready to deploy Chemical Dependence Residential treatment once Medicaid restoration occurred. As a result of outreach activities and site preparation of potential facilities, it is anticipated that Chemical Dependence Residential Treatment facilities in Mohave and Navajo County will be secured, renovated, and licensed before the end of the calendar year.

Description of network activities, including payment reform/value based purchasing efforts, aimed at enhancing efficiencies and improving the quality of care provided to members.

To address issues related to substance use disorder, NARBHA has begun the process of adding two Chemical Dependence Residential Treatment facilities to their provider network. This addition is being done by transitioning NARBHA's stabilization facility in Holbrook into a residential treatment facility and developing a new residential treatment facility in Bullhead City. NARBHA has facilitated network activities by ensuring members with SMI are supported in the community in the planned development of 35 additional supported housing units. Furthermore, NARBHA will develop a residential facility for member with SMI to support members discharged from Pine View Psychiatric Hospital in Show Low. NARBHA will continue to expand, specialize, and enhance our network of crisis services. This will include the development of an observation/stabilization unit in Flagstaff, the transition of the Kingman Subacute facility to a Medicare Certified Psychiatric Hospital and expansion of peer-delivered services in our network of psychiatric hospitals.

To improve the system NARBHA will be requiring all RAs to have a Joint Protocol with first responders in their community and is strengthening relationships with county governments and justice system partners. NARBHA is closely monitoring and providing input into the Board of Behavioral Health Examiners rulemaking process to help ensure that barriers to professional growth and workforce development are minimized. NARBHA is also working with the 11 Tribal Nations in our GSA to expand access to services, offer trainings and technical assistance, support and expand tele-medicine services among 638 Tribal Entities and TRBHAs and is developing a Traditional Practitioner program. NARBHA is ensuring that its provider network is culturally competent to meet member needs with focused work in the coming year with Veterans and the LGBTQ population. NARBHA conducts trainings on ASAM, Mental Health First Aid, Adverse Childhood Experiences, and Trauma Informed Care, among. Closing the Gap continues to meet in Flagstaff. In addition to the development of a Joint Protocol with the first responders in the Flagstaff/Coconino County area, the local coalition is also developing a housing program for individuals with substance use disorders. Through a partnership with

Catholic Charities, Flagstaff Medical Center, Southwest Behavioral Health, and NARBHA a Housing First model program is in development to improve individual access to services and treatment and reduce utilization of Emergency Department services, first responder time, and incarceration rates.

In the past year NARBHA has enacted financial incentives to provider agencies in the areas of support and rehabilitation for children; counseling, vocational services, and peer support for adults; completion of the evidence-based Stanford CDSMP program; PCP coordination, and peer support following inpatient services.   In FY14 NARBHA has distributed $1,172,701 to providers who have achieved performance goals under NARBHA's incentive programs and more funds are still to be distributed in the rest of the fiscal year.

To increase efficiencies and to allow NARBHA's largest Peer & Family Run Organization (PFRO) to focus upon the delivery of peer support, rather than complex administrative requirements, NARBHA has an "embedded staff" at NAZCARE. The embedded staff from NARBHA assists and supports NAZCARE in claim submission, tracking and collection of current treatment plans and referrals, and assists with related quality and compliance activities.

Description of how the RBHA will handle the loss (closure, contract termination) of a major healthcare provider (hospital, nursing facility, large provider group).

NARBHA ensures that disruptions to member care and services would be minimized if there were the loss of a major healthcare provider.   NARBHA would work to establish contingency plans for all covered services that were lost prior to the actual loss of the provider. This would involve agreements with other providers to operate the facility being lost and/or agreements with other providers to accept and serve the members into a different agency.   Communication of the change and the contingency plans would be communicated to each member in writing (after receiving ADHS/DBHS approval of the member communication), local stakeholders would be notified of the change and contingency plans, and NARBHA would hold Community Meetings to discuss the change in each community affected. Each member served by the lost provider would then be individually tracked by NARBHA to ensure that there was a smooth transition of the services in each member's service plan to the new provider or providers. NARBHA would encourage and help in facilitating the staff from the lost agency to transition to other agencies, as appropriate, to help in continuity of services for members. NARBHA would expand its Member Service Unit capacity on a temporary basis to ensure there was timely response to questions, concerns, and member transitions to the new provider(s). The tracking of services would continue until each member's services that were delivered by the lost provider were in place and functioning smoothly. NARBHA's provider contracts include requirements for transition of care and services if a provider were no longer contracted or able to continue delivering services for any reason.

Relationships between the various network partners (focus on provider to provider contact and facilitation of such by the T/RBHA; e.g. PCP, Specialists, Hospitals:
NARBHA has coordinated with outside organizations and periodically met with a broad spectrum of behavioral and physical health providers to improve service delivery to ensure care coordination and or service delivery improvements in the following ways:

- NARBHA has entered into data sharing agreements with the AHCCCS Health Plans in their service area. NARBHA meets monthly with the AHCCCS Health Plans in their service area for the purpose of discussing their shared super utilizers or high risk/high cost members.

- The NARBHA Associate Medical Director has developed monthly lightning rounds with a pain specialist in Mohave County to discuss pain management for members with a high MEDD/DEDD risk score. At risk members care and prescription histories are reviewed in detail to determine alternatives or tapering strategies for opioids and or benzodiazepines.

- NARBHA is participating in UNM's Project ECHO clinic for managing chronic pain and headaches. Through a Community Reinvestment grant NARBHA has incentivized PCP's and pain specialists to participate in the weekly clinic. NARBHA has had participation from three PCP's, a pharmacist, nurses, and two pain specialists thus far. Recruitment activities continue.

- NARBHA has engaged its RA's in many wellness and integrated care activities such as SBIRT, Chronic Disease Self-Management Program CDSMP, peer support development, Trauma Informed Care, and Website support linking the NARBHA website with the RA websites. NARBHA has encouraged the RA's to develop their own marketing strategies to encourage behavioral health members to participate in their Integrated Care Clinics and wellness activities.

- NARBHA continues to support and encourage partnerships with Peer Run organizations such as NAMI and NAZCARE.

- Contracted with Hope Lives for members transitioned from jail.

NARBHA was selected to be in an Integrated Care Learning Community sponsored by the National Council for Behavioral Health, the Arizona Council of Behavioral Health Providers and St. Luke's Health Initiative in April 2013- October 2013. NARBHA's goal was to develop a pediatric model for integrated care.

In collaboration with Child and Family Support Services (a NARBHA child-serving Responsible Agency), Mountain View Pediatrics and the CMDP Health Plan Medical Director, NARBHA identified a number of opportunities to enhance integrated care for children and youth, especially during that vulnerable and chaotic time just after children are removed from their homes by DCS. Foster families are free to choose any PCP they desire for the children in their care. NARBHA will act as the hub for assigning an RA to do the DCS Removal 72 hour behavioral health evaluation and connecting with the previous Health Plan for the child's EPSTD records, immunizations, chronic conditions, medications and last PCP visit. This behavioral health and medical information will be given to the RA and to the DCS worker who can then coordinate with the new foster family and the new PCP who is required to do a pediatric "check-up" within seven days of removal. NARBHA will also contact CMDP with an alert that the child will be assigned to that Health Plan and to engage the CMDP Behavioral Health Consultant to assist if necessary. The goal for this protocol in its first year is to coordinate previous medical records to PCPs for at least 40% of the Medicaid children removed from home.

Description of the available alternatives to Nursing Facility placement such as Assisted Living Facilities, alternative residential settings, or home and community based services for members:

NARBHA contracts with a variety of home and community based service providers to avoid placements in nursing care institutions and other institutional settings. NARBHA's length of stay in institutional settings, such as psychiatric hospitals or subacute facilities, is short and the average length of stay is typically between six-eight days. NARBHA maintains a network of small residential facilities for adults (16 beds and under) who may be transitioning out of an inpatient setting or who may need additional support before living independently in the community. These residential facilities are typically homes in private neighborhoods that have 24/7 staff to provide treatment, support and rehabilitative services. NARBHA also has an ever-growing network of supported housing for members, including young adults receiving SMI services.

In accordance with Children's Principle #6, "Services are delivered in the most appropriate setting" NARBHA has established, and continues to grow, a network of family-based services for children through providers of HCTC Homes (formerly known as therapeutic foster care homes) in northern Arizona which provide family-based treatment for children; currently NARBHA has 33 HCTC homes under contract in northern Arizona and NARBHA is supporting two additional agencies, Community Counseling Centers in Navajo County and Child and Family Support Services, in becoming DES licensed Child Placement Agencies which will enable these agencies to recruit, train, and support additional HCTC homes. NARBHA contracts with two Generalist Agencies that deliver flexible wrap-around services in a member's home. NARBHA has residential facilities in northern Arizona for adolescents, including adolescents with sexualized behaviors.

To help ensure that dually enrolled members (DD/BH) are not institutionalized, NARBHA, in collaboration with DES/DDD, developed block purchase contracts for specialized assessment, treatment planning, and skill building for dually enrolled members and their families. In partnership with DES/DDD and the Navajo Nation DBHS, NARBHA recently expanded this program and is delivering this service to dually enrolled (DD/BH) members on the Navajo Nation through bi-lingual Navajo Behavioral Analysts that are employed through Behavioral Consultation Services of Northern Arizona, which is affiliated with Northern Arizona University. Also to support dually enrolled members, NARBHA worked

with a provider to develop a short term residential setting for dually enrolled adolescents in need of stabilization services in Flagstaff.

Description of efforts taken to ensure that a priority is placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institution or alternative residential setting. To that end, the development of home and community based services shall include provisions for the availability of services on a seven day a week basis, and for extended hours, as dictated by member needs:

To ensure that NARBHA members are able to live in their own homes NARBHA has greatly expanded its supported housing program and now has over 400 supported housing units for members with SMI throughout the GSA. Last year, with unspent Non-TXIX SMI funds, NARBHA received ADHS permission to purchase 33 additional housing units at five (5) different locations throughout northern Arizona. NARBHA has been in the process of renovating this housing and preparing the new units for occupancy.   NARBHA has also partnered with NAZCARE, a PFRO, to develop housing that is supported by the Recovery Support Specialists employed by the PFRO. In addition to NARBHA's ever-growing housing programs, NARBHA established a Move-in Assistance and Eviction Prevention Program to financially assist members to overcome the high cost of moving into and maintaining occupancy in their own home.

To ensure that members and families have access to flexible support and rehabilitation services that are available anytime that meets the family's needs, NARBHA contracts with Arizona Children's Association and Child & Family Support Services for the delivery of Generalist Services throughout the region. Generalist services are part of the Meet Me Where I Am initiative and offer support and rehabilitation services that are available in a family's home and at any time the family needs – including weekends and nights.

Description of the interventions the RBHA implements to reduce avoidable/preventable ER utilization and the outcome of those interventions.

NARBHA continually seeks to reduce avoidable ER utilization by ensuring collaboration at the local level between service providers and first responders, developing alternative observation/stabilization facilities, and participating in community initiatives to develop appropriate alternative services such as, "housing first" models of housing, and prevention activities that promote wellness and special responses for high-risk members.

To ensure that mobile crisis services are integrated and coordinated with local first responders, NARBHA is requiring all RAs to develop a Joint Protocol with first responders in each community to ensure that ERs are appropriately utilized. NARBHA also participates in the Closing the Gap community forums to find alternative methods to reduce "serial inebriation" and its personal and community costs. As part of Closing the Gap activities, a couple years ago NARBHA supported a, "Street to Home" initiative which provided "wet housing" to several members in the community who were high-utilizers of ER and first responder services. Ultimately this program was not successful because the housing units were scattered sites and the members were quickly evicted; however, the development of Closing the Gap led to stronger ties with law enforcement agencies, an expansion of Traditional Practitioner services, and collaboration with Native American Connections to develop housing services for members with substance abuse issues in the Flagstaff area.

NARBHA has been working with their network of inpatient providers to develop observation/stabilization units where members who are intoxicated and/or who may be a danger to self or others may be safely observed by medical staff at the RA's facility, rather than in an ER. The Guidance Center in Flagstaff is the first in the NARBHA provider network to develop an observation/stabilization unit, which should be open in the fall of 2014.

NARBHA has developed and maintained four (4) Substance Abuse Stabilization facilities in communities that border Tribal Nations: Holbrook, Winslow, Page, and Flagstaff. These "safe shelters" help prevent ER utilization and are overseen by EMTs or similarly trained staff.   In the past year, these four facilities served 874 members.

NARBHA Care Managers and physicians ensure that high risk members are immediately identified and tracked, and that the SHOUT protocol is followed for that member during the year. Members with an attempted hanging, suffocation,

strangulation or firearms; or more than one attempt requiring medical intervention, are placed on the SHOUT registry. The SHOUT Protocol uses actionable, evidence-based interventions beginning in the ED. It is incorporated into the provider contracts. Each person on the registry is followed through monthly telephone rounds conducted by the NARBHA Associate Medical Director, a NARBHA care manager, and the provider clinical team to ensure adherence and clinical oversight. Only 10.8% of these highest risk members have had subsequent attempts—a 50% reduction prior to SHOUT.

The RBHA's process for addressing preventable crisis stabilization and psychiatric in-patient utilization.

The causes of avoidable/preventable crisis stabilization/inpatient utilization for NARBHA are multi-faceted, over-lapping, and can include a lack of:

- Available and accessible community based services such as respite, vocational services, care management, transportation, and family and peer support services that can prevent inpatient services;
- Safe and affordable housing;
- Engagement with the member, their family, and community natural supports;
- Awareness of where to turn for help before a crisis occurs;
- Same-day access to medical practitioners who can adjust and renew medications when members have urgent needs;
- Specialty providers, such as Behavioral Analysts who specialize in working with dually enrolled (DD/BH) members;
- Coordination and communication between physical health and other behavioral health providers; and
- Alternatives to inpatient care and crisis de-escalation such as Substance Abuse Stabilization services and peer-run Warm Line services.

Stigma related to behavioral health disorders can also be a barrier to a member or family seeking or receiving community-based services that can prevent the need for inpatient services. Other barriers to accessing community based services include fear of being discovered as an undocumented person, fear of incurring financial costs related to treatment if a person does not have AHCCCS or another source of payment for services, or concern that community based services will not be relevant or respectful to a person's cultural beliefs and practices.

NARBHA's RAs have either implemented, or are in the process of implementing, Open Access or same-day appointments for members. Open Access allows members to be seen by behavioral health staff person on the same day they call or walk in to request an appointment instead of having to wait for a scheduled appointment at a future date. Open Access has improved member satisfaction, improved member motivation, and reduced "no show" rates.

In addition, each of NARBHA's RAs maintains an urgent care program that allows nurses and medical practitioners to set aside time to address immediate needs. The urgent care programs at the RA clinics provide an intermediate step between emergency services and routine care. Typically for an urgent care visit, a nurse will conduct the initial triage and history gathering and then the medical practitioner will handle the urgent care.   Urgent care services can be accessed directly through a member's request or through referral from a case manager, crisis team, or another medical practitioner.

To prevent unnecessary inpatient utilization through urgent care/crisis facilities, NARBHA has developed four Substance Abuse Transitional facilities throughout the region. These four facilities are located in Flagstaff, Page, Winslow and Holbrook. The facilities are staffed with Emergency Medical Technicians, peer support specialists, and other behavioral health staff. The facilities are specifically designed to support and assist the member in a safe setting that is operating on a 24/7 basis and helps prevent the need for inpatient services.

Through NARBHA's Inpatient Work Group the exploration of safe and cost-effective alternatives to inpatient services are continually identified and discussed. "Living Room" models, outpatient and hospital-based Observation and Stabilization services are being explored. Another model NARBHA is actively pursuing that would provide crisis services are

combinations of out-patient clinics licensed to provide crisis services in conjunction with Substance Abuse Transitional Agency or residential treatment services. As NARBHA moves the Holbrook Transitional facility to Chemical Dependence residential treatment there will be a greater continuum of crisis and treatment services in rural communities. Therefore, first responders, family members, or individuals in crisis will have greater access to crisis services and connections to out-patient treatment, community supports, or if needed, a higher level of care.

B. Special Populations

Developmental Disability-Adult &Child

NARBHA takes necessary and appropriate steps to ensure that special consideration is given when coordinating services for members with developmental disabilities. The DDD Liaison at NARBHA works in conjunction with staff from DES/DDD in northern Arizona as well as staff from the RAs to develop plans and implement services that meet both the behavioral health and developmental needs of the members. Child and Family and Adult Team (CFT/AFT) members include behavioral health and DDD staff, as well as any other participants requested by the member/family. Behavior treatment goals are developed with the special needs of the members and services are centered on a positive approach to skill development.

A block purchase agreement is in place with CPES/Counseling & Consulting to provide outpatient services such as functional behavior assessments, counseling and specialized behavioral plans for members with developmental disabilities. In the past year, (and despite funding shortfalls), NARBHA worked with CPES/Counseling and Consulting to expand the block purchase contract for residential services in Flagstaff for dually enrolled (DD/BH) youth who required stabilization services. A contract is also in place with Dr. Joe Gentry, an autism specialist, to provide a variety of assessment and consulting services for members within the network who are diagnosed with autism. Specialized assessment services for dually-enrolled members are also available through CPES/Counseling & Consulting and Behavioral Consultation Services of northern Arizona. In the coming year, NARBHA will be expanding the contract with Behavior Consulting Services of northern Arizona, a specialty provider with considerable experience working with children and adults with developmental disabilities. This provider will also be engaged to provide functional behavior assessments, counseling, training, and positive behavioral support to Navajo Nation members with developmental disabilities.

NARBHA has also mandated that, due to the unique needs of this population, all members with developmental disabilities (unless otherwise documented) are to have a crisis plan developed by the CFT/AFT in order to avoid restrictive behavioral health placements whenever possible. To better serve this population, NARBHA requires each Responsible Agency (RA) to have at least one DD specialist who is trained on the unique needs and strengths of members with developmental disabilities and how to effectively navigate the DES/DDD system of care. These individuals have completed a specialized training and competency curriculum specific to the DD population, the DDD system and the interaction and collaboration between DDD and NARBHA.

NARBHA currently has seven DDD specialists with a DBHS Attestation. One (1) is located in Coconino County where there are 223 DDD members, three (3) are in Yavapai County which has the most DDD members at 339, one (1) is in Mohave County with 201 members and two (2) specialists are located in Phoenix. Adult DD specialists have increased in FY14 by nine. All medical practitioners at NARBHA's RAs currently work with DD members, though they do not have a DBHS specialty attestation. NARBHA requires that each of our provider agencies has at least one DD Specialist who has completed the NARBHA required curriculum course – this curriculum trains the staff person in the unique treatment and system needs but does not include the extensive ADHS/DBHS training to become designated as a DBHS specialty provider. Child DD specialists have also increased for FY14 by three (3). All medical doctors at NARBHA's RAs also currently work with DD members, though they do not have a DBHS specialty attestation.

CMDP

NARBHA ensures that any child who is removed from their home by DCS is assessed by a behavioral health representative within 72 hours of that removal. The assessor provides a face-to-face evaluation of the behavioral health needs of the child. If the needs are immediate, services are provided at that time. The behavioral health assessor also provides any necessary support to the care giver. Assessment findings are made available to DCS for inclusion in the

initial court hearing. Children involved with the DCS system are provided the full continuum of services based upon assessed need with family and DCS staff input. Specialized services include HCTC homes, neuropsychological testing, positive behavioral supports, specialized assessments and treatment planning for CMDP members who may also have developmental disabilities, and psychosexual evaluations.

Sex Offender Treatment-Adult & Child
Sequel Care operates residential facilities and an out-patient clinic in northern AZ for youth with sexually maladaptive behaviors.   Outpatient services and specialized counseling are provided by West Winds Counseling in Yavapai County and Grossman and Grossman in Maricopa County.

Sexual Abuse Trauma-Adult & Child
NARBHA has trained all providers in trauma informed care and also has 24 specialists who meet the ADHS/DBHS criteria for Specialty providers in sexual abuse trauma.

Substance Use-Women, Adult, Child, & IV Drug Use
NARBHA has 343 IV Drug Users being served in the SAPT program. NARBHA RAs provide both counseling and Intensive Out-Patient Groups for adults and youth with substance use disorders. Three (3) RAs operate Chemical Dependence Residential Treatment (one (1) specific to Women and two (2) coed) and two (2) additional RAs are developing Chemical Dependence Residential Treatment (one (1) specific to American Indian men and one (1) coed).   Three (3) RAs operate Substance Abuse Stabilization facilities. One (1) RA operates three (3) methadone clinics in the region.

Infant & Early Childhood
Each NARBHA RA has staff designed and trained in (birth to 5) services and there are five practitioners who meet the ADHS/DBHS Specialty staff criteria. The ratios for children with an open EOC to specialty providers are the highest in Mohave County. For children under the age of five, there is an identified clinical team in a RA in Coconino County that could serve Navajo and Apache County members as well. There are other teams in Yavapai County and in Mohave County who work closely with system partners in the Best for Babies program.

Arizona Early Intervention Program (AzEIP)
NARBHA makes every effort to ensure that behavioral health services are provided with ongoing consideration of the special needs of children in need of the Arizona Early Intervention Program. All children who are referred to NARBHA, many through 72 hour response, have a basic screening completed to determine the nature of each child's needs. If it is suspected that there may be developmental delays the child is referred to AzEIP. If assessments determine that the child requires services from both NARBHA and AzEIP, ongoing coordination of care is maintained through the CFT process.

When a child (birth to 5) is assessed by a BH provider, the provider completes a standardized developmental assessment (normally "ages and stages.") If the clinician sees some developmental delays, he/she will refer to DES AZEIP so they can assess and provide therapeutic techniques to help the child "catch up." This provides support to early intervention programs, providers and families through an interagency agreement with the Department of Economic Security (DES). Through interagency agreements with the Division of Developmental Disabilities (DDD), the Arizona Schools for the Deaf and the Blind (ASDB) and its own contractors, AzEIP is responsible for administrating and overseeing early intervention services throughout the State.

Homeless
NARBHA contracts with Catholic Charities Community Services to conduct outreach to homeless members and implement the Projects in Assisting the Transition from Homelessness (PATH) grant. In FY13 PATH outreached to 823 members in Coconino and Yavapai Counties resulting in 98 newly enrolled members with an open EOC.

Significant focus continues to be placed on providing a full continuum of support and services to each enrolled member, ranging from basic survival necessities to medical care to supportive housing, providing an individualized platform from which to tackle the cycle of homelessness. NARBHA's PATH Team outreaches on a daily basis in both Coconino and Yavapai counties. NARBHA is an active participant in the Balance of State Continuum of Care group that serves to

identify, analyze and plan for the homeless population in Rural Arizona. NARBHA participates in the HUD sponsored Homeless Point In Time Count (PIT Count), which serves to locate and accurately count the number of members experiencing homelessness on a specific day, providing homeless persons with an array of resources to access in order to attain the goals of stable housing.

NARBHA contracts with Catholic Charities Community Services to conduct outreach to homeless individuals and implement the Projects in Assisting the Transition from Homelessness (PATH) grant. In FY2014 PATH outreached to 1070 people in Coconino and Yavapai Counties resulting in 116 newly enrolled PATH clients.

The number of homeless individuals enrolled in PATH by the outreach team in FY2014 reflects the focus of success for each individual enrollee, rather than enrolling as many individuals as possible. Significant focus is placed on providing a full continuum of support and services to each enrolled client, ranging from basic survival necessities to medical care to supportive housing, providing an individualized platform from which to tackle the cycle of homelessness. Additionally, on the client level, there was a concerted effort in FY 2014 to gain knowledge and understanding of the SSI/SSDI Outreach, Access and Recovery (SOAR) processes in assisting PATH clients with their applications for disability benefits.

NARBHA's PATH Team outreaches on a daily basis in both Coconino and Yavapai counties. NARBHA is an active participant in the Balance of State Continuum of Care group that serves to identify, analyze and plan for the homeless population in Rural Arizona. NARBHA participates in the HUD sponsored Homeless Point In Time Count (PIT Count), which serves to locate and accurately count the number of people experiencing homelessness on a specific day, providing homeless persons with an array of resources to access in order to attain the goals of stable housing. The information from the PIT Count is then reported and incorporated into annual State and Federal reports on homelessness. The information can then be utilized when applying for grant monies to serve the homeless population. The numbers from the PIT Count are analyzed and used to identify areas of high need, assisting NARBHA, Responsible Agencies and other providers in grant and report writing geared toward expanding services to homeless individuals and families.

Additionally, NARBHA contracts with Mohave County Community Services to administer the pilot Bridge Subsidy Program (BSP) and administers the Flagstaff Pines Housing program. BSP consists of providing housing to members/families that are homeless or at risk of becoming homeless, and have a Serious Mental Illness (SMI) diagnosis. BSP serves to bridge the waiting time between applying for Section 8 permanent housing and actually receiving a voucher, which can span years. The Flagstaff Pines House Program is a HUD supportive housing grant that provides housing to homeless or at-risk members in Coconino County experiencing a disabling condition such as Serious Mental Illness or Substance Use Disorder.

Border Communities
Network development in NARBHA's border communities has focused upon expanding the Chemical Dependence (CD) residential facilities – one (1) in Holbrook (Navajo County) and one (1) in Bullhead City (Mohave County). The Holbrook CD residential facility will have a sweat lodge and access to Traditional Healers and other American Indian healing ways.

Also in the past year NARBHA's collaborative program for dually enrolled (DD/BH) American Indians was launched and is growing. Through a collaborative partnership with DES/DDD, ADHS/DBHS, NARBHA and the Navajo TRBHA, a contract was established with Behavioral Consultation Services of Northern Arizona (BCSNA) to increase the penetration rates and offer culturally relevant services to Navajo DD members on the Navajo Nation. BCSNA, a pioneer in Behavioral Analysis and affiliated with Northern Arizona University, has hired and trained Navajo Behavioral Analysts to support and assist families with dually enrolled members.

Veterans
NARBHA is partnering with the Veterans Administration and training providers to tailor behavioral health services specific to the unique needs of Veterans and their families. Ensuring Veterans receive the understanding, support and help they deserve is a priority for NARBHA. NARBHA and its provider network participate in local Stand Downs for the expansion of housing and related services for veterans and NARBHA provides training to its provider network on the unique needs of veterans. In August of 2014 NARBHA, in collaboration with the Prescott Veterans Administration, is co-

hosting a program on building capacity and competencies within our communities and network to better serve our veterans. This program will include increasing navigators, resources and barriers to accessing services, and supporting families of veterans.

All NARBHA members who are veterans receive a full array of Behavioral Health Covered Services. NARBHA currently has 340 veterans with an open episode of care, Specific services provided to veterans are: Counseling, Case management, Peer Support, Living Skills, Job training, Doctor and RN services, Med Management, Lab, Psychiatric Inpatient, Detox Inpatient, Personal Care, and Transportation.

LGBTQ
Expanding and improving services for members of the LGBTQ community remains a NARBHA priority.   NARBHA established a sub-committee to its Cultural Awareness and Diversity Committee on LGBTQ issues to develop and implement provider staff competencies in serving LGBTQ members. NARBHA is also reaching out to Tribal Nations to bring awareness and focus upon the unique needs and issues related to LGBTQ members. In late 2014 NARBHA will sponsor a LGBTQ summit to increase resources, expand staff competencies, raise awareness, and develop "safe spaces." NARBHA is working with a nationally recognized consultant to develop curriculums for provider agencies and Tribal communities to better serve LGBTQ members and reduce stigma and other barriers to effective services.

All NARBHA members receive a full array of Behavioral Health Covered Services. NARBHA currently has 496 members with an open EOC in the LGBTQ populations. There are 98 Asexual, 190 Bisexual, 65 Gay, 123 Lesbians and 20 members that are questioning their sexual orientation. Specifically, services provided to LGBTQ members are: Counseling, Case management, Peer Support, Living Skills, Job training, Doctor and RN services, Med Management, Lab, Psychiatric Inpatient, Behavioral Health Residential, Personal Care, and Transportation. NARBHA is providing training to provider staff on the unique needs and issues of LGBTQ members.   At least one RA is providing a LGBTQ support group for members. NARBHA is working with Hess III Consulting to develop comprehensive approach to LGBTQ issues and treatment needs.

Transition-Aged Youth
NARBHA continues to support and monitor the utilization of nine full time equivalent's funded through the 18-21 GMH/SA Support and Rehabilitation Services initiative. Program development meetings are conducted between providers and NARBHA on a quarterly basis. Regional Transition to Adulthood training continues to be offered by NARBHA at RAs or stakeholders across northern Arizona. As a part of the training curriculum, providers are familiarized with the availability and value associated with utilizing support and rehabilitation services to address the needs of young adult consumers. NARBHA provided a Transition to Adulthood workshop at the 1st Annual Coconino County Transition Fair

GSA 2, 3, & 4
Cenpatico consists of three (3) separate GSAs and includes the counties of La Paz and Yuma (GSA 2), Greenlee, Graham, Cochise and Santa Cruz (GSA 3), and Gila and Pinal (GSA 3). All Colorado River Indian tribal land also falls within the geographic boundaries of GSA 2, however, these tribal members are served by a Tribal Regional Behavioral Health Authority (TRBHA). Cenpatico provides all behavioral health members a choice of two Intake and Care Coordination agencies within 30 miles of their residences. These agencies are contracted to supply a full array of outpatient behavioral health services, as outlined in the ADHS/DBHS Covered Services Guide. Cenpatico has funded most Intake and Care Coordination providers to serve all members in each Behavioral Health Category (Child/Adolescent, General Mental Health, persons with Substance Use Disorders (SUDs) and persons with Serious Mental Illness), with consideration for special populations, including persons with developmental disabilities, homeless persons, tribal members, members residing in border communities, transition age youth, CMDP and AzEIP. All Intake and Care Coordination providers are required to provide timely access to covered behavioral health services that are effective in achieving individual service plan (ISP) goals and delivered in a manner consistent with the Arizona System Principles. If the Intake and Care Coordination agency does not offer a needed service, the provider is responsible for developing the service or referring the member to another qualified service provider within the network. In situations where there may not be a provider qualified to provide the service, the provider may request services through an out-of-network provider.

A. How members access the system

Members access Cenpatico's system primarily by presenting at any Intake agency within one of Cenpatico's service areas. The intake agency will access for eligibility and with the members input design an individual service plan. If specialty services are required the intake agency will contact the provider agency and ensure they have received the necessary paperwork to offer services. At times, members access the system straight from the ED or hospital through a crisis mobile team. After the crisis has been abated, the member is offered services through an intake agency where an individual service plan is created.

Description of how the RBHA assesses the medical and social needs of new members to determine how the RBHA may assist the member in navigating the network more efficiently:

Cenpatico providers assist members in achieving the best possible health outcomes and to look at the whole person and not just behavioral health needs. Cenpatico's network of providers work with members based upon the Eight Dimensions of Wellness. Efforts taken via Cenpatico's network of providers may include accompanying a member to a PCP visit, a case manager assisting a member with locating spiritual outlets, or providing a member with resources for leisurely activities to enhance the member's social network.

Description of what assistance is provided to members with a high severity of illness or higher utilization to better navigate the provider network:

Members with a high severity of illness or higher utilization are tracked in Cenpatico's Previdence system. The Previdence system was built around the Eight Dimensions of Wellness and tracks the member's current health condition, lifestyle, and assess chronic conditions, etc. Cenpatico members with high needs are seen at least once a month where updated information is entered into Previdence.

Members with High Needs are referred to High Need Recovery Centers. High Need Recovery Centers employ 24/7 Road to Recovery programs for adults and 24/7 Meet Me Where I Am programs for youth. These Centers maintain a low staff to member Dedicated Recovery Coach (Dedicated Case Manager) ratio at a 1:20 ratio. The focus of treatment is based on the principles of recovery, and includes wrap around services, supportive employment, health promotion, and stable housing. By providing intensive community supports, members are able to stay in their homes and communities and avoid ED utilization. Support and Rehabilitation Services is an important component in supporting an individual's recovery. The funding of additional support and rehabilitation staff, along with the decreased caseloads carried by the Dedicated Recovery Coaches, allow for the delivery of more intensive services to aid in the reduction of out-of-home placements, inpatient hospitalizations and emergency room visits. The Road to Recovery Program not only focuses on getting members involved in school, employment, volunteering or other community integration activities, but also has a Wellness component that assists individuals in improving their health and thus reducing hospitalizations pertaining to medical issues.

All High Needs Recovery Centers participate in the monthly Road to Recovery and Meet Me Where I Am Program technical assistance conference calls. Technical assistance is provided regarding Evidenced Based Practices related to the needs of Individuals with High Needs, appropriate service utilization and expectations for this population are discussed and High Need Recovery Center staff are given an opportunity to discuss the successes they are experiencing in implementing the program and address any barriers that have been identified.

Monthly member success stories provided by each Center indicate that the Road to Recovery Program and Meet Me Where I am programs are meeting the established outcome goals. Success stories provide anecdotal information indicating that adult members are engaging in more daily meaningful activities, integrating more into the community, more open to receiving services, are engaging in both volunteer and employment activities and even starting their own businesses. Youth members are remaining in School and in the Community.

Description of how members with chronic medical conditions are identified by the RBHA including a description of how placement options are coordinated with/communicated to Contractors providing Acute Care services:

Chronic medical conditions are identified during the intake for the initial demographic. Cenpatico encourages network providers to integrate physical health programming with behavioral health programing as often as the member desires. Cenpatico's Intake and Care Coordination Agencies (ICC) work closely with the AHCCCS health plan. Working closely with the AHCCCS health plan enables Cenpatico to provide physical health oversight which allows for the opportunity to achieve a successful discharge from any hospital setting. Providing physical health oversight also assists in reducing hospitalization readmission and ensures the health of the member.

Methodology(ies) the RBHA uses to collect and analyze member, provider, staff and other stakeholder feedback about the network's design and performance. When specific issues are identified, the protocols for handling those issues.

Cenpatico holds Peer & Family Advisory Councils in 14 different communities throughout Cenpatico's GSAs every month. Information is disseminated to these Councils regarding the performance of the Cenpatico network and input is obtained from community members for the System of Care Plans. Cenpatico also hosts a Quarterly Cenpatico Peer & Family Advisory Board comprised of participants and family members from all regions to aid in the development of network plans. In addition, each month a Quality Management measure is presented to the Peer and Family Advisory Councils and they are asked for feedback on how Cenpatico might improve the positive outcomes of that measure.

Each spring, the CEO of Cenpatico and other key staff members host a forum in the six major communities in GSA 02 and 04; Apache Junction, Globe, Casa Grande, Payson, Yuma and Parker. In the fall, Cenpatico hosts forums in seven (7) communities in GSA 03 (Nogales, Bisbee, Sierra Vista, Douglas, Benson, Safford, and Willcox). These forums provide Cenpatico the opportunity to share information regarding both past and future initiatives as well as give members in the communities the chance to voice any comments or concerns regarding the services provided or needs in their own community.

Cenpatico has invited representatives from each GSA to act as members of the Efficiency Committee in order to ensure that providers are involved in decisions involving provider processes and reports. Additionally, Cenpatico works with provider agency staff in developing the System of Care Plans. Cenpatico uses all of these avenues to help determine new initiatives and how these new initiatives can be rolled out across the network. Cenpatico invites provider representatives to participate in several of their internal committees.

Cenpatico's staff has multiple opportunities to express concerns or make suggestions to the Network Development division and Cenpatico expects staff to be "solution-focused" in addressing issues across the System of Care. Staff is invited to communicate thoughts and opinions regarding the network to supervisors and any staff that attends one of Cenpatico's various committees has the opportunity to provide input – regarding the network – at these committee meetings. Also, Cenpatico's upper management has an open door policy with all employees, encouraging them to express their input/feedback regarding the Cenpatico Network.

Description of the most significant barriers to efficient network deployment within the RBHA's service area.

Cenpatico has experienced difficulty with securing licensed professional with specific specializations in certain areas as the eligible/enrolled population may be too small to provide enough work to support the position. Cenpatico has continued to support provider' workforce development efforts by sharing various recruitment methods, and promoting internship and loan repayment opportunities. Another significant barrier that has challenged Cenpatico is providing residential and inpatient services in remote areas. There is a limited demand for residential and inpatient services in the remote areas that does not justify the cost of developing facilities in rural communities. To circumvent this barrier, Cenpatico promotes the use of tele-medicine for psychiatry services along with extensive transportation services to overcome access to care challenges in remote areas.

Description of network activities, including payment reform/value based purchasing efforts, aimed at enhancing efficiencies and improving the quality of care provided to members.

To increase participation in their provider network Cenpatico has instituted non-financial incentive programs such as encouraging providers to improve the quality of services through publishing comparative data in the form of dashboard

reports, public celebrations of success, and collaborative corrective action processes. In addition, Cenpatico holds several educational events throughout the year, which allows contracted providers to gain access to critical state and federal updates, new evidence-based standards in care, and an ability to share their own lessons learned with their peers. Cenpatico has seen that providers who meet minimum quality standards are subject to fewer audits—which is made transparent to all providers.

Cenpatico also provides monetary incentives to improve and sustain key measures of performance. Cenpatico's subcontracted providers can earn incentive monies by satisfying the given criteria for a specific performance measure. Cenpatico offers certain data-driven incentives that are paid based on performance measures by Cenpatico's data system. Some of the monetary incentives Cenpatico offers are for performance in the following areas: Assessment Updates, Consumer Satisfaction with Service Outcomes, and Operational Excellence.

Description of how the RBHA will handle the loss (closure, contract termination) of a major healthcare provider (hospital, nursing facility, large provider group).

In the instance that a large provider group leaves the Cenpatico network there are processes in place that help to guarantee continued treatment for members. Initially, Cenpatico coordinates with the agency that will be leaving the network to make sure that all of their members have access to the services they have been receiving at other agencies in the area. When the agency of best fit is found for the member, Cenpatico coordinates communication between both agencies to ensure a proper transition of the member. Cenpatico continues monitoring the progress of members' transitions after the actual transition occurs to make sure that the member was not *only* transferred to their new agency, but is actually receiving services. If Cenpatico, in cooperation with the member, is unable to find a suitable provider in network, or if the member requests to continue services at the previous provider – assuming that the provider did not close – a single case agreement will be pursued in order to grant the member access to the best possible treatment available to them. Additionally, if the loss of a major provider leaves a gap in the network, action will be taken to contract with similar providers in the area.

Relationships between the various network partners (focus on provider to provider contact and facilitation of such by the T/RBHA; e.g. PCP, Specialists, Hospitals:

Cenpatico members may choose to change providers at any time. The member's transfer request is entered into the provider portal where the request is accessed by the provider of the member's choosing. Cenpatico monitors the process to ensure the transfer is completed in a timely manner. Additional services from specialty agencies are available to members if deemed necessary by the treatment team. In the event that specialty services are needed, the specialty service agency is contacted to participate in the Child Family Team (CFT) or Adult Recovery Team (ART) meeting and the services that will be provided by the specialty agency is added to the member's ISP.

Individual Member Care Coordination: Cenpatico works with all of the acute care health plans to coordinate care for high need/high cost members. Their Medical Management Care Managers focus on integrated care and keeps in regular contact with providers and health plans in order more effectively coordinate care for members with high members. Cenpatico is working with the Nursewise Crisis Line to flag members considered to be high need or high cost. New lists are sent each month on the last business day of the month, from Cenpatico to NurseWise. NurseWise uses Trucare queues to report if contact has been made with the members and the outcome of the calls.

Program Development Efforts: Cenpatico assigns stakeholder liaisons and program development staff to work directly with system partners to align programs and facilitate opportunities to work in collaboration to serve the needs of shared members. Regular meetings are conducted with each system partner to identify areas for better collaboration and coordination of care. Meetings are held with DES/DDD, AOC, DCS/CMDP, VA, County Juvenile and Adult Probation, DES/RSA, DOC, Department of Education and local School Districts, County Problem Solving Courts, Health Plans, first responders, local jails, and ERs. The meetings focus on system collaboration, identifying system partner goals, identifying gaps in services and overcoming barriers to care.

Description of the available alternatives to Nursing Facility placement such as Assisted Living Facilities, alternative residential settings, or home and community based services for members:

Cenpatico makes every effort to offer services to members that allow them to stay in their homes and communities. Cenpatico's Meet Me Where I AM (MMWIA) campaign has focused its efforts on high needs children serving 1,495 children 1,561,758 units of service in FY13. In addition, Cenpatico's Road to Recovery campaign for high needs adults saw 3,479 members with high needs during FY'13 and those members received 372,718 units of service during that time frame. Both the MMWIA and Road to Recovery programs offer services outside normal business hours and on the weekends to accommodate member's needs. If the member is found to need additional services for a period of time, 46 facilities offering Behavioral Health Residential services are available in Cenpatico's GSAs. Behavioral Health Residential services are meant to be a short term response to an intense need. Cenpatico ensures discharge planning begins right away to make certain that the member is safe and secure in their home after discharge.

Adults with high needs are wrapped in services based upon the Eight Dimensions of Wellness. Cenpatico's ICC agencies have been trained to look at the whole person that includes their social, physical, environmental, occupational, spiritual, and mental health needs. In addition to the six dimensions mentioned, the ICC agencies work with the members to ensure they are financially stable and have adequate housing. Agencies have been tasked with meeting with all high needs members no less than once per month and assessing their needs and updating their progress toward achieving their goals.

Nursing Facilities are not an approved provider type under the current DBHS Covered Services Guide or B2 matrix for RBHAs. Cenpatico does not utilize Nursing facilities for treatment or Crisis Stabilization. Cenpatico utilizies Crisis Living Rooms, 23 Hour Placements, Behavioral Health Residential Facilities, the Assessment and Intervention Center, Rural Stabilization and Recovery facilities, the Meet Me Where I Am and the Road to Recovery programs to stabilize members and assist their successful return to the community.

Description of efforts taken to ensure that a priority is placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institution or alternative residential setting. To that end, the development of home and community based services shall include provisions for the availability of services on a seven day a week basis, and for extended hours, as dictated by member needs:

Cenpatico implemented Meet Me Where I Am (MMWIA) and Road to Recovery as an alternative to placing children and adults in out of home placement. MMWIA agencies were chosen based on capacity and ability to serve children. Agencies offering MMWIA services in GSA 2 and 3 are: Community Intervention Associates (CIA) and Arizona Counseling and Treatment Services (ACTS). MMWIA services offered in GSA 4 are: Arizona Children's Association (AZCA), Mountain Health and Wellness (MHW), and Horizon Human Services (HHS). Each of the agencies that provide MMWIA services assists high needs children and families in need of support and rehabilitation services that are essential to the youth remaining at home and in the community.

Cenpatico used the MMWIA campaign as the basis for the development of the Adult Road to Recovery program that was implemented at the end of FY2010. Road to Recovery focuses on employment, housing, support and rehabilitation services and health & wellness. Cenpatico contracts with at least one High Need Recovery (HNR) provider throughout GSAs 2, 3 and 4. The Road to Recovery program provides 24/7 service that is geared toward helping adults live successfully in their communities. Cenpatico collaborates closely with the HNR Providers to ensure the delivery of peer support services, skills training services, employment services and health promotion services over basic case management services, to ensure members are equipped to live independently in the least restrictive environment possible.

Cenpatico closely monitors out-of-home care. With exception to substance use disorder treatment, all out-of-state placements are reviewed for prior authorization and continued stay authorization. This process ensures that Cenpatico's treatment teams do everything they can to bring adults and children back to their communities as soon as medically appropriate. Out of Home Placements in this instance include Behavioral Health Inpatient Facilities, Behavioral

Health Residential and HCTC Placements. Cenpatico typically has a low number of children placed in HCTC or residential facilities. Cenpatico currently has no children in Acute Residential Behavioral Health facilities.

Description of the interventions the RBHA implements to reduce avoidable/preventable ER utilization and the outcome of those interventions.

Cenpatico reduces Emergency Room Utilization through liaison activities with local Police, EMS, Sheriff and EDs. Cenpatico educates first responder stakeholders as well as the communities and providers on avoiding ED utilization on members not experiencing a medical emergency.

Cenpatico developed a Crisis Living Room in Yuma and Rural Substance Abuse Recovery Centers in Yuma, Casa Grande, Benson, Globe and Payson. These facilities accept police drop offs and help to reduce the overuse of EDs. Cenpatico have Crisis Mobile Teams in every community over 5000 citizens. These Crisis Mobile Teams meet members in the community settings reducing the dependence on EDs. Cenpatico developed the Road to Recovery for adults who were determined to have high needs which mirrored the MMWIA programs for children. R2R is the programming for adults that are receiving services from our High Needs Recovery Centers (HNRC). By providing intensive community supports, members will be able to stay within their homes and communities and avoid ED utilization. R2R services are available to members in all of Cenpatico's GSAs.

Cenpatico also conducts seven (7) and thirty (30) day follow-up tracking to ensure that a member who was previously hospitalized receives the care they need in a timely and consistent fashion when they leave the hospital. The seven (7) day portion of the audit ensures that a Cenpatico member will have access to an appointment at an intake agency within seven (7) days of their release from the hospital. The thirty (30) day portion of the audit ensures that the member was seen again within thirty (30) days of their release from the hospital in order to ensure that the member is receiving consistent and adequate service for their particular need.

In addition, Cenpatico has been tracking members with high needs using the Previdence web application. Using Previdence, Cenpatico is able to view the status and/or progress of members with high needs on a monthly basis. Previdence and Cenpatico will alert providers when a member shows any "red flags" that could possibly lead to a hospital admission. To this end, Previdence has become an integral part of monitoring the high needs population and keeping hospital re/admission rates to a minimum.

Cenpatico has been receiving ER utilization data from University Health Plan for approximately nine months. The data are used by the Utilization Management department as part of the algorithm to identify high risk high cost members. Utilization Management Care Managers coordinate care with the health plans for these members. This information is provided to Intake and Coordination of Care Agencies to address in their treatment team meetings. These members are referred to High Need centers. The Cenpatico Road to Recovery Program is designed to help adult members live successful lives in the community, reduce the avoidable use of ERs, and avoid unnecessary out of home placements by identifying persons at risk and providing supportive services in the community on a 24/7 basis. Cenpatico's High Need Recovery Centers for Adults offer an array of Support and Rehabilitation Services to adults with complex needs. They provide support where it is needed: in the home, neighborhood, and other community settings where problems occur or stresses arise, and provide flexible, individualized care which is scheduled around the needs of the member (outside of normal business hours). Road to Recovery services are provided to adults who need them most, when and where they need them, for as often and as long as they need them, as determined by the Adult Recovery Team. These services have assisted in preventing and responding to crisis situations.

Due to challenges with the ER claims data (claims lag, data lag), it is difficult to design an analysis of the impact of their efforts to avoid the over-utilization of ERs. This will be easier to address with the integrated RBHA serving Adults with SMI. Cenpatico has also found ERs unwilling to collaborate on reducing ER utilization, presumably due to the prospect of reduced revenue. The 7 and 30 day follow up after discharge scores are increasing. Cenpatico has previously had over a 95% passing rate before provider type 77 was disallowed by the BQ&I specifications manual. Since then we have been working with providers to modify their processes and their billing practices.

The RBHA's process for addressing preventable crisis stabilization and psychiatric in-patient utilization.

Cenpatico developed a Crisis Living Room in Yuma and Rural Substance Abuse Recovery Centers in Yuma, Casa Grande, Benson, Globe and Payson. These facilities accept police drop offs and help to reduce the overuse of EDs. Cenpatico have Crisis Mobile Teams in every community over 5000 citizens. These Crisis Mobile Teams meet members in the community settings reducing the dependence on EDs. Cenpatico developed the Road to Recovery (R2R) for adults who were determined to have high needs which mirrored the MMWIA programs for children. The R2R is the programming for adults that are receiving services from our High Needs Recovery Centers (HNRC). By providing intensive community supports, members will not only be able to stay within their homes and communities and avoid ED utilization. R2R services are available to members in all of Cenpatico's GSAs.

The Road to Recovery Program emphasizes the importance an increase in Support and Rehabilitation Services plays in an member's recovery. The funding of additional support and rehabilitation staff, along with the decreased caseloads carried by the Dedicated Recovery Coaches, allow for the delivery of more intensive services to aid in the reduction of out-of-home placements, inpatient hospitalizations and emergency room visits. The Road to Recovery Program not only focuses on getting members involved in school, employment, volunteering or other community integration activities, but also has a Wellness component that assists members in improving their health and thus reducing hospitalizations pertaining to medical issues.

In addition to working with PCPs, Cenpatico and their contracted ICCs work directly with hospitals to ensure quality care for members. For instance, Cenpatico's Utilization Management department works with ICCs on planned hospitalizations, Cenpatico's contracted ICCs work with hospitals during every member's discharge, and hospitals contact the Nursewise crisis line when they believe a hospitalized individual is in need of a BH Intake. Nursewise is the hub of the crisis system and outreaches the ICC and care coordination agencies when the member in an open episode of care is seen in crisis. Nursewise also has the ability to book emergency appointments (within 24 hours) with all the Intake and care coordination agencies to further assure members needs are met during a crisis.

Cenpatico proactively educates the community, system partners, providers and families about alternatives to hospitalization and helps everyone understand that hospitalization can cause further trauma to children and should only be utilized in the most serious of circumstances. The majority of youth who are hospitalized in a psychiatric hospital are self-referred. Cenpatico utilizes a brief intervention program (BIPs) and Assessment and Intervention Center (AIC) to prevent psychiatric inpatient stays for child and youth members whenever possible. The BIPs provide a behavioral health residential environment for the short term (less than 7 days) to assess the needs of the child and give them a safe place to stay until such time that they are ready to return to their home or DCS placement. The AIC serves as a short term (approximately two to three weeks) assessment center where members receive a full psychological evaluation, a functional behavioral assessment, a psychiatric examination and given a plan to implement once discharged. The AIC team of professionals works with the Child and Family Team to develop a plan to maximize the opportunity for the child to live and thrive in the community. In addition to these specialty options, High Needs Recovery Centers were created to provide 24/7 wrap around services to children and families to help them live successfully in the community.

B. Special Populations
Developmental Disability-Adult &Child
Cenpatico updates the Collaborative Protocols annually in regards to working effectively and collaboratively with the Division of Development Disabilities. The goal of this meeting is to encourage purposeful partnership and collaboration. Cenpatico has included in the provider contract the requirements for DDD adults and children.

Cenpatico has identified which communities the majority of members with Developmental Disabilities reside. Based on the data, Cenpatico identified agencies with an area of concentration specific to the DD population and contracted with them to ensure the needs of this unique population are met. Cenpatico worked with Community Provider of Enrichment Services (CPES) to expand their expertise in DD /PDD population to provide specialized services in each GSA and major community. CPES provides Functional Behavioral Assessments (FBAs) and behavioral coaching in home and in their Assessment and Intervention program. CPES has offices in Yuma, Casa Grande, Tucson and Phoenix to cover the Cenpatico service area.

CMDP

Cenpatico coordinates with CMDP via the exchange of benefit information through telephonic communication and face-to-face interactions. When there is a barrier to care, both agencies work collaboratively to solve the issue and ensure the members have adequate coverage to fund medically necessary services. All services are tailored to the needs of children; however, the unique needs of children in state custody include sometimes frequent moves, increased needs for wraparound services, and coordination with multiple stakeholders.   In addition, CMDP staff has been instructed to contact Cenpatico Customer Service staff to work out any coverage gaps that may have occurred or for information on how to re-enroll a member with Cenpatico and restate their other AHCCCS benefits.

Cenpatico provides a Unique Needs Training Module in all GSAs in order to train staff on the unique needs of children in child protective custody. Between October 1, 2013 and September 1, 2014, 197 Cenpatico employees completed this training module across all GSAs to better serve the CMPD population and ensure high quality of care.

Sex Offender Treatment-Adult & Child

In GSA 2 and 4, Helping Associates and Grossman and Grossman provide sex offender outpatient services to adults and children with sexually acting out behaviors. In GSA 03, Helping Associates are available through telemedicine. Cenpatico contracts with Casa De Tucson that serves children from all GSAs in their behavioral health residential facility. Behavioral health inpatient facilities are available to Cenpatico youth members in need of sex offender treatment.

Sexual Abuse Trauma-Adult & Child

Cenpatico has a network of providers that offer treatment for sexual abuse trauma. In GSA 2, Arizona Counseling and Treatment and Community Intervention offers masters level counseling for adults and children. Master's level counseling for adults and children in GSA 3 is offered by the following providers: SEABHS, ACTS, CIA, and AZCA. In GSA 4, HHS, MHW, Corazon, AZCA, and Southwest Behavioral Health (SWBH) provide master's level counseling. In 2013, Cenpatico provided trauma focused CBT training for providers. Of the 70 clinicians attending, 50 clinicians were from Cenpatico providers.

Substance Use-Women, Adult, Child, & IV Drug Use

In GSA 2, Cenpatico providers offer low to high intensity substance use services. Methadone treatment is offered by Yuma Treatment Center. Community Bridges offers adult residential and outpatient substance use treatment services. Members in need of medical detox are transported to CBI sub-acute facility in Mesa. Crossroads operates an adult Substance Abuse Transitional Facility. Children under the age of 18 can receive substance use services from ACTS and CIA agencies. ACTS and CIA offer evidenced-based Matrix Model to treat children with substance abuse and dependence. Transitional Living Center (TLC) offers services such as: substance use peer support, informal job and housing referrals for members, and transitional housing for Cenpatico adult members transitioning from being incarcerated. Sub-acute hospitalization for members with co-occurring disorders is offered via MHW.

In GSA 3, Cenpatico providers offer gender responsive substance use treatment for women at the Renaissance House. Women are able to bring their children to this program, which removes the child care barrier to women with dependent children in recovery. These members receive assistance with employment and housing to transition back into the community. Many of the women are referred to this program by the courts, particularly for dependency and DCS issues. CBI provides a Substance Abuse Transition Facility and an adult Behavioral Residential facility for men and women. This site includes police and "sheriff drop off" services. Members needing medical detox are transported to CBI Mesa site. The Transitional Living Center (TLC) provides peer services for men and women in recovery in addition to employment support and informal housing arrangements. Wellness Connections offers peer support services in Sierra Vista and Douglas while NAZCARE provides peer support in Bisbee. Substance abuse services for children and families are offered by ACTS, SEABHS, CIA, and Corazon.

In GSA 4, Cenpatico providers offer a range of substance abuse services. Community Bridges operates a Substance Abuse Transitional Facility in Casa Grande, Globe, and Payson. These sites also include "sheriff drop off" services and can triage members to CBI in Mesa if the person needs medical detox. New Hope, in Mesa provides methadone services. Horizon Human Services runs an adult male and female substance use BH Residential in Casa Grande. Transitional Living Center and NAZCARE offer peer services for men and women. TLC operates a transitional housing program in Casa Grande for

members with a SMI who have been incarcerated. Intake and Care Coordination Agencies provide substance abuse treatment services for children and families using evidenced based practices such as the Matrix Model or ACRA.

IV Drug Users are served by all Cenpatico intake agencies and referrals are made for those needing methadone treatment. Cenpatico intake providers are required to have Buprenorphine treatment available throughout GSA 2, 3, and 4. Yuma Treatment Center provides methadone treatment in GSA 2. In GSA 4, New Hope offers methadone treatment and in GSA 3 La Frontera is the specialist agency providing methadone dispensing. Peer, employment and skills training enhances treatment for IV drug users at all intake agencies. GSA 3 and 4 has less demand for methadone compared to Yuma. All agencies have adequate capacity to serve IV drug users at this time.

Infant & Early Childhood
Cenpatico provider agencies considered to have a specialty area of concentration with the birth to five population serve communities throughout the GSAs. These agencies have an infant/toddler focus and staff expertise in the field, with a minimum of two(2) staff per county having achieved the Infant Mental Health Endorsement. The following agencies were identified and developed to strengthen the capacity of Cenpatico's network in responding to the unique needs of children birth to five years old:

- GSA 2: Arizona Children's Association, Easter Seals Blake Foundation
- GSA 3: Easter Seals Blake Foundation
- GSA 4: Corazon, Easter Seals Blake Foundation

Provider staff working with the birth to five population have competencies necessary to meet the unique needs of infants, toddlers, and young children, and are trained in:

o The effects of trauma on young children and how to prevent re-occurrence of trauma.
o Early childhood brain development, infant/toddler mental health, autism spectrum disorders, fetal alcohol syndrome, and disorders of attachment.
o The identification of children at risk of attachment disorders, and the prevention and treatment of childhood attachment disorders.
o The utilization of screening, assessment, evaluation tools that prove consistent with the assessment guideline and best practice established by the American Academy of Child and Adolescent Psychiatry and Zero to Three.

Arizona Early Intervention Program (AzEIP)
Cenpatico and its network of providers strive toward effective coordination of care for children identified as having, or likely having, disabilities or developmental delays. Further, Cenpatico ensures that children birth to three years of age is referred to AzEIP as appropriate. Cenpatico ensures that children who are suspected as having a disability or developmental delay will be referred to their PCP and health plan for their EPSDT exam. A Cenpatico provider will collaborate with the AzEIP service provider through the CFT process to coordinate any services the child and family are receiving. Cenpatico attends many local and regional meetings with AzEIP to ensure system service delivery information is disseminated. Cenpatico contracts with Easter Seals/Blake Foundation for any assessments or behavioral health services the child may need in GSAs 2, 3 and 4. ES/BF is also a contractor for AzEIP services. In order to make informed referrals as part of the service planning process, Cenpatico's network of providers who work with infants, toddlers, and very young children and their families are required to become familiar with community services and supports that serve young children.

Homeless
In GSA 2, there are a total of eight intake agencies that offer case management services, outreach and engagement services, treatment services, peer support services, employment services, health promotion services and other direct support services to the homeless population. Each intake agency is equipped with staff to assist the homeless population in receiving the services they are in need of, including conducting referrals for shelter or housing services.

Crossroads Mission provides emergency shelter services for men, women and children, transitional housing for men and women, free meals, case management services, GED preparation, drug and alcohol stabilization and recovery services.

Community Bridges, a Behavioral Health Residential Facility located in Yuma, provides psychiatric, co-occurring and Substance Use Disorder treatment services. The Living Center, located in Yuma, provides members with the opportunity to learn computer skills, has a job bank to assist members in looking for employment and provides a number of social and recreational activities. Cenpatico and its network of providers are actively involved in coordination of services for persons who are homeless through participation in the Housing and Urban Development (HUD) Balance of State Continuum of Care. The Continuum of Care coordinates the Street Count of Homeless Individuals and Cenpatico and its service providers actively participate in this count. The Street Count information is included in the Regional Plan and is used to justify and prioritize the area for the receipt of HUD Homeless and Housing grants.

In GSA 3, there are a total of six (6) intake agencies that offer case management services, outreach and engagement services, treatment services, peer support services, employment services, health promotion services and other direct support services to the homeless population. Each intake agency is equipped with staff to assist the homeless population in receiving the services they are in need of, including conducting referrals for shelter or housing services.

Community Bridges, located in Benson, provides both psychiatric and Substance Use Disorder residential services to the homeless population. Services include crisis intervention, triage, stabilization and short-term recovery, peer support, case management, community outreach, and counseling services. Comfort Zone in Sierra Vista and Safford provides employment services, peer support services and mobile outreach services to homeless members. The Living Center, located in Nogales, provides homeless members with the opportunity to learn computer skills, has a job bank to assist members in looking for employment and provides a number of social and recreational activities.

In GSA 4, there are a total of ten intake agencies that offer case management services, outreach and engagement services, treatment services, peer support services, employment services, health promotion services and other direct support services to the homeless population. Each intake agency is equipped with staff to assist the homeless population in receiving the services they are in need of, including conducting referrals for shelter or housing services.

Community Bridges, located in Casa Grande, Globe and Payson, provides Substance Abuse Transitional Facility (Level IV Substance Use Disorder) services to the homeless population. Services include crisis intervention, triage, stabilization and short-term recovery, peer support, case management, community outreach, and counseling services. The Living Center, located in Casa Grande, provides homeless members with the opportunity to learn computer skills, has a job bank to assist members in looking for employment and provides a number of social and recreational activities. The Fresh Start Program/PHC, located in Casa Grande, provides homeless members with laundry and shower services, 8am-5pm, Monday-Friday.

Border Communities
Cenpatico collaborates with the Regional Center for Border Health in Somerton by attending local meetings and by developing communication networks in order for their members to understand how to enroll in behavioral health treatment. Cenpatico staff holds monthly meetings in the border towns of Nogales, Douglas and San Luis to discuss with community stakeholders any issues or barriers they have with the system. There are several outreach events Cenpatico participates in to ensure communities know about the services and how to access those services. All information is provided in both English and Spanish and the outreach staff is all bilingual. In addition, Cenpatico has four (4) volunteer Promotores that are trained and providing information to the Latino community in San Luis, Somerton and Yuma on how to access behavioral health services, as well as general information on diabetes, high blood pressure and other physical and behavioral topics. These "platicas" are held at both public locations and at member's homes.

Veterans
Cenpatico trains staff from provider agencies each month on resources and culture of veterans and their families. There are 221 veterans in an open episode of care throughout GSA 2, 3 and 4. Cenpatico awarded Pinal Hispanic Council Community Reinvestment dollars to help fund a veteran's resource center in Eloy. Cenpatico Clinical Operations trained case managers from the VA on services available from Cenpatico, Trauma Informed Care, and Supported Employment. In 2014 Cenpatico continues to seek opportunities to work with the VA and serve veterans.

LGBTQ

Cenpatico develops, maintains and monitors trainings for cultural competence, CLAS standards, LEP and special populations inclusion to ensure cultural relevance and increase cultural awareness of LGBTQ population. Cenpatico also promote alcohol prevention initiatives targeting LGBTQ college students across Arizona. Due to the rural nature of this network, access to LGBTQ programs and specialty trained providers to serve the LGBTQ population is challenging. Since demand for LGBTQ group services has been limited in rural communities, services are provided to LGBTQ members on an individualized care basis. Corazon has developed a specialization in the provision of LGBTQ programs and services in Casa Grande, Nogales and Douglas and has made it a point to employ LGBTQ staff. Most of the providers have LGBTQ staff employed at their agencies.

Transition-Aged Youth

Cenpatico continues its focus on supporting young members with mental and substance use challenges as they transition to adulthood. Cenpatico staff hosts a monthly Transition Committee to provide guidance and resources regarding effective practice for staff working with youth transitioning to adulthood. Agenda topics during the Transition Committee have included the DBHS Practice Protocols, Casey Life Skills Assessment, Transition to Independence Model (TIP), and youth advocacy. Resources and training opportunities are regularly shared. To help improve outcomes for transition age youth, Cenpatico staff and contracted provider staff working with the transition age population also participate in local community meetings /groups (such as Terrific Teens).

Cenpatico providers are required to support the delivery of children's and adult services during the transition period. In order to ensure that adult system staff attend and are a part of the CFT, Cenpatico clarified specific language within all Child Intake provider agency contracts. Cenpatico regularly monitors services and supports provided to youth in transition. Cenpatico pulls a list of youth turning eighteen years old within 6-18 months, and tracks specific activities as outlined in the DBHS Practice Protocol – Transition to Adulthood. Technical assistance and coaching has been provided directly to provider agency staff and enforcement action initiated as needed.

Cenpatico providers submit the Youth and Young Adult Program Narrative quarterly- allowing the opportunity to provide programming updates around education, employment, independence, health and wellness, and forming social relationships. Additionally, providers offer updates on the progress with their agency youth advisory councils and share success stories about the youth and young adults they are serving.

GSA 5

Community Partnership of Southern Arizona (CPSA) consists of approximately 9,186 square miles, which includes most of the land on the Tohono O'odham Nation located west of Tucson and Pima County. Most Pascua Yaqui tribal land also falls within the geographic boundaries of GSA 5, however, these tribal members are served by a Tribal Regional Behavioral Health Authority (TRBHA). CPSA provides comprehensive mental health and substance use treatment and prevention services to approximately 29,000 Title XIX/XXI members in Pima County (GSA 5). CPSA also provides services to approximately 3,200 Non-Title XIX/XXI members diagnosed with SMI and 6,224 other Non-Title XIX/XXI members, as funding allows. All persons in Pima County remain eligible for crisis services regardless of eligibility. CPSA coordinates, by way of a comprehensive network of qualified providers, the delivery of covered behavioral health services in partnership with adults, children, adolescents and their families, as well as with providers, state agencies, and other community stakeholders. The provider network structure is designed to ensure ease of access, offer member choice, maximize opportunities for collaboration across communities, stabilize crisis situations and respond to members and their families in a culturally proficient manner.

A. How Members Access the System

CPSA continuously monitors the flow of new Title XIX/XXI and Non-Title XIX adults and children entering the behavioral health system and ensures an equitable distribution of new members to the comprehensive service providers (CSPs). All CPSA adult and children's CSPs are currently accepting new members in all eligibility groups. CPSA ensures member choice of providers by contracting with nine CSPs, all strategically located throughout GSA 5. Each CSP offers a full array of covered behavioral health services through use of evidence-based programs available at multiple sites and via use of

subcontractors. Assignment to a CSP is based on member choice, accessibility, location and cultural preferences. A list of provider intake sites and other services are available on an interactive map on CPSA's website.

Description of how the RBHA assesses the medical and social needs of new members to determine how the RBHA may assist the member in navigating the network more efficiently:

CPSA recognizes that a member's behavioral and physical well-being is determined by the status of several life domains. At their first meeting with new members, all providers assess (and create treatment plans for) the following: housing, employment, education, physical symptoms, conditions and diagnoses; cultural preferences, and strengths.

CPSA encourages providers to identify whole-health goals for members and to explore the feasibility and logistics behind creating one whole-health service plan for each member. One behavioral health provider has partnered with a federally qualified health center to provide its members with whole-health care. In this partnership, the FQHC completes a thorough medical assessment, the majority of which is completed with the physical health-care provider. When appropriate, the member's data are entered into registries specific to chronic and high-risk conditions.
Another behavioral health agency has fully integrated care and uses the Four Quadrant Clinical Integration Model to identify the stage and level of need, based on a thorough assessment of presenting physical and behavioral characteristics. Lastly, a behavioral health agency is using a nurse practitioner to deliver both psychiatric and primary medical care to members identified with chronic health conditions and/or complex needs during their intake and annual assessments. While having only one provider yields a limited caseload, these members benefit from having a single treatment team and whole-health service plan.

Description of what assistance is provided to members with a high severity of illness or higher utilization to better navigate the provider network:

CPSA Medical Management has established guidelines and oversight practices for behavioral health management for members with high-risk and/or chronic conditions, who likely would benefit from additional care administration. CPSA and its comprehensive service providers' (CSP) care-management programs identify members whose needs may be unmet, as indicated by high utilization of costly services and by frequent hospitalization/readmissions, frequent use of crisis services including detoxification services, and frequent or repeated incarceration. One of the roles of CPSA's care-management department is to improve coordination of services throughout the complex public system of care. Another role is to ensure use of evidence-based practices to better effect health outcomes for members.

Description of how members with chronic medical conditions are identified by the RBHA including a description of how placement options are coordinated with/communicated to Contractors providing Acute Care services:

CPSA has established guidelines and oversight practices for behavioral health management for members with high-risk and/or chronic conditions, who would benefit from additional care administration. The care-management department improves coordination of services throughout the system of care and ensures the use of evidence-based practices to better effect health outcomes for members. Their comprehensive service providers' care-management programs identify members with unmet needs by reviewing high utilization of costly services, repeated incarceration, and frequent use of hospitalization/readmissions, crisis services and detoxification services.

Provider practices around whole-health goals are assessed and tracked quarterly. CPSA has contracted with a new health-and-wellness center, providing whole-health assessments and service planning, nutritional and self-management education, and an exercise assessment. These services are available to all CPSA members with serious mental illness. Members participating in this program are assessed by a primary-care physician and have access to the physician during and after their participation. Adult-serving CSPs within the system of care offer empirically supported chronic disease self-management services as part of their efforts to prevent over-utilization of costly services and reduce recidivism into hospitals and crisis services.

CPSA completed a review of its providers' internal capacity to track and use care-management EHR elements and practices to create a process for assessing the feasibility of using a health risk assessments at all adult providers. Providers completed an exercise to demonstrate their ability to "pull" specific health and medical data. Providers vary in their capacity to provide either direct physical-health services and/or care-navigation services for members with high severity of illness.

CPSA and CSP care-management programs provide or arrange for intensive monitoring of members with chronic and/or complex conditions. Care-management program activities include; overseeing coordination with health plans and other agencies to facilitate management of physical and behavioral health care and avoid gaps in service. Care-management staff also coordinate with hospital-based social-work staff to ensure timely referral to the Arizona Long Term Care System when hospitalized members' chronic medical needs require the intensity of those services. In addition, the CPSA Acute Health Plan Liaison is available to primary-care providers, health-plan behavioral health coordinators and community stakeholders for coordination of physical and behavioral health care.

The CPSA customer-service's provider offers technical assistance and oversight to CSPs requiring assistance referring members to health plans or coordinating chronic medical needs through the health-plan behavioral health coordinator. Customer service's staff facilitates communication between the CSP liaisons and the AHCCCS plans' behavioral health coordinators by identifying key staff to contact when coordination is necessary and through quarterly meetings.

CSPs are responsible for coordinating care with the member's PCP and/or acute health plan as appropriate. Increasingly, CSPs are developing integrated-health programs where primary and behavioral health care are co-located or delivered collaboratively to minimize barriers to care. In addition to providing more-coordinated care, CSPs are better able to assess the health of their members through coordinated data collection.

CPSA continues to coordinate physical and behavioral care with members who are discharged from acute medical facilities. Medical and psychosocial interventions are integrated into the discharge-planning process for members discharging from an inpatient facility, and utilization-management staff now coordinates care for the member's medical needs with the inpatient facility, and the CSP hospital liaison upon discharge.

Methodology(ies) the RBHA uses to collect and analyze member, provider, staff and other stakeholder feedback about the network's design and performance. When specific issues are identified, the protocols for handling those issues.

In an ongoing effort to identify trends and gaps in CPSA's system of care, CPSA uses a combination of quantitative and qualitative methods to gather information and feedback from members, families, providers, stakeholders and other community partners. The specific methodology for collecting this information varies by information source.

CPSA continues to work in partnership with state and county agencies to develop collaborative protocols that strengthen care coordination among system partners. The protocols apply to all CPSA-enrolled members and address specific areas to secure coordination of care, cooperation across agency boundaries and a collaborative approach to delivering behavioral health care, including teaming on protocols. CPSA ensures that a variety of mechanisms are available for stakeholders, families, comprehensive service providers (CSPs) and community partners to provide feedback about the system of care. Quarterly meetings are conducted to keep lines of communication open and provide an additional venue for feedback. Multiple methods allow members to provide feedback into the design and performance of CPSA's system of care. CPSA is dedicated to including members in key stages of its network development. Through focus groups, forums, town hall meetings and an open customer-service line, members and stakeholders are able to influence the system of care they utilize.

CPSA's customer service provider, Community Partnership Care Coordination (CPCC), is often a key resource for members wanting to provide input about their experiences with the system. This feedback is documented and analyzed, then reviewed in work groups, committees, councils and executive meetings where areas of improvement are identified and plans for improvement initiated. Complaints and/or grievances can be initiated by the member, the member's

family or a CSP through CPCC or the CPSA Office of Grievance and Appeals (OGA). Member complaints and feedback are trended, and when a trend or gap is identified, it is presented to the CPSA Compliance Committee. Gaps in service availability or accessibility are addressed by executive management, and plans for correction or development are initiated or presented to NDIC.

CPSA's Individual and Family Affairs (I&FA) department gathers member and family input on a regular basis. When a need for member input is identified by a provider or partner, I&FA is contacted to help facilitate a focus group. After the focus group, a summary is generated and shared with internal CPSA departments to review content and shared ideas. Areas of concern are addressed through a collaboration of CPSA leadership and the CPSA Network Design and Improvement Committee (NDIC).

The Adult and Youth Consumer Services surveys (formerly the Mental Health Statistics Improvement Program survey) are used to evaluate the behavioral health system through direct member feedback across eight domains. The domains include access to services, service quality and appropriateness, outcomes, participation in treatment planning, general satisfaction, improved functioning, social connectedness, and cultural sensitivity and appropriateness. Members rate their satisfaction using a Likert scale, with response options ranging from strongly agree to strongly disagree. Results of the surveys affect the provider's quality-management plan, performance incentives and CPSA's performance-improvement report and are presented to NDIC. Additionally, CPSA requires performance-improvement plans from CSPs that do not meet minimum performance standards on any of the domains.

Another venue for collecting information from members, providers and staff is through the system of care practice review (SOCPR), which is employed to identify a system's strengths and opportunities to improve outcomes for children with serious emotional disturbances and their families. An important component of the SOCPR process is family-member input about their satisfaction with the case management, treatment, and support and rehabilitation services provided by the CPSA system. Trends, gaps and/or concerns are compiled, reviewed and analyzed by NDIC.

Description of the most significant barriers to efficient network deployment within the RBHA's service area.

One significant barrier to efficient network deployment is the unique population distribution and "urban" designation of GSA 5 in regard to minimum network standards. Due to the number of members who reside in rural areas of GSA 5, it has been difficult for CPSA to meet the distance requirements. The impact of this barrier would be less significant if access-to-care standards considered regional and local differences, rural/urban characteristics, member culture and access to appropriate services, rather than provider types and service sites.

Workforce issues can create a significant barrier in ensuring system consistency and improving quality of care in specified areas. Access-to-care standards often instill some rigidity in reporting methods, as only the number of staff with specific credentials is required and there is little attention given to whether staff is available to meet a member's unique needs. Allowing standards to be flexible enough to include workforce members such as nurses, community health workers, and peer support specialists/health coaches among those qualified to provide behavioral and physical health services and supports would improve CPSA's ability to deploy a more robust system.

In October 2013, the Division of Licensing Services (DLS) formalized the first phase of new licensure rules. CPSA and many of its providers engaged in work groups and provided feedback through online surveys through DLS. CPSA tracked changes in licensure with each draft-rules release, while providers speculated about which changes would be finalized and how they would affect their agency. This uncertainty created an atmosphere of caution, in which providers did not enthusiastically engage in the rule-development process. After the licensure rules were finalized, providers reported difficulty in transitioning to the new processes, creating additional reluctance to expand current services.

Description of network activities, including payment reform/value based purchasing efforts, aimed at enhancing efficiencies and improving the quality of care provided to members.

CPSA utilizes many means to enhance efficiencies and improve quality of care. Staff and departments specifically focus on performance improvement, quality management, population health management and outcomes, care management, disease management and integrated health care. Providers are financially incentivized to perform favorably on specific

performance measures. Claim record and longitudinal reporting is given to providers, comparing their statistics against the aggregate of all providers by lines of business. CPSA has significant experience in provider risk arrangements and long-established managed-care practices including preventive care, prior authorization for facilities and medications, post-engagement activities, cost containment and cost-avoidance practices.

Description of how the RBHA will handle the loss (closure, contract termination) of a major healthcare provider (hospital, nursing facility, large provider group).

CPSA maintains a diverse, comprehensive and stable system of care. No provider terminations were necessary, but CPSA maintains the ability to effectively mobilize other community agencies if such an event were to occur. CPSA monitors the health of each CSP and would be aware of any closure before service cessation. CPSA has monitored and managed the closures of minor providers.

CPSA makes every effort to determine network gaps before any significant issues occur. There may be times when CPSA has not had time or resources to develop an appropriate intervention for an identified gap, resulting in the need for a more immediate, short-term intervention. In these instances, CPSA will issue a letter of intent (LOI) to ensure there are no barriers to implementing services immediately. If the provider is not already credentialed but is required to be, CPSA will utilize the temporary-credentialing process.

If a contract must be terminated, CPSA will have a strategic plan in place before termination. CPSA has remained consistent and diligent in ensuring notification of any change or closure of a provider is made in a timely manner, in accordance with Notification of Material Change policies. CPSA makes every effort to ensure members will maintain access to comprehensive services and takes every precaution to ensure contract termination does not impede members' rights to services.

Relationships between the various network partners (focus on provider to provider contact and facilitation of such by the T/RBHA; e.g. PCP, Specialists, Hospitals:

The CPSA system of care is designed so members are assigned to one (1) of nine (9) CSPs for the provision of covered services. Each member's assigned CSP is responsible for all coordination-of-care efforts between various levels of care, to ensure the member's needs are met. In addition to the communication and collaboration between the various levels in the system, there are three additional entities that provide coordination, ensure follow- through, and support members as they navigate the system.

CPSA's customer-service provider, Community Partnership Care Coordination (CPCC), acts as a point of contact for anyone seeking information or enrollment into behavioral health services in GSA 5. CPCC staff coordinates with CSPs to ensure intake and follow-through with new members who seek services through CPCC's customer-service department.

CPSA's Crisis Response Center (CRC) functions as the command and control center for the crisis system in Pima County. The CRC houses a 24/7 crisis call center, 23-hour crisis stabilization for adults and children, and a behavioral health inpatient unit for adults requiring additional time to stabilize. CSP clinical liaisons and warm-line staff are co-located at the CRC to help coordinate care for all enrolled members who present to the CRC for services.

The community-wide crisis line (CWCL) coordinates care for all members through its relationships with all levels of care. The CWCL is responsible for dispatching Mobile Acute Crisis (MAC) Teams and crisis transportation; referring to and coordinating crisis-stabilization services; directing service recipients to detoxification services or admission to a hospital, special hospital or behavioral health inpatient facility; and directing the flow of persons under emergency application for evaluation under Title 36. Call-center staff is also responsible for tracking acute psychiatric inpatient bed availability in Pima County and reporting this data to CPSA for review.

The CPSA system of care is designed so members are assigned to one of ten CSPs for the provision of covered services. Each member's assigned CSP is responsible for all coordination-of-care efforts between various levels of care, to ensure the member's needs are met. In addition to the communication and collaboration between the various levels in the

system, there are three additional entities that provide coordination, ensure follow-through, and support members as they navigate the system. CPSA's customer-service provider, Community Partnership Care Coordination (CPCC), acts as a point of contact for anyone seeking information about, or enrollment into behavioral health services in GSA 5. CPCC staff coordinates with CSPs to ensure intake and follow-through with new members seeking services through CPCC's customer-service department.

Providers within the CPSA system of care have frequent opportunities to work together and all have strong relationships with one another as evidenced by the provider's ability to engage in timely coordination of care efforts for members in accordance with contract timeframes. CPSA fosters these relationships by facilitating recurrent collaborative meetings with the providers, which offers a time for provider agencies to discuss successes and challenges within their respective systems, and work together to address systemic challenges they may be facing.

Description of the available alternatives to Nursing Facility placement such as Assisted Living Facilities, alternative residential settings, or home and community based services for members:

From initial contact CPSA ensures members seeking behavioral health services are comprehensively assessed, their needs identified, and individual service plans created in concert with the member, family, adult recovery team (ART) and other identified supports. Plans are developed with an overall goal of maintaining the member in the lowest level of care possible. CPSA ensures sufficient resources are available in the care system to meet the needs of members and families by providing access to behavioral health services 24/7.

CPSA contracts with qualified providers who administer the preadmission screening and annual resident review evaluation to determine whether a member being referred to a skilled nursing facility (SNF) meets criteria for this level of care. If not, alternative options are identified through the ART process. CPSA and its CSPs utilize alternative residential settings, behavioral health therapeutic homes and home- and community-based services, including intensive wraparound services, as alternatives to SNF placement. When a CPSA member is placed in an ALC, the CSP is required to coordinate with these facilities to provide in-home services to the member.

CPSA's network comprises 10 provider agencies that operate one or more behavioral health residential facilities and two (2) agencies that provide oversight to 11 adult behavioral health therapeutic homes. In addition to residential alternatives, CPSA's network includes habilitation providers who provide skills development and training or personal-care services in-home or in semi-independent-living settings, allowing adult members to remain in the lowest level of care possible.

Peer-support services, unplanned respite care, family support and specialized case-management services are readily available to adult members through several support-service agencies and CSPs throughout Pima County. Peer-to-peer support is a best practice that is highly successful in the CPSA system of care. Peer-support outcomes include overall symptom improvement, reduction in hospitalizations, shorter inpatient stays and improved daily functioning. To increase utilization of peer-support services, CPSA has redefined eligibility criteria for staff that can provide peer support and required qualified peers to complete specific training to ensure service quality. CPSA also has increased the number and frequency of Recovery Support Specialist (RSS) Institutes to increase the number of certified RSS staff able to provide these services.

One of CPSA's consumer-operated providers has also expanded its contract with CPSA to provide peer services before and after a crisis, beginning with the co-location of its Supportive Peers Assisting as Navigators (SPAN) program at the Crisis Response Center (CRC). SPAN offers recovery and community-navigation support members in crisis and their families, and helps members integrate back into the community.

Description of the interventions the RBHA implements to reduce avoidable/preventable ER utilization and the outcome of those interventions.

CPSA is exploring methods to collect more-consistent emergency department (ED) utilization data, as ED claims are currently managed by acute-care plans. Despite data and tracking challenges for ED utilization, CPSA has placed significant emphasis on establishing and monitoring alternatives to prevent ED use.

CPSA believes the best care is coordinated, comprehensive and provided by a team knowledgeable of a member's history and needs. Utilization of an ED for acute behavioral health needs can delay access to appropriate care, increase costs and produce less-successful short-term outcomes for members. EDs are not structured to address the unique needs of CPSA members in crisis. CPSA supports use of wraparound services and chronic disease self-management education to increase independent functioning and self-care of members. The following initiatives have been implemented, in part, to help decrease utilization of EDs.

MMWIA is an ADHS/DBHS initiative focusing on meeting children and families where they are, in the community and in their recovery. All children's CSPs are required to have services available 24 hours a day, 7 days a week in the member's home and/or community. Using MMWIA services, crises can be managed in the home while a direct-service provider demonstrates for the family how to manage symptoms, escalations and behaviors. Peer-to-peer support is a best practice that is highly successful in the CPSA system of care. Peer-support outcomes include overall symptom improvement, reduction in hospitalizations, shorter inpatient stays and improved daily functioning.

A number of adult CPSA members have co-occurring disorders and are dually enrolled with CPSA and the Arizona Department of Economic Security's Division of Developmental Disabilities (DDD). These members are often at greater risk of placement disruption due to behavioral health issues. The CCI program was developed six years ago to increase collaboration between CPSA and DDD, enhance service provision and improve outcomes for dually enrolled members. Members referred to the CCI program have had frequent visits to the ED for behavioral health issues; have been arrested or experienced other police interventions; have engaged in acts of self-harm, harm to others and/or property destruction; and/or have experienced disruption in their placement.

Members accepted into the CCI program are provided with functional behavioral assessment, prevention strategies, information on environmental changes to reduce triggers, skills training, positive behavioral supports and a collaborative team that involves experts from CPSA and DDD. Participation in the CCI program has resulted in a 13% decrease in psychiatric hospital/inpatient admissions compared to the previous year and a 57% decrease in cumulative days admitted at that level.

CPSA is engaged in two (2) performance improvement plans (PIPs) to help reduce preventable/ avoidable ED utilization. In addition to participating in the ADHS/DBHS PIP Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services, CPSA implemented the "Super-Utilizers" PIP with all AHCCCS health plans. Through these two PIPs, CPSA and the health plans have begun collaborating to impact avoidable/preventable ED utilization, as well as over-utilization of services throughout the system of care.

In FY14, CPSA actively participated in a performance improvement plan with contractors, acute care AHCCCS plans, the American Indian Health Program, and the Comprehensive Medical and Dental Program to identify high cost and high risk AHCCCS members. One of the foci of the project was to divert frequent utilizers of emergency departments, crisis services, and inpatient care to lower levels of care and/or more clinically appropriate settings. Among the strategies discussed with partners was the promotion of afterhours call centers as well as the availability of urgent care centers. Increasingly CPSA asked its contractors to work with the acute care AHCCCS plans to assure members lacking a regular source of health care acquire a primary care provider, schedule an initial (and follow-up) appointment, and to help members with support services to minimize no-shows. In some circumstances, this coordination of care also involved identifying specialists, like cardiology or immunology, as well as dental care for members to address their specific needs that drive them to emergency departments or crisis service providers.

CPSA also worked with contractors and the acute care AHCCCS plans to develop better discharge and crisis plans to address the specific behaviors that result in repeated emergency department, crisis service, or inpatient utilization. This process was led by licensed nursing and social work staff from CPSA reviewing the current service plan, diagnoses, and medications of members with a pattern of frequent and/or expensive utilization.

The RBHA's process for addressing preventable crisis stabilization and psychiatric in-patient utilization.

CPSA's crisis system has continued to ease demand on area EDs, both by providing an alternative for individuals and families to go for care in a behavioral health crisis and by facilitating transfers from EDs when individuals need stabilization for a behavioral health crisis. CPSA's crisis system includes use of the CRC, a crisis-stabilization facility that includes 23-hour observation and subacute services; Mobile Acute Crisis (MAC) Teams; the Desert Hope detoxification facility; acute crisis services; and the community-wide crisis line. CPSA's Crisis Response Center (CRC) functions as the command and control center for the crisis system in Pima County. The CRC houses a 24/7 crisis call center, 23-hour crisis stabilization for adults and children.

The CRC continues to have a significant impact on the emergency-care system. In FY 2013, 950 individuals were transferred to the CRC from area EDs. The number of transfers from EDs is trending down, while the numbers of adults seen at the CRC remains stable – an indication that individuals are utilizing the crisis system more frequently than EDs for behavioral health issues. Much of this can be attributed to the efforts of CPSA's Medical Management/Utilization Management Department in working with hospital administrators.

CPSA continues its enhancement of the children's crisis-services continuum. Started in FY 2013, this effort continues as needs are identified through collaboration and feedback from the community, providers and system partners. Two components of the most recent crisis-system redesign have directly contributed to moving children in crisis away from EDs and into an appropriate behavioral health setting when hospitalization is not needed. In late FY 2013, CPSA expanded the capacity of its unplanned respite program to stabilize children ages birth through 11 years to six beds, and also opened a seven-bed short-term residential facility with programming designed to stabilize youth ages 12 through 17.

Both crisis-stabilization options are contracted directly with CPSA and available to any children's comprehensive service provider (CSP) for stays up to seven days per member. Children who are not Title XIX/XXI eligible can be referred to the respite program directly by the CRC and served for up to 72 hours through available crisis funding. Both types of placement allow children and youth to be removed from environmental factors that may contribute to negative behaviors, while keeping them in the lowest appropriate level of care.

A number of adult CPSA members have co-occurring disorders and are dually enrolled with CPSA and the Arizona Department of Economic Security's Division of Developmental Disabilities (DDD). These members are often at greater risk of placement disruption due to behavioral health issues. The CCI program was developed six years ago to increase collaboration between CPSA and DDD, enhance service provision and improve outcomes for dually enrolled members. Members referred to the CCI program have had frequent visits to the ED for behavioral health issues; have been arrested or experienced other police interventions; have engaged in acts of self-harm, harm to others and/or property destruction; and/or have experienced disruption in their placement.

Description of efforts taken to ensure that a priority is placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institution or alternative residential setting. To that end, the development of home and community based services shall include provisions for the availability of services on a seven day a week basis, and for extended hours, as dictated by member needs:

CPSA's philosophy of care includes making available appropriate behavioral health services in the least-restrictive environment possible; to keep members in their homes and communities and to ensure all members receive care in accordance with the Guiding Principles for Recovery-Oriented Adult Behavioral Health Systems, the Five System Principles for Person-Centered Planning and the Arizona Vision and Principles.

CPSA's network consists of CSPs, inpatient facilities, residential facilities, outpatient treatment centers, community-service agencies (CSAs) and behavioral health supportive homes, all of which prioritize offering community-based services that meet the unique needs of each member. This includes offering services outside normal business hours, including service provision on weekends, evenings and holidays.

CPSA obtains and maintains data related to service hours offered by providers, including utilization of secret-shopper calls to both providers and members to ensure an array of service hours remain available.

Contracts with CSPs require discharge planning activities to begin immediately upon admission of a member into any higher level of care. This early engagement in discharge planning assists in identifying measurable goals needed for discharge and aftercare services necessary for members to achieve success in maintaining services and supports in their own community.

B. Special Populations

Developmental Disability

CPSA continues its strong collaboration with the Division of Developmental Disabilities (DDD), which has included participation in work groups with the Arizona Health Care Cost Containment System (AHCCCS) and ADHS, aimed at addressing the needs of dually enrolled individuals by utilizing behavioral interventions. Through this collaboration and the support of CPSA's Best Practices Committee, successful implementation of the Consultation and Clinical Intervention (CCI) program occurred in 2009. CPSA, DDD and the CSPs continue to meet quarterly to collaborate, ensure coordination of care and enhance the ability of both systems to better serve dually enrolled children and adults. The CCI team continues to provide functional behavioral assessments and service planning, including development of crisis plans, support and rehabilitation services, and individual, group and family counseling to adults identified for the program.

CPSA continues to collaborate with DDD staff and service providers involved with both adult and child members. Ongoing collaboration meetings are held with CPSA, DDD and CSPs to discuss successes and challenges of serving the DDD population and to determine solutions to any potential barriers to efficient and timely service provision. Each CSP has designated DDD staff and/or teams that are responsible for treatment planning and service provision to the member and his/her family. CPSA is also exploring options for expanding the continuum of services to adults and children who are DDD and RBHA-enrolled. This exploration includes discussion with inpatient facilities to determine ways they could accept adults and children with more challenging behaviors, possible development of a residential facility for children with aggressive behaviors, and the increased availability of intensive wraparound teams that provide 1:1 support to both children and adults with difficult behaviors to maintain their housing and/or placement.

At this time the children's system is focused on addressing the challenges of service provision in the home to help maintain youth in their homes and communities. The 12 Principles identify success in school as a primary goal, another area in which dually enrolled children experience difficulties. The CSPs have trained staff to use positive behavioral supports to increase opportunities for success in the academic setting. The adult system engages in staffing to ensure all members have meaningful goals and activities in their lives. Vocational opportunities, training, social events and improved relationships are the primary areas of emphasis. Adult recovery teams (ARTs) work closely with DDD support coordinators, as well as family and residential placement providers, to offer these opportunities. If there is disagreement within the ART, CPSA's customer services provider, Community Partnership Care Coordination (CPCC), advocates for the best outcomes for members.

CPSA has worked with the state medical director for DDD, to provide training at the Crisis Response Center to help staff be more effective and comfortable with members who are dually enrolled and present in crisis. In addition, a consultant to CPSA, schedules education opportunities with CRC staff, primarily those working with children. The consultant is also available for initial training and then follow-up coaching.

CMDP

CMDP staff provides technical assistance and intensive oversight, such as weekly collaboration with Department of Child Safety, weekly chart reviews at each provider, monitoring of encounter values and outreach to CMDP members for reengagement. Additionally, the Child/Adult Collaboration Pilot identifies evidence-based practices and sets standards for treatment service provision. The CSPs have adopted these standards for serving all enrolled CMDP youth, not just those in the pilot.

Sex-Offender Treatment-Adult and Child
Sex-offender treatment is provided by individual specialty providers employed by or contracted with the CSPs. CPSA's network of provider agencies includes three specializing in sex-offender treatment to adults and juveniles enrolled in the behavioral health system. Two of the provider agencies serve adults, and all three provider agencies serve children. Services provided include individual, single-gender groups, and life skills training teaching strategies for stopping abusive behavior, being accountable and taking responsibility for harm done. The goals of these services are to cease abusive behavior and assist members in recognizing triggers to prevent recurrent maladaptive sexualized behavior.

Sex-Abuse Trauma-Adult and Child
Each CSP has sufficient access to sex-abuse trauma specialty providers. In addition to individual specialty providers, CSPs contract with outpatient treatment centers specializing in sex-abuse trauma and post-traumatic stress disorder treatment. Las Familias, a subsidiary of Arizona's Children Association, specializes exclusively in the treatment of individuals and their families who have experienced trauma from childhood sexual abuse. They offer services that utilize individual, family and group therapy along with therapeutic recreation to develop critical social skills and address the long-term impact on the survivor's life. Each adult- and child-serving CSP has adopted trauma-informed practices and offers trauma therapies to its enrolled members. Each adult- and child-serving CSP has access to individuals who are attested specifically as Sexual Abuse Trauma specialty providers, either through direct employment with their agency or through subcontract. Two provider agencies within the CPSA system of care specialize in sexual abuse trauma. Through subcontracts between CSPs and these provider agencies, all CSPs have sufficient access to specialized providers who can meet the sexual abuse trauma needs of adults and children alike. In addition, family/systems therapy available within the care system supports children's recovery from trauma.

Substance Use Disorder (SUD) Treatment
Access to SUD treatment services, as well as other specialty programs that focus on substance abuse and co-occurring disorders, is offered through each outpatient site. Pregnant and parenting women have access to gender-specific intensive outpatient programs (IOPs) and residential programs. The Center of Excellence offers an IOP serving methamphetamine-abusing men and women, and Desert Hope serves as the primary detoxification facility. Evidence-based SUD treatment services are offered through multiple contracts with a wide array of service providers in GSA 5, including adult- and child-serving CSPs and SAPT-funded provider agencies. Title XIX/XXI- and SAPT-eligible pregnant women, women with children, children/adolescents and intravenous drug users (IVDUs) are given priority and have access to gender-specific outpatient services, intensive outpatient programs (IOPs), residential programs and, when medically necessary, methadone clinics and physicians waivered to prescribe buprenorphine. Services for SUD are available to Title XIX/XXI- and SAPT-eligible adults and children through assignment to one of CPSA's nine CSPs, and to SAPT-eligible adults and children through direct enrollment with a specialized SUD treatment agency contracted to conduct intakes and enrollments.

CPSA holds specialized contracts with La Frontera's Center of Excellence, which offers evidence-based IOP services to methamphetamine-, cocaine- and prescription drug-abusing adults, two residential SUD facilities that accept women and their children, and an IOP that includes on-site childcare for the children of women participating in the program. CPSA makes detoxification services available to adults through availability of six inpatient or residential treatment facilities, all of which maintain the capability to provide withdrawal management with medications as necessary.

CPSA monitors SAPT priority-population access to services, interim service provision and wait-list management through monthly reports submitted by SAPT-funded providers. Provider reports include the date of each new referral, the date interim services began and the member's population status. This allows CPSA to monitor accessibility of services for each population and to ensure interim services are provided on a timely basis.
In FY 2014, CPSA developed a six-bed residential substance-use treatment program for adolescents ages 12 through 17. The program includes a therapeutic milieu utilizing a positive-behavior support system, recreational programs including experiential therapy, individual and group therapy and gender-specific programming for both males and females. To date, the facility has served approximately 15 members, discharging several adolescents to their families and into

independent living settings. Due to the need for adolescent treatment for SUDs, CPSA has also contracted with several out-of-area inpatient providers that have specific SUD treatment programming.

Human immunodeficiency virus (HIV) early-intervention services are provided by the Insiders HIV program, which provides HIV testing, prevention, education, risk assessment, pre- and post-test counseling, and support and treatment-retention services to CPSA members. The Insiders drop-in center offers expanded HIV testing by the Pima County Health Department, including testing for tuberculosis, syphilis and hepatitis B and C, as well as vaccinations against hepatitis B and tetanus. Processing of confirmatory test results occurs through the health department in conjunction with the Arizona State Lab. Linkage to behavioral health services is immediately provided, and counseling/ support services are provided through the Insiders drop-in center as indicated by the risk assessment and the person's reported needs. In addition to the drop-in center, Insiders provides on-site education, counseling and testing at any treatment location, adult or child, within the CPSA system of care.

Substance Use-IV Drug Use
Enrolled members who use substances intravenously are eligible through Title XIX/XXI or SAPT funds to receive substance use treatment at any of CPSA's CSPs or specialized providers. At this time, all CPSA-contracted treatment providers serve individuals with SUDs regardless of substance or means of administration. In addition to the methadone sites and waivered buprenorphine physicians, three of CPSA's adult providers have medication assisted treatment (MAT) programs designed to provide medication-assisted opioid therapies.

Infant and Early Childhood Mental Health
CPSA contracts with Easter Seals Blake Foundation (ESBF) to provide urgent behavioral health response services to children from birth to 5 years of age who have been removed from their parents' care by DCS. ESBF serves as a specialty provider in Pima County for this population, providing intensive infant and early-childhood assessment, therapy and parent skill-building services. ESBF provides the initial developmental and behavioral health assessments for children who enter CPSA's system through the urgent-response process and is able to maintain continuity of care by providing intensive ongoing services to children from birth to 13 months and their primary caregivers. In addition to services provided by ESBF, two of CPSA's CSPs have specialty-provider infant programs for intensive infant/early-childhood mental health services, assessment and therapies.

Arizona Early Intervention Program (AzEIP)
CPSA requires all its CSPs to screen for developmental delays and refer to AzEIP for further screening and assessment on any eligible child enrolling with their agency. Each CSP is then required to maintain communication with AzEIP for all eligible children, including ongoing coordination-of-care efforts and participation in the child and family team (CFT) as appropriate.

Homeless
CPSA provides rental assistance through six Housing and Urban Development (HUD) permanent-housing grants. These tenant- and sponsor-based grants all serve homeless individuals who are CPSA-enrolled. Programs of significance include Sonrisa Apartments and Frontiers, both of which are HUD projects specifically for members between the ages of 18 and 24. Sonrisa, a 10-unit Platinum LEED-certified complex for young adults ages 18 to 24 with SMI, remains at full capacity since its opening in 2012. In January 2013, CPSA received the signed contract from HUD for Frontiers, which provided 22 additional units of tenant-based, permanent supportive housing. The grant includes partners serving members with SUD and HIV/AIDS as well as the SMI population. CPSA collaborated with specialized community partners to provide support services to these tenants. After apartment complexes are identified and leases are signed, tenants can begin moving in. In early 2014, CPSA acquired Mental Health Resources, Inc. (MHRI), a local organization offering affordable housing at properties throughout Pima County. The acquisition of MHRI increased CPSA's property ownership to over 260 units, available to members qualifying as very low-income.

Border Communities
CPSA oversees various communities that are in close proximity (within 70 miles) to the international border with Mexico. Those communities include Sahuarita, Sasabe, Topawa, Green Valley, Three Points, Ajo, Why, Lukeville, Arivaca and the majority of the Tohono O'odham Nation. Each of these communities has a designated CSP located in or around the community. Staff comprises community members, and services are provided in the member's primary language.

In FY 2013, CPSA began the process of establishing a rural CSP to provide timely and accessible behavioral health services in border communities as well as other rural areas of Pima County. Green Valley and Three Points were targeted as the first two communities for expansion, with the expectation that the new CSP would collaborate with local federally qualified health centers (FQHCs) to provide integrated care. In addition, Desert Senita serves the rural communities through a subcontract with one of CPSA's largest adult- and child-serving CSPs.

CPSA also regularly provides various education and training opportunities to staff working in and members residing in border communities. This includes Mental Health First Aid (MHFA) training and Trauma Informed Care training, which emphasizes utilization of the Adverse Childhood Experiences (ACE) Study to guide treatment planning. In August 2014, CPSA's Tribal Liaison will facilitate a one-day conference for youth living on the Tohono O'odham Nation reservation, titled "The Intergenerational Transmission of Historical Trauma."

Veterans
CPSA recognizes the unique needs of veterans and has been actively involved in ensuring services are available and staff has the training needed to provide these services. CPSA began providing veteran-related training in 2009. Since the April 2013 Network Adequacy & Sufficiency Analysis submission, CPSA provided a five-part training series on active duty/veteran behavioral health services.

Since CPSA's Rally Point Tucson (RPT) program for veterans, service members and their families rolled out in July 2012, it has provided peer-navigation services to more than 300 veterans and families. Because of the positive impact this program has had on the community, CPSA decided to sustain the program when its grant funding ended, and, to date, RPT continues to provide peer-navigation services to veterans and their families. In addition to RPT, one of CPSA's adult CSPs offers services to veterans and their families through a similar program, called Rally Point Arizona. Services provided by that program include crisis prevention, peer support and enhanced veteran crisis-navigation services, as well as a veteran's peer-connect group, veteran's family-group night, a women's veterans group and a mindfulness-based stress-reduction group.

Services specific to veterans also include employment and housing services to homeless veterans in the community. Housing units are available for 52 veterans and provide up to 24 months of housing assistance. In addition, veterans are connected to physical and behavioral health services, community support, education and life-skills resources, vocational assessment and training, financial benefits and – perhaps most significantly – a healthy community.

LGBTQ
CPSA continues to participate in statewide efforts to create awareness of the unique needs of and resources and support for LGBTQ children and adults in Arizona. In January 2014, CPSA's cultural diversity specialist was elected chair of the LGBTQ Behavioral Health Coalition of Southern Arizona and continues to provide trainings to system partners, stakeholders, provider agencies and others in the community.

CPSA and one of its CSPs co-developed the Creating Change and iTEAM groups for LGBTQ adults and children. The goal of these groups is to reduce self-harm and suicidal ideation, build resiliency and protective factors, help members set healthy boundaries, and increase empathetic responses. Services are provided in a variety of settings in the community and include case management, crisis services and group therapy.

In addition, one of CPSA's CSPs is developing an LGBTQ wellness center to open in late 2014. The center will focus on providing supportive groups along with integrated care, health promotion and skills training.

Transition-Aged Youth

CPSA recognizes the special needs of transition-age youth and ensures that appropriate services are available for this population through a variety of measures. CPSA staff monitor adult- and child-serving CSPs every six months to verify that requirements are met, which includes use of the Ansell Casey Life Skills Assessment and provision of services identified as needed through this process. The Transition to Independence (TIP) Protocol is practiced throughout GSA 5 through both child- and adult-serving CSPs.

A recent change has seen the quarterly Transition Age Youth Initiative meeting expand from a CPSA/CSP collaboration to become a Community in Transition meeting that includes community partners and providers invested in the transition of youth to successful adulthood. Invitees include Joint Technical Education District (JTED), Goodwill, Tucson Pima Collaboration to End Homelessness, Interfaith Community Council, Department of Child Safety (DCS) and Rehabilitation Services Administration (RSA).

GSA 6

Mercy Maricopa is a local not-for-profit health system, sponsored by Mercy Care Plan (MCP) and Maricopa Integrated Health System (MIHS), that serves as the Regional Behavioral Health Authority (RBHA) for GSA 6, which encompasses Maricopa County, and parts of Pinal County in Arizona. Under a contract with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), beginning April 1, 2014, Mercy Maricopa administers integrated, whole-health care for approximately 18,000 members who are diagnosed with a serious mental illness (SMI), as well as approximately 700,000 other adult, child and adolescent members with general mental health and substance abuse issues (GMH/SA), most of whom are Medicaid or Medicare eligible.

As the RBHA, Mercy Maricopa contracts with a wide, community-based network of behavioral and physical health-care providers to deliver services to eligible members. Mercy Maricopa is committed to actively striving toward health delivery transformation to yield better health outcomes and lower costs. Mercy Maricopa believes it is essential to collaborate with the State of Arizona, both with ADHS/DBHS and the Arizona Health Care Cost Containment System (AHCCCS), to improve population health and promote system reform from a payment and delivery perspective. A public, integrated, managed-care system of this scale is unique in the nation, and Mercy Maricopa's innovative, collaborative approach – together with widespread provider and community support for this model – helps position Arizona to expand and build upon these initiatives and partnerships.

A. How members access the system

Families and stakeholders can access Mercy Maricopa's system in a variety of ways. Referrals for intake and assessments can be made directly to the Qualified Service Provider (QSP), through the Children's Provider Network Organizations (CPNO) or Adult PNOs, or by calling Mercy Maricopa's Member Service Line. After an intake has occurred, the assigned QSP or PNO/ CPNO provider coordinate the member's treatment, which includes referrals for any outpatient services provided by a different provider. New referral contact is made through customer service and the person is scheduled for an assessment by Crisis Preparation and Recovery (CPR). This assessment is reviewed for eligibility by CRN to determine if the person meets SMI criteria. CRN determination is sent to DBHS. DBHS sends the file to Mercy Maricopa, and Mercy Maricopa then validates the information. Eligibility and the member's AHCCCS number are validated. If member eligibility or AHCCCS numbers are invalid, Mercy Maricopa submits enrollment via the Member Portal. A clinic is then assigned based on the member's preference, or based on the nearest geographic location. If PPSA exist then EOC is validated and all applicable type demographics are submitted by the current or new PPSA site. The member is scheduled for an intake with the PNO. The PNO completes an intake (assessment, transition plan) and services begin.

 Entry into Mercy Maricopa's system occurs via referral for evaluation to SMI services. Determination of SMI status can occur as a new referral (newly determined to be SMI) or as pre-SMI, which means their enrollment has been open at an adult PNO for more than one year. If a person has already been determined to be SMI eligible but is not currently open at a clinic for over 1 year –an assessment is scheduled with CPR and then the assessment is forwarded to Mercy Maricopa's Member Services for clinic assignment, intake and service delivery. If a person has been determined to be SMI eligible and is not opened with a clinic but has been within a year, the person is assigned to their prior clinic and

services start. Members access outpatient providers via referrals from their clinical team. Accessibility to outpatient services can be member requested, crisis provider requested or provider initiated.

Description of how MMIC assesses the medical and social needs of new members to determine MMIC may assist the member in navigating the network more efficiently.

Mercy Maricopa's management reviews documentation and completes assessments to provide information to the PNOs to ensure the member's needs are met. For SMI adult members enrolled with an Adult SMI clinic Provider (APNO), Mercy Maricopa contracts with the providers to deliver case management and psychiatric services which includes psychiatric prescriber appointments and RN services. Thru these services, the clinical team completes an assessment and treatment plan outlining areas of needs and treatment services. Included in this assessment process is a health risk assessment which is completed by any member of the clinical team. Once completed, the assessment is shared with Mercy Maricopa's Care Management and utilized by Care Management in the development of a care plan which is then provided to the Adult SMI Clinic provider's clinical team.

In regards to the delivery of and navigation of services, the clinical team would coordinate services with the members' assigned medical provider to address medical needs. To help navigate the network more efficiently, Mercy Maricopa's Care Management staff coordinates with the clinical team as needed. The provider Case Manager and clinical team work directly with the member in accessing and monitoring services needed.

Description of what assistance is provided to members with a high severity of illness or higher utilization to better navigate the provider network

Members with chronic conditions and high utilization are identified by a CORE (Consolidated Outreach and Risk Evaluation) report which is based on predictive modeling. Mercy Maricopa members are provided with an integrated care manager who can share necessary information and serve as an advocate for the member.

In addition, a daily inpatient report is provided to care management staff so high utilizers can be identified. During the start-up of the integrated care model PNO clinics were asked to identify the members who were at highest risk for morbidity and mortality, so they could be care managed at an intensive level of care. Mercy Maricopa's Care Managers review the member's physical and behavioral health records and use clinical guidelines to assess for any gaps in care. The Care Manager addresses any gaps identified by reaching out to the appropriate provider or the PNO staff, whichever is appropriate. The Care Manager also provides the PNO clinical team with member education to convey to the member.

Description of how members with chronic medical conditions are identified by the RBHA, including a description of how placement options are coordinated with/ communicated to Contractors providing Acute Care services

Members with chronic medical conditions are identified through multiple avenues, including: health risk assessments; medical profile reviews; utilization management reports that identify member diagnosis; inpatient, observation or Ed notifications that trigger at risk score or utilization history; provider referral; member or legal representative; self-reporting; and pharmacy claims, data and record reviews.

The care management staff works closely with the internal utilization review team to quickly identify members who are in the hospital so that discharge planning can begin upon admission. In addition, care management staff work with residential housing staff, utilization review and the case manager at the PNO to coordinate the most optimal placement for each member.

If the concurrent review staff or medical management care management/coordinator become aware of a GMH/SA member in need of placement, they are responsible for outreach to the behavioral health coordinator at the Acute Health plan. They are also responsible for coordinating placement and ensuring ongoing care to meet the member's needs.

Methodology(ies) the RBHA uses to collect and analyze member, provider, staff and other stakeholder feedback about the network's design and performance. When specific issues are identified, the protocols for handling those issues.

Mercy Maricopa staff have meetings on a weekly basis. Departmental meetings including: Operations, SOC (children and Adults), UM meetings, Leadership meetings, Executive Council meetings, etc. Mercy Maricopa's weekly meetings allow departments and staff the opportunity to discuss pressing issues and also to share what is successfully working. Staff input is valued but every staff has the opportunity to discuss and present feedback to their direct supervisor. Policies and procedures are discussed with staff during meetings and staff has the opportunity to give feedback. Leadership and decision makers are always a part of all the meetings to allow for decisions to be made and action to be taken immediately.

Provider's feedback is encouraged and once received; the feedback is reviewed in order to make decisions about expansions to the network. Provider's Requests for Information (RFI) and Request for Proposals (RFPs) are utilized during Mercy Maricopa's decision making process regarding network expansion. Providers may be asked to be part of the development of strategies and implementation (based on their feedback). Another avenue providers have to deliver feedback to Mercy Maricopa is via surveys.

Stakeholder's feedback is encouraged and welcomed during meetings facilitated by Mercy Maricopa such as: Mercy Maricopa's Governance Board meeting; Adult Systems of Care meetings; and Advisory Council meetings. In addition to the aforementioned meetings, Mercy Maricopa facilitates a variety of weekly and monthly meetings that Stakeholders may attend to contribute beneficial input.

Mercy Maricopa ensures members and their families have opportunities and are encouraged to provide feedback regarding the network design and network performance outcomes. Members and their families are invited to participate in various committees such as Advisory Committees in which network issues and quality indicators are addressed. Members and their families are also encouraged to participate in Mercy Maricopa's QI committees as a method to produce valuable feedback. Another tool used by Mercy Maricopa to gather feedback from members is through surveys.

Description of the most significant barriers to efficient network deployment within the RBHA's service area.

Mercy Maricopa launched April 1 with the existing Magellan network as requested by DBHS. Identifying gaps in the network has been a challenge and is a focus to improve placements (especially for those members in emergency rooms and inpatient settings).

Defining "integrated care" with the behavioral health network will be significant. Fear of the "paperwork" that comes with the Arnold stipulation has providers hesitant about taking on the SMI member. Mercy Maricopa will need to continue to work very closely and educate the physical health and behavioral health providers to alleviate their concerns. Disruption of a long-standing closely controlled network by bringing in new providers and thereby bringing "competition" sometimes causes friction.

Description of network activities, including payment reform/value based purchasing efforts, aimed at enhancing efficiencies and improving the quality of care provided to members.

Mercy Maricopa has a number of "value-based purchasing" arrangements with providers. The Patient Centered Medical Home (PCMH), Person Centered Health Care Home (PCHCH) agreements with community based physicians and shared savings arrangements with larger physician organizations such as the Arizona Care Network and Phoenix Children's Care Network have quality measurement requirements, incentive based opportunities for reductions in unnecessary/preventive ER usage, inpatient re-admissions, etc. Mercy Maricopa will continue to expand these types of arrangements, launching innovative payment pilots and monitoring provider and member utilization patterns.

In partnership with the Arizona Council of Human Service Providers, MCAP and the Behavioral Health Coalition of Southern Arizona, Mercy Maricopa co-sponsored the Arizona Payment Reform Conference on September 8th, 2014. In

addition, the GMH/SA department has made strident efforts to offer opportunities for the provider network to improve and strengthen the quality of their services to specialty populations.

Description of how the RBHA will handle the loss (closure, contract termination) of a major healthcare provider (hospital, nursing facility, large provider group).

Mercy Maricopa enforce the actions listed below upon learning of potential loss, contract termination, closure for any reason, or serious quality of care concerns:

- Facilitate a meeting with the provider and DBHS to be held prior to the effective date of contract termination or any change related to contract status that could have an impact on members and/or their representatives. This includes taking steps to avoid any termination that is unrelated to quality of care.

- Develop a communication plan that informs members and their representatives of the contract termination and the member's option to continue residing in facility or remaining with the provider until open enrollment.

- Work with the member regarding available options, which may include transferring to another provider or facility.

- Submit the communication plan for approval by DBHS, provide impacted members with an explanation regarding the contract termination, and inform impacted members of the steps they need to take during open enrollment.

- If there are no alternative providers in the community Mercy Maricopa will work with other contracted providers in Arizona and/or outside the state to cover services until an alternate provider can be located.

If Mercy Maricopa or an outside entity identifies quality of care events that place the member in immediate jeopardy, Mercy Maricopa offers the member an alternative provider or placement. Mercy Maricopa's Medical Director may also engage the member's primary care provider (PCP) to assist in explaining the seriousness of the situation.

Relationships between the various network partners (focus on provider-to-provider contact and facilitation of the T/RBHA; e.g. PCP, specialists, hospitals)

Mercy Maricopa is launching health information technology that will allow providers to share information more quickly about the care members are receiving. Crisis network providers and provider network organizations (PNOs) are all connected to Mercy Maricopa's health information network. This allows the crisis network providers the ability to search for historical clinical information for members who have received services at a PNO.

In fall of 2014, Mercy Maricopa in collaboration with the Behavioral Health Network of Arizona and the Health Information Network of Arizona will launch a virtual health record with select providers. The virtual health record will pull information about a member's past physical and behavioral health services into a single document which can then be shared among other members of the care team (physician, case manager, psychiatrist, etc.).

Additional technology will be built and launched throughout the year that will facilitate providers' usage of the information. For example, information that alerts a provider that a gap in care exists or when there is the potential for a possible drug interaction.

Mercy Maricopa's Care Managers and Care Coordinators have been assigned to key providers in the network. The role of the Care Manager and Care Coordinator is to facilitate communication between the behavioral health, physical health and health plan teams about member care needs. Additional team members are available to train members on how to access the HIE, how to understand profile reports, etc.

Workforce Development

Strategies the Integrated RBHA has for Workforce Development

Mercy Maricopa's Learning and Performance department values transparent knowledge sharing for their workforce, providers and community members to ensure efficient collaboration and open dialogue as part of a professional team. Mercy Maricopa employees, providers and workforce are required to attend Mercy Maricopa overview, which explains the 9 guiding principles for recovery-orientated adult behavioral health services and 12 guiding principles of the children's system. Employees, providers and the workforce are required to complete Cultural Competency –101 Embracing Diversity, a class implemented by DBHS and offered on a weekly basis with a certified instructor. Mercy Maricopa's training program process focuses on understanding and teaching clinical and behavioral practices using adult learning methods in prevention and treatment in a way that is culturally relevant.

Mercy Maricopa Learning and Performance department uses adult learning principles while aligning the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration (SAMSHA-HRSA) core competencies with state and federal regulations. Furthermore, Mercy Maricopa's comprehensive training curriculums are focused on meeting the requirements of state and federal entities as well as meeting the requirements for legal settlements such as Arnold v. ADHS.   The specific core competency areas of focus include, but are not limited to: interpersonal communication, screening and assessment, collaboration and teamwork, and care planning coordination. The SAMSHA-HRSA competency sets are used as reference points to design and deliver training programs to shape the integrated care health care workforce.

Mercy Maricopa's goal is to create trainings and materials that enable members at every level to support a holistic, integrated recovery system. The training curriculum is designed and delivered in a variety of ways, including instructor-led, self-study, technology-based training and on-the-job training with a preceptor. This allows members with different learning styles to determine their own place, time, pace and method of learning.

Assessment and Evaluation

Mercy Maricopa Integrated Care identifies training needs by gathering best practice information through two screening and assessment mechanisms. The first mechanism provides qualitative data from ADHS/DBHS technical assistance, community forums, provider surveys, employee feedback, training consortiums and workforce operations committee meetings hosted by Mercy Maricopa for providers, as well as DBHS-hosted workforce operations committee meetings. The second mechanism provides quantitative data that is focused on trends in provider performance that can identify areas that additional training is needed. The quantitative data that can be collected from providers include, but is not limited to: case file reviews, complaints, utilization, grievance and appeals, system of care and court system data.

Mercy Maricopa will also collaborate with other T/RBHAs and ADHS/DBHS by providing streamlined core content applicable to common data trends. In addition, Mercy Maricopa hosts and finance the cost of the Gila River TBHA user licenses to access a learning management system which has robust reporting capabilities. Common data trends are reviewed during DBHS' quarterly operations meetings with T/RBHAs. The screening and assessment processes is one determinate of ongoing training programs that focuses on understanding and teaching clinical and behavioral practices using adult learning methods in prevention and treatment in a way that is culturally relevant and supports health care consumer's recovery and resilience.

Analyses of the quality of care and other performance data will drive ongoing training offerings and updates to training curriculum. A regular cycle of review of all training curriculum will take place at minimum biannually. The assessment and evaluation processes provided in the training plan will put the member at the center of their integrated health care.

Providers partnering with Mercy Maricopa are responsible for ensuring that training requirements of Mercy Maricopa's Provider Manual are being met. In support of those training requirements, Mercy Maricopa has purchased a license for each identified workforce employee to the learning management system Relias. Each provider has identified a learning administrator to manage their organization's enrollment, users and compliance reporting. The Relias learning management system contains pre-packaged curriculum through self-paced learning whose content comprises almost

80% of the contractual training requirements. The remaining 20% of required training is either offered or sponsored directly through Mercy Maricopa. All required trainings, evidence of training participation and applicable assessment scores and attestation acknowledgements will be received by Mercy Maricopa 90 days after the start of the contract and annually throughout the duration of the contract. If providers are deficient in their reporting, a plan to correct the deficiency is required. The supportive role Mercy Maricopa has with providers lends opportunities to identify training best practices within GSA 6.

Strategies including residency programs, Graduate Medical Education (GME) programs, and dental student training programs, and paraprofessional programs (attendant care, personal care and homemaker) as per contract:

There have been initial conversations with Dignity Health and Creighton University about creating a residency pathway for primary care physicians around integrated care and training upcoming physicians on population health management. The residency pathway will focus on using data to manage care, outcome/valued-based care, and understanding quality and utilization management. Mercy Maricopa is committed to addressing workforce development and system of care capacity as it relates to physical and behavioral health integration. Mercy Maricopa plans to work closely with partners such as Creighton University, Midwestern University, Maricopa Integrated Health System, St. Joseph's Hospital and Medical Center, and Phoenix Children's Hospital to improve the primary care and behavioral health residency. The collaboration will also improve internship programs by better addressing integrated care.

The recent affiliation agreement has laid the groundwork for Maricopa Medical Center to become the principle academic affiliate of the University Of Arizona College Of Medicine. Additionally, Mercy Maricopa will collaborate with local community colleges to recruit and train direct service staff to serve members. Mercy Maricopa will also continue to support the use of peer and family support partners to outreach and engage members by funding and facilitating training and certification courses. Furthermore, Mercy Maricopa has partnered with Midwestern University, Special Olympics of Arizona, Optometry, Podiatry, and Dental associations in Arizona to create the Healthy Athletes Village program. The Healthy Athletes Village program is a bi-annual program that provides Special Olympics athletes with vision, hearing, dental and podiatric screenings. These services are provided via community providers and residents in Midwestern University's medical programs. The community providers and Midwestern University residents will assist in identifying needs, maintaining general health and wellness, and assist in providing cultural sensitivity training to the medical community and future providers. Mercy Maricopa recently provided over 300 Special Olympians an opportunity to participate in the healthy Athletes village program on May 2 and 3, 2014.

Description of the adequacy of the geographic access to tertiary hospital services

Mercy Maricopa has contracts, which includes inclusive medical and psychiatric care, with Dignity, Maricopa Integrated Health System, Abrazo, Banner, Scottsdale, and IASIS system facilities. Additionally, Mercy Maricopa contracts with specialty facilities such as Los Ninos, Restora and Aurora facilities. The network allows for easy access for all Mercy Maricopa members to physical health and/or mental health facilities within their Geographic Service Area (GSA). Mercy Maricopa does not require authorization for any member to access care on an emergent basis and will pay any claim for emergent services to any non-par provider. This affords all membership ready and accessible care to tertiary hospital services based upon the emergent needs of the member. In the event a member has an emergent episode outside of GSA 6, Mercy Maricopa pays the cost of transportation to the nearest facility that can accommodate the member's medical needs.

Description of the available alternatives to Nursing Facility Placement such assisted living facilities, alternative residential settings, or home and community based services for members

When Mercy Maricopa identifies that a member has a need for a level of care, Mercy Maricopa Utilization Management evaluates what the members needs are, and what facilities can meet that member's needs. If a member needs a Skills Nursing Facility (SNF), Mercy Maricopa's Utilization Management team assesses the need, and makes a determination if that is the appropriate level of care, or if an alternate level of care can meet the member's need. Utilization Management reviews the clinical documentation and coordinates with the PNOs. After coordinating, a determination is

made on if an assisted living facility, behavioral health residential, or home health services can best meet the member's needs.

Mercy Maricopa contracts with behavioral health residential facilities that provide 24 hour professional staffing and therapeutic activities to adults experiencing behavioral health issues. Mercy Maricopa's Meet Me Where I Am (MMWIA) providers are a subset of the direct support providers that have the ability to provide intensive direct support services for a youth/family. Services through the MMWIA program may be one of the support services utilized by the family in order to allow the youth to live in the least restrictive environment. Processes have been put in place to ensure that MMWIA (Generalist) Support Services are prioritized for youth and families with the highest needs. This process ensures capacity for youth and families who may be returning from residential settings or require a high level of support services so that they can remain in a community based setting.

In addition to the Children's Provider Networks, Mercy Maricopa also holds a contract with Native Health to provide support services for the Tohono O'odham Tribe. Marley House is contracted to support the integrated health to their children's outpatient network and Family Involvement Center provides services which specifically support the guardian/families.

The Integrated RBHA's strategy for incorporating Medical homes into its Network, and its progress in maximizing the capacity of medical homes

To maximize capacity that is potentially available within the current Provider Network Organizations (PNOs), Mercy Maricopa has met with all PNOs to assess current status and readiness to expand physical healthcare offerings beyond the current 8 co-located sites.

Mercy Maricopa is working with each PNO to identify ways to bring physical health services and create medical home members. These strategies include building strategic partnership with physical health care providers as well as exploring the possibilities of PNOs employing Primary Care Providers. For example, Partners In Recovery Arrowhead Clinic has established a partnership with Dr. Rodd Aking, M.D., to be a Primary Care Provider (PCP) in this location. This will allow members the choice of having their PCP services provided by a physician that is embedded and interacting with the staff in an integrated model.

Other expansions projects being evaluated include:

- Maricopa Integrated Health System (MIHS) – Expanding the offering of behavioral health services in order to create Person Centered Medical Homes at their existing Comprehensive Healthcare Centers. MIHS is also a Federally Qualified Health Center look alike.
- Valle del Sol - Already has Primary Care and services for the GHMSA population. Work to expand services for the SMI population.
- Dignity Health – Explore the array of behavioral health services provided onsite in conjunction with primary care to meet the needs of the SMI and GMHSA populations.
- Mountain Park Health Center (FQHC)/Adelante Health Center (FQHC) - Expanding the offering of behavioral health services in order to create Person Centered Medical Home 2015.
- Circle the City – Medical respite center which provides for physical and behavioral health care needs for homeless members that are discharging from a hospital and need additional care.
- Head to Toe – Child focused Integrated Health Care practice with BH/PCP/Specialty.

Mercy Maricopa currently has the following medical homes in operation:

- Mountain Health and Wellness (Primary Care, SMI and GMH services)
- Valle del Sol (Primary Care and GMH services. Looking to expand SMI services)
- St. Joseph's Family Practice (Primary Care. Limited BH services in partnership with Southwest Behavioral Health)
- Cigna Medical Group

Provider Assistance

The assistance provided to PCPs when they refer members to specialist

Communications to PCPs and Medicare providers must occur on a regular basis to ensure safety and positive clinical outcomes for persons receiving care. The methods for communication, methods for coordination of care; and how does Mercy Maricopa assures that it will occur is as follows:

Mercy Maricopa will educate providers about Provider Manual (PM) section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers, that gives guidance for the proper method of coordinating care between the provider, PCP and AHCCCS health plan. PM section 4.3 is vital in the proper collaboration and coordination between provider and PCP, regarding a member's integrated care needs, and its use is pivotal in understanding state expectations, requirements and filing time frame.

The methods used to communicate the availability of this assistance to the providers

Mercy Maricopa sends notifications to providers frequently to reference the Provider Manual and subsequent notices will target Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers. Information regarding Coordination of Care is easily found on the Mercy Maricopa website. Mercy Maricopa's Provider Relations staff will include these section in future educational in-services, so staff at all levels understand the importance of this coordination and where to locate this PM section as well.

Mercy Maricopa ensures providers are responsible for training their staff on PM section 4. Providers will also educate their staff regarding the importance of completing the PCP communication form 4.3.1 which is required to ensure coordination of care between the provider and PCP occurs and is documented properly. The 4.3.1 PCP communication form is retained in the member's health record and is an important historical document in future coordination and indicating provider compliance/non-compliance in this area of coordination.

In addition, members served by Mercy Maricopa Integrated RBHA are assigned a Care Manager / Care Coordinator. This individual reviews medical and behavioral health records, as well as predictive modeling information, to identify gaps in the members care and develops a care plan to address services needed. The Care Plan is shared with individuals on the member's Care Team (PCP, BH Professionals, Peer / Community Supports, etc…) to facilitate collaboration, coordination, and address identified needs.

Mercy Maricopa and their contracted provider staff can contact Behavioral Health Plan coordinators in order to improve communication, understand plan requirements and discuss how to establish and maintain a two-way communication method between providers, PCPs and the AHCCCS plan. Mercy Maricopa will conduct behavioral health record audits, with a standard relating to the proper use of the 4.3.1 PCP communication form. If there are indications in the member's health care record that a change has occurred in the member's care to warrant a PCP and/or health plan notice, the 4.3.1 PCP communication form must be present and contain appropriate Coordination of Care information and filed in the required timeframes, or the provider will be found to be non-compliance.

Description of efforts taken to ensure that a priority is placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institution or alternative residential setting. To that end, the development of home and community based services shall include provisions for the availability of services on a seven day a week basis, and for extended hours, as dictated by member needs.

Mercy Maricopa's Adult PNO case managers work closely with members in determining the least restrictive level of care appropriate and/or desired. In doing this, member's services are tailored around their individual needs based upon a multitude of factors, with their current or proposed housing being one of them. The Mercy Maricopa housing department works on direction from the APNO clinical team when referrals for housing are received. At the time that Mercy Maricopa receives the application, the PNO should have already determined the specifics. In addition, there are supportive services available to help members be successful in the community, including ACT services to help them maintain the lowest level of care. Mercy Maricopa is adding four ACT teams for FY15. The first ACT team is a Forensic

ACT team that was implemented April 2014, under Community Bridges. Assertive Community Treatment (ACT) teams provide critical support that allows members with complex needs to maintain in the community. Currently, in Maricopa County, 15 ACT teams are available to serve 1500 members determined to have a serious mental illness. In FY14, these ACT teams served approximately 1361 members. In FY15, Mercy Maricopa intends to increase the number of ACT teams by four, for a total of 19 ACT teams.

Mercy Maricopa has continued to support and prioritize the availability of Generalist Direct Support and Specialty Services to help support youth within their community. Generalist direct support services through programs such as "Meet Me Where I Am" (MMWIA). MMWIA provides support and rehabilitation services for children with complex needs and are available 24 hours a day/7 days a week. The primary purpose of the MMWIA Program is to reduce the necessity for utilizing out-of-home treatment interventions by providing intensive, individualized support and rehabilitation services, working with children and families in their homes and community settings. In addition to the MMWIA Program, the JFCS Hospital Crisis Team can be utilized in order to meet the immediate needs of youth being discharged from an ER or hospital setting. As the need for these services are growing, Mercy Maricopa is looking to enhance and expand these types of programs over the next year.

Mercy Maricopa oversees an array of housing options that range from scattered site rental subsidy support to treatment based housing locations. Mercy Maricopa requires providers to deliver permanent supportive housing services consistent with the SAMHSA definition. Permanent Supportive Housing is permanent housing with tenancy rights and support services that enable members to attain and maintain integrated affordable housing. It enables Members to have the choice to live in their own home and with whom they wish to live. Permanent Supportive Housing also includes rental subsidies or vouchers and bridge funding to cover deposits and other household necessities.

Mercy Maricopa will implement Housing Navigators to increase access to housing supports for adults and families that are experiencing homelessness and housing instability. Navigators will work with members and their clinical team to develop tailored plans for services that bridge the gap between housing and support programs and systems. Navigators will also work one-to-one with members and families to help them access and make the best use of available resources by facilitating connections to housing and other support services. In addition, specialty housing is available for members on ACT teams. Mercy Maricopa is targeting an increase in the supportive housing services by 1,200 by the end of FY16 under the Arnold Settlement Agreement

Supported employment is a well-defined approach in assisting individuals with psychiatric disabilities obtain and maintain competitive employment. As a model it does not traditionally utilize prevocational training and recognizes the importance of assisting an individual to move quickly into employment by matching the member to preferred employment and providing necessary supportive services.

Description of the interventions the RBHA implements to reduce avoidable/preventable ER utilization and the outcome of those interventions.

Mercy Maricopa has added capacity to the JFCS Hospital Team which provides support and rehabilitation services for youth who are being discharged from a hospital, ER or crisis facility. In addition, Mercy Maricopa has added an extended Hospital Team through Child and Family Support Services. Mercy Maricopa contracts with St Luke's to provide 23 hour crisis stabilization and observation unit for children. This program recently revamped their program to be more inclusive of the guardian/care giver and has expanded capacity from 3 to 12 beds. Through its practice profile report, primary care physicians and PNOs are able to identify the emergency room utilization for members assigned to them.   Recently, Mercy Maricopa met with the PNOs and assisted them with understanding the information.

Mercy Maricopa is committed to focusing on providing peer and family support services at critical transitions in care. Mercy Maricopa is working with providers to expand peer support to include: care transition services for members discharged from hospital inpatient stays, residential facilities, crisis services and members released from correctional facilities. By providing members with the support they need, Mercy Maricopa expect to see a decrease in readmission rates, a decline in length of stay in residential services, a decrease in recidivism for members who are incarcerated, and decreased lengths of stay in correctional facilities. For these members, Peer Support Specialists will build upon their

relationships with community providers to facilitate successful transitions of care. The Peer Support Specialist will collaborate with the member and their clinical team to determine the member's needs and level of services required to support the individual in achieving independence.

Mercy Maricopa is partnering with peer run agencies to provide support to members during their inpatient admission by participating in team staffing and discharge planning as well as providing follow-up care post-discharge. Upon the member's discharge, a Peer Support Specialist provides peer wraparound services, which include: transportation to recovery centers to participate in groups and social activities; home visits during post-discharge; telephonic contact and support; ongoing communication with the member's clinical team; connecting the member to community-based activities; and participating in activities hosted by Peer Run Organizations.

The RBHA expects all contracted providers to assess and address member needs on an ongoing basis. This includes the identification of stressors and behavioral changes that might indicate the need for additional support services as well as a need for an unscheduled appointment with their medical provider to review current medications. Mercy Maricopa also ensures through their quality management process that providers coordinate care with all entities involved in a member's treatment. MMIC also requires providers to train all of their staff on Crisis Prevention and Intervention Training (CPI) to be able to address crisis on an outpatient or residential level and reduce the need for more emergent services. Mercy Maricopa also contracts for the warm line, which is a peer operated where recipients can access non crisis support 24/7 to avoid a crisis situation. Mercy Maricopa also has the crisis line which is available to recipients 24/7/365, which is located on the Mercy Maricopa website and is in many Mercy Maricopa publications. In addition MMIC requires that contracted Crisis Providers Engage members to prevent crisis situations by:

- Developing crisis plans to support the member in the community if they experience an increase in symptoms;
- Being available to help implement the crisis plan, including intervening in the early stages of distress; and
- Providing crisis support on a walk-in or telephonic basis during business hours.

Description of how members with special health care needs are assigned to specialists for their primary care needs.

SMI members enrolled in the integrated program select their own PCPs. In the absence of a member-driven selection, the RBHA auto-assigns a member to a PCP based upon language preferences of the member, along with the geographic distance from the member's home to the office of the PCP. If the member requires the services of a specialist, the PCP coordinates with member's case manager and the Care Management team from the RBHA to identify an in-network specialist or ancillary service facility to meet the needs of the member. If the member requires services from an out of network specialist or ancillary facility is required, the RBHA utilizes a Single Case Agreement (SCA) process to ensure the member can access the specialist services.

Description of the interventions the Contractor implements to address and reduce no-show rates including how the Contractor assesses the efficacy its efforts.

The provider is responsible for providing appropriate services so that members understand their health care needs and are compliant with prescribed treatment plans. Providers should strive to manage members and ensure compliance with treatment plans and with scheduled appointments. Assistance in helping noncompliant members is MMA's Provider Assistance Program. The purpose of the program is to help coordinate and/or manage the medical care for members at risk. The Provider completes the **Provider Assistance Program form** and submits it to Member Services for possible intervention. The provider may elect to remove the member from their panel with at least 30 days written notice prior to removal and ask the members to contact Member Services to change their provider. The members will NOT be removed from a provider's panel unless the provider's efforts and those of the Health Plan do not result in the members' compliance with medical instructions.

The RBHA's process for addressing preventable crisis stabilization and psychiatric in-patient utilization.

Mercy Maricopa is in the process of gathering data to complete an analysis to identify the potential causes of the psychiatric in-patient utilization for children. Once the analysis is complete Mercy Maricopa will be creating a strategic plan based off of the identified trends.

Mercy Maricopa's Children's PNOs, as well as Qualified Service Providers (QSP's) have language in their contracts which state they are responsible for being available at a minimum of an on-call basis 24 hours a day, 7 days a week, and 365 days a year, in the event of a crisis. The Provider shall offer same-day appointments to serve members who may be at risk for an increase in symptoms and shall offer follow-up with a member who had a recent crisis episode.

Mercy Maricopa contracts with St Luke's to provide a 23 hour crisis and observation unit for children. The program was recently revamped to be more inclusive of the guardian/caregiver and has expanded capacity. The GMH/SA provider network developed various strategies addressing member needs at the decompensating stage to prevent unnecessary hospitalizations or use of crisis services. Providers in Maricopa's provider network reserve blocks of time on the schedule each day for members that call requesting an emergent appointment. This process ensures an available appointment daily for such unscheduled, emergency requests. Some providers adhere to a "Same Day Access" scheduling model in which all schedules are open until the morning of that day. Providers encourage members to call that morning to schedule appointments; and, those determined to be in emergent need are prioritized. Members are encouraged to contact their PPSA prior to utilizing crisis services when their behavioral health needs could be better addressed at that level of care. Additionally, Community Bridges operates two Access Points located in the East and West Valley serving as entry points for walk-ins and drop-offs. These Access Points provide 24 hour triage, 7 days a week. Services provided include assessment, brief intervention and transition support.

B. Special Populations
Developmental Disabilities
Mercy Maricopa's Children's Provider Networks work with several providers (Arizona Autism United, SEEK, TERROS, Counseling and Consulting, Youth ETC and Jewish Family & Children's Services) who have taken a large role in assisting members who are also enrolled with the Department of Developmental Disabilities. The CPNOs and Qualified Services providers also have specialty clinicians who are able to provide technical assistance as well as treatment services. For residential services, Sequel Care and Devereux have residential programs that can meet the needs of some DDD youth. Mercy Maricopa has also secured single case agreements with several out of state providers to provide care for those youth who need residential services. In addition, Mercy Maricopa has established a contractual relationship with Developmental Pediatricians Dr. Daniel Kessler and is in the process of securing a contract Dr. Timothy Jordon in order to meet the needs of the younger youth with a developmental delay. Mercy Maricopa also employs a DDD Liaison who assists with coordination of care and promotes services for this population. The DDD liaison facilitates a monthly meeting with representation from the Department of Developmental Disabilities and leadership at Mercy Maricopa. In response to the increase in enrollment in this population on the adult and children side, Mercy Maricopa increased access to care funding in FY2014 and will continue to monitor the availability of services across the network.

CMDP
Mercy Maricopa's contracted provider staff has received training on the unique needs of recipients in the DCS/DES System. All contracted providers have the ability to serve the CMDP/CPS involved population. Mercy Maricopa has children's provider staff co-located at ten DCS/DES offices to assist with enrollment and coordination of care and are working with DCS to have the ability to place co-located staff in four additional locations over the next year. The Rapid Response Team is available to assess the need for behavioral health services for children who have been removed from their home within 72 hours of the referral. DCS is also able to refer youth directly to the Crisis Stabilization Team. This team is set up to provide short-term crisis support services to children in group home settings.

Mercy Maricopa leadership and CMDP leadership hold routine meetings to address strategies for improving coordination of care and services for the CMDP Population. Mercy Maricopa is also meeting with DES Division of Child and Youth Services (DCYF) on a monthly basis. Mercy Maricopa has developed the Department of Child Safety

Assessment Plan. This plan outlines strategies that are being implemented to ensure CMDP Youth receive a behavioral health comprehensive assessment.

Sex Offender Treatment
At this time, the Children's Provider Networks contract with The Resolution Group and Touchstone for outpatient treatment for youth with sexually maladaptive behaviors. Mercy Maricopa also contracts directly with Youth Development Institute, UTurn and Sequel Care to provide residential services for this population. Mercy Maricopa is exploring options on how to increase capacity and expand the provider network for this population. Mercy Maricopa's provider network currently includes 11 providers that offer sex offender treatment to adults.

Sex Abuse Trauma
Mercy Maricopa's Children's Provider Network contracts with ChildHelp, The Resolution Group, Christian Family Care, and Child Crisis Center, to provide specialized services for children that has experienced sex abuse trauma. Individual Clinicians, who are qualified to provide therapy for sex abuse trauma, can also be found within the various Qualified Service Providers. Mercy Maricopa will continue to focus on enhancement to services in this area through focused trainings and the identification of clinicians for this specialty area. Mercy Maricopa will also continue to work with providers who specialize in services for children who act out sexually to ensure they have the capacity to either provide services or refer to a specialist that can provide treatment for sexual abuse trauma. Mercy Maricopa's provider network currently includes 27 providers that offer sex abuse trauma treatment to adults.

Substance Use Disorder Treatment-Child
Mercy Maricopa Children's Provider Network contracts with Valle del Sol, Touchstone, Youth Etc, EMPACT, Native American Connections, JFCS and Touchstone Behavioral Health for intensive outpatient services for substance abuse. Each of the adolescent SAPT treatment providers utilizes a community-based EBP and has been awarded SAPT Funding. Several EBPs are represented in the Mercy Maricopa Network of adolescent SAPT providers. The representation of EBPs allows choice for service recipients, referral sources, and appropriate matching of services to individualized needs.

Individual clinicians who are qualified to provide substance abuse therapy can also be found within the various Qualified Service Providers. Mercy Maricopa contracts directly with The New Foundation and OASIS to provide residential services for this population.

Substance Use – Woman, Adult and IV Drug Use
Mercy Maricopa offers the community a General Mental Health/ Substance Abuse (GMH/SA) network that have sites throughout GSA-6 to receive services in a timely and efficient manner through multiple entry points. These services include outpatient treatment, rehabilitation, medical, support, inpatient, residential treatment, detoxification, peer support, supportive housing, and day program services among others. Mercy Maricopa also offers a Women's Treatment Directory as well as programs dedicated to specialty populations. Programs dedicated to specialty populations include pregnant and parenting women with substance use disorders, transition aged youth, sexual offenders, domestic violence (victim and perpetrator), and sexual abuse trauma victims.

Providers contracted with Mercy Maricopa to provide Opioid Treatment include: Community Bridges; Community Medical Services-Alpha; Intensive Treatment Systems-North; New Hope Behavioral Health Center, Inc.; Southwest Behavioral Health Center, Inc.; Southwest Network; and Terros-Maverick House.

Infant and Early Childhood Mental Health
Mercy Maricopa Children's Provider Network contracts with Southwest Human Development, Child Crisis Center and Christian Family Care, to provide specialized services for children from birth to 5. Individual clinicians, who are qualified to provide therapy for children age 0-5, can also be found within the various Qualified Service Providers and on the DCS Rapid Response Teams.

Arizona Early Intervention Program (AzEIP)
Mercy Maricopa's DCS Rapid Response Team facilitates referrals to AzEIP once a child is assessed and services that AzEIP provides are indicated. Mercy Maricopa's Case Managers for children with high needs work in collaboration with the

AzEIP staff through the treatment planning and CFT process in order to ensure the youth's treatment needs are being met. Mercy Maricopa continues to work collaboratively with AzEIP as one of the participants in the Best for Babies Initiative.

Homeless
Mercy Maricopa Network Providers have access to programs such as Home Base Youth Services and Tumbleweed. These programs include services such as Street Outreach, Mobile Medical Outreach, Employment and Life Skills Training, Substance Abuse and Mental Health Care, a Resource Center, a Transitional Living Program, and an Independent Living Program.

The needs of the homeless youth and families are also addressed through the Child and Family Team process. Provider agency staff helps to coordinate supports/services so the family can eventually sustain on their own. These services may include the Family Support Partners, Case Managers and/or Clinical Care Managers assisting the family with finding shelter. Once shelter services are secured, the provider staff will continue to coordinate services with the shelter staff as needed. The provider staff can also assist the family with locating community resources for permanent housing, food, clothing and/or job training. If needed, the agency may utilize flex funds in order to secure resources to meet the child family's needs. The team may also help the family explore informal resources such as friends and family to stay with temporarily and utilize services through a Family Support Partner to help provide additional support to the family.

Mercy Maricopa contracts with Lodestar Day Resource Center, who provides homeless outreach, peer support, IOP, and individual counseling services. This provider also assists homeless adults in securing transitional and permanent housing and provides them supports as they focus on their recovery. Crisis Transition Navigators are co-located at the CASS campus and the Lodestar Day Resource Center to assist members experiencing behavioral health needs that could become crises without some sort of intervention.

POCN clinics serve a high number of members that are homeless. All PNOs receive referrals for members that are chronically homeless. Mercy Maricopa residential and housing department and the Maricopa County Human Services Campus assists homeless recipients in locating safe permanent housing through numerous community resources. In addition, Mercy Maricopa has deployed a number of network providers to the Human Services Campus to assist in the identification of members who may need behavioral health services as well as support those members currently enrolled who are experiencing homelessness.

Border Communities
Mercy Maricopa is contracted with a number of providers with locations specifically targeted to serve the border regions of GSA 6 including an SMI DCC in Wickenburg, an integrated health care clinic to serve both SMI and GMHSA members in Apache Junction, GMHSA outpatient clinics in Queen Creek and a GMHSA outpatient clinic in Buckeye. Mercy Maricopa identified a need for services in San Tan Valley and efforts to bring services to this area are currently underway. Ongoing analysis of population growth in border communities is taken into consideration when expanding existing contracts and deciding to add new providers. Furthermore, transportation is provided to members when deemed clinically necessary to link them to services.

Veterans
Mercy Maricopa facilitated four meetings with the Veterans Administration leadership to receive feedback and identify opportunities for providing more coordinated integrated care services for our members who are also eligible for services from the Veterans Administration. Input received from the Veterans Administration leadership has been documented in Mercy Maricopa's Collaborative Protocol with the Veterans Administration. Additionally, Mercy Maricopa has been meeting with the Arizona Coalition for Military Families and representation from the National Guard to identify gaps in service delivery and discuss additional opportunities to provide ongoing support to military families. Mercy Maricopa attended the Arizona Coalition for Military Families Conference in April 2014 to gain additional insight to the needs of our members and system partners.

LGBTQ
Mercy Maricopa currently has 30 providers that offer services specifically designed for the LGBTQ population.

Furthermore, Mercy Maricopa has included the LGBTQ Advisory Committee in discussions on the design and implementation of integrated care for GSA 6. In collaboration with the LGBTQ Consortium, Mercy Maricopa has funded an initiative (administered by Terros) called *Safe Out* that is aimed towards reducing excessive alcohol consumption and its negative consequences for the LGBTQ community in Maricopa County.

Transition-Age Youth
Mercy Maricopa's Qualified Service Providers, Direct Support Providers, and Adult and Children's Provider Network Organizations provide services and oversee the treatment planning for this population. In addition, Mercy Maricopa has two providers that offer the full TIP Model as well as six TIP-informed providers. TIP-informed providers utilize the TIP model to influence services such as positive behavioral support, peer support services, and intensive outpatient substance abuse services. These TIP Model and TIP-informed programs have been arranged to serve young adults through the Children's, General Mental Health/ Substance Abuse (GMHSA), and Seriously Mentally Ill (SMI) service-delivery systems. All of these services are designed to empower youth/young adults with skills necessary to live an independent life that is meaningful, healthy and successful.

Mercy Maricopa's Transition Age Youth (TAY) Coordinator has been active in developing and expanding on its community of practice strategies for the TAY population. The TAY Coordinator has been working with providers to collect data on outcomes and capacity of existing services. Moving forward, TAY Coordinator will conduct an environmental scan to gather additional information on the capacity of existing services, outcomes currently being measured by these programs and unmet needs of this population.

As chair of the Youth Leadership Council (YLC) Committee, TAY Coordinator will be working closely with YLC members in further enhancement of the TAY delivery-system. The YLC will be provided opportunities to give feedback on existing programs as well as to assist in defining the gaps in services for further program development.

Tribal Regional Behavioral Health Authorities (TRBHA)

Network Management receives and reviews various deliverables submitted by the TRBHAs. These deliverables are received on a quarterly, annually, and ad hoc basis. Provider Network and Single Case Agreement Listings, Provider Termination Due to Rates, and Diminished Scope of Services and/or Closed their Panel deliverables are received quarterly by the TRBHAs. Ad Hoc deliverables include key personnel changes and Network Material Changes; and annually Network Management receives the results from the Behavioral Health Member Satisfaction Survey, Assurance of Network Adequacy and Sufficiency Plan. Additionally, Network Management participates in the annual Administrative Reviews and reviews the quarterly System of Care reports. Network Management staff attend collaborative meetings within the division which provides additional information and insight to network sufficiency. Those meetings include; Quality Management Committee, Policy Committee, Compliance Committee, Cultural Competence Steering Committee, and Housing Review Committee to name a few. This provides numerous opportunities for Network Management to evaluate, adequacy, accessibility and availability of providers for the TXIX and TXXI members being served and provides an avenue to identify gaps or potential gaps in services.

Each TRBHA is committed to providing services in an atmosphere of dignity, harmony, and respect for the tribal members they serve.   Their approach is with a holistic, multi-disciplinary and person-centered approach, honoring other tribal cultures and cultural uniqueness. They encourage active participation in counseling and open expression of thoughts and feelings and support members in reaching their goals: encouraging healthy lifestyle changes to improve wellness while honoring their member's spirituality, history, and wisdom. Traditional counselors and services are available to provide culturally appropriate services. Also, drumming, talking circles, smudging, and sweat lodge services are available. Notices, services, written information and materials are provided in the member's primary or preferred language. Written information is translated into a member's alternative language so the member can understand. Interpreters are made available when needed 24/7/365. Arizona Interpreting Service, Inc. and Community Outreach Program for the Deaf are examples of the services used for members who are deaf or hard of hearing to provide sign language interpretation. In addition, auxiliary aids are available including computer-aided transcriptions, written materials, assistive listening devices or systems, closed and open captioning, as well as other effective methods of making aurally delivered materials available to members with hearing loss.

A good majority of the contracted service providers in the TRBHA networks are located outside the community and off of the reservations. Despite the location of a large percentage of their contracted providers, services are provided in home or in their respective communities as members do not have available transportation and public transportation is not readily available. The exception is residential and inpatient levels of care. The TRBHAs monitor their use of single case agreements to identify any area or population that may indicate the need for an additional provider to be added to their network.

XII.   Conclusion

The Provider Network Development and Management Plan's purpose is to align the Division of Behavioral Health Services' vision with oversight and monitoring of the Regional Behavioral Health Authorities, Integrated Regional Behavioral Health Authority, and Tribal Authorities provider networks, utilizing a foundation that supports an individual's needs. As member's needs change so does ADHS scope of work. In early 2015 ADHS will announce the awardee of the integrated plans for the newly re-assigned GSA structure. The existing six (6) GSAs will be condensed to a North, South and Maricopa Service area. The start of the new contracts for North and South are intended for October 1st, 2015. This alignment and new service delivery model will significantly impact our most vulnerable population by providing better care and cost efficient methods.