ARIZONA OFFICE OF THE AUDITOR GENERAL

Department of Health Services
Behavioral Health Services—Reporting Requirements (Report Highlights)

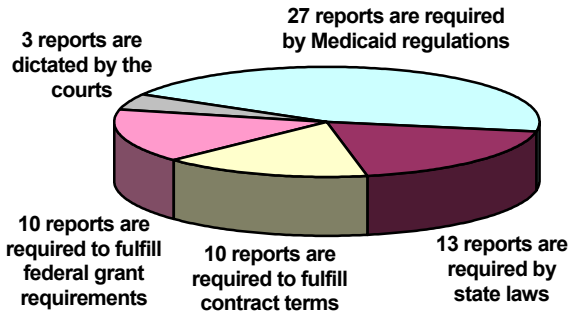
December 2001

Arizona's behavioral health system is administered by the Department of Health Services' Division of Behavioral Health Services (Division), which provides publicly funded mental health treatment and substance abuse treatment and prevention services through five Regional Behavioral Health Authorities (RBHAs) and a network of more than 350 service providers. These entities prepare 63 different reports in response to federal and state laws and regulations, contract requirements, and court mandates. The Auditor General's Office conducted a review to identify any duplicative or outdated reporting requirements, while considering criteria that measure the Division's performance.

Our Conclusions:

Most of the 63 reports cannot be eliminated because they are prepared in response to federal regulations and grant requirements, particularly Medicaid regulations. However, two major reports were consolidated during our audit and another six reports can be eliminated. While the Division measures performance in four key areas, it can take some steps to further improve its measurement of system performance.

Reporting requirements:



Opportunities for Consolidating, Eliminating Reports

Two large reports were consolidated during our review and another six can be eliminated, representing about one-eighth of the reports we reviewed.

Consolidating reports—Until October 3, 2001, the Division produced two reports addressing quality and appropriateness of care. Both reports were based on extensive case file reviews that not only addressed some of the same information, but also may have examined some of the same files. These reports were prepared in response to two different Medicaid regulations calling for:

- A report on the quality of care for a different client group each year; and
- A report on the quality of care for Title XIX and XXI clients.

During our review, the Division's Medicaid contract was amended to allow the Division to conduct one file review and issue one report to meet both requirements.

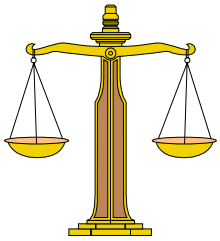
Eliminating reports—Six other reports can be eliminated. Specifically, the Division can eliminate five reports because they are duplicative, no longer used, or related to procedures that may no longer apply. These reports are:

- Three financial reports that either duplicate information in other reports or are not used at all.
- Two reports that had been required previously by legislation but are no longer needed because the mandates no longer exist.

Further, the Legislature could consider eliminating a sixth report.

- One report required for involuntary commitments of alcoholics. Such commitments are no longer considered appropriate treatment and a report has not been filed since 1992, but the statutory mandate still exists.

Court-mandated reports still needed—The Division also produces three other reports pursuant to negotiated settlements in two class-action lawsuits, *Arnold v. Sarn* and *J.K. v. Eden*. These reports are necessary to demonstrate progress toward meeting the lawsuit settlements. However, the Division and the court monitor may be able to streamline these reports by eliminating some questions as settlement criteria are completed.



The Division should:

- ✓ Eliminate five reports we identified as duplicative or unneeded; and
- ✓ Work to streamline the reports required by courts.

The Legislature should:

- ✓ Consider reviewing and revising the involuntary commitment statute for chronic alcoholics and eliminate the associated report, if appropriate.

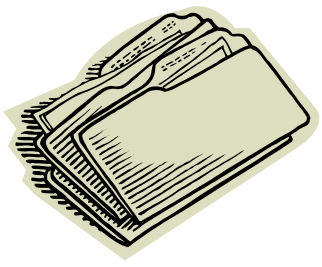
Division Can Continue To Improve Performance Measurement

In reviewing the behavioral health system reports, we were also directed to consider criteria for measuring the Division's performance in the following areas:

- Clinical quality,
- Availability of services,
- Quality of service as rated by patients and their families; and
- Quality of RBHA services as rated by providers.

We found some measures exist in all four of these areas, with the most measurement occurring for clinical quality. Much less is done to measure provider satisfaction with RBHA services. However, measurement can be improved in all four areas.

Clinical quality—The Division uses case file reviews to measure clinical quality and has at least four other mechanisms, such as reports on the use of client seclusion and the success of clinical treatment methods, for measuring various aspects of clinical quality. One of the case file reviews focuses on a different client group or diagnosis each year, such as people with schizophrenia or substance-



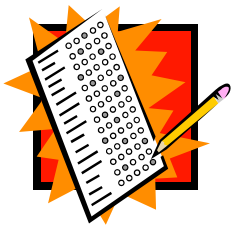
abusing pregnant women, and compares the services provided to establish guidelines and best practices for care and treatment.

The Division can improve its measures of clinical quality by continuing to develop care and treatment guidelines for other client groups based on their diagnoses. Currently, the Division has guidelines for 15 diagnoses, but there are many other conditions that clients are being treated for, such as bipolar disorder, that still lack guidelines.

Service availability—The Division measures service availability by how long it takes clients to receive services and by what services are needed but unavailable. To help improve service availability, the Division is using mapping software to assess the sufficiency of the statewide provider network.

However, the definitions the Division uses in measuring service availability have not been consistent. For example, the Division only recently defined the term "enrolled," which caused inconsistencies in calculating measures relying on enrollment data. The Division should use the new definitions consistently and ensure it develops and uses uniform definitions in the future.

Quality of service as rated by patients—The Division measures quality of service by mailing a survey to patients and their families. The survey contains questions drawn from a national survey, so the Division should be able to see how it compares nationally. However, because the Division relies on mail-in surveys, response rates are below 20 percent. In contrast, states that conduct face-to-face surveys have response rates as high as 84 percent.



Quality of RBHA services—The Division does very little to measure the quality of RBHA services as rated by the providers that contract with each RBHA. One RBHA participates in a legislatively established pilot incentive program that provides monetary awards based on service provider satisfaction. Providers for this RBHA receive a ten-question survey three times a year that asks them to rate quality of RBHA services, such as the timeliness of RBHA claims processing and bill payment.

However, provider satisfaction for the other four RBHAs is not measured by surveys. The Division has indicated that it monitors provider satisfaction for these four RBHAs through the number of grievances filed and through other means, such as provider forums.

The Division should:

- ✓ Continue to develop care and treatment guidelines for additional behavioral health diagnoses;
- ✓ Consistently use uniform definitions for service availability performance measures;
- ✓ Improve the response rate for its consumer survey by using different survey methods; and
- ✓ Consider expanding its provider satisfaction survey to all RBHAs.

To Obtain More Information

- A copy of the full report can be obtained by calling (602) 553-0333 or by visiting our Web site at:

  www.auditorgen.state.az.us

- The contact person for this report is ***Shan Hays.***