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**2008 INDEPENDENT REVIEW**

**OFFICE OF THE MONITOR**

*ARNOLD v. ADHS*

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**IN THE SUPERIOR COURT OF THE STATE OF ARIZONA  
IN AND FOR THE COUNTY OF MARICOPA**

**CHARLES ARNOLD, MARICOPA COUNTY  
PUBLIC FIDUCIARY, as guardian and next friend on  
behalf of JOHN GOSS; NANCY E. ELLISTON, as  
guardian, conservator and next friend on behalf of  
CLIFTON DORSETT and as next friend on behalf of  
RICHARD SCHACHTERLE, SUSAN SITKO, and  
TERRY BURCH; and on behalf of all others similarly  
situated,**

*Plaintiffs*

**v.**

**ARIZONA DEPARTMENT OF HEALTH SERVICES,  
ARIZONA STATE HOSPITAL, and MARICOPA  
COUNTY BOARD OF SUPERVISORS**

*Defendants*

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*No. C-432355*

**OFFICE OF THE MONITOR'S  
2008 INDEPENDENT REVIEW  
JANUARY 2009**

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**I. INTRODUCTION**

The purpose of this report is to present the findings of the Office of the Monitor's 2008 Annual Independent Review pursuant to the *Joint Stipulation*, Appendix C and the *Supplemental Agreement in Arnold v. Arizona Department of Health Services*. An additional aim is to report on other information systematically gathered in the Monitors' Independent Review about other service elements and processes relevant to examining the system's performance on key lawsuit requirements associated with exit from this case.

The standards and measures employed in assessing compliance issues in the 2008 audit were set forth in two sets of agreements by the parties to the *Arnold* class action lawsuit and signed as orders of the Court. These governing documents for the 2008 audit were the *Joint Stipulation on Exit Criteria and Disengagement* and the Supplemental Agreement. Completion dates for each of the requirements in these stipulations were negotiated by the parties to insure that ADHS was given a reasonable opportunity to meet the exit requirements.

The target compliance percentages for completion of the items due in 2008 are as follows:

<b>Appendix C Requirement</b>	<b>Requirement</b>	<b>2008 Target</b>
C.2	Priority clients have a clinical team which includes the client, nurse, physician, case manager and vocational specialist unless employment has been determined by the team and the client to no longer be an issue.	85 %
C.3	Priority clients have an ISP with a functional assessment and a long-term view.	90 %
C.4	Priority clients shall have periodic reviews at least every six months.	85 %
C.5	Whenever there is a substantial reduction of services, modification of a residential setting or day/vocational program or a termination of services, class member's ISPs are modified with the client's consent or consistent with the ISP rules.	80 %
C.6	Class members are informed of their right to appeal eligibility and treatment decisions.	90 %
C.7	The needs of priority class members are met consistent with their ISP.	29 %
C.8	The needs of non priority class members are substantially met consistent with their ISP.	80 %
C.9	Class members participate in the planning and development of their ISP.	80 %
C.10	If special assistance is needed, it is currently being provided or offered by ADHS or the RBHA.	80 %

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C.11	Is there documentation of informed consent to take the behavioral health medication and to ECT?	85 %
C.12	Class members, if still remaining for more than seven days in an inpatient treatment setting, have an ITDP by the tenth day, which is derived from their ISP.	85 %

The 2008 Independent Review is an in-depth look at 316 randomly selected individual class members currently residing in the community. A class member is an individual with serious mental illness residing in Maricopa County. This review did not include any individuals currently in the Arizona State Hospital, in jail or in prison. The review included 157 class members designated as “priority” class members.

Priority class members are individuals with serious mental illness enrolled in the behavioral health system who:

1. Had been an inpatient in the Arizona State Hospital since July 1, 1993; or
2. Is or has been a resident of a Supervisory Care Home since July 1, 1995; or
3. Had been an inmate in jail with a major biological illness since July 1, 1995.

The Independent Review also included 159 randomly selected “non priority” class members.

In 2006, Dr. Jose Ashford (Office of the Monitor expert) and Dr. Michael Shafer (ADHS expert) developed guidelines for the Independent Review process designed to strengthen the reliability and validity of the audit process and the resulting data. These guidelines, as documented in the “Statement of Consensus: Suggested Methodological Enhancements for the Arnold v. Sarn Field Review Protocol,” were followed during this review.

It is important to note that Magellan became the Regional Behavioral Health Authority (RBHA) in Maricopa County in September 2007. Therefore, the 2008 Independent Review is the first review by the Office of the Court Monitor that measures system performance relevant to the provision of behavioral health services provided by Magellan.

## **II. REVIEW METHODOLOGY**

The Case Review Instrument (CRI) used for this audit was Version 24.00. The CRI is a 105 page booklet with 219 questions. The only change made to the 2007 CRI version was to include additional clarifying instructions on certain questions.

### **A. AUDITOR RECRUITMENT**

Forty-two (42) individuals met the required educational and professional qualifications to be a reviewer for the 2008 audit. The 2008 auditors were diverse. Many individuals had prior or current employment experience in direct behavioral health services, quality

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management, hospitals or other community behavioral health programs. The review team was comprised of the following:

- Sixteen (16) Clinical Coordinators from Magellan (38%);
- Fifteen (15) staff from Magellan (32%).
- Six (6) staff from the Division of Behavioral Health Services (DBHS/ADHS) (14%);
- Five (5) independent contractors (12%).

Therefore, 88% of the review team either worked for the Maricopa County RBHA, Magellan, or Defendant DBHS/DHS.

Twenty-four (24) of the reviewers had previously met or exceeded the acceptable gold standard of 80% on a simulated case. These individuals attended a refresher training prior to participating in the 2008 review. The remaining 18 reviewers attended an in-depth training on the Independent Review process and the Case Review Instrument. At the conclusion of training, candidates completed a post-test to determine their understanding of the training material. Following the scoring of the post-test, accurate responses for each question were reviewed with the group. The post-tests were collected and tabulated by the Monitor.

### B. PRE-AUDIT FIELD RELIABILITY

In order to ensure reliable performance in the field, auditors must successfully complete a simulated case. Two simulated cases were developed by experts from the Office of the Monitor and DBHS to establish a “gold standard” for the training process. Of the 18 reviewer candidates who completed a simulation case following the training, 14 passed the minimum threshold of 80%. Four (4) of the remaining candidates who did not reach the minimum score of 80% chose to complete a second simulation case. All exceeded the minimum standard of 80% for their second case. The results of the simulation cases were as follows:

<b>Auditor Results – “Gold Standard” Simulation Cases</b>			
<b>TIME 1</b>		<b>TIME 2</b>	
<b>Percent of Correct Responses – 1<sup>st</sup> Case</b>	<b>Number of Auditors</b>	<b>Percent of Correct Responses – 2<sup>nd</sup> Case</b>	<b>Number of Auditors</b>
100%	2	100%	1
92%	7	92%	1
85%	5	85%	2
77%	2		
69%	2		
	Total=18		Total=4

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### C. SAMPLE

To measure compliance with the *Stipulation Re: Revised Completion Dates, Joint Stipulation on Exit Criteria and Disengagement, Appendix C, and the Supplemental Agreement*, the Office of the Monitor employed proportional random sampling and simple random sampling procedures to select priority and non-priority cases. The total sample of 316 class members was selected from a data base maintained by the ADHS/DBHS.

Based on data provided by the ADHS/DBHS, there were 3,548 priority class members at the time the sample was selected for the audit (e.g. Arizona State Hospital, Supervisory Care and Jail). Separate sampling fractions were generated to randomly select cases in each priority strata. Arizona State Hospital class members represented 28 (17.8%) of the priority sample. Supervisory Care class members represented 26 (16.6%) of the priority sample. The majority of the priority sample was 103 class members (65.6%) who had been in the jail. In addition, the Office of the Monitor employed simple random sampling procedures to select non-priority subjects (n=159) at an 80% confidence interval.

This review did not include any individuals currently in the Arizona State Hospital, jail or in prison. If the sample chose a class member currently in one of these institutions, the next class member on the list who was living in the community was used as a replacement.

### D. AUDIT PROCESS

The process for the Independent Review uses a person-centered approach. Each case is reviewed within the context of an individual's own personal clinical needs, concerns, preferences and outcomes of their involvement with the system. For each person selected in the sample, a comprehensive review is completed that typically takes an entire day. The field portion of the 2008 Independent Review was completed in October 2008.

Each individual case review starts with a comprehensive review of the person's case management/clinical record for the past twelve (12) months. Copies are made of all relevant assessments, including the Comprehensive Assessment. A copy of the Individual Service Plan (ISP) is also obtained. Next, the reviewer conducts a detailed structured interview with the case manager and/or clinical liaison. The reviewer then makes every attempt to interview the person in their home so that first hand observations can be made of their living situation. In the 2008 review, 245 out of 316 class member interviews were conducted. The reviewer also interviews guardians, family members, and providers of community based services when available.

After the interviews, the reviewer takes all of the information gathered and documented, synthesizes this information and develops conclusions and findings using the format and instructions of the Case Review Instrument (CRI). Finally, all copies of documentation and the completed CRI are submitted to the case judge. The case judge carefully reviews all of the documentation and reviews each response and justification noted in the CRI.

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The case judge notes any inconsistencies, questions, or deviations from established criteria. Subsequently, the case judge and the reviewer meet on each of the cases to review and reconcile the questions or concerns identified by the case judge. Any necessary corrections or changes are made after discussion and agreement between the case judge and the reviewer. Every case reviewed in the 2008 Independent Review has complied with the rigorous case judging process in order to insure the accuracy, reliability and consistency of the findings. After case judging, the data from the CRI is entered into the Office of the Monitor's Independent Review database for compilation.

### E. ON-GOING FIELD RELIABILITY

To ensure on-going reliability and consistency during the audit process, one case assigned to each field reviewer was also completed by another reviewer. In this process, 33 cases were duplicated. For these cases, the reviewer's evaluated documentation independently and jointly conducted interviews. The rating of questions in the Case Review Instrument was completed separately. Dr. Ashford determined the percentage of agreement for each item displayed in the table below and calculated the overall percentage of agreement. None of the items fell below the standard of acceptability of 80%. The percentage of agreement across all Appendix C items was 89%.

#### Auditor Results On-Going Field Reliability

Appendix C Requirement	Requirement	Percentage of Agreement
C.2	Priority clients have a clinical team which includes the client, nurse, physician, case manager and vocational specialist unless employment has been determined by the team and the client to no longer be an issue.	85%
C.3	Priority clients have an ISP with a functional assessment and a long-term view.	100%
C.4	Priority clients shall have periodic reviews at least every six months.	94%
C.5	Whenever there is a substantial reduction of services, modification of a residential setting or day/vocational program or a termination of services, class member's ISPs are modified with the client's consent or consistent with the ISP rules.	82%
C.6	Class members are informed of their right to appeal eligibility and treatment decisions.	85%
C.7	The needs of priority class members are met consistent with their ISP.	97%
C.8	The needs of non priority class members are substantially met consistent with their ISP.	91%
C.9	Class members participate in the planning and development of their ISP.	85%

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C.10	If special assistance is needed, it is currently being provided or offered by ADHS or the RBHA.	97%
C.11	Is there documentation of informed consent to take the behavioral health medication?	91%
C.11	Is there documentation of informed consent to ECT?	100%
C.12	Class members, if still remaining for more than seven days in an inpatient treatment setting, have an ITDP by the tenth day, which is derived from their ISP.	100%
	Overall Percentage of Agreement	89%

### III. SAMPLE DEMOGRAPHICS

Comparisons between the Independent Review sample and total population of enrolled persons with serious mental illness were computed for purposes of assessing the representativeness of the sample. The sample characteristics are displayed in the following table.

**Sample Characteristics**

<b>Variables</b>	<b>Priority Class Sample</b>	<b>Total Priority Class</b>	<b>Non-Priority Sample</b>	<b>Total Non Priority Class</b>
Age	Mean = 44	Mean=43	Mean = 44	Mean=44
Gender:				
Male	66%	60%	42%	42%
Female	34%	40%	58%	58%
Ethnicity:*				
White	71%		76%	
Black/African American	14%		10%	
Latino	12%	17%	11%	16%
Asian	1%			
Native American	2%			
Other			3%	
Priority Status:				
Arizona State Hosp.	18%	15%	N/A	N/A
Supervisory Care	16%	16%	N/A	N/A
Jail	66%	69%	N/A	N/A
Diagnosis:				
Schizophrenia or other psychotic disorder	50%	56%	35%	33%
Mood Disorder	48%	42%	50%	53%
Other	1%	1%	13%	10%
Unknown	1%	1%	2%	4%

\*Ethnicity data provided by ADHS for the total population included only Hispanic and non Hispanic data as represented in the table.

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The table below identifies the living arrangements for the 157 priority class members and 159 non-priority class members. For both groups, the most common living arrangement is independent living, alone or with a roommate (37%) followed by living at home with family, spouse or friends (36%). Class members whose living arrangement is described as “other” primarily live in provider sponsored and/or staffed community placements.

**Living Arrangements**

Living Situation	Priority Class			Non-Priority Class		
	Frequency	Valid %	Cumulative Percent	Frequency	Valid %	Cumulative Percent
Independent (alone or with roommate)	53	34.9	34.9	64	42.1	42.1
Level I, II or III behavioral health treatment program	15	9.9	44.7	4	2.6	44.7
Supervisory Care/Asst. Living	7	4.6	49.3	1	.7	45.4
Transitional Housing (Level IV)	1	.7	50.0	2	1.3	46.7
Homeless	2	1.3	51.3	5	3.3	50.0
Missing	-	-	-	2	1.3	51.3
Home with family/spouse/friends	49	32.2	83.6	64	42.1	93.4
Halfway House/Boarding Home	9	5.9	89.5	3	2.0	95.4
Hotel/Motel	-	-	-	1	.7	96.1
Other	15	9.9	99.3	5	3.3	99.3
Crisis Shelter	1	.7	100	1	.7	100
Unknown	5			7		
Total	157	100	100	159	100	100

Class members included in the 2008 Independent Review are distributed across all clinical team sites as represented in the following table.

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**Class Member Site Assignment – Sample**

SITE	PRIORITY (n=157)	NON-PRIORITY (n=159)
Alma School	9	13
Arcadia	9	9
Cave Creek	8	10
Centro Esperanza	6	13
West McDowell	4	2
East Mesa	9	10
East Phoenix	7	1
Glendale	5	8
1300 N. Central	11	1
Heatherbrae	9	5
West Valley	6	13
Highland	6	3
Metrocenter	11	6
Osborn	2	7
Park North	5	6
South Central	13	2
Wickenburg	1	0
Thomas Road	3	8
Tempe	10	11
Townley	10	12
West Camelback	10	12
Garden Lakes	1	4
Washington House	2	3
Total	157	159

The following table sets forth the Medicaid (AHCCCS) eligibility of the sample.

	Priority Class	Non-Priority Class
Medicaid Eligibility	79.6%	70.4%

#### **IV. INDEPENDENT REVIEW FINDINGS**

This part of the report is divided into two sections. The first section describes the system's levels of compliance with stipulated targets for the 2008 audit. In addition, it reviews charts that compare findings from the 2008 audit with findings from the 2006 and the 2007 audits.

In the second section, the Monitor will report on additional data that was systematically gathered in the annual audit that addresses other elements relevant to understanding the systems performance on factors affecting the health and well-being of class members.

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The report is describing these additional findings to aid the Court and the parties in obtaining a broader understanding of the system's performance on clinical service, consumer rights, and quality of life measures. With the benefit of the information, we hope that Court and the parties can identify service gaps and implementation problems affecting the system's performance on key clinical practices.

The comparison charts are as follows:

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**AUDIT COMPARISON DATA  
PRIORITY SAMPLE – 157**

<b>Item</b>	<b>Requirement</b>	<b>Target 2008</b>	<b>Results 2006</b>	<b>Results 2007</b>	<b>Results 2008</b>
C.2	Priority Clients have an appropriately constituted clinical team	85%	68%	60%	40%
C.3	Priority clients have an ISP with a functional assessment and long-term view.	90%	35%	13%	19%
C.4	Priority clients shall have periodic reviews at least every six months.	85%	79%	57%	64%
C.5	Whenever there is a substantial reduction of services, a substantial modification of a residential setting or day/vocational program, or a termination of services, class members' ISPs are modified with the client's consent or consistent with the ISP rules.	80%	41%	19%	21%
C.6	Class members are informed of their right to appeal eligibility and treatment decisions.	90%	91%	79%	83%
C.7	The needs of priority class members are met, consistent with their ISP. Living Work/Meaningful Day Social/Community Integration	29% N/A N/A N/A	29% 55% 38% 45%	13% 36% 21% 28%	17% 41% 22% 31%
C.9	Class members participate in the planning and development of their ISP.	80%	79%	68%	62%
C.10	Class members in need of special assistance are offered or provided reasonable assistance by ADHS or the RBHA in the ISP and grievance processes.	80%	36%	21%	15%
C.11	Class members' charts show documentation of adequate informed consent to medication and ECT, if applicable.	85%	81%	82%	81%
C.12	Class members, if still remaining for more than 7 days in inpatient treatment settings, have an ITDP by the 10 <sup>th</sup> day which is derived from their ISP.	85%	58%	50%	57%

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**AUDIT COMPARISON DATA  
PRIORITY SAMPLE – 157**

	<b>Supplemental Agreement</b>	<b>Target 2008</b>	<b>Results 2006</b>	<b>Results 2007</b>	<b>Results 2008</b>
	Coordination of Care with the PCP.	N/A	57%	57%	57%
	The person's physical health related issues and needs are being addressed.	N/A	64%	61%	62%
	The Comprehensive Assessment is current.	N/A	84%	71%	87%
	The Comprehensive Assessment is complete.	N/A	52%	36%	20%
	The case manager/clinical team respond to changes in the person's treatment needs/life circumstances in a timely manner.	N/A	59%	51%	40%
	The person receives the level of case management they need.	N/A	61%	52%	47%
	There is evidence of communication between the person and each of their clinical team members.	N/A	72%	65%	50%
	The clinical team assures that all services are in place in accordance with the ISP.	N/A	57%	40%	35%
	The case manager/clinical team monitor the services provided.	N/A	70%	57%	55%
	The class member is treated with dignity and respect by the case management agency, provider and any other involved individual.	N/A	63%	53%	47%

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**AUDIT COMPARISON DATA  
NON PRIORITY SAMPLE – 159**

<b>Item</b>	<b>Appendix C Requirement</b>	<b>Target 2008</b>	<b>Results2006</b>	<b>Results 2007</b>	<b>Results 2008</b>
C.5	Whenever there is a substantial reduction of services, a substantial modification of a residential setting or day/vocational program, or a termination of services, class members' ISPs are modified with the client's consent or consistent with the ISP rules.	N/A	36%	32%	19%
C.6	Class members are informed of their right to appeal eligibility and treatment decisions.	N/A	88%	79%	80%
C.8	The needs of non priority class members are substantially met consistent with their ISP. Living Work/Meaningful Day	80%	44% 60% 52%	17% 35% 22%	14% 33% 21%
C.9	Class members participate in the planning and development of their ISP.	N/A	86%	68%	56%
C.10	Class members in need of special assistance are offered or provided reasonable assistance by ADHS or the RBHA in the ISP and grievance processes.	N/A	20%	13%	20%
C.11	Class members' charts show documentation of adequate informed consent to medication and ECT, if applicable	N/A	87%	87%	85%
C.12	Class members, if still remaining for more than 7 days in inpatient treatment settings, have an ITDP by the 10 <sup>th</sup> day which is derived from their ISP.	N/A	71%	0%	0%

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**A. CLINICAL SERVICES**

**1. Clinical Team/Case Management**

The clinical team is the group of individuals working in collaboration who are actively involved in a person’s assessment, service planning and service delivery. The composition of the clinical team is critical to assure the person’s needs are identified and then met. Each member brings their own expertise and experience to the team. The Case Review Instrument questions that relate to the composition of the clinical team are as follows.

Case Review Instrument Question	Priority Class	Non-Priority Class
Q203. Is there evidence of participation in service planning by the following: a. Person	62% Yes 38% No	55% Yes 45% No
b. Guardian	17% Yes 3% No 80% N/A	2% Yes 5% No 93% N/A
c. Psychiatrist/Nurse Practitioner/Physician Assistant	66% Yes 34% No	64% Yes 36% No
d. Nurse	68% Yes 32% No	62% Yes 38% No
e. Case Manager	71% Yes 29% No	66% Yes 34% No
f. Vocational Specialist	54% Yes 40% No 6% N/A	40% Yes 45% No 15% N/A
Q204. Does the priority client have an appropriate clinical team? (Appendix C.2)	40% Yes 60% No	N/A

For the sample of 157 priority class members, 95 (40%) were found to have an appropriate clinical team. This is a 20% decrease from 2007 data and a 28% decrease from 2006 data. The data shows that the low compliance with Appendix C.2 was not due to absence of one particular team member but to a fairly low participation rate across the board. The person most frequently absent from the service planning process was a vocational specialist. It should be noted that a vocational specialist was considered to be any clinical team member who is actively involved in employment related services, even if the person’s title was not vocational specialist. The second person most frequently absent from the service planning process was the person themselves. In 60 of the 157 (38%) priority class members there was no evidence that the person participated in the planning of their services. This fact is incongruent with principles of the recovery model.

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One of the critical components of recovery is the person's active participation in his or her treatment.

The case manager plays an important role on the clinical team. In an effort to provide appropriate and effective case management to class members, DBHS/ADHS provides for a three tier case management system. Class members receive services from a case management team that is commiserating with their level of need. The three tiers are as follows:

1. Assertive Case Management Treatment Teams (ACT) assume responsibility for directly providing needed treatment, rehabilitation and support services to class members with severe and persistent mental illness. These class members are persons who have severe symptoms and impairments not effectively remedied by available treatments or who, because of reasons related to their mental illnesses, resist or avoid involvement with mental health services. The ACT team strives to deliver 75 percent or more of the services outside the clinic offices. The ACT team emphasis is on outreach, relationship building and individualization of service. ACT teams should have no more than 12 class members assigned to one case manager.
2. Supportive Case Management Treatment Teams are designed to address the treatment and rehabilitation needs of persons exhibiting severe to moderate functional impairment. Supportive treatment is for people who are pursuing recovery goals and are able to express clear preferences about the direction of their lives. Supportive teams strive to maximize community resources. Case managers on a supportive team should not have more than 30 assigned class members.
3. Connective Case Management Treatment Teams serve class members who have largely achieved recovery and are concerned with maintaining their level of functioning and who are able to manage their illness with moderate levels of supportive counseling and guidance and independently seek outpatient services. Persons served by a connective team typically make monthly (but at least quarterly) visits to the clinic for medication management. A connective team case manager should have a caseload size of no more than 70 class members.

Individual case managers were interviewed during the Independent Review. Data regarding case manager caseload size and longevity on the job were collected.

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<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-Priority Class</b>
Q115. What is the current caseload for the case manager?		
0-12 cases	13%	4%
13-30 cases	26%	14%
31-40 cases	39%	50%
41-50 cases	13%	22%
50+ cases	9%	10%
Q116. How long has the person had the case manager?		
Under 3 months	27%	26%
3-6 months	16%	15%
6-9 months	14%	14%
9-12 months	18%	16%
Over 12 months	25%	29%
Q117. What kind of team is the person assigned?		
Assertive	22%	4%
Supportive	71%	87%
Connective	7%	9%

Comparing the caseload data with the team data clearly illustrates that case managers are carrying higher caseloads than allowed by DBHS. For instance, for the priority population, 93% of the class members were on either an ACT or supportive team. If caseload maximum requirements were met then at least 93% of the case managers should have caseloads of 30 or less. However, only 39% of the case managers had caseloads of 30 or less. This means that 54% of the priority class members had case managers with caseloads higher than DBHS requires. For the non-priority sample, 73% of the class members had case managers with caseloads higher than the maximum allowed. Additionally, the data shows that 43% of the priority class members and 41% of the non-priority class members have had their case managers for 6 months or less.

## **2. Comprehensive Assessment**

The comprehensive assessment is the first step in identifying the person's strengths and areas of need. It is developed within ninety days of the person's initial enrollment and updated at least annually or more often as needed to reflect significant changes in the person's life. The comprehensive assessment forms the basis for the Individual Service Plan. A complete comprehensive assessment is important because the information gathered is used to identify the needs and services that will be planned for in the ISP. If relevant information is not gathered during assessment, it may not be addressed in the ISP. In order to develop a complete Comprehensive Assessment the clinical team must know the person and engage them and others involved in their life. Therefore, a face-to-face interview is important in completing the assessment. To ensure that the comprehensive assessment gathers all relevant information, the A.A.C. R9-21-305 (c)

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outlines 17 different components that must be addressed. Twenty questions in the Case Review Instrument address the comprehensive assessment as outlined in the table below. It should be noted that not all required areas below apply to every class member. For example, criminal justice history, substance use history and developmental history were not relevant issues for some class members. If not applicable, the information was not included in the data.

Case Review Instrument Question	Priority Class	Non-Priority Class
Q163. Is there a current comprehensive assessment? (Supplemental Agreement #3)	87% Yes 13% No	65% Yes 35% No
Q164. Was a face-to-face interview conducted during the assessment/evaluation process?	73% Yes 27% No	83% Yes 17% No
Does the Comprehensive Assessment Include the Following Components:		
Q165. Mental status, including mental status exam	66% Yes 34% No	75% Yes 25% No
Q166. Legal status and apparent capacity	76% Yes 24% No	76% Yes 24% No
Q167. Living environment	66% Yes 34% No	81% Yes 19% No
Q168. Interpersonal and social skills	47% Yes 53% No	53% Yes 47% No
Q169. Social setting	70% Yes 30% No	76% Yes 24% No
Q170. Physical health status	58% Yes 42% No	81% Yes 19% No
Q171. Level of daily living skills	69% Yes 31% No	78% Yes 22% No
Q172. Criminal justice history	56% Yes 44% No	87% Yes 13% No
Q173. Developmental history	24% Yes 76% No	57% Yes 43% No
Q174. Employment and vocational training	54% Yes 46% No	75% Yes 25% No
Q175. Education	75% Yes 24% No	87% Yes 13% No
Q176. Language abilities	92% Yes 8% No	91% Yes 9% No
Q177. Public and private resources/entitlements	66% Yes 34% No	63% Yes 37% No
Q178. Substance abuse history	56% Yes 44% No	75% Yes 25% No

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Q179. Risk Assessment	62% Yes 38% No	82% Yes 18% No
Q180. Sexual Behavior/Sexual Abuse	31% Yes 69% No	66% Yes 33% No
Q181. Recommendations and next steps	47% Yes 53% No	60% Yes 40% No
Q182. Is the comprehensive assessment complete? (Supplemental Agreement # 4)	20% Yes 80% No	25% Yes 75% No

For the priority sample, the comprehensive assessment was current for 137 out of 157 (87%) class members. This represents a 16% compliance increase from the findings of the 2007 Independent Review. For the non-priority population, the comprehensive assessment was current for 103 out of 159 (65%) class members. This constitutes a 4 % compliance decrease from 2007. For the priority sample, only 20% of the assessments were accurate and reasonably addressed all the required and applicable components. Overall, this represents a 16% compliance decrease from the findings of the 2007 Independent Review. For the non-priority class members, only 25% of the assessments were complete. Overall, this constitutes a 19% compliance decrease from 2007.

It is interesting to note the differences between the comprehensive assessment data components for the priority and non-priority class members. For priority class members, there were 8 different applicable components of the comprehensive assessment that were either missing or incomplete more than 40% of the time. These components were:

- Interpersonal and social skills (73 out of 137 class members);
- Physical health status (57 out of 137 class members);
- Criminal justice history (47 out of 107 class members);
- Developmental history (25 out of 33 class members);
- Employment and vocational training (63 out of 137 class members);
- Substance abuse history (51 out of 116 class members);
- Sexual behavior/sexual abuse (34 out of 49 class members);
- Recommendations and next steps (72 out of 137 class members).

In contrast, the non-priority sample had only 2 comprehensive assessment components that were missing or incomplete over 40% of the time (interpersonal and social skills and developmental history).

### **3. Individual Service Planning**

The Individual Service Plan (ISP) is the roadmap for delivering services. The ISP is not meant to be “paperwork” but a living, breathing document that forms the basis for the person’s recovery. The first part of the ISP is the long term view/vision. In order to effectively plan for a person’s recovery and treatment, it is imperative for the clinical team to have a thorough understanding of the person and his or her history, likes, dislikes, abilities, dreams, challenges, resources, preferred resources and desired outcomes. The

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person’s long term vision, along with the person’s needs, set the direction of the person’s ISP. The long term vision is a planning statement that identifies, from the person’s perspective: where the person would like to live, what the person would like to be doing, and how the person would like to interact socially in the community. It is based on the person’s unique interests, strengths and personal desires. The clinical team assists the person in identifying what is important in their life, so that treatment goals can be consistent with their life goals. The Case Review Instrument asked three basic questions about the long term vision section of the ISP.

<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-Priority Class</b>
Q187. Does the long-term view/vision address the future of where the person wants to be in each life area: a. Living Situation?	85% Yes 15% No	34% Yes 66% No
b. Learning/Working/Meaningful day?	76% Yes 24% No	39% Yes 61% No
c. Social/Community Integration?	81% Yes 19% No	37% Yes 63% No

For the priority sample, the data illustrates that the long term vision was met on a much higher rate than in the non-priority population. Additionally, the data does not show that one particular area of the long term vision was neglected more than another area.

The functional assessment is the second part of the ISP. This is an assessment of the person’s current status in terms of independent living, employment and social/community integration. It also must include an analysis of the support or skills, if any, necessary to achieve the person’s long term vision. The functional assessment considers the challenges and issues the person may face and what the person needs to learn in order to be successful in achieving their long term view.

<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-Priority Class</b>
Q188. Does the functional assessment address where the person is (current status and skills) and what the person needs in order to progress toward their long term view/vision in each life area? a. Living Situation?	43% Yes 57% No	42% Yes 58% No
b. Working/Learning?	38% Yes 32% No	32% Yes 68% No
c. Social/Community Integration?	39% Yes 61% No	38% Yes 62% No

The functional assessment in both the priority and non-priority population did not address living, working and social integration even half the time. The functional assessments addressed living situations a small percentage better than the working/learning and

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community integration areas. Across the board improvement is needed with adequate completion of functional assessments.

In addition to the long term view and the functional assessment, the ISP needs to contain individualized goals or objectives and specific steps/methods that describe how the goals or objectives will be achieved. The ISP should address all areas of need for the person. Furthermore, professional input from the clinical team is necessary for ISP development. It is critical that the person participate in the planning and development of their ISP whenever possible. The ISP also must be current. The ISP is considered current if it has been completed or updated within the past 12 months. The Independent Review questions below set forth relevant data regarding the ISP.

Case Review Instrument Question	Priority Class	Non-Priority Class
Q189. Are there individualized service goals or objectives in the Individual Service Plan (ISP)?	66% Yes 34% No	64% Yes 36% No
Q190. Are there specific steps/methods documented in the ISP that describe how the goal will be achieved?	46% Yes 54% No	51% Yes 49% No
Q191. Is there evidence of professional input in the development and formulation of the ISP?	66% Yes 34% No	76% Yes 24% No
Q192. Based on the comprehensive assessment and other documentation are all areas of need addressed in the ISP?	32% Yes 68% No	30% Yes 70% No
Q215. Did the person participate in the planning and development of their ISP? (Appendix C.9)	62% Yes 38% No	56% Yes 44% No
Q186. Does the person have a current ISP?	86% Yes 14% No	69% Yes 31% No
Q193. Does the priority client have an ISP with a functional assessment and a long term vision? (Appendix C.3)	19% Yes 81% No	N/A
Q194. For non-priority class members, is there an adequate individual service plan that includes a long term vision and a functional assessment?	N/A	10% Yes 90% No

Appendix C, criterion 9 (Question 215) asks whether the person participated in the planning and development of their ISP. This criterion was measured using the responses to interviews conducted and by reviewing documentation in the clinical record. For example, persons reviewed were asked whether they knew what was stated on their ISP, whether choices and options for services were explained to them and whether they were provided opportunities for input into their ISP goals and services. For the priority sample, 62% of class members participated in their ISP development. This represents a 6% decrease in compliance from 2007 and a 17% decrease in compliance from 2006. For the non-priority sample, 56% of class members participated in their ISP development. This constitutes a 12% decrease in compliance from 2007 and a 30% decrease in compliance from 2006.

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Only 19% of the priority class members met the Appendix C.3 requirement of an ISP with a functional assessment and a long term vision. This is a 6% increase from the 2007 Independent Review and a 16% decrease from 2006 findings. For the non-priority population, only 10% met the ISP requirement.

### 4. Implementation and Monitoring of Individual Service Plan

Since the ISP is the roadmap for delivering services, it is important that it is updated as needed when additional information is gained during the course of treatment. A current and complete ISP assures that the person and clinical staff understands their role and responsibilities in receiving or providing care and that, as the person's needs change so does their ISP. The periodic review and modification to the ISP assures that as staff change the direction of treatment remains on course. Appendix C, Criterion 4 addresses the period review of the ISP.

Case Review Instrument Question	Priority Class	Non-Priority Class
Q201. For priority clients, was the plan reviewed within the last six months? (Appendix C.4)	64% Yes 36% No	N/A

For priority class members, 64% of the class members had their ISP reviewed within the last six months. This represents a 13% increase in compliance from 2007 and a 15% decrease in compliance from 2006.

The implementation and monitoring of the ISP is an important job for the clinical team. Initially, the clinical team must assure that all the services in the ISP are in place. Then the clinical team must continually monitor the progress, lack of progress, or changes in the person's treatment needs. When changes in life circumstances or treatment needs occur, the case manager or clinical team must respond in a timely manner so the person can continue their recovery process. The following Case Review Instrument questions relate to the implementation and monitoring of the ISP.

Case Review Instrument Question	Priority Class	Non-Priority Class
Q195. Do progress notes or any other documents reflect progress, lack of progress, or changes in behavioral health needs?	67% Yes 34% No	58% Yes 42% No
Q196. Is there evidence that the team has taken action on problems noted in the progress notes?	46% Yes 54% No	52% Yes 48% No
Q197. Does the case manager/clinical team respond to changes in the person's treatment needs and/or life circumstances in a timely manner? (Supplemental Agreement #5)	40% Yes 60% No	48% Yes 52% No
Q205. Does the person receive the level of case management they need? (Supplemental Agreement #6)	47% Yes 53% No	47% Yes 53% No

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Q206. Is there evidence of communication between the person and each of their clinical team members? (Supplemental Agreement #7)	50% Yes 50% No	52% Yes 48% No
Q213. Does the clinical team assure that all services are in place in accordance with the ISP? (Supplemental Agreement #8)	35% Yes 65% No	32% Yes 68% No
Q214. Do the case manager/clinical team monitor the services provided? (Supplemental Agreement #9)	55% Yes 45% No	48% Yes 52% No

The Supplemental Agreement criterion regarding ISP implementation and monitoring are similar for both the priority and non-priority population. The case manager/clinical team respond to changes in the persons needs in a timely manner for less than 50% of all class members. Only 47% of the priority and non-priority class members receive the level of case management they need. The case management question should be considered in conjunction with the data gathered on case manager caseloads and longevity. High caseloads and high turnover may contribute to problems in class members obtaining effective and appropriate case management. In all the questions concerning ISP implementation and monitoring, the compliance for priority and non-priority populations was below 2006 and 2007 levels. (See Appendix A).

If a person experiences a substantial reduction of services, substantial modification of a residential setting, day or vocational program, or a termination of a service, the clinical team must either have the person's consent or follow the process outlined in the administrative rules. Appendix C, Criterion 5 pertains to situations where services have been reduced or terminated.

<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-Priority Class</b>
Q198. During the past year, was there a substantial reduction of services, substantial modification of a residential setting, day/vocational program or a termination of services?	36% Yes 64% No	37% Yes 63% No
Q199. If yes, was the person's ISP modified with their consent or consistent with the ISP rules? (Appendix C.5)	21% Yes 79% No	19% Yes 81% No
Q200. Were the changes clinically indicated?	64% Yes 36% No	70% Yes 30% No

For 57 of the 157 (36%) priority class members, there was a substantial reduction or termination of service. Only 13 of 61 (21%) class members had the ISP modified with their consent or consistent with ISP rules. This is a 2% increase in compliance from 2007 and a 16% decrease in compliance from 2006. For 58 of the 159 non-priority class members, there was a substantial reduction or termination of service. Only 11 of these 58 non-priority class members (19%) had their ISP modified with their consent or consistent with ISP rules. This represents a 13% decrease in compliance from 2007.

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**5. Medication**

Psychiatric medication can be an important component of a person’s behavioral health treatment and recovery. Since many medications have adverse side effects, it is critical that class members are informed of these potential side effects. When adverse side effects are experienced, the clinical team should follow up to ensure the side effects are addressed or a medication change is considered. Additionally, class members should be informed of risks related to procedures such as ECT. Questions regarding informed consent of medication are as follows:

<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-priority Class</b>
Q18. Is the person currently prescribed behavioral health medication?	95% Yes 5% No	95% Yes 5% No
Q32. Is there evidence that the person/guardian provided verbal or written consent to take the psychiatric medication? (Appendix C-11)	81% Yes 19% No	85% Yes 15% No
Q33. Is there documentation of informed consent to ECT or surgically related procedures to address mental health conditions? (Appendix C-11)	N/A	N/A
Q27. If there are adverse reactions to medications, is there documentation of follow-up actions and/or treatment to address the adverse effects?	60% Yes 40% No	75% Yes 25% No

Ninety-five percent (95%) of class members in the sample are currently prescribed behavioral health medicine. For Appendix C, Criterion 11, in the non-priority sample, target compliance for 2008 was met as 85% of the cases had evidence of verbal or written consent to psychiatric medication. Compliance in the priority population was 81%. For informed consent to ECT, there were no class members in the sample that had ECT or surgically related procedures during the review period. (Include numbers b/c N/A in most instances)

In the priority sample, adverse reactions to medications (such as allergies or side effects) occurred for 79 out of 157 (50%) class members. For those 79 class members, 47 (60%) received follow up attention from their clinical team to address the side effects. (Add non-priority data)

Since failure to take psychiatric medication as prescribed may be a sign or symptom of a person’s relapse, it is important for the clinical team to assist the person in taking their medication. The clinical team should follow up with the person after missed medication or treatment appointments. The Case Review Instrument asks several questions that provide information about the clinical team’s assistance with medication issues.

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<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-Priority Class</b>
Q28. Is there evidence that the person does <u>not</u> take the behavioral health medicine as prescribed?	50% Yes 50% No	50% Yes 50% No
Q29a. If yes, the person does not take the medication as prescribed, then was there evidence that the person was assisted to take the medication?	45% Yes 55% No	55% Yes 45% No
Q29b. If yes, the person does not take the medication as prescribed, then was there a change to the medication or dosage that was more acceptable to the person?	69% Yes 31% No	65% Yes 35% No
Q30. Is follow-up or outreach documented following missed medication or treatment appointments?	58% Yes 42% No	49% Yes 51% No

For both priority and non-priority population, there was evidence that 50% of the class members did not take their behavioral health medication as prescribed. For priority class members, when medication was not taken as prescribed, the clinical team assisted the person in taking the medication 45% of the time. For 69% of the priority class members there was a change to the medication or dosage. In cases where a medication or treatment appointment was missed, the clinical team followed up with 58% of with the priority class members and 49% of non-priority class members.

### **6. Inpatient Treatment and Coordination of Care**

Sometimes a class member may need to be admitted inpatient to a psychiatric hospital for care. If the inpatient stay is more than 7 days, then an Inpatient Treatment and Discharge Plan (ITDP) must be developed for the person. The purpose of the ITDP is to form the basis for individual treatment during the hospitalization and to facilitate the person's discharge back into the community. The administrative rules require that the ITDP be developed within 10 days of the inpatient stay. Additionally, the ITDP should reflect the goals and services of the ISP. Appendix C, Criterion 12 measures compliance with the inpatient treatment planning rules.

<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-Priority Class</b>
Q35. Has the person had an inpatient admission within the last 12 months?	17% Yes 83% No	13% Yes 87% No
Q36. Was the inpatient stay more than 7 days?	15% Yes 2% No 83% N/A	8% Yes 4% No 87% N/A
Q46. Was an inpatient treatment and discharge plan developed by the 10 <sup>th</sup> day of the inpatient stay? (Appendix C-12)	57% Yes 43% No	58% Yes 42% No

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Q47. Does the inpatient treatment and discharge plan reflect the goals and services of the ISP? (Appendix C-12)	39% Yes 61% No	42% Yes 58% No
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For priority class members, 23 out of 157 (15%) class members had inpatient stays longer than 7 days. Of those 23 class members, 13 (57%) had an ITDP developed by the 10<sup>th</sup> day and 9 (39%) had an ITDP that was derived from their ISP. (Appendix C.12) The 2008 target compliance for Appendix C.12 is 85%.

Many class members have physical health related needs along with their behavioral health needs. It is important that the clinical team coordinate care with the person's primary care physician by sharing records and other relevant information with the person's consent. Possible interactions between behavioral health medications and other medications prescribed by the primary care physician must be reviewed. Additionally, the clinical team can assist the person is ensuring that their physical health care needs are being properly met. Supplemental Agreement questions # 1 and # 2 address coordination of care with the primary care physician and physical health care needs.

Case Review Instrument Question	Priority Class	Non-Priority Class
Q34. Is there evidence that behavioral health care has been coordinated with the primary care physician and behavioral health records and other relevant information is shared with the PCP? (Supplemental Agreement #1)	57% Yes 43% No	54% Yes 46% No
Q216. Overall, are the person's physical health related issues and needs being addressed? (Supplemental Agreement #2)	62% Yes 38% No	73% Yes 27% No

For the priority sample, 57% of class members received proper coordination of care between the clinical team and their primary care physician. For the non-priority sample, 54% of class members received proper coordination of care. Overall, 62% of the priority class members and 73% of the non-priority class members had their physical health needs addressed.

### B. CLASSMEMBER RIGHTS

Individuals with serious mental illness have certain rights outlined in Title 9, Chapter 21 of the Arizona Administrative Code. Three of these important rights are the right to appeal eligibility or treatment decisions, the right to be treated with dignity and respect, and the right to special assistance if needed. Appendix C, Criterion 6 addresses the person's right to appeal decisions.

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<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-priority Class</b>
Q 211. Class members are informed of their right to appeal eligibility and treatment decisions? (Appendix C.6)	83% Yes 17% No	80% Yes 20% No

For the sample, 83% of priority class members and 80% of non-priority class members were informed of their right to appeal eligibility and treatment decisions. This constitutes a 4% compliance increase from 2007 for the priority class members and a 1% compliance increase for the non-priority class members. The target compliance for Appendix C, Criterion 6 is 90%.

One of the most critical rights of individuals with serious mental illness is the right to be treated with dignity and respect. The Case Review Instrument measured the determination of whether a class member was treated with dignity and respect by the consideration of the following factors:

- ◆ Indication that the person is treated as a unique and valued individual (such as calls returned in a timely manner, etc.);
- ◆ Individual's rights are honored and protected (such as being given information, having a current ISP, etc.);
- ◆ Provision of special assistance, when applicable;
- ◆ Person's input, preferences, choices and personal goals are included in the ISP process and their participation encouraged in the process (such as individualized goals and multiple attempts made to engage the person);
- ◆ Changes in the person's circumstances are responded to by the clinical team (such as timeliness of service provision and ISP revised when new or emerging needs develop);
- ◆ Ethnic and cultural differences are recognized and respected by the clinical team (inquiring about cultural preferences and incorporating these into the person's service provision, when applicable);
- ◆ All information gathered from all of the interviews conducted during the audit.

Supplemental Agreement question # 10 asks directly whether overall the person is treated with dignity and respect. Two other questions that implicate respect and dignity are whether the person was given treatment options and whether efforts were made to engage the person.

<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-priority Class</b>
Q208. Is there evidence that the clinical team offered various treatment options for the person to choose from?	43% Yes 57% No	45% Yes 55% No
Q209. Has the clinical team continually made efforts to engage the person in rehabilitation, treatment and support services?	38% Yes 62% No	37% Yes 63% No

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Q212. Overall, is the person treated with dignity and respect? (Supplemental Agreement #10)	47% Yes 53% No	40% Yes 60% No
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The Independent Review found that 47% of the priority class members were treated with dignity and respect. This represents a 6% compliance decrease from 2007 data. Only 40% of the non-priority class members were found to be treated with dignity and respect. This constitutes a 19% decrease from the 2007 Independent Review.

A person has a right to special assistance if they need help to participate in the service planning or the grievance process. An example of a person who requires special assistance is someone with physical disabilities or language difficulties impacting their ability to communicate decisions or participate in meetings. Three questions evaluate whether the class member has been provided special assistance.

Case Review Instrument Question	Priority Class	Non-priority Class
Q183. Did the clinical team assess whether the person needs special assistance in the ISP and grievance processes?	80% Yes 20% No	68% Yes 32% No
Q184. Regardless of the team assessment decision does the person currently require special assistance?	16% Yes 84% No	6% Yes 94% No
Q185. If special assistance is needed, is it currently being provided or offered by ADHS or the RBHA? (Appendix C.10)	15% Yes 85% No	20% Yes 80% No

For 80% of the priority class members, the clinical team assessed whether the person needed special assistance in the ISP and grievance processes. The Independent Review found that 25 (16%) priority class members required special assistance. Only 15% of the class members who required special assistance were offered or provided reasonable assistance. This represents a 6% decrease in compliance from 2007 data and a 21% decrease in compliance from 2006 data. While 68% of non-priority class members were assessed for special assistance needs, the Independent Review found only 10 class members (6%) required special assistance. Two (2) of those 10 (20%) non-priority class members who required special assistance were offered or received special assistance. This constitutes a 7% increase in compliance for the non-priority population compared to the 2007 data.

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**C. QUALITY OF LIFE OUTCOMES**

<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-Priority Class</b>
Q217a. Are the person's behavioral health needs met, in the following domains: Living Situation?	41% Yes with ISP 29% Yes w/o ISP 30% No	33% Yes with ISP 35% Yes w/o ISP 32% No
The reason for the "No" determination: <input type="checkbox"/> The service/support identified on the ISP is not being provided.	17%	6%
<input type="checkbox"/> The person or their clinical team has identified a needed service/support that has not been pursued/initiated by the clinical team.	19%	9%
<input type="checkbox"/> The reviewer identifies a needed service that has not been identified by the clinical team.	20%	18%
<input type="checkbox"/> The person is unwilling to participate in the development of their ISP and the clinical team has <u>NOT</u> identified strategies to engage the person in exploring available living options.	5%	1%
<input type="checkbox"/> Other	17%	8%

<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-Priority Class</b>
Q217b. Are the person's behavioral health needs met, in the following domains: Meaningful day/work situation?	22% Yes with ISP 20% Yes w/o ISP 57% No	21% Yes with ISP 24% Yes w/o ISP 55% No
The reason for the "No" determination: <input type="checkbox"/> The service/support identified on the ISP is not being provided.	29%	13%
<input type="checkbox"/> The person or their clinical team has identified a needed service/support that has not been pursued/initiated by the clinical team.	18%	11%
<input type="checkbox"/> The reviewer identifies a needed service that has not been identified by the clinical team.	18%	22%
<input type="checkbox"/> The person is unwilling to participate in the development of their ISP and the clinical team has <u>NOT</u> identified strategies to engage the person in exploring available living options.	11%	4%
<input type="checkbox"/> Other	20%	18%

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<b>Case Review Instrument Question</b>	<b>Priority Class</b>	<b>Non-Priority Class</b>
Q217c. Are the person's behavioral health needs met, in the following domains: Social/community integration?	30% Yes with ISP 23% Yes w/o ISP 46% No	25% Yes with ISP 31% Yes w/o ISP 44% No
The reason for the "No" determination: <input type="checkbox"/> The service/support identified on the ISP is not being provided.	19%	9%
<input type="checkbox"/> The person or their clinical team has identified a needed service/support that has not been pursued/initiated by the clinical team.	17%	11%
<input type="checkbox"/> The reviewer identifies a needed service that has not been identified by the clinical team.	23%	13%
<input type="checkbox"/> The person is unwilling to participate in the development of their ISP and the clinical team has <u>NOT</u> identified strategies to engage the person in exploring available living options.	10%	6%
<input type="checkbox"/> Other	17%	11%

## **V. Conclusions/ Recommendations**

The findings of this audit, when compared to the 2006 Independent Review results show the following:

### **CLINICAL TEAM/CASE MANAGEMENT**

- 28% decline for the priority class in the requirement that the client has an appropriately constituted clinical team (Appendix C.2);
- 14% decline for the priority class (21% decline for the non-priority class) in the requirement that the person receives the level of case management they need (Supplemental Agreement #6);

### **COMPREHENSIVE ASSESSMENT**

- 3% increase for the priority class (19% decline for the non-priority class) in the requirement that the person has a current comprehensive assessment (Supplemental Agreement # 3);
- 32% decline for the priority class (40% decline for the non-priority class) in the requirement that the comprehensive assessment is complete (Supplemental Agreement #4);

### **INDIVIDUAL SERVICE PLANNING**

- 16% decline for the priority class in the requirement that the client has an ISP with a functional assessment and a long term view (Appendix C.3);

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- 17% decline for the priority class (30% decline for the non-priority class) in the requirement that the client participate in the planning and development of their ISP (Appendix C.9);
- 15% decline for the priority class (17% decline for the non-priority class) in the requirement that the client's ISP is reviewed every 6 months (Appendix C.4);
- 20% decline for the priority class ( 17% decline for the non-priority class) in the requirement that the client's ISP is modified when there is a reduction or modification in a residential or day/vocational program, or a termination of services (Appendix C.5);
- 19% decline for both the priority and non-priority class in the requirement that the case manager/clinical team respond to changes in the person's treatment needs/life circumstances in a timely manner (Supplemental Agreement # 5);
- 22% decline for the priority class (20% decline for the non-priority class) in the requirement that there is evidence of communication between the client and each of their clinical team members (Supplemental Agreement # 7);
- 2% decline for the priority class (28% decline for the non-priority class) in the requirement that the clinical team assures that all services are in place in accordance with the ISP (Supplemental Agreement # 8);
- 15% decline for the priority class (23% decline for the non-priority class) in the requirement that the case manager/clinical team monitor the services provided (Supplemental Agreement # 9);

### MEDICATION, INPATIENT TREATMENT AND COORDINATION OF CARE

- No percentage change for the priority class (2% decline for the non-priority class) in the requirement that documentation is present regarding adequate informed consent to medication and/or ECT, if applicable (Appendix C.11);
- 1% decline for the priority class (32% decline for non-priority class) that clients in inpatient settings have an ITDP by the 10th day which is derived from their ISP (Appendix C.12);
- No percentage change for the priority class (10% decline for non-priority class) in the requirement that coordination of care with the client's PCP is present (Supplemental Agreement #1);
- 2% decline for both the priority and non-priority class in the requirement that the person's physical health related issues and needs are addressed (Supplemental Agreement #2);

### CLASS MEMBER RIGHTS

- 8% decline for both priority and non-priority class members in the requirement that class members are informed of the their right to appeal eligibility and treatment decisions (Appendix C.6);
- 21% decline for the priority class (no change for the non-priority class) in the requirement that class members in need of special assistance are offered or provided reasonable assistance by ADHS or the RBHA (Appendix C.10);
- 16% decline for the priority class (29% decline for the non-priority class in the requirement that the class member is treated with dignity and respect (Supplemental Agreement #10); and

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### QUALITY OF LIFE OUTCOMES

- 12% decline for the priority class (30% decline for the non-priority class) in the requirement that the person receives all the services and supports needed in order to move towards recovery (Appendix C.7 & C.8)

The findings contained in this report, with a few exceptions, reflect an ongoing pattern of noncompliance with many of the court-ordered Exit Criteria. Of equal concern, much of the data and information included in this report reflect serious deficiencies in the provision of clinically sound practices and raise serious questions about the behavioral health treatment, safety, and overall well-being of all class members.

It is important to note that over the past several years, the ADHS and the Plaintiffs have met and negotiated multiple corrective action plans, performance improvement plans, network expansion plans, and a variety of other mutually agreed to documents that were supposed to rectify the very problems that still plague the current system. Unfortunately, most of these plans and actions have not been successful in providing relief to class members. There can be no doubt that they have not materially improved outcomes for class members.

In addition, ADHS informed the Court on numerous occasions that it had taken affirmative steps to improve the behavioral health system by contracting with a new company to serve as the Maricopa County RBHA. ADHS claimed that it had negotiated a much more rigorous contract that ensured better outcomes and gave ADHS the authority and tools to monitor and enforce relevant legal requirements.

However, the findings of this audit indicate that none of these actions have produced the desired results. In fact, the audit results show a pattern of regression and significant declines in a number of areas.

Looking ahead, there is no reason to believe that other already-initiated reforms will fare any better or produce any better outcomes. For instance, just by moving the case management sites from the control of the RBHA to the new Provider Network Organizations (PNO's), in and of itself, is not likely to create the change that will be necessary to improve outcomes for class members in Maricopa County. Nor has the change from one large for-profit corporation to another (Value Options to Magellan) made any difference or is likely to make much difference in the future.

Over the years, the Monitor has observed systemic problems in the behavioral health system in Maricopa County that has prevented it from adequately serving class members. These include: (1) since the entire behavioral health management system is re-bid and re-contracted every three years resulting in a new corporation taking charge, there is inherent instability in the entire behavior health structure. Every few years, the community starts over. Various problems arise with this perpetual change such as the management corporation owning the data systems with all the information about Maricopa County clients. (2) The behavioral health system lacks local control. Major decisions about the system and clients are made outside Maricopa County.

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(3) Guaranteed profits for the contracted managed care company take needed dollars out of the service system. The Monitor believes these systemic issues have contributed to the poor results in this audit.

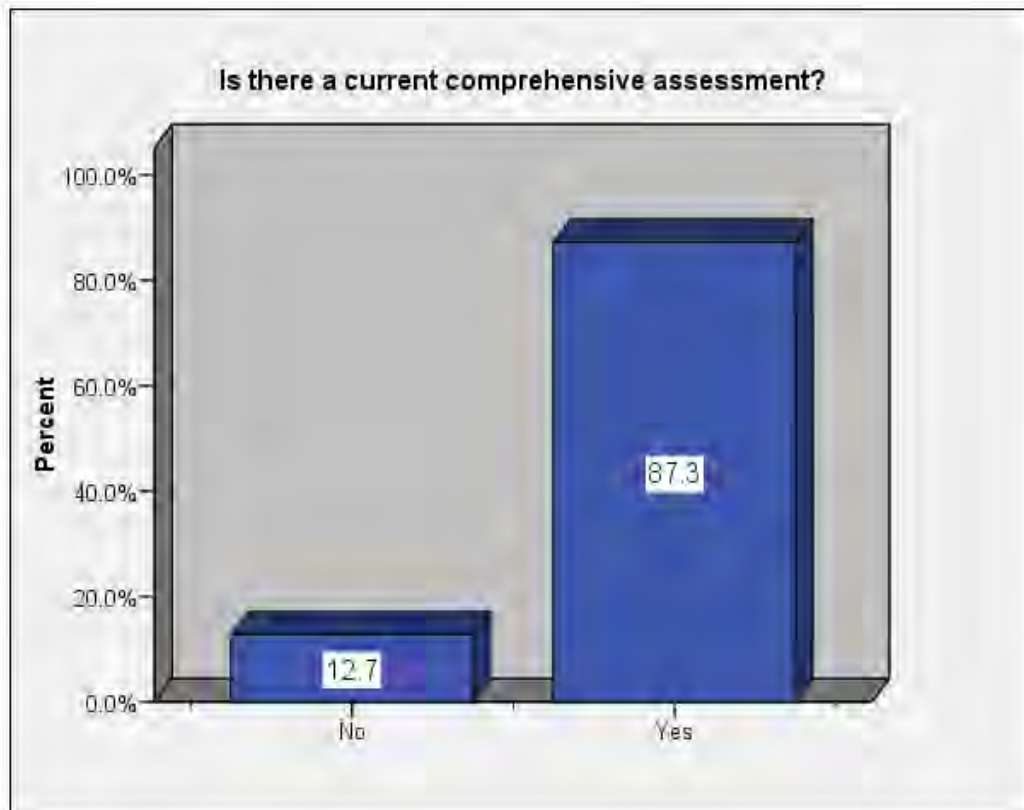
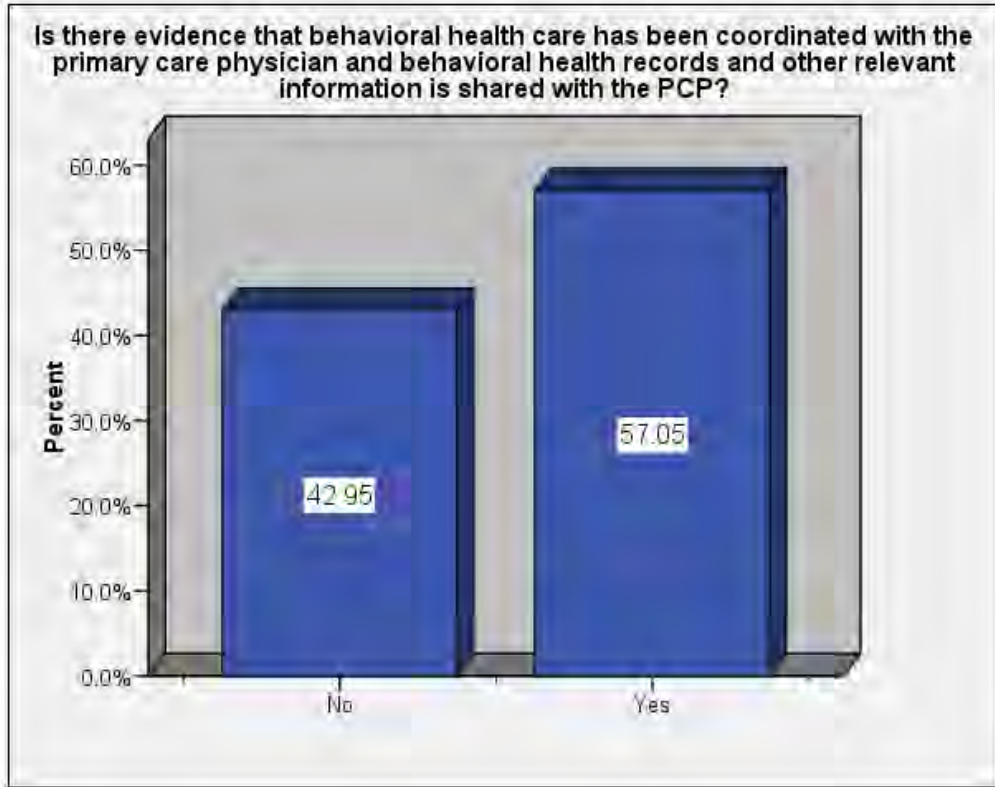
The results of the audit indicate that an increasing number of class members do not have minimally adequate Individual Service Plans, do not have minimally adequate case management, and do not receive the services and support they need to move towards recovery and a better quality of life. Moreover, the percentage of class members still lacking these basic elements of mental health care is actually increasing, rather than the reverse. Because the past corrective actions have not produced the desired outcomes, nor significantly improved the behavioral health system in Maricopa County, the Monitor believes that dramatic reforms and a complete overhaul of the service system is necessary.

APPENDIX A  
PRIORITY DATA

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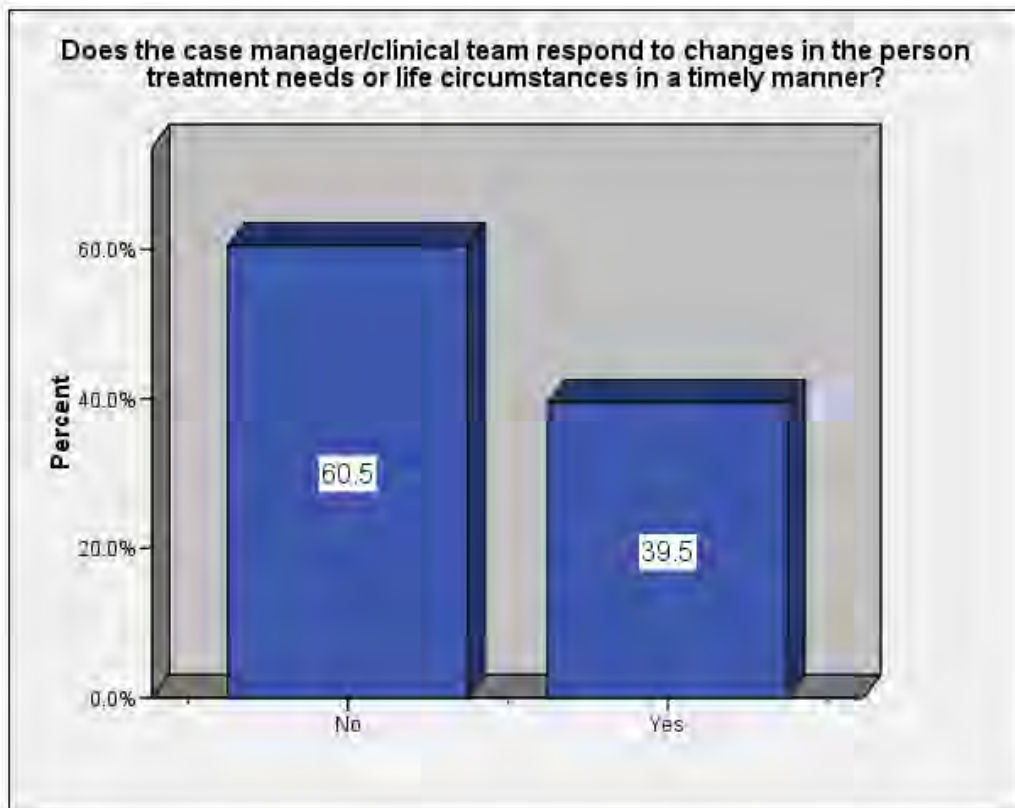
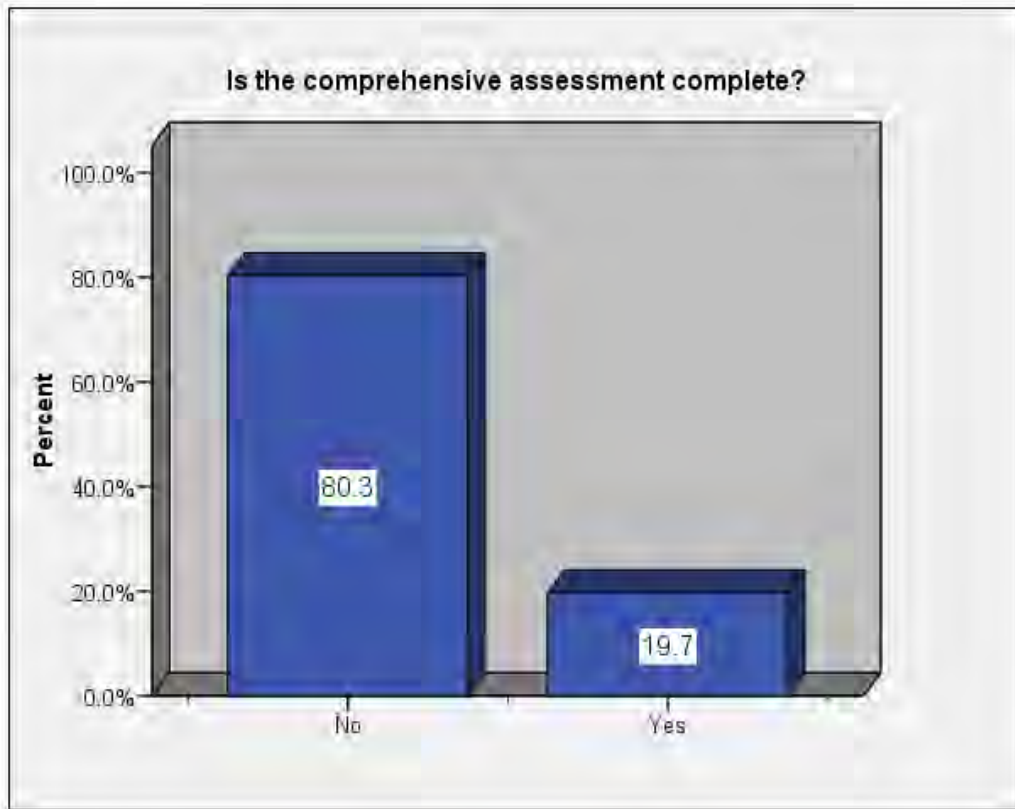
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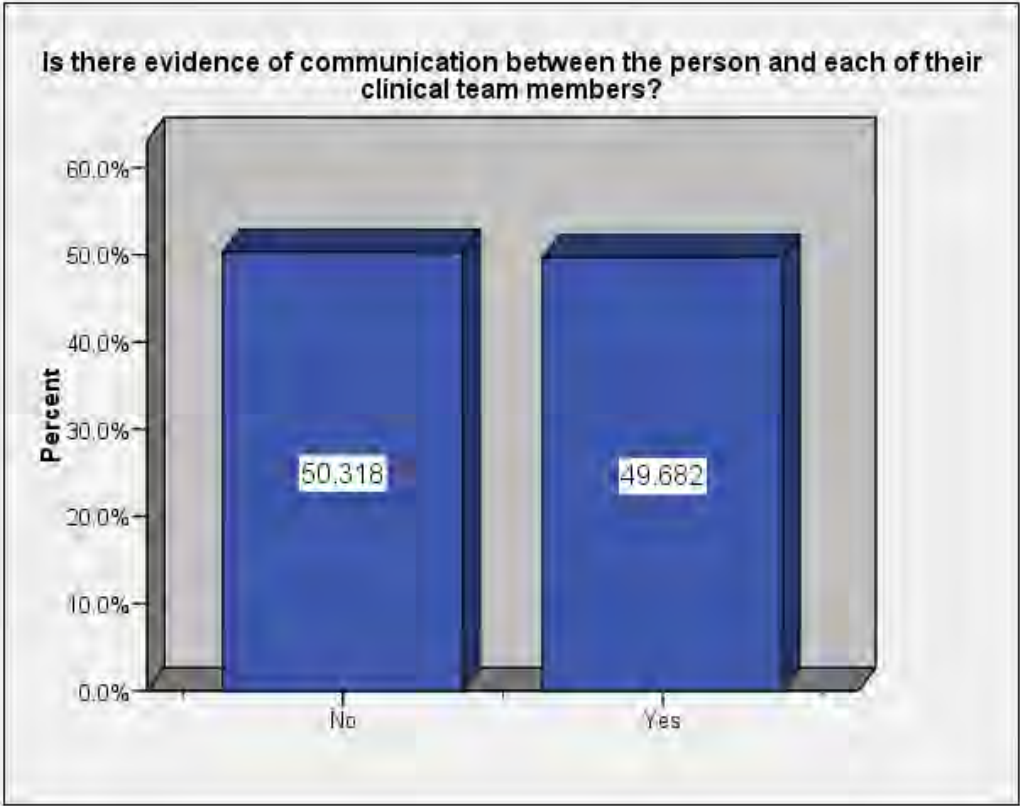
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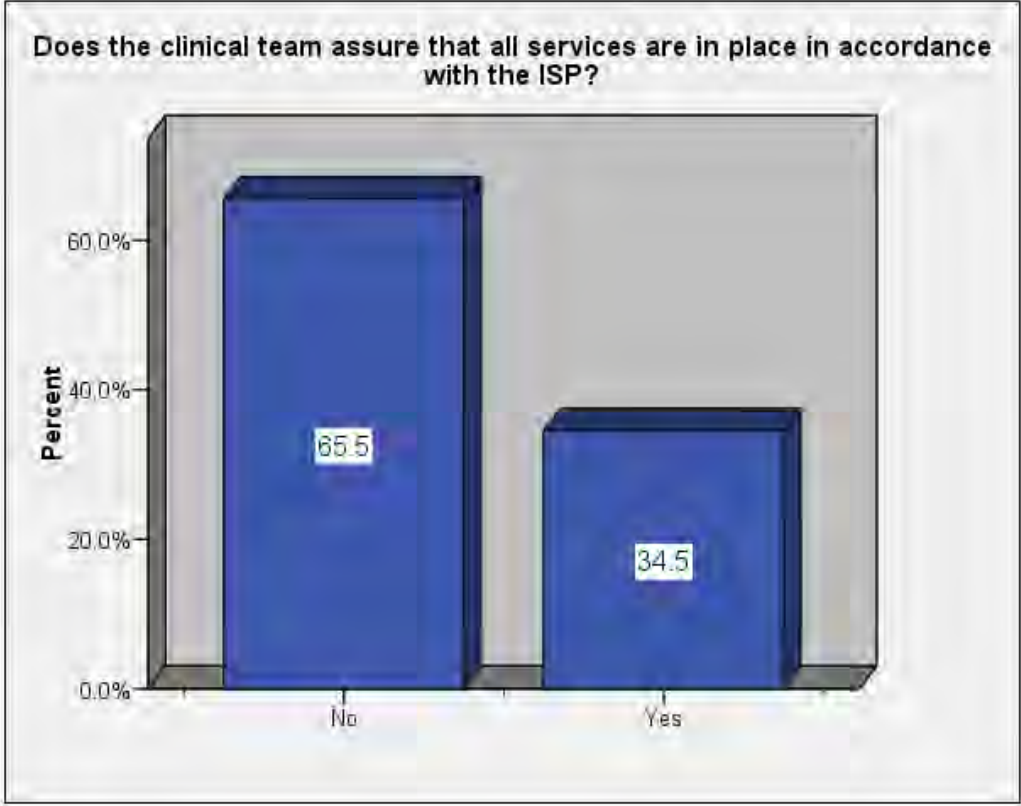
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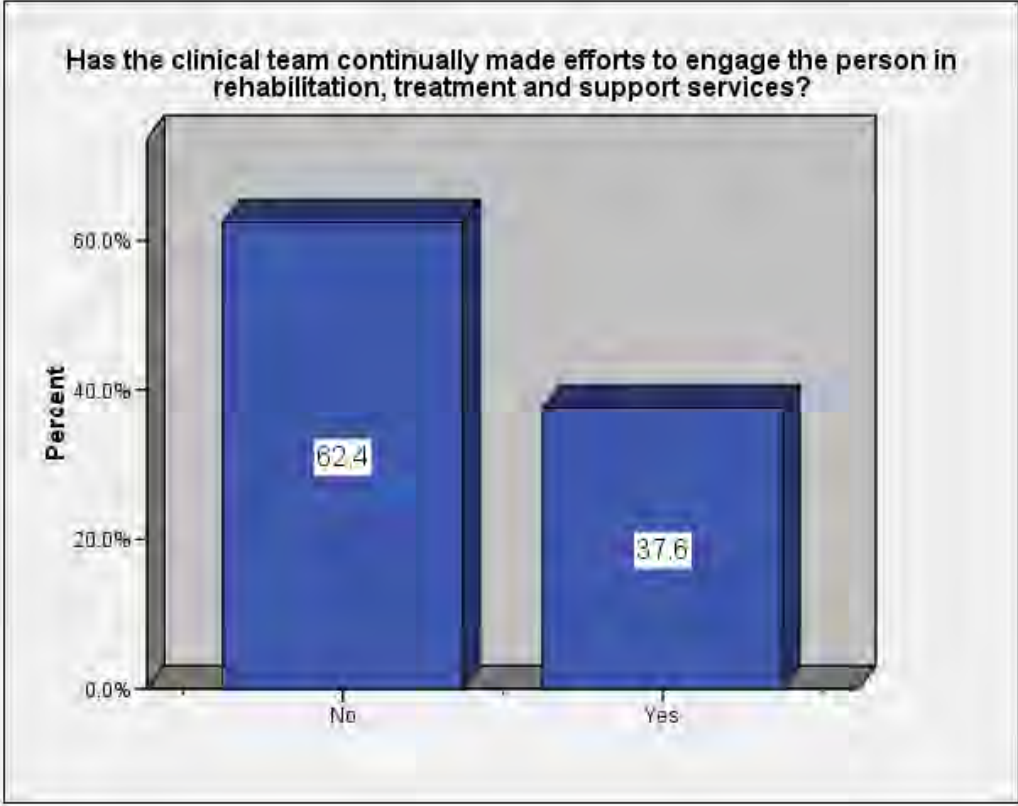
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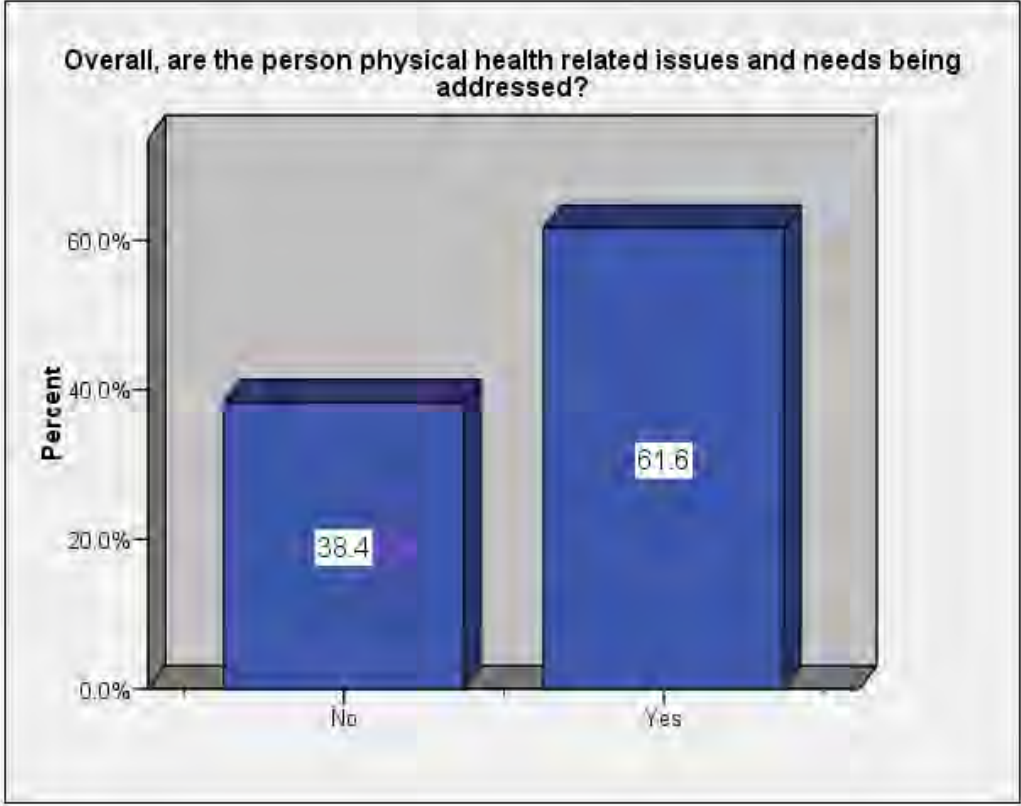
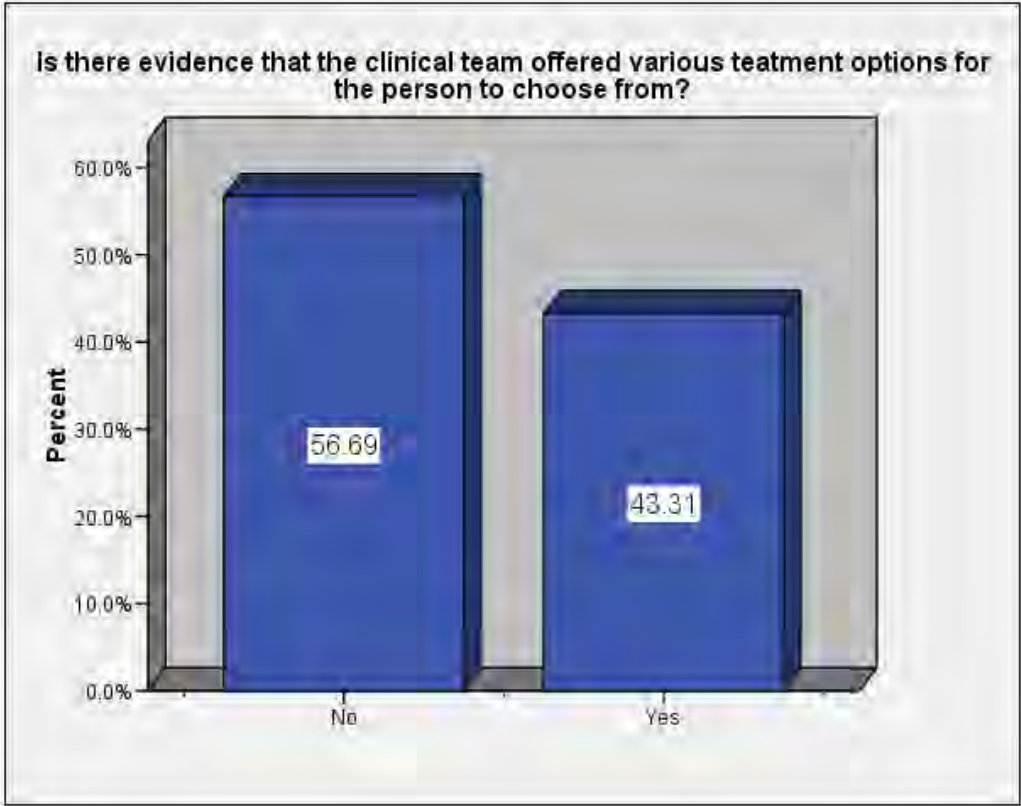
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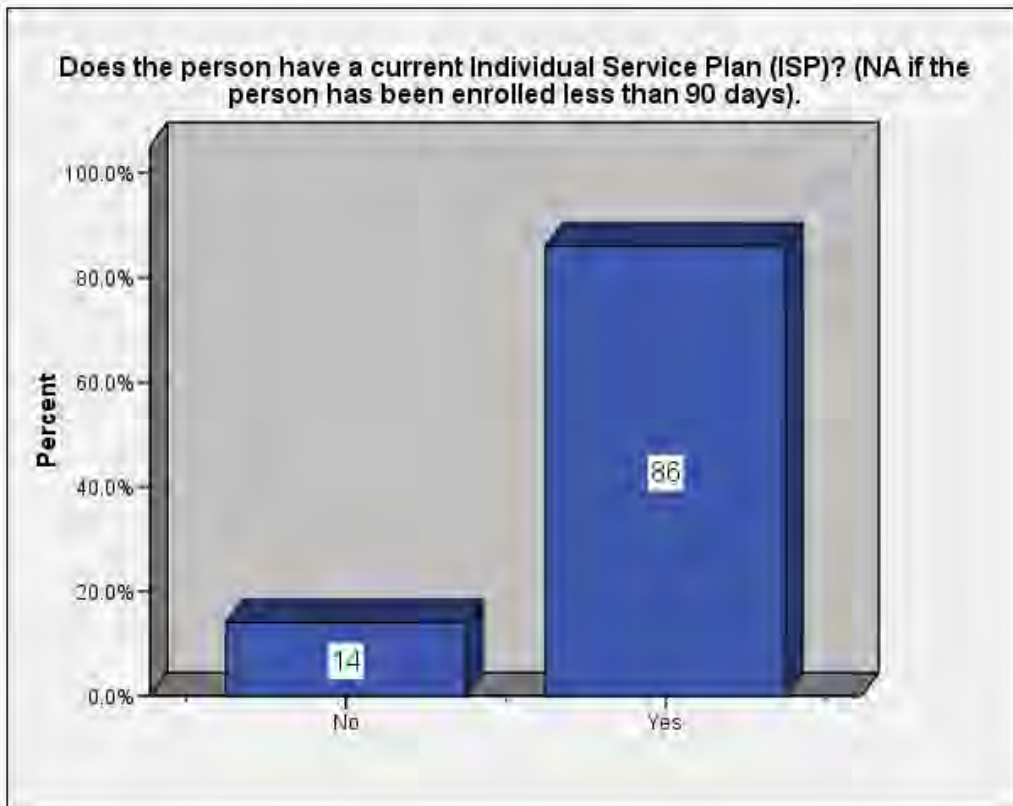
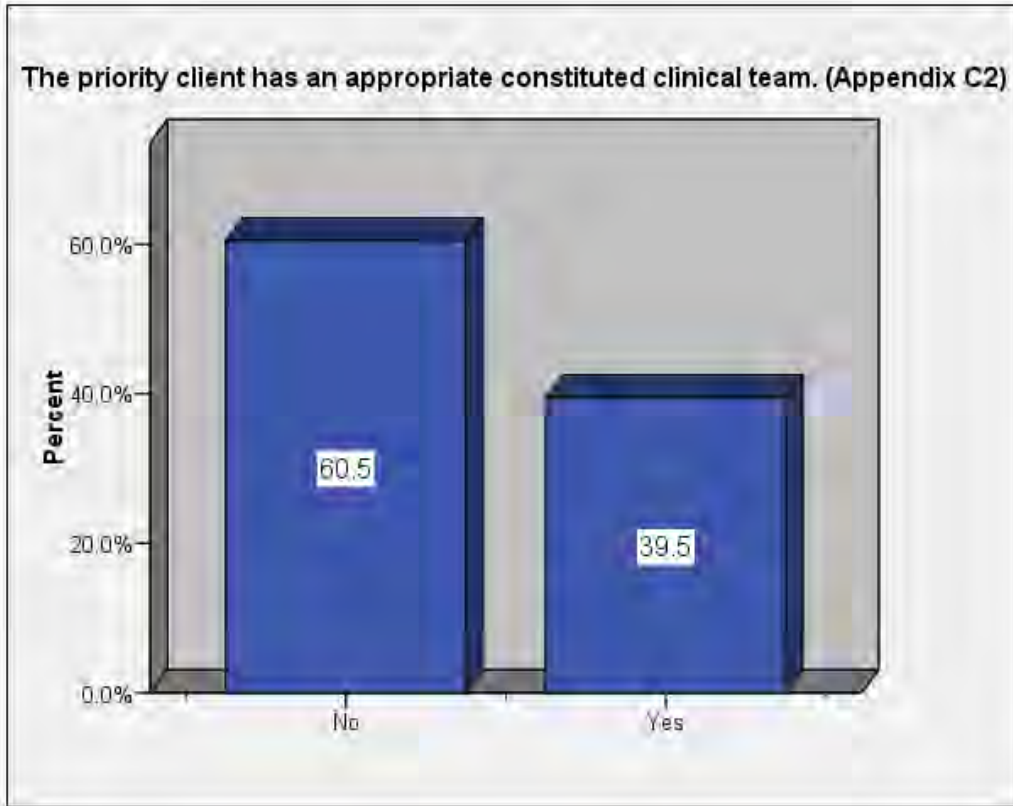
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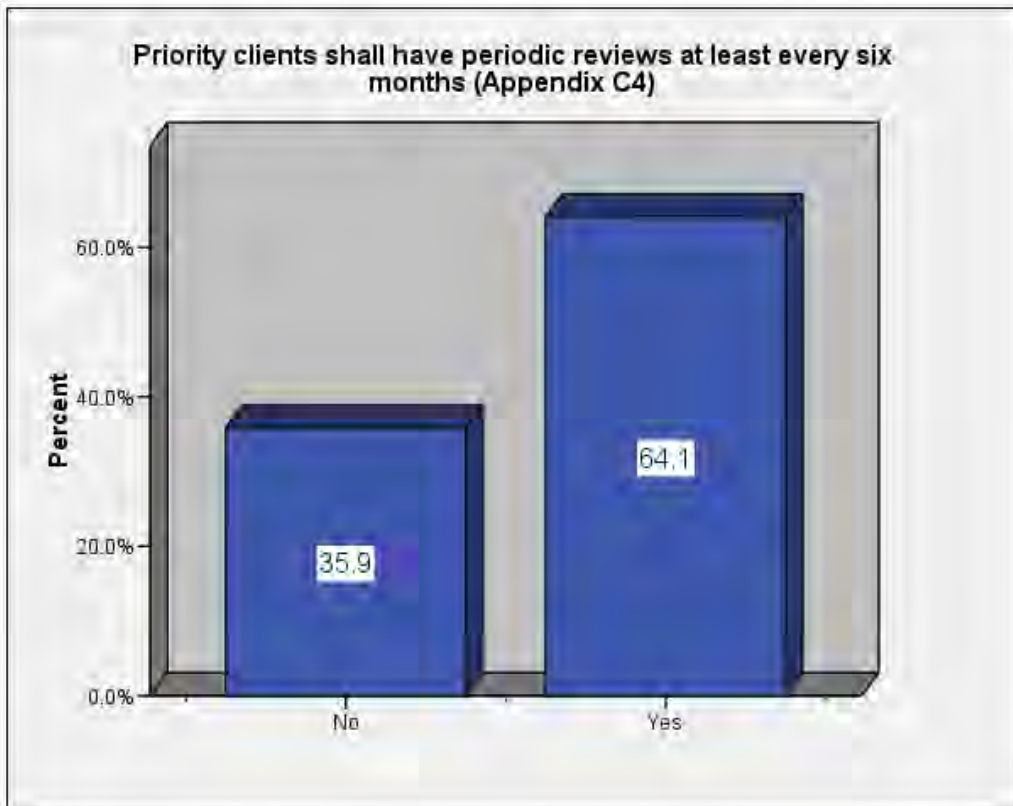
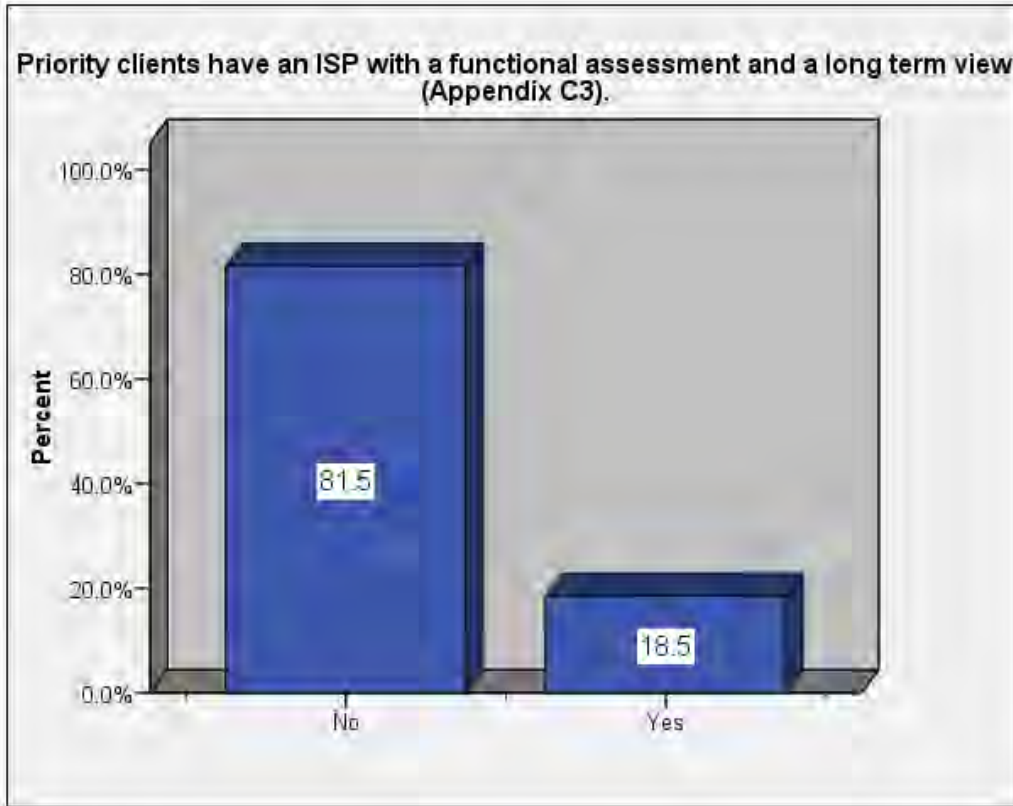
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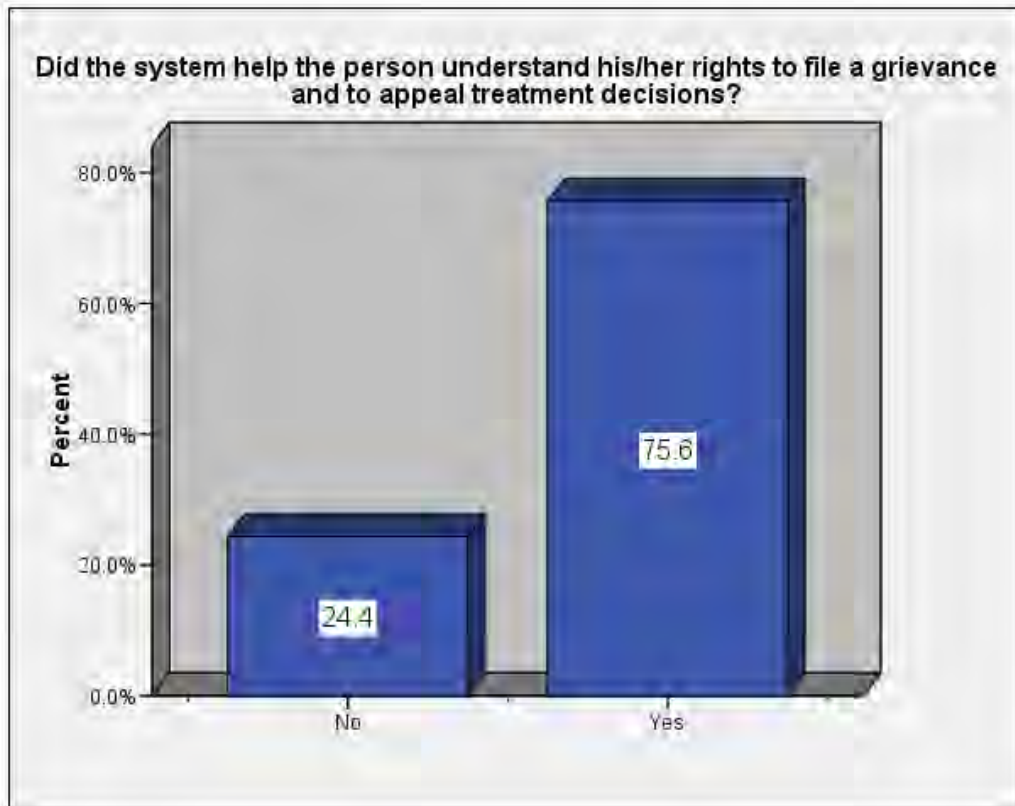
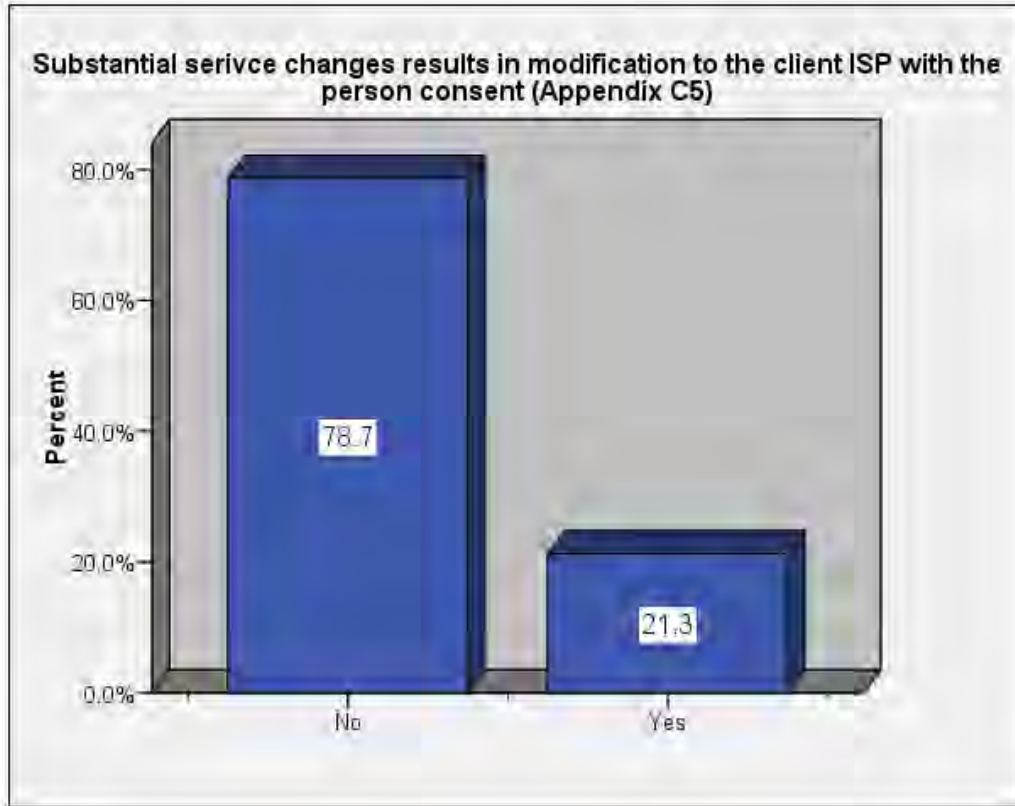
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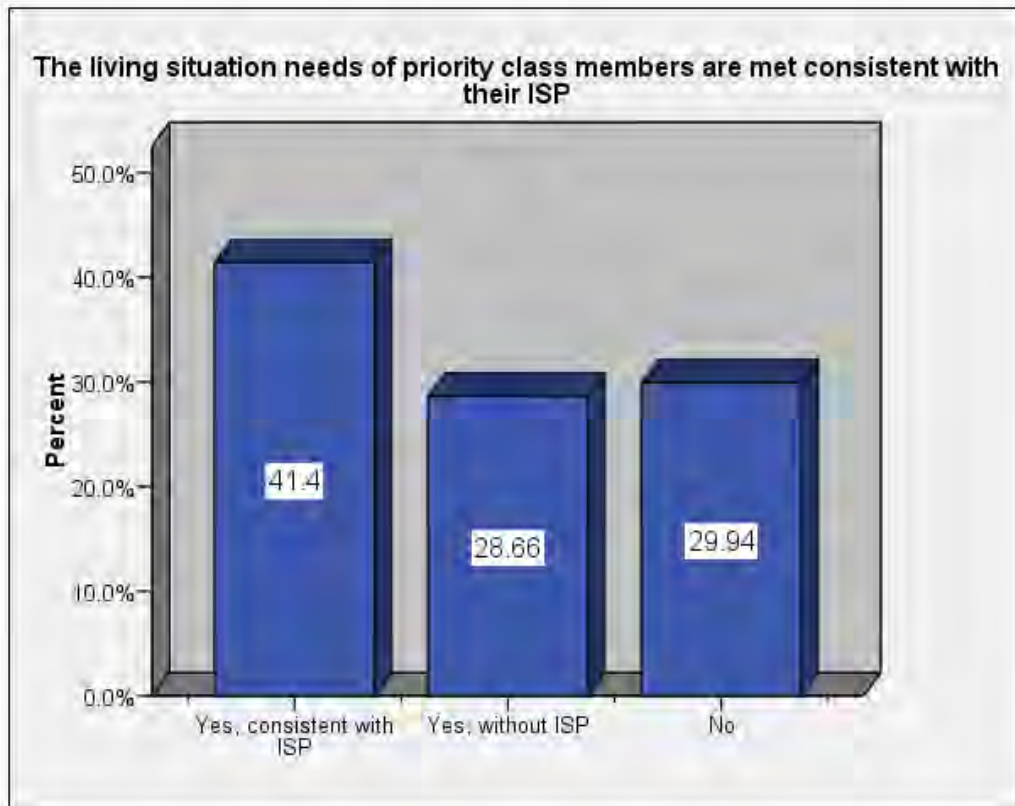
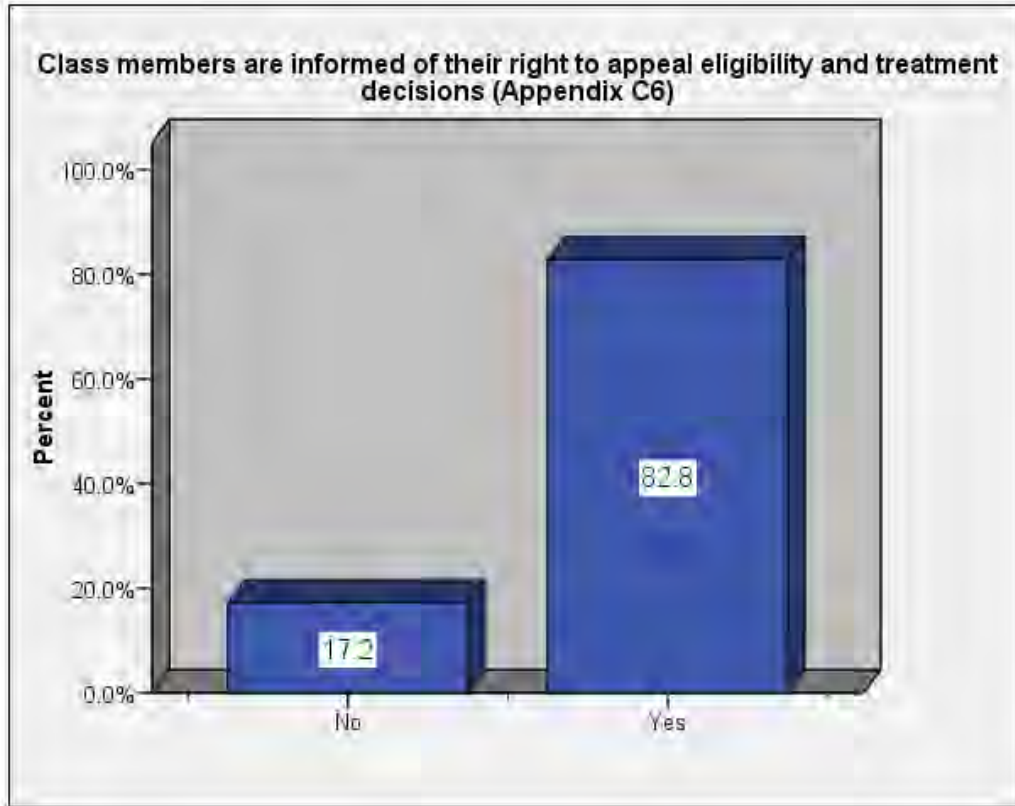
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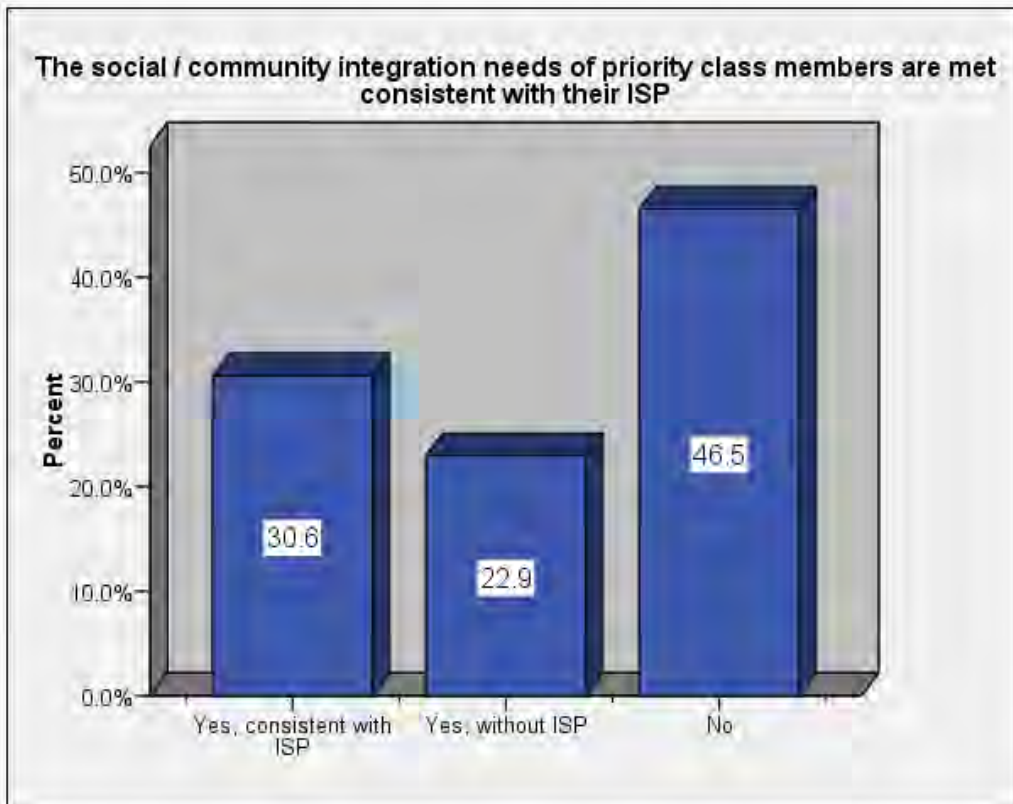
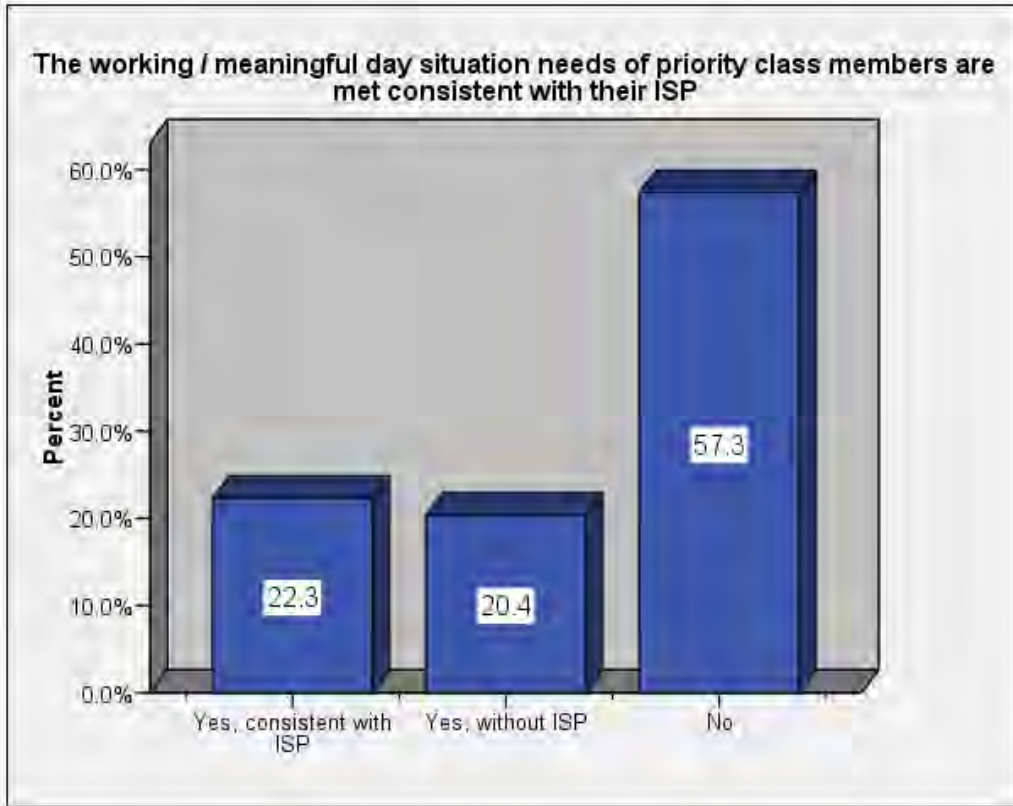
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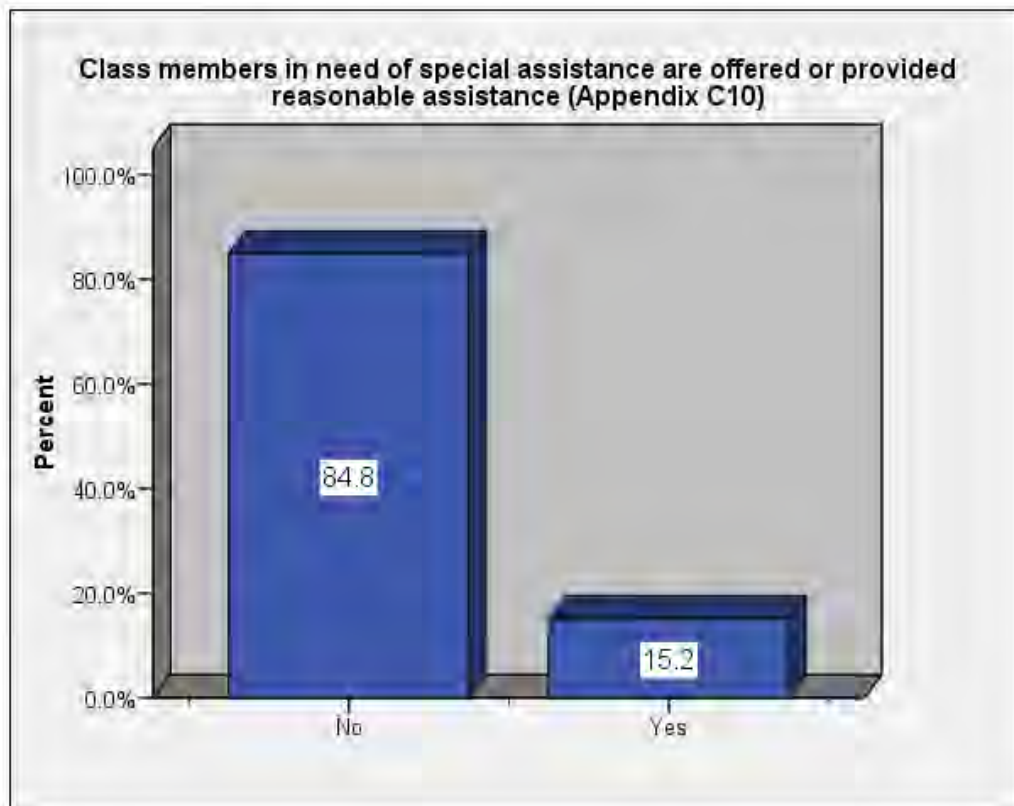
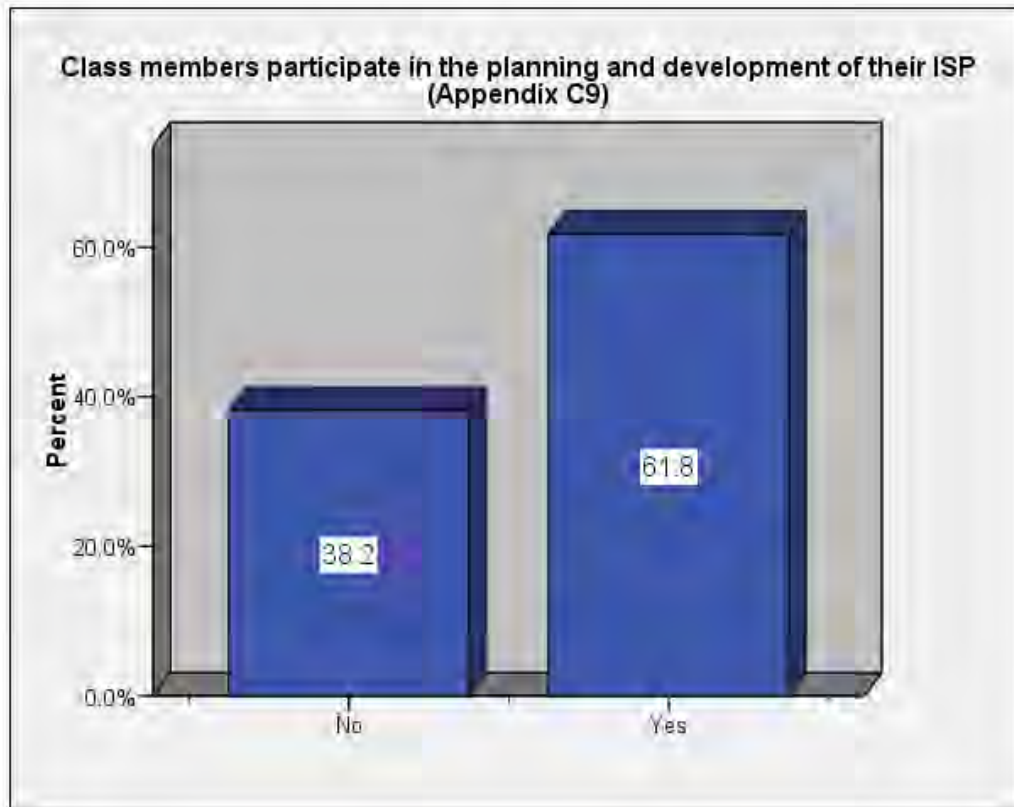
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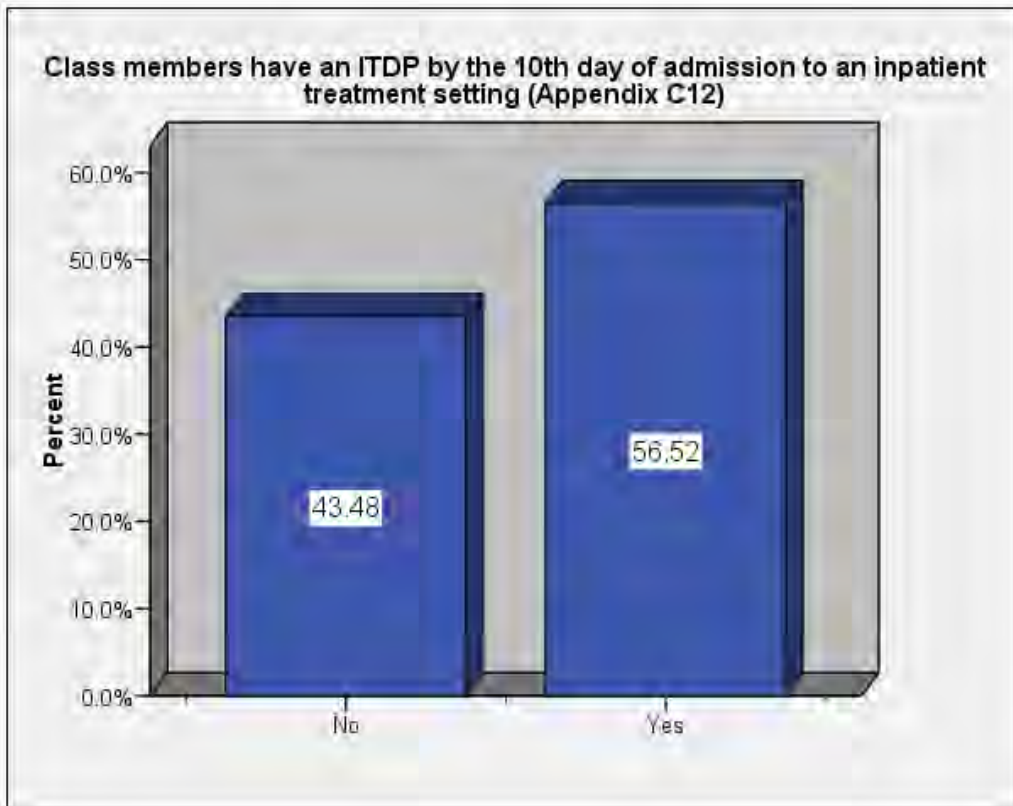
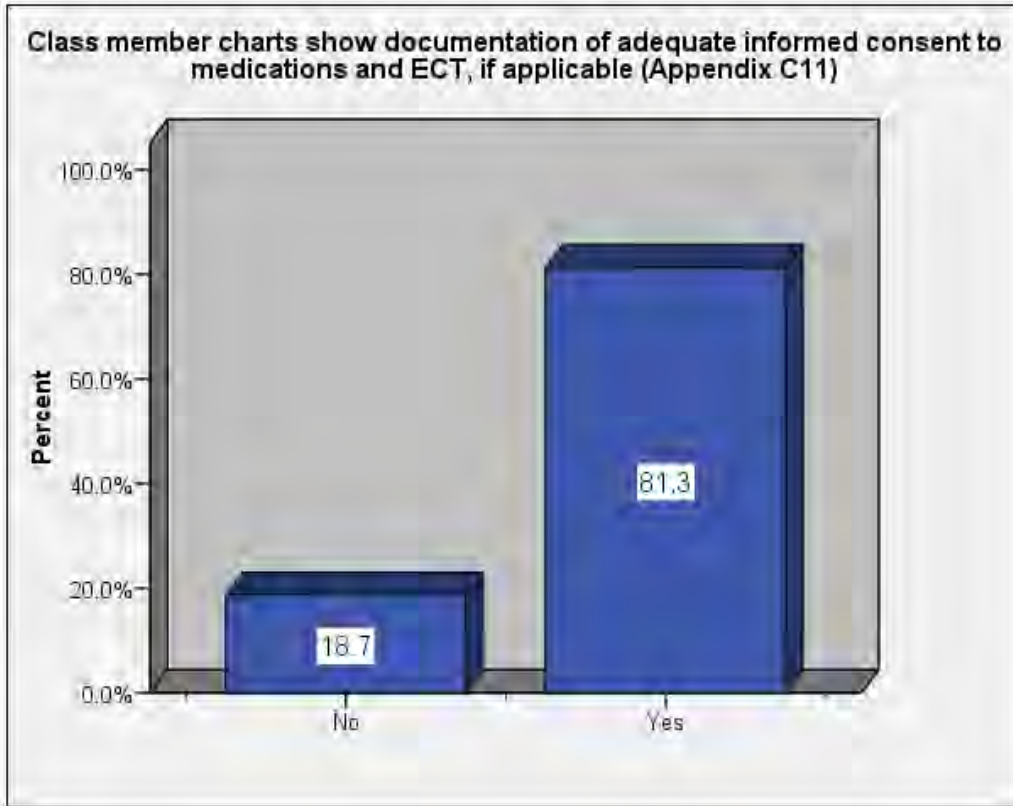
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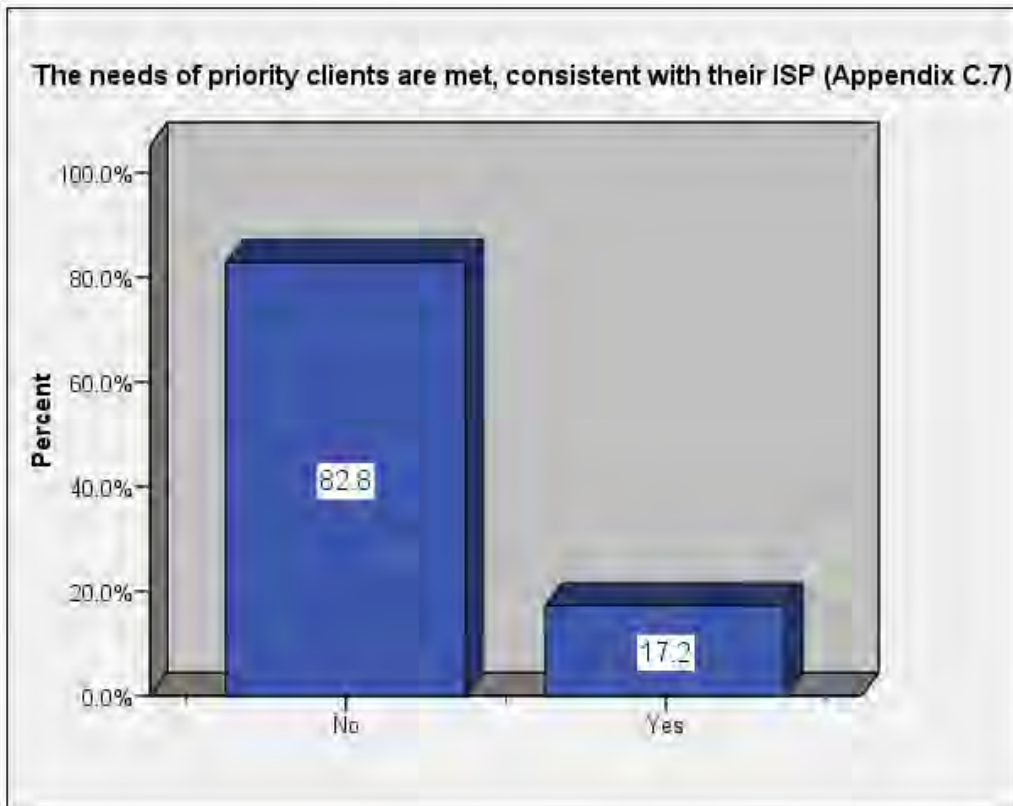
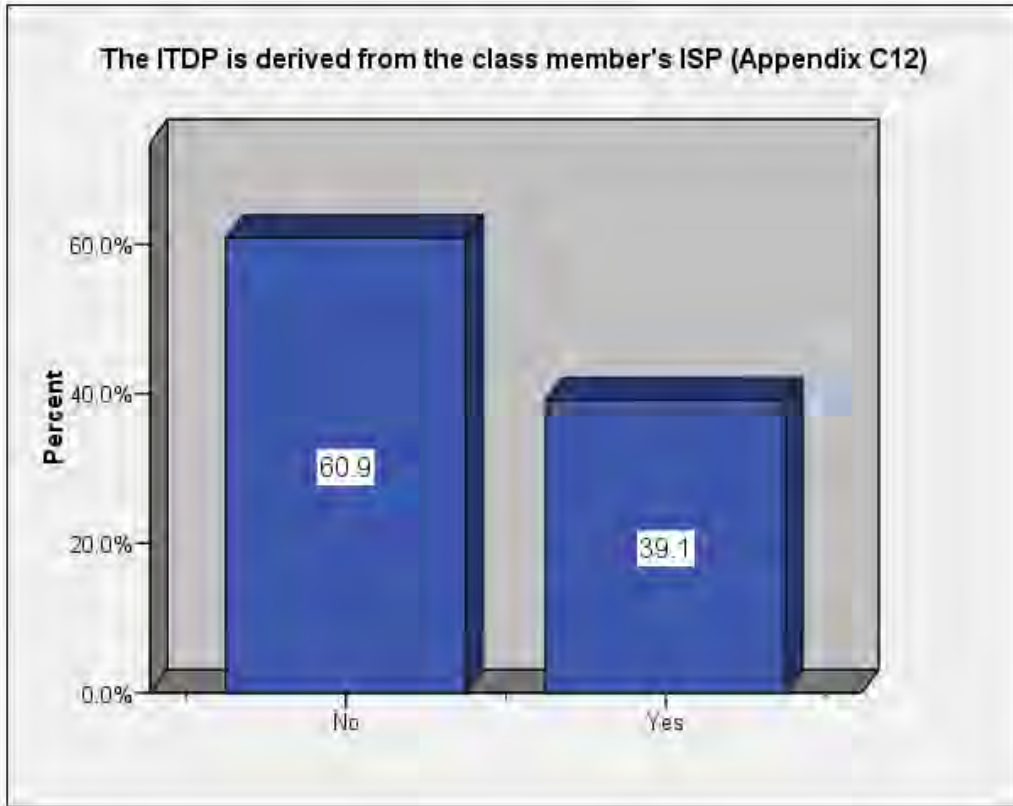
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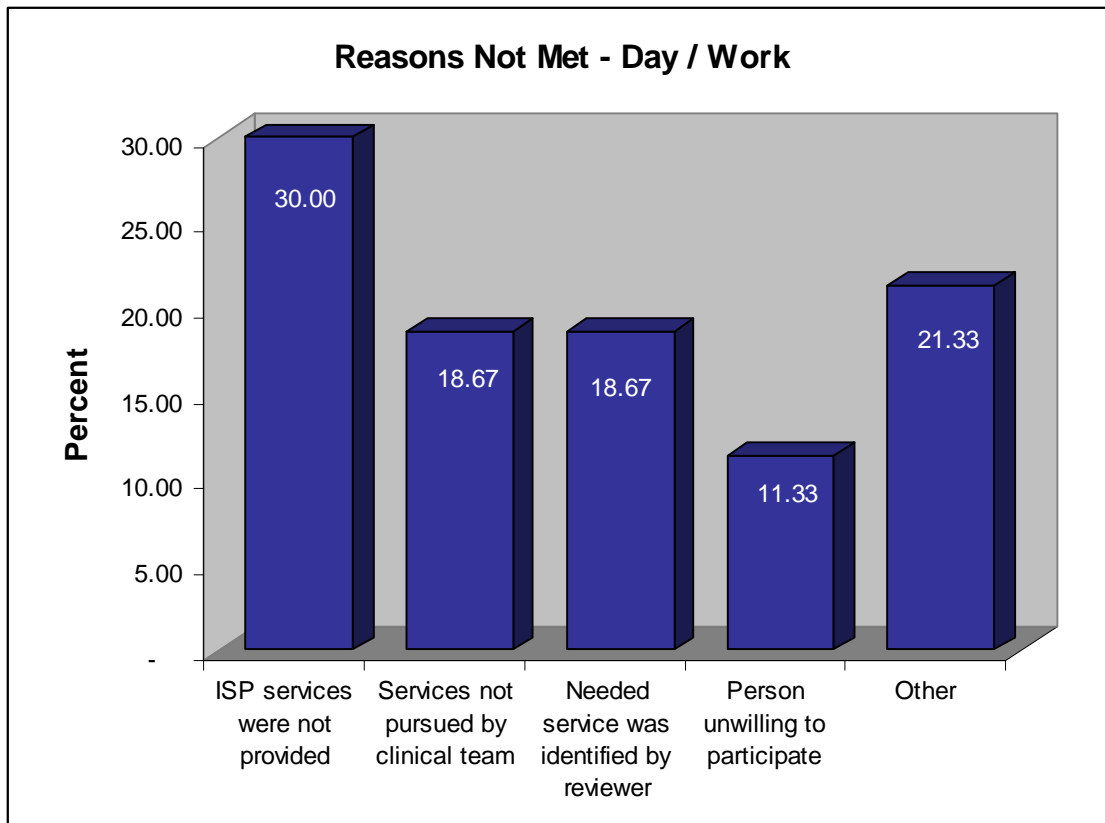
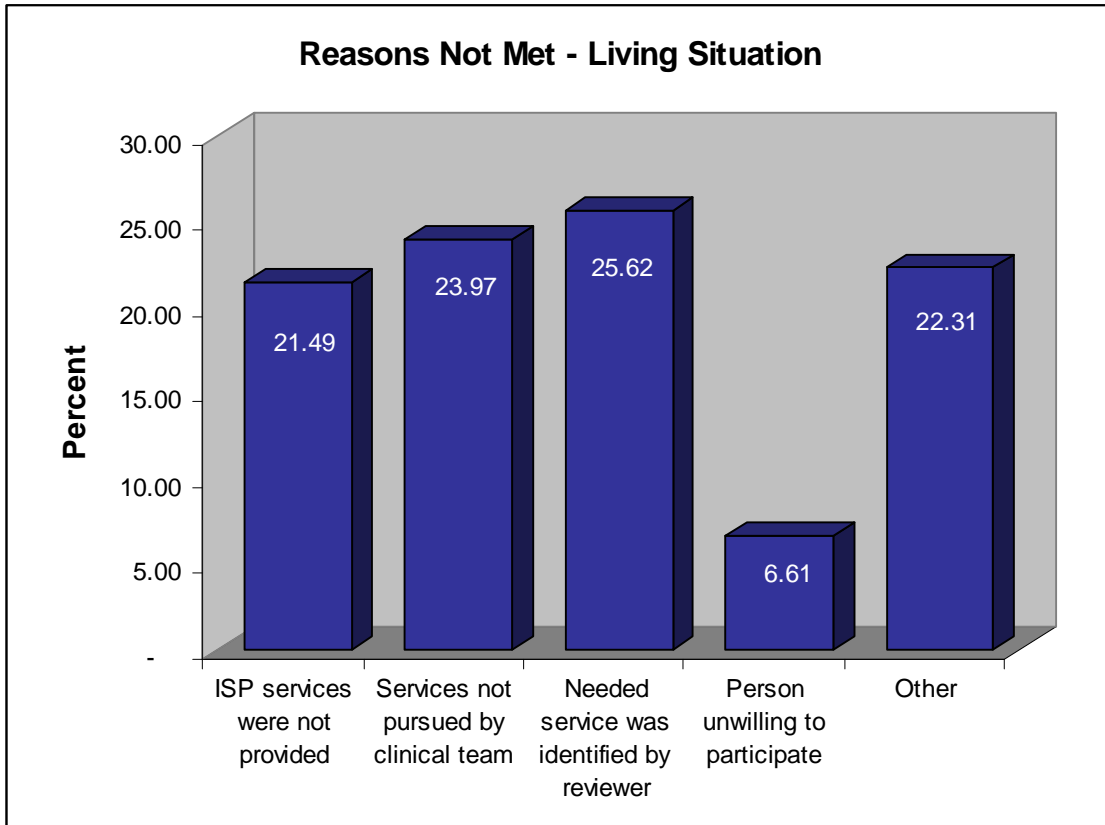
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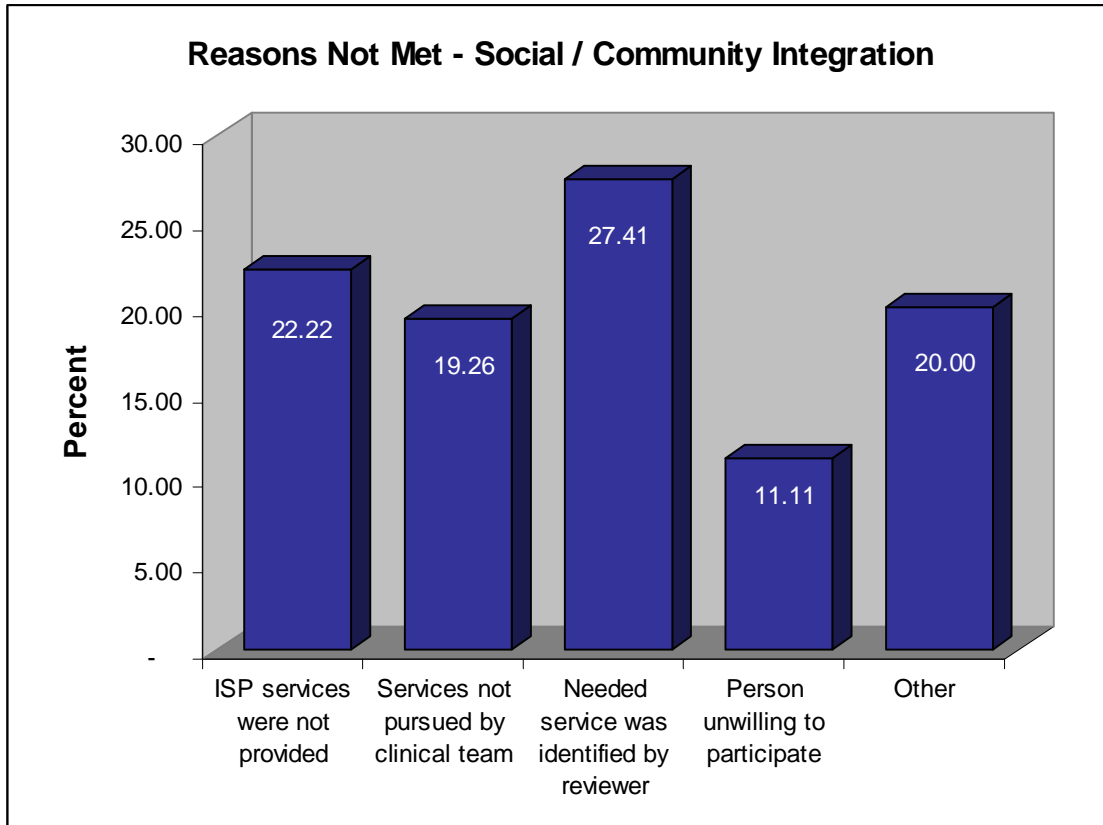
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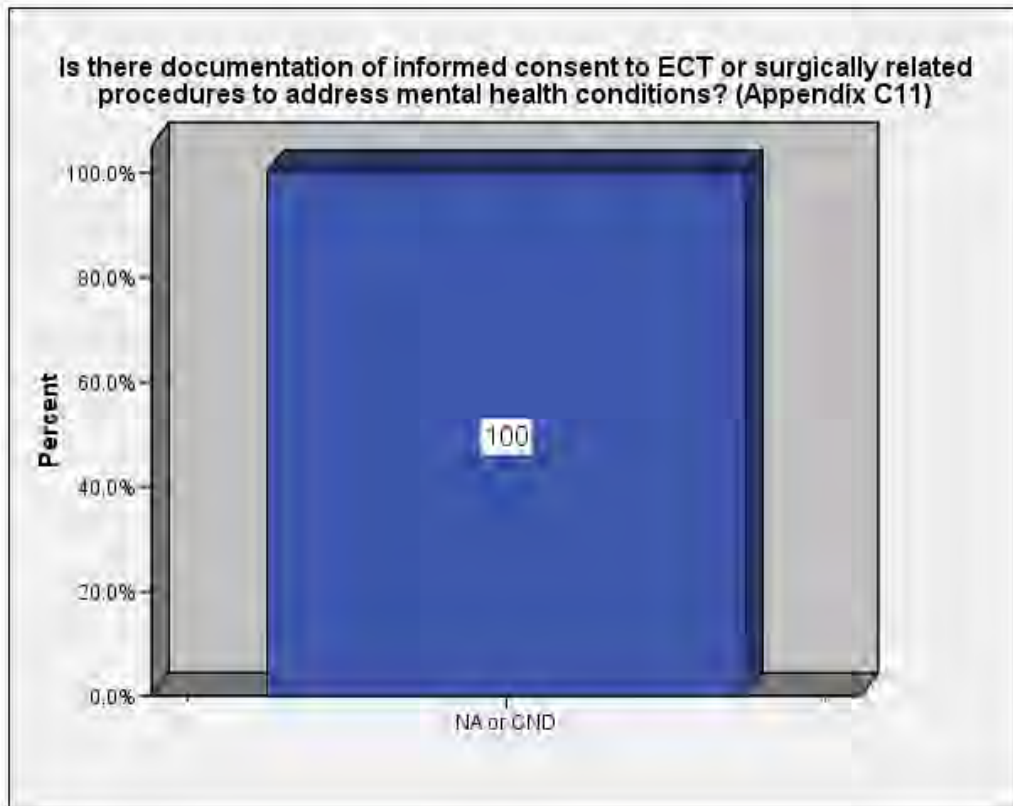
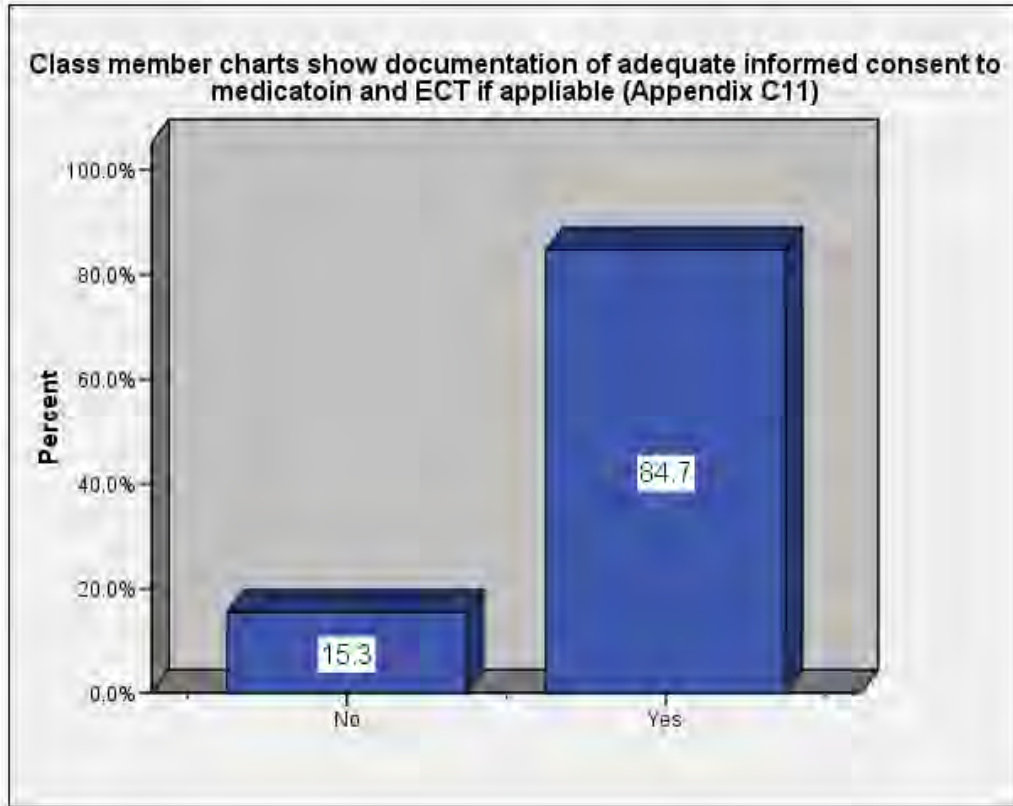


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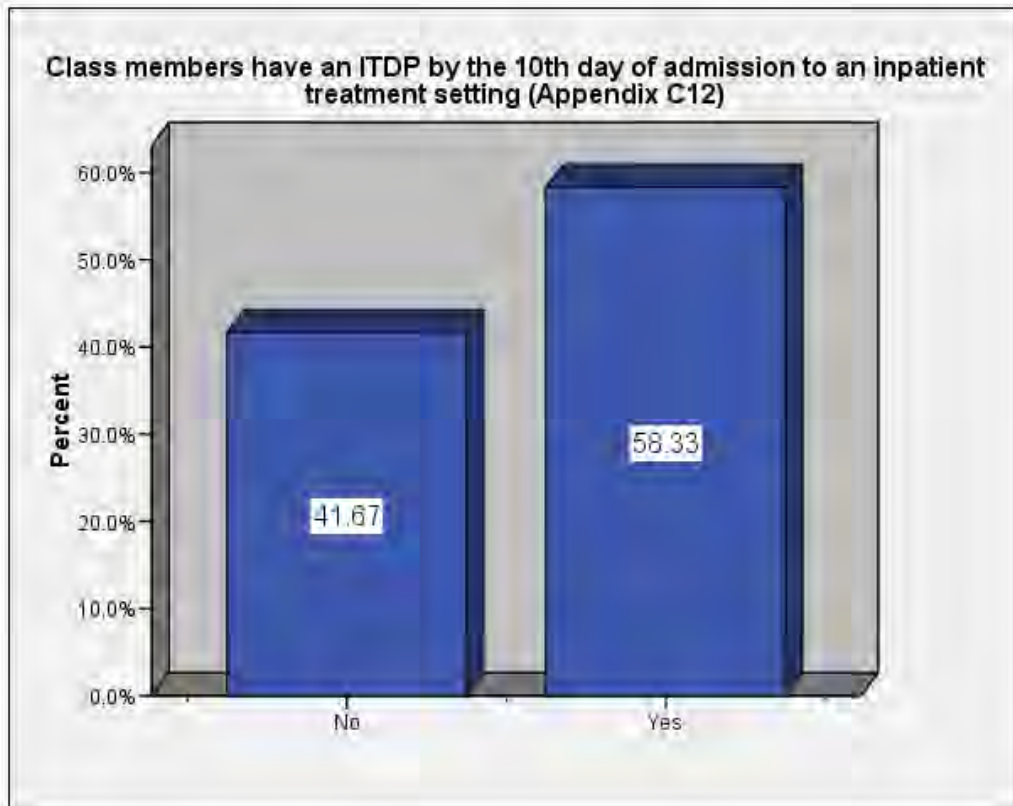
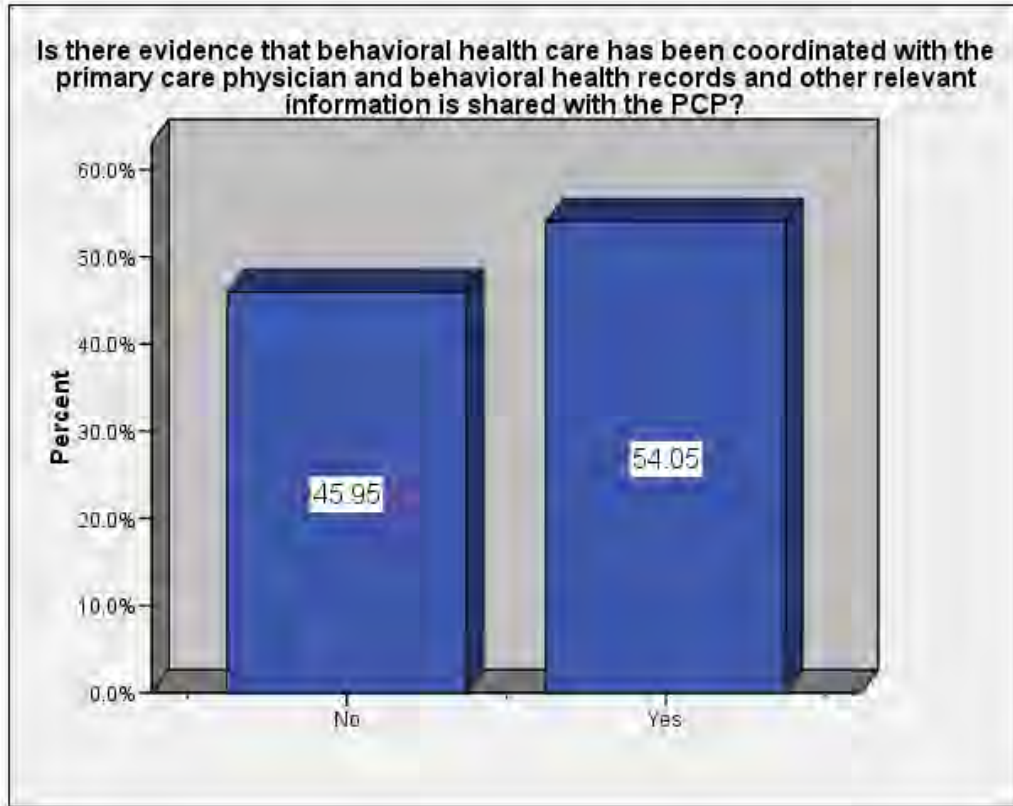
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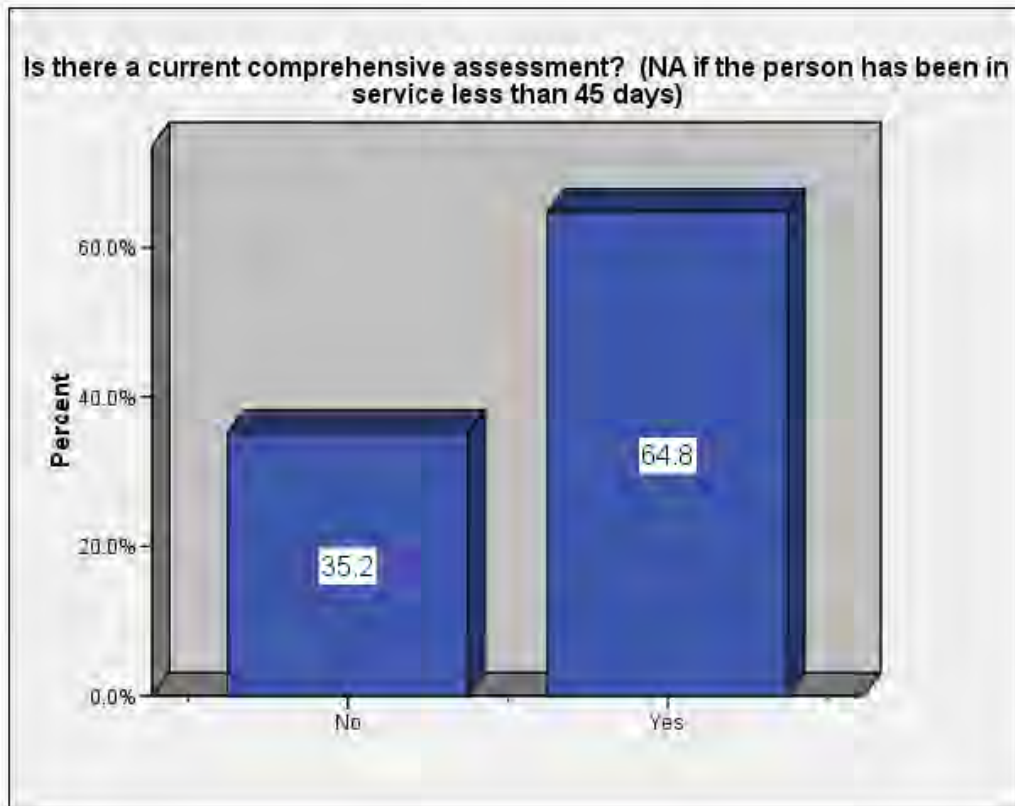
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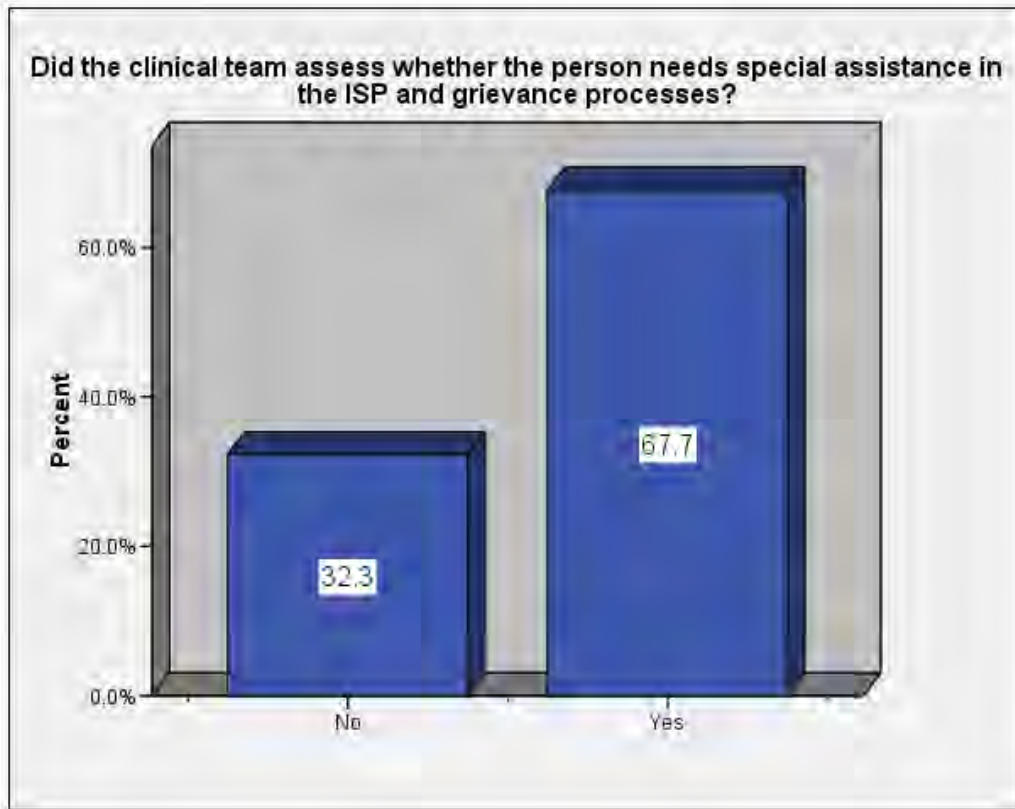
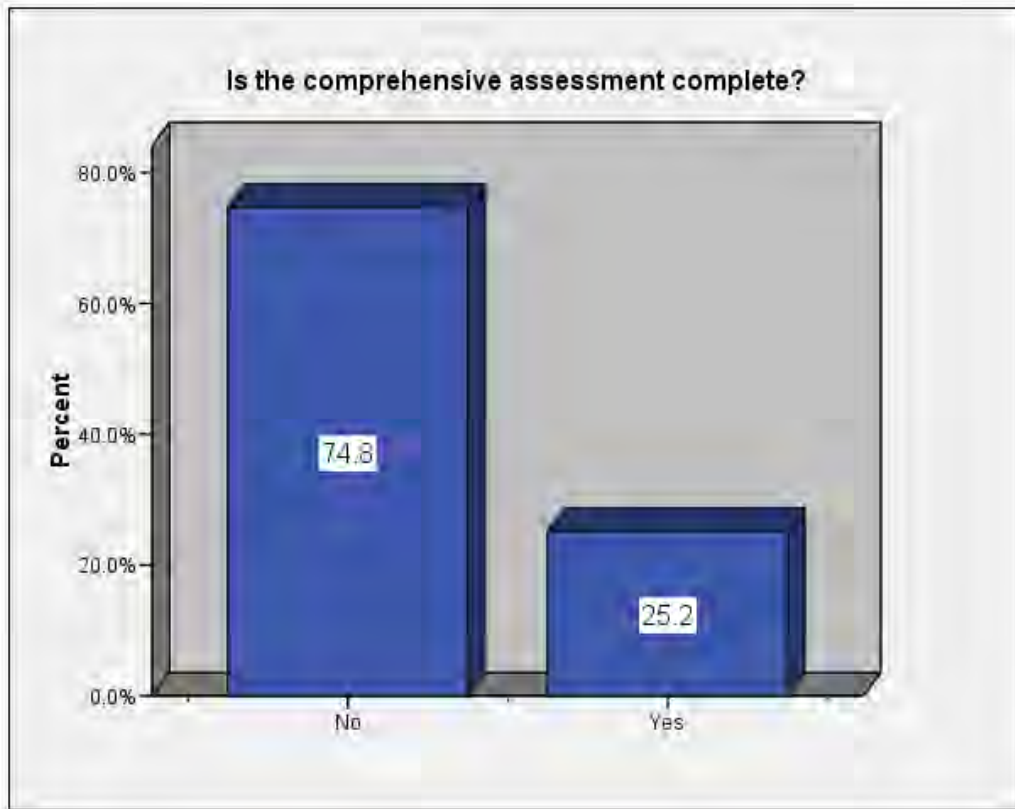
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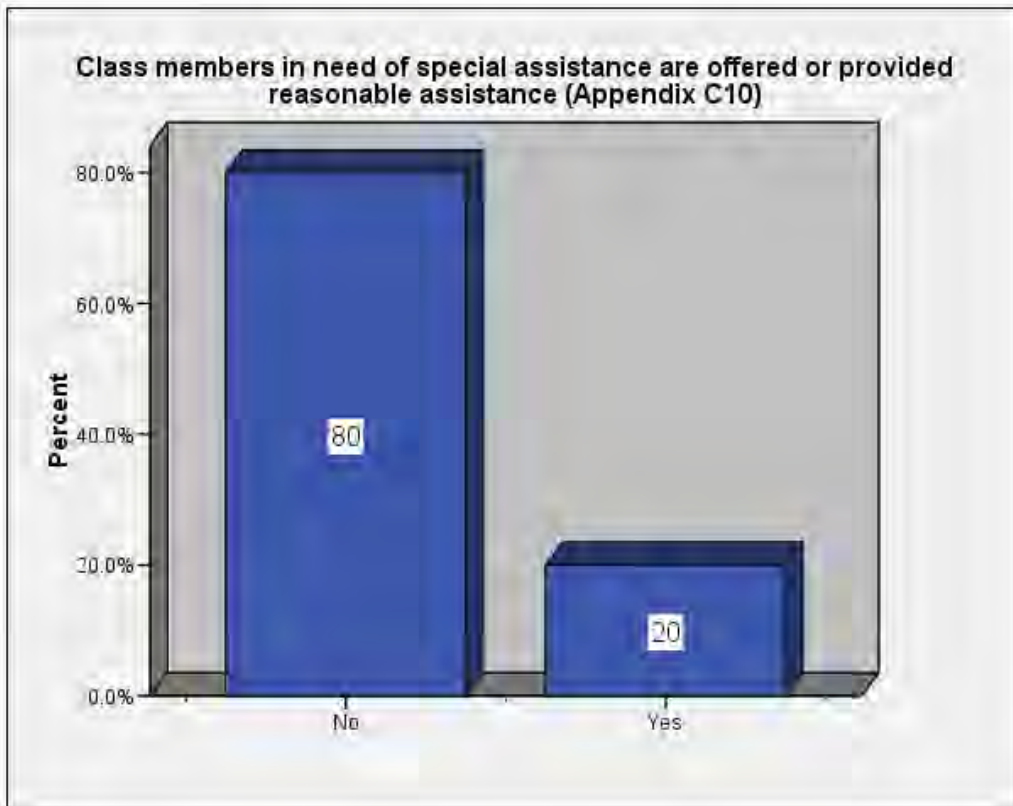
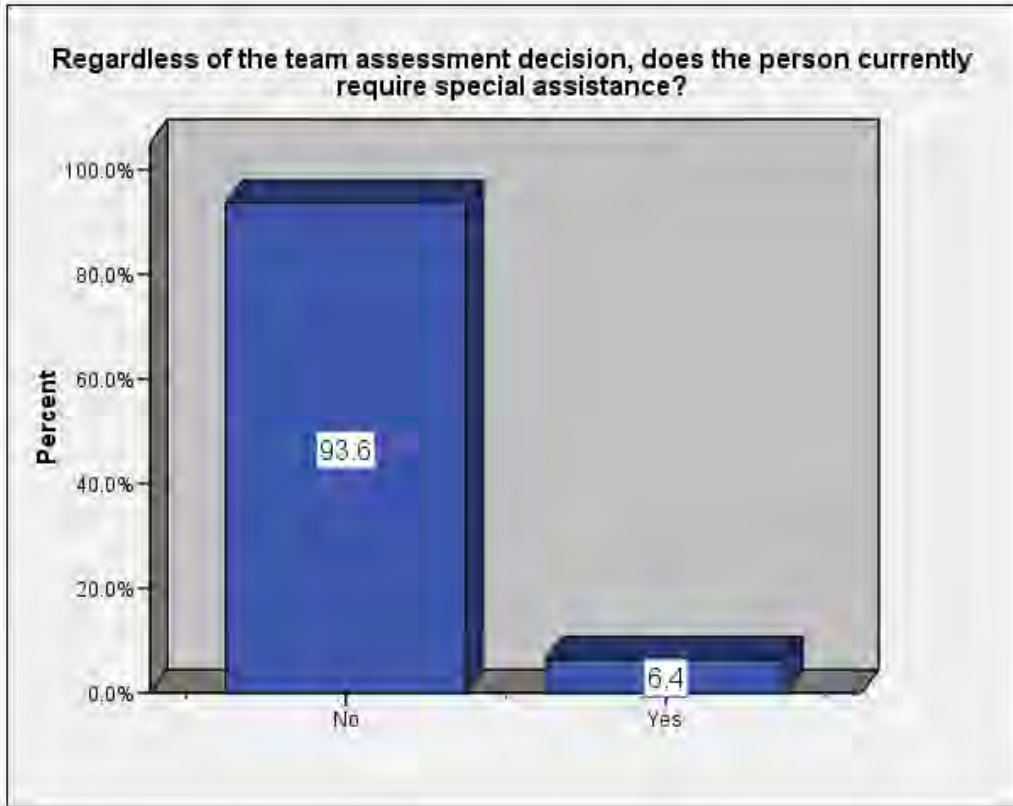
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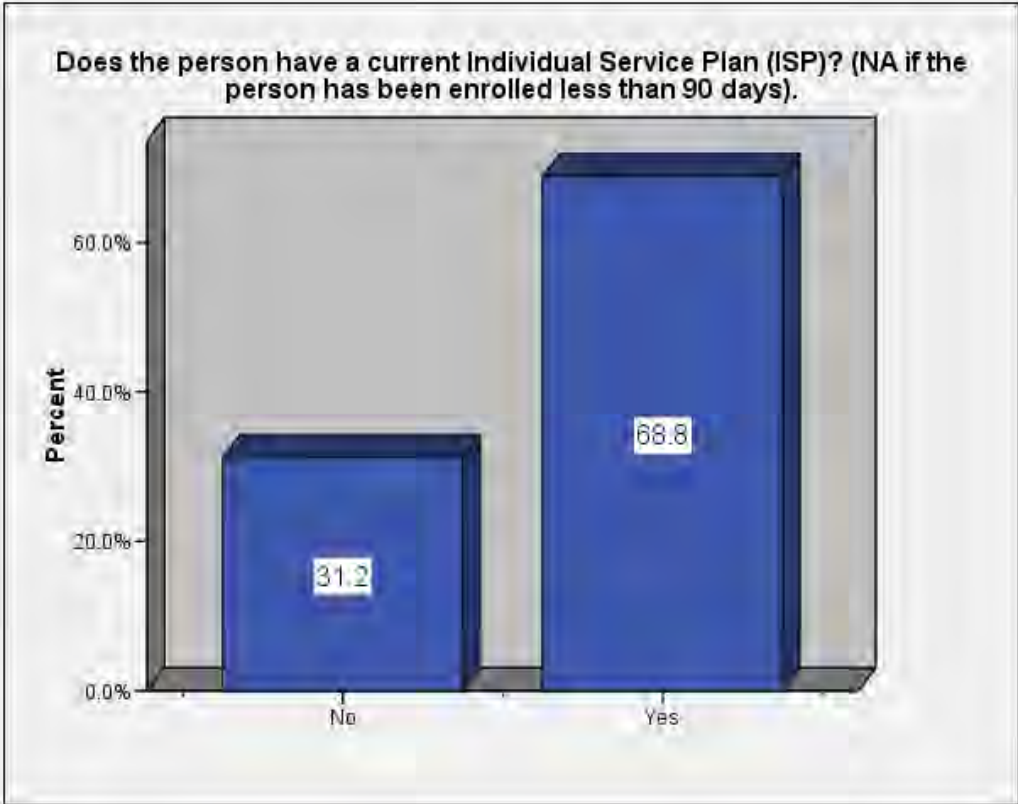
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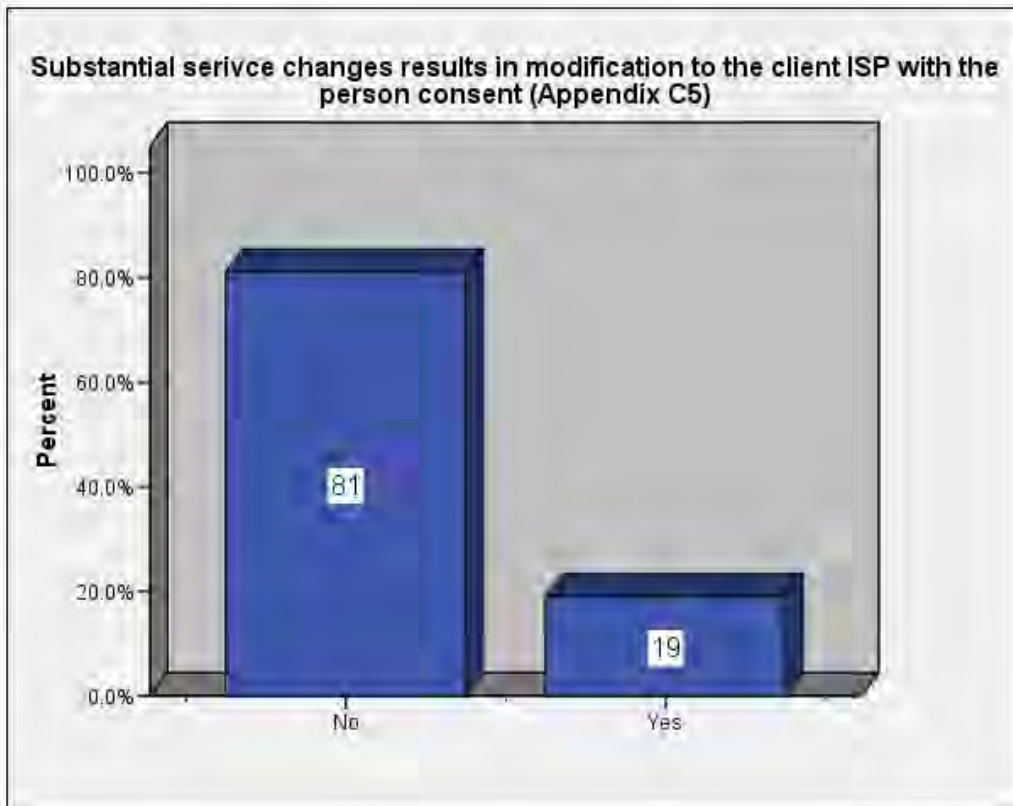
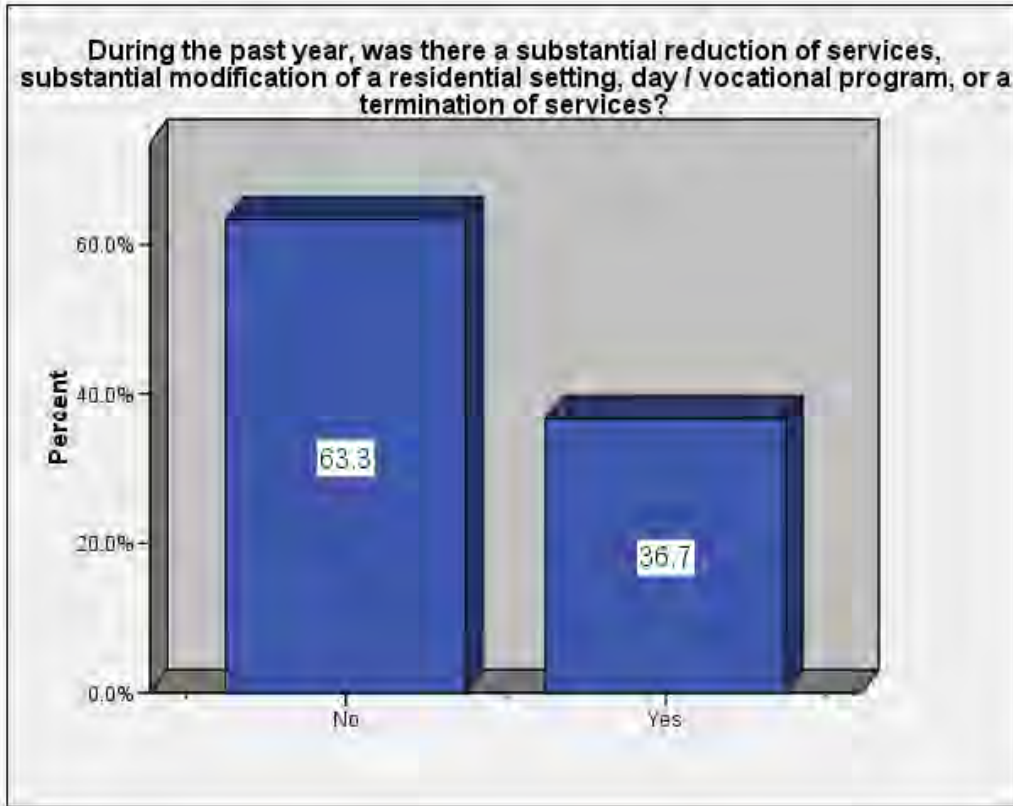
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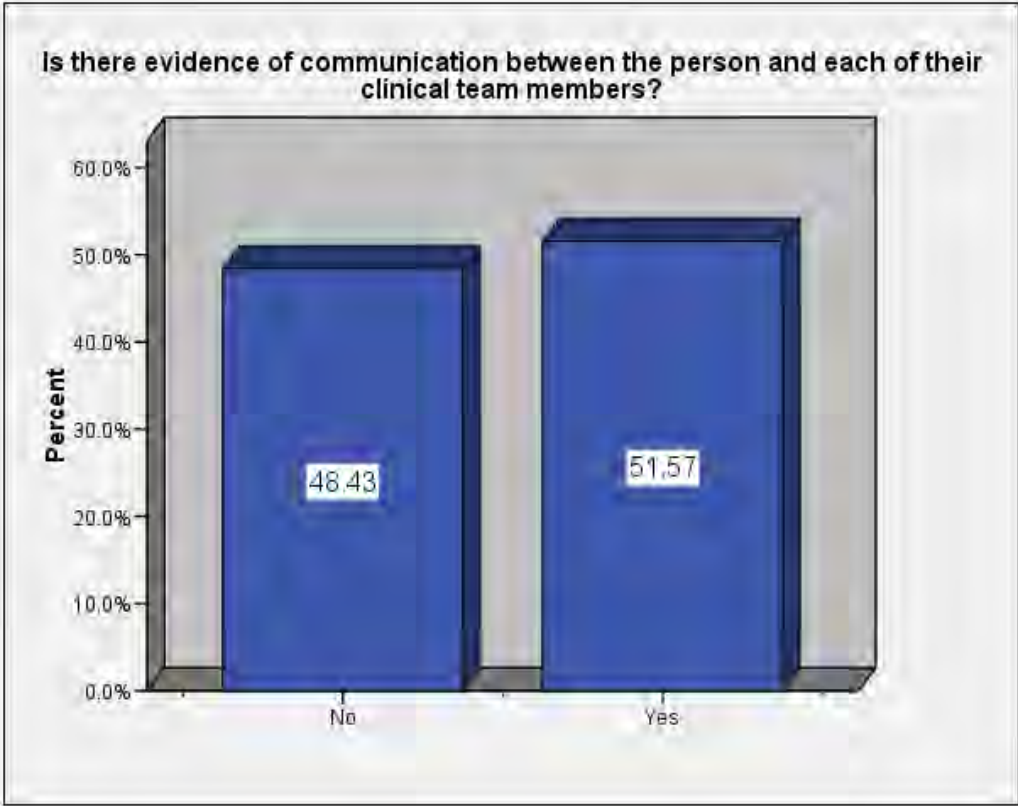
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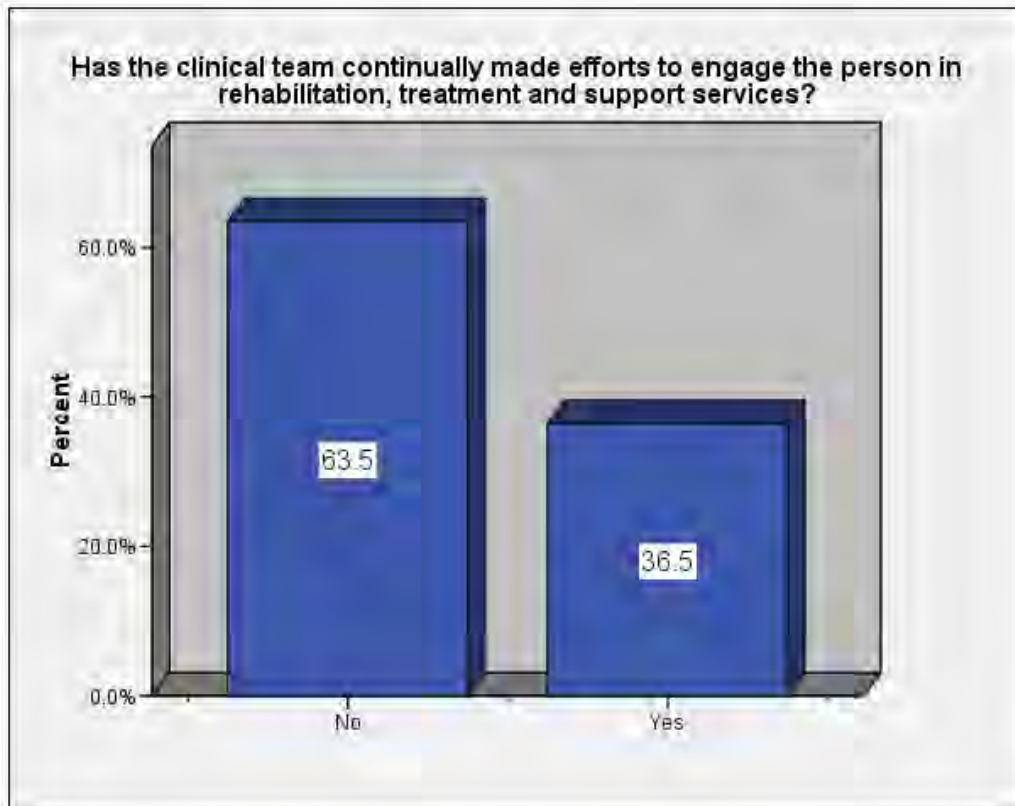
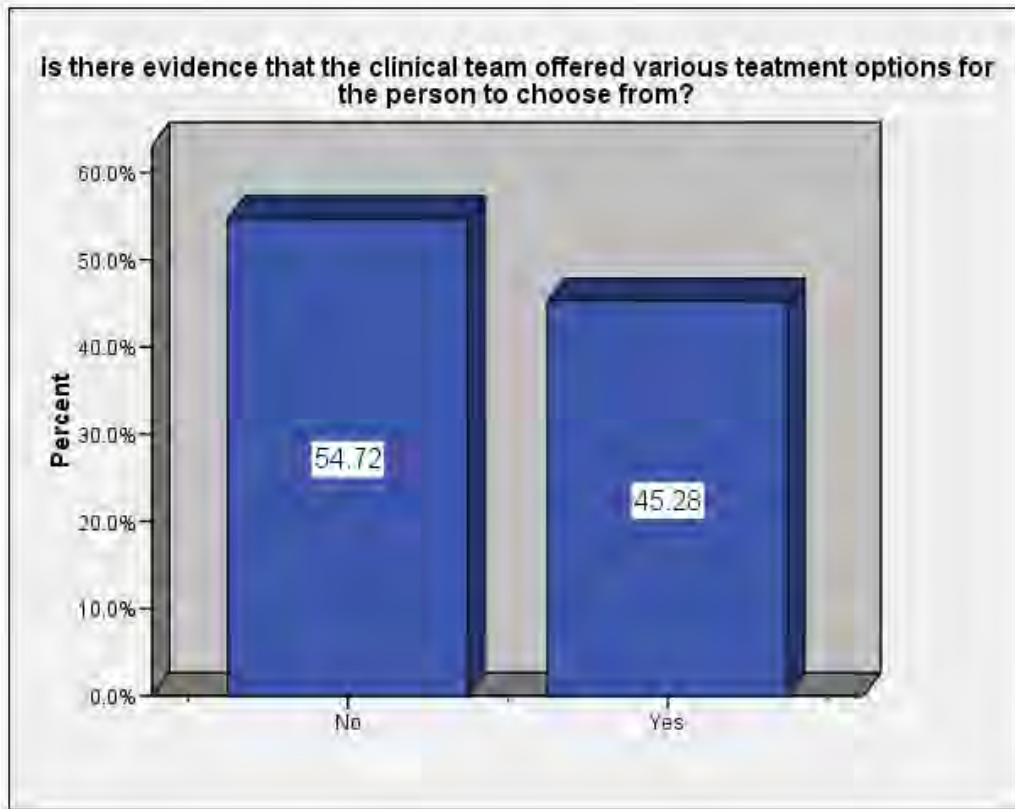
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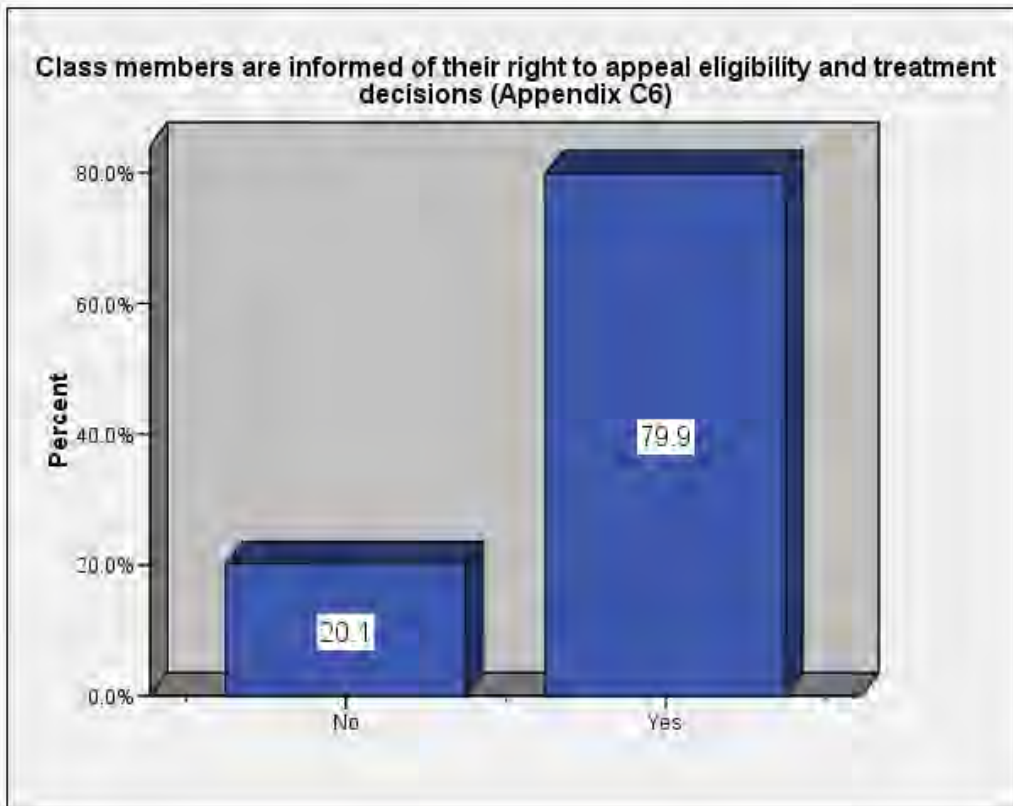
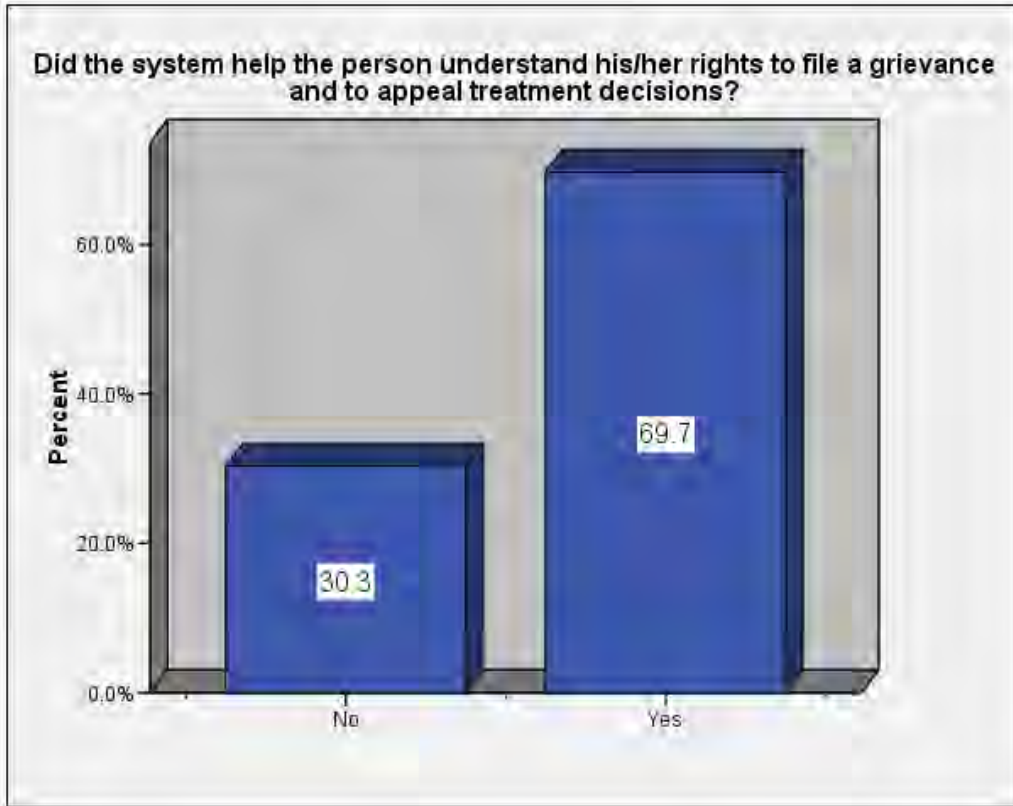
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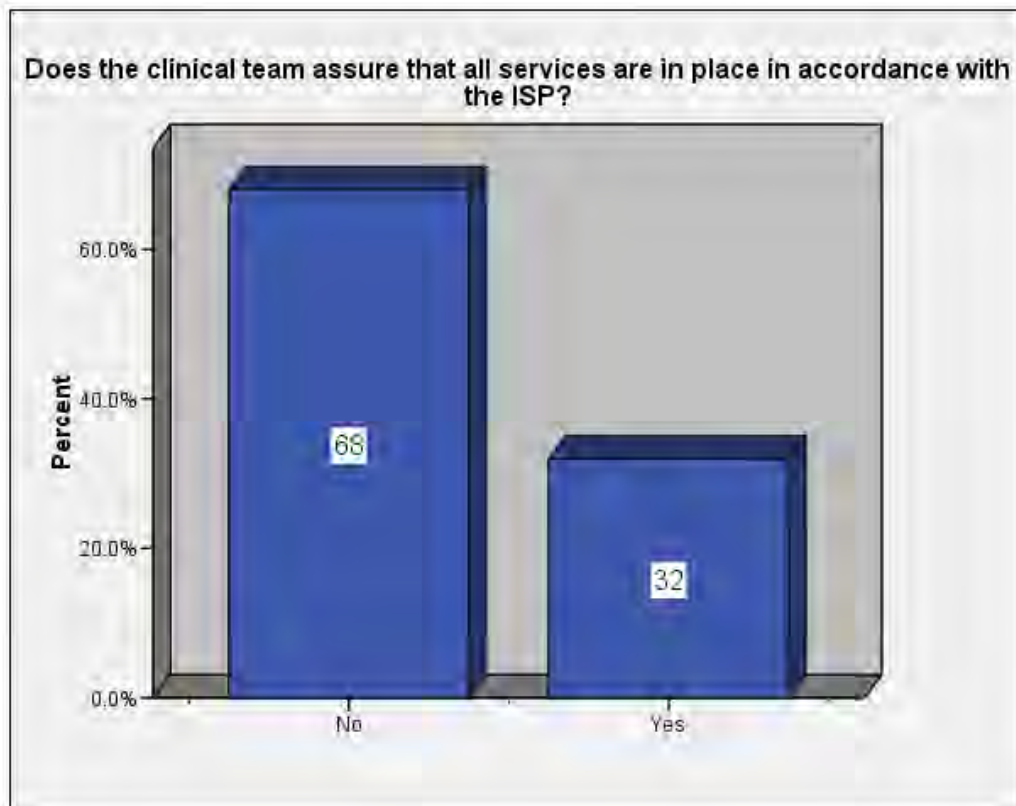
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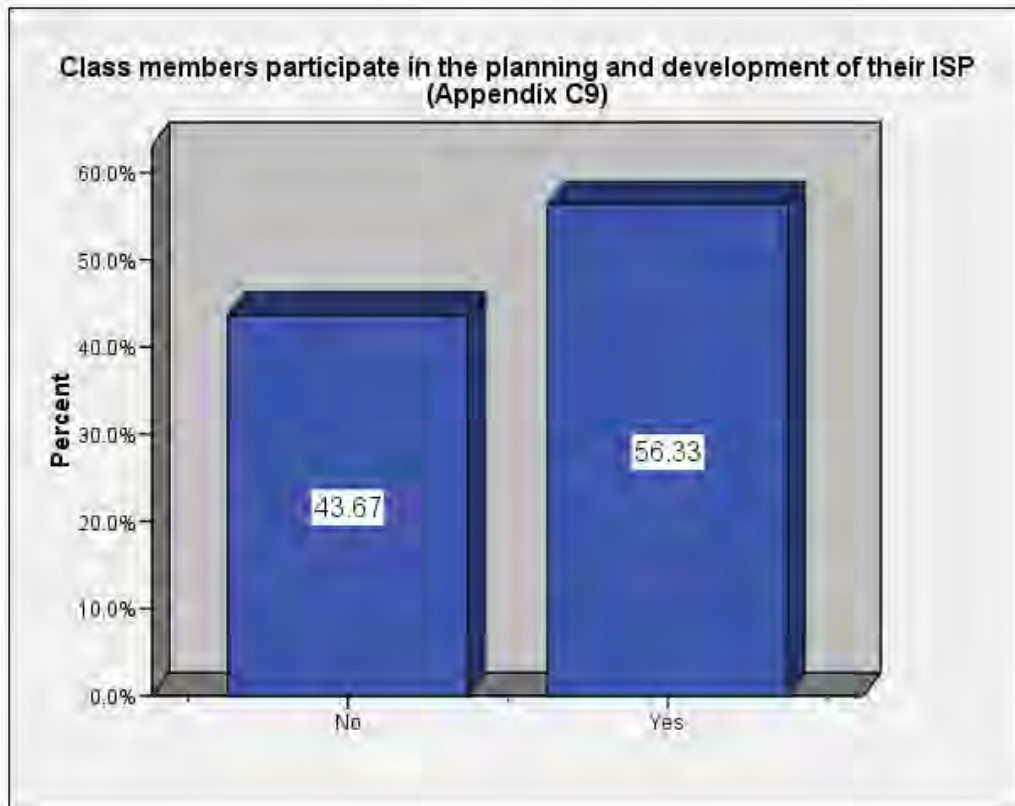
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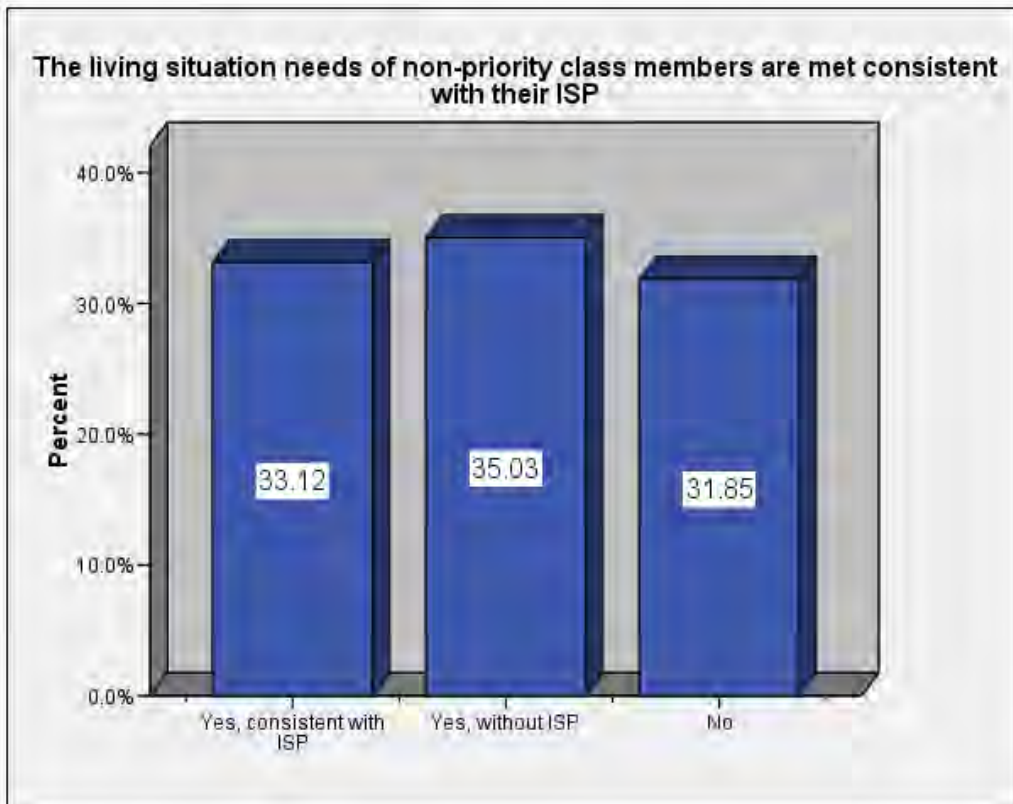
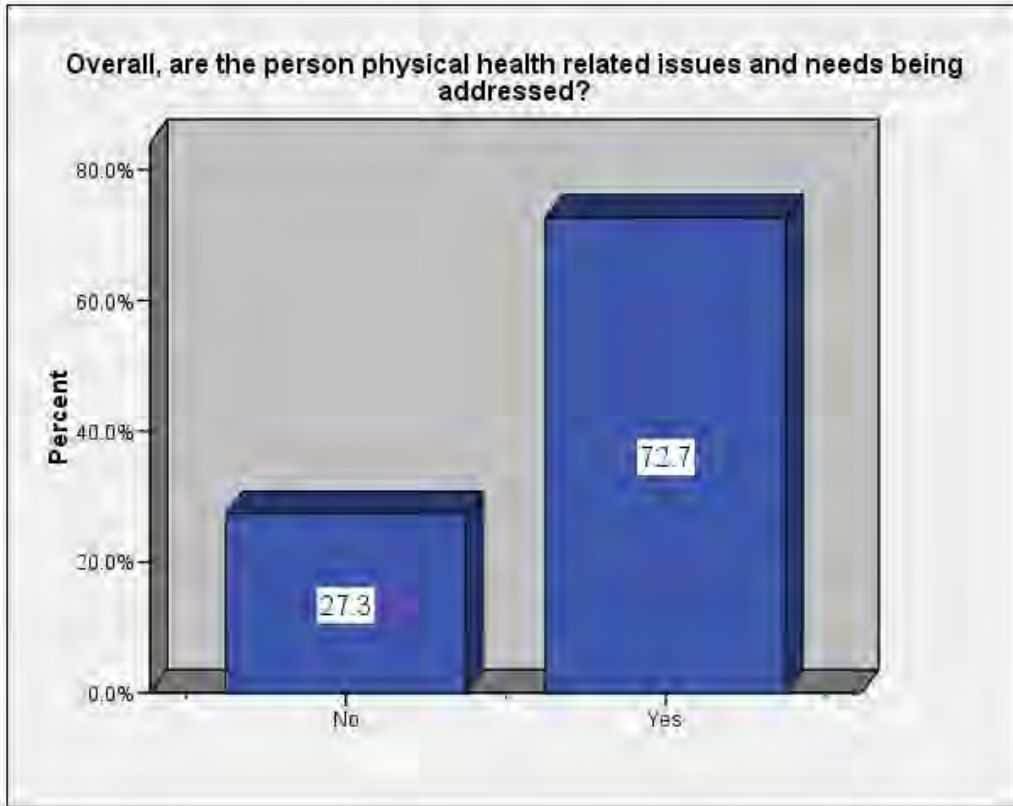
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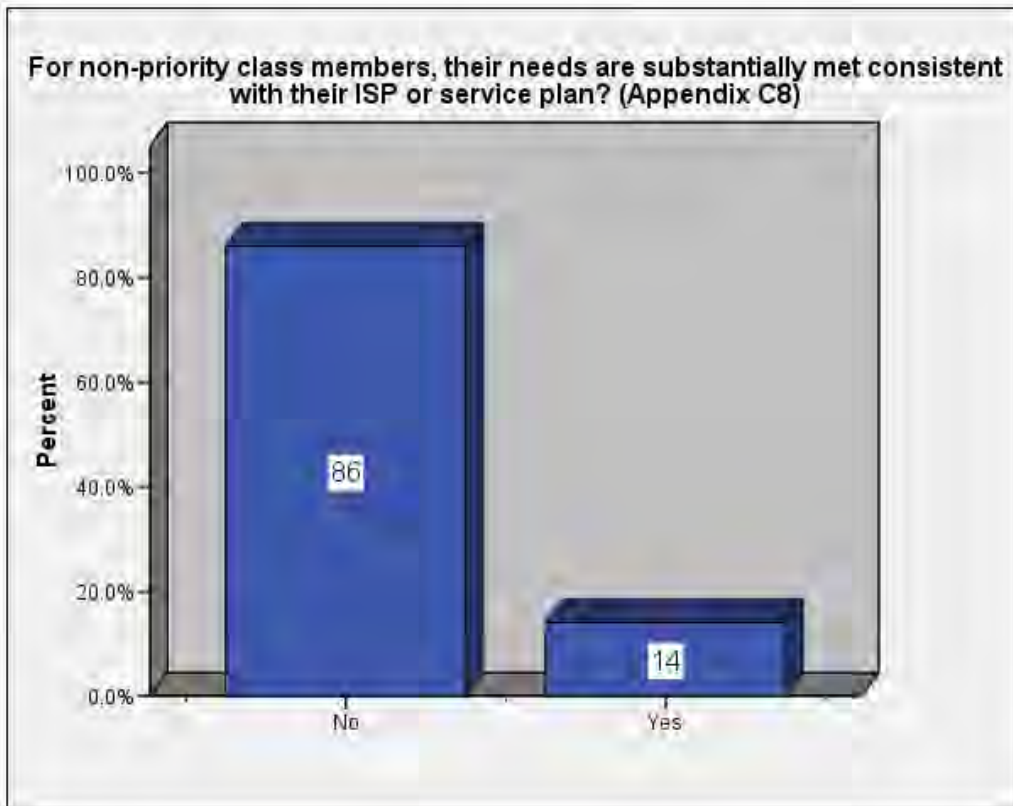
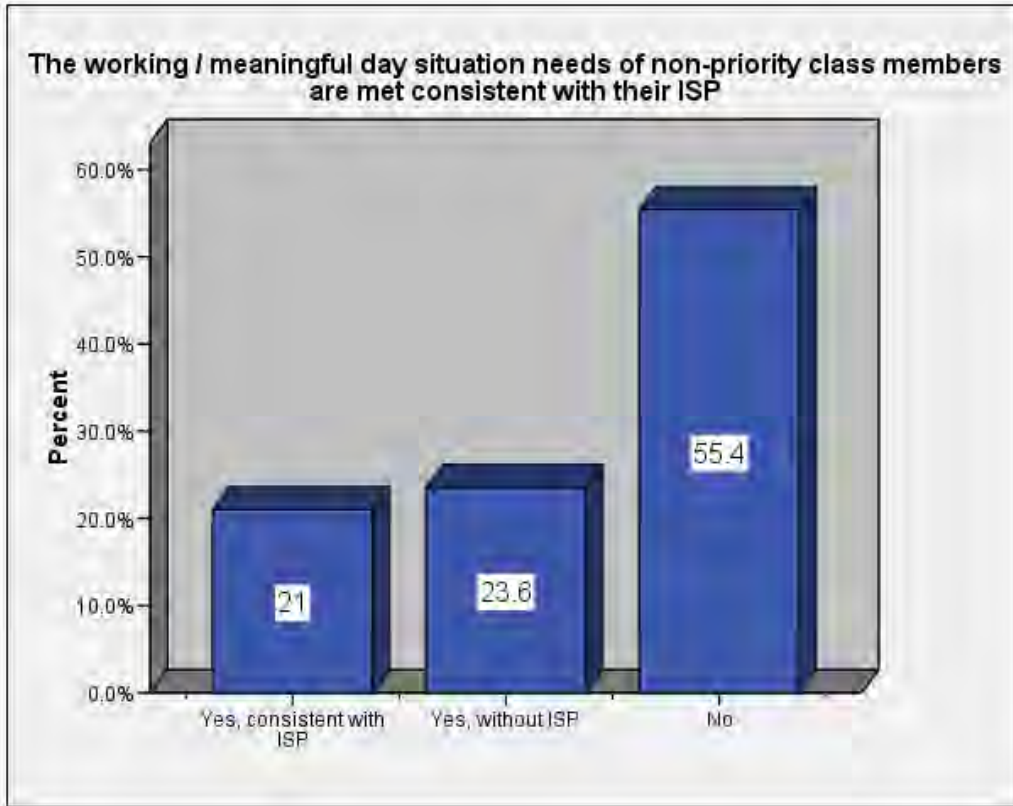
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