Arizona

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/13/2019 5.04.49 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

NOT FINAL

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State SAPT DUNS Number

Number 805346798

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Arizona Health Care Cost Containment System (AHCCCS)

Organizational Unit

Mailing Address 701 E Jefferson MD 6500

City Phoenix

Zip Code 85034

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Jami

Last Name Snyder

Agency Name Arizona Health Care Cost Containment System

Mailing Address 801 East Jefferson MD

City Phoenix

Zip Code 85034

Telephone 602-417-4711

Fax

Email Address jami.snyder@azahcccs.gov

State CMHS DUNS Number

Number 805346798

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Arizona Health Care Cost Containment System

Organizational Unit Division of Health Care Management

Mailing Address 701 East Jefferson MD6500

City Phoenix

Zip Code 85034

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Thomas

Last Name Betlach

Agency Name Arizona Health Care Cost Containment System (AHCCCS)

NOT FINAL

Mailing Address	801 E Jefferson
City	Phoenix
Zip Code	85034
Telephone	
Fax	
Email Address	

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ○ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	
Last Name	
Telephone	
Fax	
Email Address	

NOT FINAL

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
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Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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Fiscal Year 2020

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Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
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Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
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State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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Footnotes:

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Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid agency for the State of Arizona. In that capacity, it is responsible for operating the Title XIX and Title XXI programs through the State's 1115 Research and Demonstration Waiver, which was granted by the Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. As of January 1, 2019, AHCCCS provides coverage to approximately 1.9 million members in Arizona.

AHCCCS' mission "reaching across Arizona to provide comprehensive, quality health care to those in need" is implemented through the vision of "shaping tomorrow's managed care…from today's experience, quality, and innovation".

AHCCCS contracts with Managed Care Organizations (MCO's) that are responsible for providing physical, behavioral, and long term care services. AHCCCS also operates the American Indian Health Program (AIHP), a fee for service program that is responsible for care for American Indian members who select AIHP. AHCCCS also has five unique intergovernmental agreements with Tribal Regional Health Authorities (TRBHAs) for the coordination of behavioral health services for American Indian members enrolled with a TRBHA.

The program has a total fund budget for SFY 2019 of approximately $14.2 billion. AHCCCS has over 81,000 active providers in Arizona, including but not limited to individual medical and behavioral health practitioners, therapy disciplines, institutions, durable medical equipment companies, and transportation entities.

On October 1, 2018, AHCCCS took the largest step to date toward this strategic goal of fully integrated care delivery when 1.6 million members were enrolled in one of seven integrated AHCCCS Complete Care (ACC) health plans and AIHP. ACC plans and AIHP provide a comprehensive network of providers to deliver all covered physical and behavioral health services to child and adult members not determined to have SMI. The ACC plans and AIHP also provide services for members with Children's Rehabilitative Services (CRS) conditions. ACC plans and AIHP are able to address the whole health needs of our state's Medicaid population which is vitally important to improving service delivery for AHCCCS members and reducing the fragmentation that has existed in our health care system. The YH19-0001 AHCCCS Complete Care Request for Proposal (ACC RFP) awarded in March of 2018 resulted in seven awarded ACC plans across the state in three Geographic Service Areas: North, Central, and South. Three of these ACC plans are affiliated with current AHCCCS RBHAs and were required to align the RBHA and ACC contracts under one organization. The following link shows the contracted ACC plans and RBHAs and the different Geographic Service Areas (GSAs) served (https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/).

In addition to overseeing the managed care organizations that provide Medicaid-funded physical health care services, AHCCCS serves as the Single State Authority on substance abuse. AHCCCS will be the agency responsible for matters related to behavioral health and substance abuse and will provide oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona. Through this integration the staff responsible for the application, implementation, and oversight of SAMHSA

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block and discretionary grants remain in one unit for coordination of care. These positions include the State Opioid Treatment Authority/Opioid Treatment Network, Women's Treatment Network, National Prevention Network and National Treatment Network representatives in the System of Care and Grant Unit within Division of Health Care Management. The integration of physical and behavioral health services in one state agency puts AHCCCS in position to improve treatment outcomes for members in Arizona. AHCCCS is developing a Division of Grants Administration (DGA) to streamline grant administration under a single unit.

AHCCCS recognizes the interconnectivity of an individual's physical health and behavioral health and the importance to assist and promote whole body healthcare for all Arizonans. AHCCCS has supported integrated healthcare through various activities including educating healthcare providers, policy makers and the community as well as addressing systemic barriers to integration. All three RBHAs are fully responsible for coordinated and integrated behavioral and physical healthcare for Medicaid eligible adults with SMI.

AHCCCS finalized a state wide substance abuse prevention needs assessment in September 2018 that highlighted areas of needs in the current statewide primary prevention system structure. The assessment generated a community prevention inventory, conducted focus groups throughout AZ, conducted key informant interviews throughout AZ, conducted an online Substance Use Prevention Workforce survey, and synthesized secondary data analysis for a multitude of data sources. AHCCCS has begun a strategic planning process that will utilize the items listed above generated from the needs assessment, as well as to address the findings of the assessment. AHCCCS has already begun addressing assessment findings through the development of training plans, prevention deliverable templates, and updating substance abuse prevention contracts to align better with current prevention science information.

In addition to the RBHAs and tribes receiving prevention funding for community based primary prevention services; AHCCCS expanded our Contractor's to the Governor's Office of Youth, Faith, and Family (GOYFF). In 2015, Arizona collaborated with the GOYFF to leverage substance abuse prevention efforts statewide. The GOYFF expanded the primary prevention scope to media campaigns, and school based programs within Arizona's middle and high schools.

AHCCCS leverages the managed care services through these contracts to provide access to care for substance use disorder prevention, treatment and recovery support services through the Substance Abuse Block Grant (SABG) funding. The SABG supports primary prevention services and treatment services for members with substance use disorders. It is used to plan, implement and evaluate activities to prevent and treat Substance Use Disorders. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance users. Arizona is not an HIV designated state, so there are not specific requirements that need to be met for SAMHSA, however prevention efforts have been continued to sustain the progress that has been made in reducing the rate of individuals who contract HIV.

SABG funds are used to ensure access to treatment and long-term recovery support services for (in order of priority):

a) Pregnant women/teenagers who use drugs by injection,

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b) Pregnant women/teenagers who use substances,
c) Other persons who use drugs by injection,
d) Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children, and
e) All other individuals with a substance use disorder, regardless of gender or route of use, (as funding is available).

Behavioral health providers must provide specialized, gender-specific treatment and recovery support services for females who are pregnant or have dependent children and their families in outpatient and residential treatment settings. Services are also provided to mothers who are attempting to regain custody of their children. Services must treat the family as a unit. As needed, providers must admit both mothers and their dependent children into treatment. The following services are provided or arranged as needed:

a) Referral for primary medical care for pregnant females,
b) Referral for primary pediatric care for children,
c) Gender-specific substance use treatment, and
d) Therapeutic interventions for dependent children.

Contractors must ensure the following issues do not pose barriers to access to obtaining substance use disorder treatment:

a) Child care,
b) Case management
c) Transportation

The Contractors shall require any entity receiving amounts from the SABG for operating a program of treatment for substance use disorders to follow procedures which address how the program:

a) Will, directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services as defined in [45 CFR 96.121] to each individual receiving treatment for such abuse,
b) In the case of an individual in need of such treatment who is denied admission to the program on the basis of the lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services, and
c) Will implement infection control procedures designed to prevent the transmission of tuberculosis, including the following:
    a. Screening of patients,
    b. Identification of those individuals who are at high risk of becoming infected,
    c. Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including [42 CFR part 2], and
    d. Will conduct case management activities to ensure that individuals receive such services.

Interim Services shall be provided to those who meet the priority populations of Pregnant Women, Women with Dependent Children, or Intravenous Drug Users if there is a waitlist to engage in services. The purpose of interim services is to reduce the adverse health effects of

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substance use, promote the health of the member, and reduce the risk of transmission of disease. The minimum required interim services include:

a) Education that covers prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C and other sexually transmitted diseases,
b) Education that covers the effects of substance use on fetal development,
c) Risk assessment/screening,
d) Referrals for HIV, Hepatitis C, and tuberculosis screening and services, and
e) Referrals for primary and prenatal medical care.

Continuum of Care

As a leader in the public behavioral health field, Arizona's approach to managed care and service delivery is nationally recognized. AHCCCS focuses its efforts and energies toward providing leadership in activities designed to integrate and adapt the behavioral health system to meet the needs of those we serve. AHCCCS Covered Behavioral Health Services Guide https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/covered-bhs-guide.pdf outlines the comprehensive array of services to assist, support, and encourage each eligible member to achieve and maintain the highest possible level of health and self-sufficiency.

The goals that influenced how covered services were developed include:

- Align services to support a person/family centered service delivery model.
- Focus on services to meet recovery goals.
- Increase provider flexibility meets individual person/family needs.
- Eliminate barriers to service.
- Recognize and include support services provided by non-licensed individuals and agencies.
- Streamline service codes.

As quoted in the Children and Family Team (CFT) guidance tool, services provided to children with Serious Emotional Disturbance (SED) are to be guided by The Twelve Principles for Children's Service Delivery (12 Principles):

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family's unique cultural heritage
11. Independence
12. Connection to natural supports

Similarly to the 12 guiding principles for children's service delivery, services for adults with SMI are to be provided as indicated in the CBHSG, which include early intervention, crisis services, inpatient, residential, and outpatient services in compliance with the Nine Guiding

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Principles of the Adult Delivery System. The Nine Guiding Principles below were developed to provide a shared understanding of the key ingredients needed for an adult behavioral health system to promote recovery. System development efforts, programs, service provision, and stakeholder collaboration must be guided by these principles.

1. RESPECT: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. PERSONS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS: A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well- rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE: A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE: A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
7. PERSONS IN RECOVERY DEFINE THEIR OWN SUCCESS: A person in recovery -- by their own declaration -- discovers success, in part, by quality of life outcomes, which may include an improved sense of wellbeing, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.
8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES: A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the

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source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY: A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

AHCCCS addresses transitions from state hospitals, through the screening of members discharged to be matched with an appropriate team to address the coordination of support services such as supported employment and education, and Peer Recovery support.
Employment and education support consists of connecting the members with the Rehabilitation Services Administration (RSA) Vocational Rehabilitation (VR). If the member is determined SMI and enrolled with the RBHA, then they would fall under the parameters of the Interagency Services Agreement (ISA) that AHCCCS has with RSA/VR, which includes, but is not limited to VR counselors who have specialized caseloads consisting of members with psychiatric disabilities. RSA/VR has assigned one of their offices to work with any referrals coming out of the State Hospital.
Additional information:

- AHCCCS and RSA/VR work together to provide specialty employment services RBHA-enrolled members who have been determined as having a SMI.
- The purpose of the ISA is to increase the number of employed people with psychiatric disabilities who are successful and satisfied with their vocational roles and environments using the combined talents, commitments, and resources from RSA/VR and AHCCCS.
- The VR program provides a variety of services to persons with disabilities, with the ultimate goal to prepare for, enter into, or retain employment. The VR program is a public program funded through a Federal/State partnership and administered by the RSA, which is part of the Arizona Department of Economic Security (ADES)

In Maricopa County, Forensic Assertive Community Treatment (FACT) teams, created in 1996 and since then have expanded. The FACT teams address the unique needs of people who have been diagnosed with a SMI and have had involvement with the criminal justice system. FACT is designed to reduce recidivism and assist members with high-needs through a full array of community-based supports and services delivered in a wrap-around model so they can achieve their recovery goals and maintain stability in the community.
The FACT team utilizes evidence-based practices to:

- Identify and engage members with complex, high needs.
- Remove barriers to services and supports.
- Address the whole person and provide a full range of community-based services and supports wherever and whenever they are needed.
- Reduce hospitalizations and contact with the criminal-justice system, improve health outcomes and help establish and strengthen natural community supports.

FACT team employees have experience in psychiatry, nursing, social work, rehabilitation services, substance-abuse interventions, employment support, independent-living skills and

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housing. A key member of the team is a peer who has lived experience with behavioral health challenges and prior interaction with the criminal justice system. The team assists members with adhering to treatment plans, activities of daily living, employment-related services, finding and maintaining affordable housing, budgeting, obtaining benefits, and engaging in community activities through delivering services in accordance with SAMHSA evidence-based practices.

AHCCCS Contracts ensure services covered through the Behavioral Health Covered Service Guide are provided in a culturally competent manner utilizing EBPs. The services are geared towards members who have a behavioral health diagnosis and identify as being a part of an identified group with norms not always addressed through traditional treatment modalities, including, but not limited to veterans, LGBT, elderly, homeless, rural, and diverse populations. The RBHAs utilize Cultural Diversity Specialists and Community Liaisons who work with providers and communities through training, education, and technical assistance to ensure implementation and monitoring of the appropriate programs and services.

Arizona also has a Demographic User Guide: The DUGless - Demographic Portal
For demographic elements with no identified alternative data source or Social Determinate identifier, AHCCCS created an online portal (DUGless) to be accessed directly by providers for the collection of the remaining data elements for members. It is AHCCCS' intent that both the provider organizations that historically provided data for the DUG as well as all providers who might typically document or provide these types of data will provide the required data via the DUGless portal as of 10/01/2018. https://www.azahcccs.gov/PlansProviders/Demographics/

The data fields contained in the demographic data set are mandatory. They must be collected and submitted within the required timeframes, recorded using valid values, in compliance with the definitions. The contents of the demographic data record must match the member's behavioral health medical records. AHCCCS periodically conducts chart reviews to ensure T/RBHA demographic data submitted is consistent with members' behavioral health medical records. Within the DUGless Arizona collects information such as race, ethnicity, gender identity, sexual orientation, etc.

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Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

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The Arizona Health Care Cost Containment System (AHCCCS) utilizes a number of data feeds, surveys, systemic evaluations, as well as stakeholder forums to determine statewide need for services; and works in tandem with the Tribal and Regional Behavioral Health Authorities (T/RBHAs) to ensure efficient resource allocation permits system capacity to correlate with service demand. AHCCCS continues to work toward a data driven decision-making process when assessing prevention, subvention, and treatment needs for both mental health and substance use disorders. The State has received recommendations and has worked to incorporate comments suggesting improvements in reporting measures and expanding membership of the Behavioral Health Planning Council.

The following section details the current instruments and methodology used for assessing service needs; identified strengths, and programmatic initiatives within Arizona's service delivery system.

Substance Use – Assessing the Need for Prevention and Treatment Services

AHCCCS currently has active policies that allow for the assessment and monitoring of unmet needs at the contract level. Arizona Contractor Operations Manual (ACOM) Policy 415 *Provider Network Development and Management Plan; Periodic Network Reporting Requirements* ensure regular assessments of needs are taking place. This Policy applies to AHCCCS Complete Care (ACC) and RBHA Contractors. The Policy states that provider networks shall be a foundation that supports an individual's needs as well as the membership in general. This Policy establishes Contractor requirements for the submission of the Network Development and Management Plan and other periodic network reporting requirements. Specific items contractors are required to manage and report on include, but are not limited to, the following:

- Contractor's Workforce Development Plan
- Contractor's Value Based Purchasing/24/7 Access Points Report
- Evaluation of the prior year's Network Plan including:
    - Actions proposed in the prior year's plan
    - Network issues over the past year that required intervention
    - Interventions taken to resolve network issues
    - Barriers to the interventions
    - Evaluation of the effectiveness of the interventions
- Contractor's current network gaps
- Contractor's network development steps for the coming year based upon its review of the prior year's Network Plan, current identified gaps, and any other priorities identified in the current plan
- Contractor's analysis demonstrating it has the capacity and the appropriate range of services adequate for the anticipated enrollment in its assigned service area
- Description of the integrated network design by GSA for the following populations:
    - Members undergoing substance use disorder treatment:
    - Pregnant Women and/or Pregnant Women with Dependent Children
    - Persons who use drug by Injection
    - Adults
    - Children

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    - General membership requiring access to the following types of substance use disorder treatment:
        - Medication Assisted Treatment
        - Outpatient
        - Intensive Outpatient
        - Partial Hospitalization
        - Residential Inpatient
- A description of subcontracts for substance abuse prevention and treatment through the Substance Abuse Block Grant (SABG) Block Grant utilizing capacity data including wait list management methods for SABG Block Grant Priority populations.

The National Survey on Drug Use and Health (NSDUH), prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA) provides the underlying methodology used by AHCCCS to quantify the need for substance abuse treatment in Arizona. On an annual basis, prevalence information from the NSDUH compares census data, both actual and estimated, for the State of Arizona.

The Arizona Substance Abuse Partnership (ASAP) serves as the single statewide council on substance abuse prevention, enforcement, treatment, and recovery efforts. Executive Order (EO) 2007-12 created the Arizona Substance Abuse Partnership (ASAP) and recognized the Substance Abuse Epidemiology Work Group (Epi Work Group) as a formal subcommittee of the ASAP. On May 28, 2013, EO 2013-05 continued the ASAP, and further institutionalized the Epi Work Group by requiring the ASAP to maintain the previously-optional workgroup.

The ASAP and the Epi Work Group foster collaboration and data-sharing among professionals in the prevention, treatment, enforcement, and recovery arenas. Indeed, EO 2013-05 tasks the ASAP and the Epi Work Group with developing and utilizing a shared-planning process that encourages state and local partnerships to maximize existing resources and with building the capacity of local communities to meet their identified needs. Further, EO 2013-05 prioritizes integrating strategies across systems to leverage existing funding and with increasing access to services at the community level. As budgets tighten and there is a better understanding of the need to combat substance use from multiple perspectives (i.e., through prevention, intervention, treatment, and recovery initiatives), we recognize that it is imperative to advance such collaborations and resource sharing.

Beginning with the Strategic Prevention Framework State Incentive Grants awarded to states by the Substance Abuse and Mental Health Services Administration (Arizona received its award in 2004), State Epidemiological Outcomes Workgroup (SEOW) composed of epidemiologists, statistical analysts, tribal representatives, prevention providers, and representatives from departments of health, mental health, education, public safety, and criminal justice, have met with the goal of bringing data related to substance abuse and behavioral problems to guide prevention planning and to build state- and community-level monitoring systems. Additionally, SEOW has been tasked with identifying, organizing, and sharing data and with training communities to understand, use, and present them in effective ways that guide policy and community efforts. The Epi Work Group serves as Arizona's SEOW.

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The Epi Work Group has four major goals, which are to:

1. Compile and synthesize information and data on substance misuse and abuse and its associated consequences and correlates, including mental illness and emerging trends, through a collaborative and cooperative data-sharing process.
2. Assess substance abuse treatment service capacity in Arizona and detail gaps in service availability.
3. Serve as a resource to the Arizona Substance Abuse Partnership and member agencies to support data-driven decision-making that makes the best use of the resources available to address substance abuse and related issues in Arizona.
4. Identify data gaps and address them in order to provide Arizona with a comprehensive picture of substance misuse and abuse in the state.

The development of the Community Data Portal (CDP) assists the SEOW in providing training and technical assistance to guide a data-driven decision-making process utilizing the CDP and other data sources. A CDP website was created to enhance the data-driven decision-making approach in Arizona (http://www.azcjc.gov/community-data-portal). The CDP website has an interactive and user friendly central repository for state, county, and community-level indicators. These indicators highlight the misuse and abuse of alcohol, tobacco, prescription, and illicit drugs, the associated consequences, and the context in which substance misuse/abuse occurs. Data is displayed at multiple levels, across demographics, and over time, including tables, graphs, maps, and downloadable data files covering a variety of reporting and visualization needs.

The NSDUH analysis and the Epidemiologic Profile reinforce the findings of Arizona's qualitative data feeds. When reviewed and used in conjunction with other special reports to assist in understanding the statewide distribution of need, demand, and capacity for substance abuse treatment, these studies generally support the resource allocation formulary used by AHCCCS for non- Medicaid priority populations including pregnant women, injecting drug users, women with dependent children, and persons at risk for Tuberculosis,. Specifically, they demonstrate:

- There is little geographic variation in the prevalence of need for substance abuse treatment;
- Demand for treatment varies most by population size, with denser areas of the state experiencing the highest demand for treatment;
- Certain high-risk groups do exist, including young adults and women in the Northern Arizona region;
- Statewide treatment capacity is insufficient to meet the needs of the general population;
- Alcohol is Arizona's most prevalently used substance and carries the greatest economic burden;
- Prescription drug abuse and related consequences have been increasing for the past five years;
- There is a lack of affordable childcare services for dependent children for those who meet eligibility criteria for the substance abuse block grant; and
- There is a lack of affordable recovery housing available for the recovery communities throughout the state.

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AHCCCS works collaboratively with the Contractors throughout the state to identify solutions to the identified gaps. Some of the progress that has been made includes expanding outreach efforts to best meet the individuals in need of services, targeting interventions to those identified as having the greatest need, working to reduce the administrative burdens associated with treating this population to increase providers willing to join the Contractor's network of providers, targeted prevention efforts on alcohol use and abuse, implementation of several opioid specific interventions including 24/7 Access Points, requesting approval from SAMHSA for childcare services for all members with dependent children, and requesting approval from SAMHSA for the Contractors to be allowed to contract to bring the Oxford House Model to Arizona. SAMHSA approved the Oxford House Model in June 2018. The Oxford House is a live-in residence for individuals in recovery from substance use disorders. An Oxford House is described as a democratically self-governed and self-support drug-free homes. AHCCCS has been successful with allowing contractors to implement the Oxford House Model in Arizona, with seven houses currently open in the state. The first three Oxford Houses were open in July 2019 and outreach workers are continuing to train and open more Oxford Houses currently.

AHCCCS works collaboratively with the Contractors throughout the state to identify solutions to the identified gaps. Some of the progress that has been made includes expanding outreach efforts to best meet the individuals in need of services, targeting interventions to those identified as having the greatest need, working to reduce the administrative burdens associated with treating this population to increase providers willing to join the Contractor's network of providers, targeted prevention efforts on alcohol use and abuse, implementation of several opioid specific interventions including 24/7 Access Points, requesting approval from SAMHSA for childcare services for all members with dependent children, and requesting approval from SAMHSA for the Contractors to be allowed to contract to bring the Oxford House Model to Arizona, and implementing the ASAM CONTINUUM®/AZ WITS.

AHCCCS contracted with FEi Systems and the American Society of Addiction Medicine (ASAM) to procure a web-based platform to access the use of the ASAM CONTINUUM® assessment tools for AHCCCS in order to ensure access to all contractors' Substance Use Disorder (SUD) Treatment Providers. FEi System is the vendor who developed a platform that provides integrations with ASAM CONTINUUM® Assessment Software through FEi Systems' (Web Infrastructure for Treatment Systems) WITS. FEi Systems developed AZ WITS which allows provider to access the ASAM 3rd edition assessment tools to fidelity without having to updated provider's EHR (Electronic Health Record) if it is not compatible. AZ WITS also provides robust reporting to AHCCCS on levels of care selection, health outcomes, cost, and access to care. Due to the volume of contractors, providers, and clinicians statewide as well as the need for ongoing access to AZ WITS training, it is require to have a recorded training by ASAM which can be utilized though ongoing Workforce Development efforts for those who will be conducting assessment through the AZ WITS and utilizing ASAM CONTINUUM® Tools. The AZ WITS is expected to go live for providers on October 1st, 2019.

Additionally, AHCCCS prepares the Uniform Reporting System (URS) tables to provide MHBG demographic and corresponding utilization data to assess service provision, members served, and unmet needs. The data is combined reports from the RBHAs based on their monitoring and reports received from providers serving those with SMI, SED, and ESMI. From the data

available there are few unmet needs identified largely because of the robust integrated care provided through expanded Medicaid services, state general funds, and the MHBG funding available.

Through the recent provision of technical assistance (TA) funds from SAMHSA, AHCCCS identified vendors to assist with the agency's top four current TA needs related to the Substance Abuse and Mental Health Block Grants (SABG and MHBG). These needs were identified based on SAMHSA feedback, agency leadership recommendations, and current service gaps/needs identified by current AHCCCS contractors. The TA needs identified are:

1. **SABG and MHBG** - Data collection through integrated care providers utilizing the Social Determinants of Health ICD-10 codes.
2. **MHBG** - Integration of MHBG Serious Emotional Disturbance (SED) funding into AZ's children's System of Care.
3. **SABG and MHBG** - Allowable activities for suicide prevention/intervention related to individuals eligible for block grant funding.
4. **SABG and MHBG** – Provide assistance to AHCCCS and its contractors with development of standard work policies, protocols and systems to manage and meet SABG and MHBG grant requirements.

These identified vendors are currently working to provide guidance to AHCCCS and its contractors to meet the needs identified above, and to provide possible solutions as applicable. Work on all above priorities is scheduled to finish September 2019.

AHCCCS also relies on the results of data management and numerous qualitative surveys to determine need and directs resources accordingly. Data management on process-related performance measures occurs with contracted providers and partners reporting independent numbers no less than quarterly. The reports are then aggregated by the Division of Health Care Management. Data management and analysis on impact and outcome measures will occur across the partner agencies; including agencies involved in the Opioid Monitoring Initiative. Sending this information to AHCCCS ensures a central location for consistent packaging and reporting to SAMHSA and for public dissemination. In regards to the qualitative surveys, these are critical to identifying potential service gaps. They are able to capture the human component, most notably, the effect a lack of services can have on a community that a quantitative analysis cannot adequately determine. These surveys, as well as other tools for assessing need are used for providing data for the tables on the following pages.

In 2017, Arizona Governor Doug Ducey signed multiple executive orders related to Arizona's fight against the current opioid crisis. A state of emergency was issued in June, 2017 to which enhanced surveillance measures were enacted statewide. The Arizona Department of Health Services (ADHS) has been tasked with the collection and management of opioid related incidence data, including suspected overdoses, suspected deaths due to overdose, rate of Neonatal Abstinence Syndrome (NAS), and number of naloxone doses administered. The executive orders requires those encountering opioid overdose related events to send their data to ADHC within 24-hours of the event, which allows for Arizona health agencies, including AHCCCS, to see almost real time data regarding opioid misuse and abuse throughout the state. In addition to the 24-hour reporting requirements, the Arizona Department of Health Services'

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public health laboratory has begun testing all blood samples from suspected opioid overdose deaths. The toxicology screening will help to bring more information on the kinds of opioids causing severe outcomes in Arizona, and will allow the entire state to prepare almost immediate responses to the opioid issues in the state (https://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/opioid-prevention/index.php). The state of emergency expired in 2018, but the systems put in place by the executive order still stand, and continue to produce quality data for the state for assessing needs and gaps in services.

In regards to AHCCCS' substance abuse prevention system to serve individuals in need of primary substance abuse prevention, some challenges include recruitment, training, and retention of personnel in remote and rural geographic areas. The selection of potential candidates is considerably small compared to urban and/or metropolitan areas. Tribal reservation and rural area prevention specialists are relatively isolated from other communities and rely on limited resources. Prevention specialists collaborate in order to implement the prevention requirements. However, to address these challenges, conference call meetings and webinar trainings are the most used methods to provide technical assistance to the prevention workforce, and to share key information. In the past, a state level credentialing process was in place to monitor and gain a better understanding of prevention specialist capacity, coalition structures, evidence-based practices, prevention cultural issues, and for networking opportunities as well. The data and resources in regards to training the prevention workforce and credentialing the workforce was managed through the statewide AZFP (Arizonans for Prevention), which is no longer in place to provide leadership and advocacy for prevention professionals and members in Arizona. While this entity is no longer in place, AHCCCS continues to develop the workforce through the development of annual prevention training plans and resource guides, and is currently taking steps to begin readying the workforce for the Certified Prevention Specialist (CPS) credentialing through the International Certification and Reciprocity Consortium (IC&RC). AHCCCS is working to achieve this through a tiered approach by contractually mandating Prevention Administrators at the RBHA levels to become credentialed within 18 months from date of hired, or contract start date. AHCCCS is currently working to identify a vendor to provide strategic planning services as the next steps in AHCCCS' progress through the Strategic Prevention Framework (SPF) model. The developed statewide strategic plan will incorporate the information captured and recommendations made from the recently finalized statewide needs assessment (finalized in September 2019) and will involve many state prevention stakeholders.
In addition, during the transition of ADHS/DBHS to AHCCCS the workforce development and turn-over of personnel impacted the prevention system across the state. Relevant and required reporting timelines were modified to accommodate the needs of existing providers and/or programs during the merging period. To address this issue, AHCCCS Prevention System redefined Contractor's deliverables and data reporting expectations which include but are not limited to: conducting an annual regional needs assessment to collect relevant substance use and misuse data in the different geographic service areas; identifying evaluation methods to measure the efficiency of programs for primary prevention and early intervention; and coordinating with AHCCCS Prevention staff biannual site visits to providers.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's **NBHQF**. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at **http://www.samhsa.gov/data/quality-metrics/block-grant-measures**. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

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etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?
   Please indicate areas of technical assistance needed related to this section.

Footnotes:

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

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Footnotes:

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Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$0		$0	$0	$0	$0	$0
a. Pregnant Women and Women with Dependent Children**	$0		$0	$0	$0	$0	$0
b. All Other	$0		$0	$0	$0	$0	$0
2. Primary Prevention	$0		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$0		$0	$0	$0	$0	$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$0		$0	$0	$0	$0	$0
10. Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

NOT FINAL

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$0	$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$0	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$0	$0	$0
7. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$0	$0	$0	$0	$0	$0
9. Administration (Excluding Program and Provider Level)***		$0	$0	$0	$0	$0	$0
10. Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

NOT FINAL

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

NOT FINAL

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	12309	3719
2. Women with Dependent Children	42095	11785
3. Individuals with a co-occurring M/SUD	30659	4242
4. Persons who inject drugs	0	5492
5. Persons experiencing homelessness	14010	8124

NOT FINAL

Please provide an explanation for any data cells for which the state does not have a data source.

There are a section of data like 'Persons who inject drugs,' where the data cannot be collected via claims/encounters data and is collected in a different data source. Because the reporting period is very current, not all data will be reported due to encounter lag time (the time it takes for a provider to submit a claim to a health plan and the health plan adjudicates the claim and sends the encounter to AHCCCS.

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Footnotes:

During the current reporting period (7/1/2018 - 6/30/2019), AHCCCS implemented a major data system change to the data source that was previously used for reporting. This resulted in a complete update to data methodology used for this report, including the addition of data sources (i.e. claims/encounters). We believe this has resulted in more robust data for the population represented in this report.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	
2 . Primary Substance Abuse Prevention	
3 . Early Intervention Services for HIV**	
4 . Tuberculosis Services	
5 . Administration (SSA Level Only)	
6. Total	**$0**

NOT FINAL

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

NOT FINAL

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
	Universal	

NOT FINAL

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
7. Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$0**
Total SABG Award*		**$0**
Planned Primary Prevention Percentage		

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

NOT FINAL

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	
Universal Indirect	
Selective	
Indicated	
Column Total	**$0**
Total SABG Award*	**$0**
Planned Primary Prevention Percentage	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

NOT FINAL

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	☐
Tobacco	☐
Marijuana	☐
Prescription Drugs	☐
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☐
Military Families	☐
LGBTQ	☐
American Indians/Alaska Natives	☐
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☐
Underserved Racial and Ethnic Minorities	☐

NOT FINAL

Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FY 2020 A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems			
2. Infrastructure Support			
3. Partnerships, community outreach, and needs assessment			
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement			
6. Research and Evaluation			
7. Training and Education			
8. Total	**$0**	**$0**	**$0**

NOT FINA

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

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Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FFY 2020 Block Grant
1. Information Systems	
2. Infrastructure Support	
3. Partnerships, community outreach, and needs assessment	
4. Planning Council Activities (MHBG required, SABG optional)	
5. Quality Assurance and Improvement	
6. Research and Evaluation	
7. Training and Education	
8. Total	**$0**

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Footnotes:

NOT FINAL

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

NOT FINAL

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

In October, 2018 Arizona Health Care Cost Containment System (AHCCCS) integrated physical and behavioral health care into seven AHCCCS Complete Care plans across the state in three Geographic Services Areas (GSAs): North, Central, and South. Three of the seven ACC plans were required to align with the three Regional Behavioral Health Authorities (RBHA) and ACC.

The three (3) existing RBHA's serve and provide integrated managed care for persons with serious mental illness (SMI). The ACC plans are required to identify members in need of RBHA services if determined SMI. Grant funding is utilized by individuals with co -occurring mental health and substance use disorders, both titled and non-titled members. Additionally Arizona's American Indian members from twenty-two tribes have unique choices for their care. The American Indian Health Program (AIHP) offers a fee for service program for non SMI American Indian members. American Indian members determined to have SMI are assigned to a RBHA for all services but have a choice of staying with the RBHA or selecting AIHP for physical health services and the RBHA or (when available)Tribal Behavioral Health Authority (TRBHA), for the provision of behavioral health services.
Those determined SMI also may enroll in an ACC plan and TRBHA or opt out to be served by the ACC plan for physical health and the RBHA for behavioral health services. American Indian members can always access services from IHS/638 facilities at any time regardless of enrollment.

The implementation of this new integrated model of RBHAs throughout the state offers opportunities to deliver primary and specialty care along with mental health and treatment in community settings. This model helps to reduce healthcare fragmentation, enhance care coordination as well as broaden accessibility of health care through a more robust network of informed providers.

Each RBHA now has a single provider network for medical, behavioral, and social health services. This strategy has shown to reduced fragmentation of care that existed when service delivery was provided by two distinct program regulators.

Contractors and providers have been encouraged by the direct communication and opportunities this integrated model has offered to blend Medicaid and non-Medicaid funding as new medication, treatment, or training is offered. The integration also offers a comprehensive look at the individuals who request assistance with services beyond medical or behavioral health such as housing, employment, transportation and peer support.

AHCCCS has offered the RBHA's, TRBHA's, ACC plans and their provider networks training and resources for new modalities and

approved medications for the treatment and prevention of opioid, alcohol and other use disorders as member need is identified throughout the state of Arizona. AHCCCS continues to meet and partner with the RBHAs, TRBHAs, ACC plans and other state agency and community programs to address and more formally track social determinants of health. The availability of non-Medicaid funds has enhanced the ability to expand services identified through these efforts.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The goal of AHCCCS is to ensure eligible members are aware of the behavioral health, physical health, and substance abuse disorder services available to them through their RBHA/TRBHA. AHCCCS requires Contractors to collect and analyze data on their providers' ability to offer and deliver urgent care and regularly scheduled services. Providers are also responsible for identifying needs of the member that may impede or facilitate their ability to participate in care. This data is reported to AHCCCS on a quarterly basis. The Division of Health Care Management (DHCM) Office which is comprised of AHCCCS' Clinical Quality Management (CQM), Operations, Data Analysis & Research (DAR), Medical Management, Office of Grants and Project Management and the clinical Resolution Unit (CRU) conducts oversight activities to confirm the data reported is accurate and reliable. DHCM also monitors access to care through its ongoing Network Management and Geo-Mapping activities. These processes allow DHCM to determine the availability of services (by provider type) within the member's geographical area and to ensure contractors are and recruiting for areas where there is a shortage of a specific provider. Contractors are required to report any network changes as soon as they are aware of the change.

AHCCCS meets on a regular basis with the ACC plans, RBHAs, and TRBHAs in order to share program updates and identify any needs, questions or concerns that have not previously been identified. Behavioral and physical health representatives, along with enrollees, family members, and peer support providers sit on the AHCCCS' Medicaid policy committee. This committee offers an opportunity for collaboration as policies are developed and implemented. The Division of Healthcare Advocacy and Advancement) which is responsible for interfacing with members, families, peers, and other community stakeholders.

Healthcare integration, including Medicaid expansion, has challenged the Arizona system of care.
For several years AHCCCS has worked with systems serving youth, young adults and adults as they transition out of correctional facilities. AHCCCS has partnered with the state, county and local agencies responsible for these transitions to create a more efficient and cost effective way to help members transition back to their community. These efforts have improved the recidivism rates among the criminal justice population that includes adults as well as young adults with special needs including those with developmental, physical and behavioral health challenges.

AHCCCS continues to work closely with the Arizona Department of Corrections (ADOC) that includes all Arizona counties covering the majority of the State's population. This is achieved through a data sharing agreement that allows AHCCCS to 'suspend' Medicaid eligibility at the point of incarceration, rather than terminating coverage. The data exchange also allows ADOC and county facilities/programs to send discharge information electronically to behavioral health a provider which simplifies the transition to care process. Through this enrollment suspension process, the contractor representative, county jails or prisons can coordinate care prior to the time of discharge. To support the transition process, all RBHAs are contractually required to have a justice systems liaison to facilitate the connection needed to obtain behavioral health/physical services for the member. Furthermore, AHCCCS's Office of Medical Management coordinates with counties to facilitate transitions into acute health plans for persons discharged with serious physical illnesses that require immediate or ongoing attention, or present potential public health concerns.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ○ No

b) and Medicaid? ○ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ○ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ○ Yes ○ No

b) Health risks such as

ii) heart disease ○ Yes ○ No

iii) hypertension ○ Yes ○ No

iv) high cholesterol ○ Yes ○ No

v) diabetes ○ Yes ○ No

c) Recovery supports ○ Yes ○ No

NOT FINAL

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ○ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ○ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

NOT FINAL

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

- a) Race — Yes / No
- b) Ethnicity — Yes / No
- c) Gender — Yes / No
- d) Sexual orientation — Yes / No
- e) Gender identity — Yes / No
- f) Age — Yes / No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? Yes / No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? Yes / No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? Yes / No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? Yes / No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? Yes / No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Footnotes:

NOT FINAL

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

NOT FINAL

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Arizona Health Care Cost Containment System (AHCCCS) has introduced multiple Differential Adjusted Fee Schedules to distinguish providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. AHCCCS has published the following documents for reference:

1. AHCCCS Differential Adjusted Payment (DAP) Activity CYE 2020 Final Public Notice Originally Posted April 30, 2019
Purpose: AHCCCS is providing the following Differential Adjusted Payment decisions: For the contracting year October 1, 2019 through September 30, 2020 (CYE 2020), select AHCCCS-registered Arizona providers which meet agency established performance criteria will receive Differential Adjusted Payments (DAP). The AHCCCS Administration is implementing these DAP rates to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic
area.https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/FinalNoticeOfPublicInformationDifferentialAdjustedPaymentsEffectiveOctober_1_20
-September_30_2020_DatesOfService.pdf

2. AHCCCS Contractor Operations Manual/Chapter 300 Finance/ 306 – Alternative Payment Model Initiative – Withhold and Quality Measure Performance Incentive
Purpose: This Policy applies to all Acute Care and ALTCS/EPD Contractors. The purpose of the AHCCCS Alternative Payment Model (APM) Initiative – Withhold and Quality Measure Performance (QMP) Incentive is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings by aligning the incentives of the Contractor and provider through APM strategies.
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/306.pdf
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/306_A.xlsx

3. AHCCCS Contractor Operations Manual/Chapter 300 Finance/307– Alternative Payment Model Initiative – Strategies and Performance-Based Payment Incentive
Purpose: This Alternative Payment Model (APM) Initiative - Strategies and Performance-Based Payments Incentive Policy applies to Acute Care, Arizona Long Term Care System Elderly and Physical Disability (ALTCS/EPD), Children's Rehabilitative Services (CRS), Regional Behavioral Health Authority (RBHA), ALTCS Division of Economic Security/Developmental Disabilities (DDD) Contractors and DDD Sub-Contractors. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through APM strategies.
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/307.pdf
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/307_A.pdf

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4. Regional Behavioral Health Contracts

Purpose: A Contract entered into by and between the Regional Behavioral Health Authority and the Arizona Health Care Cost Containment System (AHCCCS). Reference pages 167-174.

https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/MMIC_Amd-9_10-1-18_Final.pdf

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

Footnotes:

NOT FINAL

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ○ Yes ◉ No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? ◉ Yes ○ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Arizona's evidence-based practices for ESMI / FEP programs engage members in an array of recovery-oriented services including, but not limited to psychotherapy, family education/support, medication management, individual and/or group therapy, case management, social interaction, supportive education, supportive employment, acute care services, and supportive housing. Further, these programs provide evidence-based, intensive, stage-specific treatment and wrap-around services for adolescents and young adults (aged 15-35) experiencing the early stages of a psychotic illness. Programs focus on inter-professional integration, patient-centeredness and population health orientation.
AHCCCS currently supports three full service Early Psychosis Intervention Centers (EPICenters): Resilient Health (formerly IMHS) EPICenter in Phoenix, the Maricopa Integrated Health System (MIHS) in Avondale, and the Banner EPICenter in Tuscon. EPICenters follow the Dr. Nicholas Breitborde model in early intervention strategies. These programs are modeled from the RAISE project and incorporate CSC components in their programs.

NAVIGATE program and OnTrack program studied through RAISE, and components of the Coordinated Specialty Care

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(CSC) model. Connections Access in Tuscon is now implementing The REACH program, an FEP program that provides post-crisis support, education, therapy, medication management, peer and family support and education, and support in the community. AHCCCS also is supporting five health homes which are implementing the Fast Forward Program (based upon the RAISE Early Treatment Program and closely mirrors CSC). Each health home has identified at least one case manager, nurse, and Behavioral Health Medical Practitioner (BHMP) to compile an FEP team that implements evidence-based practices to serve to members with FEP.

Programs throughout Arizona are also utilizing Cognitive Remediation Therapy, Cognitive Enhancement Therapy (CET), Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), recovery coaching, peer support, individual, group and family therapy, medication treatment, and school and employment supports to treat and support members with FEP.

Lastly, AHCCCS supports National Alliance on Mental Illness – Southern Arizona (NAMI-SA) to provide the Ending the Silence and Text, Talk, Act trainings to schools across Arizona. This is a two-part 50-minute training that educates young people, teachers, school counselors and school staff about mental illness, signs of mental illness, and opens a dialogue of mental illness to aid in decreasing stigma and engage young people in seeking assistance early on in the illness process.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Arizona's behavioral health system has transitioned to an integrated model to include combined behavioral and medical care. In addition, Arizona has undergone an administrative simplification and transitioned to contract with three Regional Behavioral Health Authorities (RBHAs) to cover the three main Geographic Service Areas (GSAs). ESMI / FEP services have been established in all three GSAs and are being promoted by each RBHA through social media campaigns, video marketing and by educating providers on the services available to eligible members. As part of the Health Home model with RBHAs, FEP services will coordinate when necessary with acute care, supportive and assertive community treatments.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? (●) Yes ( ) No

5. Does the state collect data specifically related to ESMI? (●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ( ) Yes (●) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Arizona's evidence-based practices for ESMI / FEP programs engage members in an array of recovery-oriented services including, but not limited to psychotherapy, family education/support, medication management, individual and/or group therapy, case management, social interaction, supportive education, supportive employment, acute care services, and supportive housing. Further, these programs provide evidence-based, intensive, stage-specific treatment and wrap-around services for adolescents and young adults (aged 15-35) experiencing the early stages of a psychotic illness. Programs focus on inter-professional integration, patient-centeredness and population health orientation.

AHCCCS currently supports three full service Early Psychosis Intervention Centers (EPICenters): Resilient Health (formerly IMHS) EPICenter in Phoenix, the Maricopa Integrated Health System (MIHS) in Avondale, and the Banner EPICenter in Tuscon. EPICenters follow the Dr. Nicholas Breitborde model in early intervention strategies. These programs are modeled from the RAISE project and incorporate CSC components in their programs.

Additional evidence-based practices implemented in Arizona for FEP include several evidence-based components of the NAVIGATE program and OnTrack program studied through RAISE, and components of the Coordinated Specialty Care (CSC) model. Connections Access in Tuscon is now implementing The REACH program, an FEP program that provides post-crisis support, education, therapy, medication management, peer and family support and education, and support in the community. AHCCCS also is supporting five health homes which are implementing the Fast Forward Program (based upon the RAISE Early Treatment Program and closely mirrors CSC). Each health home has identified at least one case manager, nurse, and Behavioral Health Medical Practitioner (BHMP) to compile an FEP team that implements evidence-based practices to serve to members with FEP.

Programs throughout Arizona are also utilizing Cognitive Remediation Therapy, Cognitive Enhancement Therapy (CET), Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), recovery coaching, peer support, individual, group and family therapy, medication treatment, and school and employment supports to treat and support members with FEP.

Lastly, AHCCCS supports NAMI-AZ to provide the Ending the Silence and Text, Talk, Act trainings to schools across Arizona. This is a two-part 50-minute training that educates young people, teachers, school counselors and school staff about mental illness, signs of mental illness, and opens a dialogue of mental illness to aid in decreasing stigma and engage young people in seeking assistance early on in the illness process.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

Regional Behavioral Health Authorities are currently in the process of submitting their program budgets and descriptions to AHCCCS for next year's MHBG allocations.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for

NOT FINAL

ESMI.

AHCCCS contracts with the RBHAs to collect and report data regarding ESMI / FEP programs and the impact of the 10 percent set aside. The RBHAs collect data from each clinical setting where an FEP / ESMI program is implemented. All data requested is in line with that which SAMHSA has requested. Additionally, RBHAs monitor monthly reports from FEP / ESMI clinics and look for the following reported outcomes: reduce emergency room contacts, reduce inpatient admissions, and improve personal tracking of mood disturbances, physical activity, social activity, thought disturbance and self-reflection activities such as journaling.

RBHA reports to AHCCCS also may include family functioning/relationships, social functioning, symptoms, satisfaction with services, school or work engagement/achievement, living situation, medication adherence, demographics and utilization of services.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Diagnostic criteria for the ESMI / FEP programs include the following: adolescents and young adults age 15-25, any ICD10 or DSM-5 diagnosis description that contains “psychosis” or “schizophrenia”. Exclusionary criteria include substance-induced psychosis, medically induced psychosis, and/or any significant MR/cognitive disorders (on a case by case basis determined by the treatment team).

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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Footnotes:

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Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person?s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person?s needs and desires.

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Arizona Health Care Cost Containment System (AHCCCS), Office of Individual and Family Affairs (OIFA) within the Division of Community Advocacy & Intergovernmental Relations (DCAIR), promotes recovery, resiliency and wellness for individuals with mental health and substance use challenges and their families. OIFA builds partnership with individuals, families, youth, communities, organizations and key stakeholders.

OIFA in partnership with the community, advocate for the development of environments that are welcoming to individuals and families; establish structures to promote diverse youth, family and individual voice throughout Arizona; ensure peer support and family support are available to all persons receiving services and their families; and deliver various presentations and trainings in the community. Also, through contract requirements, AHCCCS each Managed Care Organization (MCO) hires an Individual and Family Affairs Administrator to help fulfill a similar role on a local level.

In addition, AHCCCS works to incorporate language into state policy intended to codify the concept of member driven care based on the specific needs, strengths, culture, and preferences of consumers and their families.

AHCCCS provides clinical guidance around family and youth involvement with the Clinical Practice Tools “Family and Youth Involvement in the Children’s Behavioral Health System” and “Youth Involvement in the Children’s Behavioral Health System”. These tools provide examples of best practices for family and youth involvement in our System of Care.

4. Describe the person-centered planning process in your state.

In Arizona, Person Centered Planning (PCP) is the planning process most commonly associated with and utilized in the Division of Developmental Disabilities. However, for both adults and children, we use planning processes based on the same principles as PCP.

In the children’s behavioral health system, Arizona utilizes Child and Family Team (CFT) practice, which is a child/youth centered and family driven planning process closely resembling “Wraparound”. In the early 2000’s, Arizona contracted with national Wraparound experts such as John VanDenBerg to train the workforce and transform the Children’s System of Care towards a more person centered, strengths based approach. As part of this transformation, Arizona developed Clinical Practice Tools outlining the State’s expectations around the planning practice in our children’s behavioral health system. In addition to the Practice Tool already mentioned these Tools include “Child and Family Team Practice,” and “Transition to Adulthood,” along with other Practice Tools, are embedded in our contracts with the Managed Care Organizations (MCOs) responsible for delivering health care to Arizonans.

The adult behavioral health system has a similar process based on the needs, strengths, goals, and preferences identified by the Adult Recovery Team (ART). The member centered planning process for both populations is described in AHCCCS Medical Policy Manual (AMPM) Policy 320-O, Behavioral Health Assessments and Treatment/Service Planning. The ART adheres to the 9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems to ensure the planning process is person centered and guided by the member and/or family. The team is facilitated by behavioral health staff responsible for working with the member to identify who the member would like to participate on the Team. This may include family, friends, advocates or anyone

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else the member and/or their representative wants to participate. The team then develops an individualized service plan based on the member/family needs, strengths, goals and preferences, and then arranges the services decided upon by the ART.

To support the processes described above, the AHCCCS Covered Behavioral Health Services Guide (CBHSG), describes an overview of a comprehensive array of covered behavioral health services to assist, support and encourage each eligible person to achieve and maintain the highest possible level of health and self-sufficiency.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section

Technical assistance is not being requested at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state?s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

The Arizona Health Care Cost Containment System (AHCCCS) Tribal Consultation Policy requires that the state agency engage in open, continuous, and meaningful dialogue with tribal nations within the state on an ongoing basis. AHCCCS is committed to working with Indian Tribes to improve the quality, availability, and accessibility to care by eliminating barriers for American Indians in Arizona. As such, the agency goes beyond the current AHCCCS Tribal Consultation Policy requirement of engaging in tribal consultation on an annual basis by holding tribal consultations at least once per quarter every calendar year. Indeed, AHCCCS held eleven tribal consultation sessions with federally-recognized tribes throughout the state during calendar year 2018 and through July 2019. Additionally, AHCCCS meets separately with Indian Health Service (IHS) leadership for consultation on a quarterly basis. AHCCCS met with IHS leadership six times for consultation during calendar year 2018 through July 2019. More information can be found at https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html.

2. What specific concerns were raised during the consultation session(s) noted above?

There were several areas of discussion or concern covered at the consultation meetings throughout the year including: the physical and behavioral health care coordination for tribal members; non-emergency transportation services; pharmacy benefits; State Plan Amendment, including traditional healing, dental benefits, and differential adjusted payments; 1115 waivers, including AHCCCS works/community engagement requirement and prior quarter coverage; housing; funding and payment details; Indian Health Services (IHS) 638 funding; Value Based Purchasing; legislative actions; best practices; and policy implications. In addition, requests were made for better and more coordinated communications between the state agency and tribal nations, including tribal-specific FAQs and resources from AHCCCS. Also, a handful of tribal leaders have requested more tribal-specific government-to-government conversations between AHCCCS leadership and tribal council or executive leadership be part of the ongoing tribal consultation process.

3. Does the state have any activities related to this section that you would like to highlight?

NOT FINAL

In addition to Tribal Consultation, AHCCCS holds quarterly meetings with the Tribal Regional Behavioral Health Authorities (TRBHAs). In State Fiscal Year (SFY) 2019, there were three meetings conducted, and one conducted thus far for SFY 2020. The Tribal Regional Behavioral Health Authorities (TRBHAs) continue to be actively involved in partnering with AHCCCS programmatic staff and the Regional Behavioral Health Authorities (RBHAs) programmatic staff in regular meetings and conference calls to coordinate the efforts of substance use disorder prevention and treatment services. The State has identified a process for which the TRBHAs and RBHAs can request additional block grant dollars, should they be needed, and this process has been clearly communicated to them as well as posted to the AHCCCS website. AHCCCS has also implemented its American Indian Medical Home Program for IHS/638 facilities for enhanced primary care case management and care coordination.

AHCCCS leadership and the agency Tribal Relations Liaison regularly engage in government-to-government and tribal community-specific conversations and discussions. Topics of discussion at the tribal government level include clarification on Memorandums of Understanding, geographic service area clarifications, and specific issues related to the community regarding AHCCCS services and accessibility.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [x] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [ ] Adults (ages 27-54)
- [ ] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [x] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

NOT FINAL

- [ ] Archival indicators (Please list)

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [x] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

Arizona Health Care Cost Containment System (AHCCCS) recently finalized an updated statewide needs assessment (September 2018) that has begun informing prevention needs throughout the state. Utilizing an outside vendor, AHCCCS collected information using the following goals to inform all assessment related efforts: develop and implement the needs assessment approach and evaluation plan, generate a community prevention inventory, conduct focus groups throughout AZ, conduct key informant interviews throughout AZ, conduct an online Substance Use Prevention Workforce survey, and synthesize secondary data analysis for a multitude of data sources. The four questions the needs assessment addressed were;

1. What are the current substance use issues in AZ by region and subpopulation?
2. What substance use prevention programs are active in AZ?
3. What are the causes for using and/or abusing substances in AZ?
4. What are the recommendations for the future of substance use prevention in AZ?

Results of the needs assessment highlighted areas currently being addressed in future prevention service delivery planning by AHCCCS staff. Findings included the following items: there is a lack of resources to address untreated mental health concerns, health disparities facing the LGBTQ population, reductions in local funding for prevention activities, and the unintended consequences of recent efforts to combat the prescription drug opioid crisis in AZ are leading to increased street drug use are being addressed through various strategies. AHCCCS is addressing these findings through the exploration and identification of additional prevention funding sources, the increased utilization of prevention interventions with dual outcomes in both mental health and substance use and the education of those available interventions, increased collaborations statewide within other agencies or entities that can lead to more effective state funding spending, and meeting with agency level decision makers to begin discussions regarding current substance abuse prevention system structure and recommendations for improvement. AHCCCS has begun making more immediate changes to the SABG funded prevention system by revising the SABG primary prevention funding contracts to be more prevention science based through the use of certain documents such as logic models and mandating basic prevention trainings, as well as providing more structure to the prevention system. This will be achieved by contractually mandating the use of AHCCCS developed templates for deliverables across all prevention contractors, and contractually mandating the use of Evidence Based Prevention Practices (EBPs) as defined by AHCCCS. These contract changes go into effect on October 1, 2019.

The Substance Use Prevention Workforce survey gave AHCCCS very insightful data regarding the issues that are currently affecting our prevention workforce. Many individuals reported not receiving prevention related training as often as they need/want, to which AHCCCS developed statewide training plan in conjunction with the Pacific Southwest Prevention Technology Transfer Center (PTTC). This training plan will give the prevention workforce a resource document that includes many online and in person training opportunities, as well as allow AHCCCS to concisely plan out an entire year of trainings, with topics such as Selecting Evidence Based Strategies, and Prevention Basics/Substance Abuse Prevention Skills Training (SAPST).

AHCCCS also uses RBHAs local data related to substance use prevalence, morbidity, mortality and suicide in the assessment. The data used is no older than three years so it is representative of the current local needs. The community needs and resource assessment contains information gathered about conditions within Arizona communities and is used to develop strategic prevention programs. Within the regions, providers and T/RBHAs conduct community needs and resource assessments for the purpose of developing programs, which meet the needs of communities, geographic service areas, and the state. Assessing the community's needs and resources is an essential step in community change. Performing needs assessments reveals patterns of substance abuse, related consequences, causal factors, as well as a community's current resources for making change.

The needs assessment informs the selection of a target population and development of program's goals and objectives. Target populations are selected by considering which populations have the highest need (as indicated by high prevalence of risk factors, low prevalence of protective factors) and comparing that to resources available to that population (existing programs, grants, other agencies). The needs and resource assessments are conducted using a number of methods such as gathering of social indicator data, key informant interviews, focus groups, surveys, and/or public forums. During the needs assessment process, community members function as resources that inform the development of the program.

NOT FINAL

If no, (please explain) how SABG funds are allocated:

N/A

NOT FINAL

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? ○ Yes ◉ No

If yes, please describe

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? ◉ Yes ○ No

If yes, please describe mechanism used

Arizona Health Care Cost Containment System (AHCCCS) is committed to advancing Arizona's Prevention System. AHCCCS is in the process of developing a statewide prevention training plan and resource guide for the statewide prevention workforce. AHCCCS is in regular communication with Arizona's designated Prevention Technology Transfer Center (PTTC) to inform the state of upcoming trainings and technical assistance opportunities, as well as discuss statewide training needs that the PTTC can help address. Additionally, each Contractor is encouraged to designate a lead prevention administrator who will serve as the primary liaison to AHCCCS. Each prevention contract requires the allocation of funding to provide training and technical assistance as required for the substance use prevention workforce development. Technical assistance is crucial to implement prevention programs successfully, which includes evidence based programs, Culturally and Linguistically Appropriate Services (CLAS) standards training to address substance use disorder in a culturally appropriate manner. In addition, educational materials are available in the preferred language of members and include examples pertaining to members' culture. Any curricula used are culturally appropriate and responsive to members.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ◉ Yes ○ No

If yes, please describe mechanism used

The AHCCCS funded prevention system follows the Strategic Prevention Framework (SPF) model, which includes the development and implementation of a statewide needs assessment at least every 3-5 years. The most recent Needs Assessment, finalized in September 2018, included a community readiness assessment that allowed AHCCCS to see the state's capacity to address current prevention needs on a large scale. Additionally, AHCCCS ensures RBHAs perform a community readiness assessment to determine workforce capacity and the level of community readiness to implement appropriate strategies. The assessment at the community level needs to identify and address those factors contributing to substance use problems. Prevention efforts are purposefully designed to meet the communities' needs.

NOT FINAL

Narratve Question

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Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

Arizona Health Care Cost Containment System (AHCCCS) will engage in a competitive bidding process to locate a vendor to develop and oversee the logistics of Arizona's new strategic planning process. Once selected, this vendor will work closely with AHCCCS prevention staff to develop an updated Strategic Plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ◉ Yes ○ No ○ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component
- **g)** ☑ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ○ Yes ◉ No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

AHCCCS is currently in the process of developing criteria for the Arizona Evidence-Based Workgroup. This is being achieved by utilizing an existing substance abuse prevention specific workgroup of the Arizona Substance Abuse Partnership (ASAP) for recommendations, as well as utilizing the National Prevention Network Representatives to inquire as to other state's EBP workgroup structures. AHCCCS has also located documents from a previous iteration of the AZ EBP Workgroup, and is currently updating these as appropriate for future use.

NOT FINAL

NOT FINAL

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Type of Activities: some of the programs providing Information Dissemination in Arizona include but are not limited to clearinghouse/information resource centers; resource and referral directories; media campaigns; educational brochures; TV/ Radio and Public Service Announcements (PSAs); newsletters; public and schools speaking engagements; health fairs and health related campaigns. Another important strategy is announcing coalition's activities at local public events and on Tribal Regional Behavioral Health Authorities and Regional Behavioral Health Authorities' events calendars. In addition, the use of social media promoting prevention for alcohol and other drug use target youth and high risk populations on Facebook, Instagram, Twitter, and media magazines to learn more about healthy choices, and to support information dissemination across the state.

b) Education:

Type of Activities: the following educational strategies implemented by Tribal Regional Behavioral Health Authorities and Regional Behavioral Health Authorities and providers including but not limited to conferences, classroom, and/or small group assemblies for all ages; parenting and family classes; peer leader/health aid programs; and education programs for youth and children about substance use prevention. The primary focus for the education programs is to decrease youth use of alcohol, marijuana, and other drugs use in Arizona. Additionally, research based curricula are implemented to reinforce the perception of harm for marijuana use among youth. Some of the curricula include, Stand with Me, Be Drug

NOT FINAL

Free ®; Keep a Clear Mind ®, Marijuana, What do you Know? ®; Marijuana Harmless? Think Again! ®; Head's Up Marijuana ®; or Drugs and the Body ®.

c) Alternatives:

Type of Activities: Tribal Regional Behavioral Health Authorities and Regional Behavioral Health Authorities providers focus on creating opportunities to develop healthy families and drug free communities using activities such as: coordination of drug free events and parties, youth/adult leadership activities, community drop-in centers, and community service activities. Alternative methods help engage family involvement in programs focused on empowering parents with skills to make safe and healthy decisions for their children and families. Some examples include activities to celebrate Dia del Nino (Children's Day), 4th of July, and other memorable holidays without alcohol, tobacco, and other drugs.

d) Problem Identification and Referral:

Types of Activities: includes employee assistance programs; student assistance programs; and driving while under the influence/driving while intoxicated education programs. Some of the prevention efforts in Arizona include, but are not limited to increasing the participation of youth with a diagnosis of Substance Use Disorder (SUD) in an outpatient services;implementing programs including education, referrals, and monitoring for reduction of drug use in the Geographical Service Agencies (GSAs); collaborations established to coordinate with community providers and share information on SUD data, screenings, trends, and services available.

e) Community-Based Processes:

Types of Activities: coalition building in high need communities, community and volunteer training, e.g., neighborhood action training, training of stakeholders in the system, staff/officials training; systematic planning; multi-agency coordination, collaboration of service providers and funders, and community team-building. A variety of evidenced based strategies are implemented in Arizona to support prevention efforts in the community including, but not limited to: local community-based youth substance abuse prevention coalitions; Community Anti-Drug Coalitions of America (CADCA), a sector-based model of membership recruiting; and applying the Strategic Prevention Framework to make data-driven decisions regarding the local populations and the needs reflected in the needs assessments.

f) Environmental:

Types of Activities: promoting the creation and review of alcohol, tobacco, and other drug use policies in schools; technical assistance aimed to assist communities to improve local enforcement procedures governing readiness and distribution of alcohol, tobacco, and other drug use; transforming alcohol and tobacco advertising practices; and product pricing strategies. These activities occur in a variety of settings and locations throughout the state.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

AHCCCS currently collaborates very closely with many other state agencies and entities to ensure there is communication regarding which primary prevention services are being funded and implemented throughout the state. This is done to ensure there is no service duplication, and the partnerships also allow AHCCCS to gather information regarding any gaps and additional needs in services throughout the state. AHCCCS is also aware of the location and strategies of current Drug Free Communities (DFC) coalitions throughout the state to address this as well. Through contracted prevention deliverables, AHCCCS has access to RBHA and contracted RBHA provider logic models and other deliverables that allow AHCCCS state staff to see which activities are being conducted in each part of the state, at both a regional and local community level. In addition, AHCCCS' use of the Strategic Prevention Framework (SPF) model allows for comprehensive state wide assessment of prevention needs, resources, and capacity that helps AHCCCS identify gaps, duplications, and other prevention needs statewide.

NOT FINAL

Narratve Question

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1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

As part of Arizona Health Care Cost Containment System (AHCCCS) current progress through strategic planning and in keeping with the Strategic Prevention Framework (SPF) model, AHCCCS will develop an evaluation plan as part of this process. AHCCCS will also be developing other state wide documents such as logic models and action plans, which will help develop evaluation activities statewide. AHCCCS' contract RBHAs and RBHA prevention providers will also develop logic models and other related prevention documents that will allow a greater focus on proper evaluation activities for local and regional prevention activities, as well as enhance the state's ability to provide oversight and monitoring of prevention activities. Although AHCCCS does not have a current evaluation plan, ongoing monitoring and evaluation efforts are essential in deciding whether or not other established goals are met and anticipated outcomes achieved. Evaluation is indispensable to the assessment of program effectiveness and quality of program implementation. The evaluation efforts identify areas for improvement and endorse the sustainability of effective policies, programs, and practices. Current program evaluations measure both processes and outcomes. Practical evaluations provide feedback that encourages programs and communities to augment their efforts to determine where interventions are successful and to modify or eliminate unsuccessful efforts. Outcome evaluations measure changes in member perceptions, attitudes, knowledge, behaviors, and risk or protective factors.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented

NOT FINAL

- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use
- ☑ Binge use
- ☑ Perception of harm
- **c)** ☑ Disapproval of use
- **d)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **e)** ☐ Other (please describe):

NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Arizona Health Care Cost Containment System (AHCCCS) has an array of covered behavioral health services defined in a continuum of service domains. The individual domains are:
Treatment Services: Treatment services are provided by or under the supervision of behavioral health professionals to reduce symptoms and improve or maintain functioning. These services are grouped into three subcategories:
• Behavioral Health Counseling and Therapy,
• Assessment, Evaluation and Screening Services, and
• Other Professional.

Rehabilitation Services: Rehabilitation services include the provision of educating, coaching, training, and demonstrating skills. Other services include securing and maintaining employment to remediate residual or prevent anticipated functional deficits. Rehabilitation services include: life skills training, cognitive rehabilitation, health promotion, and ongoing support to maintain employment.

Medical and Pharmacy Services: Medical professionals provide medical services, which may include services ordered by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a person's symptoms, improve or maintain functioning, and promote or enhance recovery from addiction. These services have been further grouped into four subcategories:
• Medication, Laboratory,
• Radiology and Medical Imaging,
• Medical Management (including medication management), and
• Electroconvulsive Therapy (ECT).

Support Services: Support services enhance the rehabilitative benefit received from other behavioral health services. These services grouped into the following categories, are as follows: Case Management, Personal Care Services, Home Care Training Family Services (Family Support), Self-Help/Peer Services (Peer Support), Home Care Training to Home Care Client (HCTC), Unskilled Respite Care, Supported Housing, Sign Language or Oral Interpretive Services, Non-Medically Necessary Covered Services, Transportation, and Child Care (Block Grant Priority Population).

Crisis Intervention Services: Crisis intervention services are available to all Arizonans for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention is available over the phone or in a variety of settings. These intensive and time limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce, or eliminate a crisis situation.

Behavioral Health Day Programs: Behavioral health day programs are services scheduled on a regular basis either hourly, half day, or full day, and may include services such as therapeutic nursery, in-home stabilization, after school programs, and specialized outpatient substance abuse programs. These programs are provided to a person, group of individuals, and/or families in a variety of settings. Based on the level/type of staffing, day programs are grouped into the following three subcategories:
• Supervised,
• Therapeutic, and
• Psychiatric/Medical.

Prevention Services: Prevention services promote the health of persons, families, and communities through education,

NOT FINAL

engagement, service provision, and outreach. These services may involve:
• Implementation of strategic interventions to reduce the risk of development of and/or emergence of behavioral health disorders, increase resilience and/or promote and improve the overall behavioral health status in targeted communities, and among individuals, and families;
• Education to the general public on improving their mental health and to general health care providers as well as other related professionals on recognizing and preventing behavioral health disorders and conditions;
• Identification and referral of persons and families who could benefit from behavioral health treatment services.
Prevention services should target conditions identified in research related to the on-set of behavioral health problems and be provided based on identified risk factors, the extent the problem occurs in the community or target group, identified community needs, and service gaps. Prevention services should target communities, neighborhoods, and audiences who are at higher risk for developing behavioral health disorders.

These services, generally provided in a group setting or public forum, are intended for individuals and families who are not enrolled or involved in the AHCCCS behavioral health treatment system and who do not have a diagnosable behavioral health disorder or condition. Prevention services are not for individuals and family members requiring treatment interventions or for family members of an enrolled member.

Inpatient Services: Inpatient services (including room and board), inpatient detoxification, and treatment services delivered in hospitals, and sub-acute facilities, including residential treatment centers that provide 24-hour supervision, an intensive treatment program, and on-site medical support services.

Residential Services: Licensed behavioral health agencies provide residential services. These agencies provide a structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Through Arizona's Child and Family Team (CFT) Practice, AHCCCS requires behavioral health staff coordinate with the school system to ensure all students eligible for Medicaid receive appropriate, medically necessary services based on the child and family's needs, strengths, goals and preferences. This is done regardless of the child's eligibility under Individuals with Disabilities Education Act (IDEA), however it is perhaps more likely a child with disabilities, especially emotional disabilities, will be enrolled in the AHCCCS behavioral health system and receiving services. For children with an Individualized Education Program (IEP), it is our expectation that the behavioral health provider participate on the child's IEP team (with parental approval) and coordinate to ensure the child is receiving the appropriate behavioral health and educational services.

3. Describe your state's case management services

Arizona contracts with the Tribal and Regional Behavioral Health Authorities (T/RBHAs) and AHCCCS Complete Care plans for oversight and monitoring of the State's behavioral health services. In each contract Case Management is defined as a collaborative process which assess, plans, implements, coordinates, monitors, and evaluates options, and services to meet an individual's health needs through communication and available resources to promote quality, cost – effective outcomes.

Case Management is a service available to all enrolled members within the AHCCCS Behavioral Health system. Case Management can be billed by any appropriately credentialed staff member. In the Adult System eachplan has developed policies and procedures

NOT FINAL

that are clinically appropriate for each level of intensity. Policies and procedures differ from individuals diagnosed with a Serious Mental Illness versus General Mental Health/Substance Abuse. Each RBHA has implemented delivery programs for members with Serious Mental Illness (SMI) consistent with Substance Abuse and Mental Health Services Administration's (SAMHSA) Assertive Community Treatment (ACT) teams statewide. The RBHAs monitor the teams to fidelity to the service delivery programs annually using the AHCCCS adopted measurement instrument.

In addition, AHCCCS has mandated in contract that certain categories of children be assigned and served by an identified case manager. Children age 6-18 are assigned a High Needs Case Manager (HNCM) if they score a 4, 5, or 6 on the Child and Adolescent Service Intensity Instrument (CASII). This tool is administered to each youth, age 6-18, when they are enrolled in behavioral health services and then annually thereafter. Children birth to 6 are assigned a HNCM based on a number of characteristics, including involvement in Arizona's Child Welfare system or Division of Developmental Disabilities (DDD), and being prescribed multiple psychotropic medications. AHCCCS stipulates these HNCMs have no more than 20 children on their caseload unless sibling groups are being served. If sibling groups are being served, it is allowable to have up to 25 children per HNCM. The HNCMs are responsible for facilitating Child and Family Team (CFT) practice which includes the creation of Strengths, Needs, and Cultural Discovery (SNCD), as well as the development of an Individualized Service Plan (ISP), based on the SNCD.

Arizona defines case management as a supportive service provided to enhance treatment goals and effectiveness within the Covered Behavioral Health Service Guide (CBHSG). Activities may include:
1. Assistance in maintaining, monitoring and modifying covered services;
2. Brief telephone or face-to-face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person's functioning;
3. Assistance in finding necessary resources other than covered services to meet basic needs;
4. Communication and coordination of care with the person's family, behavioral and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies;
5. Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services and family counseling);
6. Outreach and follow-up of crisis contacts and missed appointments;
7. Participation in staffings, case conferences or other meetings with or without the person or their family participating; and
8. Other activities as needed.

4. Describe activities intended to reduce hospitalizations and hospital stays.

AHCCCS requires their Contractors and their provider contractors to have policies, procedures, and processes in place regarding the utilization of hospital services for the integrated health care in Arizona. Providers are required to create and implement procedures that review medical necessity prior to a planned admission and for determination of the medical necessity for ongoing hospitalization. RBHAs and providers are able to review all requirements and guidelines the AHCCCS Medical Policy Manual (AMPM). Policies and procedures that are currently in place address concurrent review, prior authorization, service authorization, discharge planning, clinical practice guidelines, unsuitable emergency department use, care coordinator/case management, and disease/chronic care management.

The concurrent review procedures must include relevant clinical information for making hospital length of stay decisions, along with specific timeframes and frequency for conducting reviews. The review must include, but is not limited to necessity of admission and appropriateness of the service setting, quality of care, length of stay, if services meet the needs of the member, discharge needs, and utilization pattern analysis. Documentation must describe proactive discharge planning. All concurrent reviews, prior authorizations, and service authorizations are to be conducted by an interdisciplinary team of Arizona licensed staff including nurses, physicians, pharmacists or behavioral health professionals with appropriate training. When appropriate, retrospective reviews are completed.

Contracted providers must have policies and procedures in place that manage the process for proactive discharge planning. The purpose of the policies and procedures are to provide structure for the management of inpatient admissions, ensure discharge needs are met, and decrease readmissions within 30 days of discharge. Post discharge services procedures must include plans for follow up appointments with the PCP or specialist within 7 days, prescription medications, referrals to appropriate community resources, and a follow up call to the member within three business days to confirm well-being and progress of the discharge plan.

Evaluation of clinical practice guidelines must occur annually by a multidisciplinary team to ensure they reflect best practices and current integrated health care standards. Additionally, evaluation of the efficacy of the guidelines themselves must be completed annually.

Providers must establish processes and procedures for Care Coordination/Case Management and Disease/Chronic Care Management. Coordination is defined as meeting the member's needs across the continuum of care based on identification of strengths, risk factors, and needs. Disease/Chronic Care Management focuses on members with high risk and/or chronic conditions. The goal for Care Management is to increase the member's ability to provide self-care and improve practice patterns of providers in order to decrease hospital stays.

NOT FINAL

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	60522	0.84
2.Children with SED	83026	1.16

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The process used to calculate prevalence and incidence rates is to determine the number of members served who meet the designation requirements of SMI or SED, and then compare those numbers to the population of the state. The members served are determined through standardized reporting based on expenditure and demographic data. The prevalence and incidence rates are used for allocation of resources throughout the state and in structuring service provision.

NOT FINAL

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

NOT FINAL

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

Arizona Health Care Cost Containment System (AHCCCS) funding and services are responsible for covering the geographic area and all populations of Arizona including rural areas. As noted above, AHCCCS contracts with RBHA's to cover over 1 million Arizonans throughout the state including rural areas and tribal areas. For the purposes of RBHA coverage, Arizona is divided into three Geographic Service Areas (GSAs) to serve the unique needs of each region of the state. While all three GSAs include rural areas, the Northern and Southern GSAs include most of the rural counties and regions characterized by low general population and population densities. A significant portion of Arizona's geography consists of reservation and tribal lands and similar to the RBHA structure, there are four Tribal Regional Behavioral Health Authorities (TRHBAs) that fulfil similar roles for their designated tribal groups. Each of these groups is responsible under contract with AHCCCS to establish a service network that meets the contractual requirements for all RBHA's while allowing the RBHA or TRHBA to address the specific needs of their GSA including delivery of services in a rural context.

Homeless coordination is one way in which the RBHA/TRBHA structure meets the needs of rural communities and how collaboration and coordination with other systems have directly improved care and services for members in rural areas. By including RBHAs and their network of clinics, services and housing programs in HMIS as access points in the Balance of State CoC (BoSCoC covers the 13 rural counties of Arizona) Coordinated Access system, homeless outreach and engagement are now provided in a number of rural counties that previously had no access strategy due to the lack of dedicated homeless programs, shelters or outreach teams in rural areas covered by AHCCCS. Similarly, rural communities and counties in Arizona may also apply for PATH grants administered by AHCCCS. In the last award round, PATH coverage was expanded to two rural counties. In the upcoming PATH RFP process, emphasis on expansion of PATH in rural counties will again be included in the solicitation.

b. Describe your state's targeted services to the homeless population.

Like many communities in the United States, Maricopa County and many AZ counties have been impacted by the affordable housing crisis and homelessness. There are an estimated 220 individuals moving to the county daily making Maricopa County the fastest growing county in the nation, rental vacancy rates in many communities are less than 3% and rents have increased rapidly reducing the availability of affordable housing to many vulnerable and income limited populations. Addressing homelessness is a major focus of the State of Arizona. In 2017/2018, Governor Ducey created a Homeless Goal Council consisting of multiple state departments, business leaders, non-profits and other providers, faith based organizations and other stakeholders to identify and implement strategies to end homelessness in the State of Arizona. Key goal council strategies and initiatives include reducing street/unsheltered homelessness, reducing recidivism from institutional discharges to homelessness, and developing increased affordable and supportive housing options. These efforts are implemented through numerous state departments and initiatives. Services for homeless and near-homeless individuals and families throughout the state are administered by state Departments through contracts with community based organizations and local agencies leveraging a combination of state, federal, and donated funds. In addition to State general fund commitments, State of Arizona agencies and departments also serve as administrators and recipients of federal and entitlement programs serving persons experiencing homelessness and other at risk populations. Key homeless housing and services funding administered by the State include Community Development Block Grants (Arizona Department of Housing-ADOH), US Department of Housing and Urban Development (HUD) Continuum of Care (ADOH), and HUD Emergency Solutions Grants ESG for Arizona's rural communities (DES). These contracts and funding sources are used to support local efforts to provide a Continuum of community-based services such as street outreach, emergency shelter, rapid re-housing, permanent supportive housing, homeless prevention, and case management.

Within this system, the Arizona Health Care Cost Containment System (AHCCCS) administers and coordinates use of Title XIX/Medicaid funded housing supportive services for individuals with a primary behavioral health or substance use diagnoses and able to live independently (with or without supports and services). AHCCCS contracted health plans are responsible for developing and offering an array of supportive housing (wrap-around) services and a network of providers to ensure safe and stable independent living housing for members that is consistent with the member's recovery goals and is in the least restrictive environment. Annually, AHCCCS receives limited State-appropriated general funds, administered by the Regional Behavioral Health Authorities (RBHA) and Tribal Regional Behavioral Health Authorities (TRBHA) contracted AHCCCS health plans, to be utilized for subsidizing housing prioritized for members determined to have a serious mental illness who meet the U.S. Department of Housing and Urban Development (HUD) definition of homelessness. State general funds are also allocated each year in an SMI Housing Trust Fund to be used primarily for the development of additional affordable units for individuals determined to have a serious mental illness including those who are homelessness.

Coordination and collaboration between these multiple stakeholders is critical to maximize resources and efforts to end homelessness. The State of Arizona has a State Homeless Coordination Office under the Arizona Department of Economic Security (ADES) that plans and coordinates overall strategic activities aimed at ending homelessness in the State of Arizona. Furthermore, Arizona has three HUD recognized Continuums of Care (CoC), Maricopa County, Pima County and Balance of State. Each is responsible for aligning and coordinating and regional homeless strategies. These CoC's involve state agency representation as well as local governmental, non-profit, faith based, business, and others in HUD mandated coordination strategies including standardized metrics, coordinated access/by name waitlists to services and use of standardized Homeless Management

Information System Databases. AHCCCS requires all contracted health plans to support the CoC efforts.
This participation has led to a number of major system improvements to better serve persons experiencing homeless, especially those individuals with both mental and physical health challenges. AHCCCS' RBHA contracted health plans, Mercy Care in Maricopa and AZ Complete Health in the southern region, now have over 40 users participating with access to the CoC Homeless Management Information System (HMIS) to improve identification, engagement, housing and supportive service coordination for homeless persons who are determined SMI as well as other at risk populations served by AHCCCS. This is resulting in coordination of housing wait lists, participation in multi-disciplinary case conferencing, and use of a standardized acuity assessment tool (the Vulnerability Index Service Prioritization Decision Assistance Tool or VI-SPDAT). Integration of the remaining northern region health plan is underway and should be completed by the end of the calendar year. In most Arizona Counties, RBHAs and ACC plans now work closely with the CoC and with the homeless outreach community. When the RBHA identifies a member as homeless, they receive a VI-SPDAT, and their housing needs are prioritized both within the HMIS and also waitlisted for AHCCCS (state general fund) housing administered by the RBHA . AHCCCS and the RBHAs are working alongside community housing providers to nurture relationships with landlords, build new properties using affordable tax credits, and prevent evictions for those currently housed.
AHCCCS receives a Project of Assistance in Transition from Homelessness (PATH) grant to provide outreach services to persons who are homeless, at risk of becoming homeless, and those determined to have a SMI, including those with a co-occurring substance use disorder to six out of the fifteen counties in Arizona; Maricopa, Pima, Cochise, Coconino, Yavapai, and Mohave. For FY2019 Arizona was allotted $1,349,474 with a minimum match of $449,825. The PATH grant provides an array of services, which include; community health screening, case management, and outreach to locations where homeless individuals commonly gather, (i.e. food banks, parks, vacant buildings and the streets). PATH staff provides community education, field assessments and evaluations, hotel vouchers in emergent situations, assistance in meeting basic needs such as: food stamps, health care, and applying for Medicaid and/or SSI/SSDI. Additionally, PATH staff can assist individuals in obtaining behavioral health case management, medications, moving assistance, and referrals for transitional and permanent housing. Services are documented within each individual's case plan and the case plan is updated as needed or every six months.
AHCCCS works with the aforementioned its state partners, health plans and other stakeholders to provide needed services to homeless individuals. Statewide PATH teams are integrated into the aforementioned CoC and HMIS coordination activities including coordinated entry, case conferencing and use of the By Name List to prioritize housing and services for the most vulnerable homeless and at risk persons. On an annual basis, the PATH funded contractors, and other volunteers perform a point-in-time street and shelter count to determine the number of homeless individuals in Arizona, including those with a serious mental illness, or a co-occurring serious mental illness with a substance use disorder.
The table below is the 2019 street count broken out by each county within Arizona. The PATH Grant will be re-bid in 2020 with the goal to possibly expand geographic coverage.

COUNTY	TOTAL HOMELESS COUNT	UNSHELTERED
Maricopa (Phoenix)	6,614	3,188
Pima (Tucson)	1,372	361
Balance of State	2,021	983

One example of the coordination of all of these elements is the Healthcare and Housing (H2) initiative that started as an initiative of the Governors Homeless Goal Council. A goal has been set to reduce unsheltered homelessness in a designated area of downtown Phoenix by 80% in the next two years. AHCCCS is working closely with its PATH team in Maricopa County, housing programs, three local public housing authorities, Mercy Care (RBHA) and the Maricopa County CoC to coordinate housing and supportive services including outreach and behavioral health services through this project. In the first few months of the project, all 300+ identified persons in the area have been contacted and over 60 are in the process of being housed with six (6) housed to date.

c. Describe your state's targeted services to the older adult population.

AHCCCS' Arizona Long Term Care System (ALTCS) program has three health plan Contractors that manage care for members who are Elderly and/or have a Physical Disability (E/PD) . The health plans provide services to over 31,000 AHCCCS members who are elderly (65 and over), blind, or disabled and at risk of institutionalization. ALTCS E/PD members receive all their medical care under the long term care program, including doctor's office visits, hospitalizations, prescriptions, lab work, long term services and supports, and behavioral health services. The ALTCS E/PD program is recognized as a national model for its success in supporting a high percentage of individuals who receive services in their own home or in the community rather than in institutional settings. In an effort to ensure that members have the opportunity to receive services in their own home, the ALTCS health plans, consistent with other health plans, are required to have a Housing Administrator to identify homeless members and/or members with affordable housing needs and leverage community partnerships or other resources to meet those needs.

NOT FINAL

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Arizona Health Care Cost Containment System (AHCCCS) incorporates the Mental Health Block Grant (MHBG) funding into the comprehensive behavioral health system operated within the state to leverage resources to meet the needs of those without access to other funding who meet eligibility criteria for a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) designation. Regional Behavioral Health Authorities (RBHA)s utilize their business models for managed care to best expend the funds to address the necessary staffing and training with the contracted providers. SMI, SED, and (Early Intervention in Psychosis (EIS)/ First Episode Psychosis (FEP) funds are all strategically utilized to provide access to evidence based practices to each population through contracted providers in each region. There is a robust system in place for emergency health services and crisis services for all Arizonans, with specialized providers available for members with SMI, SED, or EIS/FEP. AHCCCS intends to continue to build upon the infrastructure already in place through other funding sources and existing contracts to expend the funds for those individuals in the greatest need without other resources to meet their behavioral health care needs. The utilization of SMI clinics, urgent care services, systems of care for children with SED, and the centers for EIS/FEP provides a basic framework for access to care to block grant funded services for these populations.

NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

NOT FINAL

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

NOT FINAL

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots ( ) Yes (●) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

It is AHCCCS' goal to ensure pregnant women, women with dependent children, and intravenous drug users have appropriate access to treatment services, sufficient outreach, specialized treatment, and recovery supports available. Contracts between AHCCCS and RBHAs and plans include language for preferential access to care and provision of interim services. AHCCCS monitors RBHAs for compliance with preferential access standards, including review of data reporting mechanisms and corrective action as appropriate. Language supporting this is in the contracts between AHCCCS and RBHAs and referenced in the AHCCCS Contractor Operations Manual (ACOM) and AHCCCS Medical Policy Manual (AMPM).

RBHAs have standing meetings with their providers about substance use disorders (SUD) and prevention. AHCCCS staff attends meetings in person and over the phone to monitor program compliance for the priority populations and additional block grant requirements. These meetings serve as collaborative opportunities to share information, address provider concerns, and ensure block grant priorities are met while addressing any compliance issues that may arise.

The State added a SABG training requirement for all Contractors. The requirement includes an overview of SABG: priority placement criteria, interim service provision, member wait list reporting, and expenditure restrictions of the SABG in accordance with requirements in the AMPM and 45 CFR Part 96. Per the recommendation of CSAT during the SABG Core Review in FY 2010, Arizona elected to develop a web-based "real time" waitlist system for tracking priority population (Pregnant Intravenous Drug Users, Pregnant, or Parenting Women with a SUD, all Intravenous Drug Users) members awaiting placement in a residential treatment facility. Effective 4/1/2011, staff at provider organizations, RBHAs, and AHCCCS were able to log into the system using a unique username and password, and enter basic information for priority population members unable to begin treatment within the specified timeframes. The State is working on implementing a new SABG Waitlist portal that is more user friendly and provides automatic updates and notifications for members who currently in the waitlist portal. These email notifications will be tied into the members provider, the member's health plan, and state.

AHCCCS receives an email in real time whenever a member is added to the waitlist. A designated member of the Grants team reviews the information and coordinates with the RBHA if needed. In addition, AHCCCS reviews the data entered into the waitlist to monitor preferential access standards, the provision of interim services, and for sufficient capacity to treat the priority populations. The T/RBHAs monitor all contractors who provide residential services paid through SABG funds. Providers of residential services report data to the T/RBHAs, in accordance with AHCCCS requirements, on a monthly basis. This report tracks all priority population recipients who completed intake assessments, and are willing to enter treatment. T/RBHAs use this data to identify provider specific and/or system wide trends and provide technical assistance to providers as needed. In Maricopa County,

NOT FINAL

the Women's Treatment Network (WTN) is comprised of the collaboration between Adult Probation, Estrella Jail, residential substance abuse providers that serve women, and the RBHA. The purpose of this collaboration is to minimize barriers to receiving behavioral health care for women who qualify for an early release program if they agree to go directly to residential services to address their substance use issues.

T/RBHAs must ensure their network providers promptly submit information to the Residential Waitlist System for priority population members (pregnant women, women with dependent children (PW/WDC), and intravenous drug users (IVDU)) who are waiting for placement in a residential treatment center. Any alternate form of submission must have written approval from AHCCCS. Contractors are responsible for providing services to priority population members sufficient in amount, duration, and scope to expect, within reason, that they achieve the purpose for which the services are furnished. To ensure this, the contractor must provide a comprehensive provider network that provides access to all services covered under the contract for all members. If the contractor's network is unable to provide medically necessary services required under contract, the contractor must adequately cover these services, in a timely fashion, through an out of network provider until a network provider is contracted.

The state is working on updating and implementing secret shopper on the phone evaluations. The state will reviewing its current secret shopper plan, will work on ways to improving different member scenarios, and provide objective valuation on providers and health plan customer service department and front-line staff members. Different scenarios and questions that will be implemented are pregnant and parenting women with dependent children and if child care availability. In addition, will be the scenario of individuals who do not qualify for Medicaid. Once the state completed the calls, data will be collected and follow up meetings with the health plans will be conducted to address and educate the findings from the state.

Lastly, AHCCCS coordinates with the Division of Public Health Services (PHS), and the Bureau of Women and Children's Health to reach a larger group of pregnant and parenting women. PHS conducted a Research Brief Neonatal Abstinence Syndrome: 2008-2013 Overview in 2014 (http://www.azdhs.gov/phs/phstats/documents/neonatal-abstinence-syndromresearch.pdf) and one of the major findings was the increase of Neonatal Abstinence Syndrome (NAS) cases. They are also working on the following:

- Arizona Opioid Prescribing Guidelines
- Controlled Substances Prescription Monitoring Program (CSPMP)
- Policies for Licensed Healthcare Facilities
- Home Visiting – Substance Abuse Screening
- Providing CME Credits to help prescribers incorporate the 2014 Arizona Opioid Prescribing Guidelines

NOT FINAL

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(●) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(●) Yes ( ) No
c)	Outreach activities	(●) Yes ( ) No
d)	Syringe services programs	( ) Yes (●) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (●) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (●) No
c)	Use of peer recovery supports to maintain contact and support	(●) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	(●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

AHCCCS serves as the SSA to provide coordination, planning, administration, regulation, and monitoring of all facets of the state public behavioral health system. AHCCCS contracts with RBHAs to administer behavioral health services. RBHAs contracts with a network of service providers similar to health plans to deliver a comprehensive array of services as outlined in Arizona's Covered Behavioral Health Services Guide geared toward prevention, treatment, and recovery for both adults and children.

The overall goal of AHCCCS' management of the SABG is to ensure appropriate access to treatment services for persons who are eligible for the priority populations including those who report IVDU. It also ensures that sufficient outreach, specialized treatment, and recovery supports are available to this population. The contracts between AHCCCS and RBHAs continue to include language for preferential access to care and provision of interim services. AHCCCS monitors the RBHAs for compliance with preferential access standards, including review of data reporting mechanisms, and corrective action as appropriate. Language continues to be expanded to specifically match the block grant requirements within the contracts between AHCCCS and RBHAs and referenced in the AHCCCS Contractors Operations Manual (ACOM).

RBHAs have standing meetings with their providers about SUD and prevention. AHCCCS staff attends the meetings in person and over the phone to monitor program compliance for the priority populations, and additional block grant requirements. These meetings serve as collaborative opportunities to share information, address provider concerns, and ensure priorities of the block grant are met, and address any potential compliance issues promptly.

The SABG supports primary prevention services and treatment services for persons with substance use disorders. It's used to plan, implement, and evaluate activities to prevent and treat substance abuse. Grant funds provide early intervention services for information, referrals, and screening for Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) for high-risk substance abusers. SABG treatment services must support the long-term treatment and substance-free recovery needs of eligible persons. Specific requirements apply regarding preferential access to services and the timeliness of responding to a person's identified needs. Behavioral health providers must also submit specific data elements to identify special populations and record specified clinical information.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes ( ) No

NOT FINAL

b) Cooperative agreement/MOU with public health entity for testing and treatment ○ Yes ○ No

c) Established co-located SUD professionals within FQHCs ○ Yes ○ No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The SABG supports primary prevention and treatment services for members at risk of developing or with SUD. Funding is for the planning, implementation and evaluation of activities to prevent and treat SUD. Grant funds provide early intervention services for HIV and tuberculosis disease (TB) in high-risk substance users.

As defined in [45 CFR 96.121] any entity receiving dollars from the SABG Grant for operating a program of treatment for substance abuse, they are required to follow specific procedures and document how their program addresses Tuberculosis and other communicable diseases.

At the time of intake, directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services to each individual receiving treatment for such abuse. In the case of an individual in need of such treatment who is denied admission to the program on the basis of the lack of the capacity of the program to admit the individual, they will refer the individual to another provider of services, implement infection control procedures designed to prevent the transmission of tuberculosis, including the screening of patients, Identification of those individuals who are at high risk of becoming infected, meet all State reporting requirements while adhering to Federal and State confidentiality requirements, including [42 CFR part 2], and will conduct case management activities to ensure that individuals receive such services.

SABG targets special population and interim services for pregnant women/women with dependent children/intravenous drug users (Non-Title XIX/XXI only) is established. Interim Services or Interim Substance Abuse Services are services that are provided until an individual is admitted to a substance abuse treatment program. The purposes of the services are to reduce the adverse health effects of such abuse, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim services include counseling and education about HIV and TB, about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services if necessary. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care. Provision of interim services must be documented in the member's chart as well as reported to AHCCCS through the online residential waitlist. Interim services are required for Non-Title XIX/XXI members who are maintained on an actively managed waitlist. Title XIX/XXI eligible persons who also meet a priority population type may not be placed on a waitlist.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ◉ No

b) Establishment or expansion of tele-health and social media support services ◉ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ◉ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ◉ Yes ○ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

N/A

NOT FINAL

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No

NOT FINAL

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

A total of 250 cases from the eligible population were reviewed.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

NOT FINAL

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ( ) Yes (●) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Preformance-based accountability (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services (●) Yes ( ) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) Mental Health TTC? (●) Yes ( ) No

c) Addiction TTC? (●) Yes ( ) No

d) State Targeted Response TTC? (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ( ) Yes (●) No

NOT FINAL

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? ○ Yes ○ No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight.

Yes, the state would like to highlight the following efforts:

a. As of early 2018, AHCCCS has implemented the Targeted Investment program which focuses on program development and implementation of social determinants of health (SD0H) at the provider level for pediatric primary care and behavioral health in order to identify possible contributors to trauma in members' lives (e.g. lack of resources, housing and food insecurity, environmental exposure to trauma and violence)

i. Milestones have been created for pediatric behavioral and physical health providers to complete trauma-informed care protocols

for their health care delivery systems.
ii. This program also focuses on justice system initiative and impacts of trauma on justice populations. Trainings are offered that provide cross-training of healthcare providers and Arizona's justice system staff.
b. In 2018 a partnership was created with a local provider that specializes in trauma-informed approaches and treatment for childhood and caregivers. The training was designed to provide training on trauma-informed care to pediatric provider for children and youth in the high-risk category under the Targeted Investment program.
c. AHCCCS contracts for its Managed Care Organizations (MCOs) require implementation of trauma-informed care principles as part of treatment, and require care coordination for survivors of sex trafficking (including resources for trauma-informed care and treatment for children and guardians)
d. Licensed clinicians are required by contract to have training in trauma-informed approaches:
i. Data from one of the MCO indicated 987 attendees participated in a trauma-informed care training and 42 licensed clinicians received training in trauma-focused Cognitive Behavioral Therapy (CBT).
ii. Over two years, another MCO trained over 190 staff on trauma-informed responses and strategies
e. AHCCCS developed a statewide behavioral health audit tool, which has specific elements that require auditors to review behavioral health clinical charts for evidence of trauma informed care treatment approaches and clinical interventions.
f. AHCCCS and MCOs offer training & technical assistance related to trauma-informed approaches.
g. AHCCCS has implemented internal trainings to AHCCCS staff on trauma-informed care models and clinical interventions.
h. Comprehensive Medical Dental Program (CMDP) implemented an initiative to enhance Primary Care Provider (PCP) awareness that all CMDP youth have experienced trauma which may result in severe behavioral symptoms. The initiative addressed the need for PCPs to recognize the potential interplay between physical health conditions and behaviors that may look very similar when there is underlying trauma. Symptoms caused by underlying trauma can look similar to some physical or behavioral health conditions (e.g. ADHD, depression, and/or anxiety disorders, diabetes, lead poisoning).
i. AHCCCS has opened five, 24/7 centers of excellence for opioid treatment since mid-2017, each of which utilizes trauma informed care approaches.
j. The Quality Caregiver Initiative was a community-based activity, the objective of which was to provide training and resources to improve knowledge of relationship-based, trauma-informed service supports for foster, kinship and adoptive parents

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

Through the leadership at AHCCCS, there continues to be active involvement in the joint activities between the behavioral health, acute care, long-term care, and Arizona's criminal and juvenile justice systems. Annually updated Collaborative Protocols and System of Care Plans provide structure for the agencies to work together. Regularly occurring meetings take place at the state and local levels to focus on policy development, implementation, improving communication, identifying system barriers, and problem-solving. Collaborative development activities such as Drug Courts, Mental Health Courts, and Juvenile Detention Alternatives Initiative (JDAI) are examples of some of the work occurring in Arizona.

In our Children's Behavioral Health System, there are representatives from both juvenile corrections and juvenile probation sitting on the Arizona Children's Executive Committee (ACEC). The ACEC brings together multiple state and government agencies, community advocacy organizations, and family members of children/youth with behavioral health needs to collectively ensure behavioral health services are being provided to children and families according to the Arizona Vision and 12 Principles. While Arizona does not have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions, screening and treatment are provided prior to adjudication and/or sentencing for individuals with mental

NOT FINAL

health and substance use disorder (SUD) screening as a part of their intake protocols.

AHCCCS Complete Care (ACC) Plans maintain active and annually updated collaborative protocols with the justice agencies in their respective Geographic Service Areas (GSAs) to ensure enrolled members or eligible persons that come in contact with the justice system, to the extent possible, have their mental health, SUD treatment needs and physical health needs assessed, addressed, relevant issues communicated, and coordinated with the judiciary and justice personnel. ACC's maintain co-located staff at both Juvenile and Adult Courts and Detention Centers in order to provide coordination of care between the acute, behavioral health system and the justice systems in meeting the enrolled members' needs. Staff is available to assist in enrolling members if they have not previously been identified as having physical/mental health, SUD treatment needs.

AHCCCS has collaborated with state and county governments and agencies to improve coordination within the justice system and create a more effective and efficient way to transition individuals from incarceration into the community. Currently, all Managed Care Organizations (MCOs) are contractually required to provide "reach-in" services and care coordination to identify members with complex health needs prior to their release from incarceration. Through the reach-in service, the MCOs connect case managers to members pre-release to provide information and schedule appointments with primary care physicians and behavioral health providers as appropriate.

Criminal and Juvenile Justice Liaisons and other co-located behavioral health staff are trained to work specifically with members involved in the criminal and juvenile justice systems as well as with those in their associated living environments. By assisting members with navigating the justice system, advocating for their individualized needs, assisting the justice system staff and judiciary, and accessing physical/behavioral health and SUD treatment for members, staff is better able to identify the appropriate services/supports within the community and connect members to appropriate levels of care.

In the state of Arizona, Correctional Health Services (CHS) has adopted practices to identify members with serious mental illness (SMI) or SUD and to divert the members to appropriate treatment services. This is an initiative implemented by the State to reduce the number of adults with mental health disorders and co-occurring SUD in correctional facilities. The initiative engages a diverse group of organizations with expertise on these issues, including sheriff's departments, jail administrators, judges, community corrections professionals, treatment providers, mental health and substance use program directors, and other system stakeholders. Enrollment and care coordination activities specifically designed for this population are established in Collaborative Protocols jointly developed by the ACCs and the local courts, parole offices, and probation departments. These protocols define activities and timeframes for care coordination, screening, enrollment, preparation for services post release, communication, and participation on individual Child and Family Teams (CFTs) and Adult Recovery Teams (ARTs) for service planning activities. Behavioral Health Case Managers facilitate CFTs and ARTs and maintain active and ongoing communication with Probation and Parole Officers. Behavioral Health Individual Service Plans (ISPs) are designed to incorporate goals included in probation and parole plans, and are reviewed and updated at CFTs and ARTs attended by probation and parole officers.

To address difficulties in receiving services after incarceration due to disenrollment, most counties in Arizona and the state Department of Corrections have established Intergovernmental Agreements (IGA) to allow coverage for an individual on the day of their release from the detention center. In order to increase capacity of personnel working with members with behavioral health issues involved in the system, ACCs provide regular cross-trainings for local court personnel on the behavioral health system, including the CFT process, medical necessity determination for out-of- home placement, and other health topics as requested by the courts in their coordination meetings.

Finally, peer and family support is a priority of the state as well as the ACCs, and currently there are peer workers embedded within SUD treatment facilities and integrated health homes, as well as dedicated peer-run organizations to ensure a comprehensive peer support network throughout the state. In addition, many peer support agencies have developed cross-agency collaboration initiatives and collaborate with jails to assist individuals who are released with enrolling in, and coordinating, treatment services prior to their release so they are able to smoothly transition back into the community, and begin treatment as soon as possible. AHCCCS supports a recovery-oriented system of care (ROSC), and understands the important role that peer support plays in recovery. As a result, providers within the ACC network have incorporated peer support throughout the continuum of care, making it available at all levels and intensity of service.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** ☑ Methadone
- **b)** ☑ Buprenophine, Buprenorphine/naloxone
- **c)** ☑ Disulfiram
- **d)** ☑ Acamprosate
- **e)** ☑ Naltrexone (oral, IM)
- **f)** ☑ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

Arizona Health Care Cost Containment System (AHCCCS) receives multiple grants from the Substance Abuse and Mental Health Service Administration (SAMHSA) to help Arizona reduce opioid deaths. In 2016, more than two Arizonans died each day due to opioid-related causes, with the number of deaths tripling due to heroin since 2012. On June 5, 2017, Governor Doug Ducey issued his first public health emergency declaration, which called for a statewide effort to reduce opioid deaths in Arizona. Currently, Arizona continues to experience an opioid epidemic, as drug overdose deaths have become a leading cause of death.

Arizona receives the (1) State Opioid Response (SOR) to increase access to Opioid Use Disorder (OUD) treatment, coordinate and integrate care, recovery support services and prevention activities to reduce the prevalence of OUDs and opioid-related overdose deaths; (2) Opioid State Targeted Response (STR) to reduce the prevalence of Opioid Use Disorders and opioid-related deaths through targeted prevention and treatment activities; and (3) Medication Assisted Treatment – Prescription Drug Opioid Addiction (MAT-PDOA) utilized to engage individuals diagnosed with OUD and involved with the criminal justice system. Specifically focusing on outreaching and screening individuals within four months of release to engage them in Medication Assisted Treatment (MAT) and provide care coordination as they reenter the community. The project also seeks to improve access to MAT services for these individuals by improving infrastructure and collaboration among criminal justice entities and Opioid Treatment Programs (OTPs). The project will also expand infrastructure and build capacity for state, regional and local collaborators to implement integrated strength-based treatment planning, screening and assessment for co-occurring disorders for the target population by increasing participation in MAT services. This is in addition to the Substance Abuse Block Grant.

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In response to the opioid epidemic, the Governor's Office along with AHCCCS and the Arizona Department of Health Services (ADHS) has collaborated in an effort to reduce overdose deaths in the state of Arizona. Naloxone is an opioid overdose reversal medication that is lifesaving for a person experiencing potentially fatal effects of opioids. Through this collaboration there are four major priorities identified to address this epidemic:

• improving access to naloxone in our communities to reverse overdoses,
• expanding access to treatment, especially medication-assisted treatment (MAT), and ensuring a pathway to treatment,
• preventing prescription opioid drug abuse through appropriate prescribing practices, and
• educating Arizonans on the dangers of opioid misuse and abuse.

Additionally, providers contracted within the network must develop Naloxone training modules for prescribers, pharmacists, and members in addition to disseminating statewide in-person community-based trainings. Priority will be given to geographic areas identified through epidemiological data as high needs areas. For data and reporting, RBHAs and providers are contracted to submit monthly reports to AHCCCS. Between January 2017 and August 2019 there have been a total of 56,315 naloxone kits distributed and over 15,492 reported naloxone doses administered.

Lastly, AHCCCS has developed policies and contract language for RBHAs and their network providers so they may implement a direct service, community Naloxone distribution network in order to meet the needs of the population. Providers are focusing specifically on the most vulnerable populations for opioid overdose, which include those living in poverty, transitioning out of the criminal justice system, and those with perceived barriers to obtaining a prescription for the medication. This past year legislation has worked to put together a program for those released from the Department of Corrections (DOC) diagnosed with opioid use disorder (OUD). This effort seeks to connect these individuals to MAT with a network provider prior to release, as well as access to a Naloxone kit upon release.

AHCCCS houses the State Opioid Treatment Authority (SOTA). The role of the SOTA in Arizona is to coordinate with the Drug Enforcement Administration (DEA), SAMHSA's Center for Substance Abuse Treatment (CSAT), and the State of Arizona's Division of Licensing Services to oversee the licensing/accreditation of outpatient Opioid Treatment Providers (OTPs). Clinics licensed as OTPs must adhere to the DEA and CSAT guidelines regarding FDA approved medications, safeguards against diversion, and provision of psychosocial treatments. Additionally, the RHBAs have procedures in place to evaluate the fidelity to the best practices and evidence-based programs providers are utilizing, including programs and medications.

AHCCCS has also recognized the important role medication-assisted treatment (MAT) plays in the treatment of SUD and access to treatment. Arizona now has six 24/7 access points to serve individuals who need immediate access to treatment services and connections to ongoing services. These 24/7 access points are located throughout Arizona. One located in the southern geographic service area (GSA), three located in the central GSA, and two located in the northern GSA. Arizona was the first state to open the first 24 hour access facility to help combat the opioid epidemic. These facilities assist community stakeholders when a member is released from prisons, jails, hospitals, during after normal business hours.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☑ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☑ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis

NOT FINAL

e) ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

The Arizona Health Care Cost Containment System (AHCCCS) integrates the provision of comprehensive crisis services through three contracted Regional Behavioral Health Authorities (RBHAs), required to deliver services for their respective contracted geographic service areas throughout the State.

RBHAs are responsible for the provision of a full continuum of crisis services to all individuals in Arizona, including but not limited to, 24/7 access to crisis telephone services, mobile crisis response teams and crisis stabilization services. The essential guiding principles of the delivery of crisis services is that services be community based, solution and recovery-oriented and focused on stabilizing the individual and returning them to their baseline of functioning. Crisis interventions are designed to avoid unnecessary hospitalization, incarceration, and/or placement in a more restrictive setting.

Highlights of RBHA contracted requirements for crisis services and notable best practices are detailed below:

Crisis Telephone Services:
RBHAs must:
- Maintain a 24 hours per day, seven days per week crisis response system, with a single toll-free crisis number. Crisis calls must be live-answered within 3 rings or less (or 18 seconds).
- Include triage, referral, and dispatch of service providers and patch capabilities to and from 911 and other crisis providers, or crisis systems as applicable.
- Provide telephone support to callers to the crisis response line including a follow-up call within 72 hours to make sure the caller is stabilized.
Mobile Crisis Response Teams:
RBHAs must establish and maintain a sufficient network of mobile crisis teams with the following capabilities:
- The team must travel to the place where the individual is experiencing the crisis and provide assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress.
- Mobile teams must have sufficient capacity and training to serve specialty needs of the population served.
- Provide crisis transportation to a more appropriate facility for further care, when appropriate.
- Respond on site within the average of 60 minutes (urban) / 90 minutes (rural) of receipt of the crisis call. Incentivize on-site mobile team response within 45 minutes of the initial crisis call.
RBHAs have employed unique best practices such as co-locating mobile crisis teams with law enforcement entities and utilizing dispatch / utilization data to locate mobile teams in strategic locations to reduce response times.

Crisis Services – Crisis Stabilization Settings:
RBHAs must establish and maintain crisis stabilization settings with the following capabilities:
- 24 hour substance use disorder/psychiatric crisis stabilization services including 23 hour crisis stabilization/observation capacity, including access to Medication Assisted treatment (MAT).
- Provide short-term crisis stabilization services (not to exceed 72 hours) to resolve the crisis and return the individual to the community, instead of transitioning to a more restrictive level of care.
- Crisis Stabilization settings must accept all crisis referrals, adhere to a "no wrong door" approach for referrals, and ensure streamlined practices for swift and easy transfer of individuals from law enforcement and public safety personnel.
- Maintain a sufficient crisis network which includes, at a minimum,
o Licensed Level I acute and sub-acute facilities,
o Behavioral Health Residential facilities, and
o Outpatient clinics offering 24 hours per day, seven days per week access.
- Include home-like settings such as apartments and single family homes where individuals experiencing a psychiatric crisis can stay to receive support and crisis respite services in the community before returning home.

In Maricopa County, Arizona's most populated region, through an intergovernmental agreement between AHCCCS, Mercy Care RBHA, and Maricopa County, the Title 36 Civil Commitment process has been integrated with crisis services, creating a unified crisis system. This allows the local alcohol reception centers and urgent psychiatric facilities to serve as the 'front-door' for the Title 36 civil commitment process. Owing to the success of this model, similar strategies are implemented in Coconino, Pima and Mohave Counties.

Law Enforcement / Community Partners
RBHAs are required to maintain collaborative relationships with community partners and have active involvement with local police, fire departments, first responders, and other community and statewide partners in the development and maintenance of strategies for crisis service care coordination and strategies to assess and improve crisis response services.

Law enforcement (LE) callers to the crisis lines are prioritized, receive direct access to crisis call supervisors, priority dispatch of crisis mobile teams. In addition, LE are able to drop off individuals at any crisis facility with a "no refusal" policy, and a target drop-off

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time at 23 hour observation units of 10 minutes or less.

RBHAs provide regular Crisis Intervention Team (CIT) training and Mental Health First Aid to LE and other community partners, including federal and tribal entities. RBHAs encourage two-way connections with LE and behavioral health providers in their communities; to enhance relationships and better support individuals experiencing behavioral health crises who engage with law enforcement. Additionally, RBHAs deliver police culture training to crisis providers to enhance system collaboration.

In Pima County, Arizona Complete Health RBHA has partnered with 911 dispatch to co-locate crisis staff at the local communications center. Crisis staff are available to divert inbound calls from 911 dispatchers for individuals experiencing a behavioral health crisis. Additionally crisis staff initiate outbound calls to individuals who have been identified by LE as needing following up for behaviors that mirror behavioral health symptomology. This partnership allows for crisis staff to initiate and prioritize crisis mobile team response, when indicated, mitigating law enforcement involvement, reducing calls to 911 dispatch, while connecting the community with behavioral health care.

Other AHCCCS Crisis System Initiatives:
Since September 2018, AHCCCS has held regular behavioral health roundtable collaboratives with statewide crisis providers, RBHAs and other AHCCCS health plans to address system issues and develop strategies to enhance the delivery of crisis services throughout Arizona.

In continuing with system integration principles and streamlining the delivery system, AHCCCS will be integrating standalone RBHA services into its existing managed care organization structure in October 2021. In early 2019, AHCCCS released a request for information to solicit feedback regarding suggestions for integrating crisis services into the AHCCCS delivery system, in addition to requesting stakeholder feedback regarding crisis system enhancements and delivery of crisis services on tribal lands.

AHCCCS is in the process of developing a new standalone crisis policy expected to be released in October 2020.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

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a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(•) Yes	( ) No
b)	Required peer accreditation or certification?	(•) Yes	( ) No
c)	Block grant funding of recovery support services.	(•) Yes	( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes	( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (•) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Arizona Health Care Cost Containment System (AHCCCS) has a general definition for Self-Help/Peer Services in the AHCCCS Covered Behavioral Health Services Guide as "assistance with more effectively utilizing the service delivery system (e.g., assistance in developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers) or understanding and coping with the stressors of the person's disability (e.g., support groups), coaching, role modeling and mentoring. Self-help/peer services are intended for enrolled persons and/or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups (e.g., Alcoholics Anonymous (AA), (Narcotics Anonymous (NA), Dual Recovery). These services may be provided to a person, group or family and are aimed at assisting in the creation of skills to promote long-term, sustainable recovery."

Arizona also complies with State Medicaid Director Letter (SMDL) 07-011; in which the Centers for Medicaid and Medicare Services (CMS) outline what states must do to receive federal reimbursement for peer and recovery support services. All Arizona's providers of peer and recovery support services are credentialed as Peer and Recovery Support Specialists (PRSS). Arizona's PRSS credentialing process is comprehensive, and includes Substance Use Disorder (SUD), Opioid Use Disorder (OUD), Co-Occurring (mental health and substance use disorder) and Mental Health recovery. This process is described in AHCCCS Medical Policy Manual (AMPM) Section 963.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Arizona makes no official distinction between recovery from mental health, substance use and/or co-occurring disorders. The upcoming revision of AMPM 963 lists SAMHSA's Working Definition of Recovery from Mental Disorders and/or Substance Use Disorders as a point of reference for the development of PRSS training programs. Refer to the description answering the question "Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state".

5. Does the state have any activities that it would like to highlight?

Arizona has expanded and strengthened the role of a state's office of consumer affairs. The AHCCCS Office of Individual and Family Affairs (OIFA) is unique because of its place in state government. OIFA was incorporated into the state's Medicaid Program in 2016 when the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) was "carved" back in to the state's public health system. Rather than being relegated to a departmental position, AHCCCS OIFA's place in the state Medicaid Program has allowed the office to take on new initiatives and expanding the areas of Peer/Recovery Support and Family Support.

There are Offices of Individual and Family Affairs at each of the 7 Managed Care Organizations contracted by AHCCCS to oversee the delivery of publicly-funded health services. These are contractually required positions and play key roles in both local and statewide initiatives to raise the voices of Medicaid members and family members. All seven OIFAs are involved in a Peer Support Development workgroup that will bring in the peer support training programs, PRSS and AHCCCS members to discuss the future of peer and recovery support programs in our state.

Arizona has Peer- Run Organizations; these service providers are owned, operated and administered by persons with lived experiences of mental health and or substance use disorders. AHCCCS members have the right to request services provided by these organizations. There are currently nine organizations and are based in the community and provide support services.

Arizona's model of peer support training is that of multiple, autonomous training programs adhering to a standardized set of core curriculum elements. This allows for the flexibility and adaptability of training programs to best meet the needs of the people they serve. The Peer Support Development workgroup will be exploring equalizing mechanisms to further strengthen the integrity and preserve this model. To this end, we intend to implement a standardized exam which all future graduates from any training program will have to pass to obtain certification.

Another equalizing mechanism the state intends to explore is the development of a systematic screening and application process in order to be admitted for peer support training. This is recommended Practice 1 in the Government Accountability Office's (GAO) 2018 report: Leading Practices for State Programs to Certify Peer Support Specialists. It is also one of the best practices identified by the Defense Centers of Excellence 2011 report: Best Practices Identified for Peer Support Programs.

Arizona has recently implemented equitable continuing education and ongoing learning requirements for PRSS through a process called Operational Review (OR). These requirements are equitable and cognizant of the stark socio-economic disparities

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between PRSS and other practitioners. The OR process demonstrated that all PRSS working in the AHCCCS networks will have access to continuing education and ongoing learning relevant to peer support as part of their standard ongoing training regimen. These will be available to the PRSS at no cost, using the Relias online-learning platform which is standardized across all the AHCCCS programs. Relias has an extensive catalogue of ongoing learning specific to peer support. This requirement was recommended Practice 5 in the GAO 2018 report.

For the past year and half, a multi-disciplinary workgroup met monthly to develop standards of practice and programmatic implementation for PRSS working with members with Opiate Use Disorder (OUD). The workgroup consisted of PRSS, providers and Contractors, with a primary representation from those serving members with OUD; many of whom have lived experience of OUD, themselves. From this workgroup, two of the participating agencies developed supplemental training curricula specific to OUD peer and recovery support to be used in various parts of the state. OUD has also been included as a required core training element in the most recent revision of the state's policy for training and credentialing of PRSS. All PRSS trained in our state will have access to education and training related to serving members with OUD.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Olmstead Plan denotes state policy required 25 days of local treatment before the Arizona State Hospital can be considered as a treatment setting. Furthermore, per Arnold vs. Sarn, there is a maximum number of Regional Behavioral Health Authority (RBHA) enrolled members who can receive treatment in the Arizona State Hospital at any one time, which is capped at 55 members who live in Maricopa County.

An outcome of the Olmstead Plan related to hospitalization is the Arizona State Hospital (AzSH) Transition Workgroup that was created to establish new processes, assessment forms, and specialized community placements to target individualized discharge planning to support successful transitions for members into community-based placements. AHCCCS requires health plan Contractors to develop and implement policies and procedures to provide high touch Contractor care management and other behavioral health and related services to each member on conditional release from AzSH consistent with the member's Court Ordered Conditional Release Plan. As stated in Contract, Contractors actively participate in the member's discharge plan prior to release. Contractors are not permitted to delegate the care management functions to a subcontracted provider and must submit a monthly comprehensive status report for each member on Conditional Release to the Psychiatric Security Review Board (PSRB), the member's attorney and to the designated AHCCCS Medical Management (MM) staff. AHCCCS staff participates in a phone discussion with Contractors regarding each member following receipt of the monthly report to ensure any potential compliance issue is thoroughly investigated. Issues of noncompliance are reported immediately by the Contractor to the PSRB, the member's attorney and AHCCCS MM designated staff. The Workgroup has resulted in timely discharges to appropriate settings and a low recidivism rate.

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In addition to the provision of the services noted above, Arizona has employed the following initiatives to enhance the service delivery system in an effort to support members to live and work in the most integrated setting:
• Implemented Active Assertive Community Treatment (ACT) case management teams in Maricopa County, and initiated the development of teams statewide that are monitored for adherence to SAMHSA fidelity standards.
• Distribution, management, and monitoring of the Serious Mental Illness (SMI) Housing (state funded) Trust Fund to support acquisition and renovation of new housing stock for members determined to have SMI.
• Provide state-funded housing and utility subsidies for members determined to have an SMI in concert with the provision of Medicaid funded housing supportive services following Permanent Supportive Housing standards to support members to live in their own home.
• Developed a system that monitors fidelity to the SAMHSA Consumer Operated Services evidenced-based practice.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

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- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? ( ) Yes (●) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ( ) Yes (●) No

b) Mental health treatment and recovery services for children/adolescents and their families? ( ) Yes (●) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Arizona Health Care Cost Containment System Administration (AHCCCS), the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), as a result of the Olmstead Decision (Olmstead v L.C., 119 S.Ct.2176(1999), determined it would be appropriate, and in the members' best interest, to convene a public planning process that would review the accomplishments of the state and identify areas for future endeavors to improve opportunities for members to live in the most appropriate, integrated setting possible. These agencies convened a workgroup in 2000 to start the planning process. The state agencies recognized this was part of a continuous improvement process in which each agency was already involved prior to the Olmstead Decision and would continue to engage in. The preparation of the plan was also consistent with the Executive Order issued by President George W. Bush on June 18, 2001 in support of the Olmstead Decision.

Arizona's Olmstead Plan was developed in 2001 and provided a comprehensive approach to demonstrating the State of Arizona's historical emphasis on principles found in the Olmstead Decision and its desire to continue to ensure persons who are elderly and persons with disabilities have appropriate access and choice regarding community-based services and placements. Although a plan was not required by the Supreme Court, Arizona believed this was an opportunity for advocates, agencies, members, and community stakeholders to collaborate on a plan that would guide the State toward improving access to home and community-

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based settings and services.

The state agencies that design, fund and provide services to persons with disabilities – AHCCCS, ADES/DDD (and previously, the ADHS/DBHS) have operated according to the premise that whenever possible, people should live in an appropriate integrated setting within the community. Since the original plan was developed, Arizona has continued expanding and developing its capacity for providing community-based services, including peer and family support services, supported employment and supportive housing services.

ADHS/DBHS initiated a plan in January 2014, calling for an increase of services in four areas: Assertive Community Treatment (ACT), Supported Employment, Supportive Housing, and Peer and Family Services. The initiative also provides for the use of several tools to evaluate services provided in Maricopa County, including a quality service review (QSR), network capacity analysis, and SAMHSA fidelity tools. The strengthening of ACT in Arizona, along with the well-established Child and Family Team (CFT) practice, has been important to improving outcomes for children and adults when they transition from hospitals to community based care. In the Children's System, this expansion is supported by collaborative efforts involving all child serving state agencies, helping to achieve The Arizona Vision which describes a System of Care in which all our state agencies work collaboratively to insure four key functional outcomes:

- Success in school,
- Avoidance of juvenile justice involvement,
- Children living successfully at home, and finally,
- Making sure our children are moving towards becoming stable, productive adults.

The 12 Principles further outline our System of Care Values and closely align with the 13 System of Care Principles described by Dr. Bob Friedman and Shelia Pires in the SAMSHA sponsored "System of Care" approach. Adherence to these 12 Principles drives our System of Care to view a family holistically, working from a family systems approach which does not identify the child as a "presenting problem," but utilizes the family strengths, culture and natural supports to develop a plan which may include specific services for the parents (i.e. parenting and life skills training), in addition to services for the child.
Currently, one of AHCCCSs strongest collaborative efforts is with our Child Welfare System. AHCCCS staff is working with Child Welfare staff to monitor the number of foster children placed in shelters over 21 days and/or foster children who have experienced more than 15 changes in placement. With these children identified and tracked, we are working with our behavioral health providers to develop child and family team service plans to ameliorate their status and reduce the number of placement disruptions these foster children suffer. In an associated initiative, AHCCCS and Child Welfare are working together to strengthen the Therapeutic Foster Care system in Arizona. This will entail re-imagining the training and supervision requirements for Therapeutic Foster care providers as well as codifying our expectations in AHCCCS Policy and Contract. Finally, although currently on hold, Child Welfare and AHCCCS are still hoping to initiate a program to identify children at risk of removal from their homes and provide behavioral health services to the parent in order to support them and, potentially, prevent removal.

AHCCCS has built a statewide system of care utilizing an individualized, family centered, youth-guided, community-based, and culturally competent approach to meet the needs of children and families. Policies, practice protocols, a covered services guide, and contract language provide guidance and direction to those working with children and families. Besides the Arizona Vision and 12 Principles, statewide policies regarding the Children's System of Care include the AHCCCS Covered Behavioral Health Services Guide (CBHSG), which includes one of the widest arrays of services and supports available to Title XIX and XXI members in the country. As mentioned earlier, the CBHSG includes a wide array of supports and services for the entire family in order to help maintain the child in the family. The AHCCCS Practice Tool, Child and Family Team (see attached) defines the "Wraparound" process and how it is to be implemented; collaborative protocols define how the behavioral health system and other child serving systems will work together; and work with family-run organizations to engage and support family member and youth voice and choice and involvement in system development.

Arizona has taken a number of steps to enhance our CFT practice. The Meet Me Where I Am (MMWIA) campaign of the ADHS/DBHS) rolled out in July 2007. MMWIA is designed to increase the both the quantity and the quality of home-based support and rehabilitation services for children and youth enrolled in the public behavioral health system across Arizona. These services consist of family support, living skills training, personal care services, and other wraparound services for kids with complex behavioral health needs and are available 24 hours per day, 7 days per week. These very intense services help maintain youth with the most complex needs in their homes and communities. AHCCCS Practice Tool, Support and Rehabilitation Services for Children, Adolescents and Young Adults (see attached) provides guidance on how best to utilize these services.

In 2008, funding was secured by ADHS/DBHS to establish an initiative to hire HNCMs in order to facilitate child and family teams for children and youth with the most complex needs in our Medicaid behavioral health system. The High Needs Case Management Initiative provides funding specifically for cadres of case managers with reduced caseloads (1 to 20) in order to work with the most complex child and family needs. There are currently over 450 of these skilled CFT practitioners serving children and families in Arizona. AHCCCS monitors the statewide policies and activities originally developed by ADHS/DBHS to codify these System of Care initiatives and they are written into the Regional Behavioral Health Authorities (RBHAs) contracts as well as contracts recently awarded to the integrated care MCOs.

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In Arizona, the "Wraparound" approach is called CFT Practice. For children and families with the most complex needs, as determined by the Child and Adolescent Service Intensity Instrument (CASII), the CFT Practice model incorporates the services of the HNCM mentioned above. HNCMs assist the family with identifying needs and resources (both formal and informal), assembling a unique team of individuals (the CFT) to brainstorm, support the family toward meeting their goals, developing a crisis plan, complete an inventory of strengths, needs, and cultural discovery, and secure services identified by the CFT. Guidelines for individualized care planning for children/youth with mental, substance use, and co-occurring disorders are defined in policy and contract. Arizona's Provider Manual and CFT Practice Tool specifically define the care planning process accomplished in the Child and Family Team.

System of care monitoring happens in multiple ways, including Children's System of Care Plans developed annually to incorporate current goals and initiatives, and reported by the RBHAs on a bi-annual basis. Additionally, for the past nine years Arizona has utilized the System of Care Practice Review (SOCPR) Tool, developed by University of South Florida, to measure CFT practice fidelity to system of care values and principles. Each year approximately 200 children with complex needs, as well as over 800 telephonic Brief Practice Reviews (BPR) for children with less complex needs are completed. In an annual summary report (see attachment for the most recent report, 2017), practice review results are provided for the provider agencies. Agencies are required to develop Practice Improvement Plans (PIPs) to target areas of practice where the SOCPR/BPR process has identified opportunities for improvement.

AHCCCS monitors and tracks service utilization, costs, and outcomes for children and youth with mental, substance use, and co-occurring disorders through the encounter system. Specific service codes are monitored in order to understand what services are being provided. For example, the use of generalist direct supports is of particular interest because of the state's investment in the MMWIA initiative. When the initiative rolled out, there was a requirement for providers to use a special modifier to their encounters so they could track increases in service utilization. This monitoring continues to be required at the RBHA level, and overseen by AHCCCS in order to monitor service availability and prioritize services to families most in need.

Annually updated collaborative protocols are in place with most child and youth serving agencies in Arizona. These protocols describe mutual support for the system of care vision and values, as well as support for provision of services through the CFT process. In addition, collaborative protocols define how the behavioral health system and its partners will work together, communicate, and problem-solve. These protocols are developed at the local level so the RBHA and the system partners in their respective geographic service area (GSA) shape the protocol to meet the specific needs of the service area. Collaborative protocols are contract requirements monitored at the state and local level via regular and ongoing meetings of providers and stakeholders. Co-located and agency-specific liaison roles further enhance collaboration in the provision of children's services. RBHAs and their providers maintain co-located positions at juvenile courts and Department of Child Safety (DCS) offices. Liaison positions are maintained at parole offices and juvenile courts to establish single points of contact for system partners to navigate the behavioral health system and resolve case-specific concerns. Although there is no official designee to the Arizona Department of Education (ADE) from AHCCCS, the two agencies and other state agencies participate, in a statewide group that has the goal of enhancing collaboration between the entities, The Arizona Community of Practice on Transition (AzCoPT).

7. Does the state have any activities related to this section that you would like to highlight?

AHCCCS promotes the use of evidence based practices (EBPs) in mental health and substance abuse prevention, treatment, and recovery services for children and adolescents, and their families through RBHA contracts. Annual Network Inventories are submitted by RBHAs outlining the entire scope of their provider networks, as well as specifying evidence based programming. In the area of substance abuse treatment; Matrix Model, Adolescent Community Reinforcement Approach (A-CRA) and Seven Challenges are examples of EBPs utilized. Other EBP implementations include the Transition to Independence Process (TIP) Model for transition aged youth and the Building Bridges Model for children transitioning from out-of-home placements into the community.

Young Adults in Arizona transition from the Children's behavioral health service system to the Adult system when they turn 18 years of age. This process is described in the AHCCCS Practice Tool "Transition to Adulthood" (see attached). This document provides instruction to provider agencies regarding the State's expectations with respect to the transition process and it includes detailed guidance for the transition of youth in foster care. In addition, AHCCCS provides guidance for working with foster youth in the Practice Tool "The Unique Behavioral Health Service Needs of Children, Youth, and Families involved with the Department of Child Safety (DCS)" (see attached).

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

The Arizona State Suicide Plan to End Suicides is updated annually and can be found on our website: https://tst.azahcccs.gov/AHCCCS/Downloads/2019StatePlantoEndSuicide.pdf.
The seven goals of our stakeholder-led state suicide prevention plan include:
1. Reducing the number of suicides in Arizona through coordinated prevention activities, including developing strong, multidisciplinary support for the Zero Suicide model
2. Reducing stigma related to suicide, including promoting responsible media reporting of suicide
3. Promote efforts to reduce access to lethal means of suicide, including the implementation of the Gun Shop Project
4. Promoting suicide prevention as a core component of health care services
5. Providing care and support to individuals affected by suicide deaths or suicide attempts and implementing community best practice-based prevention, intervention, and postvention strategies
6. Increasing the timeliness and usefulness of national, state, tribal, and local surveillance systems relevant to suicide prevention and improving the ability to collect, analyze, and use this information for action.
7. Evaluate the impact and effectiveness of suicide prevention interventions and systems and disseminate these findings
Our plan lists detailed activities paired with each of these goals.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ( ) Yes (●) No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

We are part of the Mayor's Challenge to reduce veteran suicides and work closely with a community coalition called Be Connected. This organization has brought together government, interfaith, community, and employment partners to better address the behavioral health needs of those who have served in the military, and their families. Through this work, and new state legislation mandating annual reporting of veteran suicides, we hope to prevent more suicide attempts and deaths.

The Arizona legislature passed a bill in 2019 mandating that all school staff receive an evidence-based, best practice suicide prevention training once every three years, beginning in 2020. We are working closely with the Arizona Department of Education to create a list of appropriate trainings for schools to being offering.

Further, we are working with the Governor's Office of Tribal Affairs to help Arizona's 22 tribal populations to create suicide prevention plans.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ○ Yes ◉ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ○ Yes ◉ No

If yes, with whom?

N/A

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

The Arizona Health Care Cost Containment System (AHCCCS) commitment to collaborative efforts begins at its administrative level, where mental health, substance abuse services, and acute care are administered out of one office. Both the Single State Authority (SSA) and State Mental Health Authority (SMHA) designation is held by the Director of AHCCCS. AHCCCS partners with numerous state agencies, including the Department of Economic Security (DES), Juvenile and Adult Corrections (JAC), Department of Education (DOE), the Administrative Office of the Courts (AOC), the Governor's Office, and the Department of Child Safety (DCS), to provide a comprehensive array of publicly funded services to children and adults through memorandums of understanding (MOUs), intergovernmental service agreements (ISAs) and/or informal relationships. Formal partnerships include:

• A partnership with the Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) through an Interagency Service Agreement (ISA), where AHCCCS and RSA work together to provide specialty employment services and supports for enrolled members with a Serious Mental Illness (SMI) determination.

• AHCCCS requires, through contract and policy, that all Managed Care Organizations (MCOs) providing behavioral health services develop Collaborative Protocols or MOUs with system stakeholders including; the Department of Child Safety, Administrative

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Office of the Courts (juvenile and adult probation), Department of Corrections (adult and juvenile), and the Veteran's Administration.

• An Interagency Service Agreement (ISA) between AHCCCS and Arizona Department of Education (ADOE) outlines the collaborative and training expectations between behavioral health and the school system in order to enhance outcomes for children involved in both systems. In addition to this ISA, the Arizona Legislature, in August of 2018, allocated 7 million dollars to be utilized by behavioral health agencies to provide behavioral health services to school-aged children specifically in a school setting. An associated allocation of 3 million dollars was given directly to the schools for them to provide Mental Health First Aid Training to school personnel. These collaborative efforts, including the ISA, support local schools provision of services under the Individuals with Disabilities Education Act (IDEA).

• In an Intergovernmental Agreement (IGA) between AHCCCS and Pima County Board of Supervisors, AHCCCS is tasked with providing a comprehensive, community-based system of mental health care for persons with an SMI who are residing in Pima County.

• AHCCCS and the Arizona Department of Housing (ADOH) developed an Interagency Service Agreement (ISA) which ADOH provided specialized real estate technical assistance for AHCCCS housing development projects, including project underwriting, risk assessment analysis, and providing recommendations to AHCCCS on the feasibility of funding particular housing projects for members with SMI. AHCCCS also entered into agreements with ADOH to leverage its SMI Housing Trust Funds into ADOH-administered Low Income Tax Credit Projects in exchange for a set-aside of units for SMI members in two new affordable housing projects, resulting in additional SMI housing capacity.

• AHCCCS entered into contractual agreements with the Housing Authorities of Maricopa County, the City of Phoenix and the City of Tempe to provide permanent housing vouchers for homeless individuals with SMI and General Mental Health Substance Use (GMHSU) problems, who were engaged through Project for Assistance in Transition from Homelessness (PATH) and other AHCCCS initiatives. AHCCCS housing funds provided temporary bridge housing to stabilize homeless members immediately while they completed housing authority voucher process. This collaboration reduced the time members experienced homelessness while maximizing housing resources for both AHCCCS and the housing authorities.

• An IGA also exists between AHCCCS and the Maricopa County Board of Supervisors. This agreement ensures service provision for remanded juveniles as well as for members with SMI, Non-SMI members, and those needing Local Alcohol Reception Services. While Maricopa County is obligated to provide certain services, this agreement ensures individuals are entered into the larger public behavioral health system at the earliest point.

• AHCCCS is a member of the Arizona Substance Abuse Partnership (ASAP) which serves as the single statewide council on substance abuse issues. ASAP brings together stakeholders at the federal, state, tribal, and local levels to improve coordination across agencies; address identified gaps in prevention, treatment, and enforcement efforts, and; improve fund allocation. ASAP utilizes data and practical expertise to develop effective methods for integrating and expanding services across Arizona, maximizing available resources. ASAP also studies current policies and recommends relevant legislation for the Arizona Legislature's consideration.

• Tribal and Regional Behavioral Health Authorities (T/RBHAs), contracted providers, and AHCCCS are all active participants in the Arizona Suicide Prevention Coalition. This group conducts research, gathers data, creates publicity, and works to make policy changes; areas of focus include the media, Native Americans, older adults, and youth.

• AHCCCS System of Care staff participates as a member of the Arizona Community of Practice on Transition. This is a collaborative group of state agencies and stakeholder organizations including the Division of Developmental Disabilities, Department of Child Safety (child welfare), Rehabilitation Service Administration (RSA), Arizona Office of the Courts (AOC), Arizona Department of Education (DOE), Arizona Department of Health Services (ADHS)/Office of Children with Special Health Care Needs, Raising Special Kids, and the Arizona Statewide Independent Living Council. The group meets monthly to collaborate, develop, and coordinate transition services, professional development, and resources related to improving the transition experience for youth who have disabilities. The Arizona Community of Practice on Transition is dedicated to the practice of shared leadership and using Leading by Convening as a framework to guide its work.

AHCCCS has focused on developing collaborations that both drive system initiatives and leverage funding. By working with the community partners as well as internal and external stakeholders, AHCCCS is able to implement policies and programs that extend beyond the behavioral health system. With cross system collaboration, AHCCCS has had the opportunity to positively impact areas such as the foster care system, the prescription drug epidemic, mental health first aid, and homeless outreach.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ○ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ○ Yes ○ No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[70]

[70] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

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Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**0**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**0**	**0.00%**
State Employees	0	
Providers	0	
Vacancies	0	
Total State Employees & Providers	**0**	**0.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	○ Yes	◉ No
b)	Posting of the plan on the web for public comment?	◉ Yes	○ No
	If yes, provide URL:		
c)	Other (e.g. public service announcements, print media)	○ Yes	◉ No

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Footnotes:

The draft block grant application was posted to the AHCCCS website on August 13, 2019. The final draft of the application will be posted on the website for the following year for public comments to be considered in the next application.

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