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 11/08/2019 12.51.44 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

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   Shelli

Last Name   Silver

Agency Name   Arizona Health Care Cost Containment System

Mailing Address   801 East Jefferson MD4100

City   Phoenix

Zip Code   85034

Telephone   602-417-4647

Fax

Email Address   shelli.silver@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   Jami

Last Name   Snyder

Agency Name   Arizona Health Care Cost Containment System (AHCCCS)

Mailing Address	801 E Jefferson MD4100
City	Phoenix
Zip Code	85034
Telephone	602-417-4458
Fax	
Email Address	jami.snyder@azahcccs.gov

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	9/3/2019 5:59:49 PM
Revision Date	11/8/2019 12:50:39 PM

VI. Contact Person Responsible for Application Submission

First Name	Michelle
Last Name	Skurka
Telephone	602-364-2111
Fax	
Email Address	michelle.skurka@azahcccs.gov

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**
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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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).

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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: Shelli Silver _____

Signature of CEO or Designee[1]: _____

Title: Deputy Director _____   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

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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
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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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.

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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: _Arizona_

Name of Chief Executive Officer (CEO) or Designee: Shelli Silver

Signature of CEO or Designee[1]: _Shelli Silver_

Title: Deputy Director

Date Signed: _8/30/19_

mm/dd/yyyy

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[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:

DOUGLAS A. DUCEY
GOVERNOR

EXECUTIVE OFFICE

April 8, 2019

Grants Management Specialist
Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Grants Management Specialist:

Due to the recent retirement announcement of Director, Thomas J. Betlach, I am designating Shelli Silver, Deputy Director of Health Plan Operations, at the Arizona Health Care Cost Containment System (AHCCCS) to serve as the role of the Single State Authority (SSA) for Arizona. I am also designating signature authority for the Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG), Project for Assistance in Transition from Homelessness (PATH) and discretionary grants during my term as Governor of Arizona, the signature authority includes the signing of any standard federal forms such as Assurances, and Certification and Disclosure of Lobbying Activities.

If you have any questions, please contact Michelle Skurka at Michelle.Skurka@azahcccs.gov or (602) 364-2111.

Sincerely,

Douglas A. Ducey
Governor
State of Arizona

Printed: 11/8/2019 12:51 PM - Arizona - OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

State Information

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

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services 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 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
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**
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**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
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**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

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.

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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

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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.)

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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: Shelli Silver

Signature of CEO or Designee[1]: _____

Title: Deputy Director_____   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

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

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services 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 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
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**
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**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
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**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

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 Costal 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 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.

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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: Shelli Silver

Signature of CEO or Designee[1]: _____

Title: Deputy Director   Date Signed: 8/30/19

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.

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

Footnotes:

AHCCCS STRATEGIC PLAN
STATE FISCAL YEARS 2018-2023

JANUARY 2018

AHCCCS
801 East Jefferson Street
Phoenix, Arizona 85034
www.azahcccs.gov

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

December 27, 2017

Dear Arizonans:

I am pleased to share with you a copy of the Arizona Health Care Cost Containment System (AHCCCS) Strategic Plan for State Fiscal Years 2018-2022. As AHCCCS looks ahead to 2018, this will be a very important and exciting year for the AHCCCS program.

Nationally, there has been a significant debate around the Medicaid program as part of the Repeal and Replace discussion. From this debate it is clear that Medicaid faces many challenges.   As the program has grown, it has consumed a larger portion of Federal and State resources, raising sustainability concerns. The program today serves a broader adult population that must be addressed through new, creative systems of care. The program is incredibly complex and fragmented and requires new approaches and policies to better serve populations like the dual eligible member. Finally, nationwide the Medicaid program faces the continual challenge of rapid leadership turnover. However, it is also important to recognize that as part of this debate the Medicaid program was shown to have incredible value for members, providers and families located in every community in Arizona.

Locally, AHCCCS is in the midst of the single largest procurement in the history of our state. The $50 billion AHCCCS Complete Care Contract will fundamentally transform the delivery system by integrating behavioral and physical healthcare services for approximately 1.5 million members. This continues the multi-year effort of AHCCCS to incrementally integrate services and will represent the single largest step both in terms of population and dollars integrated.

As a system that serves over 1.9 million Arizonans and spends $33 million per day, it is critical that AHCCCS pursue a broad array of strategies that are focused on creating a sustainable program. The growth in the AHCCCS program must be manageable and cannot crowd out other policy priorities like education and public safety. The program must be able to address the various challenges highlighted above.

It is within this context that this plan was developed. The plan offers four overarching goals which will guide the overall direction AHCCCS will take in the next five years. These four goals build on previous accomplishments and represent the collaborative efforts of the AHCCCS leadership team:

Goal 1.	*AHCCCS must pursue and implement long term strategies that bend the cost curve while improving member health outcomes.*
Goal 2.	*AHCCCS must pursue continuous quality improvement.*
Goal 3.	*AHCCCS must reduce fragmentation driving towards an integrated sustainable healthcare system.*
Goal 4.	*AHCCCS must maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations.*

AHCCCS continues to serve as an innovative model for delivering efficient and effective health care to Arizonans in need. AHCCCS recognizes that for over the past two decades the share of General Fund and increased pressure of spending at the federal level results in crowding out other policy priorities. The strategies pursued within this Strategic Plan are critical to developing a program that is sustainable over the long-term.

AHCCCS welcomes the opportunity to continue to be a leader and agent of change in the Arizona healthcare delivery system.

Sincerely,

Thomas J. Betlach
Director

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INTRODUCTION

The AHCCCS Strategic Plan for 2018-2023 begins with statements of the AHCCCS vision, mission and core values. This is followed by an overview of the programs and populations served, a review of accomplishments during the past fiscal year, and a description of the strategic goals which drive AHCCCS operations.

The Plan identifies four strategic goals for AHCCCS. These are:
1. AHCCCS must pursue and implement long term strategies that bend the cost curve while improving member health outcomes.
2. AHCCCS must pursue continuous quality improvement
3. AHCCCS must reduce fragmentation driving towards an integrated sustainable healthcare system.
4. AHCCCS must maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations

The Plan then concludes with a summary of Goals, Strategies, and Performance Measures that will serve to focus the efforts and energy of the program over the next few years.

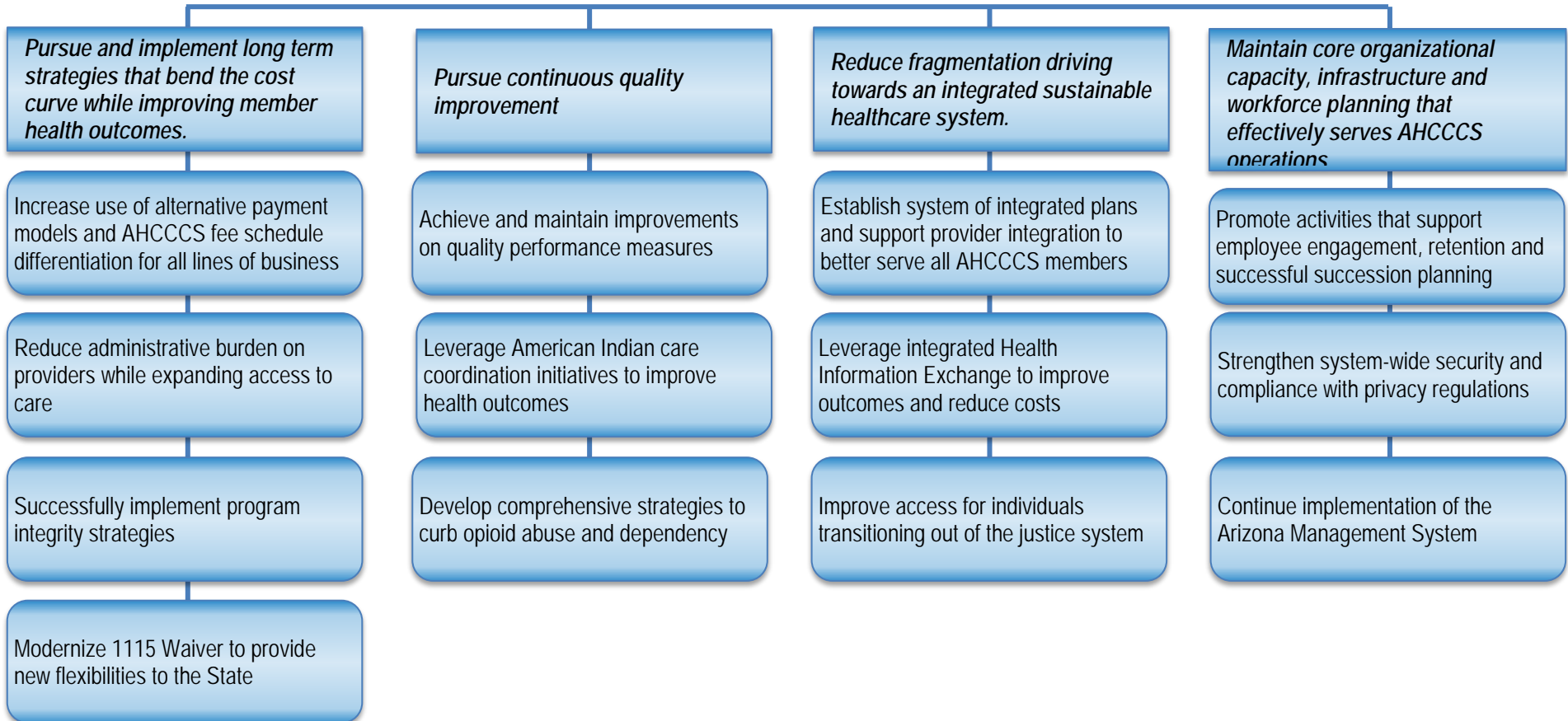| **AHCCCS VISION:**	**AHCCCS MISSION:**
Shaping tomorrow's managed health care from today's experience, quality, and innovation.	Reaching across Arizona to provide comprehensive, quality health care for those in need.

Core Values

1. **Passion:** Good health is a fundamental need of everyone. This belief drives us, inspires and energizes our work.
2. **Community:** Health care is fundamentally local. We consult with, are culturally sensitive to and respond to the unique needs of each community we serve.
3. **Quality:** Quality begins as a personal commitment to continual and rigorous improvement, self-examination, and change based on proper data and quality improvement practices.
4. **Respect:** Each person with whom we interact deserves our respect. We value ideas for change, and we learn from others
5. **Accountability:** We are personally responsible for our actions and understand the trust our government has placed on us. We plan and forecast as accurately as possible. Solid performance standards measure the integrity of our work. We tell the truth and keep our promises.
6. **Innovation:** We embrace change, but accept that not all innovation works as planned. We learn from experience.
7. **Teamwork:** Our mission requires good communication among interdependent areas inside and outside the agency. Internally, we team up within and across divisions. Externally, we partner with different customers as appropriate.
8. **Leadership:** We lead primarily in two ways: by setting the standards by which other programs can be judged and by developing and nurturing our own future leaders.

Reaching Across Arizona to Provide Comprehensive, Quality Health Care for Those in Need

Pursue and implement long term strategies that bend the cost curve while improving member health outcomes.	*Pursue continuous quality improvement*	*Reduce fragmentation driving towards an integrated sustainable healthcare system.*	*Maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations*
Increase use of alternative payment models and AHCCCS fee schedule differentiation for all lines of business	Achieve and maintain improvements on quality performance measures	Establish system of integrated plans and support provider integration to better serve all AHCCCS members	Promote activities that support employee engagement, retention and successful succession planning
Reduce administrative burden on providers while expanding access to care	Leverage American Indian care coordination initiatives to improve health outcomes	Leverage integrated Health Information Exchange to improve outcomes and reduce costs	Strengthen system-wide security and compliance with privacy regulations
Successfully implement program integrity strategies	Develop comprehensive strategies to curb opioid abuse and dependency	Improve access for individuals transitioning out of the justice system	Continue implementation of the Arizona Management System
Modernize 1115 Waiver to provide new flexibilities to the State			

AHCCCS OVERVIEW

The Arizona Health Care Cost Containment System (AHCCCS), the State's Medicaid Agency, uses federal, state, and county funds to provide health care coverage to the State's acute and long-term care Medicaid populations. Since 1982, when it became the first statewide Medicaid managed care system in the nation, AHCCCS has operated under a federal Research and Demonstration 1115 Waiver authority that allows for the operation of a total managed care model.

AHCCCS makes prospective capitation payments to contracted health plans responsible for the delivery of care to members. The model is a true public-private partnership that seeks to leverage competition and choice. The result is a managed care system that mainstreams recipients, allows them to select their providers, and encourages quality care and preventive services.

As of November 1, 2017, over 1.9 million Arizonans were enrolled in AHCCCS.

AHCCCS Complete Care

On October 1, 2018 AHCCCS will implement new Managed Care Contracts that will be fully integrated products that offer both behavioral and physical healthcare services for the majority of the AHCCCS population. This integrated model will better meet the needs of AHCCCS members by establishing a single accountable plan that is responsible for partnering with providers to address the whole healthcare need of AHCCCS members.

Recent studies have documented that a small percentage of the Medicaid population makes up a significant portion of the overall cost of the Medicaid population. In the majority of instances the most complex Medicaid members have both physical and behavioral healthcare needs. Modernizing the AHCCCS delivery system to better serve members is one of the overarching multi-year strategies that AHCCCS has pursued. October 1, 2018 will mark an important milestone in this ongoing integration journey.
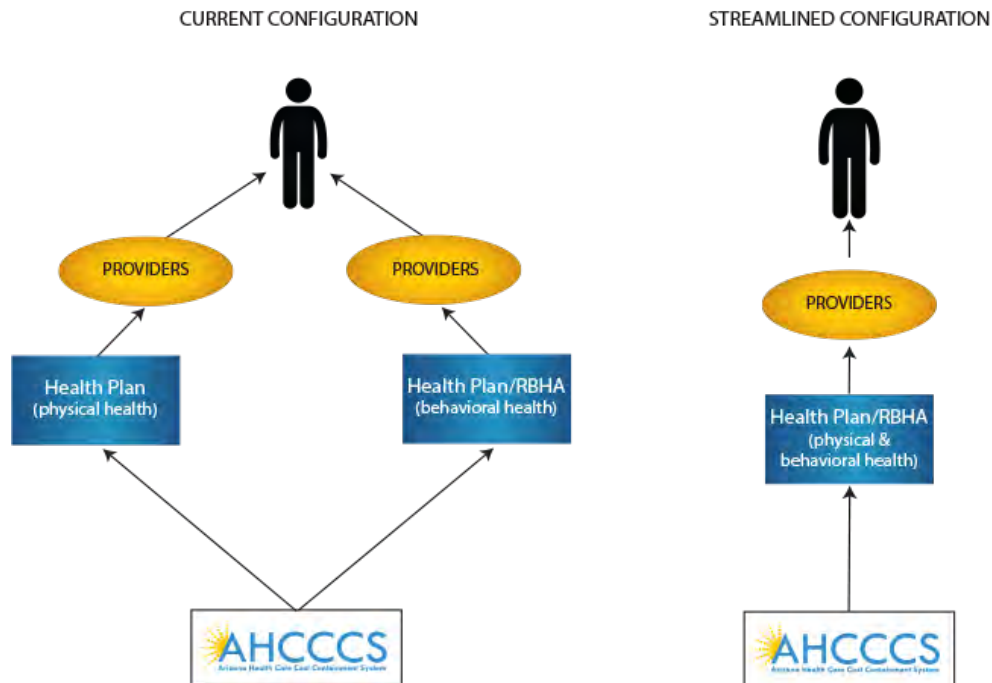
Regional Behavioral Health Authority (RBHA) Functions

Even with the establishment of the AHCCCS Complete Care Contracts on October 1, 2018 there will continue to remain important RBHA functions that are the responsibilities of AHCCCS Managed Care Organizations. These functions include:

1. Providing integrated services for Individuals with Serious Mental Illness.
2. Development and support of a regional crisis system.
3. For the near term, providing behavioral health services for children that are served by the Department of Child Safety.
4. Allocation of non-title XIX funding including Substance Abuse and Mental Health Services Administration (SAMHSA) grants and other sources of funding.

ALTCS

The Arizona Long Term Care System (ALTCS) provides acute care, behavioral health services, long-term care, and case management to individuals who are elderly, have physical disabilities or developmental disabilities and meet the criteria for institutionalization. Services for individuals with developmental disabilities in ALTCS are offered through the Arizona Department of Economic Security (ADES), Division of Developmental Disabilities (DDD). Whereas ALTCS members account for less than 4.0% of the AHCCCS population, they account for approximately 21.7% of the costs. The ALTCS program encourages delivery of care in alternative residential settings and has one of the highest home and community placement rates in the United States.
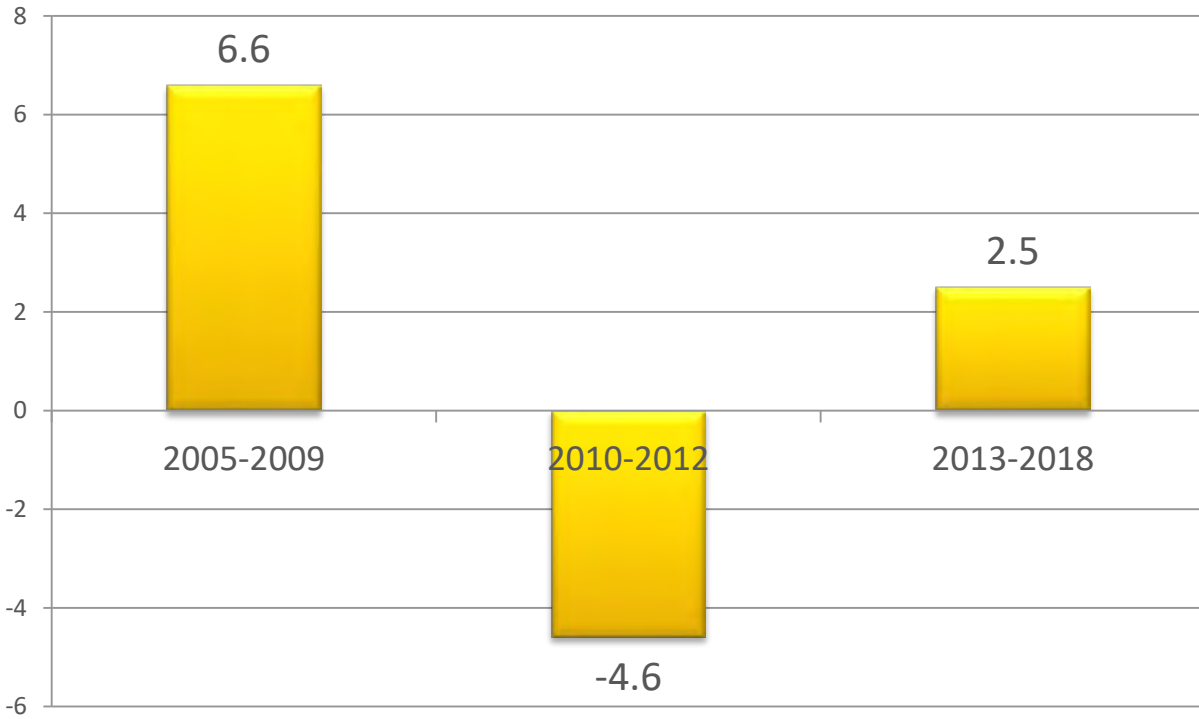
KidsCare

While not delineated as part of the delivery system below, the AHCCCS program is responsible for KidsCare. The Children's Health Insurance Program (CHIP), known as KidsCare in Arizona, offers affordable insurance coverage for low income families. Children under age 19 may qualify for the program if their family's income exceeds the limit allowed for Medicaid eligibility, but is below 200% of the Federal Poverty Level (FPL).   In 2016, Governor Ducey signed Senate Bill 1457 into law ending the enrollment freeze on the Kidscare program. Proposed Congressional action will likely result in reduced federal funding for the program starting in Federal Fiscal Year 2020. Under current state law if the federal match drops below 100% AHCCCS must institute a freeze in KidsCare. If the Arizona legislature is interested in a different policy approach that will need to be addressed in the spring of 2019 as part of the FY 2020 budget.
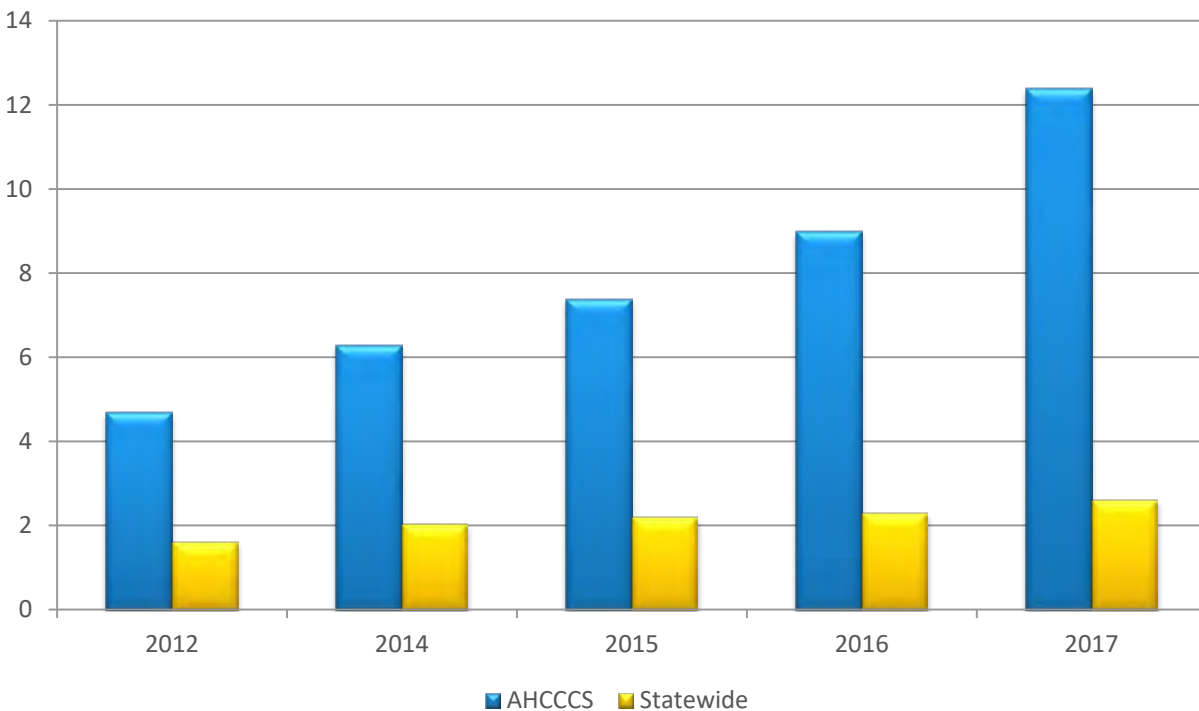
KEY ACCOMPLISHMENTS

- AHCCCS successfully defended in court the current statutory structure of the Hospital Assessment funding.
- AHCCCS successfully awarded the ALTCS RFP and transitioned over 9,000 members on October 1, 2017.
- The ALTCS program began implementing a new eligibility system in November of 2017.
- The Office of Human Rights eliminated the waitlist for special assistance services and currently provides assistance to the largest number of individuals ever. The Office of Human Rights has 2,504 individuals identified as Special Assistance and provides direct advocacy via assignment to 702 members.
- AHCCCS implemented a new Assessment Policy and streamlined demographic reporting to reduce provider and member administrative burdens.
- AHCCCS received approval from CMS to begin the American Indian Medical Home program and has begun the process of implementation
- AHCCCS received approval for a $300 million Targeted Investments program, helping facilitate integration at approximately 500 provider sites across the state
- AHCCCS established new VBP Strategies for NFs and providers who utilize E-prescriptions
- AHCCCS completed a rebase of the APR-DRG methodology, better aligning inpatient reimbursement with current data.
- The AHCCCS Leadership Academy was established, providing an opportunity for 30 staff to broaden perspectives of the Agency's mission, explore key issues within health care, better understand the health care delivery system, and build personal networks.
- AHCCCS expanded access to Hepatitis C medication while lowering the overall drug costs.
- AHCCCS implemented several strategies to combat the opioid epidemic including implementing 7 day opioid naïve fills.
- Cross–agency collaboration between AHCCCS, DOC and County justice partners resulted in over six thousand incarcerated individuals becoming eligible for AHCCCS prior to release.
- The number of HIE providers increased from 250 to 350.
- AHCCCS increased the funding for physicians who are affiliated with graduate medical education by $40 million.
- AHCCCS implemented a new reimbursement methodology for Free-Standing Emergency Departments
- AHCCCS Office of the Inspector General completed a review by CMS and the results were very positive.
- AHCCCS transitioned approximately 130,000 acute members as part of the closure of Phoenix Health Plan and Maricopa Health Plan.
- AHCCCS began registering Board Certified Behavior Analyst (BCBA) providers.
- AHCCCS held 4 quarterly Tribal Consultations which saw the largest turnout in AHCCCS history.
- AHCCCS completed an RFI, held public meetings and released the largest procurement in the history of Arizona for AHCCCS Complete Care.
- AHCCCS participated in the Repeal and Replace discussions and published timely analysis of proposed legislation.
- For Contract Year Ending 2018, the overall weighted average capitation rate increase was 2.9% which continues the overall trend for capitation rate growth of below 3% for the program.
- AHCCCS continued to have overall employee engagement scores that far exceeded the statewide average.

AHCCCS Cap Rate History

Cap rate values by period:
- 2005-2009: 6.6
- 2010-2012: -4.6
- 2013-2018: 2.5

Employee Engagement

Year	AHCCCS	Statewide
2012	4.7	1.6
2014	6.3	2.0
2015	7.4	2.2
2016	9.0	2.3
2017	12.4	2.6

STRATEGIC GOALS

The next section highlights the four strategic goals for AHCCCS and the comprehensive multi-year strategies which are being implemented in order to achieve these goals.

1. AHCCCS must pursue and implement long term strategies that bend the cost curve while improving member health outcomes.

One of the biggest challenges facing health care today is that incentives are often not aligned for providers and payers. Even with significant managed care penetration in Arizona Medicaid, many providers were reimbursed through fee-for-service mechanisms that reward volume over value.

Value based purchasing is a critical policy strategy for moving to a financially sustainable healthcare delivery system, which rewards high quality care provided at an affordable cost. There are many value based approaches with varying degrees of breadth and depth within Medicaid, Medicare and commercial coverage. Reforms include outcome based care models, risk bearing models, population based payments and episodic payments that can lead to improved health and overall program savings. Many AHCCCS stakeholders are engaged in developing initiatives and arrangements that embrace the key features of alternative payment models.

AHCCCS remains committed to maximizing the efficiencies within its program as demonstrated by the multi-year contractual requirements for Managed Care contractors. AHCCCS has supported a public-private collaborative market based approach that incentivizes payers and providers to establish new value based arrangements that align incentives to improve efficiency and member outcomes.

Additionally, AHCCCS has pursued adjustments in the fee-for-service payment schedule to incentivize certain value measures for providers. For example, this past year AHCCCS added an adjustment that rewards physicians for their use of e-prescribing technology.

Finally, as part of the efforts to bend the cost curve and ensure overall fiduciary oversight, AHCCCS continues to dedicate significant agency resources to program integrity efforts. The agency develops an annual strategic plan focused entirely on efforts to reduce fraud, waste and abuse along with improving coordination of benefits and other important initiatives.

2. AHCCCS must pursue continuous quality improvement.

AHCCCS has built its quality structure over time by continual review of applicable national standards and regional trends, collaboration with partners, and its own experiences. The Quality Strategy includes both the Medicaid and CHIP programs and encompasses all AHCCCS contractors. It also incorporates measures to improve the Agency's internal processes involving enrollee information, monitoring, and evaluation.

AHCCCS establishes performance measures based on the CMS Core Measure sets and the National Committee for Quality Assurance (NCQA) HEDIS measures, as well as measures unique to Arizona's Medicaid program. AHCCCS establishes minimum performance standards and goals for each performance measure that are based on national standards, such as the NCQA National Medicaid means, whenever possible. AHCCCS utilizes the Consumer

Assessment of Healthcare Providers and Systems (CAHPS). It is a survey tool created by the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of members' experiences with health care.

AHCCCS Contractors are expected to conduct Performance Improvement Projects (PIPs) in clinical care and non-clinical areas that are anticipated to have a favorable impact on health outcomes and member satisfaction. The health and safety of AHCCCS members receiving covered services remains a focus for the Agency. AHCCCS utilizes a multi-agency and Contractor approach in implementing oversight health and safety requirements.

AHCCCS remains committed to the health and safety of our American Indian members. Case management services are provided as an administrative service through managed care organizations. Many American Indian members receive care through the American Indian Health Program on a fee for service basis rather than through a Managed Care Organization. In order to close this gap and improve health outcomes, AHCCCS is establishing the American Indian Medical Home program to provide care coordination services to members of this population.

AHCCCS has also dedicated significant agency resources to address the ongoing opioid epidemic that has occurred in the United States. In collaboration with the Governor and the Department of Health Services, AHCCCS has pursued a number of strategies to leverage limited grant funding and the Medicaid delivery system to expand capacity to services while at the same time establishing protocols to limit the number of prescriptions to opioid naïve members.

Finally, AHCCCS believes it is important for members to have complete information regarding quality of care when making a decision on which Managed Care Organization to enroll in. It is therefore a priority of AHCCCS to increase the transparency of health plan performance. AHCCCS is actively working to improve and update the health plan scorecard to provide this vital information to members in an easily digestible manner.

### 3. *AHCCCS must reduce fragmentation driving towards an integrated sustainable healthcare system.*

The definition of a system is "an assemblage or combination of things or parts forming a complex or unitary whole". Unfortunately, health care delivery has become increasingly fragmented, leading to coordination and communication challenges for patients and clinicians. Ultimately, this fragmentation degrades the quality of health care due to disrupted relationships, poor coordination of care, and communication within and across provider groups. In an effort to address this issue, the structure of the Medicaid delivery system in Arizona is transforming to support an integrated care delivery model with better alignment of incentives that seek to efficiently and effectively improve health outcomes.

AHCCCS has been engaged in a multi-year effort to reduce fragmentation at the provider, payer and policy level for AHCCCS members. Starting in 2013, AHCCCS successfully integrated services for a number of populations. AHCCCS recognizes that system design matters and has worked with a variety of important stakeholders to develop new delivery systems that are focused on whole person health integrating both physical and behavioral health services. These integration efforts include:

1. Children's Rehabilitative Services – Previously 17,000 children with complex medical needs were served by three different payers. These included an acute plan, RBHA and CRS plan. These members are now served by a single Integrated Contractor.

2. Individuals with Serious Mental Illness – In 2014 and 2015, almost 40,000 individuals with Serious Mental Illness went from potentially up to 4 different payers involved in covering select services to a single organization that was responsible for all services for that member.

3. General Mental Health and Substance Abuse services for dual eligible members – In 2015, AHCCCS integrated services for 80,000 dual eligible members.

4. American Indian members –In 2016, as a result of the DBHS merger, AHCCCS was able to streamline the requirements for TRBHA organizations creating an opportunity to integrate services and work more closely with Tribes on the delivery and coordination of services.

5. Dual Eligible members – AHCCCS continues to pursue strategies to better align services for members that are enrolled in both Medicare and Medicaid. In 2016, AHCCCS had approximately 48% of the population aligned which is the highest percentage ever.

6. AHCCCS/DBHS merger – In 2016, AHCCCS completed a merger with the Department of Health Services, Division of Behavioral Health Services. This merger brought behavioral health and physical health together at the policy level and ensured behavioral health and physical health policies and system requirements are established with a focus on whole person health.
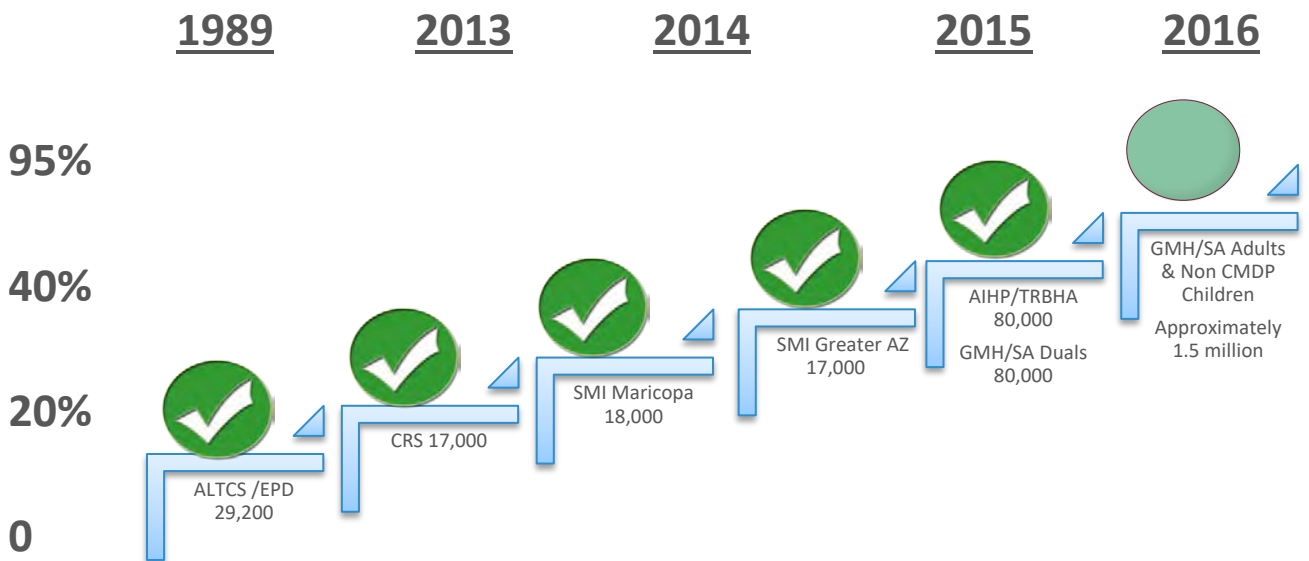
Looking ahead the work around transformation through integration and reducing fragmentation will continue. AHCCCS is pursuing strategies to reduce fragmentation as part of the October 1, 2108 AHCCCS Complete Care product implementation. At the contractor level, AHCCCS plans to offer an integrated contract for all AHCCCS members by 2020. AHCCCS will also focus on increasing the number of integrated providers in the system and plans to increase the number of

integrated clinics available to members by 50%. Furthermore, AHCCCS has already invested significant capital in integrating health information across providers. As a result of this strong community support, Arizona now has a fully functioning Health Information Exchange. AHCCCS will now focus on leveraging this system to increase information flow across delivery systems.

Finally, AHCCCS will continue implementing strategies to improve access for individuals transitioning out of the justice system. AHCCCS does not provide health care services for those who are incarcerated. Upon their release, many of these men, women, and children become eligible for AHCCCS. AHCCCS has partnered with the Arizona Department of Corrections, county justice programs and private sector partners to ease this transition. Once enrolled in AHCCCS, these members can receive quality health care in an efficient manner reducing unnecessary emergency department visits and the likelihood for recidivism.

4. AHCCCS must maintain core organizational capacity and workforce planning that effectively serves AHCCCS operations

If the agency is going to be successful in pursuing these important delivery system transformations, there are a number of other important infrastructure capabilities that must be addressed over the next several years.

Workforce

In order for AHCCCS to achieve the established operational and strategic objectives, the organization must have a dedicated, professional staff that is committed to the mission. Based on the most recent state survey AHCCCS had 12.4 staff engaged for every staff member not engaged. This compares to the state government rate of 2.2 to 1.

A few other important metrics include:
1. 97.7% - I respect and value the members of my team and their contributions.
2. 97.3% - I believe in the AHCCCS mission.
3. 94.0% - I recognize fellow employees for work well done.

However, there are challenges to sustaining the high level performance of the AHCCCS workforce. AHCCCS continues to operate with approximately 25% less staff than prior to the start of the Great Recession. Turnover rates are, on the average 15% while approximately 15% of the current AHCCCS workforce is eligible to retire.

AHCCCS is pursuing several strategies to address these challenges.
1. Increasing AHCCCS' presence in the employment marketplace for purposes of enhancing our ability to attract the most qualified applicants;
2. Identifying and implementing relevant compensation strategies;
3. Maintaining an environment conducive to staff engagement;
4. Expanding innovative, low-cost professional development opportunities for existing employees;
5. Retaining critical staff;
6. Workforce and succession planning in order to ensure continuity of services and avoid leaving a significant gap in the Agency's knowledge base; and
7. Continuing to provide flexibility.

Approximately 23% of the AHCCCS workforce is Virtual Office with an even higher percentage on some variation of a flexible work schedule. This type of flexibility has proven essential to retention and assisting employees with striking a work-life balance.

Systems

System resources will continue to be a challenge and maintaining the appropriate infrastructure to manage and analyze the millions of records generated by the AHCCCS system requires appropriate investment. Over the next 3 years AHCCCS will be looking to enhance its quality management, provider registration, and eligibility systems.

Security

The AHCCCS Information Systems Division (ISD) must be ever vigilant regarding the security posture of the systems and important information contained within these systems. Proactive mitigation of security risks strengthens the ability to safeguard and protect Personally Identifiable Information (PII) and Protected Health Information (PHI) data entrusted to the Agency by our more than 1.9 million members. In addition to the AHCCCS mainframe system (PMMIS), ISD will continue to keep non-mainframe systems and applications running consistently and efficiently. This includes server based applications, network infrastructure, the data warehouse, and digital communication.

Leveraging Data Analytics

The availability of reliable and valid information and the capacity to make that information actionable is critical to the decision-making process. Data-driven decision-making is the best way for true reform to occur in the healthcare system. However, determining the most effective way to utilize data, and having the time and resources to effectively review or explore data can produce challenges. As a result, there is an increased value and emphasis being placed on data analytics. The Office of Business Intelligence (OBI) is responsible for the AHCCCS Data Warehouse, which provides the Agency with information that is easily accessible and reliable. The information allows the organization to gain greater insight into its operations. AHCCCS will work with internal and external data analytics experts to develop the organization's capacity as a whole to turn solid information into effective actions.

Arizona Management System
Governor Ducey has deployed a professional, results-driven management system to transform the way agencies think and do business. AHCCCS has fully embraced this system and is committed to tracking and improving performance every day. Across the agency AHCCCS employees now meet regularly around huddle boards where staff can monitor performance and hold themselves accountable for results. The agency will continue to gather data and work toward delivering results for the people of Arizona.

GOAL 1.

AHCCCS must pursue and implement long term strategies that bend the cost curve while improving member health outcomes.

STRATEGY 1.1
Increase use of alternative payment models and AHCCCS fee schedule differentiation for all lines of business

PERFORMANCE MEASURE 1.1.1
47% of Health Plan spend in alternative payment models by 10/1/18

PERFORMANCE MEASURE 1.1.2
Payment on value available for 50% of FFS spend exclusive of IHS/638 reimbursement

STRATEGY 1.2
Reduce administrative burden on providers while expanding access to care

PERFORMANCE MEASURE 1.2.1
Implement three ICD strategies in 2018 to reduce administrative burden on providers

STRATEGY 1.3
Successfully implement Program Integrity strategies

PERFORMANCE MEASURE 1.3.1
Percent of overall strategies implemented

STRATEGY 1.4
Modernize 1115 Waiver to provide new flexibilities to State

PERFORMANCE MEASURE 1.4.1
Implement IMD Substance Use Disorder Waiver by 4/1/18

GOAL 2.

AHCCCS must pursue continuous quality improvement

STRATEGY 2.1
Achieve and maintain improvements on quality performance measures

PERFORMANCE MEASURE 2.1.1
Percent of measures which exceed the NCQA mean

STRATEGY 2.2
Leverage American Indian care coordination initiative to improve health outcomes

PERFORMANCE MEASURE 2.2.1
Number of facilities achieving medical home status

STRATEGY 2.3
Develop comprehensive strategies to curb opioid abuse and dependency

PERFORMANCE MEASURE 2.3.1
Overall number of prescribed opioids

GOAL 3.
AHCCCS must reduce fragmentation driving towards an integrated sustainable healthcare system

STRATEGY 3.1
Establish system of integrated plans and support provider integration to better serve all AHCCCS members

PERFORMANCE MEASURE 3.1.1
Implement AHCCCS Complete Care Contracts for 10-1-18

PERFORMANCE MEASURE 3.1.2
Increase dual members aligned

PERFORMANCE MEASURE 3.1.3
Retain 95% of TI participants and make year 2 payments by Jan 2019

STRATEGY 3.2
Leverage integrated Health Information Exchange to improve outcomes and reduce costs

PERFORMANCE MEASURE 3.2.1
Number of provider organizations participating in the HIE

STRATEGY 3.3
Improve access for individuals transitioning out of the justice system

PERFORMANCE MEASURE 3.3.1
Establish 2 clinics inside probation and parole offices by 10/1/18

PERFORMANCE MEASURE 3.3.2
Increase percentage of eligible individuals who receive AHCCCS enrollment within 72 hours of release

GOAL 4.
AHCCCS must maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations

STRATEGY 4.1
Promote activities that support employee engagement and retention
PERFORMANCE MEASURE 4.1.1
AHCCCS Overall Employee Engagement Score

STRATEGY 4.2
Strengthen system-wide security and compliance with privacy regulations

PERFORMANCE MEASURE 4.2.1
ADOA evaluation score – maintain 700 ranking

STRATEGY 4.3
Continue implementation of the Arizona Management System

PERFORMANCE MEASURE 4.3.1
Improved employee recognition around importance of AMS

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.

AHCCCS' 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 American Indian Health Plans (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 a Serious Mental Illness (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 Regional Behavioral Health Authorities (RBHA) 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/).

The definition of a RBHA is a contracted Managed Care Organization (also known as a health plan) responsible for the provision of comprehensive behavioral health services to all eligible individuals assigned by the administration and provision of comprehensive physical health services to eligible persons with a Serious Mental Illness enrolled by the Administration. Also, the definition of a Tribal Regional Behavioral Health Authority (TRBHA) is a tribal entity that

has an intergovernmental agreement with the administration, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health services to all eligible individuals assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401 and A.R.S. §36-3407.

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 Substance Abuse and Mental Health Services Administration (SAMHSA) block and discretionary grants will all be part of the Division of Grants Administration (DGA) 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, Project Directors/Coordinators, etc.

AHCCCS is actively recruiting for an Assistant Director for the Division of Grants Administration (DGA). AHCCCS is developing a Division of Grants Administration (DGA) to streamline grant administration under a single unit. This unit was formed in 2019, and will report to the Deputy Director of Business Operations in the Office of the Director.

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,
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 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 (CBHSG) 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 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 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). 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 in Arizona falls under the Arizona Department of Economic Security (ADES).

AHCCCS has a partnership with RSA/VR, through an Interagency Service Agreement (ISA), where AHCCCS and RSA/VR work together to provide specialty employment services and supports for RBHA-enrolled members with a Serious Mental Illness (SMI) determination. These specialty employment services and supports include, but are not limited to, the following:

- VR Counselors have specialized caseloads of members with SMI determinations.
- The timeframe to determine VR eligibility is modified from 60 days to 30 days.
- VR Counselors are part of the Clinical Team and are able to conduct some of their business at the assigned Provider sites.
- VR Counselors and Provider employment staff work closely together and have weekly consultations regarding the progress of mutual program participants.
- Working in collaboration with Providers, RSA/VR conducts VR Orientations at least 1x/month at assigned Provider sites.

Additionally, and not related to the ISA, RSA/VR has assigned one of their offices to work with any referrals coming out of the State Hospital and has a part-time VR Counselor assigned to the Human Services Campus, which is Maricopa County's largest homeless services provider.

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 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 (EBP).

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, lesbian, gay, bisexual, and transgender (LGBT), elderly, homeless, rural, and diverse populations. The Managed Care Organizations 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.

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.

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

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Footnotes:

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 Managed Care Organizations, including 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

- 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.

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.

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.

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 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 1, 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 Managed Care Organizations based on their monitoring and reports received from providers serving those with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and Early Serious Mental Illness (ESMI). From the data available there are few unmet need services identified largely because of the robust integrated care provided through expanded Medicaid services, state general funds, and the Mental Health Block Grant (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' 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,

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.

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

Footnotes:

Quality and Data Collection Readiness

<u>Arizona Data Collection and Reporting System</u>

The Arizona Health Care Cost Containment System (AHCCCS) is capable of collecting and reporting information by client, provider and/or other levels with limited restrictions. The current data collection and reporting system includes all clients receiving Medicaid services (acute, behavioral health, substance abuse).

The most significant limitation at this time pertains to linking member service provision to specific funding streams, or line-item allocations. Given the structure of the service delivery system, and the various funding sources (Medicaid, Federal Block Grant, Federal Discretionary Grants, State General Fund and County, City or local funds) used to provide services to our clients, as it pertains to clients who do not qualify for Medicaid Coverage, AHCCCS is not readily able to specifically identify which funding source was used to provide services down to the client level.

AHCCCS maintains a data system which is comprised of three interdependent databases used for storing client eligibility, demographic (DUGless), and service encounters information. The three systems utilize a unique identifier (AHCCCS ID) as a primary key for joining, and operate as follows:

Enrollment and Eligibility
All clients receiving services must be enrolled in the behavioral health system under one of the defined eligibility categories (State-Only or Medicaid Eligible). The Enrollment and Eligibility database maintains the historical enrollment segments for all clients. The database allows AHCCCS to determine, and subsequently report, the number of enrolled Medicaid eligible clients, compared to those who would otherwise be funded through other means, including State General Funds, or Federal Block Grants.

Demographics (DUGless)
AHCCCS collects certain client data directly from providers through online portal (DUGless). Among the data gathered during this process are several identifiable factors, such as date of birth, National Outcome Measures (NOMs), and reasons for seeking treatment. Furthermore, this information must be submitted for new clients or upon a significant change in the client's life - such as gaining employment. For more information please see the *DUGless Portal Guide*, available   at (https://www.azahcccs.gov/PlansProviders/Downloads/Demographics/DUGlessPortalGuide.pdf).

Service Encounters
Client service encounter data is also reported by the Managed Care Organizations (MCO's), and is required to be submitted to the AHCCCS no later than 210 days following the date of service. This information includes the type of service being provided, i.e. group counseling, case management, or a clinical assessment, the number of service units the client received in a unique session (typically based on 15 minute increments, or per-diem, depending on service type), the total dollar value for that service session, and the provider offering the service. This reporting

standard allows the AHCCCS to measure service utilization, prescription drug utilization, by service type and provider, at the client level; in other words, the AHCCCS can report the precise number of service units, and the corresponding dollar value, each client received, or each agency provided, within a given timeframe.

Population Level Data

In addition to the data captured above, Arizona utilizes population level data that is collected through the Arizona Youth Survey (AYS) administered by the Arizona Criminal Justice Commission. The Arizona Youth Survey (AYS) was administered to a statewide sample of 8th, 10th, and 12th grade youth during the spring of 2018 under the direction of the Arizona Criminal Justice Commission's Statistical Analysis Center and in partnership with the Arizona State University's School of Criminology & Criminal Justice to comply with Arizona Revised Statute §41-2416. Based on the nationally recognized Risk and Protective Factor model and the Communities That Care survey (Hawkins et al., 1992), the AYS assesses the prevalence and frequency of youth substance use, gang involvement, and other risky behaviors, and helps stakeholders to better understand the risk and protective factors that are correlated with these behaviors. Arizona uses this data for the related prevention measures in this report. AYS data is collected every two years.

Arizona utilizes the Arizona Department of Health Services, Bureau of Population Health and Vital Statistics data for related suicide mortality and suicide prevention reporting. This statewide data set is collected annually. The Bureau of Public Health Statistics collects a variety of health and vital data in addition to suicide data, and maintains these in several primary databases for public health purposes, and for general public information.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #:   1

Priority Area: Underage Alcohol Use

Priority Type: SAP

Population(s):   PP, Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Decrease the percentage of youth reporting past 30 day alcohol use (more than just a few sips) from the current level of 11.5% to 9.5% of those in the 8th grade, 20.2% to 18.2% of those in the 10th grade, and 30.7% to 28.7% of those in the 12th grade, as measured by the 2022 Arizona Youth Survey.

Objective:

Increase awareness and use of educational messaging regarding the harms of underage alcohol use, and increase use of evidence based prevention practices that address underage alcohol use.

Strategies to attain the objective:

Strategies to attain the objective:
Provide education on available evidence based practices related to addressing underage alcohol use, and provide training on how to choose EBPs based on community need. Increase the use of Evidence Based Programs (EBP) with activities to include:
• Enhancing the ability of local community coalitions to more effectively provide prevention services for alcohol including: organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking.
• Provide alternatives for underage drinking for youth including: drug free dances and parties, Youth/adult leadership/mentor activities, community drop-in centers and community service activities.
• Establish or change written and unwritten community standards and codes and attitudes that factor into underage alcohol use, including: promoting the establishment or review of alcohol, tobacco and drug use policies in schools, technical assistance to communities to maximize local enforcement, procedures governing availability and distribution of alcohol, tobacco, and other drug use, modifying alcohol and tobacco advertising practices, and product pricing strategies.
• Provide underage alcohol use education and educational opportunities that involve two-way communication and is distinguished from the Information Dissemination by the fact that interaction between the educator/facilitator and the participants is the basis of its activities, including: education to affect critical life and social skills, decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.
• Provide awareness and knowledge of the nature and extent of local and state underage alcohol use, abuse and addiction and their effects on individuals, families and communities, and increase awareness of available prevention programs and services through: clearinghouse/information resource center(s), resource directories, media campaigns,, brochures, radio/TV public service announcements, speaking engagements, and health fairs/health promotion.
• Identify those who have indulged in illegal/age-inappropriate use of alcohol in order to assess if their behavior can be reversed through education, including: student assistance programs, and driving while under the influence/driving while intoxicated education programs.

Annual Performance Indicators to measure goal success

Indicator #:   1

Indicator: Annual Performance Indicators to measure success on a yearly basis.

Baseline Measurement: The percentage of youth reporting past 30 day alcohol use (more than just a few sips) at 11.5% of those in the 8th grade, 20.2% of those in the 10th grade, and 30.7% of those in the 12th grade, as measured by the 2018 Arizona Youth Survey.

First-year target/outcome measurement: Decrease the percentage of youth reporting past 30 day alcohol use (more than just a few sips) from the current level of 11.5% to 10.5% of those in the 8th grade, 20.2% to 19.2% of those in the 10th grade, and 30.7% to 29.7% of those in the 12th grade, as measured by the 2020 Arizona Youth Survey.

Second-year target/outcome measurement: Decrease the percentage of youth reporting past 30 day alcohol use (more than just a few sips) from 10.5% to 9.5% of those in the 8th grade, 19.2% to 18.2% of those in the 10th grade, and 29.7% to 28.7% of those in the 12th grade, as measured by the 2022 Arizona Youth Survey.

Data Source:

Arizona Youth Survey (AYS)

Description of Data:

Data obtained from the Pre and Post Tests (Adolescent Core Measure) from the AYS

Data issues/caveats that affect outcome measures::

AYS is released every two years so the 2019 numbers will be difficult to evaluate until 2020.
http://azcjc.gov/sites/default/files/pubs/AYSReports/2018/2018_Arizona_Youth_Survey_State_Report.pdf

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Priority #:	2
Priority Area:	Underage Alcohol, Tobacco and Other Drug (ATOD) Use
Priority Type:	SAP
Population(s):	PP, Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 33.2% in 2018 to 31.2%, as measured by the 2022 Arizona Youth Survey.

Objective:

Increase the use of prevention strategies that address community, family, school, and peer/individual risk factors through the use of evidence based practices and strategies that address both risk factors and ATOD use.

Strategies to attain the objective:

Provide education to increase awareness of available evidence based practices that address community, family, school, and peer/individual risk factors, and provide training on how to choose EBPs based on community need. Activities to include:
• Enhancing the ability of local community coalitions to more effectively provide prevention services for ATOD including: organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking
• Provide alternatives of ATOD use for youth including: drug free dances and parties, Youth/adult leadership/mentor activities, community drop-in centers and community service activities.
• Establish or change written and unwritten community standards and codes and attitudes that factor into ATOD use, including: promoting the establishment or review of alcohol, tobacco and drug use policies in schools, technical assistance to communities to maximize local enforcement, procedures governing availability and distribution of alcohol, tobacco, and other drug use, modifying alcohol and tobacco advertising practices, and product pricing strategies.
• Provide ATOD education and educational opportunities that involve two-way communication and is distinguished from information dissemination by the fact that interaction between the educator/facilitator and the participants is the basis of its activities, including: education to affect critical life and social skills, decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.
• Provide awareness and knowledge of the nature and extent of local and state ATOD use, abuse and addiction and their effects on individuals, families and communities, and increase awareness of available prevention programs and services through: clearinghouse/information resource center(s), resource directories, media campaigns,, brochures, radio/TV public service announcements, speaking engagements, and health fairs/health promotion.
• Identify those who have indulged in illegal/age-inappropriate use of ATOD in order to assess if their behavior can be reversed through education, including: student assistance programs, and driving while under the influence/driving while intoxicated education programs.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement:	The percentage of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) is 33.2%, according to the 2018 Arizona Youth Survey.
First-year target/outcome measurement:	Decrease the percentage of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th

grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors), to 32.2% as measured by the 2020 Arizona Youth Survey.

Second-year target/outcome measurement: Decrease the percentage of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors), to 31.2% as measured by the 2022 Arizona Youth Survey.

Data Source:

Arizona Youth Survey (AYS)

Description of Data:

Data obtained from the Pre and Post Tests (Adolescent Core Measure) from the AYS

Data issues/caveats that affect outcome measures::

AYS is released every two years so the 2019 numbers will be difficult to evaluate until 2020.

http://azcjc.gov/sites/default/files/pubs/AYSReports/2018/2018_Arizona_Youth_Survey_State_Report.pdf

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Priority #:	3
Priority Area:	Youth
Priority Type:	SAT
Population(s):	Other (Adolescents w/SA and/or MH)

Goal of the priority area:

Increase the percentage of those how are in the behavioral health system diagnosed as having a substance use disorder and received treatment under the age of 18.

Objective:

Implement programs that are inclusive of education, implementation, and monitoring/oversight.

Strategies to attain the objective:

Arizona Health Care Cost Containment System (AHCCCS) Managed Care Organizations (MCOs) lines of business will continue to collaborate and meet regularly with child/adolescent providers to share information on substance abuse screening, trends, and best practices. AHCCCS and the MCO will provide and promote access to substance abuse training initiatives available to child/adolescent providers including those employed though other agencies such as the Department of Child Safety (DCS).
AHCCCS and the MCOs will continue to educate providers, contractors, and coalitions on how to engage community stakeholders in identifying and referring youth to early intervention and substance abuse treatment centers. AHCCCS will ensure the availability of the standardized, parent-friendly, screening tool to identify substance use/abuse in the children and adolescents.
Additionally, AHCCCS is currently in the process of implementing the ASAM (American Society of Addiction Medicine) CONTINUUM®/AZ WITS (Web Infrastructure for Treatment System). Providers will to utilize an online portal that contains the ASAM CONTINUUM® to place members in the appropriate level of care. AHCCCS will monitor enrollment number of youth diagnosed with a substance use diagnosis within the system of care.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The number of persons under the age of 18 diagnosed with SUD and received treatment.
Baseline Measurement:	In State Fiscal Year 18, 35% of those with a substance use disorder and received treatment were under the age of 18.
First-year target/outcome measurement:	First-year target/outcome measurement (Progress to end of SFY 2020), 37%
Second-year target/outcome measurement:	Second year target/outcome measurement (Final to end of SFY 2021), 20.7% (Progress to end of SFY 2021), 39%
Data Source:	

Arizona Health Care Cost Containment System's (AHCCCS).

Description of Data:

Arizona Health Care Cost Containment System's (AHCCCS) eligibility, enrollment, claims, and encounters data.

Data issues/caveats that affect outcome measures::

No Data related issues identified.

Priority #:	4
Priority Area:	IV Drug Users
Priority Type:	SAT
Population(s):	PWID, Other (Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Increase the availability and service utilization of Medication-Assisted Treatment (MAT) options for members with a SUD. AHCCCS will focus on reaching out to the IV drug use population. Arizona has worked to improve MAT access and availability through provider network monitoring to assess needs, expanding lists of approved MAT medications, and increasing convenience of locations and hours. Providers and their prescribers receive training on the availability and use of MAT services, as well as education on MAT medications. Additionally, there are now Methadone and Suboxone Directories available for Maricopa County to assist in making appropriate referrals. These services and ease of access to services continue to be a collaborative goal of the block grant and additional Opioid focused grants.

Objective:

Educate providers, members, and stakeholders on MAT options in the community.

Strategies to attain the objective:

AHCCCS will further rollout the expanded MAT services available to those with a substance use diagnoses through additional advertising within the community. AHCCCS and RBHAs will provide education for healthcare practitioners on best practices and availability of MAT services. AHCCCS will update the Behavioral Health page to provide links to locate MATs available throughout the State to assist members in locating appropriate services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Annual Performance Indicators to measure on a yearly basis
Baseline Measurement:	In Fiscal Year 18, 89.3% of those with a substance use disorder and received treatment were IV drug users.
First-year target/outcome measurement:	First year target/outcome measurement (Progress to end of SFY 2020), 90%
Second-year target/outcome measurement:	Second-year target/outcome measurement (Final to end of SFY 2021), 91%

Data Source:

CIS (Client Information Services)

Description of Data:

Arizona Health Care Cost Containment System's (AHCCCS) eligibility, enrollment, claims, and encounters data.

Data issues/caveats that affect outcome measures::

No data related issues identified.

Priority #:	5
Priority Area:	Older Adults
Priority Type:	SAT
Population(s):	Other

Goal of the priority area:

Increase the percentage of those who are in the behavioral health system diagnosed as having a substance use disorder and received treatment aged 55 years and older.

Objective:

Implement programs that are inclusive of education, implementation, and monitoring/oversight.

Strategies to attain the objective:

The Managed Care Organizations (MCOs) AHCCCS contracts with will continue efforts to promote access to substance abuse treatment services for older adults during meetings with providers and collaborators, and through community-based trainings. Trainings provided by the RBHAs have included components on how to screen for substance abuse in the older adult population, and effective substance abuse treatment and other evidence-based practices targeting the older adult population.

Additionally, providers continue to utilize Substance Abuse screening tools, including ASAM. AHCCCS will monitor enrollment numbers for older adults diagnosed with a substance use diagnosis who receive substance use disorder (SUD) treatment. The MCOs will continue to collaborate and meet regularly with providers to share information on substance abuse screening, trends and best practices. AHCCCS and the MCOs will provide and promote access to substance abuse training initiatives available to Arizona Long Term Care System (ALTCS) providers.

AHCCCS and the MCOs will educate treatment providers, and coalitions on how to engage community stakeholders in identifying and referring older adults to substance abuse treatment services. AHCCCS will ensure the availability of a standardized, age appropriate, screening tool to identify substance use/abuse in older adults.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The number of persons 55 years and older diagnosed with SUD and received treatment.
Baseline Measurement:	In State Fiscal Year 18, 20.3% of those with a substance use disorder and received treatment were 55 years and older.
First-year target/outcome measurement:	First year target/outcome measurement (Progress to end of SFY 2020), 20.5%
Second-year target/outcome measurement:	Second year target/outcome measurement (Final to end of SFY 2021), 20.7%

Data Source:

Arizona Health Care Cost Containment System's (AHCCCS).

Description of Data:

Arizona Health Care Cost Containment System's (AHCCCS) eligibility, enrollment, claims, and encounters data.

Data issues/caveats that affect outcome measures::

No Data related issues identified.

Priority #:	6
Priority Area:	Pregnant Women and Women with Dependent Children
Priority Type:	SAT
Population(s):	PWWDC

Goal of the priority area:

Ensure women have ease of access to all specialty population related substance use disorder treatment and recovery support services.

Objective:

Increase outreach and educate the community about services available to pregnant women and women with dependent children.

Strategies to attain the objective:

Arizona Health Care Cost Containment System (AHCCCS) and the assigned Managed Care Organization (MCO) will collaborate on ways to expand public awareness campaigns directed towards the priority populations. AHCCCS and the assigned MCOs will regularly monitor treatment waitlists to

ensure access to care. AHCCCS will review encounter codes to ensure pregnant women and women with children receive the full array of covered services. AHCCCS and the assigned MCO or the utilization of services for this priority population.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis.

Baseline Measurement: Number of those with a substance use disorder and received treatment who were pregnant and/or women with dependent children. SFY18 was 30.2%.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2020), 30.5%

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2021), 30.8%

Data Source:

Arizona Health Care Cost Containment System's (AHCCCS).

Description of Data:

Arizona Health Care Cost Containment System's (AHCCCS) eligibility, enrollment, claims, and encounters data.

Data issues/caveats that affect outcome measures::

No Data related issues identified

Priority #: 7

Priority Area: Tuberculosis (TB) Screening

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Increase the number of tuberculosis screenings for members entering substance abuse treatment.

Objective:

Increase documentation around screening for TB and related services.

Strategies to attain the objective:

Strategies that providers are and will continue to implement include: integrating TB education, in addition to hepatitis C, HIV, and other infectious diseases into member orientations, educational material, referrals handouts for TB, hepatitis C, and HIV testing at specified locations, as well as including elements to capture TB screening documentation in contactor's audit tools.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis.

Baseline Measurement: Fiscal Year18 data on the number of members receiving substance abuse treatment with document screening for tuberculosis (TB), hepatitis C, HIV, and other infectious diseases was at 69%

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2020), 75%

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2021), 80%

Data Source:

Independent Case Review

Description of Data:

A random sample of charts is pulled and scored based on pre-determined elects that include documented evidence of screenings and

referrals for TB services, screening for hepatitis C, and HIV

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Priority #:   8

Priority Area: Suicide Prevention/Intervention

Priority Type: MHS

Population(s):   SMI, SED, ESMI

Goal of the priority area:

Reduce the Arizona Suicide Rate to 17.4% per 100,000 by the end of calendar year (CY) 2021.

Objective:

Promote suicide awareness through the use of technology and trainings.

Strategies to attain the objective:

AHCCCS will work collaboratively with other health agencies to research and implement strategies to reduce the suicide rate. Strategies will include but are not limited to: social media messaging, social market/public awareness, youth leadership programs, gatekeeper trainings, improved data surveillance, and ongoing collaboration with stakeholders or systemic improvement.

Annual Performance Indicators to measure goal success

Indicator #:   1

Indicator: Annual Performance Indicators to measure success on a yearly basis.

Baseline Measurement: The suicide rate in Arizona for CY17 was 18.1% per 100,000 population (1304 suicide/7,171,646 population.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of CY20), 17.7% per 100,000

Second-year target/outcome measurement: Second-year target/outcome measurement (Progress to end of CY21), 17.4% per 100,000

Data Source:

Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS)

Description of Data:

Each Fall, the Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS) calculates the State's suicide rate by determining the number of death certificates of Arizona residents where "suicide" was indicated by a medical examiner as the cause of death during the second most recent calendar year (i.e. CY 2019 data will be available in Fall 2020). Aggregated across the general population, this number establishes a suicide rate per 100,000 persons.

Data issues/caveats that affect outcome measures::

No data related issues at this time.

https://pub.azdhs.gov/health-stats/report/im/index.php?pg=suicides

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Footnotes:

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	$60,632,684		$683,351,380	$52,879,271	$6,067,110	$0	$0
a. Pregnant Women and Women with Dependent Children**	$7,001,554		$0	$0	$0	$0	$0
b. All Other	$53,631,130		$683,351,380	$52,879,271	$6,067,110	$0	$0
2. Primary Prevention	$0		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$16,168,716		$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)	$4,042,178		$0	$745,590	$0	$0	$0
10. Total	**$80,843,578**	**$0**	**$683,351,380**	**$53,624,861**	**$6,067,110**	**$0**	**$0**

* 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:

The amounts in Column C reflect the projected amount to be spent in Medicaid (State & Federal) funding for SFY2020 & SFY2021. Local funds should be reported as -0-.

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)**		$3,698,206	$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		$2,514,780	$604,964,418	$0	$35,096,458	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$28,919,972	$2,718,564,436	$0	$157,715,032	$0	$0
9. Administration (Excluding Program and Provider Level)***		$1,849,104	$0	$274,725	$0	$0	$0
10. Total	$0	$36,982,062	$3,323,528,854	$274,725	$192,811,490	$0	$0

* 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:

The amounts in Column C reflect the projected amount to be spend in Medicaid (State & Federal) funding for SFY2020 & SFY2021. Local funds are reported as -0-.

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

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.

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

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[*]	$30,316,342
2 . Primary Substance Abuse Prevention	$8,084,358
3 . Early Intervention Services for HIV[**]	$0
4 . Tuberculosis Services	$0
5 . Administration (SSA Level Only)	$2,021,089
6. Total	$40,421,789

* 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:

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	$942,293
	Selective	$410,048
	Indicated	$55,406
	Unspecified	$10,000
	Total	**$1,417,747**
2. Education	Universal	$1,152,658
	Selective	$535,749
	Indicated	$94,878
	Unspecified	$0
	Total	**$1,783,285**
3. Alternatives	Universal	$681,036
	Selective	$59,705
	Indicated	$23,024
	Unspecified	$20,000
	Total	**$783,765**
4. Problem Identification and Referral	Universal	$141,187
	Selective	$82,502
	Indicated	$60,660
	Unspecified	$4,000
	Total	**$288,349**
	Universal	$1,002,509

	Selective	$336,196
5. Community-Based Process	Indicated	$51,004
	Unspecified	$73,334
	Total	**$1,463,043**
	Universal	$949,963
	Selective	$32,177
6. Environmental	Indicated	$4,000
	Unspecified	$23,000
	Total	**$1,009,140**
	Universal	$12,866
	Selective	$0
7. Section 1926 Tobacco	Indicated	$0
	Unspecified	$0
	Total	**$12,866**
	Universal	$12,274
	Selective	$36,761
8. Other	Indicated	$17,000
	Unspecified	$19,465
	Total	**$85,500**
Total Prevention Expenditures		**$6,843,695**
Total SABG Award*		**$40,421,789**
Planned Primary Prevention Percentage		**16.93 %**

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

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Footnotes:
The 20% Set Aside amount that will be expended under FFY2020 is $8,084,358. The amount of Table 6 Non-Direct Services/System Development (SA) to be expended is $1,240,663. This amount added to the total at the bottom of Table 5a ($6,843,695) equals $8,084,358 from Table 4 - SABG Planned Expenditures and meets the 20% Set Aside requirement.

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*	**$40,421,789**
Planned Primary Prevention Percentage	**0.00 %**

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

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Footnotes:

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	☑

Footnotes:

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	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
	FY 2020		
1. Information Systems	$333,965	$170,872	
2. Infrastructure Support	$72,989	$11,333	
3. Partnerships, community outreach, and needs assessment	$492,095	$251,699	
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement	$427,114	$238,949	
6. Research and Evaluation	$556,603	$290,315	
7. Training and Education	$542,541	$277,495	
8. Total	**$2,425,307**	**$1,240,663**	**$0**

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

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Footnotes:

Amount of SABG Primary Prevention funds (from Table 4, Row 2) to be used for SABG Prevention Non-Direct Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = $1,240,663.

Amount of SABG Administration funds (from Table 4, Row 5) to be used for SABG Prevention Non-Direct Services/System Development Activities for SABG Treatment, Column A, SABG Prevention, Column B, and/or SABG Combined, Column C = $0.

Planning Tables

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

MHBG Planning Period Start Date: 10/01/2019   MHBG Planning Period End Date: 09/30/2021

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)	$5,000
5. Quality Assurance and Improvement	
6. Research and Evaluation	
7. Training and Education	
8. Total	**$5,000**

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Footnotes:
The amount on Line 4, Planning Council Activities, reflects the amount set aside for Planning Council members travel reimbursements from the MHBG Block Grant, if needed.

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

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 (ACC) 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

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based ○ Yes ○ No

contractual relationships that advance coordination of care?

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

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

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Footnotes:

AHCCCS COVERED BEHAVIORAL HEALTH
SERVICES GUIDE

Revision Date November 2017

THIS DOCUMENT IS A GUIDELINE ONLY AND DOES NOT TAKE THE PLACE OF THE COVERED
SERVICES ON THE PMMIS SYSTEM

TABLE OF CONTENTS

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THIS DOCUMENT IS A GUIDELINE ONLY AND DOES NOT TAKE THE PLACE OF THE COVERED SERVICES ON THE PMMIS SYSTEM

3

THIS DOCUMENT IS A GUIDELINE ONLY AND DOES NOT TAKE THE PLACE OF THE COVERED
SERVICES ON THE PMMIS SYSTEM

I. Introduction

A. Purpose

The AHCCCS Behavioral Health Services has developed 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. 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 to better meet individual person/family needs.
- Eliminate barriers to service.
- Recognize and include support services provided by non-licensed individuals and agencies.
- Streamline service codes.
- Maximize Title XIX/XXI funds.

Title XIX is Federal Medicaid and Title XXI is State Children's Health Insurance Program. The impact of maximizing Title XIX/XXI funds is far-reaching. Not only will it bring more federal dollars into the state to pay for services, but it also will free up non-Title XIX/XXI dollars to provide services to non-Title XIX/XXI eligible persons and to provide non-Title XIX/XXI services to all eligible persons. To maximize Title XIX/XXI funds, it is critical Tribal and Regional Behavioral Health Authorities (T/RBHAs) and their subcontractors also maximize their efforts to ensure all Title XIX/XXI eligible individuals are enrolled in the Arizona Health Care Cost Containment System (AHCCCS).

In addition, maximization of Title XIX/XXI funds is dependent on claims being submitted correctly. There are three critical components that must be in place to successfully bill for Title XIX/XXI reimbursement:

- The person receiving the service must be Title XIX/XXI eligible.
- The individual or agency submitting the bill must be an AHCCCS registered provider.
- The service must be a recognized Title XIX/XXI covered behavioral health service and be billed using the appropriate billing code.

These individual components are addressed in depth in this service guide.

In order to maintain the integrity of the AHCCCS Behavioral Health Covered Services Guide, a consistent process for requesting and considering changes has been developed. Requested changes, including changes to the services, the service codes, the provider types, and the listed rates, will be implemented on a quarterly basis unless the Deputy Director authorizes a change to take effect immediately. Changes that must take effect immediately will be communicated to T/RBHAs through Edit Alerts.

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A request for change to the AHCCCS BEHAVIORAL HEALTH Covered Services Guide may be made by representatives of AHCCCS BEHAVIORAL HEALTH SERVICES, the T/RBHAs or their contractors, persons and/or their families, advocates or other state agencies/stakeholders. Written requests should be forwarded to the AHCCCS BEHAVIORAL HEALTH SERVICES at CBHSG@azahcccs.gov for consideration. The final disposition of any written requests for changes to the AHCCCS BEHAVIORAL HEALTH SERVICES Covered Services Guide will be communicated back to the requestor.

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B. **Organizing Principles**

AHCCCS BEHAVIORAL HEALTH SERVICES has organized its array of covered behavioral health services into a continuum of service domains for the purpose of promoting clarity of understanding through the consistent use of common terms that reach across populations. The individual domains are:

- Treatment Services
- Rehabilitation Services
- Medical Services
- Support Services
- Crisis Intervention Services
- Inpatient Services
- Residential Services
- Behavioral Health Day Programs
- Prevention Services

This continuum not only applies to delivering services but also serves as the framework for program management and reporting.

Within each domain, specific services are defined and described including identification of specific provider qualifications/service standards and limitations. Additionally, code specific information (both service descriptions and billing parameters) is provided.

General information is also provided about the use of national UB04 revenue codes, national drug codes and CPT codes; however, detailed procedure code descriptions for these codes covered by AHCCCS BEHAVIORAL HEALTH SERVICES should be referenced in the following manuals:

- *UB04 Manual*
- *National Drug Coding (NDC) Standards*
- *Physicians' Current Procedural Terminology (CPT) Standards*
- *Healthcare Procedure Coding System (HCPCS) Standards*

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C. General Guidelines

In order to appropriately utilize the array of covered services to improve a person's functioning and to be able to effectively bill for those services provided, there are a number of general principles/guidelines that are important to understand. While Section II discusses the delivery of specific services, there are overarching themes that apply to the delivery of all services, which must be understood. This discussion is divided into three subsections:

- Provision of Services
- Provider Qualifications and Registration
- Billing for Services

These guidelines provide an overview of key covered services components. More detailed descriptions and requirements can be found in AHCCCS BEHAVIORAL HEALTH SERVICES policies.

D. Provision of Services

1. Eligibility and Funding Source

Factors that may impact the provision and availability of behavioral health services are the eligibility status of the person being served as well as the funding source and funding availability. AHCCCS BEHAVIORAL HEALTH SERVICES is responsible for providing services to persons with behavioral health needs including:

- Title XIX eligible persons enrolled with Arizona Health Care Cost Containment System (AHCCCS) acute care health plans or American Indian Health Program (AIHP).
- Title XIX eligible persons enrolled with Arizona Long Term Care System (ALTCS) – Arizona Department of Economic Security/Division of Developmental Disability (ADES/DDD).
- Title XXI (Kids Care) eligible children and parents enrolled with AHCCCS acute care health plans.
- Non-Title XIX/XXI eligible persons determined to have Serious Mental Illness (SMI).
- Non-SMI, Non-Title XIX/XXI eligible persons, based on the availability and prioritization of funding.

Depending on a person's eligibility status, funding can impact benefit coverage. Services for non-Title XIX/XXI persons must be paid for with non-Title XIX/XXI monies. In addition, non-Title XIX/XXI funds are used to pay for services not covered by Title XIX/XXI, to both Title XIX/XXI and non-Title XIX/XXI eligible persons. The ability to provide these services may be limited by the amount of state funds that are appropriated annually or by the availability of other non-Title

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XIX/XXI funds. Since non-Title XIX/XXI funds are limited, AHCCCS BEHAVIORAL HEALTH SERVICES requires they be prioritized according to procedures set forth in AHCCCS BEHAVIORAL HEALTH SERVICES policy.

Lastly, some coverage restrictions may apply depending on the funding source. For example, federal block grants designate both the type of services to be funded as well as the priority populations to be served.

Non-Title XIX/XXI persons determined to have a Serious Mental Illness (SMI) are eligible for services listed in Policy 201 Covered Services AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual Policy 201, Covered Health Services.

CPT and HCPCS codes that can be used to bill for services provided to Non-Title XIX/XXI persons determined to have SMI are limited. The following codes can be used to bill for the service categories listed below:

Assessments are covered for non-Title XIX/XXI persons when they are conducted to determine SMI eligibility. Non-Title XIX/XXI SMI General Funds can be used for the assessment, regardless of whether the person is found SMI.

Psychiatric Assessment (for newly enrolled Non-Title XIX/XXI SMI members or when a new or different medical professional assumes responsibility for treatment of the member): 90791, H0031, 99201, 99202, 99203, 99204 and 99205.

Psychiatric Follow-up Visits (for medication management): 99212, 99213, 99214, 99215, 99354, 99355, 99358, 99359 and 90853.

Non-emergency Transportation: A0090, A0100, A0110, A0120, A0120 TN, A0130, A0130 TN, A0160, T2003, S0209, S0215, S0215 TN, T2005, T2005 TN, T2049 and T2049 TN.

2.   Enrollment

AHCCCS eligible persons are enrolled with AHCCCS for acute care and behavioral health services. AHCCCS assigns individuals to a Tribal or Regional Behavioral Health Authority (T/RBHA) based on the zip code in which individuals reside. Although American Indian members are also automatically assigned based on zip code, American Indians have the option to receive behavioral health services from a RBHA, TRBHA, IHS, or a 638 tribal facility. Services provided to American Indian members who receive behavioral health services at IHS or 638 tribal facilities are billed directly to AHCCCS (see Appendix A for further information). However, emergency and other behavioral health services provided off reservation to these members at a non-IHS or non-638 tribal facility continue to be billed through a T/RBHA to AHCCCS BEHAVIORAL HEALTH SERVICES.

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Non-Title XIX/XXI eligible persons are enrolled with a T/RBHA to receive behavioral health services in Arizona's public behavioral health system. Enrollment by a T/RBHA is based on the zip code or tribal community in which the behavioral health recipient resides.

When encounters are submitted for "unidentified" individuals (such as in crisis situations when a person's eligibility or enrollment status is unknown), the service provider should use the applicable pseudo-ID numbers (e.g., NR010XXMO) that are assigned to each RBHA. Pseudo ID numbers are not assigned to TRBHAs. Encounters are not submitted for prevention services.

3. Family Members

For purposes of service coverage and this guide, family is defined as:

"The primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child (ren) with adult(s) performing duties of parenthood for the child (ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family."

In many instances it is important to provide behavioral health services to the family member as well as the person seeking services. For example, family members may need help with parenting skills, education regarding the nature and management of the mental health disorder, or relief from care giving. Many of the services listed in the service array can be provided to family members, regardless of their enrollment or entitlement status as long as the enrolled person's treatment record reflects that the provision of these services is aimed at accomplishing the service plan goals (i.e., they show a direct, positive effect on the individual). This also means that the enrolled person does not have to be present when the services are being provided to family members.

For situations in which a family member is determined to have extensive behavioral health needs, the family member her/himself should be enrolled in the system, if eligible.

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E. Provider Qualifications and Registration

Any person or agency may participate as an AHCCCS BEHAVIORAL HEALTH SERVICES provider if the person or agency is qualified to render a covered service and meets the AHCCCS BEHAVIORAL HEALTH SERVICES requirements for provider participation. These requirements include:

- Obtaining any necessary license or certification (including Centers for Medicare and Medicaid Services - CMS certification for tribal providers).
- Meeting provider standards as set forth in this service guide for the covered service, which the provider wishes to deliver.
- Registering with AHCCCS as an AHCCCS provider.
- Obtaining an AHCCCS BEHAVIORAL HEALTH SERVICES provider ID as directed by AHCCCS BEHAVIORAL HEALTH SERVICES.
- Contracting with the appropriate Regional Behavioral Health Authority (RBHA) or Tribal Regional Behavioral Health Authority (TRBHA).

For some services, individual providers are required to register, render and bill for the service. In other instances, individual providers are required to be affiliated with an agency that in turn is responsible for billing for the service. Individual provider qualification and provider billing requirements are discussed for each service in Section II of this guide.

1. AHCCCS Registered Providers

For most covered behavioral health services, a provider must be registered with the AHCCCS Administration as a Title XIX/XXI provider regardless of whether the service is provided to a Title XIX/XXI or a non-Title XIX/XXI eligible individual. (See discussion below regarding billing provider type).

A provider's AHCCCS ID number will be terminated for inactivity if the provider has not submitted a claim or encounter to the AHCCCS Administration within the past 24 months.

A new registration packet will be required to reactivate providers who reapply following termination for inactivity. Providers should refer to Chapter 3 of the AHCCCS Fee-for-Service Provider Manual for information on provider participation.

2. Board Certified Behavior Analysts (BCBA) effective October 1, 2016

The Arizona HEALTH Care Cost Containment System (AHCCCS) is continuing to process applications from licensed Board Certified Behavior Analysts (BCBA). This new AHCCCS provider type became effective October 1, 2016 and is designated as BC in the AHCCCS Provider Registration System.

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AHCCCS has updated the code set (B2 Matrix) to be linked to the new AHCCCS provider type for BCBAs and anticipates future code changes will occur as the Cover Behavior Health Services Guide is updated. BCBA will have a dual code set that includes traditional codes and Category III codes (T codes).

Category of Service

For all provider types there are mandatory and occasionally optional AHCCCS Categories of Services (COS). In addition to the provider type, the COS will determine the specific services for which the provider can bill. For purposes of behavioral health, the following COS are relevant:

01 – Medicine
06 – Physical Therapy
09 – Pharmacy
10 – Inpatient Hospital
12 – Pathology & Laboratory
13 – Radiology
14 – Emergency Transportation

16 – Outpatient Facility Fees
26 – Respite Care Services
31 – Non-Emergency Transportation
39 – Habilitation
47 – Mental Health Services

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In order to qualify for some of these COS, the providers may have to meet additional licensing/certification requirements. It is important for providers when registering to make sure they qualify and register for the necessary COS that will allow them to bill the desired service codes. Providers can reference Appendix B-2 to identify the applicable COS associated with each procedure code.

Additional information as well as registration materials may be obtained by calling the AHCCCS Provider Registration Unit at:
Phoenix area: (602) 417-7670 (Option 5)
In-State: 1-800-794-6862 (Option 5)
Out of state: 1-800-523-0231 (Ext. 77670)

AHCCCS Provider Registration materials are also available on the AHCCCS Web site at azahcccs.gov

3.   **Tribal Provider Certification and Registration**

In addition to registering with AHCCCS and in lieu of Division of Licensing Services (DLS), tribal providers must be certified by the Center for Medicare and Medicaid Services (CMS) to provide services. Tribal providers must submit completed certification forms indicating that the provider meets the same standards as other comparable providers. AHCCCS will review the provider application and submit the CMS certification to CMS for approval.

Additional information regarding tribal provider certification and registration can be found in
the azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

4.   **Individuals Employed by or Under Contract with Licensed DLS Agencies**

For licensed DLS residential and outpatient clinics, there are three (3) types of individual providers who are not allowed to bill independently for services. These include:

-       Behavioral Health Professionals: Only a subset of behavioral health professionals as defined in 9 A.A.C. 10 must be affiliated with an Outpatient Clinic. This primarily includes social workers, counselors, marriage and family therapists, and substance abuse counselors who are licensed by the Arizona Board of Behavioral Health Examiners pursuant to ARS Title 32, Chapter 33 or other recognized licensing boards and who either are not allowed to practice independently or do not meet the AHCCCS registration criteria as an independent biller (Provider Types 08, 11, 12, 18, 19, 31, 85, 86, 87 A4 and BC).

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- Behavioral Health Technicians as defined in 9 A.A.C. 10.

- Behavioral Health Paraprofessionals as defined in 9 A.A.C. 10.

5. Community Service Agencies

Non-DLS licensed agencies can become a Community Service Agency (CSA) and provide rehabilitation and support services. To provide these services, individual providers have to meet certain qualifications and have to be associated with a CSA.

In addition to meeting specific provider requirements set forth in this guide for the services they will be providing, these providers will need to submit certain documentation as part of their registration packet. A description of documentation-requirements is described in AHCCCS Medical Policy Manual, Policy 961 Peer, Family and CSA Training, Credentialing and Oversight Requirement, 961-C Community Service Agencies..

6. Habilitation Providers

A Habilitation Provider is a Home and Community Based Service (HCBS) provider certified through the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) and registered with the AHCCCS Administration. T/RBHAs must ensure adequate liability insurance before contracting with a Habilitation Provider, regardless if the provider is an ADES certified individual or agency.

Prior to the delivery of behavioral health services, the Habilitation Provider must receive an orientation to the unique characteristics and specific needs of the eligible person under their care. Habilitation Providers must be informed regarding whom to contact in an emergency, significant events or other incidents involving the eligible person. The behavioral health provider is responsible for the timely review and resolution of any known issues or complaints involving the eligible person and a Habilitation Provider.

A Habilitation Provider (Provider Type 39) who is ADES/HCBS certified to provide habilitation services must contact ADES HCBS Certification to add Category of Service 47 (Mental Health) to their profile. Only the following codes (including modifiers) should be billed:

- H2014 – Skills training and development
- S5150 and S5151 – Unskilled respite (COS 26)
- T1019 and T1020 – Personal care services
- H2017 – Psychosocial rehabilitation service
- S5110 – Home care training, family

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The child and family team or the eligible person's treatment team as part of the service planning process must periodically review services provided by Habilitation Providers. Further, services provided by Habilitation Providers must be documented per AHCCCS BEHAVIORAL HEALTH SERVICES policy.

F.   Billing for Services

In addition to the general principles related to the provision of services, there are also general guidelines, which must be followed in billing for covered behavioral health services to ensure that services will be reimbursed, and/or the encounters accepted.

The Covered Behavioral Health Services Guide is provided for general information purposes only. Providers shall conform all billing practices to comply with all federal, state and local laws, rules, regulations, standards, and executive orders, all AHCCCS and/or contractor provider manuals, policy guidelines, and standards (including reference tables), ICD9 or ICD10, whichever is in effect on the date of service, CPT, HCPCS, CDT, and Health Insurance Portability and Accountability Act Transactions and Code Sets (HIPAA TCS) compliance standards, **notwithstanding** anything contained in this Covered Services Guide, whether expressed or implied.

AHCCCS Provider, Profile and Reference tables are provided twice a month and should be used by all T/RBHAs and Providers to determine the correct values on submitted claims/encounters. The values listed throughout the Covered Behavioral Health Services Guide and on the B2 Appendix are only provided as information and should not be used to determine if a value can be used on an encounter or claim.

1.   Service Codes

There are two types of codes that can be billed for services provided:

- AHCCCS Allowable Codes that may be paid for with Title XIX/XXI funds and/or non-Title XIX/XXI funds depending on the person's eligibility status; and
- Codes that are not allowable under AHCCCS and can **only** be paid for with non-Title XIX/XXI funds.

a.   AHCCCS Allowable Codes

AHCCCS allowable codes are to be used to bill for services provided to any person eligible to receive services through AHCCCS BEHAVIORAL HEALTH SERVICES, regardless of their eligibility status (e.g., Title XIX/XXI, non-Title XIX/XXI). To bill AHCCCS allowable codes the provider must be an AHCCCS registered provider.

AHCCCS allowable codes can be further subdivided into the following categories:

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(1.)   CPT

AMA's CPT Guide (Current Procedural Terminology) contains nationally recognized service codes. For more information regarding these codes see the *AMA's CPT Guide (Current Procedural Terminology),* https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology?-process-how-code-becomes-code, which contains a systematic listing and coding of procedures and services, such as surgical, diagnostic or therapeutic procedures.

(2.)   HCPCS

Healthcare Common Procedure Coding System (HCPCS) contains nationally recognized service codes. For more information regarding these codes see the *Healthcare Common Procedure Coding System (HCPCS) Manual,* which is a systematic listing and coding for reporting the provision of supplies, materials, injections and certain non-physician services and procedures. A subset of the HCPCS codes are not Title XIX/XXI reimbursable; these are identified in the Appendix B-2, azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls, where COS is S.

(3.)   National Drug Codes (NDC)

These nationally recognized drug codes are used to bill for prescription drugs.

(4.)   UB04 Revenue Codes

These nationally recognized revenue codes are used to bill for all inpatient and certain residential treatment or outpatient services. Information regarding these codes can be found in the *UB04 Manual.*

b.   Codes that are not Allowable under AHCCCS

Some codes are not reimbursable under Title XIX/XXI. Appendix B-2, azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls (where COS is S) identifies the service codes that are not reimbursable through AHCCCS funding. If there is not an applicable AHCCCS allowable code, then these codes may be used to bill for the service. These codes may be billed regardless of the person's Title XIX/XXI eligibility status.

2.   Billing Provider Types

Appendix B-2, azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/Appendix

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[B2.xls](B2.xls) provides a listing of the service codes that can be billed by each provider type.

a.   AHCCCS Provider Billing Types

All AHCCCS reimbursable service codes must be billed by an AHCCCS registered provider. AHCCCS provider billing types relevant to behavioral health providers include the following:

02 – Level I Hospital
03 – Pharmacy
04 – Laboratory
06 – Emergency Transportation
08 – Physician (Allopathic)*
11 – Psychologist*
12 – Certified Registered Nurse Anesthetist*
18 – Physician Assistant*
19 – Nurse Practitioner*
28 – Non-emergency Transportation
29 – Rural Health Clinics (RHCs)
31 – Physician (Osteopathic)*
39 – Habilitation Provider
71 – Level I Psychiatric Hospital (IMD)
72 –Tribal Regional Behavioral Health Authority/Regional Behavioral Health Authority (T/RBHA)
73 – Out-of-state, One Time Fee For Service Provider
77 – Behavioral Health Outpatient Clinic
78 – Level I Residential Treatment Center – Secure (non-IMD)
85 – Licensed Clinical Social Worker*
86 – Licensed Marriage/Family Therapist*

87 – Licensed Professional Counselor*
97 – Air Transport Providers
A3 – Community Service Agency
A4 – Licensed Independent Substance Abuse Counselor*
A5 – Behavioral Health Therapeutic Home
A6 – Rural Substance Abuse Transitional Agency
B1 – Level I Residential Treatment Center – Secure (IMD)
B2 – Level I Residential Treatment Center – Non-Secure (non-IMD)
B3 – Level I Residential Treatment Center – Non-Secure (IMD)
B5 – Level I Subacute Facility (non-IMD)
B6 – Level I Subacute Facility (IMD)
B7 – Crisis Services Provider
B8 – Behavioral Health Residential Facility
C2 – Federally Qualified Health Centers (FQHCs)
IC – Integrated Clinics

BC – Board Certified Behavioral Analysts

* These individuals are referred to as "Independent Billers."

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In addition to having the correct provider type, providers also have to be registered to provide the COS in which the service code is classified.

3. Modifiers

In some instances, in order to clearly delineate the service being provided, a "modifier" must be submitted along with the service code. In these circumstances codes are assigned modifiers as described in the text of this guide and in Appendix B-2, azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls. For example, there is a single code for counseling, but reimbursement for counseling provided in the office, the home or in group can vary, so the accurate use of modifiers is essential. Assigned codes and when applicable, modifiers, must be used on submitted claims and encounters to specify service(s) rendered. Additional modifiers may be used as indicated by CPT or HCPCS to further define a procedure code. The following is a list of modifiers used in this guide:

CG- Policy criteria applied
GT- Via interactive audio and video telecommunication systems
HA- Child/Adolescent Program
HB- Adult Program, Non Geriatric
HC- Adult Program, Geriatric
HG- Opioid addiction treatment program
HK- Specialized mental health programs for high risk populations
HN- Bachelor's degree program (for staff not designated as behavioral health
    professionals)
HO- Master's degree level (for behavioral health professionals)
HQ- Group setting
HR- Family/couple with client present
HS- Family/couple without client present
HT- Multi-disciplinary team
HW- Funded by State Mental Health Agency (Service Delivery Fully Aligns with
    SAMHSA's Permanent Supportive Housing or Supported Employment Evidence-
    Based Practice. Please only use with members of the SMI population.)
SE- State and/or federally funded programs/services (May also be used to identify Support
    and Rehabilitation Services – Generalist Type Program)*
TF- Intermediate level of care
TG- Complex/high level of care
TN- Rural

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* Modifier SE is to be used to identify when services are being provided for a child (birth through 17 years) as part of a Support and Rehabilitation Services – Generalist Type Program and should only be used by employees of a recognized Support and Rehabilitation Services – Generalist Type provider. The modifier should not be used with other support and rehabilitation services that are provided as part of a regular outpatient program. This modifier can only be used with the following service codes: H0004, H0004HR, H0004HS, H0001, H0002, H0031, H2014, H2014HQ, H2017, H0025, H0034, H2025, H2026, H2027, T1016HO, T1016HN, T1019, T1020, S5110, H0038, H0038HQ, H2016, S5150, S5151, H0043, H2011, S9484 and S9485.

4. Place of Service (POS) Codes

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Accurate POS codes must be submitted on claims and encounters to specify where service was rendered. The following is a link to the Centers for Medicare and Medicaid Services (CMS) POS table that lists POS codes and their descriptions: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf. To determine which POS codes are available for use with specific service codes, please reference the B2 matrix (see Appendix B-2, azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls)

5.   Group Payment ID

An organization may act as the financial representative for any AHCCCS registered provider or group of providers who have authorized this arrangement. Such an organization must register with AHCCCS as a group payment provider. Under their group payment ID number, the organization may not provide services or bill as the service provider. Group payment providers submit claims and encounters to the RBHA according to established procedures. The RBHA then submits the encounters to AHCCCS BEHAVIORAL HEALTH SERVICES. TRBHA group payment providers submit claims directly to AHCCCS according to established procedures.

Each AHCCCS registered provider using the group payment arrangement must sign a group payment authorization form and ensure their provider ID number appears on each claim even though a group payment ID number will be used for payment. If a provider has multiple locations, the provider may be affiliated with multiple group payment associations.

6.   Diagnosis Codes

Covered behavioral health services may be provided to persons regardless of their diagnosis or even in the absence of any diagnosis at the time of services, so long as there are documented behaviors or symptoms that require treatment. This means that a diagnosis is not necessary prior to enrolling a person in the AHCCCS BEHAVIORAL HEALTH SERVICES system. Likewise, the provision of covered services is not limited by a person's diagnosis (e.g., any of the covered services may be provided to address both mental illness and substance abuse disorders, at-risk behaviors/conditions or family members impacted by the person's disorder). While a diagnosis is not needed to receive treatment, a diagnostic code is needed for service code billing.

The ICD-10-CM diagnosis codes must be used when submitting claims and encounters (see the *International Classification of Diseases – 9th Revision – Clinical Modification Manual)*. While each claim or encounter must include at least one valid ICD-10 diagnosis code describing the person's condition, there are a number of very general ICD-10 codes that can be used for those cases in which no specific diagnosis has been established at the time of the service.

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If a code of R69 is assigned under the DSM-IV criteria and is not changed to a more specific diagnostic or descriptive "Z" code before a claim is submitted to AHCCCS BEHAVIORAL HEALTH SERVICES, the AHCCCS PMMIS data system reads it as if it were an ICD-10-CM code, that is, the clinician does not know what the specific problem is. This diagnosis code will be denied for any inpatient or laboratory service. Further, it is difficult to gather meaningful data regarding populations, trends and program effectiveness when the primary diagnostic code isR69.

Providers are strongly encouraged to limit the use of R69 and to use instead codes which more clearly describe the person's situation. An individual who presents to the mental health system for services but who does not have a diagnosis on Axis I or II will very likely have a situation that is described by a "Z" code (e.g., Z71.89, counseling for parent-child problem, unspecified;Z69.010, counseling for victim of child abuse, etc.).

Inpatient UB04 encounters/claims for revenue codes submitted by inpatient provider types (02, 71, 78, B1, B2, B3, B5, and B6) must be submitted indicating a principle ICD-10 mental health or substance abuse diagnosis (see Appendix B-3: Encounter/Claims Principle Behavioral Health ICD-10 Diagnostic Codes). Although a patient may have other diagnosis codes (e.g., a "Z" code or other ICD-10 diagnostic code), the encounter/claim for inpatient psychiatric service must indicate a principle mental health or substance abuse diagnosis to adjudicate successfully. The exception is the use of ICD-10 diagnostic codes 099.32* (Report correct Trimester) and 099.34* (Report correct trimester) as principle diagnoses for complications of pregnancy while an individual is receiving inpatient psychiatric services.

Although ICD-10 and DSM-IV diagnosis codes are substantially alike, DSM-IV codes must not be used. Areas of differences include:

-   Two ICD-10 codes may each require different specificity see your ICD-10 CM manual to determine the appropriate digits and code order placement.

ICD-10 codes should be used at their highest level of specificity (i.e., highest number of digits possible). This means:

-   Use a three-digit code only if there is no four-digit sub classification for that category.
-   Use a four-digit code only if there is no fifth digit sub classification for that category.
-   Use a five-digit code only if there is no sixth digit sub classification for that category.
-   Use a six-digit code only if there is no seventh digit sub classification for that category.
-   Use a seven-digit code only for those categories where the seventh digit sub classification exists.

ICD-10 codes are the industry standard and are required for Medicaid/Medicare billing purposes.

7.   Core Billing Limitations

For some of the services there are core billing limitations, which must be followed when billing. Services may have additional billing limitations, which are applicable to that specific service. The specific billing limitations are set forth in Section II of this guide.

a.   General Core Billing Limitations

General core billing limitations include the following:

1.   A provider can <u>only</u> bill for their time spent in providing the actual service. For all services, the provider <u>may not</u> bill any time associated with note taking and/or medical record upkeep as this time has been included in the rate.

2.   For all services except case management and assessment services, the provider may not bill any time associated with phone calls, leaving voice messages, sending emails and/or collateral contact with the enrolled person, family and/or other involved parties as this time is included in the rate calculation.

3.   The provider may only bill the time spent in <u>face-to-face direct contact</u>; however, when providing assessment or case management services, the provider may also bill <u>indirect contact</u>. Indirect contact includes phone calls, leaving voice messages and sending emails (with limitations), picking up and delivering medications, and/or collateral contact with the enrolled person, family and/or other involved parties.

4.   A provider should bill all time spent in directly providing the actual service, regardless of the assumptions made in the rate model. Providers must indicate begin and end times on all progress notes.

5.   A professional who supervises the Behavioral Health Professional, Behavioral Health Technician and/or Behavioral Health Paraprofessional providing the service <u>may not</u> bill this supervision function as a HCPCS/CPT code. Employee supervision has been built into the service code rates. Supervision means direction or oversight of behavioral health services provided by a qualified individual in order to enhance therapeutic competence and clinical insight and to ensure client welfare by guiding, evaluating, and advising how services are provided.

6.   If the person and/or family member(s) misses their appointment, the provider <u>may not</u> bill for the service.

7.   Parents (including natural parent, adoptive parent and stepparent) **may** only provide personal care services if the adult child receiving services is 21 years or older and the parent is not the adult child's legal guardian. Under **no** circumstances may the spouse be the personal care services provider. The T/RBHA is responsible for monitoring that personal care services are provided by appropriate personnel.

8. Parents (including natural parent, adoptive parent and stepparent) who are certified Habilitation providers may only encounter/bill for applicable covered behavioral health services delivered to their adult children who are 21 years or older.

9. When necessary, covered services, in addition to those offered through a DLS Level I Behavioral Health facility, may be delivered to the enrolled person. See the billing limitation section associated with each specific service for additional information.

10. For services with billing units of 15 minutes, the first unit of service can be encountered/billed when 1 or more minutes are spent providing the service. To encounter/bill subsequent units of the service, the provider must spend at least one half of the billing unit for the subsequent units to be encountered/billed. If less than one half of the subsequent billing unit is spent providing the service, then only the initial unit of service can be encountered/billed.

11. More than one provider agency may bill for certain services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs. Please refer to the billing limitations for each service for applicability.

12. If otherwise allowed, service codes may be billed on the same day as admission to and discharge from inpatient services (e.g., billing Crisis Intervention Service (HCPCS H2011) on the same day of admission to Inpatient Hospital (Bill type 0114)).

13. A single provider cannot bill for any other covered service while providing transportation to client(s).

14. Payment for services related to Provider-Preventable Conditions is prohibited, in accordance with 42 CFR Section 447.26. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). Additional information regarding the prohibition of payment for services related to Provider-Preventable Conditions is located in the AHCCCS Medical Policy Manual (AMPM), Chapter 900, Policy 960.

15. CPT and HCPCS codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to Appendix B-2, Allowable Procedure Code Matrix azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls to identify providers who can bill using CPT codes.

b. Core Provider Travel Billing Limitations

The mileage cost of the first 25 miles of provider travel is included in the rate calculated for each service; therefore, provider travel mileage may not be billed separately except when it exceeds 25 miles. In these circumstances, providers bill the additional miles traveled in excess of 25 miles using the HCPCS code A0160.

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When a provider is traveling to one destination and returns to the office, the 25 miles is assumed to be included in the round trip. If a provider is traveling to multiple out-of-office settings, each segment of the trip is assumed to include 25 miles of travel. The following examples demonstrate when to bill for additional miles:

1. If Provider A travels a total of 15 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), travel time and mileage is included in the rate and may not be billed separately.

2. If Provider B travels a total of 40 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), the first 25 miles of provider travel are included in the rate but the provider may bill 15 miles using the provider code A0160 (40 miles minus 25 miles).

3. If Provider C travels to multiple out-of-office settings (in succession), he/she must calculate provider travel mileage by segment. For example:
First segment = 15 miles; 0 travel miles are billed
Second segment = 35 miles; 10 travel miles are billed
Third segment = 30 miles; 5 travel miles are billed
Total travel miles billed = 15 miles are billed using provider code A0160. The provider may bill for travel miles in excess of 25 miles for the return trip to the provider office.

4. Providers may not bill for travel for missed appointments.

8. Telehealth Services

While telehealth services is not a treatment service ("modality") AHCCCS BEHAVIORAL HEALTH SERVICES does recognize real time telehealth services as an effective mechanism for the delivery of certain covered behavioral health services (see AHCCCS BEHAVIORAL HEALTH SERVICES Policy 410, Use of Telemedicine). The following types of covered behavioral health services may be delivered to persons enrolled with a T/RBHA utilizing telehealth services technology:

- Diagnostic consultation and assessment
- Psychotropic medication adjustment and monitoring
- Individual and family counseling
- Case management

A complete listing of the services that can be billed utilizing telehealth services can be found in Appendix B-2, https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls .

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When providing services telephonically, providers should list the place of service as 02. When providing services via telemedicine (i.e., via interactive audio and video telecommunications), the GT modifier and POS 02 should be utilized.

9. Claim Information

For more detailed information about submitting claims and encounters refer to the AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, /Section 2, Finance/Billing.

10. Reimbursement

Appendix B-2, azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls provides a listing of fee-for-service rates established by AHCCCS BEHAVIORAL HEALTH SERVICES for allowable procedure codes. These rates function as "default" payment rates for service providers in absence of a contract (i.e., fee-for-service) and for providers subcontracted with a Tribal RBHA. Use of these rates in contracts is not required except for Tribal RBHA subcontracted providers; the Non-Tribal RBHAs are encouraged to use them only as benchmarks when contracting for services. Providers should contact their RBHA for specific contracted rates. TRBHA providers may view rates on the AHCCCS website at: azahcccs.gov/commercial/ProviderBilling/rates/rates.aspx.

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II. Service Descriptions

II. A. 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 have been further grouped into the following three subcategories:

- Behavioral Health Counseling and Therapy
- Assessment, Evaluation and Screening Services
- Other Professional

II. A. 1. Behavioral Health Counseling and Therapy

General Information

General Definition

An interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral problems or conflicts, and provide support, education or understanding for the person, group or family to resolve or manage the current problem or conflict and prevent, resolve or manage similar future problems or conflicts. Services may be provided to an individual, a group of people, a family or multiple families.

Service Standards/Provider Qualifications

Behavioral Health Counseling and Therapy services must be provided by individuals who are qualified *behavioral health professionals* or *behavioral health technicians* as defined in 9 A.A.C. 10.
For behavioral health counseling and therapy services that are billed by a behavioral health agency, the agency must be licensed by DLS and meet the requirements for the provision of behavioral health counseling and therapy services as set forth in 9 A.A.C. 10.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Individual Counseling and Therapy
90832	Psychotherapy, 30 minutes with patient and/or family member.
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).
90834	Psychotherapy, 45 minutes with patient and/or family member.

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| 90836 | Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure). |

| 90837 | Psychotherapy, 60 minutes with patient and/or family member. |

| 90838 | Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure) |

| 90845 | Medical psychoanalysis - No units specified |

| 90880 | Hypnotherapy |

CODE	**DESCRIPTION-Family Counseling and Therapy**
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy, with patient present)
90849	Multiple-family group psychotherapy

| **CODE** | **DESCRIPTION-Group Counseling and Therapy** |
| 90853 | Group psychotherapy (other than of a multiple-family group) |

HCPCS Codes

Except for behavioral health counseling and therapy services provided by those individual behavioral health professionals allowed to bill CPT codes, all other behavioral health counseling and therapy services should be billed using the following HCPCS codes.

- **H0004 - Individual Behavioral Health Counseling and Therapy -- Office:** Counseling services (see general definition above for behavioral health counseling and therapy) provided face-to-face at the provider's work site to an individual person.

  Billing Unit: 15 minutes

- **H0004 - Individual Behavioral Health Counseling and Therapy – Home:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to an individual person at the person's residence or other out-of-office setting.

  Billing Unit: 15 minutes

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- **H0004 HR - Family Behavioral Health Counseling and Therapy** – **Office, With Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to the member and member's family at the provider's work site. ****HR modifier required and must specify place of service****

  Billing Unit: 15 minutes per family

- **H0004 HS - Family Behavioral Health Counseling and Therapy** – **Office, Without Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to members of a person's family at the provider's work site. ****HS modifier required and must specify place of service****

  Billing Unit: 15 minutes per family

- **H0004 HR – Family Behavioral Health Counseling and Therapy – Out-of-Office, With Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to members of a person's family at the family's residence or other out-of-office setting. ****HR modifier required and must specify place of service****

  Billing Unit: 15 minutes per family

- **H0004 HS – Family Behavioral Health Counseling and Therapy - Out-of-Office, Without Client Present:** Counseling services (see general definitions above for counseling) provided face-to-face to members of a person's family at the family's residence or other out-of-office setting. ****HS modifier required and must specify place of service****

  Billing Unit: 15 minutes per family

- **H0004 HQ - Group Behavioral Health Counseling and Therapy:** Counseling services (see general definition above for counseling and therapy) provided to a group (of any size) of persons, which occurs at a provider's worksite. For example, if eight persons participated in group counseling for 60 minutes, the provider would bill four units for each person for a total of 32 units. ****HQ modifier required and must specify place of service****

  Billing Unit: 15 minutes per each person in the group

Billing Limitations

For behavioral health counseling and therapy services the following billing limitations apply:

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1. See general core billing limitations in Section I.

2. Provider travel time is included in the rates for H0004—Individual Behavioral Health Counseling and Therapy, Family Behavioral Health Counseling and Therapy, and Group Behavioral Health Counseling and Therapy. See core provider travel billing limitations in Section I.

3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. More than one provider agency may bill for behavioral health counseling and therapy services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

5. Generally, H0004 HQ (Group Behavioral Health Counseling and Therapy) may not be billed on the same day as Level I Residential Treatment Center (0114, 0124, 0134, 0154, 0116, 0126, 0136 or 0156) or Behavioral Health Short-Term Residential (H0018) Services. However, based on behavioral health recipient needs, certain specialized group behavioral health counseling and therapy services may be billed on the same day as Level I Residential Treatment Center or Behavioral Health Short-Term Residential Services and be provided in the residential setting or other places of service listed for H0004 HQ. The clinical rationale for providing specialized group behavioral health counseling and therapy services must be specifically documented in the Service Plan and Progress Note. AHCCCS BEHAVIORAL HEALTH SERVICES has created a quarterly report to monitor the appropriate use of H0004 HQ when billed on the same day as Level I Residential Treatment Center or Behavioral Health Short-Term Residential services.

II. A. 2. Assessment, Evaluation and Screening Services

General Information

General Definition

Gathering and assessment of historical and current information which includes face-to-face contact with the person and/or the person's family or other informants, or group of individuals resulting in a written summary report and recommendations.

Service Standards/Provider Qualifications:

Behavioral health professionals or *behavioral health technicians* (as defined in 9 A.A.C. 10) must meet the AHCCCS BEHAVIORAL HEALTH SERVICES credentialing requirements in order to provide assessment and evaluation services.

For behavioral health screening, assessment and evaluation services that are billed by a behavioral health agency, the agency must be licensed by DLS and meet the requirements for the provision of behavioral health assessment, evaluation and screening services as set forth in 9 A.A.C. 10.

Code Specific Information

CPT Codes

CODE	DESCRIPTION- Assessment, Evaluation and Screening Services
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach, WAIS), administered by a computer, with qualified health care professional interpretation and report.

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96110	Developmental screening, with interpretation and report, per standardized instrument form.
96111	Developmental testing, (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment (e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report
96119	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
99241	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99242	Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and, straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

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99243	Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and, medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99245	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.
99304	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

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99306 Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit.

99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit.

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the

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bedside and on the patient's facility floor or unit.

99315   Nursing facility discharge day management. (30 minutes or less)

99316   Nursing facility discharge day management. (More than 30 minutes)

99318   Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a detailed interval history; a comprehensive examination; and medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 30 minutes with the patient and/or family or caregiver. (Do not report 99318 on the same day of service as nursing facility services codes 99304-99316).

HCPCS Codes

Except for assessment, evaluation and screening provided by those independently registered individual behavioral health professionals billing CPT codes, all other assessment, evaluation and screening services should be billed using the following HCPCS codes.

- **H0001 – Alcohol and/or drug assessment**

    Provider Qualifications:
    AHCCCS BEHAVIORAL HEALTH SERVICES credentialed behavioral health professionals and behavioral health technicians

- **H0002 - Behavioral Health Screening to Determine Eligibility for Admission:** Information gathered using a standardized screening tool or criteria including those behavioral health screening activities associated with DUI screening. Includes the triage function of making preliminary recommendations for treatment interventions or determination that no behavioral health need exists and/or assisting in the development of the person's service plan. May also include the preliminary collection of information necessary to complete a supported employment assessment.

    Provider Qualifications:
    Behavioral health technician or behavioral health professional as defined in 9 A.A.C. 10.

- **H0031- Mental Health Assessment –By Non-Physician-** Gathering and assessment of information necessary for assessment of a person, resulting in a written summary report. Recommendations, which may be in response to specific questions posed in an assessment request, are made to the person, family, referral source, provider, or courts, as applicable. May also include the review and modifications to the person's service plan, comprehensive

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assessments, a rehabilitative employment support assessment and DES-DDD Positive Support Plans.

Provider Qualifications:
AHCCCS BEHAVIORAL HEALTH SERVICES credentialed behavioral health professionals and behavioral health technicians

Billing Limitations

For assessment, evaluation and screening services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation (emergency and non-emergency) provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Rehabilitative employment support assessments may only be provided when the assessment service is not available through the federally funded Rehabilitation Act program administered by Arizona Department of Economic Security/Rehabilitation Service Administration (ADES/RSA) or the Tribal Rehabilitation Services Administration. The T/RBHA must monitor the proper provision of this service.

5. Preparation of a report of a member's psychiatric status for primary use with the court is not Title XIX/XXI reimbursable. Title XIX/XXI funds may be used for a report to be used by a treatment team or physician. The fact that the report may also be used in court does not disqualify the service for Title XIX/XXI reimbursement.

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II. A. 3. Other Professional

General Information

In addition to behavioral health counseling therapy and assessment, evaluation and screening, there are a number of other treatment services that may be provided by qualified individuals in order to reduce symptoms and improve or maintain functioning. These services are described below.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Other Professional
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes
90899	Unlisted psychiatric services or procedure (Psychiatric services without patient face to face contact)
90901	Biofeedback training by any modality
99199	Unlisted special service, procedure or report

HCPCS Codes

Except for alcohol and/or drug services and multisystemic therapy (MST) for juveniles provided by behavioral health professionals allowed to bill CPT codes, all other alcohol and/or drug and multisystemic behavioral health services should be billed using the following HCPCS codes.

- **H0015 – Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention and activity therapies or education.**

  Billing Unit: Per Diem

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Billing Limitations

For alcohol and/or drug services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Alcohol and/or drug services (H0015) and multisystemic therapy for juveniles (H2033) may not be billed on the same day as each other or on the same day as an inpatient service.

- **H2033 – Multisystemic therapy for juveniles:** Multisystemic therapy uses the strengths found in key environmental settings of juveniles (under age 21) to promote and maintain positive behavioral changes. These services focus on individual, family and extrafamilial (such as peer, school and neighborhood) influences and can include a range of family and community-based services that vary from outpatient to home-based. Documentation of services must include weekly progress notes.

Billing Unit: 15 minutes

Billing Limitations

For multisystemic therapy for juveniles the following billing limitations apply:

1. MST is an all-inclusive service paid at a bundled rate. All case related direct-service activity is billable. Billing is submitted on a weekly basis. This includes all face-to-face time with clients as well as collateral contact related to the client treatment plan.

2. Weekly consultation and supervision of MST personnel with the national MST staff if considered part of the cost of rendering the service and has been factored in the rate. This is not considered a billable activity.

3. See general core billing limitations in Section I.

4. Travel time and expenses are not billable activities and cannot be included in units billed during claims submission.

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5. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

6. Alcohol and/or drug services (H0015) and multisystemic therapy for juveniles (H2033) may not be billed on the same day as each other or on the same day as an inpatient service.

State Funded HCPCS Codes (not reimbursable by Medicaid Title XIX or KidsCare Title XXI)

- **H0046 –Mental Health Services (NOS) (formerly Traditional Healing Services):** Treatment services for mental health or substance abuse problems provided by qualified traditional healers. These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the person's functional ability.

  Billing Unit: 15 minutes

  Auricular Acupuncture general definition:
  The application by a certified acupuncturist practitioner pursuant to: A.R.S. 32-3922 of auricular acupuncture needles to the pinna, lobe or auditory meatus to treat alcoholism, substance abuse or chemical dependency.

- **97810 –Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.**
  - **+97811 –Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s). (List separately in addition to code for primary procedure)***

- **97813-Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.**
  - **+97814-Acupunture, 1or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s). (List separately in addition to code for primary procedure)**

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II. B. Rehabilitation Services

Rehabilitation services include the provision of educating, coaching, training and demonstrating. Other services include securing and maintaining employment to remediate residual or prevent anticipated functional deficits. Except for cognitive rehabilitation, which is billed using a CPT code, rehabilitation services are billed using HCPCS codes. Rehabilitation services include:

- Skills Training and Development and Psychosocial Rehabilitation Living Skills Training
- Cognitive Rehabilitation
- Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion)
- Psychoeducational Service (Pre-Job Training and Job Development) and Ongoing Support to Maintain Employment (Job Coaching and Employment Support)

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II. B. 1. Skills Training and Development and Psychosocial Rehabilitation Living Skills Training

General Information

General Definition

Teaching independent living, social, and communication skills to persons and/or their families in order to maximize the person's ability to live and participate in the community and to function independently. Examples of areas that may be addressed include self-care, household management, social decorum, same- and opposite-sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources. Services may be provided to a person, a group of individuals or their families with the person(s) present.

Service Standards/Provider Qualifications

Skills training and development and psychosocial rehabilitation living skills training services must be provided by individuals who are qualified *behavioral health professionals*, *behavioral health technicians* or *behavioral health para-professionals* as defined in 9 A.A.C. 10. This may also include Licensed Practical Nurses (LPNs) who have training in providing these services as required by the person's service plan.

Code Specific Information

HCPCS Codes

Skills training and development and psychosocial rehabilitation living skills training services should be billed using the following codes:

- **H2014 – Skills Training and Development – Individual:** See general definition above.

  Billing Unit: 15 minutes

- **H2014 GT with Place of Service 02 - Skills Training and Development and Psychosocial Rehabilitation Living Skills Training – Telemedicine**

  Billing Unit: 15 minutes

- **H2014 with Place of Service 02 – Skills Training and Development and Psychosocial Rehabilitation Living Skills Training - Telephonic**

  Billing Unit: 15 minutes

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- **H2014 HQ –Skills Training and Development – Group:** See general definition above. If eight persons participated in group skills training and development session for 60 minutes, the provider would bill four units for each person for a total of 32-units.

  Billing Unit: 15 minutes per person

- **H2017–Psychosocial Rehabilitation Services (Living Skills Training):** See general definition above.

  Billing Unit: 15 minutes per person

Billing Limitations

For skills training and development services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates.

3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Service code H2014, Skills Training and Development, may be billed up to 8 hours. Service code H2017, Psychosocial Rehabilitation, cannot be billed if under 8 hours are needed and should be billed for the length of the service. Service codes H2014, Skills Training and Development and Service code H2017, Psychosocial Rehabilitation cannot be billed on the same day, with certain exceptions.   For exceptions see section Home Care Training to Home Care Client under Billing Limitations.

5. More than one provider agency may bill for skills training and development services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

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II. B. 2. Cognitive Rehabilitation

General Information

General Definition

The facilitation of recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible. Goals of cognitive rehabilitation include: relearning of targeted mental abilities, strengthening of intact functions, relearning of social interaction skills, substitution of new skills to replace lost functioning and controlling the emotional aspects of one's functioning. Treatment may include techniques such as auditory and visual attention directed tasks, memory training, training in the use of assistive technology, and anger management. Training can be done through exercises or stimulation, cognitive neuropsychology, cognitive psychology and behavioral psychology, or a holistic approach to include social and emotional aspects. Training is generally provided one-on-one and is highly customized to each individual's strengths, skills, and needs.

Service Standards/Provider Qualifications

Cognitive rehabilitation services must be provided by individuals who are qualified *behavioral health professionals* as defined in 9 A.A.C. 10 and who can bill independently using the appropriate CPT codes.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Cognitive Rehabilitation
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one on one) patient contact by the provider, each 15 minutes.

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II. B. 3. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)

General Information

General Definition

Education and training are single or multiple sessions provided to an individual or a group of people and/or their families related to the enrolled person's treatment plan. Education and training sessions are usually presented using a standardized curriculum with the purpose of increasing an individual's behavioral knowledge of a health-related topic such as the nature of an illness, relapse and symptom management, medication management, stress management, safe sex practices, HIV education, parenting skills education and healthy lifestyles (e.g., diet, exercise). DUI health promotion education and training must be approved by DLS.

Service Standards/Provider Qualifications

Behavioral health prevention/promotion education services may be provided by individuals who are qualified *behavioral health professionals* or *behavioral health technicians* as defined in 9 A.A.C. 10 or who are educators or subject matter experts. This may also include other medical personnel, such as Licensed Practical Nurses (LPNs) or Registered Nurses (RNs) who are not allowed to bill independently using CPT codes. All individual providers must be appropriately licensed/certified/trained in the area in which they are providing training.

Code Specific Information

HCPCS Codes

Behavioral health prevention/promotion education and medication training and support services should be billed using the following codes:

- **H0025 - Behavioral Health Prevention Education Service: (delivery of** services with target population to affect knowledge, attitude and/or behavior). See general definition above.

- **H0025 HQ- Behavioral Health Prevention Education Service – Group**

- **H0025 WITH Place of Service 02: Behavioral Health Prevention Education Service- Telephonic**

  Billing Unit: 30 minutes

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- **H0034 – Medication Training and Support: (**Health promotion) Education and training provided to a person and/or their family related to the enrolled person's medication regime.

  <u>Billing Unit</u>:   15 minutes

Billing Limitations

For behavioral health prevention/promotion education and medication training and support services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. More than one provider agency may bill for behavioral health prevention/promotion education and medication training and support services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

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II. B. 4. Psychoeducational Services and Ongoing Support to Maintain Employment

General Information

General Definition

Psychoeducational services and ongoing support to maintain employment services are designed to assist a person or group to choose, acquire, and maintain a job or other meaningful community activity (e.g., volunteer work)

Service Standards/Provider Qualifications

Psychoeducational services and ongoing support to maintain employment services may be provided individually. These services must be provided using tools, strategies and materials which meet the individual's support needs. While the goal may be for persons to achieve full time employment in a competitive, integrated work environment, having other employment goals may be necessary prior to reaching that level. Therefore, these services need to be tailored to support persons in a variety of settings (e.g., part time job, unpaid work experience or in meaningful volunteer work). Some individuals may not be ready to identify an educational or employment goal, and will need assistance in exploring their strengths, while others may desire to focus on socialization goals, which should also be addressed in Skills Training and Development, and are often the first step to moving towards competitive employment and further independent involvement in the community.

Code Specific Information

HCPCS Codes

- **H2027 – Psychoeducational Services (Pre-Job Training and Development):** Services which prepare a person to engage in meaningful work-related activities may include but are not limited to the following: career/educational counseling, job shadowing, job training, including Work Adjustment Training (WAT); assistance in the use of educational resources necessary to obtain employment; attendance to RSA/VR Information Sessions; attendance to Job Fairs; training in resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), work activities, professional decorum , time management, and assistance in finding employment.

- H2027 HQ – Psychoeducational Services (Pre-Job Training and Development) – Group: See general definition above. This applies to services provided to two (2) or more individuals. For example, if eight persons participated in a group session for 60 minutes, the provider would bill four (4) units for each person for a total of 32 units

  Provider Qualifications:

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Behavioral health professionals, behavioral health technicians and behavioral health paraprofessionals, as established by the Provider Administrator.

For Community Service Agencies, please see AHCCCS Medical Policy Manual, Policy 961 Peer, Family and CSA Training, Credentialing and Oversight Requirement, 961-C Community Service Agencies for further detail on service standards and provider qualifications for this service.

Billing Unit: 15 minutes

- **H2025 – Ongoing Support to Maintain Employment:** Includes support services that enable a person to maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, and supportive counseling.

- **H2025 (Place of Service 02) – Ongoing Support to Maintain Employment Telephonic**

- H2025 HQ – Ongoing Support to Maintain Employment – Group: See general definition above. This applies to services provided to two (2) or more individuals. For example, if eight persons participated in a group session for 60 minutes, the provider would bill four (4) units for each person for a total of 32 units

Provider Qualifications:

Behavioral health professionals, behavioral health technicians and behavioral health paraprofessionals, as established by the Provider Administrator.

For Community Service Agencies, please see AHCCCS Medical Policy Manual, Policy961 Peer, Family and CSA Training, Credentialing and Oversight Requirement, 961-C Community Service Agencies, for further detail on service standards and provider qualifications for this service.

Billing Unit: 15 minutes

- **H2026 – Ongoing Support to Maintain Employment:** See definition above.

Provider Qualifications:

Behavioral health professionals, behavioral health technicians and behavioral health paraprofessionals, as established by the Provider Administrator.
For Community Service Agencies, please see AHCCCS Medical Policy Manual, Policy 961 Peer, Family and CSA Training, Credentialing and Oversight

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Requirement, 961-C Community Service Agencies for further detail on service standards and provider qualifications for this service.

Billing Unit: Per Diem

Billing Limitations

For psychoeducational services and ongoing support to maintain employment services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation provided to persons is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Psychoeducational services and ongoing support to maintain employment services are provided only if the services are not available through the federally funded Rehabilitation Act program administered by DES-RSA, which is required to be the primary payer for Title XIX eligible persons. The T/RBHA must monitor the proper provision of this service.

5. Service code H2025, Ongoing Support to Maintain Employment, may be billed up to 8 hours. Service code H2026, Ongoing Support to Maintain Employment (per diem), cannot be billed if under 8 hours are needed and should be billed for the length of the service. Service codes H2025, Ongoing Support to Maintain Employment and Service code H2026, Ongoing Support to Maintain Employment (per diem) cannot be billed on the same day.

6. More than one provider agency may bill for psychoeducational services and ongoing support to maintain employment services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

7. Peer employment training is not a billable service for costs associated with training an agency's own employees.

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II. C. Medical Services

Medical services are provided or ordered by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a person's symptoms and improve or maintain functioning. These services have been further grouped into the following four subcategories:

- Medication
- Laboratory, Radiology and Medical Imaging
- Medical Management (including medication management)
- Electroconvulsive Therapy (ECT)

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II. C. 1. Medication Services

General Information

General Definition

Drugs prescribed by a licensed physician, nurse practitioner or physician assistant to prevent, stabilize or ameliorate symptoms arising from a behavioral health condition or its treatment.

Service Standards/Provider Qualifications

Most prescribed medications must be provided by a licensed pharmacy or dispensed under the direction of a licensed pharmacist. Some medications are administered by (e.g., injections, opioid agonist drugs) or under the direction of a licensed physician, nurse practitioner, or physician assistant.

AHCCCS BEHAVIORAL HEALTH SERVICES maintains a minimum list of medications to ensure the availability of necessary, safe and cost effective medications for persons with behavioral health disorders. These medications must be made available to persons in accordance with the AHCCCS BEHAVIORAL HEALTH SERVICES Policy 1301AHCCCS BEHAVIORAL HEALTH SERVICES Drug List.

Code Specific Information

National Drug Codes

The National Drug Codes (NDC) must be used for billing all prescribed medications dispensed by a pharmacy (provider type 03). These pharmacy claims are reimbursed based on a fee schedule amount plus a dispensing fee.

CPT Codes

CODE	DESCRIPTION-Medication Services
96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

HCPCS Codes

CODE	DESCRIPTION-Medication Services
J0515	Injection, Benztropine Mesylate, per 1mg
J1200	Injection, Diphenhydramine HCL, up to 50 mg
J1630	Injection, Haloperidol, up to 5 mg

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J1631	Injection, Haloperidol Decanoate, per 50 mg
J2680	Injection, Fluphenazine Decanoate, up to 25 mg
J2794	Injection, Risperidone (Risperidal Consta), long-acting, 0.5 mg
J3410	Injection, Hydroxyine HCL, up to 25 mg

While prescribed opioid agonist drugs that are dispensed by a pharmacy should be billed using the NDC code for the drug itself, the administration of opioid agonist by licensed medical practitioners in an office setting (non-inpatient) should be billed using the codes listed below. The administration of opioid agonist drugs must be done in compliance with federal regulations, (see 42 CFR Part 8), state regulations (9 A.A.C. 10) and AHCCCS BEHAVIORAL HEALTH SERVICES guidelines related to opioid agonist administration.

- **H2010 HG –Comprehensive Medication Services**: Administration of prescribed opioid agonist drugs to a person *in the office setting* in order to reduce physical dependence on heroin and other opiate narcotics. Providers must be AHCCCS registered as a Category of Service (COS) type 01 (Medicine).

  Billing Unit: 15 minutes

- **H0020 HG – Alcohol and/or Drug Services; Methadone Administration and/or Services (provision of the drug by a licensed program)**: Administration of prescribed opioid agonist drugs for a person *to take at home* in order to reduce physical dependence on heroin and other opiate narcotics. Providers must be AHCCCS registered as a Category of Service (COS) type 01 (Medicine).

  Billing Unit: 1 dose per day (includes cost associated with drug and administration). While the billing unit is a single dose of medication per day, the take home medicine can be provided for more than one day.

Billing Limitations

For medication services the following billing limitations apply:

1. Medications provided in an inpatient general acute care or psychiatric hospital setting are included in the per diem rate and cannot be billed separately.

2. As described in the AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 902 Coordination of Care with AHCCCS Health Plans, PCP and Medicare Providers, in certain circumstances the person's primary

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care physician (PCP) may prescribe psychotropic medications (For the treatment of depression, anxiety and Attention-Deficit Hyperactivity Disorder). Care should be coordinated with other prescribers including AHCCCS Health Plan PCPs.

3. Other than opioid agonist drugs (see limitation #4 below), the T/RBHA and/or provider should determine the maximum number of days and/or unit doses for prescriptions.

4. The Comprehensive Medication Services (Office) and Methadone Administration and/or Services (Take-Home) procedure codes are to be billed one dose per day (includes cost associated with drug and administration). While the billing unit for Methadone Administration and/or Services (Take-Home) is a single dose of medication per day, the take home medicine can be provided for more than one day.

5. AHCCCS BEHAVIORAL HEALTH SERVICES does not cover items relating to medical marijuana. This includes application fees or the drug itself.

6. Transportation provided to the AHCCCS BEHAVIORAL HEALTH SERVICES person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

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II. C. 2. Laboratory, Radiology and Medical Imaging

General Information

General Definition

Medical tests ordered for diagnosis, screening or monitoring of a behavioral health condition. This may include but is not limited to blood and urine tests, CT scans, MRI, EKG, and EEG.

Service Standards/Provider Qualifications

Laboratory, radiology, and medical imaging services may be prescribed by a licensed physician, nurse practitioner, or physician assistant within the scope of their practice.

With the exception of specimen collections in a medical practitioner's office, laboratory services are provided in Clinical Laboratory Improvement Act (CLIA) approved hospitals, medical laboratories and other health care facilities that meet state licensure requirements as specified in A.R.S. Title 36, Chapter 4. (Also see requirements related to federal Clinical Laboratory Improvement Amendments in 9 A.A.C.14-101 and the federal code of regulations 42 CFR 493, Subpart A).

Radiology and medical imaging are provided in hospitals, medical practitioner's offices, and other health care facilities by qualified licensed health care professionals.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Laboratory, Radiology and Medical Imaging
36415	Collection of venous blood by venipuncture
80048	Basic metabolic panel, this panel must include the following: calcium total, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, urea nitrogen (BUN)
80050	General health panel, this panel must include the following: comprehensive metabolic panel, blood count complete (CBC) automated and automated differential WBC count or blood count, complete (CBC) automated and appropriate manual differential WBC count, thyroid stimulating hormone (TSH).
80051	Electrolyte panel, this panel must include the following: carbon dioxide, chloride, potassium, sodium.

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80053	Comprehensive metabolic panel, this panel must include the following: albumin, bilirubin total, calcium total, carbon dioxide (bicarbonate), chloride, creatinine, glucose, phosphatase alkaline, potassium, protein total, sodium, transferase alanine amino (ALT) (SGPT), transferase aspartate amino (AST) (SGOT), urea nitrogen (BUN).
80061	Lipid panel, this panel must include the following: cholesterol serum total, lipoprotein direct measurement, high density cholesterol (HDL cholesterol), triglycerides.
80076	Hepatic function panel, this panel must include the following: albumin, bilirubin total, bilirubin direct, phosphatase alkaline, protein total, transferase alanine amino (ALT) (SGPT), transferase aspartate amino (ALT) (SGOT).
80156	Carbamazepine; total
80164	Dipropylacetic acid (valproic acid)
80171	Drug Screen Quantitative Gabapentin
80178	Lithium
80299	Quantitation of drug, Not Elsewhere Specified (NOS)
80420	Dexamethasone suppression panel, 48 hour, this panel must include the following: free cortisol urine, cortisol, volume measurement for timed collection.
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, Ph, protein, specific gravity, urobilinogen, and any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, Ph, protein, specific gravity, urobilinogen, and any number of these constituents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, Ph, protein, specific gravity, urobilinogen, and any number of these constituents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose,

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hemoglobin, ketones, leukocytes, nitrite, Ph, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy

81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81025	Urine pregnancy test, by visual color comparison methods
81050	Volume measurement for timed collection, each
82075	Alcohol (ethanol); breath
82382	Catechloamines, total urine
82465	Cholesterol, serum or whole blood, total
82492	Chromatography Quan Column Multiple Analytes
82530	Cortisol, free
82533	Cortisol, total
82542	Column chromatography/mass spectrometry (EG, GC/MS, or HPLC/MS), analyte not elsewhere specified; quantitative, single stationary and mobile phase
82565	Creatinine; blood
82570	Creatinine (other source)
82575	Creatinine, clearance
82607	Cyanocobalamin (Vitamin B12)
82746	Folic acid; serum
82947	Glucose, quantitative, blood (except reagent strip)
82948	Glucose, blood, reagent strip
82977	Glutamyltransferase (GGT)
83036	Hemoglobin; Glycosylated (A1C)
83037	Hemoglobin; Glycosylated (A1C) by device cleared by FDA
83788	Mass Spect & Tandem Mass Spect Anal Qual Ea Spec

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83789	Mass Spect & Tandem Mass Spect Anal Quan Ea Spec
83986	PH body fluid Not Elsewhere Specified
83992	Assay of Phencyclidine (PCP)
84132	Potassium; serum, plasma or whole blood
84146	Prolactin
84311	Spectrophotometry Analyte Not Elsewhere Specified
84436	Thyroxine; total
84439	Thyroxine, free
84443	Thyroid stimulating hormone (TSH)
84520	Urea nitrogen, blood (BUN); quantitative
84703	Gonadotropin, chorionic (Hcg), qualitative
85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	Blood count; blood smear, microscopic examination without manual differential WBC count
85009	Blood count; manual differential WBC count, buffy coat
85013	Blood count; spun microhematocrit
85014	Blood count; hematocrit (Hct)
85018	Blood count; hemoglobin (Hgb)
85025	Blood count; complete (CBC), automated (Hgb), Hct, RBC, WBC, and platelet count) and automated differential WBC count
85027	Blood count; complete (CBC), automated (Hgb), Hct, RBC, WBC, and platelet count)
85048	Blood count, leukocyte (WBC), automated
85651	Sedimentation rate, erythrocyte; non-automated

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85652	Sedimentation rate, erythrocyte; automated
86580	Skin test, tuberculosis, intradermal
86592	Syphilis test; qualitative (e.g., VDRL, RPR, ART)
86593	Syphilis test; quantitative
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86701	Antibody; HIV-1
86702	Antibody; HIV-2
86703	Antibody; HIV-1 and HIV-2, single result
87390	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-1
87391	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-2
70450	Computed tomography, head or brain, without contrast material
70460	Computed tomography, head or brain; with contrast material(s)
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70551	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material
70552	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); with contrast material(s)
70553	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

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93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
93040	Rhythm ECG, one to three leads, with interpretation and report
93041	Rhythm ECG, one to three leads, tracing only, without interpretation and report
93042	Rhythm ECG, one to three leads, interpretation and report only
95819	Electroencephalogram (EEG) including recording awake and asleep

HCPCS Codes

G0431	Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
G0434	Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
G6030	Assay of Amitriptyline
G6031	Assay of Benzodiazepines
G6032	Assay of Desipramine
G6034	Assay of Doxepin
G6035	Assay of Gold
G6036	Assay of Imipramine
G6037	Assay of Nortriptyline
G6038	Assay of Salicylate
G6039	Assay of Acetaminophen
G6040	Assay of Alcohol; Any Specimen except Breath
G6041	Alkaloids Urine Quantitative
G6042	Assay of Amphetamine or Methamphetamine

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G6043	Assay of Barbiturates Not Elsewhere Specified
G6044	Assay of Cocaine or Metabolite
G6045	Assay of Dihydrocodeinone
G6046	Assay of Dihydromorphinone
G6047	Assay of Dihydrotestosterone
G6048	Assay of Dimethadione
G6049	Assay of Epiandrosterone
G6050	Assay of Ethchlorvynol
G6051	Assay of Flurazepam
G6052	Assay of Meprobamate
G6053	Assay of Methadone
G6054	Assay of Methsuximide
G6055	Assay of Nicotine
G6056	Opiate Drug and Metabolites Each Procedure
G6057	Assay of Phenothiazine
G6058	Drug Confirmation Each Procedure

Billing Limitations

For laboratory, radiology and medical imaging the following billing limitation applies:

Laboratory, radiology, and medical imaging services provided in an inpatient hospital setting are included in the per diem rate and cannot be billed separately.

II. C. 3. Medical Management

General Information

General Definition

Assessment and management services that are provided by a licensed medical professional (i.e., physician, nurse practitioner, physician assistant or nurse) to a person as part of their medical visit for ongoing treatment purposes. Includes medication management services involving the review of the effects and side effects of medications and the adjustment of the type and dosage of prescribed medications.

Service Standards/Provider Qualifications

Appropriately licensed physicians, nurse practitioners, physician assistants, and nurses must provide medical management services. Psychiatric consultation services are provided for AHCCCS primary care providers who wish to prescribe psychotropic medications in accordance with AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 902 Coordination of Care with AHCCCS Health Plans, PCP and Medicare Providers DLS licensed agencies must operate within the scope of services authorized through the agency's license.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Medical Management
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-

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face with the patient and/or family.

| 99203 | Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a detailed history; a detailed examination; and, medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. |

| 99204 | Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family. |

| 99205 | Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family. |

| 99211 | Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. |

| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. |

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99213   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; medical decision-making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

99304   Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

99305   Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical

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decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

99306   Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination, and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit.

99307   Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit.

99308   Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

99309   Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically

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spend 25 minutes at the bedside and on the patient's facility floor or unit.

99310   Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

99315   Nursing facility discharge day management. (30 minutes or less)

99316   Nursing facility discharge day management. (more than 30 minutes)

99318   Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a detailed interval history; a comprehensive examination; and medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 30 minutes with the patient and/or family or caregiver. (Do not report 99318 on the same day of service as nursing facility services codes 99304-99316.)

99324   Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.

99325   Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate

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severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.

99326   Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.

99327   Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

99328   Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.

99334   Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.

99335   Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key

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components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

99336 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.

99337 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; and medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

99341 Home visit for the evaluation and management of a new patient which requires these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99342 Home visit for the evaluation and management of a new patient which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or

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family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99343 Home visit for the evaluation and management of a new patient which requires these 3 key components: a detailed history; a detailed examination; and decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99344 Home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99345 Home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.

99347 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99348 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision-making of low complexity.

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Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99349 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

99350 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision-making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99354 Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour. (List separately in addition to code for office or other outpatient evaluation and management service)

99355 Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged physician service 99354)

99358 Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records and tests, communication with other professionals and/or the patient/family); first hour (list separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient evaluation and management service).

99359 Prolonged evaluation and management service before and/or after

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direct (face-to-face) patient care (e.g., review of extensive records and tests, communication with other professionals and/or the patient/family); each additional 30 minutes (list separately in addition to code for prolonged physician service 99358)

99499   Unlisted evaluation and management service.

HCPCS Codes

- **T1002 - RN Services:** Medical management services (including medication monitoring) related to the treatment of a behavioral health disorder. As allowed by the individual provider's scope of practice may include such activities as the measurement of vital signs, assessment and monitoring of physical/medical status, review of the effects and side effects of medications and administration of medications.

    Provider Qualifications:
    Licensed registered nurse (within the scope of their license)

    Billing Unit: 15 minutes

- **T1003 – LPN Services:** Medical management services (including medication monitoring) related to the treatment of a behavioral health disorder. As allowed by the individual provider's scope of practice may include such activities as the measurement of vital signs, assessment and monitoring of physical/medical status, review of the effects and side effects of medications and administration of medications.

    Provider Qualifications:
    Licensed practical nurse (within the scope of their license)

    Billing Unit: 15 minutes

- **T1015 –** Clinic visit/encounter, all-inclusive A face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

    Provider Qualifications:
    Federally Qualified Health Center (FQHC)
    Community/Rural Health Center (RHC)

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Billing Limitations

For medical management services the following billing limitations apply:

1. RN and LPN Services (T1002 and T1003) provided on the same day as a higher level of service (e.g., services by a psychiatrist or other physician) are considered inclusive of the higher level of service. See also general core billing limitations applicable to T1002 and T1003 in Section I." The same day billing limitation was communicated through AHCCCS BEHAVIORAL HEALTH SERVICES Office of Program Support (OPS@azahcccs.gov) on November 18, 2013, and is effective for services provided on or after October 1, 2013.

2. Where applicable, travel time by the provider is included in the rate for RN and LPN Services (T1002 and T003). See core provider travel billing limitations in Section I.

3. Nursing services provided in a DLS licensed inpatient, residential or medical day program setting are included in the rate and cannot be billed separately.

4. Transportation provided to the AHCCCS BEHAVIORAL HEALTH SERVICES enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

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II. C. 4. Electroconvulsive Therapy

General Information

General Definition

The application of alternating current at or slightly above the seizure threshold through the use of electrodes attached to the scalp of a person who has received short-acting general anesthetic and muscle depolarizing medication.

Service Standards/Provider Qualifications

Electroconvulsive therapy services must be provided by a licensed physician with anesthesia support in a hospital.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Electroconvulsive Therapy
00104	Anesthesia for electroconvulsive therapy.
90870	Electroconvulsive therapy (includes necessary monitoring).

Revenue Codes

In addition to the CPT codes billed for the professional services, hospitals (02), free standing psychiatric facilities (71) or subacute facilities (B5, B6) may bill **Revenue Code 0901** – electro shock treatment for the facility based costs associated with providing electroconvulsive therapy to a person in the facility. The rate for revenue code 0901 is set by report.

When electroconvulsive therapy is provided as part of an inpatient hospital admission, the following revenue codes are billed in addition.

0114 – Psychiatric; room and board – private
0124 – Psychiatric; room and board – semi private two beds
0134 – Psychiatric; room and board – semi private three and four beds
0154 – Psychiatric; room and board – ward.

II. D. Support Services

Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services. These services have been grouped into the following categories:

- 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

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II. D. 1. Case Management

General Information

General Definition

Case management is a supportive service provided to enhance treatment goals and effectiveness. Activities may include:

- Assistance in maintaining, monitoring and modifying covered services;
- 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;
- Assistance in finding necessary resources other than covered services to meet basic needs;
- 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;
- 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);
- Outreach and follow-up of crisis contacts and missed appointments;
- Participation in staffings, case conferences or other meetings with or without the person or their family participating; and
- Other activities as needed.

Case management **does not** include:

- Administrative functions such as authorization of services and utilization review;
- Other covered services listed in the AHCCCS BEHAVIORAL HEALTH SERVICES Covered Behavioral Health Services Guide.

Service Standards/Provider Qualifications

Case management services must be provided by individuals who are qualified *behavioral health professionals*, *behavioral health technicians*, *or behavioral health paraprofessionals* as defined in 9 A.A.C. 10.

If case management services are not provided by behavioral health professionals, these services must be provided under their direction or supervision.

Code Specific Information

CPT Codes

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CODE	DESCRIPTION
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician.
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional.
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
99442	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.

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99443   Telephone evaluation and management service provided by a
             physician to an established patient, parent, or guardian not originating
             from a related E/M service provided within the previous 7 days nor
             leading to an E/M service or procedure within the next 24 hours or
             soonest available appointment; 21-30 minutes of medical discussion.

90887   Interpretation or explanation of results of psychiatric, other medical
             examinations and procedures, or other accumulated data to family or
             other responsible persons, or advising them how to assist patient.

90889   Preparation of report of patient's psychiatric status, history, treatment,
             or progress (other than legal or consultative purposes) for other
             physicians, agencies, or insurance carriers.

HCPCS Codes:

▪ **T1016 HO– Case Management by Behavioral Health Professional - Office:** Case
  management services (see general definition above for case management services)
  provided at the provider's work site.

  Provider Qualifications:
  Behavioral health professional

  Billing Unit: 15 minutes

▪ **T1016 HO – Case Management by Behavioral Health Professional - Out-of-
  Office:** Case management services (see general definition above for case
  management services) provided at a person's place of residence or other out-of-office
  setting.

  Provider Qualifications:
  Behavioral health professional

  Billing Unit: 15 minutes

▪ **T1016 HN – Case Management - Office:** Case management services (see general
  definition above for case management services) provided at the provider's work site.

  Provider Qualifications:
  Behavioral health technician or Behavioral health paraprofessional

  Billing Unit: 15 minutes

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- **T1016 HN – Case Management - Out-of-Office:** Case management services (see general definition above for case management services) provided at a person's place of residence or other out-of-office setting.

- **T1016 GT WITH PLACE OF SERVICE 02 Case Management – Telemedicine**

- **T1016 with Place of Service 02 – Case Management Telephonic**

Provider Qualifications:
Behavioral health technician or behavioral health paraprofessional

Billing Unit: 15 minutes

Billing Limitations

For case management services the following billing limitations apply:

1. Case management services provided by a DLS licensed inpatient, residential or in a therapeutic/medical day program setting are included in the rate for those settings and cannot be billed separately. However, providers other than the inpatient, residential facility or day program can bill case management services provided to the person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.

2. A single provider may not bill case management for any time associated with a therapeutic interaction, nor simultaneously with any other services.

3. Multiple provider agencies may bill for this service during the same time period when more than one provider is simultaneously providing a case management service (e.g., a staffing). In addition, more than one individual within the same agency may bill for this service (e.g., individuals involved in transitioning a person from a residential level of care to a higher (subacute) or lower (outpatient) level of care, staff from each setting may bill case management when attending a staffing.

4. Billing for case management is limited to individual providers who are directly involved with service provision to the person (e.g., when a clinical team comprised of multiple providers, physicians, nurses etc. meet to discuss current case plans).

5. Transportation provided to an AHCCCS BEHAVIORAL HEALTH SERVICES enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

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6. For Case Management codes:

   - See general core billing limitations in Section I.
   - Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.
   - The provider should bill all time he/she spent in direct or indirect contact with the person, family and/or other parties involved in implementing the treatment/service plan. Indirect contact includes telephone calls, picking up and delivering medications, and/or collateral contact with the person, family and/or other involved parties.
   - Written electronic communication (email) and leaving voice messages are allowable as case management functions. These functions are not to become the predominant means of providing case management services and require specific documentation as specified below.
   - Written electronic communication (email) must be about a specific individual and is allowable as case management, as long as documentation (a paper copy of the email) exists in the case record.
   - When voice messages are used, the case manager must have sufficient documentation justifying a case management service was actually provided. Leaving a name and number asking for a return call is not sufficient to bill case management.
   - When leaving voice messages, a signed document in the client chart granting permission to leave specific information is required.

7. When a provider is picking up and dropping off medications for more than one behavioral health recipient, the provider must divide up the time spent and bill the appropriate case management code for each involved behavioral health recipient.

8. In accordance with other case management restrictions, RBHAs shall be permitted to encounter behavioral health case management for services provided within 60 days of planned discharge from the Arizona State Hospital for the purposes of coordinating care between inpatient and outpatient providers.

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II. D. 2. Personal Care Services

General Information

<u>General Definition</u>

Personal care services involve the provision of support activities to assist a person in carrying out daily living tasks and other activities essential for living in a community. These services are provided to maintain or increase the self-sufficiency of the person. For DD/ALTCS enrolled persons, Personal Care Services includes general supervision; however, providers must document the need for general supervision.

<u>Service Standards/Provider Qualifications</u>

Personal care services may be provided by a licensed behavioral health agency or Community Service Agency (CSA)utilizing individuals who are qualified as *behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals* as defined in <u>9 A.A.C. 10</u>.

Code Specific Information

<u>HCPCS Codes</u>

- **T1019 –Personal Care Services, not for an inpatient or resident of a hospital, nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF/MR) or (Institution of Mental Disease (IMD), part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant):** Personal care services (see general definition above) provided to a person for a period of time (up to 11¾ hours).

  <u>Billing Unit:</u> 15 minutes

- **T1020 – Personal Care Services, not for inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant):** Personal care services (see general definition above) provided to a person, for 12 or more hours.

  <u>Billing Unit:</u> Per Diem

Billing Limitations

For personal care services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Personal care services provided in a DLS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately, with certain exceptions. For exceptions see section on Modifiers. This service is also included in the HCTC service rate and cannot be billed separately for persons receiving HCTC services. See also section on Home Care Training to Home Care Client under Billing Limitations.

4. Transportation (emergency and non-emergency) provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. Personal Care Services (T1019) and Personal Care Services (T1020) cannot be billed on the same day.

6. More than one provider agency may bill for personal care services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

7. A Community Service Agency cannot provide services that would otherwise require the agency to be licensed as a health care institution (see 9 A.A.C. 10)..

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II. D. 3. Home Care Training Family (Family Support)

General Information

General Definition

Home care training family services (family support) with family member(s) directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the person in the home and community. May involve support activities such as assisting the family to adjust to the person's disability, developing skills to effectively interact and/or guide the person, understanding the causes and treatment of behavioral health issues, understanding and effectively utilizing the system, or planning long term care for the person and the family.

Service Standards/Provider Qualifications

Home care training family services (family support) must be provided by *behavioral health professionals, behavioral health technicians, or behavioral health para-professionals* as defined in 9 A.A.C. 10.

Code Specific Information

HCPCS Codes

- **S5110 –Home Care Training, Family; (Family Support):** See general definition above.

- **S5110 HQ-**Home Care Training, Family; (Family Support) – Group

- **S5110 GT with Place of Service 02** Home Care Training, Family; (Family Support) – Telemedicine

- **S5110 with Place of Service 02** – Home Care Training, Family; (Family Support) - Telephonic

- **S5110 CG-** Home Care Training, Family; (Family Support) – **Credentialed** through State Approved Training

- **S5110 CG GT with Place of Service 02 -** Home Care Training, Family; (Family Support) – **Credentialed** through State Approved Training – Telemedicine

- **S5110 CG with Place of Service 02** – Home Care Training, Family; (Family Support) – **Credentialed** through State Approved Training - Telephonic

- **S5110 CG HQ-** Home Care Training, Family; (Family Support) – **Credentialed** through State Approved Training -Group

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Billing Unit: 15 minutes

Billing Limitations

For home care training family services (family support) the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Family support services provided in a DLS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately, with certain exceptions. For exceptions see section Behavioral Health Counseling and Therapy under Billing Limitations. This service is also included in the HCTC service rate and cannot be billed separately by the behavioral health therapeutic home, with certain exceptions. For exceptions see section Home Care Training to Home Care Client under Billing Limitations. However, providers other than the inpatient, residential facility, day program or behavioral health therapeutic homes can bill home care training family services (family support) provided to the person residing in and/or transitioning out of the inpatient, residential settings, behavioral health therapeutic home or who is receiving services in a day program.

4. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. More than one provider agency may bill for home care training family services (family support) services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

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THIS DOCUMENT IS A GUIDELINE ONLY AND DOES NOT TAKE THE PLACE OF THE COVERED SERVICES ON THE PMMIS SYSTEM

II. D. 4. Self-Help/Peer Services (Peer Support)

General Information

General Definition

This may involve 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.

Service Standards/Provider Qualifications

Individuals providing self-help/peer services must be employed by or contracted with a Community Service Agency or a licensed facility allowed to bill the procedure code. Community Service Agencies providing this service must be Title XIX certified by AHCCCS.

Self-help/peer services are provided by those who have been credentialed as Peer/Recovery Support Specialists through an AHCCCS BEHAVIORAL HEALTH SERVICES approved Peer Support Employment Training Program, self-identify as a "peer" and are qualified as *behavioral health professionals, behavioral health technicians, or behavioral health para-professionals* as defined in 9 A.A.C. 10. A "peer", as referenced in these provider qualifications, is defined as an individual who is, or has been a recipient of behavioral health services or substance abuse and has an experience of recovery to share.

Code Specific Information

HCPCS Codes

- **H0038 – Self-Help/Peer Services:** Self-help/peer services (see general definition above) provided to an individual person for a short period of time (up to 2 ¾ hours).

Billing Unit: 15 minutes

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- **H0038 HQ – Self-Help/Peer Services - Group**: Self-help/peer services (see general definition above) provided to a group of individuals and/or their families.

- **H0038 GT with Place of Service 02** - Self-Help/Peer Services (Peer Support) – Telemedicine

- **H0038 with Place of Service 02** – Self-Help/Peer Services (Peer Support) - Telephonic

Billing Unit: 15 minutes

- **H2016 – Comprehensive Community Support Services (Peer Support)**: Self-help/peer services (see general definition above) provided to a person for a period of time, 3 or more hours in duration.

Billing Unit: Per Diem

Billing Limitations

For self-help/peer services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel, time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Self-help/peer services provided in a DLS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately, with certain exceptions. However, providers other than the inpatient, residential facility or day program can bill self-help/peer services provided to the person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.

4. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. Self Help/Peer Services (H0038) and Comprehensive Community Support Services (H2016) cannot both be billed on the same day.

6. More than one provider agency may bill for self-help/peer services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

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II. D. 5. Home Care Training to Home Care Client

General Information

General Definition

Home Care Training to Home Care Client (HCTC) services are provided by a behavioral health therapeutic home to a person residing in their home in order to implement the in-home portion of the person's behavioral health service plan. HCTC services assist and support a person in achieving their service plan goals and objectives. It also helps the person remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services such as personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the person to therapy or visitations and/or the participation in treatment and discharge planning. (See HCTC billing limitations below)

Service Standards/Provider Qualifications

Provider of Services to Children
Behavioral health therapeutic homes providing HCTC services to children must meet the following qualifications:

▪ Be a ADES licensed professional foster care home (A.A.C. R6-5-5850); or

▪ Be licensed by federally recognized Indian Tribes that attest to CMS (via AHCCCS) that they meet equivalent requirements.

Provider of Services to Adults
Behavioral health therapeutic homes providing HCTC services to adults must meet the following qualifications:

▪ Be a DLS licensed Behavioral Health Therapeutic Home (9 A.A.C. 10); or

▪ Be licensed by federally recognized Indian Tribes that attest to CMS (via AHCCCS) that they meet equivalent requirements.

For all providers of HCTC services, prior to providing a service for either an adult or child, the T/RBHAs must ensure that:

a.   The behavioral health therapeutic home providers have successfully completed pre-service training in the type of care and services required for the individual being placed in the home.

b.   The behavioral health therapeutic home providers have access to crisis intervention and emergency consultation services.

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c.   A Clinical Supervisor has been assigned to oversee the care provided by the behavioral health therapeutic home provider.

Code Specific Information

<u>HCPCS Codes</u>

- **S5109 HB–Home Care Training to Home Care Client (Adult) – Age 18-64 years**

- **S5109 HC-Home Care Training to Home Care Client (Adult geriatric) – Age 65 years and older**

- **S5109 HA-Home Care Training to Home Care Client (Child) – Age 0-17 years**

<u>Billing Unit</u>: Per Session

Billing Limitations

For HCTC services the following billing limitations apply:

1. Personal care services, skills training and development and home care training family services (family support) are provided by the behavioral health therapeutic home provider and are included in the HCTC rate. Counseling, evaluation, support and rehabilitation services provided to the AHCCCS BEHAVIORAL HEALTH SERVICES member may be billed using the appropriate procedure code.

2. The HCTC procedure code does not include any professional services; therefore, professional services provided should be billed by the appropriate provider using the applicable CPT codes.

3. The HCTC procedure code does not include day program services, this service should be billed by the appropriate provider using the applicable procedure code.

4. Room and board services are to be billed separately. The State-funded HCPCS code for room and board is to be used for all persons except for state-placed children (i.e., ADES or AOC) whose room and board should be paid by the placing agency.

5. A licensed professional who supervises and trains the behavioral health therapeutic home provider may not bill for these functions. Employee supervision and training has been built into the procedure code rate.

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6. Pre-training activities associated with the HCTC setting is included in the rate. This service may not be billed outside the HCTC procedure code rate by either the licensed professional or behavioral health therapeutic home provider.

7. Prescription drugs are not included in the rate and should be billed by appropriate providers using the applicable NDC procedure codes.

8. Over-the-counter drugs and non-customized medical supplies are included in the rate and should not be billed separately.

9. Emergency transportation provided to an AHCCCS BEHAVIORAL HEALTH SERVICES member is not included in the rate and should be billed separately by the appropriate provider using the applicable transportation procedure codes.

10. Non-emergency transportation is included in the rate and cannot be billed separately.

11. Any medical services provided to persons, excluding those medical services included in the AHCCCS BEHAVIORAL HEALTH SERVICES covered service array as set forth in this guide should be billed to the member's health plan.

12. HCTC services cannot be encountered/billed on the same day as Unskilled Respite Care (S5151).

13. Based on behavioral health recipient needs, Personal Care Services (T1019), Skills Training and Development (H2014/H2014HQ), Home Care Training Family Services (S5110) and Psychosocial Rehabilitation Services (H2017) may be provided and billed on the same day that HCTC services are furnished. The clinical rationale for providing these additional services must be specifically documented in the Service Plan and Progress Note.

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II. D. 6. Unskilled Respite Care

General Information

General Definition

"Respite" means short term behavioral health services or general supervision that provides rest or relief to a family member or other individual caring for the behavioral health recipient. Respite services are designed to provide an interval of rest and/or relief to the family and/or primary care givers and may include a range of activities to meet the social, emotional and physical needs of the behavioral health recipient during the respite period. These services may be provided on a short-term basis (i.e., few hours during the day) or for longer periods of time involving overnight stays.

Respite services can be planned or unplanned. If unplanned respite is needed, agency personnel will assess the situation with the caregiver and recommend the appropriate setting for respite.

Licensed programs providing respite must develop and implement policy and procedures demonstrating the following:
- A respite admission does not cause the agency to exceed the licensed capacity identified on the agency's license,
- A behavioral health recipient being admitted for respite meets the admission requirements in 9 A.A.C. 10,
- A behavioral health recipient being admitted for respite receives an assessment and treatment plan for the period of time the person is receiving respite from the agency, and
- A behavioral health recipient's treatment plan addresses how the person will be oriented to and integrated into the daily activities at the agency.

The setting in which respite services are received should be the most conducive to the behavioral health recipient's situation. A behavioral health recipient in need of assistance in the self-administration of medication while receiving respite services must be able to get the assistance from a provider meeting the requirements in 9 A.A.C. 10. A behavioral health recipient's clinical team must consider the appropriateness of the setting in which the recipient receives respite services. Safety of the behavioral health recipient and the provider must be considered when the recipient has exhibited behavior requiring an emergency safety response (see 9 A.A.C. 10). When respite services are provided in a home setting, household routines and preferences should be respected and maintained when possible. It is essential that the respite provider receive orientation from the family/caregiver regarding the behavioral health recipient's needs as well as the individual service plan (ISP). At all times the respite provider shall respect and maintain the confidentiality of the family/caregiver.

Respite services, including the goals, setting, frequency, duration and intensity of the service, are defined in the behavioral health recipient's service plan. Respite services are

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not a substitute for other medically necessary covered services. The treatment team will also explore the availability and use of informal supports and other community resources to meet the caregiver's respite needs.

Summer day camps, day care or other ongoing, structured activity programs are not respite unless they meet the definition/criteria of respite services and the provider qualifications.

Parents receiving behavioral health services may receive necessary respite services for their non-enrolled children as indicated in their service plan. Non-enrolled siblings of a child receiving respite services are not eligible for behavioral health respite benefits.

Service Standard/Provider Qualifications

Respite services may be provided in a variety of settings (for licensed providers, this would include settings listed in 9 A.A.C. 10). Each provider type must meet licensing or certification requirements and other local authorities (i.e., county, city, etc.). The type of setting in which respite services are provided must ensure the behavioral health recipient's current service plan can be appropriately supported and services provided are within the respite provider's qualifications and experience.

Licensed providers must meet all applicable qualifications, as described in 9 A.A.C. 10.

Code Specific Information

Revenue Codes

Respite services provided in a DLS licensed Level I facility should be billed using the applicable revenue codes listed in Section II. F. Inpatient Services for the facility type.

HCPCS Codes

▪ **S5150– Unskilled respite care: - not hospice:** Unskilled respite services (see general definition above) provided to a person for a short period of time (up to 12 hours in duration).

  Billing Unit: 15 minutes

▪ **S5151– Unskilled respite care - not hospice:** Unskilled respite services provided to a person for more than 12 hours in duration.
  Billing Unit: Per Diem

Billing Limitations

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For respite services, the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Respite services billed using the two HCPCS codes S5150 and S5151 are limited to no more than 600 hours of respite services per year (October 1st through September 30th) per person. T/RBHAs must ensure the accurate tracking of respite service limitations for their enrolled members.

3. For Behavioral Health Residential facilities providing respite services, room and board may be billed in addition to the per diem rate.

4. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

5. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

6. Respite services cannot be billed for persons who are residing and receiving treatment in a DLS licensed Level I facility, ADES group home or nursing home.

7. A Community Service Agency cannot provide respite services.

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II. D. 7. Supported Housing

General Information

General Definition

Supported housing services are provided to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes owned or leased by a subcontracted provider. These services may include rent and utility subsidies, and relocation services to a person or family for the purpose of securing and maintaining housing.

Service Standards/Provider Qualifications

Supported housing services are provided by *behavioral health professionals*, *behavioral health technicians* or *behavioral health paraprofessionals*. Staff providing the services must have knowledge of state and local landlord/tenant laws.

Code Specific Information

State Funded HCPCS Codes:

▪ **H0043 – Supported Housing**

Billing Unit: Per Diem

Billing Limitations

For supported housing services the following billing limitations apply:

1. Supported housing services do not include meals, furnishing(s), cost of telephones or telephone usage fees or other household equipment. . The T/RBHA must monitor to ensure the proper use of this service code.

2. Direct payment for supported housing services to the behavioral health recipient and/or their family are not permitted.

3. Supported housing services must not be used to cover residential treatment facility room and board charges.

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II. D. 8. Sign Language or Oral Interpretive Services

General Definition

Sign Language and oral interpretation services are required to be made available to members free of charge; services for all non-English languages and the hearing impaired must be available to potential members, free of charge, when oral information is requested.

Sign language or oral interpretive services are required by Medicaid regulations and as defined in 9 A.A.C. 21 and must be paid for with Title XIX and Title XXI Administrative Capitation Funds or grant funding for services provided with grant funding. Sign language or oral interpretive services are provided to persons and/or their families with limited English proficiency or other communication barriers (e.g., sight or sound) during instructions on how to access services, counseling, and treatment activities that will ensure appropriate delivery of mental health services for individuals.

Service Standards/Provider Qualifications

Oral interpretive services must be provided by: qualified interpreter staff, qualified bilingual staff, contracted qualified interpreters, telephone interpretation services or from a qualified individual provider office, agency, or facility. Sign language services are to be provided by license interpreters for the deaf and the hard of hearing pursuant to A.R.S. § 36-1946.

Code Specific Information

Encounters are to be submitted to AHCCCS BEHAVIORAL HEALTH SERVICES for sign language or oral interpretive services, utilizing the T1013 code requirements as described below.

State Funded HCPCS Codes

▪ **T1013 –Sign Language or Oral Interpretive Services:** (see general definition above)

Billing Unit: 15 minutes

Billing Limitations

For interpreter services the following billing limitation applies:

1. The sign language or oral interpretive service code must be billed in combination with a code for a behavioral health service that cannot be delivered effectively without the availability of sign language or interpreter services.

2. For DLS licensed inpatient and residential facilities, sign language or oral interpretive services are included in the per diem rate, however, these services must be documented and encountered separately by the facility with a zero dollar bill value (0.00).

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II. D. 10. Transportation

General Information

<u>General Definition</u>

Transportation services involve the transporting of a person from one place to another to facilitate the receipt of, or benefit from, medically necessary covered behavioral health services, allowing the person to achieve their service plan goals. The service may also include the transportation of a person's family/caregiver with or without the presence of the person, if provided for the purposes of carrying out the person's service plan (e.g., counseling, family support, case planning meetings). Urban transports are defined as those originating within the Phoenix or Tucson metropolitan areas. All other transports are defined as rural. Odometer readings or other T/RBHA approved documentation methods that clearly and accurately support mileage may be used when billing transportation services.

<u>Service Standards/Provider Qualifications</u>

Transportation services may be provided by:

- Non-emergency transportation providers (e.g., vans, buses, taxis) who are registered with AHCCCS as a non-emergency transportation provider and have proof of insurance, drivers with valid driver's licenses and any other insurance as required by state law.
- Emergency transportation providers (e.g., air or ground ambulance) who are registered with AHCCCS as emergency transportation providers and have been granted a certificate of necessity by the AHCCCS Behavioral Health Services/Bureau of Emergency Medical Services (<u>A.R.S. 36-2233</u>).

In most instances, transportation services should be provided by non-emergency transportation providers. Transportation services furnished by a ground or air ambulance provider should be provided in situations in which the person's condition is such that the use of any other method of transportation is contraindicated and medically necessary behavioral health services are not available in the hospital from which the person is being transported.

Emergency transportation service shall not require prior authorization.

Non-emergency transportation must be provided for persons and/or families who are unable to arrange or pay for their transportation or who do not have access to free transportation in order to access medically necessary covered behavioral health services.

<u>Record Keeping for Non-Emergency Transportation Providers</u>

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AHCCCS BEHAVIORAL HEALTH SERVICES has added the following guidance based on AHCCCS' established guidelines for documentation of non-emergency transportation services.

1. Complete Service Provider's Name and Address

2. Name and signature of the driver who provided the service

3. Vehicle Identification (car, van, wheelchair van, etc.)

4. Recipient (being transported) name

5. Recipient's AHCCCS ID

6. Complete date of service, including month, day and year

7. Complete address of the pick-up site

8. Complete address of drop off destination

9. Type of trip - round trip or one way

10. Escort (if any) must be identified by name and relationship to the member being transported

11. Signature of recipient, verifying services were rendered

It is the provider's responsibility to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment IF the required documentation is not maintained or covered services cannot be verified.

Code Specific Information

HCPCS Codes-Emergency Transportation Providers Only

- **A0382 – Basic Life Support (BLS) routine disposable supplies**
- **A0398 – Advanced Life Support (ALS) routine disposable supplies**
- **A0420 – Ambulance waiting time (ALS or BLS), one-half (½) hour increments**
- **A0422 – Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation**
- **A0888 – Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)**
- **A0426 – Ambulance service, ALS; non-emergency transport, level 1 (ALS 1)**
- **A0427 – Ambulance service, ALS; emergency transport, level 1 (ALS 1-emergency**
- **A0428 – Ambulance service, BLS base rate, non-emergency transport (BLS)**

- **A0429 – Ambulance service, BLS base rate, emergency transport (BLS-emergency)**
- **A0434 – Specialty Care Transport (SCT) (this code may be used only by TRBHAs)**
- **A0430 – Ambulance service, conventional air services, transport, one-way (fixed wing)**
- **A0431 – Ambulance service, conventional air services, transport, one way (rotary wing)**
- **A0435 – Fixed wing air mileage, per statute mile**
- **A0436 – Rotary wing air mileage, per statute mile**

HCPCS Codes-Non-Emergency Transportation Providers Only

- **A0090* – Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest**

*This code must be used by friends/relatives/neighbors when transporting a client.

- **A0100 – Non-emergency transportation; taxi**
- **A0110 – Non-emergency transportation and bus, intra- interstate carrier (may be used to encounter and/or bill for bus passes)**
- **A0170 –Transportation ancillary; parking fees, tolls, other**
- **A0180 – Non-emergency transport; ancillary: lodging-recipient**
- **A0190 – Non-emergency transport; ancillary: meals-recipient**
- **A0200 – Non-emergency transport; ancillary lodging-escort**
- **A0210 – Non-emergency transport; ancillary meals-escort**
- **A0120* – Non-emergency transportation; mini-bus, mountain area transports or other transportation systems**

*This code may be used for vans or cars.

- **A0120 TN* - Non-emergency transportation; mini-bus, mountain area transports - Rural**

* This code may be used for vans or cars.

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- **A0130 – Non-emergency transport; wheel-chair van**
- **A0130 TN – Non-emergency transport; wheel-chair van - Rural**
- **A0140 – Non-emergency transport; and air travel (private or commercial), intra- or interstate**
- **A0160 – Non-emergency transportation per mile-case worker or social worker**
- **T2003 – Non-emergency transportation; encounter/trip**

HCPCS Codes-Emergency and Non-emergency Transportation Providers

- **S0209 – Wheelchair van mileage, per mile**
- **S0209 TN – Wheelchair van mileage, per mile- Rural**
- **S0215 – Non-emergency transportation mileage, per mile**
- **S0215 TN – Non-emergency transportation mileage, per mile - Rural**
- **T2005 – Non-emergency transportation; stretcher van**
- **T2005 TN - Non-emergency transportation; stretcher van – Rural**
- **T2007 – Transportation waiting time, air ambulance and non-emergency vehicle, ½ hour increments**
- **A0425 – Ground mileage, per statute mile**
- **T2049 – Non-emergency transportation; stretcher van, mileage; per mile**
- **T2049 TN - Non-emergency transportation; stretcher van, mileage; per mile – Rural**
- **A0999 – Unlisted ambulance service. Determine if an alternative national HCPCS Level II code or a CPT code better describes the service. This code should be used only if a more specific code is unavailable.**

Billing Limitations

For transportation services the following billing limitations apply:

1. See core transportation billing limitations in Section I.

2. Emergency transportation required to manage an emergency medical condition and includes the transportation of a person to the same or higher level of care for immediate medically necessary treatment at the nearest appropriate facility is covered for AHCCCS members and is the responsibility of the AHCCCS contracted Health Plan.

3. Depending on the setting and the service being provided, certain transportation costs may be included as part of a provider's rate and cannot be billed separately.

4. Like all other non-emergency transportation, A0090 may only be billed if a person and/or family is unable to arrange or pay for their transportation or does

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not have access to free transportation in order to obtain medically necessary covered behavioral health services.

5. When providing transportation to multiple clients, the provider bills a base rate for each client and the loaded mileage for each person transported. Loaded mileage is the actual number of miles each enrolled person is transported in the vehicle beginning when the enrolled person is picked up and ending when the enrolled person is dropped off.

6. For most transports, the provider should bill the applicable base rate code and the number of loaded miles using the appropriate mileage code. Loaded mileage is the distance traveled while a person and/or family is being transported.

7. The following provider types may bill A0120, S0215, S0215 TN or A0120 TN, when providing crisis intervention – (H2011 HT) or crisis intervention service via two-person team or crisis intervention service (H2011):
    -Level I Hospital (02)
    -Out-of-state, One Time Fee For Service Provider (73)
    -Behavioral Health Outpatient Clinic (77)

8. More than one provider agency may bill for transportation services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

9. A provider may bill for transportation services provided to a behavioral health recipient in order to receive a Medicare covered service.

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II. E. Crisis Intervention Services

Beginning July 1, 2010, "crisis" is defined as: "A Crisis is when a person presents with a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior." Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are provided in a variety of settings (see places of service below) or over the telephone. 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.

T/RBHAs are responsible for providing 72 hours of inpatient emergency behavioral health services to Title XIX/XXI members with psychiatric or substance abuse diagnoses. AHCCCS health plans continue to be responsible for all emergency medical services including triage, physician assessment and diagnostic tests. T/RBHAs will continue to be responsible for medically necessary psychiatric consultations provided to Title XIX/XXI members in emergency room settings.

Many types of services throughout this Covered Behavioral Health Services Guide may be billed when providing crisis intervention services (e.g. screening, counseling and therapy, case management). All services billed/encountered as crisis must be identified by entering the emergency indicators. This section describes codes for additional crisis intervention services.

CPT Codes:

CODE	DESCRIPTION-Crisis Services
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; and straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

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99283   Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate severity.

99284   Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

99285   Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status; a comprehensive history; a comprehensive examination; and medical decision- making of high complexity. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

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II. E. 1. Crisis Intervention Services (Mobile, Community Based)

General Information

General Definition

Crisis intervention services are provided by a mobile team or individual who travels to the place where the person is having the crisis (e.g., person's place of residence, emergency room, jail, community setting). Crisis intervention services include services aimed at the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress. The purpose of this service is to:
- Stabilize acute psychiatric or behavioral symptoms;
- Evaluate treatment needs; and
- Develop plans to meet the needs of the persons served.

Depending on the situation, the person may be transported to a more appropriate facility for further care (e.g., a crisis services center).

Service Standards/Provider Qualifications

Crisis intervention services must be provided by DLS licensed agencies.

If a two-person team responds, one person may be a Behavioral Health Paraprofessional, including a peer or family member, provided he/she has supervision and training as currently required for all mobile team members.

In some situations (e.g., the safety of staff and control of the environment are not primary concerns, such as in hospitals, schools, residential settings) it may only be necessary to send a single individual out to intervene, however that individual must be a behavioral health professional or a behavioral health technician. Depending on the acuity of the person, the crisis intervention services may be provided by either a qualified behavioral health professional or behavioral health technician.

All individuals providing this service must at a minimum have been trained in first aid, Cardiopulmonary Resuscitation (CPR) and non-violent crisis resolution. Additionally, individuals must have valid Arizona driver licenses and vehicles used must be insured as required by Arizona law.

The T/RBHA or applicable provider agency must ensure that:

- Individuals providing this service have a means of communication, such as a cellular phone, pager, or radio for dispatch, that is available at all times.
- On-call behavioral health professionals are available 24 hours a day for direct consultation.
- If transporting persons, the requirements specified in 9 A.A.C. 10 (outings and transportation) are met.

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Code Specific Information

<u>HCPCS Codes</u>

▪ **H2011 HT – Crisis Intervention Service – multi-disciplinary team:** See general definition above.

   <u>Billing Unit:</u>   15 minutes

▪ **H2011 – Crisis Intervention Service, per 15 minutes –** See general definition above.

   <u>Billing Unit:</u>   15 minutes

Billing Limitations

For crisis intervention services (mobile) the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Billing for this service should not include mobile crisis response services provided by fire, police, EMS, and other providers of public health and safety services.

3. Transportation provided to the person receiving the crisis intervention services is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Services provided in the jail setting are not Title XIX/XXI reimbursable.

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II. E. 2. Crisis Intervention Services (Stabilization, Facility Based)

General Information

General Definition

Crisis intervention services (stabilization) is an immediate and unscheduled behavioral health service provided: (a) In response to an individual's behavioral health issue to prevent imminent harm, to stabilize or resolve an acute behavioral health issue; and (b) At an inpatient facility or outpatient treatment center (Provider Type IC) in accordance with 9 A.A.C. 10. Persons may walk-in or be referred/transported to these settings.

Provider Standards/Service Standards

Crisis intervention services (stabilization) must be provided by facilities that are DLS licensed facilities (excluding behavioral health residential facilities). Individuals providing these services must be *behavioral health professionals, behavioral health technicians or behavioral health para-professionals* as defined in 9 A.A.C. 10.

Laboratory, radiology and psychotropic medications may be provided by an AHCCCS registered provider if prescribed by a qualified practitioner.

Code Specific Information

HCPCS Codes

- **S9484 – Crisis Intervention Mental Health Services – (Stabilization)** See definition above. Up to 5 hours in duration.

  Billing Unit: One hour

- **S9485 – Crisis Intervention Mental Health Services – (Stabilization)** See definition above. More than 5 hours and up to 24 hours in duration.

  Billing Unit: Per Diem

Billing Limitations

For crisis intervention services (stabilization) the following billing limitations apply:

1. See general core billing limitations in Section I.

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2. Crisis intervention services are limited to up to 24 hours per episode. After 24 hours the person, depending on their discharge plan, must be transferred and/or admitted to a more appropriate setting for further treatment (e.g., inpatient hospital, subacute facility, respite, etc.) or sent home with arrangements made for follow-up services, if needed (e.g., prescription for follow-up medications, in-home stabilization services).

3. If a client receives service code S9484 or S9485 at a Level I inpatient hospital or subacute facility, then the client is admitted to a Level I inpatient hospital or subacute bed in that same facility on the same day, the per diem Level I rate and code for the inpatient or subacute facility must be billed. Codes S9484 or S9485 for an inpatient hospital or inpatient subacute facility cannot be billed on the same date of service for the same client by the same provider.

4. Medical supplies provided to a person while in a crisis services setting and provided by the crisis service provider type are included in the rate and should not be billed separately.

5. Meals are included in the rate and should not be billed separately.

6. Transportation services are not included in the rate and should be billed separately using the appropriate transportation procedure codes.

7. Laboratory and radiology services are not included in the rate and should be billed separately.

8. Medications are not included in the rate and should be billed separately.

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II. E. 3. Crisis Intervention (Telephone)

General Information

General Definition

Crisis intervention (telephone) services provide triage, referral and telephone-based support to persons in crisis; often providing the first place of access to the behavioral health system. The service may also include a follow-up call to ensure the person is stabilized.

Service Standards/Provider Qualifications

The personnel for the crisis phone must include, at a minimum, behavioral health technicians supervised by a behavioral health professional. These individuals must be able to quickly assess the needs of the caller. While some situations may be resolved on the telephone, other situations may require face-to-face intervention in which case the telephone personnel must be able to ensure the provision of the most appropriate intervention (e.g., call 911, dispatch mobile team, referral to crisis intervention services).

Billing Information

When a behavioral health provider provides crisis telephone services to an enrolled person, the provider should bill the appropriate case management service code.

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II. F. Inpatient Services

Inpatient services (including room and board) are provided by a DLS licensed Level I behavioral health agency and include the following subcategories:

- Hospitals
- Subacute Facilities
- Residential Treatment Centers (RTC)

These facilities provide a structured treatment setting with 24 hour supervision and an intensive treatment program, including medical support services.

Service Standards/Provider Qualifications

Inpatient services may only be provided by DLS licensed behavioral health agencies that meet the general Level I licensure requirements set forth in 9 A.A.C. 10. In addition, depending on the type of services being provided, the facility may need to meet supplemental requirements as set forth in the licensing rules.

Institution for Mental Diseases (IMD)

Except for general hospitals with distinct units (Provider Type 02), all other Level I facilities with more than 16 beds (Provider Types 71, B1, B3 and B6) are considered under Title XIX/XXI to be Institutions for Mental Diseases (IMDs). An IMD is defined under 42 CFR 435.1010 as an institution with more than 16 beds that are primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and other related services.

Code Specific Information

CPT Codes

Services provided in hospitals are inclusive of all services, supplies, accommodations, staffing, and equipment. T/RBHAs are responsible for the payment of behavioral health professional services, such as psychiatric consultations, provided in an inpatient setting (regardless of the bed or floor where the patient is located).

CODE	**DESCRIPTION-Inpatient Services (Professional)**
99217	Observation care discharge day management (this code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status"). To report services to a patient designated as "observation status" or "inpatient status" and discharge on the same date, use the code for Observation or Inpatient care services (including Admission and Discharge services, 99234-99236

as appropriate).

99218   Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

99219   Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

99220   Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

99221   Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision-making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

99222   Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making

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of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

99223   Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

99231   Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem-focused interval history; a problem-focused examination; medical decision-making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99232   Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

99233   Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend

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35 minutes at the bedside and on the patient's hospital floor or unit.

99234   Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision-making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.

99235   Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical-decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.

99236   Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components: a comprehensive history; comprehensive examination; and medical-decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.

99238   Hospital discharge day management; 30 minutes or less.

99239   Hospital discharge day management; more than 30 minutes.

99251   Inpatient consultation for a new or established patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; and straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

99252   Inpatient consultation for a new or established patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and straightforward medical

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decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

99253   Inpatient consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

99254   Inpatient consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

99255   Inpatient consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

99307   Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit.

99308   Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an

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expanded problem focused examination; medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

99356 Prolonged physician service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)

99357 Prolonged physician service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged physician service-99356)

Revenue Codes

Except for crisis intervention services, all Level I inpatient behavioral health facilities must bill on a UB04 claim form or electronically through an 837I for an inpatient residential stay. Unlike other services in which a specific rate has been established for a specific service code, the residential rates for these facilities have been established based on the provider type. For example, while a hospital and a Residential Treatment Center

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(RTC) may both bill revenue code 0114, the fee-for-service rate will be different depending on the provider type billing the service.

<u>HCPCS Codes</u>

A licensed hospital, psychiatric hospital or subacute facility should use codes under category of service 47 (Mental Health) to bill for crisis intervention services provided in a crisis services setting in addition to the CPT codes for those services provided by certain health care professionals.

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II. F. 1. Hospital

General Information

General Definition

Provides continuous treatment that includes general psychiatric care, medical detoxification, and/or forensic services in a general hospital or a general hospital with a distinct part or a freestanding psychiatric facility. Also includes 24 hour nursing supervision and physicians on site and on call.

The Contractor's responsibility for payment of behavioral health services includes per diem claims for inpatient hospital services, when the principal diagnosis on the hospital claim is a behavioral health diagnosis. The hospital claim, which may include both behavioral health and physical health services, will be paid by the Contractor at the per diem inpatient behavioral health rate prescribed by AHCCCS and described in A.A.C. R9-22-712.61. For more detailed information about Contractor payment responsibility for physical health services that may be provided to members who are also receiving behavioral health services refer to ACOM Policy 432.

Service Standards/Provider Qualifications:

General and freestanding hospitals may provide services to persons if the hospital is:

-Accredited through an accrediting body approved by CMS or surveyed by DLS if providing treatment to clients under the age of 21; and
-Meets the requirements of 42 CFR 440.10 and Part 482 and is licensed pursuant to A.R.S. 36, Chapter 4, Articles 1 and 2 and 9 A.A.C. 10; or
-For adults age 21 or over, certified as a provider under Title XVIII of the Social Security Act; or
-For adults age 21 or over, currently determined by the Office of Medical Facility Licensing and DLS to meet such requirements.

If seclusion and restraint is provided, then the facilities must meet the requirements set forth in 9 A.A.C. 10.

Code Specific Information

Revenue Codes:

Hospitals may bill the following revenue codes:

0114 – Psychiatric; room and board – private
0124 – Psychiatric; room and board – semi private two beds
0134 – Psychiatric; room and board – semi private three and four beds
0154 – Psychiatric; room and board – ward

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0116 – Detoxification; room and board – private
0126 – Detoxification; room and board – semi private two beds
0136 – Detoxification; room and board – semi private three and four beds
0156 – Detoxification; room and board – ward
0110 – Room and board - private
0111 – Medical-Surgical-Gyn - private
0112 – OB - private
0113 – Pediatrics - private
0120 – Room and board - semi-private 2 beds
0121 – Medical-Surgical-Gyn - 2 beds
0122 – OB - 2 beds
0123 – Pediatrics - 2 beds
0130 – Room and board - Semi private 3 and 4 beds
0131 – Medical-Surgical-Gyn - 3 and 4 beds
0132 – OB - 3 and 4 beds
0133 – Pediatrics - 3 and 4 beds
0150 – Room and board - ward
0151 – Medical-Surgical-Gyn - ward
0152 – OB - ward
0153 – Pediatrics - ward
0160 – Room and board -general
0200 – Intensive Care
0201 – Intensive Care Unit - surgical
0202 – Intensive Care Unit - medical
0203 – Intensive Care Unit – pediatrics
0206 – Intensive Care Unit - intermediate
0209 – Intensive Care Unit - other
0210 – Coronary Care
0115 – Hospice private
0117 – Oncology private
0118 – Rehab private
0119 – Other private
0125 – Hospice 2 beds
0127 – Oncology 2 beds
0128 – Rehab 2 beds
0129 – Other 2 beds
0135 – Hospice 3 & 4 beds
0137 – Oncology 3 & 4 beds
0138 – Other 3 & 4 beds
0139 – Other 3 & 4 beds
0155 – Hospice ward
0157 – Oncology ward
0158 – Rehab ward
0159 – Other ward
0164 – R & B sterile
0167 – R & B self

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0169 – R & B other
0190 – Subacute general
0191 – Subacute care level I
0192 – Subacute care level II
0193 – Subacute care level III
0194 – Subacute care level IV
0199 – Other Subacute Care
0204 – ICU/Psych stay
0207 – ICU/Burn care
0208 – ICU/Trauma
0211 – CCU/MYO Infarc
0212 – CCU/Pulmonary
0213 – CCU/Transplant
0214 – CCU/Intermediate
0219 – CCU other

Billing Provider Type:
Level I Hospital (02)
Level I Psychiatric Hospital (IMD) (71)

Billing Unit: Per Diem

A Level I Psychiatric Hospital (71) may bill for bed hold or home pass days. Level I Hospital (02) can only bill for home pass days. These are days in which the hospital reserves the person's space in which they have been residing while the individual is on an authorized/planned overnight leave from the facility related to:

- Therapeutic leave to enhance psychosocial interaction or as a trial basis for discharge planning (billed using revenue code 0183 – home pass) or
- Admittance to a hospital for a short stay (billed using revenue code 0189 – bed hold).

After the leave, the person is returned to the same bed within the Level I Psychiatric Hospital. Any combination of bed hold leave is limited to up to 21 days per contract year (July 1st through June 30th). The following revenue codes must be used to bill for home pass and bed hold days:

0183 – Home pass

Billing Provider Type:
Level I Hospital (02)
Level I Psychiatric Hospital (IMD) (71)

Billing Unit: Per Diem

0189 – Bed hold

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Billing Provider Type:
Level I Psychiatric Hospital (IMD) (71)

Billing Unit: Per Diem

Billing Limitations

1. Non-emergency travel for a person in a hospital/psychiatric hospital is included in the rate and should not be billed separately.

2. Emergency transportation provided to a person residing in the facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

3. Medical services provided to a person while in a hospital/psychiatric hospital are included in the rate and should not be billed separately.

4. Medical supplies provided to a person while in a hospital/psychiatric hospital are included in the rate and should not be billed separately.

5. Miscellaneous costs such as insurance, housekeeping supplies, laundry, clothing, resident toiletries and expenses, and staff training materials, are included in the rate and should not be billed separately.

6. Meals are included in the rate and should not be billed separately.

7. The revenue codes for hospital/psychiatric hospital services are billed per day for each person receiving services.

8. Medication provided/dispensed by the hospital/psychiatric hospital are included in the rate and cannot be billed separately.

9. Laboratory, Radiology and Medical Imaging provided by the hospital/psychiatric hospital are included in the rate and should not be billed separately.

10. A Level I hospital, (provider type 02), cannot bill for therapeutic leave/bed hold.

11. Accommodation revenue codes 0110-0113, 0120-0123, 0130-0133, 0150-0153, 0160, 0200-0203, 0206, 0209-0210 can be billed when prior authorization is obtained from the T/RBHA, the member is medically stable, and there is a principal mental health or substance abuse diagnosis on the claim. The T/RBHA is only responsible for the inpatient stay while the member is primarily receiving psychiatric treatment.

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II. F. 2. Subacute Facility

General Information

General Definition

Continuous treatment provided in a subacute facility to a person who is experiencing acute and severe behavioral health and/or substance abuse symptoms. Services may include emergency reception and assessment; crisis intervention and stabilization; individual, group and family counseling; detoxification and referral. Also includes 24 hour nursing supervision and physicians on site or on call. May include crisis intervention services provided in a crisis services setting licensed as a subacute facility, but which does not require the person to be admitted to the facility.

Service Standards/Provider Qualifications:

Subacute facilities must be accredited by The Joint Commission, COA, or CARF and licensed by DLS as a Level I facility meeting the specific requirements of 9 A.A.C. 10. Additionally, the facilities must meet the requirements set forth in 9 A.A.C. 10 for seclusion and restraint if the facility has been authorized by DLS to provide seclusion and restraint.

Code Specific Information

Revenue Codes:

Level I subacute facilities may bill the following revenue codes:

0114 – Psychiatric; room and board – private
0124 – Psychiatric; room and board – semi private two beds
0134 – Psychiatric; room and board – semi private three and four beds
0154 – Psychiatric; room and board – ward
0116 – Detoxification; room and board – private
0126 – Detoxification; room and board – semi private two beds
0136 – Detoxification; room and board – semi private three and four beds
0156 – Detoxification; room and board – ward

Billing Provider Type:
Level I Subacute Facility (non-IMD) (B5)
Level I Subacute Facility (IMD) (B6)

Billing Unit: Per Diem

Billing Limitations

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1. See general core billing limitations in Section I.

2. The revenue codes for subacute facility services are billed per day for each person receiving services.

3. Non-emergency transportation for a person in a subacute facility is included in the rate and should not be billed separately.

4. Emergency transportation provided to a person residing in the facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. Medical services provided to a person while in a subacute facility are included in the rate and should not be billed separately.

6. Laboratory, Radiology, Medical Imaging and Psychotropic Medication provided by the subacute facility are not included in the rate and should be billed separately. Laboratory, Radiology, Medical Imaging and Psychotropic Medication services related to a behavioral health condition are the responsibility of the T/RBHA.

7. Miscellaneous costs such as insurance, housekeeping supplies, laundry, clothing, resident toiletries and expenses, and staff training materials are included in the rate and should not be billed separately.

8. Meals are included in the rate and should not be billed separately.

II. F. 3. Residential Treatment Center

General Information

General Definition:

Inpatient psychiatric treatment, which includes an integrated residential program of therapies, activities, and experiences provided to persons who are under 21 years of age and have severe or acute behavioral health symptoms. There are two types of residential treatment centers:

Secure - a residential treatment center which generally employs security guards and uses monitoring equipment and alarms.

Non-secure – an unlocked residential treatment center setting.

Service Standards/Provider Qualifications:

Residential treatment facilities must be accredited by an accrediting body approved by CMS and licensed by DLS as a Level I facility meeting the specific requirements of 9 A.A.C. 10. Additionally, the facility must meet the requirements for seclusion and restraint set forth in 9 A.A.C. 10 and in accordance with 42 CFR 441 and 483 if the facility has been authorized by DLS to provide seclusion and restraint.

Code Specific Information

Revenue Codes:

For inpatient stays the residential treatment center may bill the following revenue codes:

0114 – Psychiatric; room and board – private
0124 – Psychiatric; room and board – semi private two beds
0134 – Psychiatric; room and board – semi private three and four beds
0154 – Psychiatric; room and board – ward
0116 – Detoxification; room and board – private
0126 – Detoxification; room and board – semi private two beds
0136 – Detoxification; room and board – semi private three and four beds
0156 – Detoxification; room and board – ward

Billing Provider Type:
Level I Residential Treatment Center – Secure (non-IMD) (78)
Level I Residential Treatment Center – Secure (IMD) (B1)
Level I Residential Treatment Center – Non-Secure (non-IMD) (B2)
Level I Residential Treatment Center – Non-Secure (IMD) (B3)

Billing Unit: Per Diem

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Residential treatment centers may bill for bed hold or home pass days. These are days in which the RTC reserves the person's space in which they have been residing while the individual is on an authorized/planned overnight leave from the facility related to:

- Therapeutic leave to enhance psychosocial interaction or as a trial basis for discharge planning (billed using revenue code 0183 – home pass) or
- Admittance to a hospital for a short stay (billed using revenue code 0189 – bed hold).

After the leave, the person is returned to the same bed within the RTC. Any combination of bed hold leave is limited to up to 21 days per contract year (July 1st through June 30th). The following revenue codes must be used to bill for bed hold or home pass days:

0183 – home pass
0189 – bed hold

Billing Provider Type:
Level I Residential Treatment Center – Secure (non-IMD) (78)
Level I Residential Treatment Center – Secure (IMD) (B1)
Level I Residential Treatment Center - Non-Secure (non-IMD) (B2)
Level I Residential Treatment Center – Non-Secure (IMD) (B3)

Billing Unit: Per Diem

Billing Limitations:

1. See general core billing limitations in Section I.

2. The RTC revenue code is billed per day for each person receiving services.

3. The RTC revenue code is a "bundled" rate that includes all HCPCS procedure code services an individual receives.

4. Expenses related to the person's education are not included in the RTC rate and should be billed separately.

5. Non-emergency transportation for a person in a RTC facility is included in the rate and should not be billed separately.

6. Emergency transportation provided to a person residing in the RTC facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

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7. Medical supplies provided to a person while in a RTC are included in the rate and should not be billed separately.

8. Miscellaneous costs such as insurance, housekeeping supplies, laundry, clothing, resident toiletries and expenses, and staff training materials, are included in the rate and should not be billed separately.

9. Meals are included in the rate and should not be billed separately.

10. Laboratory, Radiology, Medical Imaging and Psychotropic Medications are not included in the rate and should be billed separately by qualified providers.

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II. G. Behavioral Health Residential Services

Residential services are provided on a 24 hour basis.

II. G. 1. Behavioral Health Residential Facility, Without Room and Board

General Information

General Definition

Residential services are provided by a licensed behavioral health agency. 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.

RBHAs must clearly set forth in provider subcontracts the type of services which are to be provided as part of the residential program, type of persons to be served, expected program outcomes, services included in the rate and those that can be billed outside the rate and documentation requirements.

These services may only be provided by DLS licensed behavioral health agencies that meet the general licensure requirements set forth in 9 A.A.C. 10.

Room and board is not covered by Title XIX/XXI for persons residing in behavioral health residential facilities. (See service description on room and board.)

Code Specific Information

HCPCS Codes

- **H0018– Behavioral Health Short-Term Residential, without room and board:** Personal Care is included in the rate for this service. See general definition above.

Billing Unit: Per Diem

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II. G. 2. Mental Health Services NOS (Room and Board)

General Information

General Definition

Room and board means provision of lodging and meals to a person residing in a residential facility or supported independent living setting which may include but is not limited to: services such as food and food preparation, personal laundry, and housekeeping. This code may also be encountered to report bed hold/home pass days in Behavioral Health Residential facilities.

Service Standards/Provider Qualifications

The provider must meet the following requirements:

- Provide safe and healthy living arrangements that meet the needs of the person and
- Provide or ensure the nutritional maintenance for the resident.

Code Specific Information

State Funded HCPCS Codes

- **H0046 SE – Mental Health Services NOS (Room and Board):** See general definition above.

  Billing Unit: Per Diem

Billing Limitations

For room and board services, the following billing limitations apply:

All other fund sources (e.g., ADES funds for foster care children, SSI) must be exhausted prior to billing this service. Outpatient Clinics may bill the Room and Board code only when providing services to persons in Supervised Independent Living settings.

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II. H. Behavioral Health Day Programs

Behavioral health day program services are 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 can be 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
- Psychiatric/Medical

RBHAs must clearly set forth in provider contracts the type of services which are to be provided as part of the behavioral health day program, type of persons to be served, expected program outcomes, documentation requirements and services included in the rate and services that are billed outside the rate.

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II. H. 1. Supervised Behavioral Health Treatment and Day Programs

General Information

General Definition

A regularly scheduled program of individual, group and/or family activities/services related to the enrolled person's treatment plan designed to improve the ability of the person to function in the community and may include the following rehabilitative and support services: skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to maintain employment, and self-help/peer services.

Service Standards/Provider Qualifications

Supervised behavioral health treatment and day programs may be provided by either DLS licensed behavioral health agencies or Title XIX certified Community Service Agencies. The individual staff that deliver specific services within the supervised behavioral health treatment and day programs must meet the individual provider qualifications associated with those services. Supervised behavioral health treatment and day programs provided by non-DLS licensed community service agencies must be supervised by a behavioral health technician or behavioral health para-professional.

Code Specific Information

HCPCS Codes

- **H2012 —Behavioral Health Day Treatment (Supervised):** See general definition above. Per hour, up to 5 hours in duration.

  Billing Unit: Per hour

- **H2015 – Comprehensive Community Support Services (Supervised Day Program):** See general definition above. Greater than 5 hours, up to 10 hours in duration.

  Billing Unit: Per 15 minutes

Billing Limitations

For supervised day programs and treatment, the following billing limitations apply:

1. See general core billing limitations in Section I.

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2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.

3. Meals provided as part of the supervised day treatment are included in the rate and should not be billed separately.

4. Emergency and non-emergency transportation provided to a person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

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II. H. 2. Therapeutic Behavioral Health Services and Day Programs

General Definition

A regularly scheduled program of active treatment modalities which may include services such as individual, group and/or family behavioral health counseling and therapy, skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to maintain employment, home care training family (family support), medication monitoring, case management, self-help/peer services, and/or medical monitoring.

Service Standards/Provider Qualifications

Therapeutic behavioral health services and day programs must be provided by an appropriately licensed DLS behavioral health agency and in accordance with applicable service requirements set forth in 9 A.A.C. 10. These programs must be under the direction of a behavioral health professional. The staff who deliver the specific services within the therapeutic day program must meet the individual provider qualifications associated with those services.

Code Specific Information

HCPCS Codes

- **H2019 – Therapeutic Behavioral Services:** See general definition above. Up to 5 ¾ hours in duration.

  Billing Unit: 15 minutes

- **H2019 TF – Therapeutic Behavioral Services:** See general definition above. Up to 5 ¾ hours in duration. ****TF modifier required for intermediate level of care.**** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

  Billing Unit: 15 minutes

- **H2020 – Therapeutic Behavioral Services:** See general definition above.

  Billing Unit: Per Diem

Billing Limitations

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For therapeutic behavioral health services and day programs, the following billing limitations apply:

1. See general core billing limitations in Section I.

2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.

3. A registered nurse who supervises therapeutic behavioral health services and day programs may not bill this function separately. Employee supervision has been built into the procedure code rates.

4. Meals provided as part of therapeutic behavioral health services and day programs are included in the rate and should not be billed separately.

5. Emergency and non-emergency transportation provided to a person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

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II. H. 3. Community Psychiatric Supportive Treatment and Medical Day Programs

General Definition

A regularly scheduled program of active treatment modalities, including medical interventions, in a group setting. May include individual, group and/or family behavioral health counseling and therapy, skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to maintain employment, home care training family (family support), and/or other nursing services such as medication monitoring, methadone administration, and medical/nursing assessments.

Service Standards/Provider Qualifications

Community psychiatric supportive treatment and medical day programs must be provided by an appropriately licensed DLS behavioral health agency and in accordance with applicable service requirements set forth in 9 A.A.C.10. These programs must be under the direction of a licensed physician, nurse practitioner, or physician assistant. The staff who deliver the specific services within the supervised day programs must meet the individual provider qualifications associated with those services.

Code Specific Information

HCPCS Codes

- **H0036– Community Psychiatric Supportive Treatment, face-to-face:** See general definition above.

  Billing Unit: 15 minutes

- **H0036 TF– Community Psychiatric Supportive Treatment, face-to-face:** See general definition above. ****TF modifier required for intermediate level of care.**** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

  Billing Unit: 15 minutes

- **H0036 TF –Community Psychiatric Supportive Treatment, face-to-face (Home):** See general definition above. ****TF modifier required for intermediate level of care.**** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

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Billing Unit: 15 minutes

- **H0037– Community Psychiatric Supportive Treatment Program**: See general definition above.

  Billing Unit: Per Diem

Billing Limitations

For community psychiatric supportive treatment and medical day programs, the following billing limitations apply:

1. See general core billing limitations in Section I.

2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.

3. Meals provided as part of community psychiatric supportive treatment and medical day programs are included in the rate and should not be billed separately.

4. Emergency and non-emergency transportation provided to a person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

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II. I. Prevention Services

General Information

General Definition

Prevention services promote the health of persons, families, and communities through education, engagement, service provision and outreach. These services may involve:

-Implementation of strategic interventions to reduce the risk of development of 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 and 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 that the problem occurs in the community or target group, identified community needs and service gaps within each T/RBHA area. Prevention services should target communities, neighborhoods, and audiences who are at elevated risk for developing behavioral health disorders.

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

Strategy Specific Information

The following strategies shall be used for services described in this section.

-Public Information on Substance Abuse and Mental Health: Public presentations of electronic, verbal and printed promotional material on preventable substance abuse and mental health disorders.

-Prevention Training to Professionals: Training provided to behavioral health or other prevention professionals on prevention concepts, strategies and activities with the purpose of enhancing the preventionist's skills, thereby improving the quality of prevention

programs. May include training of trainers or professional seminars, and must include goals and objectives based on a training needs assessment.

-Community Education: Sequential educational sessions provided to a targeted group to promote change in unhealthful attitudes and behaviors.

-Parent/Family Education: Sequential educational sessions provided to parents and their family members to improve parenting skills and to promote healthy family functioning.

-Community Activities for At Risk Populations: Supervised alternative leisure/free time activities to enrich community opportunities for youth, families and adults at risk for the emergence or development of behavioral health disorders.

-Community Mobilization: Assistance to communities in the development of local solutions and community plans to address community conditions and behavioral health issues, in accordance with an approved community needs assessment. Also includes development of partnerships, assistance with planning, identification of needs, resources and strategies and ongoing training and technical assistance.

-Life Skills Development: Sequential educational sessions that assist individuals in developing or improving critical life skills, such as decision-making, coping with stress, values awareness, resistance skills, problem solving and conflict resolution.

-Peer Leadership Skills: Leadership skills development through the pairing of trained and supervised peers with others. Must have curriculum; may include a variety of activities designed to reinforce leadership capabilities.

-Mentorship: Use of role models to provide support and guidance to youth and adults at risk for the development or emergence of behavioral health disorders, through the establishment and maintenance of positive personal relationships.

Service Standards and Provider Qualifications

Prevention services may be provided by a variety of qualified prevention professionals, including but not limited to behavioral health technicians, behavioral health para-professionals, public health specialists, and educators. These individuals must have documented training in prevention theory and practice and demonstrate qualifications for the specific strategy and service delivered.

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Billing Limitations

Reimbursement for these services is restricted to monies available to the state from the Federal Substance Abuse Prevention and Treatment Block Grant (SAPT) and other applicable state-funded appropriations and must be provided in accordance with limitations set forth by the applicable funding source. Prevention programs and services shall comply with AHCCCS BEHAVIORAL HEALTH SERVICES guidelines as described in the Prevention Framework for Behavioral Health.

Reimbursement

Prevention services are contracted through a Tribal or Regional Behavioral Health Authority. Contracts for prevention services shall specify the scope of work to be performed, duration and prevention strategy to be delivered, number of participants to be served, evaluation methods to be used, specific reporting requirements and method and amount of payment for satisfactory completion of services, among other provisions. Encounters are not submitted for prevention services.

III. Appendices

A. Billing for Behavioral Health Services: IHS and 638 Tribal Factsheets

A-1 Memorandum

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA1.pdf

A-2 638 Billing Matrix

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA2.pdf

A-3 Power Point

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA3.pdf

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A-4 Case Management

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA4.pdf

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B. Reference Tables
B-1. Reserved

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB1.pdf

B-2. AHCCCS BEHAVIORAL HEALTH SERVICES Allowable Procedure Code Matrix

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls

B-3. "Retired" - B3 Matrix – ICD-9 Diagnosis Codes; replaced by B4 Matrix ICD-10 Diagnosis Codes effective 10/1/2015

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B-4. Encounters/Claims Principle Behavioral Health ICD-10 Diagnosis Codes.
(COVERED SERVICES EFFECTIVE 10/01/2015)

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/B-4-ICD-10-DIAGNOSIS-CODE-EFF-10-1-15.xlsx

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B-5.   Billing Limitations Matrix

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB5.pdf

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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.

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[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**

[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:

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.

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[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.

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.

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.

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:

Overview & 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. AHCCCS will implement DAP rates for the following providers:[1]

1. Hospitals Subject to APR-DRG Reimbursement, excluding Critical Access Hospitals
2. Critical Access Hospitals
3. Other Hospitals and Inpatient Facilities
4. Nursing Facilities
5. Integrated Clinics
6. Behavioral Health Outpatient Clinics
7. Physicians, Physician Assistants, and Registered Nurse Practitioners
8. Dental Providers
9. Home and Community Based Services Providers

The DAP rates currently in place expire after September 30, 2019 dates of service. The DAP rates in this notice for CYE 2020 will be effective with dates of service beginning October 1, 2019, through September 30, 2020, and all noted providers (based on distinct Provider Types) will have the opportunity to be considered for meeting the criteria described further below.

The DAP Schedule represents a positive adjustment to the AHCCCS Fee-For-Service (FFS) rates. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. These fee schedules will be limited to dates of service in CYE 2020. Unless otherwise specified, AHCCCS managed care organizations (MCOs; including Regional Behavioral Health Authorities - RBHAs) will be required to pass-through DAP increases to their contracted rates to match the corresponding AHCCCS FFS rate increase percentages.

Please note – Funding for DAP rate increases is subject to the appropriation of State funds and State budget constraints. Federal funding for DAP rate increases is contingent upon federal approval. All decisions or considerations included in this notice are therefore subject to the availability of funds and federal approval.

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[1] IHS and 638 tribally owned and/or operated facilities are exempt from this initiative based on payments primarily at the federally-mandated all-inclusive rate.

1

1. **Hospitals Subject to APR-DRG Reimbursement**   (Up to 4.0%)

   Hospitals, Provider Type 02, are eligible for DAP increases under the following criteria.

   a. <u>Health Information Exchange Participation</u>   (2.5%)

      Participation in a qualifying Health Information Exchange (HIE) organization qualifies the hospital for a 2.5% DAP increase for both inpatient and outpatient services. Participation means that by May 15, 2019, the hospital (both those addressed in sections i. and ii. below) must have submitted a Letter of Intent (LOI) to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

      i. Providers That Did Not Participate in CYE 2019 DAP:

         1. Milestone #1: No later than July 31, 2019 the hospital must execute an agreement with a qualifying HIE organization.
         2. Milestone #2: No later than October 31, 2019 the hospital must approve and authorize a formal scope of work (SOW) with a qualifying HIE organization to develop and implement the data exchange necessary to meet the requirements of Milestones #3 and #4.
         3. Milestone #3: No later than March 31, 2020 the hospital must electronically submit actual patient identifiable admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, to the production environment of a qualifying HIE organization.
         4. Milestone #4: No later than June 30, 2020 the hospital must electronically submit actual patient identifiable laboratory and radiology information (if the provider has these services), transcription, medication information, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments/procedures conducted during the stay, active allergies, and discharge destination to the production environment of a qualifying HIE organization.

      ii. Returning CYE 2019 DAP Participants:

         1. Base requirement: The hospital must already have in place an active participation agreement with a qualifying HIE organization and must maintain the data submission requirements of the CYE 2019 DAP requirements throughout CYE 2020.

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2. Milestone #1: No later than July 1, 2019 the hospital must submit actual patient identifiable immunization data to the production environment of a qualifying HIE organization.
3. Milestone #2: No later than October 1, 2019 the hospital must approve and authorize a formal SOW with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization.
4. Milestone #3: No later than December 31, 2019 the hospital must complete the initial data quality profile with a qualifying HIE organization.
5. Milestone #4: No later than March 31, 2020 the hospital must complete the data quality scope of work by producing the final data quality profile with a qualifying HIE organization.

For criteria (i)(3), (i)(4), and (ii)(2), the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2.

In order to receive the 2.5% DAP increase for HIE participation a hospital (both those addressed in sections (i) and (ii) above) <u>must</u> submit an LOI to the HIE and AHCCCS by May 15, 2019 at the following email addresses:

FFSRates@azahcccs.gov, and
ceo@healthcurrent.org

If a hospital has already achieved one or more of the CYE 2020 milestones as of May 15, 2019, the LOI must include a commitment by the hospital to maintain its participation in those milestone activities for the period May 15, 2019 through September 30, 2020.

If a hospital submits an LOI and receives the 2.5% DAP increase for CYE 2020, but fails to achieve one or more of the milestones by the specified date, or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive DAP for dates of service from October 1, 2020 through September 30, 2021 (CYE 2021) if a DAP is available at that time.

b. <u>Sepsis Care Performance Measure</u>   (1.0%)

Hospitals that meet or exceed the state-wide average for the Sepsis Care performance measure will qualify for a 1.0% DAP increase. On April 30, 2019, AHCCCS will download data from the Medicare Hospital Compare website for the Early Management Bundle, Severe Sepsis/Septic Shock (SEP-1) performance measure. This measure reflects the percentage of patients who received appropriate care for severe sepsis and septic shock. Facility results will be compared to the Arizona average results for the measure. Hospitals that meet or exceed the state-wide average percentage will qualify for the DAP increase.

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A pediatric hospital will qualify to receive this DAP increase if it is a participant in the Improving Pediatric Sepsis Outcomes (IPSO) collaborative for 2019, as identified on April 30, 2019 on the following website: https://www.childrenshospitals.org/-/media/Files/CHA/Main/Quality_and_Performance/Sepsis/2018-IPSO-Enrolled-Hospitals.pdf.

c. Pediatric Preparedness Certification   (0.5%)

Hospitals that hold a Pediatric-Prepared Emergency Care certification will qualify for a 0.5% DAP increase. By May 1, 2019, the hospital must have obtained a Pediatric-Prepared Emergency Care certification from the Arizona Chapter of the American Academy of Pediatrics (AzAAP).

AHCCCS does not intend to consider this metric for a DAP increase for CYE 2021.

2. **Critical Access Hospitals**   (Up to 28.5%)

Hospitals designated as a Critical Access Hospital (CAH) by May 1, 2019 are eligible for DAP increases under the following criteria.

a. Health Information Exchange Participation   (8.0%)

Participation in a qualifying HIE organization qualifies the CAH for a 8.0% DAP increase for both inpatient and outpatient services. Participation means that by May 15, 2019, the CAH must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

1. Base requirement: The hospital must already have in place an active participation agreement with a qualifying HIE organization and must maintain the data submission requirements of the CYE 2019 DAP requirements throughout CYE 2020.
2. Milestone #1: No later than July 1, 2019 the hospital must submit actual patient identifiable immunization data to the production environment of a qualifying HIE organization.
3. Milestone #2: No later than October 1, 2019 the hospital must approve and authorize a formal SOW with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization.
4. Milestone #3: No later than December 31, 2019 the hospital must complete the initial data quality profile with a qualifying HIE organization.
5. Milestone #4: No later than March 31, 2020 the hospital must complete the data quality scope of work by producing the final data quality profile with a qualifying HIE organization.

For criteria (i)(3), (i)(4), and (ii)(2), the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. It

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must include all patient data, including behavioral health data and data covered by 42 CFR Part 2.

In order to receive the 8.0% DAP increase for HIE participation a hospital <u>must</u> submit an LOI to the HIE and AHCCCS by May 15, 2019 at the following email addresses:

> FFSRates@azahcccs.gov, and
> ceo@healthcurrent.org

If a hospital has already achieved one or more of the CYE 2020 milestones as of May 15, 2019, the LOI must include a commitment by the hospital to maintain its participation in those milestone activities for the period May 15, 2019 through September 30, 2020.

If a hospital submits an LOI and receives the 8.0% DAP increase for CYE 2020, but fails to achieve one or more of the milestones by the specified date, or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive DAP for dates of service from October 1, 2020 through September 30, 2021 (CYE 2021) if a DAP is available at that time.

b. Level I-IV Trauma Center located less than five miles from Interstate 10   (20.0%)

Critical Access Hospitals which meet all of the criteria in subsection (a) above, have a Level I-IV trauma center, and are located less than five miles from Interstate 10 will receive an additional 20.0% DAP increase for both inpatient and outpatient services.

c. Pediatric Preparedness Certification   (0.5%)

Hospitals that hold a Pediatric-Prepared Emergency Care certification will qualify for a 0.5% DAP increase. By May 1, 2019, the hospital must have obtained a Pediatric-Prepared Emergency Care certification from the AzAAP.

AHCCCS does not intend to consider this metric for a DAP increase for CYE 2021.

3. **Other Hospitals and Inpatient Facilities**   (Up to 4.0%)

Psychiatric Hospitals, with the exception of public hospitals, Provider Type 71; Subacute Facilities (1-16 Beds), Provider Type B5; Rehabilitation Hospitals, Provider Type C4; Long Term Acute Care Hospitals, Provider Type C4 are eligible for DAP increases under the following criteria.

a. <u>Health Information Exchange Participation</u>   (2.0%)

Participation in a qualifying HIE organization qualifies the hospital for a 2.0% DAP increase for both inpatient and outpatient services. Participation means that by May 15, 2019, the hospital (both those addressed in sections i. and ii. below) must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

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1. Milestone #1: No later than July 31, 2019 the hospital must execute an agreement with a qualifying HIE organization.
2. Milestone #2: No later than October 31, 2019 the hospital must approve and authorize a formal SOW with a qualifying HIE organization to develop and implement the data exchange necessary to meet the requirements of Milestones #3 and #4.
3. Milestone #3: No later than March 31, 2020 the hospital must electronically submit actual patient identifiable admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, to the production environment of a qualifying HIE organization.
4. Milestone #4: No later than June 30, 2020 the hospital must electronically submit actual patient identifiable laboratory and radiology information (if the provider has these services), transcription, medication information, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments/procedures conducted during the stay, active allergies, and discharge destination to the production environment of a qualifying HIE organization.

ii. Returning CYE 2019 DAP Participants:

1. Base requirement: The hospital must already have in place an active participation agreement with a qualifying HIE organization and must maintain the data submission requirements of the CYE 2019 DAP requirements throughout CYE 2020.
2. Milestone #1: No later than October 1, 2019 the hospital must approve and authorize a formal SOW with a qualifying HIE organization to initiate and complete a data quality profile to be produced by a qualifying HIE organization.
3. Milestone #2: No later than January 1, 2020 the hospital must complete the initial data quality profile with a qualifying HIE organization.

For criteria (i)(3), (i)(4), and (ii)(2), the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2.

In order to receive the 2.0% DAP increase for HIE participation a hospital (both those addressed in sections i. and ii. above) must submit an LOI to the HIE and AHCCCS by May 15, 2019 at the following email addresses:

FFSRates@azahcccs.gov, and

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If a hospital has already achieved one or more of the CYE 2020 milestones as of May 15, 2019, the LOI must include a commitment by the hospital to maintain its participation in those milestone activities for the period May 15, 2019 through September 30, 2020.

If a hospital submits an LOI and receives the 2.0% DAP increase for CYE 2020, but fails to achieve one or more of the milestones by the specified date, or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive DAP for dates of service from October 1, 2020 through September 30, 2021 (CYE 2021) if a DAP is available at that time.

b. <u>Inpatient Psychiatric Facility Quality Reporting Program</u>   (2.0%)

Hospitals that meet the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) performance measure will qualify for a 2.0% DAP increase. On April 30, 2019, AHCCCS will download the most current data from the QualityNet.org website to identify Medicare's Annual Payment Update (APU) recipients. APU recipients are those facilities that satisfactorily met the requirements for the IPFQR program, which includes multiple clinical quality measures. Facilities identified as APU recipients will qualify for the DAP increase.

c. <u>Long-Term Care Hospital Pressure Ulcers Performance Measure</u>   (2.0%)

Hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for a 2.0% DAP increase. On April 30, 2019, AHCCCS will download the most current data from the Medicare Long Term Hospital Compare website for the rate of pressure ulcers that are new or worsened. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.

d. <u>Inpatient Rehabilitation Pressure Ulcers Performance Measure</u>   (2.0%)

Hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for a 2.0% DAP increase. On April 30, 2019, AHCCCS will download the most current data from the Medicare Inpatient Rehabilitation Facility Compare website for the rate of pressure ulcers that are new or worsened. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.

4. **Nursing Facilities**   (Up to 2.0%)

Nursing Facilities, Provider Type 22, are eligible for DAP increases under the following criteria.

a. <u>Pressure Ulcer Performance Measure</u>   (1.0%)

Nursing facilities that meet or fall below the state-wide average percentage for the Pressure Ulcer performance measure will qualify for a 1.0% DAP increase. On April 30,

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2019, AHCCCS will download data from the Medicare Nursing Home Compare website for the percent of High-Risk Residents with Pressure Ulcers (Long Stay) based on the facility's performance results for long-stay, high-risk residents with Stage II-IV pressure ulcers reported in the Minimum Data Set (MDS) 3.0. Facility results will be compared to the Arizona Average results for the measure. Facilities with percentages less than or equal to the state-wide average score will qualify for the DAP increase.

b. Urinary Tract Infection Performance Measure   (1.0%)

Nursing facilities that meet or fall below the state-wide average percentage for the Urinary Tract Infection (UTI) performance measure will qualify for a 1.0% DAP increase. On April 30, 2019, AHCCCS will download data from the Medicare Nursing Home Compare website for the percent of long-stay residents with a UTI. Facility results will be compared to the Arizona Average results for the measure. Facilities with percentages less than or equal to the state-wide average score will qualify for the DAP increase.

5. **Integrated Clinics**   (Select 10.0%)

Integrated Clinics, Provider Type IC, are eligible for a DAP increase of 10.0% for select physical health services by meeting all of the following criteria for licensure, behavioral health utilization, and HIE participation.

a. Licensure

The provider must be licensed by the ADHS as an Outpatient Treatment Center which provides both behavioral health services and physical health services.

b. Behavioral Health Services Utilization At Least 40.0%

Behavioral health services for the provider must account for at least 40.0% of total AHCCCS claims and encounters. Utilizing claims and encounter data for dates of service from October 1, 2017 through September 30, 2018, AHCCCS will compute claims and encounters for behavioral health services as a percentage of total claims and encounters as of May 1, 2019 to determine which providers meet the 40% minimum threshold.
   i. Only approved and adjudicated AHCCCS claims and encounters will be utilized in the computations.
   ii. AHCCCS will not consider any other data when determining which providers qualify for the DAP increase.

c. HIE Participation

By May 15, 2019, the clinic must have executed an agreement with a qualifying HIE organization and electronically submitted actual patient identifiable information, including both a registration event as well as an encounter summary, to the production environment of the qualifying HIE organization. The clinic must maintain this HIE requirement through September 30, 2020.

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If a clinic is in the process of integrating a new Practice Management and Electronic Health Record system, then it may have until September 1, 2019 to electronically submit actual patient identifiable information, including both a registration event as well as an encounter summary, to the production environment of the qualifying HIE organization.

The information transferred to the qualifying HIE organization must be actual patient data; the transfer of test data does not fulfill this requirement. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2.

The DAP rates will be paid for select physical health services and will provide an increase of 10.0% over the AHCCCS FFS rates for dates of service in CYE 2020.

Physical health services which qualify for the increase include Evaluation and Management (E&M) codes, vaccine administration codes, and a global obstetric code. See Attachment A for the specific list of codes which are proposed to increase for purposes of DAP.

6. **Behavioral Health Outpatient Clinics and Integrated Clinics**   (Up to **7.0%**)

Behavioral Health Outpatient Clinics, Provider Type 77, and Integrated Clinics, Provider Type IC, are eligible for DAP increases under the following criteria.

   a. Partnerships with Schools to Provide Behavioral Health Services   (1.0%)

   A clinic that meets the criteria for partnering with schools to provide behavioral health services will qualify for a 1.0% DAP increase. Partnership is defined as a provider that has memoranda of agreement or understanding (MOA or MOU) with three or more schools in place as of May 15, 2019 that allow for the clinic to provide behavioral health services to school-aged children in the school setting. On May 15, 2019, AHCCCS will review such documents as have been submitted by each provider by e-mail to FFSRates@azahcccs.gov in order to determine the number of qualifying MOAs or MOUs for each provider. Providers with three or more MOAs or MOUs that meet this requirement will qualify for the DAP increase.

   b. Autism Centers of Excellence   (3.0%)

   A clinic that meets the criteria to be considered an Autism Center of Excellence (COE) will qualify for a 3.0% DAP increase. An Autism COE is defined as a provider that has been identified as such by any AHCCCS MCO in the "Value Based Providers/Centers of Excellence" attachment to its "Provider Network Development and Management Plan," submitted by November 15, 2018. Providers that have been identified as an Autism COE in this manner will qualify for the DAP increase.

   c. Provision of Services to Members in a Difficult to Access Location   (**3.0%**)

   A clinic that meets the criteria for provision of services to members in a difficult to access location that cannot be accessed by ground transportation due to the nature and extent of the surrounding Grand Canyon terrain will qualify for a DAP increase of **3.0%**

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on all claims **and encounters**. Provision of services is defined as a provider that has an MOA or MOU with a tribal government to access tribal territory in order to provide behavioral health services to members located in the Grand Canyon. The signed MOA or MOU must be in place by **May 31, 2019** and submitted to AHCCCS by e-mail to FFSRates@azahcccs.gov. On **May 31, 2019**, AHCCCS will review such documents as have been submitted by each provider in order to determine providers that meet this requirement and will qualify for this DAP increase.

AHCCCS intends to consider this initiative for inclusion as a DAP in CYE 2021.

7. **Physicians, Physician Assistants, and Registered Nurse Practitioners** (1.0%)

Physicians, Physician Assistants, and Registered Nurse Practitioners (Provider Types 08, 18, 19, and 31) are eligible for a DAP increase under the following criteria.

a. Electronic Prescriptions   (1.0%)

Providers who have written at least 80 prescriptions for AHCCCS members, and who have written at least 65% of their total AHCCCS prescriptions as Electronic Prescriptions (E-Prescriptions) will qualify for a 1.0% DAP increase for all services billed on the CMS Form 1500. E-Prescription statistics will be identified by the AHCCCS provider ID for the prescribing provider, and computed by AHCCCS based on the following factors:

   i. Only approved and adjudicated AHCCCS claims and encounters for July 1, 2018 through December 31, 2018 dispense dates will be utilized in the computations.
   ii. AHCCCS will compute claims and encounters for this purpose as of May 1, 2019 to determine which providers meet the minimum threshold.
   iii. AHCCCS will not consider any other data when determining which providers qualify for the DAP increase.
   iv. E-Prescriptions include those prescriptions generated through a computer-to-computer electronic data interchange protocol, following a national industry standard and identified by Origin Code 3.
   v. Refills of original prescriptions whereby the original prescriptions meet the definition of E-Prescriptions shall not be counted as E-Prescriptions.

The DAP will apply to claims for covered AHCCCS services where the rendering provider ID on the claim is the same as the prescribing provider ID that was identified and found to meet the criteria described above.

Due to operational issues related to contracting arrangements with entities rather than individual practitioners, AHCCCS' MCOs may pay the DAP in a manner other than on an individual claim basis, on at least a quarterly basis. In the event an expected quarterly payment to an entity is less than twenty five dollars, the MCOs will be permitted to delay payment to the entity until the earlier occurs: payments due of at least twenty-five dollars or final quarterly payment for CYE 2020.

8. **Dental Providers**   (1.0%)

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Dental Providers (Provider Types D1, D2, D3, D4, 07, 54) are eligible for a DAP increase under the following criteria.

a. Dental Sealants for Children Performance Measure (1.0%)

A provider that meets the criteria for the dental sealants for children performance measure will qualify for a 1.0% DAP increase. Providers that increased the number of AHCCCS child members from 5 through 15 years of age to whom they provided dental sealants from CYE 2017 to CYE 2018 are considered to meet this measure. AHCCCS will review only approved and adjudicated claims and encounter data in order to compute a count of the number of AHCCCS members who are children aged 5 through 15 years who received a dental sealant for each time period. AHCCCS will compute claims and encounters for this purpose as of May 1, 2019. Providers with a computed increase to their count will qualify for the DAP increase.

9. **Home and Community Based Services Providers** (1.0%)

Home and Community Based Services (HCBS) Providers (Provider Types A3, FI, IC, 23, 39, 40, 46, 77, and 95) are eligible for a DAP increase under the following criteria.

a. Electronic Visit Verification Readiness Survey (1.0%)

AHCCCS has requested HCBS Providers respond to an Electronic Visit Verification (EVV) readiness survey. A provider that completes the EVV survey in its entirety **by May 28, 2019** will qualify for a 1.0% DAP increase. The DAP increase will be applicable to select Attendant Care, Companion Care, Habilitation, Home Health (aid, therapy, nursing services), Homemaker, Personal Care, Respite, and Skills Training services that are provided with place of service (POS) Home, Assisted Living Facility, and Other. See Attachment B for the specific list of codes which are proposed to increase for purposes of DAP **(code list updated May 20, 2019)**.

The DAP increase will be applicable to the specified services provided either on a FFS basis, or by all AHCCCS Contractors, for all lines of business, including the Arizona Long Term Care System (ALTCS).

Future Health Information Exchange Initiatives

In partnership with the HIE, AHCCCS intends to implement DAP initiatives relative to HIE participation for different provider types as appropriate and consistent with organizational and provider resources and capacity. The HIE participation DAP strategy for CYE 2021 is described below. Please also see Attachment C for a high-level outline of the multi-year HIE participation DAP strategy by provider type.

1. AHCCCS anticipates CYE 2021 DAP criteria for hospitals and other inpatient facilities will include criteria directed at developing and executing a data quality improvement plan with a qualifying HIE organization built upon the data quality profiles produced under the CYE 2020 criteria. DAP incentives will be available for hospitals and other inpatient facilities that meet data quality standards as set by the HIE during the measurement period of January 1, 2020 to March 31,

2020. The data quality standards will be developed by the qualifying HIE in calendar year 2019 in consultation with the HIE's advisory councils, as appropriate, its board of directors, and with input by hospital and other inpatient facility stakeholders.

2. AHCCCS anticipates CYE 2021 DAP criteria for <u>IHS/638 Tribally Owned and/or Operated Facilities and Integrated Clinics </u>could include meeting first-year HIE participation criteria as described in 1(a)(i). Qualifying HIE organization services are available on a first come, first serve basis; therefore, initiating activity in CYE 2019 is encouraged if achievement of the proposed CYE 2021 DAP criteria is desired.

3. AHCCCS anticipates CYE 2021 DAP criteria for <u>Behavioral Health Outpatient Clinics</u> will include signing a participation agreement with a qualifying HIE organization, as well as accessing patient data via the HIE services, including but not limited to HIE portal access and/or receiving alerts and notifications. Qualifying HIE organization services are available on a first come, first serve basis; therefore, initiating activity in CYE 2019 is encouraged if achievement of the proposed CYE 2021 DAP criteria is desired.

<u>Other Future Considerations</u>

AHCCCS will consider implementing other DAP initiatives in future years. The following items are areas of interest for future consideration.

1. Hospitals Subject to APR-DRG Reimbursement
    a. CYE 2021 – Enter into a Care Coordination Agreement with IHS/638 Facility.
    b. CYE 2021 – Meet Leapfrog Hospital Safety Grade, qualifying criteria to be specified.

2. Critical Access Hospitals
    a. CYE 2021 – Enter into a Care Coordination Agreement with IHS/638 Facility.

3. Other Hospitals and Inpatient Facilities
    a. CYE 2021 – Enter into a Care Coordination Agreement with IHS/638 Facility.

4. Nursing Facilities
    a. CYE 2021 – Nursing facilities that achieve at least a 4-star rating for the Staffing Rating performance measure.

5. Physicians, Physician Assistants, and Registered Nurse Practitioners
    a. CYE 2021 – E-prescribing, increase criteria from 65% to 70%.

6. Home and Community Based Services Providers
    a. CYE 2021 – For providers that do not have an EVV system and use the statewide system, achievement of training objectives.
    b. CYE 2021 – For providers that do have an EVV system and use the statewide system as a data aggregator, submission and acceptance of data file transfers.
    c. CYE 2022 – Workforce Stability Activities
    d. CYE 2022 – Employment of AHCCCS Members as Direct Care Workers

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7. Multiple Provider Types
   a. CYE 2021 – Completion of a Social Determinants of Health (SDoH) Screening Tool.

Timeline

The following table is a summary of key activities in the DAP Strategies decision making and communication processes.

Date	Activity
4/30/2019	Final Public Notice (This Document)
5/15/2019	Qualifying Providers Identified
Early June 2019	Post Notice of Proposed Rulemaking (NPRM)
Mid-July 2019	NPRM Public Comments Due
7/1/2019	438.6 (c) Request for Approval Due to CMS
8/15/2019	MCO Capitation Rates Due to CMS (including prospective funding for DAPs)

AHCCCS anticipates that the criteria for DAP could change for CYE 2021 and may differ for inpatient and outpatient services. AHCCCS also expects to expand DAP to other provider types for CYE 2021. DAP increases noted above may change based on budgetary considerations.

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Integrated Clinic (IC) Physical Health Services Codes for AHCCCS Differential Adjusted Payments

CPT DESCRIPTION
59400 ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, VAGINAL DELIVERY (WITH OR WITH
90471 IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS,
90472 IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS,
90473 IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; ONE VACCINE (SINGLE OR
90474 IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; EACH ADDITIONAL
99201 New patient office or other outpatient visit, typically 10 minutes
99202 New patient office or other outpatient visit, typically 20 minutes
99203 New patient office or other outpatient visit, typically 30 minutes
99204 New patient office or other outpatient visit, typically 45 minutes
99205 New patient office or other outpatient visit, typically 60 minutes
99211 OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLI
99212 Established patient office or other outpatient visit, typically 10 minutes
99213 Established patient office or other outpatient visit, typically 15 minutes
99214 Established patient office or other outpatient, visit typically 25 minutes
99215 Established patient office or other outpatient, visit typically 40 minutes
99243 Patient office consultation, typically 40 minutes
99244 Patient office consultation, typically 60 minutes
99245 Patient office consultation, typically 80 minutes
99381 INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVI
99382 INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVI
99383 INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVI
99384 INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVI
99385 INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVI
99391 Established patient periodic preventive medicine examination infant younger than
99392 Established patient periodic preventive medicine examination, age 1 through 4 ye
99393 Established patient periodic preventive medicine examination, age 5 through 11 y
99394 Established patient periodic preventive medicine examination, age 12 through 17
99395 Established patient periodic preventive medicine examination age 18-39 years
99403 PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S)

*Descriptions are truncated due to field length limitations in the AHCCCS mainframe

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Attachment B – HCBS EVV Survey

The HCBS EVV DAP is applicable the following Places of Service (POS), provider types, and service codes only when used in combination with each other. A qualifying service must be provided by a qualifying provider type with a qualifying POS in order to qualify for DAP.

Place of Service Description	POS Code
Home	12
Assisted Living Facility	13
Other	99

Provider Description	Provider Type
Attendant Care Agency	PT 40
Behavioral Outpatient Clinic	PT 77
Community Service Agency	PT A3
Fiscal Intermediary	PT FI
Habilitation Provider	PT 39
Home Health Agency	PT 23
Integrated Clinic	PT IC
Non-Medicare Certified Home Health Agency	PT 95
Private Nurse	PT 46

Service	Service Codes
Attendant Care	S5125
Companion Care	S5135
Habilitation	**T2016 and T2017**
Home Health (aide, therapy, nursing services)	Nursing (G0299, G0300, S9123 and S9124) Home Health Aide (T1021) Therapies Physical Therapy (G0151 and S9131) Occupational Therapy (G0152 and S9129) Respiratory Therapy (S5181) Speech Therapy (G0153 and S9128)
Homemaker	S5130
Personal Care	T1019
Respite	S5150 and S5151
Skills Training	H2014

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HIE DAP Criteria	CYE 17	CYE 18	CYE 19	CYE 20	CYE 21	CYE 22	CYE 23	CYE 24	CYE 25
Hospitals	Agreement	Agreement	Milestones	Data Prep	Data Quality	Data Quality	Data Quality	Data Quality	Data Quality
IHS/638 Facilities					Milestones	Data Prep	Data Quality	Data Quality	Data Quality
Integrated Clinics (Ics)			Milestones	Milestones	Data Prep	Data Quality	Data Quality	Data Quality	Data Quality
BH OP Clinics & Ics					Data Access	Milestones	Data Prep	Data Quality	Data Quality
Nursing Facilities						Milestones	Data Prep	Data Quality	Data Quality
HCBS Providers							Data Access	Milestones	Data Prep
Physicians, PAs, etc.							Data Access	Milestones	Data Prep

Agreement	Execute agreement and electronically submit information.
Milestones	LOI with milestones for: execute agreement, approve SOW, transmit ADT, and transmit lab/radiology data. For non-inpatient facilities, transmit registration events and encounter summaries.
Data Access	Execute agreement and access HIE data via HIE services.
Data Prep	LOI with milestones for: submit immunization data (if applicable), execute data quality SOW, and submit data quality profile.
Data Quality	Measure data quality in first quarter of calendar year using a metric to be defined.

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306 – ALTERNATIVE PAYMENT MODEL INITIATIVE – WITHHOLD AND QUALITY MEASURE PERFORMANCE INCENTIVE

EFFECTIVE DATE: 10/01/17

I. 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.

II. DEFINITIONS

ADJUSTMENT FACTOR	A factor that ensures that the total Withhold amount by QMPM equals the total of the Earned Withhold and the QMP Incentive payment amounts by QMPM. This factor is applied to the performance rank score and varies by the different QMPMs and number of Contractors meeting the minimum standards.
COMBINED PERFORMANCE SCORE	The computation which adds the Performance Measure Score and Performance Rank Score to determine the Contractors' Earned Withhold and the QMP Incentive payments.
EARNED WITHHOLD	Amounts returned to Contractors, by QMPM, based on the results of the combined performance score, not to exceed 100% of each Contractor's Withhold.
ENCOUNTER	For the purposes of this policy, all encounters must be in an adjudicated and approved status.
MEASUREMENT YEAR	The period for which this Policy applies, which shall be 10/1 through 9/30.
PERFORMANCE MEASURE SCORE	This score measures the Contractor's performance relative to the minimum performance standards established by AHCCCS Quality Improvement for each QMPM.
PERFORMANCE RANK SCORE	This score measures the ranking of the Contractor's performance for each QMPM.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

PROSPECTIVE GROSS CAPITATION	Acute Care: Prospective capitation payments, prior to adjustments for the Health Insurance Provider Fee payment, made to Contractors on a monthly basis which includes medical expense, reinsurance offset, administration, risk/contingency and premium tax, and any subsequent amendments thereof. For purposes of this policy, Prospective Gross Capitation is exclusive of Delivery Supplemental, KidsCare, APSI (see ACOM Policy 325) and State Only Transplant payments.
	ALTCS/EPD: Prospective capitation payments, prior to adjustments for Nursing Facility enhanced payments and Health Insurance Provider Fee payments, made to Contractors on a monthly basis which includes medical expense, reinsurance offset, share of cost offset, administration, case management, risk/contingency and premium tax, and any subsequent amendments thereof. For purposes of this policy, Prospective Gross Capitation is exclusive of Acute Care only payments.
QUALITY MANAGEMENT PERFORMANCE MEASURES (QMPM)	Health care quality measures utilized by AHCCCS Quality Improvement. Subsets of these measures were selected for use in this policy.
QUALITY MANAGEMENT MEASUREMENT REPORT	The report issued by AHCCCS Quality Improvement annually which includes results by Contractor on QMPMs.
QUALITY MANAGEMENT MINIMUM PERFORMANCE STANDARD	The minimum standard established by AHCCCS Quality Improvement for each QMPM and used in calculating the performance measure score.
QUALITY MEASURE PERFORMANCE INCENTIVE (QMP INCENTIVE)	Amounts earned over and above the capitation rates, by QMPM, based on the results of the combined performance score (Not all Contractors may receive an incentive payment).
QUALITY MEASURE PERFORMANCE (QMP) INCENTIVE POOL	The fund source for the QMP Incentive payment, calculated as the difference between the total Withhold amount and the total QMP Earned Withhold.
RANK FACTOR	A factor applied in the calculation of Contractor's combined performance score based on the rank of the Contractor for the performance rank score.
SCALING FACTOR	A factor applied in the calculation of Contractor's combined performance score for the performance measurement score.

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WITHHOLD A specified percentage of all Contractors' Prospective Gross Capitation payments that will be withheld via a recoupment after the completion of the contract year.

III. POLICY

A. GENERAL

In order to qualify for an Earned Withhold and/or QMP Incentive payment, the Contractor shall meet the APM strategies qualifying criteria as described in ACOM Policy 307. Failure to meet or certify to meeting the criteria in a particular measurement year will disqualify the Contractor from any Earned Withhold and QMP Incentive payment for that year. However, the Contractor's Withhold amount will still be assessed and included to fund the Earned Withhold and QMP Incentive payments to all other Contractors.

Earned Withhold and QMP Incentive payments will be made to Contractors based on relative Contractor performance for the measurement year, as determined by AHCCCS Quality Improvement, on selected Quality Management Performance Measures (QMPMs - see Attachment A). Each QMPM is allocated a percentage of the total Withhold funds available for disbursement, see Attachment B for the percent of Withhold amount by QMPM. Each measure will be considered independently of other measures, such that a Contractor can obtain an Earned Withhold and QMP Incentive payment on any or all of the QMPMs.

The combined performance score used to determine the Earned Withhold and QMP Incentive payments is based on two factors: Contractors' performance relative to minimum performance standards established by AHCCCS Quality Improvement (i.e. performance measure score), and Contractors' rankings on QMPMs (i.e. performance rank score), as illustrated in Attachment B. The combined performance score first determines payments based on the performance measure score. The balance of Withhold funds allocated to the QMPM is then distributed based on the performance rank score. The adjustment factor is applied to the performance rank score to ensure that the total Earned Withhold and QMP Incentive payment amounts equal the total Withhold amounts.

Modifications to the combined performance score, its components, and additional methods for determining the Earned Withhold and QMP Incentive payments, including computations based on improvement in measures from year-to-year, may be considered in future measurement years.

AHCCCS reserves the right to eliminate a particular QMPM for use in this Policy. In such a case, AHCCCS will remove each Contractor's Withhold amount for that measure.

AHCCCS reserves the right to exclude a particular Contractor from one or more QMPMs used in this Policy based on insufficient population for the denominator of the measure to provide for a credible statistic or other reasons determined by AHCCCS. In such a case, AHCCCS will remove the Contractor's Withhold amount for that measure, provided that the

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Contractor has met and certified to meeting the qualifying criteria under APM strategies stipulated in ACOM Policy 307.

The Withhold is equal to one percent of Prospective Gross Capitation for the measurement year.

The methods and procedures used for data sources, validation and tabulation of results will be described in the AHCCCS QMPM Report for the measurement year. Risk adjustment methods for the QMPMs will be considered and utilized, if deemed appropriate.

B. AHCCCS RESPONSIBILITIES

1. After the completion of the contract year, AHCCCS shall recoup the full amount of the Withhold from each Contractor.

2. Between one and three months after the AHCCCS QMPM Report for the measurement year has been issued, AHCCCS shall tabulate the combined performance score for each QMPM by Contractor.

   The Withhold amount may be adjusted, if necessary, for the elimination of a particular measure or the elimination of a Contractor from a particular measure as indicated above.

   The full amount of the Withhold will be distributed among Contractors based on performance on the quality measures, unless otherwise noted in this Policy. The combined performance score by QMPM will be calculated as follows (see Attachment B for an example):

   W = Withhold amount
   S = Scaling Factor
   CMeasure = Contractor's QMPM Result
   MinStd = Quality Management Minimum Performance Standard
   A = Adjustment Factor
   R = Rank Factor

   Performance Measure Score:
   If equal to or above MinStd, then W * S * ([CMeasure – MinStd]/MinStd)
   If below minimum standard, then zero

   Performance Rank Score: A * W * R

   Combined Performance Score: Performance Measure Score + Performance Rank Score

3. Calculation of the Earned Withhold: The Earned Withhold will be calculated by comparing the combined performance score by Contractor by QMPM to the Withhold by Contractor by QMPM. The Contractor may earn less than or equal to the Contractor's Withhold by QMPM, the Contractor shall not earn greater than the Contractor's Withhold by QMPM in accordance with Federal regulation.

4. The QMP Incentive Pool will be calculated by subtracting the total Earned Withhold payments for all Contractors from the total Withhold amount for all Contractors.

5. Calculation of the QMP Incentive Payment: The QMP Incentive will be calculated by comparing the combined performance score by Contractor by QMPM to the Earned Withhold by QMPM. If the Earned Withhold amount by QMPM is equal to or less than the total Withhold, the Contractor will not receive a QMP Incentive payment. If the combined performance score by Contractor by QMPM is greater than the Earned Withhold amount, the difference between the Earned Withhold and the combined performance score by QMPM will be considered the QMP Incentive payment and will be due to the Contractor.

6. Due to Federal requirements, the maximum QMP Incentive payment across all QMPMs made to any Contractor will be limited to five percent of annual prospective gross capitation. (See Attachment C for example.) Any amount in excess of the limit shall be reduced to bring the final due to within the Federal requirement.

7. The results computed in B.3 and B.5 will be adjusted for premium tax. See Attachment C for example.

   AHCCCS will provide the Contractor with the Earned Withhold and QMP Incentive payment calculations and written notice of the deadline for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and address any issues as warranted.

   Any amount due to or due from the Contractor will be paid or recouped through a future monthly capitation payment.

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307– ALTERNATIVE PAYMENT MODEL INITIATIVE – STRATEGIES AND PERFORMANCE-BASED PAYMENTS INCENTIVE

EFFECTIVE DATE: 10/01/17

I. 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.

II. DEFINITIONS

ALTERNATIVE PAYMENT MODEL STRATEGIES (IN LAN-APM CATEGORY ORDER)	A model which aligns payments between payers and providers to incentivize quality, health outcomes and value over volume to achieve the goals of better care, smarter spending and healthier people.

The APM strategies discussed in this initiative originate from the Learning Action Network APM Framework (LAN-APM) which include the following categories and strategies:

- Fee-For-Service – No Link To Quality & Value,
- Fee-For-Service – Link To Quality & Value (Foundational Payments for Infrastructure & Operations, Pay for Reporting, Pay for Performance),
- APMs Built on Fee-For-Service Architecture (APMs with Shared Savings, APMs with Shared Savings and Downside Risk),
- Population Based Payment (Condition-Specific Population-Based Payment, Comprehensive Population-Based Payment, Integrated Finance & Delivery Systems).
  See Attachment A to view the LAN-APM strategies.

FEE-FOR-SERVICE – NO LINK TO QUALITY & VALUE (LAN-APM CATEGORY 1)

BLOCK PURCHASE PAYMENT ARRANGEMENT METHODOLOGY	A current payment arrangement methodology where a contracted amount for a block of services is divided by 12 and paid in monthly installments to the provider. AHCCCS considers this to be LAN-APM Category 1 **This strategy, when not linked to quality and value as described in LAN-APM Categories 2, 3, and 4, shall not be counted towards the minimum qualifying criteria outlined under B.1.**
FEE-FOR-SERVICE (NO LINK TO QUALITY AND VALUE)	Purchasing strategy in which providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. (LAN-APM Category 1) **This strategy, when not linked to quality and value as described in LAN-APM Categories 2, 3, and 4, shall not be counted towards the minimum qualifying criteria outlined under B.1.**

FEE-FOR-SERVICE – LINK TO QUALITY & VALUE (LAN-APM CATEGORY 2)

FOUNDATIONAL PAYMENTS FOR INFRASTRUCTURE & OPERATIONS	Purchasing strategy in which payments are made for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics. Examples include care coordination fees and payments for health information technology investments. (LAN-APM Category 2A) **This strategy shall not be counted towards the minimum qualifying criteria outlined under B.1.**
PAY FOR REPORTING	Purchasing strategy in which providers/physicians are rewarded with bonus payments for reporting quality data or penalties for not reporting quality data. (LAN-APM Category 2B) **This strategy can be counted towards the minimum qualifying criteria outlined under B.1 only upon pre-approval by AHCCCS for expansion to services/service providers/provider types not traditionally utilized for APM arrangements.**

| PAY FOR PERFORMANCE | Purchasing strategy in which providers are rewarded for performing well on quality metrics. It can also include penalties for providers who do not perform well on quality metrics. In this strategy specific providers are responsible for the cost and quality associated with a particular set of procedures or services. Payments are not subject to rewards or penalties for provider performance against aggregate cost targets, but may account for performance on a more limited set of utilization measures.(LAN-APM Category 2C) |

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE (LAN-APM CATEGORY 3)

| APMS WITH SHARED SAVINGS | Purchasing strategy where providers share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. However, providers do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met. In this strategy multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. (LAN-APM Category 3A) |

| APMS WITH SHARED SAVINGS AND DOWNSIDE RISK | Purchasing strategy where providers share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Payers recoup from providers a portion of the losses that result when cost or utilization targets are not met. In this strategy, multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. This strategy includes episode-based payments for procedures and comprehensive payments with upside and downside risk. (LAN-APM Category 3B) |

POPULATION BASED PAYMENT (LAN-APM CATEGORY 4)

| CONDITION-SPECIFIC POPULATION-BASED PAYMENT | Purchasing strategy of prospective, population-based payments, for all care delivered by particular types of clinicians structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice. This strategy includes per member per month payments, payments for specialty services, such as oncology or mental health, and bundled payments for the comprehensive treatment of specific conditions. (LAN-APM Category 4A) |

COMPREHENSIVE POPULATION-BASED PAYMENT	Purchasing strategy of prospective, population-based payments, covering all of an individual's health care needs, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a comprehensive collection of care. This strategy includes global budgets or full/percent of premium payments which encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct. (LAN-APM Category 4B)
INTEGRATED FINANCE & DELIVERY SYSTEMS	Purchasing strategy of prospective, population-based payments structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a highly integrated finance and delivery system. This strategy includes global budgets or full/percent of premium payments in integrated systems. (LAN-APM Category 4C)
ENCOUNTER	For the purposes of this policy, all encounters shall be in an adjudicated and approved status.
PERFORMANCE BASED PAYMENT	A payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals/measures in accordance with the APM strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment will typically occur after the completion of the contract period, but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

III. POLICY

A. GENERAL

The Contractor shall meet the APM strategies qualifying criteria in B.1 and B.3, and certify as described in B.2. Failure to meet or certify to meeting the criteria in a particular contract year will result in:

- Disqualification of Acute Care and ALTCS/EPD Contractors from any Earned Withhold or Quality Measure Performance Incentive Payments discussed in

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ACOM Policy 306 - Alternative Payment Model Initiative – Withhold and Quality Measure Performance Incentive

- Assessment of sanctions for CRS, RBHA and DDD Contractors and DDD sub-contractors up to a maximum of the amounts listed in the table below

CONTRACTOR	MAXIMUM SANCTION AMOUNT
CRS	$250,000
Maricopa County RBHA	$600,000
South RBHA	$400,000
North RBHA	$200,000
Affiliated Acute Contractor and RBHA	$250,000
DDD Sub-Contractors	$50,000

B. CONTRACTOR RESPONSIBILITIES

1. A minimum percentage of total Title XIX payments (both APM and non-APM, whether contracted or non-contracted), shall be governed by APM strategies for the contract year, according to the table below

	• Acute [1]	• ALTCS/EPD	• CRS [1]	• RBHA		• DDD	
		• (EPD/ • MA-DSNP[2])		• SMI-Integrated [1]	• Non Integrated	• Sub-Contractors [1]	• LTSS
CYE 18	50%	35%/35%	50%	25%	10%	20%	5%

[1] A minimum of 25 percent of the percentage requirement noted above shall be with an organization that includes Primary Care Providers (PCPs).

[2] Relative to the MA-DSNP contract for ALTCS/EPD Duals, should a Contractor's MA-DSNP contract serve AHCCCS populations other than ALTCS/EPD Dual members, the Contractor shall split out their MA-DSNP populations served to prove that they have met the minimum percentage requirements for the ALTCS/EPD MA-DSNP population. Contractors may count both aligned and non-aligned members in their ALTCS/EPD MA-DSNP population.

AHCCCS intends that the minimum value threshold will grow each year according to the schedule below.

	AHCCCS COMPLETE CARE	ALTCS/EPD (EPD/ MA-DSNP)	RBHA		DDD	
			SMI-INTEGRATED	NON-INTEGRATED	SUB-CONTRACTORS	LTSS
CYE 19 Anticipated	50%	50%/50%	35%	20%	35%	10%
CYE 20 Anticipated	60%	60%/60%	50%	25%	50%	20%
CYE 21 Anticipated	70%	70%/70%	60%	25%	60%	35%

Strategies for this initiative may not include:
- Block Purchase Payment Arrangement Methodology with no link to quality and value
- Fee-For-Service Strategy with no link to quality and value (LAN-APM Category 1)
- Foundational Payments for Infrastructure & Operations strategy (LAN-Category 2A)

Strategies that incorporate the Pay for Reporting strategy (LAN-APM Category 2B) will be considered by AHCCCS to meet the qualifying criteria on case by case basis and prior approval is required:
- AHCCCS will only consider approval of LAN-APM Category 2B for expansion to services/service providers/provider types not traditionally utilized for APM arrangements
- AHCCCS expects to consider approval only on a short-term basis

Strategies utilized shall meet the definitions provided under Section II. Strategies shall be designed to achieve cost savings and quantifiable improved outcomes.

For ALTCS/EPD Contractors: Inclusion of payments for Room and Board for members residing in Nursing Facilities (which are included in per diem payments and not separately identifiable) are permissible when computing the percentage of total payments that are governed by APM strategies.

AHCCCS will have a requirement beginning in CYE19 for specific usage of strategies in LAN-APM Categories 3 and 4, this information will be determined based upon a review of Contractor deliverables and will be released in a Public Notice published in or after January 2018. AHCCCS intends that the required percentage of strategies in LAN-APM Category 3 and Category 4 grow each year.

The Contractor shall be responsible for identifying which strategy applies to each APM contract and whether each contract applies to a limited cost of care, where the provider can only impact direct and limited costs attributed to members, or the total cost of care attributed to members. For example, a contract with a transportation provider which rewards the provider for improvement in on-time pick-ups would count as a limited cost of care contract since the provider has no impact on the members' total medical costs and

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only directly affects transportation expense. Alternatively, a contract with a PCP which rewards the provider for reducing total medical expenses attributed to members, including those not directly provided by the PCP, would count as a total cost of care contract.

The same dollars shall not be counted under multiple contracts.

Additionally, one contract shall not be counted under multiple strategies.

The Contractor may use quality measures other than the measures identified in ACOM Policy 306 - Alternative Payment Model Initiative – Withhold and Quality Measure Performance Incentive as part of the Contractor's APM strategies.

In order to count towards meeting the qualifying criteria, strategies shall be evidenced by written contracts. For those contracts executed prior to February 1 of each contract year, AHCCCS shall count the strategies for the time period in the contract year for which the contract is in effect. For those contracts executed after February 1 of each contract year, AHCCCS shall count the strategies for the time period from the execution date forward for which the contract is in effect.

2. The Contractor will certify to AHCCCS that these requirements will be met by submitting both an executed copy and an electronic copy in an Excel format and through the Structured Payment File described in Section D:
   a. An initial APM strategies Certification as provided in Attachment B to the DHCM Finance Manager within 60 days of the start of the contract year, and
   b. A final APM strategies Certification as provided in Attachment B to the DHCM Finance Manager, and the Structured Payment File, due 270 days after the end of the contract year.

   For ALTCS/EPD and RBHA Contractors: Attachment B contains two tabs to be submitted as an executed copy and an electronic copy as listed below in accordance with B.2.a. and B.2.b.

CONTRACTOR	POPULATIONS	
ALTCS - EPD	EPD	MA-DSNP
RBHA	SMI- Integrated	Non-Integrated

   DDD will submit the APM strategies certifications on behalf of the DDD Sub-Contractors.

   In the case of differences between the executed copy and electronic template submissions, the executed copies will prevail.

   Failure to certify to the APM strategies qualifying criteria in a particular contract year will result in disqualification from the provisions of ACOM Policy 306 or the application of sanctions listed in Section A.

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AHCCCS reserves the right to request an audit of the Certifications included in Attachment B. The Contractor, upon the request of AHCCCS, will provide documentation of APM contracts and payments to providers for performance based payments.

3. Acute Care Contractors Affiliated with a RBHA Contract, and RBHA Contractors:
   a. In addition to those requirements outlined above in Section B.1, an Acute Care Contractor Affiliated with an entity that holds a RBHA Contract, and the RBHA Contractor, shall also enter into at least two APM contracts with integrated providers who offer physical and behavioral health clinical integration, for aligned members who are not already integrated under the Acute or RBHA contract, but who receive their acute care or behavioral health services from affiliated entities, e.g. children, non-dual adults with GMH/SA needs, non-integrated adults with SMI. Contracts executed under this requirement may be used to fulfill the APM strategies qualifying criteria under B.1.
   b. The Contractor shall certify to AHCCCS that this requirement will be met by completing and submitting the comporting section in Attachment B. The Contractor shall submit Attachment B as outlined in Section B.2 above.

   Failure to attest to the APM strategies qualifying criteria in a particular contract year will result in sanctions up to a maximum of $250,000.

   AHCCCS reserves the right to request an audit of the Certifications included in Attachment B. The Contractor, upon request of AHCCCS, will provide documentation of APM contracts and payments to providers for performance based payments.

C. AHCCCS RESPONSIBILITIES

1. The performance-based payments made by the Contractor to providers will be paid by AHCCCS through a lump sum payment through a future monthly capitation payment. For DDD this payment is limited to Long Term Care services for HCBS providers. No performance-based payment incentives will be made for DDD Sub-Contractors. Upon receipt and review of the final APM Strategies Certification discussed in B.2.b, AHCCCS will perform testing of the performance-based payment amounts reported by the Contractor prior to payment of the incentive, including review of Contractor documentation of APM contracting and payments to providers for performance-based payments. The performance-based payment incentive will be adjusted for premium tax.

   The Contractor shall report the performance-based payments on an accrual basis. AHCCCS reserves the right to perform a look-back and true-up of the previous year's accrual in a subsequent year's payment.

2. For any APM contract that is effective for a period other than the measurement year, AHCCCS will allow performance-based payments to be included in the year to which the lump sum performance-based payments incentive is attributable. For example, a

contract effective from April 1, 201X to March 31, 201Y will have six months (April 1, 201X – September 30, 201X) in the 201X lump sum payment and six months (October 1, 201X – March 31, 201Y) in the 201Y lump sum payment.

The Contractor is not required to meet the APM strategies qualifying criteria in B.1 and B.3 in order for the performance-based payments incentive to be paid to the Contractor.

AHCCCS shall test the total amount of performance-based payments incentive due to the Contractor to ensure that the Federal limit of 5% of annual prospective gross capitation is met. Any amount in excess of the limit shall be reduced to bring the final due payment within the Federal requirement. Federal regulation requires that all incentive payments combined shall not exceed this 5% limit, thus the test of the 5% limit will include both the performance-based payment incentives included in this Policy, and the Quality Measure Performance Incentive payments described in ACOM Policy 306.

D. STRUCTURED PAYMENT FILE AND POST ADJUDICATED/POST SUBMITTED FILE

1. AHCCCS has developed a Structured Payment File to automate the APM Strategies Certification excel file. The Contractor shall submit this file annually. (See B.2.b.) For details on the file layout and FTP submission process, refer to the AHCCCS Structured Payment Transmission User Manual https://azahcccs.gov/Resources/Downloads/OperationsReporting/StructuredPayment TransmissionCompanionGuide.pdf.

2. In order to link encounters to the Structured Payment File, the Contractor shall add an APM Indicator to encounters paid under an APM contract. Refer to the AHCCCS Technical Interface Guidelines (TIG) - Post Adjudicated Structured Payment File for information on the APM Indicator. https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/PostAdjudicated StructuredPaymentFileLayout.pdf.

   If the Contractor knows upfront that the encounter is tied to a member/provider under APM contract, the Contractor should include the APM Indicator in the original encounter submission.

   If the Contractor does not know upfront that the encounter is tied to a member/provider under APM contract, the Contractor shall add the APM Indicator to the adjudicated encounter via the Post Adjudicated/Post Submitted File. The Contractor may choose to only use the post adjudication adjustment process to add the APM Indicator to adjudicated encounters, if desired.

   All applicable encounters should have the APM Indicator included 270 days following the contract year end.

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

(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?

Each Regional Behavioral Health Authority (RBHA) has submitted a plan and budget for MHBG FEP funds for the upcoming fiscal year. The planned activities for each RBHA are as follows:

Steward Health Choice Arizona: Steward Health Choice Arizona (SHCA) plans to continue supporting the Fast Forward Program, a

CSC model, in 5 health homes. SHCA plans to expand FEP services by adding a .5 FTE nurse at each agency due to the increased number of members identified who are anticipated to be enrolled in FEP services.

SHCA also plans to launch the Early Psychosis Intervention (EPI) Project ECHO Clinic to improve the competency of SHCA network staff in addressing needs of individuals with FEP or ESMI. The ECHO Clinic will be open to behavioral health professionals, social workers, and community partners such as primary care providers and other community direct service providers. Monthly ECHO sessions including case presentations and lectures are planned. The clinic will include a panel of subject matter experts, who will collaborate to develop a curriculum focusing on best practices in prescribing, diagnostics, family engagement, and team-based treatment.

Arizona Complete Health: Arizona Complete Health (AzCH) plans to continue supporting the Banner EPICenter, Connections Health Solutions, and plans 126 trainings across 4 counties of NAMI-SA Ending the Silence and Text, Talk, Act.

Mercy Care: Mercy Care plans to continue to support the Resilient Health EPICenter and the Maricopa Integrated Health Services (MIHS) First Episode Clinic, which is changing its name to Valleywise Health. Both programs will utilize the OnTrackNY Program Treatment Team model

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

Footnotes:

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.

    AHCCCS has an Office of Individual and Family Affairs (OIFA) within the Division of Community Advocacy & Intergovernmental Relations (DCAIR). OIFA is staffed by individuals and family members of individuals with lived experiences of mental health and/or substance use disorders. Arizona's OIFA is one of the few "offices of consumer affairs" in the US to operate out of a State's Medicaid Program, and not housed within a department of health. AHCCCS OIFA's advocacy is non-exclusive to mental health and/or substance use disorders, and also houses the state's foster-care community liaison; providing a valuable link to that special population and the family members involved within it. OIFA maintains a weekly newsletter that reaches over 1,900 subscribers. It contains an extensive listing of community resources, news, event notifications and an entire section devoted to gathering public comment on AHCCCS policies which are up for revision.

    To uphold the values of member and family Voice and Choice, the Office of Individual and Family Affairs actively works with Family -Run and Peer- Run Organizations, advocacy groups, providers and other stakeholders in our communities to develop strategies intended to enhance member and family engagement in the recovery process. OIFA communicates, AHCCCS policy and contract expectations via community forums and other meetings, to improve communication and understanding of State expectations as far as planning and service delivery. AHCCCS includes in its contract requirements that each contracted MCO hires an Individual and Family Affairs Administrator, and staff sufficient to support that position, to help fulfill a similar role within the MCO's network(s)..

    Staff from OIFA offer assistance to the Arizona Behavioral Health Planning Council and support its goal to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems;

    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 individual members 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 (see attached) 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, in our System of Care, for both adults and children, we use planning processes based on the same principles as PCP.

    Arizona has a comprehensive system of values, visions and guiding principles outlining the expectations for person-centered-planning in both the adult and children's systems of care. These ideals are found in the overview chapter for each of the AHCCCS bodies of policy: The AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor Operations Manual (ACOM).

    ADULT SYSTEM OF CARE – NINE GUIDING PRINCIPLES (ACOM 100 & AMPM 100)

The following principles were developed to promote recovery in the adult behavioral health system. System development efforts, programs, service provision, and stakeholder collaboration shall be guided by these Nine Guiding Principles:

1. Respect
2. Persons in Recovery Choose Services And Are Included in Program Decisions and Program Development Efforts
3. Focus On Individual As A Whole Person, While Including And/Or Developing Natural Supports
4. Empower Individuals Taking Steps Towards Independence And Allowing Risk Taking Without Fear Of Failure
5. Integration, Collaboration And Participation With The Community Of One's Choice
6. Partnership Between Individuals, Staff And Family Members/Natural Supports For Shared Decision Making With A Foundation Of Trust
7. Persons In Recovery Define Their Own Success
8. Strengths-Based, Flexible, Responsive Services Reflective Of An Individual's Cultural Preferences
9. Hope Is The Foundation For The Journey Towards Recovery

CHILDREN'S SYSTEM OF CARE – VISION AND GUIDING PRINCIPLES (ACOM 100 & AMPM 100)

Arizona Vision:
In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.

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

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". Arizona invested millions of dollars in the early 2000's bringing in national Wraparound experts such as John VanDenBerg to train our workforce and transform our 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," (see both attached). These documents, along with other Practice Tools, are embedded in our contracts with the Managed Care Organizations (MCOs) responsible for delivering health care to Arizonans. They are posted on the AHCCCS web page.

The adult BH 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 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" (see attached) 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 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), has an incredibly rich assortment of services including Treatment, Support, Medical, and Rehabilitation services, which enable the CFT or the ART to develop a highly individualized service plan utilizing the strengths and culture of the consumer/family while addressing the identified needs and achieving the desired outcomes as determined by the consumer and their families.

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

Technical assistance is not being requested at this time.

Footnotes:

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?

   AHCCCS contracts with three Regional Behavioral Health Authorities (RBHAs) for the provision of SAMHSA Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) services and funding. These Contracts delineate the requirements of the RBHAs, including their responsibilities for implementing and monitoring subcontractors whom are the providers of direct care services and treatment. Notwithstanding any relationship(s) the RBHA may have with any subcontractor, the RBHA maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. RBHAs subcontract with providers in their Geographic Service Area (GSA) to ensure members may access services within their communities. Provider networks must meet access-to-care standards for the populations served.

   AHCCCS also holds Intergovernmental Agreements (IGAs) with three Tribal Regional Behavioral Health Authorities (TRBHAs) for the provision of MHBG and SABG services and funding. The TRBHA's IGAs ensures that services and treatment funded under the federal block grants meet all the legal requirements of the respective block grant. The TRBHAs are responsible for implementing and monitoring direct care services and treatment; and as funds are available, are responsible for the development and implementation of primary substance abuse prevention services.

   Contracts/IGAs are updated and amendments executed as needed to revise and implement reporting, monitoring, evaluation, and

compliance requirements. Additionally, RBHAs are required to align their programs and activities with the following AHCCCS System Values and Guiding Principles:

1. Member and family member involvement at all system levels,
2. Collaboration with the greater community,
3. Effective innovation promoting evidence-based practices,
4. Expectation for continuous quality improvement,
5. Cultural competency,
6. Improved health outcomes,
7. Reduced health care costs,
8. System transformation,
9. Transparency,
10. Prompt and easy access to care,
11. The Adult Service Delivery System- Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, and
12. The Arizona Vision-Twelve Principles for Children Service Delivery as outlined in AMPM Policy 430.

Monitoring

Within AHCCCS, many divisions collaborate to ensure compliance with block grant program integrity responsibilities. The Division of Health Care Management (DHCM), the Office of the Director (OOD), the Division of Community Advocacy & Intergovernmental Relations (DCAIR), and the Division of Fee-for-Service Management (DFSM) play an integral role in the ongoing monitoring for programmatic compliance, including promoting the proper expenditure of block grant funds, improving block grant program compliance, and demonstrating the effective use of block grant funds. RBHAs and TRBHAs are required to ensure reporting requirements and deliverables outlined in their contract/IGA are met.

Corporate Compliance/Fraud, Waste, and Abuse: AHCCCS has an established a comprehensive Corporate Compliance Program to achieve the goals of preventing and detecting fraud, waste, and abuse of the program. The Program ensures Contractor compliance with applicable laws, rules, regulations, and contract requirements. Continued collaboration efforts include regularly scheduled meetings held to share information with RBHAs and TRBHAs regarding their Corporate Compliance Program that includes all program integrity activities.

Operational Reviews: Effective October 1, 2019, AHCCCS will conduct annual RBHA and TRBHA SABG/MHBG Operational Reviews to verify Contractor performance which will include review of internal monitoring of grant activities; verification of timely and accurate notifications to providers of sub-awards, funding, and audits; verification of tracking and implementation of decisions regarding provider audit findings; and appropriate tracking of grant funding.

Reporting Requirements: Regular deliverable submissions to AHCCCS by each RBHA and TRBHA are required and analyzed to ensure program integrity efforts are met. These include at a minimum: annual Independent Case Reviews; MHBG and SABG annual and semi-annual Prevention Reports; annual MHBG and SABG Activities and Expenditures Plans and Reports; quarterly Member Grievances/Complaints and provider claim disputes reporting; and annual/quarterly/monthly Financial Reporting. A brief description of each is provided below:

1. AHCCCS oversees the Independent Case Reviews (ICRs) to meet the Peer Review requirement of the block grant to ensure the quality and appropriateness of treatment services and indications of treatment outcomes. An ICR interdisciplinary team from an independent agency completes case reviews.

2. RBHAs and TRBHAs must administer a prevention system utilizing the Strategic Prevention Framework (SPF) model as a framework for all system activities and a community based prevention model as described by AHCCCS. Prevention planning and reporting includes: identifying methodology and data used to identify populations to be served for Prevention of Substance Use and treatment of Substance Use Disorders (SUD), including SAMHSA's identified priority populations and specific underserved populations; outreach efforts; strategies and actions taken to fully expend and monitor funds, identifying services and providers to meet the needs of members; identification of, and actions taken to address any barriers.

3. RBHAs and TRBHAs must provide information regarding MBHG and SABG activities and expenditures outlining use of funds, strategies for monitoring expenditures and making adjustments in a timely manner to best meet the needs of the community.

4. RBHAs and TRBHAs must for all members, subcontractors, and providers administer all Grievances and Appeal System processes competently, expeditiously, and equitably. RBHAs and TRBHAs are required to report provider claim disputes, member grievances, SMI Grievances and SMI Appeals as delineated in Arizona Administrative Code Title 9, Chapter 21, Article 4.

5. RBHAs and TRBHAs are required to submit financial statements and reporting packages, which must be based on an AHCCCS, approved cost allocation plan. Expenditures must comply with contractual requirements for management of federal block grant funds: SABG for planning, implementing, and evaluating activities to prevent and treat substance use and related activities addressing HIV and tuberculosis services and MHBG for services for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED), Evidence Based Practices for First Episode Psychosis, as well as an assessment to determine

eligibility for SED funded Non-Title XIX/XXI services,

Policies and Procedures
In addition to the Contracts/IGAs, multiple policies and procedures are developed and implemented for RBHAs and TRBHAs to ensure operational and programmatic compliance and appropriate service delivery. Two priority manuals are the AHCCCS Contractor Operations Manual (ACOM) and the AHCCCS Medical Policy Manual (AM/PM). Policies within these Manuals are written with input from multiple divisions at AHCCCS with revisions completed as needed due to federal or state legislation, contractual requirements, operational changes, monitoring requirements, benefit coverage, etc. All applicable policies are incorporated by reference in the Contracts/IGAs.

Listed below are several Policies important to note which relate to RBHA grant services and funding; member and provider notifications; and access to care requirements (this is not an all-inclusive list):

1. ACOM Policy 103, Fraud, Waste, and Abuse
2. Finance Policies
3. ACOM Policy 323, RBHAs Title XIX/XXI Reconciliation and Non-Title XIX/XXI Profit Limit
4. ACOM Policy 404, Contractor Website and Member Information
5. ACOM Policy 406, Member Handbook and Provider Directory
6. ACOM Policy 416, Provider Information
7. ACOM Policy 436, Provider Network Requirements
8. ACOM Policy 444, Notice of Appeal Requirements (SMI Appeals)
9. AMPM Policy 580, Behavioral Health Referral and Intake Process
10. AMPM Policy 310-B, Title XIX/XXI Behavioral Health Services Benefit
11. AMPM Policy 320-T, Non-Title XIX/XXI Behavioral Health Services Benefit
12. AMPM Policy 650, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening, Application for Public Health Benefits Provider Eligibility
13. AMPM Policy 1040, Outreach, Engagement, Re-Engagement and Closure for Behavioral Health

Communication of Policy Updates: Contractors, providers, and members have full access to the ACOM, AMPM, and other Guides and Resources via the AHCCCS website. Policies are made available to stakeholders for a 45-day Tribal Consultation/ Public Comment period and revision memos accompany each Policy revision explaining the changes and notification of changes is sent via email. Additionally, AHCCCS hosts the AHCCCS Managed Care Organization (MCO) Update Meetings with contracted health plans, state agencies, and TRBHAs; these meetings are typically held every two months. AHCCCS also holds quarterly Tribal Consultation meetings to consult with tribes, Indian Health Service, tribal health programs operated under P.L. 93-638, and urban Indian health programs in Arizona on policy and programmatic changes that may significantly impact members. Individualized communication with each RBHA formally occurs in person during regular meetings with AHCCCS to review issues, concerns, and new information. If an improvement plan is established, oversight and communication from AHCCCS occurs more frequently.

RBHAs and TRBHAs are responsible for ensuring that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals. In the event of a modification to AHCCCS Policy, guidelines and Manuals, RBHAs and TRBHAs shall issue a notification of the change to its effected subcontractors within 30 calendar days of the published change and ensure amendment of any affected subcontracts. Additionally, RHBAs are contractually required to hold provider forums semi-annually to improve communication between the Contractor and providers and to address issues (or to provide general information, technical assistance, etc.).

Additionally, to ensure providers have adopted policies and processes that promote compliance with program requirements as well as include quality and safety standards, the RBHAs are required to conduct annual site visits to each provider receiving SABG funds where AHCCCS staff, Contractor Prevention Coordinator, and Provider staff, coalition's, members, and relevant program coordinators are present. RBHAs submit a report to AHCCCS of the findings.

As stated in Contracts and IGAs respectively, RBHAs and TRBHAs shall comply with all reporting requirements contained in Contract/IGA and Policy.

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:

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?

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.

Footnotes:

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)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ 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)

- ☑ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☐ Adults (ages 27-54)
- ☐ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities
- ☑ 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)

☐   Archival indicators (Please list)

☑   National survey on Drug Use and Health (NSDUH)

☑   Behavioral Risk Factor Surveillance System (BRFSS)

☑   Youth Risk Behavioral Surveillance System (YRBS)

☑   Monitoring the Future

☐   Communities that Care

☑   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.

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

N/A

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.

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.

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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.

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.

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.

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

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.

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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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

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):

Footnotes:

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,

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.

An additional resource is AHCCCS Medical Policy Manual (AMPM) 300, Exhibit 300-2B, AHCCCS Covered Services Behavioral Health Non-Title XIX/XXI Person.

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 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) for low, medium, and high needs. Arizona has implemented 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.

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.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

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

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.

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.

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.

Footnotes:

Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems

Background

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. We must utilize these principles to guide our decision making process and our interactions with each other.

Foundation and Influences

These Guiding Principles were influenced by the Substance Abuse and Mental Health Services Administration Consensus Statement, the U.S. Psychiatric Rehabilitation Association Core Principles, the AZ Department of Health Services, Division of Behavioral Health Services Vision Statement, Arizona's Five Principles for Person-Centered Treatment Planning, and Arizona's 12 Principles for Children's Behavioral Health Care. They also were influenced by the groundbreaking work done by a large group of peers, family members, stakeholders, service providers, and administrators in Maricopa County who developed a Recovery Report Card under the guidance of Dr. Mark Ragins from the Mental Health America Village program in Long Beach, California. The Recovery Report Card provides indicators of a recovery-oriented system while giving concrete examples of ways programs can promote recovery and develop healing relationships.

Statewide Development

With assistance of the Regional Behavioral Health Authorities, peer focus groups were held in in all regions of the state to dialogue around the needed ingredients for a recovery oriented system and to seek input in the development of these Guiding Principles. The Statewide Family Committee provided feedback and input. A particular emphasis was placed on ensuring that these Guiding Principles correlated with and complimented the 12 Principles for Children's Behavioral Health Care. The Statewide Consumer Advisory Committee hosted additional input and discussion sessions over the course of a year, opening the sessions up to all individuals and family members from around the state. This committee along with the Behavioral Health Planning Council took the lead in gathering all input. These efforts resulted in the Nine Guiding Principles and narratives that were crafted and agreed upon as the necessary foundation of our adult behavioral health system.

Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems

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 well being, 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 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.

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

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

Criterion 2

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, 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.

Secret Shopper – The purpose for the Secret Shopper program was to determine how members are being served when they call a provider seeking help with substance use issue. The approach is to have a "no wrong door" to receiving guidance and/or assistance, understanding that this may be the first phone call the person is making so we need to ensure they are receiving the services and/or guidance to ensure that receive access to treatment and long-term recovery support services for the priority populations;
There were total of six callers and they made approximately 12 calls each, understand this was not a statistically significant number but it was a way to begin and get a snapshot of what is actually happening. These calls were made in April 2018. The scenarios were designed to address the following areas:
• Pregnant woman using drugs by injection / with minor children/turned down for AHCCCS
• Male using drugs by injection wanting MAT/applied for Medicaid but haven't received confirmation yet
• Substance using female in jeopardy of losing her baby and is attempting to get help/doesn't qualify for AHCCCS
• Substance using male ready to make a change and checking out available outpatient programs

With the development of each scenario, there were key areas that should have been addressed by the provider and areas were as follows:
1. The priority population listed above
2. Individuals who do not qualify for AHCCCCS are entitled to services or while waiting for a determination
3. Specialized, gender-specific treatment and recovery support services
4. Services treat the family as a unit
5. Transportation cannot pose a barrier
6. As needed, admission to both mothers and their dependent children into treatment
7. Insuring that childcare doesn't pose a barrier
8. Time constraints for serving the priority populations
9. Interim services are required for priority population who are maintained on an actively managed waitlist

AHCCCS met with each Regional Behavioral Health Authorities with their particular findings and provided technical assistance. During each meeting AHCCCS addressed the concerns, discussed what should be happening, required they provide a plan to resolve the concerns raised to include technical assistance, and for them to provide a policy and procedures to make sure each provider understood the expectations when a call is made by a member with substance use issues. In addition, AHCCCS strongly recommended that they do their own secret shopper calls to insure the issues raised were addressed.

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

Narratve Question

Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

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

    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.C§ 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

Narratve Question

Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independant Peer Review

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

  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)

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

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.

Footnotes:

Arizona Health Care Cost Containment System

Division of Health Care Management

Substance Abuse Prevention and Treatment
Case File Review Findings

FY 2018

June 2019

HSAG HEALTH SERVICES ADVISORY GROUP

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Substance Abuse Prevention and Treatment Case File Review Findings

State of Arizona

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Health Services Advisory Group, Inc. (HSAG), an Arizona-based external quality review organization (EQRO), was contracted by the Arizona Health Care Cost Containment System (AHCCCS), Division of Health Care Management (DHCM), to conduct a case file review of behavioral health records. Behavioral health records vary per case file. The case files may include, but are not limited to, the following documents:

- Demographic information
- Initial assessment
- Risk assessment
- Individual service plan
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria
- Medication record
- Progress notes that may include:
  – Case management records
  – Therapy records, including group, individual and family therapy
  – Outreach documentation
  – Correspondence
- Crisis plan
- Substance use testing reports
- Discharge summary report

The case file review is a requirement of the Substance Abuse Prevention and Treatment Block Grant (SABG), which is administered through the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA awarded the SABG to AHCCCS. AHCCCS has chosen to fulfill its requirement by reviewing the case files of individuals enrolled in substance abuse treatment programs, which are contracted through the Regional Behavioral Health Authorities (RBHAs). AHCCCS contracts with RBHAs across the State to deliver a range of behavioral health services. The grant requires the State to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant. AHCCCS fulfills this requirement by reviewing substance use treatment programs that are contracted through the RBHAs. The objective of the review was to determine the extent to which substance abuse treatment programs use nationally recognized best practices in the areas of screening, assessment, treatment, engagement, and retention in accordance with the terms of their contracts and State and federal regulations. In addition, the case file review included the collection of data pertaining to National Outcome Measures (NOMs).

AHCCCS developed, implemented, and validated the sampling methodology for the case file review. Members of the study population and sampling frame identified by AHCCCS were:

- Substance abuse clients with a substance abuse treatment service and episode of care (EOC) during fiscal year 2018: July 1, 2017, through June 30, 2018.
- Disenrolled/EOC end date before or on June 30, 2018.
- At least 18 years of age during the treatment episode.
- Within Behavioral Health Category G, which refers to adults who received substance abuse services and were not diagnosed with a serious mental illness.
- Enrolled in geographic service area (GSA) 6, GSA 7, or GSA 8.
- Disenrolled due to completing treatment, declining further service, or lack of contact.
- A minimum of 5 percent of the provider agencies for each GSA must be sampled.
- A total client sample size consisting of 200 records.
- Clients must have received substance abuse treatment during the treatment period.
- Clients must have received a counseling treatment during the treatment period.
- Clients must have been enrolled in a treatment center for at least 30 days.
- Clients must have had a minimum of one episode of care.
- Clients must not be enrolled in a Tribal Behavioral Health Authority.

The study population excluded members who:

- Did not have any service encounters during the treatment episode.
- Only had a crisis encounter during the treatment episode.
- Only had assessment services during the treatment episode.
- Did not have any counseling encounters during the treatment episode.
- Only had a detoxification hospitalization encounter during the treatment episode.
- Only had services provided by an individual private provider.

AHCCCS randomly selected 200 cases from the eligible population.

AHCCCS developed the case file review tool, which HSAG converted to an electronic format. The data collection tool contained clinical measures ranging from assessments to discharge planning and re-engagement. In addition, the tool included the collection of NOMs. Experienced HSAG behavioral health record reviewers conducted the case file reviews. The reviewers abstracted behavioral health charts on-site at HSAG.

Due to changes in the sampling methodology, the data collection tool, and contracted RBHAs, caution should be exercised when comparing findings across years.

Table 1-1 depicts the distribution of the case file review sample by RBHA, gender, and age.

Table 1-1—Demographic Table

RBHA	Sample Cases	Percent of Sample	Gender				Age (Years)	
			Female		Male		Mean	Median
			N	%	N	%		
Cenpatico Integrated Care	66	33.0%	15	22.7%	51	77.3%	34.1	30.5
Health Choice Integrated Care	40	20.0%	3	7.5%	37	92.5%	30.4	28.5
Mercy Maricopa Integrated Care	94	47.0%	20	21.3%	74	78.7%	35.0	33.0
Total	**200**	**100.0%**	**38**	**19.0%**	**162**	**81.0%**	**33.8**	**31.0**

Table 1-2 describes, by RBHA, the distribution of providers covered by the case file review sample compared to the total number of SABG-funded treatment providers.

Table 1-2—5% Provider Review

	SABG-Funded Treatment Providers	SABG-Funded Treatment Providers Included in the Independent Case Review	Percentage of SABG Treatment Providers Included in the Independent Case Review
Cenpatico Integrated Care	18	12	66.7%
Health Choice Integrated Care	14	5	35.7%
Mercy Maricopa Integrated Care	25	11	44.0%
Statewide*	**49**	**25**	**51.0%**

* AHCCCS determined that 49 unique SABG-funded treatment providers were available statewide, as a limited number of providers are contracted with more than one RBHA.

As a requirement for the SABG, it is mandatory that the state of Arizona assess the quality, appropriateness, and efficacy of treatment services provided to the individuals under the program involved. A minimum of 5 percent of the provider agencies for each GSA were sampled to ensure that the peer review was representative of the total population of the entities providing services in the state. This ensures that the provider agencies that are reviewed are a representation of the total population of agencies that provide treatment services. As the independent case review is divided into three GSAs, each GSA must meet the 5 percent minimum of provider agencies reviewed to obtain an accurate depiction of their local area.

Table 1-3 and Figure 1-1 illustrate the distribution of the case file review sample by RBHA and reason for closure.

Table 1-3—Distribution Based on Reason for Closure

RBHA	Sample Cases	Client Declined Further Service		Lack of Contact		Treatment Completion		Missing	
		N	%	N	%	N	%	N	%
Cenpatico Integrated Care	66	20	30.3%	14	21.2%	32	48.5%	0	0.0%
Health Choice Integrated Care	40	8	20.0%	3	7.5%	27	67.5%	2	5.0%
Mercy Maricopa Integrated Care	94	27	28.7%	31	33.0%	35	37.2%	1	1.1%
Total	**200**	**55**	**27.5%**	**48**	**24.0%**	**94**	**47.0%**	**3**	**1.5%**

Note: Due to rounding, the sum of the percentages in each row may not equal 100 percent.

Figure 1-1—Distribution Based on Reason for Closure
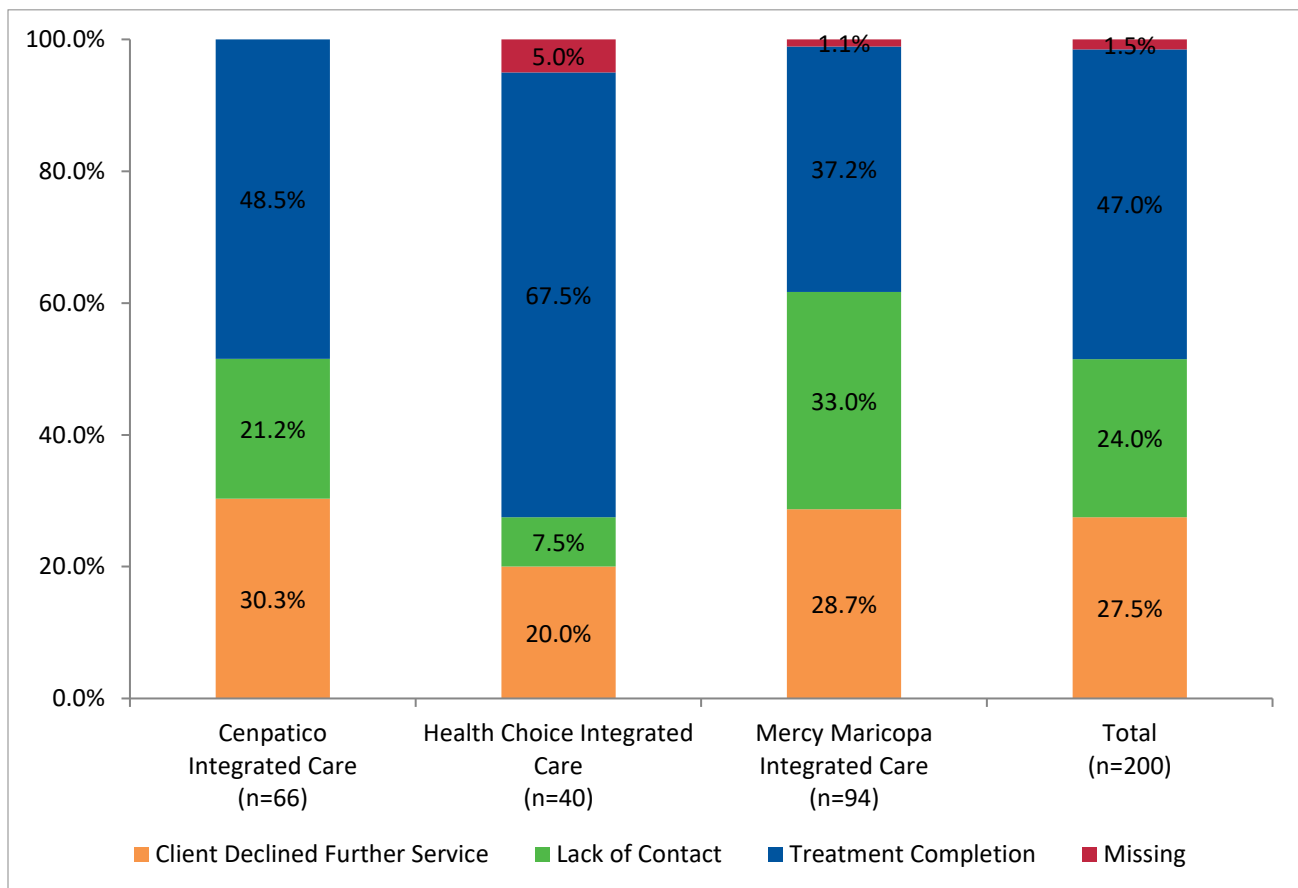
Note: Due to rounding, the sum of the percentages in each row may not equal 100 percent.

Table 1-4 displays the case file review sample by RBHA and the top three referral sources.

Table 1-4—Top Three Referral Sources*

RBHA	Sample Cases	Referral Sources	N	%
Cenpatico Integrated Care	66	Criminal Justice/Correctional (AOC-Probation, ADOC, ADJC, Jail, etc.)	42	63.6%
		Self/Family/Friend	16	24.2%
		DCS: Department of Child Safety	3	4.5%
Health Choice Integrated Care	40	Criminal Justice/Correctional (AOC-Probation, ADOC, ADJC, Jail, etc.)	27	67.5%
		Self/Family/Friend	7	17.5%
		AHCCCS Health Plan / PCP	2	5.0%
		DCS: Department of Child Safety	2	5.0%
Mercy Maricopa Integrated Care	94	Criminal Justice/Correctional (AOC-Probation, ADOC, ADJC, Jail, etc.)	52	55.3%
		Self/Family/Friend	35	37.2%
		Other Behavioral Health Provider	3	3.2%
Total	200	Criminal Justice/Correctional (AOC-Probation, ADOC, ADJC, Jail, etc.)	**121**	**60.5%**
		Self/Family/Friend	**58**	**29.0%**
		DCS: Department of Child Safety	**5**	**2.5%**

*AOC=Administrative Office of the Courts; ADOC = Arizona Department of Corrections; ADJC = Arizona Department of Juvenile Corrections; DCS=Department of Child Safety; DDD = Division of Developmental Disabilities; RSA = Rehabilitation Services Administration

Table 2-1 and Table 2-2 represent the aggregate case file review findings for the three AHCCCS contracted RBHAs.

To measure performance across measures I through VIII, a "Yes" answer was scored as one point and a "No" answer was scored as zero points. For each indicator, the denominator was defined as the sum of all "Yes" and "No" answers such that the "% of YES" column represents the sum of all "Yes" answers divided by the denominator. Answers of "NA" (not applicable) were excluded from the denominator to ensure that only applicable cases were evaluated in the measure's performance. However, the total number of "NA" answers is provided in the "# of NA" columns. An asterisk (*) represents a standard for which the "NA" response was not an option.

For indicator III.A, "Best Practices": Note that indicator III.A includes 23 cases that included therapy progress notes, but the documentation was not sufficient to determine if evidence-based practices were used.

Due to the variation in the denominator size of the individual indicators, caution should be used when interpreting the findings. The aggregate results for Measure IX are presented in Table 2-2 and Figure 2-1.

Indicators II.A.1, III.A.1, III.B.1, IV.A, IV.C, IV.D, and VIII.C (other) were for informational purposes and were therefore excluded from scoring.

Table 2-1—Substance Abuse Prevention and Treatment

		DENOMINATOR	# of YES	% of YES	# of NA
	Case File Review Findings for Measures I–VIII				
I	**Intake/Treatment Planning**				
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	198	183	92.4%	2
	Did the behavioral health assessment:				
	1. Address substance-related disorder(s)?	183	183	100.0%	*
	2. Describe the intensity/frequency of substance use?	183	181	98.9%	*
	3. Include the effect of substance use on daily functioning?	183	173	94.5%	*
	4. Include the effect of substance use on interpersonal relationships?	183	167	91.3%	*
	5. Include a completed risk assessment?	183	176	96.2%	*
	6. Document screening for tuberculosis (TB), hepatitis C, HIV, and other infectious diseases?	183	127	69.4%	*
	7. Document screening for emotional and/or physical abuse/trauma issues.	183	166	90.7%	*
	B. Was there documentation that charitable choice requirements were followed?	4	3	75.0%	196
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	197	191	97.0%	3
	Was the ISP:				
	1. Developed with participation of the family/support network?	83	30	36.1%	108
	2. Congruent with the diagnosis(es) and presenting concern(s)?	191	189	99.0%	*
	3. Developed with measurable objectives and time frames to address the identified needs?	191	186	97.4%	*
	4. Developed to address the unique cultural preferences of the individual?	191	168	88.0%	*

		DENOMINATOR	# of YES	% of YES	# of NA
	Case File Review Findings for Measures I–VIII				
II	**Placement Criteria/Assessment**				
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) Dimensions were used to determine the proper level of care at intake?	200	176	88.0%	*
	1. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
	Level 0.5: Early Intervention	176	0	0.0%	*
	OMT: Opioid Maintenance Therapy	176	6	3.4%	*
	Level I: Outpatient Treatment	176	93	52.8%	*
	Level II: Intensive Outpatient Treatment/Partial Hospitalization	176	38	21.6%	*
	Level III: Residential/Inpatient Treatment	176	39	22.2%	*
	Level IV: Medically Managed Intensive Inpatient Treatment	176	0	0.0%	*
	B. Did the individual receive the level of services identified by the placement criteria/assessment?	200	170	85.0%	*
	C. Were the American Society of Addiction Medicine (ASAM) dimensions revised/updated during the course of treatment?	200	98	49.0%	*
	D. Were additional assessment tools utilized during the course of treatment?	200	15	7.5%	*
III	**Best Practices**				
	A. Were evidence-based practices used in treatment? *Note that the denominator for indicator III.A includes 23 cases that included therapy progress notes, but the documentation was not sufficient to determine if evidence-based practices were used.*	200	177	88.5%	*
	1. The following evidence-based practices were used in treatment:				
	Adolescent Community Reinforcement Approach (A-CRA)	177	2	1.1%	*
	Beyond Trauma: A Healing Journey for Women	177	1	0.6%	*

Case File Review Findings for Measures I–VIII				
	DENOMINATOR	# of YES	% of YES	# of NA
Cognitive Behavioral Therapy (CBT)	177	64	36.2%	*
Contingency Management	177	9	5.1%	*
Dialectal Behavioral Therapy (DBT)	177	7	4.0%	*
Helping Women Recover	177	4	2.3%	*
Matrix	177	55	31.1%	*
Moral Reconation Therapy (MRT)	177	10	5.6%	*
Motivational Enhancement/Interviewing Therapy (MET/MI)	177	46	26.0%	*
Relapse Prevention Therapy (RPT)	177	107	60.5%	*
Seeking Safety	177	30	16.9%	*
SMART Recovery	177	16	9.0%	*
Thinking for a Change	177	4	2.3%	*
Trauma Recovery and Empowerment Model (TREM)	177	0	0.0%	*
Trauma-Informed Care (TIC)	177	1	0.6%	*
Wellness Recovery Action Plan (WRAP)	177	11	6.2%	*
Other	177	2	1.1%	*
B. Medication-assisted treatment	200	26	13.0%	*
1. The following medications were used in treatment:				
• Alcohol-related				
Acamprosate (Campral)	26	0	0.0%	*
Disulfiram (Antabuse)	26	0	0.0%	*
• Opioid-related				
Buprenorphine/Subutex	26	0	0.0%	*
Methadone/ Levo-Alpha-Acetylmethadol (LAAM)	26	25	96.2%	*
Naloxone	26	3	11.5%	*
Naltrexone; long-acting injectable (Vivitrol)	26	1	3.8%	*
Suboxone	26	2	7.7%	*
C. Was screening for substance use/abuse conducted during the course of treatment?	200	95	47.5%	*

Case File Review Findings for Measures I–VIII					
		DENOMINATOR	**# of YES**	**% of YES**	**# of NA**
	D. Were peer support services offered as part of the treatment continuum?	183	68	37.2%	17
	E. Were peer support services used as part of the treatment continuum?	68	56	82.4%	*
IV	**Treatment/Support Services/Rehabilitation Services**				
	A. The following services were used in treatment:				
	1.Individual counseling/therapy	200	151	75.5%	*
	2. Group counseling/therapy	200	170	85.0%	*
	3. Family counseling/therapy	200	3	1.5%	*
	4. Case management	200	174	87.0%	*
	B. Was there evidence of progress or lack of progress toward the identified ISP goals?	193	181	93.8%	7
	C. The number of completed counseling/therapy sessions during treatment was:				
	0–5 sessions	200	48	24.0%	*
	6–10 sessions	200	45	22.5%	*
	11 sessions or more	200	107	53.5%	*
	D. Documentation showed that the individual reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	No documentation	200	104	52.0%	*
	0 times during treatment	200	15	7.5%	*
	1–4 times during treatment	200	14	7.0%	*
	5–12 times during treatment	200	6	3.0%	*
	13–20 times during treatment	200	27	13.5%	*
	21 or more times during treatment	200	34	17.0%	*
	E. If there was evidence of lack of progress toward the identified goal, did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	74	50	67.6%	126
	F. If the individual was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	94	66	70.2%	106

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Case File Review Findings for Measures I–VIII				
		DENOMINATOR	# of YES	% of YES	# of NA
	G. If the individual was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	99	45	45.5%	101
	H. If the individual was not involved with a meaningful community activity (volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	82	28	34.1%	117
	I. Does the documentation reflect that substance abuse services were provided?	200	197	98.5%	*
V	**Gender Specific (female only)**				
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	8	6	75.0%	30
	B. If the female was pregnant, was there documentation of coordination of care efforts with the primary care physician and/or obstetrician?	3	3	100.0%	35
	C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	3	1	33.3%	35
	D. If the female had a child less than 1 year of age, was there evidence that screening was completed for postpartum depression/psychosis?	1	0	0.0%	37
	E. If the female had dependent children, was there documentation to show that child care was addressed?	6	1	16.7%	32
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	37	16	43.2%	1

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Case File Review Findings for Measures I–VIII					
		DENOMINATOR	# of YES	% of YES	# of NA
VI	**Opioid Specific**				
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	200	69	34.5%	*
	B. Was there documentation that the member was provided Medication-Assisted Treatment (MAT) education as a treatment option?	69	28	40.6%	*
	C. If yes to VI B, were they referred to a MAT provider?	28	27	96.4%	41
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	20	17	85.0%	49
	E. If a physical health concern was identified, were alternative pain management options addressed?	10	6	60.0%	59
	F. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or Buprenorphine during the course of pregnancy?	0	0	---	69
	G. Was there documentation that the member was provided with relevant information related to overdose, Naloxone education, and actions to take in the event of an opioid overdose?	69	14	20.3%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	69	29	42.0%	*
VII	**Discharge and Continuing Care Planning** **(completed only if individual completed treatment or declined further services)**				
	A. Was there documentation present that a relapse prevention plan was completed?	156	96	61.5%	*
	B. Was there documentation that staff provided resources pertaining to community supports, including recovery self-help and/or other individualized support services?	156	115	73.7%	*

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Case File Review Findings for Measures I–VIII					
		DENOMINATOR	**# of YES**	**% of YES**	**# of NA**
	C. Was there documentation that staff activity coordinated with other involved agencies at the time of discharge?	124	82	66.1%	32
VIII	**Re-engagement** **(completed only if individual declined further services or chose not to appear for scheduled services)**				
	The following efforts were documented:				
	A. Was the individual (or legal guardian if applicable) contacted by telephone at times when the individual was expected to be available (e.g., after work or school)?	107	83	77.6%	*
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	64	47	73.4%	42
	C. Were other attempts made to re-engage the individual, such as:				
	Home visit	61	8	13.1%	45
	Call emergency contact(s)	54	7	13.0%	51
	Contacting other involved agencies	68	34	50.0%	38
	Street outreach	38	1	2.6%	68
	Other	50	2	4.0%	54

Note: An asterisk (*) represents a standard for which the "NA" response was not an option.

Measure I—Intake/Treatment Planning

Initial Behavioral Health Assessment

- 92.4 percent of the sampled behavioral health case files contained evidence that a behavioral health assessment was completed within the required time frame of 45 days from the individual's initial appointment. In two cases there was no completed behavioral health assessment, and the case closed prior to 45 days from the initial appointment.
- The performance scores for the indicators pertaining to the required components of an initial behavioral assessment (I.A.1–7) ranged from 69.4 percent to 100.0 percent.
- 69.4 percent of the behavioral health assessments contained documentation of screening for tuberculosis, hepatitis C, HIV, and other infectious diseases.
- 100.0 percent of the sampled behavioral health assessments addressed the substance-related disorder(s).

- Documentation of compliance with charitable choice requirements was present in 75.0 percent of the sampled behavioral health case files. Charitable choice did not apply in 196 behavioral case files.

Individual Service Plan (ISP)

- 97.0 percent of the sampled behavioral health case files contained evidence that an ISP was completed within the required time frame of 90 days from the individual's initial appointment. Three cases had no ISP and closed prior to the required 90 days from the initial appointment.
- 99.0 percent of the behavioral health case files contained evidence that the ISP was congruent with the individual's diagnosis(es) and presenting concern(s).
- 36.1 percent of the behavioral health case files contained evidence that the ISP was developed with the participation of the family/support network. In 108 behavioral health case files, there was no family/support network or the individual declined inclusion of others in the service planning process.

Measure II—Placement Criteria/Assessment

- 88.0 percent of the sampled behavioral health case files contained evidence that the ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service.
- 85.0 percent of behavioral health case files contained evidence that the individual received the level of services identified by the placement criteria/assessment.
- 49.0 percent of the sampled behavioral health case files contained evidence that the ASAM Patient Placement Criteria were revised/updated during the course of treatment. In 7.5 percent of the behavioral health case files, additional assessment tools were used during treatment.

Measure III—Best Practices

- 88.5 percent of sampled behavioral health case files contained documentation that evidence-based practices were used in treatment. Twenty-three behavioral health case files included therapy progress notes but lacked sufficient documentation to determine if evidence-based practices were used. RPT was used in 60.5 percent of the sampled behavioral health case files. The reviewers could select more than one response for Question III.A.1.
- Opioid-related MAT was documented in 13.0 percent of the sampled behavioral health case files. Methadone/LAAM was used in 96.2 percent of the MAT cases.
- 47.5 percent of sampled behavioral health case files contained evidence that screening for substance use/abuse was conducted during treatment.
- In 37.2 percent of the behavioral health case files, peer support services were offered as part of the treatment continuum. Seventeen clients declined peer support. 82.4 percent of clients who responded "Yes" to peer support services received peer support services during treatment.

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Measure IV—Treatment/Support Services/Rehabilitation Services

- Documentation in the sampled behavioral health case files contained evidence that 87.0 percent of individuals received case management services, 85.0 percent received group counseling/therapy, 75.5 percent received individual counseling/therapy, and 1.5 percent received family counseling/therapy. The reviewers could select more than one response to this question.

- 93.8 percent of behavioral health case files contained documentation of progress or lack of progress toward the identified ISP goals. Seven behavioral health case files had no ISP present or contained documentation that services were recent and there was no change in progress.

- 53.5 percent of the behavioral health case files contained evidence that individuals completed 11 or more counseling/therapy sessions during treatment, 22.5 percent completed six to 10 sessions, and 24.0 percent completed zero to five sessions.

- 52.0 percent of behavioral health case files did not contain documentation of the number of self-help or recovery group sessions completed during treatment.

- If there was evidence of lack of progress toward the identified goal, in 67.6 percent of the behavioral health case files, there was documentation that the provider revised the treatment approach and/or sought consultation to facilitate improvement. In 126 case files, symptomatic improvement was documented.

- 70.2 percent of behavioral health case files demonstrated evidence that if the individual was unemployed at intake, the individual's interest in finding employment was explored. In 106 behavioral health case files, the individual was employed at the time of intake or employment was not relevant to the individual's situation.

- 45.5 percent of behavioral health case files demonstrated evidence that if the individual was not participating in an educational or vocational training program at intake, the individual's interest in participating in such a program was explored. In 101 case files, the individual was involved in education or vocational training at the time of intake or it was not relevant to the individual's situation.

- 34.1 percent of behavioral health case files demonstrated evidence that if the individual was not involved with a meaningful community activity at intake, the individual's interest in becoming involved in such a program was explored. In 117 case files, the individual was involved in a community activity at the time of intake or it was not relevant to the individual's situation.

- 98.5 percent of behavioral health case files contained evidence that substance abuse services were provided.

Measure V—Gender Specific (female only)

- 75.0 percent of the sampled behavioral health case files contained a completed safety plan in cases where there was a history of domestic violence. Thirty behavioral health case files contained no documentation of domestic violence issues.

- 100.0 percent of the behavioral health case files of pregnant females demonstrated coordination of care with the primary care physician and/or obstetrician.

- Education on the effects of substance abuse on fetal development was documented in 33.3 percent of the behavioral health case files of pregnant females. In 35 behavioral health files, the individual was not pregnant.
- Child care for dependent children was addressed in 16.7 percent of the behavioral health case files.
- Evidence of gender-specific treatment services was found in 43.2 percent of behavioral health case files. In one of the behavioral health case files, documentation demonstrated evidence that the individual declined gender-specific treatment services.

Measure VI—Opioid Specific

- 34.5 percent of the behavioral health case files contained documentation of a diagnosed OUD.
- In 40.6 percent of the behavioral health case files of members diagnosed with OUD, MAT education was presented as a treatment option.
- 96.4 percent of members who accepted MAT as a treatment option were referred to a MAT provider.
- 85.0 percent of members with withdrawal symptoms were provided a referral and/or intervention with a medical provider.
- 20.3 percent of members with a diagnosis of OUD were provided information related to overdose, Naloxone education, and actions to take in the event of an opioid overdose.
- 42.0 percent of members who were diagnosed with an OUD received education on the effects of polysubstance use with opioids.

Measure VII—Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services)

- 61.5 percent of the sampled behavioral health case files contained evidence that a relapse prevention plan was completed.
- 73.7 percent of behavioral health case files contained documentation that the individual received information pertaining to community supports and other individualized supports.
- 66.1 percent of the behavioral health case files contained evidence of active coordination of care with other involved agencies. In 32 cases, there were no other agencies involved.

Measure VIII—Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services)

- 77.6 percent of the sampled behavioral health case files contained evidence that telephone outreach was conducted at times when the individual was expected to be available.
- 73.4 percent of behavioral health case files contained evidence that a letter requesting contact was mailed to the individuals who were not reachable by telephone. In 42 cases, a letter was not mailed as the individual was contacted by other means.

- Other types of outreach conducted to re-engage individuals in treatment included conducting a home visit, documented in 13.1 percent of behavioral health case files; contacting other involved agencies, evident in 50.0 percent of behavioral health case files; calling the emergency contact, documented in 13.0 percent of behavioral health case files; and street outreach, documented in 2.6 percent of behavioral health case files. The reviewer could select more than one response to this question.

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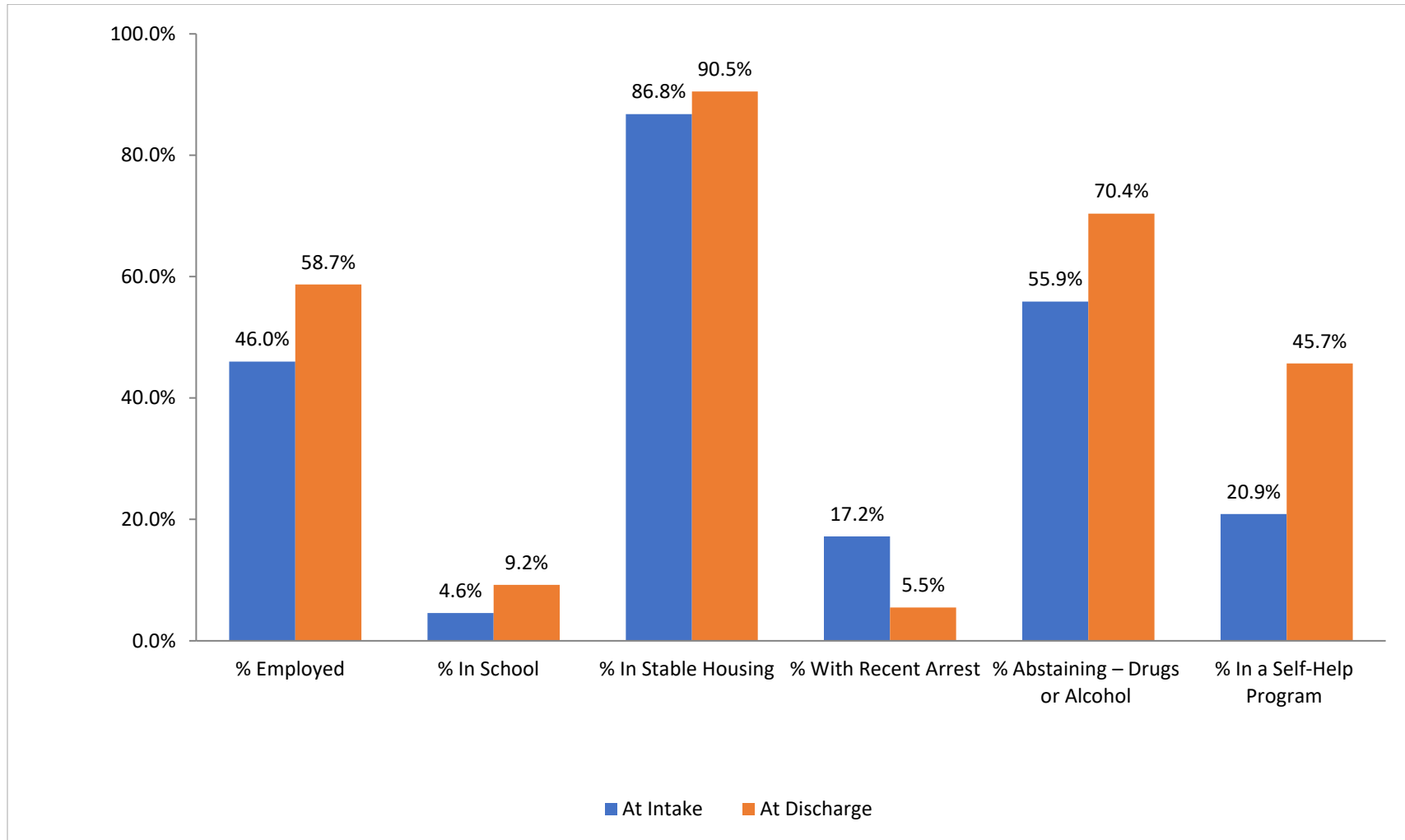
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Table 2-2 and Figure 2-1 illustrate the aggregate case file review findings pertaining to Measure IX, the National Outcome Measures (NOMs). This table displays the number of "Yes" and the percentage of "Yes" responses for the corresponding NOMs, both at intake and at discharge. Measure D, which measures the individual's arrest history 30 days prior to both intake and discharge, is a reverse measure. Therefore, a lower number of "Yes" responses constitutes a more favorable outcome.

Table 2-2—Aggregate Case File Review Findings for Measure IX
National Outcome Measures

National Outcome Measures	At Intake			At Discharge		
	Denominator	# of Yes	% of Yes	Denominator	# of Yes	% of Yes
A. Employed?	198	91	46.0%	167	98	58.7%
B. Enrolled in school or vocational educational program?	196	9	4.6%	163	15	9.2%
C. Lived in a stable housing environment? (not homeless)	197	171	86.8%	168	152	90.5%
D. Arrested 30 days prior?	192	33	17.2%	163	9	5.5%
E. Abstinent from drugs and/or alcohol?	195	109	55.9%	152	107	70.4%
F. Participated in social support recovery 30 days prior?	163	34	20.9%	140	64	45.7%

Note: Documentation was missing for a limited number of members regarding whether or not selected NOM indicators were completed at program intake.

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**Figure 2-1—Distribution of Measure IX
National Outcome Measures: Aggregate**

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Cenpatico Integrated Care (CIC)

Table 3-1 represents the aggregate case file review findings for the CIC sampled behavioral health case files.

Due to the denominator sizes of the individual indicators, caution should be used when interpreting the results.

Differences in the number of indicators evaluated were due to some responses not being applicable to all sampled individuals. Questions II.A.1, III.A.1, III.B.1, IV.A, IV.C, IV.D, and VIII.C (other) were for informational purposes and were therefore excluded from scoring. The CIC results for Measure IX are presented in Table 3-2 and Figure 3-1.

For indicator III.A, "Best Practices": Note that the denominator for indicator III.A includes 8 cases with therapy progress notes, but the documentation was not sufficient to determine if evidence-based practices were used.

Table 3-1—Substance Abuse Prevention and Treatment—Cenpatico Integrated Care

		DENOMINATOR	# of YES	% of YES	# of NA
	Care Case File Review Findings for Measures I–VIII—CIC				
I	Intake/Treatment Planning				
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	64	55	85.9%	2
	Did the behavioral health assessment:				
	1. Address substance-related disorder(s)?	55	55	100.0%	*
	2. Describe the intensity/frequency of substance use?	55	55	100.0%	*
	3. Include the effect of substance use on daily functioning?	55	53	96.4%	*
	4. Include the effect of substance use on interpersonal relationships?	55	51	92.7%	*
	5. Include a completed risk assessment?	55	52	94.5%	*

Care Case File Review Findings for Measures I–VIII—CIC					
		DENOMINATOR	# of YES	% of YES	# of NA
	6. Document screening for tuberculosis (TB), hepatitis C, HIV, and other infectious diseases?	55	33	60.0%	*
	7. Document screening for emotional and/or physical abuse/trauma issues.	55	49	89.1%	*
	B. Was there documentation that charitable choice requirements were followed?	3	2	66.7%	63
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	63	59	93.7%	3
	Was the ISP:				
	1. Developed with participation of the family/support network?	29	8	27.6%	30
	2. Congruent with the diagnosis(es) and presenting concern(s)?	59	57	96.6%	*
	3. Developed with measurable objectives and time frames to address the identified needs?	59	57	96.6%	*
	4. Developed to address the unique cultural preferences of the individual?	59	54	91.5%	*
II	Placement Criteria/Assessment				
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) Dimensions were used to determine the proper level of care at intake?	66	50	75.8%	*
	1. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
	Level 0.5: Early Intervention	50	0	0.0%	*
	OMT: Opioid Maintenance Therapy	50	3	6.0%	*
	Level I: Outpatient Treatment	50	25	50.0%	*
	Level II: Intensive Outpatient Treatment/Partial Hospitalization	50	16	32.0%	*
	Level III: Residential/Inpatient Treatment	50	6	12.0%	*
	Level IV: Medically Managed Intensive Inpatient Treatment	50	0	0.0%	*

		DENOMINATOR	# of YES	% of YES	# of NA
		Care Case File Review Findings for Measures I–VIII—CIC			
	B. Did the individual receive the level of services identified by the placement criteria/assessment?	66	49	74.2%	*
	C. Were the American Society of Addiction Medicine (ASAM) Dimensions revised/updated during the course of treatment?	66	23	34.8%	*
	D. Were additional assessment tools utilized during the course of treatment?	66	8	12.1%	*
III	**Best Practices**				
	A. Were evidence-based practices used in treatment? *Note that the denominator for indicator III.A includes 8 cases with therapy progress notes, but the documentation was not sufficient to determine if evidence-based practices were used.*	66	58	87.9%	*
	1. The following evidence-based practices were used in treatment:				
	Adolescent Community Reinforcement Approach (A-CRA)	58	1	1.7%	*
	Beyond Trauma: A Healing Journey for Women	58	0	0.0%	*
	Cognitive Behavioral Therapy (CBT)	58	25	43.1%	*
	Contingency Management	58	3	5.2%	*
	Dialectal Behavioral Therapy (DBT)	58	4	6.9%	*
	Helping Women Recover	58	3	5.2%	*
	Matrix	58	20	34.5%	*
	Moral Reconation Therapy (MRT)	58	10	17.2%	*
	Motivational Enhancement/Interviewing Therapy (MET/MI)	58	14	24.1%	*
	Relapse Prevention Therapy (RPT)	58	40	69.0%	*
	Seeking Safety	58	10	17.2%	*
	SMART Recovery	58	9	15.5%	*

		DENOMINATOR	# of YES	% of YES	# of NA
	Care Case File Review Findings for Measures I–VIII—CIC				
	Thinking for a Change	58	1	1.7%	*
	Trauma Recovery and Empowerment Model (TREM)	58	0	0.0%	*
	Trauma-Informed Care (TIC)	58	1	1.7%	*
	Wellness Recovery Action Plan (WRAP)	58	9	15.5%	*
	Other	58	2	3.4%	*
	B. Medication-assisted treatment	66	7	10.6%	*
	1. The following medication was used in treatment:				
	• Alcohol-related				
	Acamprosate (Campral)	7	0	0.0%	*
	Disulfiram (Antabuse)	7	0	0.0%	*
	• Opioid-related				
	Buprenorphine/Subutex	7	0	0.0%	*
	Methadone/ Levo-Alpha-Acetylmethadol (LAAM)	7	7	100.0%	*
	Naloxone	7	0	0.0%	*
	Naltrexone; long-acting injectable (Vivitrol)	7	0	0.0%	*
	Suboxone	7	1	14.3%	*
	C. Was screening for substance use/abuse conducted during the course of treatment?	66	35	53.0%	*
	D. Were peer support services offered as part of the treatment continuum?	58	34	58.6%	8
	E. Were peer support services used as part of the treatment continuum?	34	27	79.4%	*
IV	**Treatment/Support Services/Rehabilitation Services**				
	A. The following services were used in treatment:				
	Individual counseling/therapy	66	47	71.2%	*
	Group counseling/therapy	66	55	83.3%	*
	Family counseling/therapy	66	1	1.5%	*
	Case management	66	55	83.3%	*
	B. Was there evidence of progress or lack of progress toward the identified ISP goals?	64	61	95.3%	2

Care Case File Review Findings for Measures I–VIII—CIC					
		DENOMINATOR	**# of YES**	**% of YES**	**# of NA**
C. The number of completed counseling/therapy sessions during treatment was:					
	0–5 sessions	66	15	22.7%	*
	6–10 sessions	66	20	30.3%	*
	11 sessions or more	66	31	47.0%	*
D. Documentation showed that the individual reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:					
	No documentation	66	32	48.5%	*
	0 times during treatment	66	8	12.1%	*
	1–4 times during treatment	66	5	7.6%	*
	5–12 times during treatment	66	2	3.0%	*
	13–20 times during treatment	66	9	13.6%	*
	21 or more times during treatment	66	10	15.2%	*
	E. If there was evidence of lack of progress toward the identified goal, did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	18	12	66.7%	48
	F. If the individual was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	28	25	89.3%	38
	G. If the individual was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	32	24	75.0%	34
	H. If the individual was not involved with a meaningful community activity (volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	27	14	51.9%	39
	I. Does the documentation reflect that substance abuse services were provided?	66	66	100.0%	*

Care Case File Review Findings for Measures I–VIII—CIC					
		DENOMINATOR	**# of YES**	**% of YES**	**# of NA**
V	**Gender Specific (female only)**				
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	2	1	50.0%	13
	B. If the female was pregnant, was there documentation of coordination of care efforts with the primary care physician and/or obstetrician?	1	1	100.0%	14
	C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	1	0	0.0%	14
	D. If the female had a child less than 1 year of age, was there evidence that screening was completed for postpartum depression/psychosis?	0	0	---	15
	E. If the female had dependent children, was there documentation to show that child care was addressed?	4	1	25.0%	11
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	15	6	40.0%	0
VI	**Opioid Specific**				
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	66	19	28.8%	*
	B. Was there documentation that the member was provided Medication-Assisted Treatment (MAT) education as a treatment option?	19	8	42.1%	*
	C. If yes to VI B, were they referred to a MAT provider?	8	7	87.5%	11
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	4	3	75.0%	15
	E. If a physical health concern was identified, were alternative pain management options addressed?	3	2	66.7%	16

Care Case File Review Findings for Measures I–VIII—CIC					
		DENOMINATOR	# of YES	% of YES	# of NA
	F. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or Buprenorphine during the course of pregnancy?	0	0	---	19
	G. Was there documentation that the member was provided with relevant information related to overdose, Naloxone education, and actions to take in the event of an opioid overdose?	19	3	15.8%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	19	6	31.6%	*
VII	**Discharge and Continuing Care Planning** **(completed only if individual completed treatment or declined further services)**				
	A. Was there documentation present that a relapse prevention plan was completed?	55	32	58.2%	*
	B. Was there documentation that staff provided resources pertaining to community supports, including recovery self-help and/or other individualized support services?	55	36	65.5%	*
	C. Was there documentation that staff activity coordinated with other involved agencies at the time of discharge?	46	29	63.0%	9
VIII	**Re-engagement** **(completed only if individual declined further services or chose not to appear for scheduled services)**				
	The following efforts were documented:				
	A. Was the individual (or legal guardian if applicable) contacted by telephone at times when the individual was expected to be available (e.g., after work or school)?	36	21	58.3%	*
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	17	9	52.9%	18

Care Case File Review Findings for Measures I–VIII—CIC				
	DENOMINATOR	# of YES	% of YES	# of NA
C. Were other attempts made to re-engage the individual, such as:				
Home visit	19	5	26.3%	16
Call emergency contact(s)	16	1	6.3%	19
Contacting other involved agencies	24	10	41.7%	11
Street outreach	14	1	7.1%	21
Other	14	0	0.0%	21

Note: An asterisk (*) represents a standard for which the "NA" response was not an option.

Measure I—Intake/Treatment Planning

Initial Behavioral Health Assessment

- 85.9 percent of the sampled behavioral health case files contained evidence that a behavioral health assessment was completed within the required time frame of 45 days from the individual's initial appointment. In two cases there was no comprehensive assessment, and the cases closed prior to 45 days from the initial appointment.
- The performance scores for the indicators pertaining to the required components of an initial behavioral health assessment (I A1–7) ranged from 60.0 percent to 100.0 percent.
- 60.0 percent of the behavioral health assessments contained documentation of screening for tuberculosis, hepatitis C, HIV, and other infectious diseases.
- 100.0 percent of the sampled behavioral health assessments addressed the substance-related disorder(s). 100.0 percent of the behavioral health assessments described the intensity/frequency of substance use.

Individual Service Plan (ISP)

- 93.7 percent of the sampled behavioral health case files contained evidence that an ISP was completed within the required time frame of 90 days from the individual's initial appointment. Three cases had no ISP and closed prior to 90 days from the initial appointment.
- 96.6 percent of the behavioral health case files contained evidence that the ISP was congruent with the individual's diagnosis(es) and presenting concern(s).
- 27.6 percent of the behavioral health case files contained evidence that the ISP was developed with the participation of the family/support network. In 30 cases, there was no family/support network or the individual declined inclusion of others in the service planning process.

Measure II—Placement Criteria/Assessment

- 75.8 percent of the sampled behavioral health case files contained evidence that the ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service.

- 74.2 percent of behavioral health case files contained evidence that the individual received the level of services identified by the placement criteria/assessment.
- 34.8 percent of the sampled behavioral health case files contained evidence that the ASAM Patient Placement Criteria were revised/updated during treatment. In 12.1 percent of the sampled behavioral health case files, additional assessment tools were used during treatment.

Measure III—Best Practices

- 87.9 percent of sampled behavioral health behavioral health case files contained documentation that evidence-based practices were used in treatment. Eight behavioral health case files lacked sufficient documentation to determine if evidence-based practices were used. RPT was used in 69.0 percent of the sampled behavioral health case files. The reviewers could select more than one response for Question III.A.1.
- MAT was documented in 10.6 percent of the behavioral health case files. The seven individuals who received MAT were prescribed methadone/ LAAM. One individual was treated with Suboxone.
- 53.0 percent of sampled behavioral health case files contained documentation that screening for substance use/abuse was conducted during the course of treatment.
- 58.6 percent of sampled behavioral health case files contained evidence that peer support was offered as treatment. Eight behavioral health case files contained documentation that peer support was declined by the individual. Of the 34 individuals who were offered peer support services, 79.4 percent used the service.

Measure IV—Treatment/Support Services/Rehabilitation Services

- Documentation in the sampled behavioral health case files contained evidence that 83.3 percent of individuals received case management services, 83.3 percent received group counseling/therapy, 71.2 percent received individual counseling/therapy, and 1.5 percent received family counseling/therapy. The reviewers could select more than one response to this question.
- 95.3 percent of behavioral health case files contained documentation of progress or lack of progress toward the identified ISP goals. Two records had no ISP present or contained documentation that services were recent and there was no change in progress.
- 47.0 percent of the behavioral health case files contained evidence that individuals completed 11 or more counseling/therapy sessions during treatment, 30.3 percent completed six to 10 sessions, and 22.7 percent completed zero to five sessions.
- 48.5 percent of behavioral health case files did not contain documentation of the number of self-help or recovery group sessions completed during treatment.
- If there was evidence of lack of progress toward the identified goal, in 66.7 percent of the sampled behavioral health case files, there was documentation that the provider revised the treatment approach and/or sought consultation to facilitate improvement.
- 89.3 percent of records demonstrated evidence that if the individual was unemployed at intake, the individual's interest in finding employment was explored.

- 75.0 percent of behavioral health case files demonstrated evidence that if the individual was not participating in an educational or vocational training program at intake, the individual's interest in participating in such a program was explored.
- 51.9 percent of behavioral health case files demonstrated evidence that if the individual was not involved with a meaningful community activity at intake, the individual's interest in becoming involved in such a program was explored.
- 100.0 percent of behavioral health case files contained evidence that substance abuse services were provided.

Measure V—Gender Specific (female only)

- 50.0 percent of the sampled behavioral health case files contained a completed safety plan in cases where there was a history of domestic violence.
- 100.0 percent of the behavioral health case files of pregnant females demonstrated coordination of care with the primary care physician and/or obstetrician.
- 25 percent of the behavioral health case files of females with dependent children had documentation indicating child care was addressed.
- Evidence of gender-specific treatment services was found in 40.0 percent of behavioral health case files.

Measure VI—Opioid Specific

- 28.8 percent of the behavioral health case files contained documentation of a diagnosed OUD.
- In 42.1 percent of the behavioral health case files of members diagnosed with OUD, MAT education was presented as a treatment option.
- 87.5 percent of members who accepted MAT as a treatment option were referred to a MAT provider.
- 75.0 percent of members with withdrawal symptoms were provided a referral and/or intervention with a medical provider.
- 15.8 percent of members with a diagnosis of OUD were provided information related to overdose, Naloxone education, and actions to take in the event of an opioid overdose.
- 31.6 percent of members who were diagnosed with OUD received education on the effects of polysubstance use with opioids.

Measure VII—Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services)

- 58.2 percent of the sampled behavioral health case files contained evidence that a relapse prevention plan was completed.
- 65.5 percent of behavioral health case files contained documentation that the individual received information pertaining to community supports and other individualized supports.

- 63.0 percent of the behavioral health case files contained evidence of active coordination of care with other involved agencies.

Measure VIII—Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services)

- 58.3 percent of the sampled behavioral health case files contained evidence that telephone outreach was conducted at times when the individual was expected to be available.

- 52.9 percent of behavioral health case files contained evidence that a letter requesting contact was mailed to the individuals who were not reachable by telephone. In 18 cases, a letter was not mailed as the individual was contacted by other means.

- Other types of outreach conducted to re-engage individuals in treatment included conducting a home visit, documented in 26.3 percent of behavioral health case files; contacting other involved agencies, evident in 41.7 percent of behavioral health case files; calling the emergency contact, documented in 6.3 percent of behavioral health case files; and street outreach, documented in 7.1 percent of behavioral health case files. The reviewer could select more than one response to this question.

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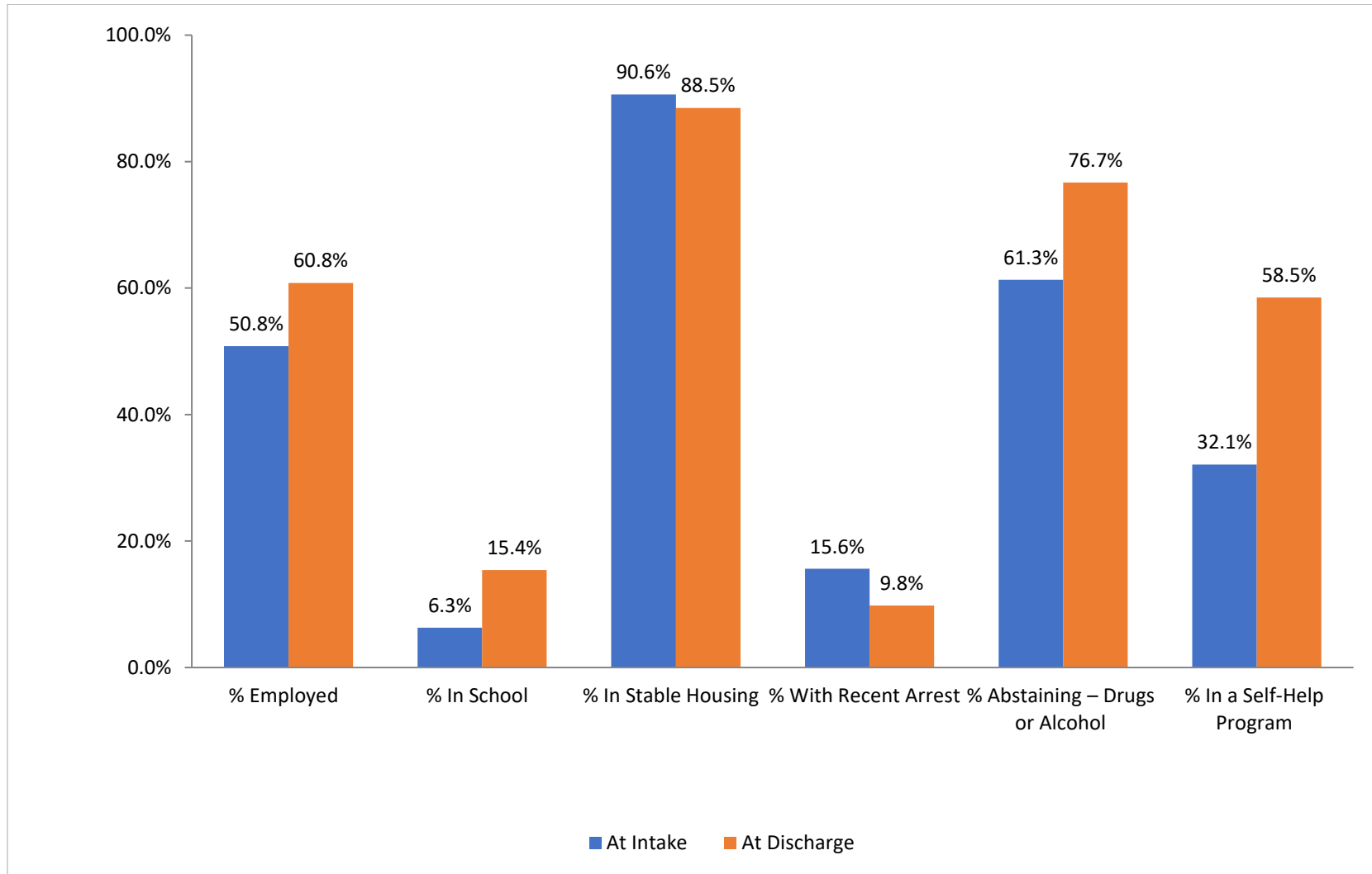
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Table 3-2 and Figure 3-1 illustrate the CIC case file review findings pertaining to Measure IX (NOMs). This table displays the number of "Yes" and the percentage of "Yes" responses for the corresponding NOMs, both at intake and at discharge. Measure D, which measures the individual's arrest history 30 days prior to both intake and discharge, is a reverse measure. Therefore, a lower number of "Yes" responses constitutes a more favorable outcome.

Table 3-2—Cenpatico Integrated Care Case File Review Findings for Measure IX
National Outcome Measures

National Outcome Measures	At Intake			At Discharge		
	Denominator	# of Yes	% of Yes	Denominator	# of Yes	% of Yes
A. Employed?	65	33	50.8%	51	31	60.8%
B. Enrolled in school or vocational educational program?	64	4	6.3%	52	8	15.4%
C. Lived in a stable housing environment? (not homeless)	64	58	90.6%	52	46	88.5%
D. Arrested 30 days prior?	64	10	15.6%	51	5	9.8%
E. Abstinent from drugs and/or alcohol?	62	38	61.3%	43	33	76.7%
F. Participated in social support recovery 30 days prior?	53	17	32.1%	41	24	58.5%

Note: Documentation was missing for up to 13 members regarding whether or not selected NOM indicators were completed at program intake.

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Figure 3-1—Distribution of Measure IX
National Outcome Measures: Cenpatico Integrated Care

Health Choice Integrated Care (HCIC)

Table 3-3 represents the aggregate case file review findings for the HCIC sampled behavioral health records.

Due to the denominator sizes of the individual indicators, caution should be used when interpreting the results.

Differences in the number of indicators evaluated were due to some responses not being applicable to all sampled individuals. Questions II.A.1, III.A.1, III.B.1, IV.A, IV.C, IV.D, and VIII.C (other) were for informational purposes and were therefore excluded from scoring. The HCIC results for Measure IX are presented in Table 3-4 and Figure 3-2.

For indicator III.A, "Best Practices": Note that the denominator for indicator III.A includes 3 cases with therapy progress notes, but the documentation was not sufficient to determine if evidence-based practices were used.

Table 3-3—Substance Abuse Prevention and Treatment—Health Choice Integrated Care

		DENOMINATOR	# of YES	% of YES	# of NA
Case File Review Findings for Measures I–VIII—HCIC					
I	**Intake/Treatment Planning**				
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	40	35	87.5%	0
	Did the behavioral health assessment:				
	1. Address substance-related disorder(s)?	35	35	100.0%	*
	2. Describe the intensity/frequency of substance use?	35	33	94.3%	*
	3. Include the effect of substance use on daily functioning?	35	29	82.9%	*
	4. Include the effect of substance use on interpersonal relationships?	35	29	82.9%	*
	5. Include a completed risk assessment?	35	32	91.4%	*
	6. Document screening for tuberculosis (TB), hepatitis C, HIV, and other infectious diseases?	35	18	51.4%	*

Case File Review Findings for Measures I–VIII—HCIC					
		DENOMINATOR	# of YES	% of YES	# of NA
	7. Document screening for emotional and/or physical abuse/trauma issues.	35	29	82.9%	*
	B. Was there documentation that charitable choice requirements were followed?	1	1	100.0%	39
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	40	39	97.5%	0
	Was the ISP:				
	1. Developed with participation of the family/support network?	22	4	18.2%	17
	2. Congruent with the diagnosis(es) and presenting concern(s)?	39	39	100.0%	*
	3. Developed with measurable objectives and time frames to address the identified needs?	39	37	94.9%	*
	4. Developed to address the unique cultural preferences of the individual?	39	33	84.6%	*
II	**Placement Criteria/Assessment**				
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) Dimensions were used to determine the proper level of care at intake?	40	35	87.5%	*
	1. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
	Level 0.5: Early Intervention	35	0	0.0%	*
	OMT: Opioid Maintenance Therapy	35	2	5.7%	*
	Level I: Outpatient Treatment	35	24	68.6%	*
	Level II: Intensive Outpatient Treatment/Partial Hospitalization	35	6	17.1%	*
	Level III: Residential/Inpatient Treatment	35	3	8.6%	*
	Level IV: Medically Managed Intensive Inpatient Treatment	35	0	0.0%	*
	B. Did the individual receive the level of services identified by the placement criteria/assessment?	40	35	87.5%	*

	Case File Review Findings for Measures I–VIII—HCIC				
		DENOMINATOR	**# of YES**	**% of YES**	**# of NA**
	C. Were the American Society of Addiction Medicine (ASAM) Dimensions revised/updated during the course of treatment?	40	18	45.0%	*
	D. Were additional assessment tools utilized during the course of treatment?	40	5	12.5%	*
III	**Best Practice**				
	A. Were evidence-based practices used in treatment? *Note that the denominator for indicator III.A includes 3 cases with therapy progress notes, but the documentation was not sufficient to determine if evidence-based practices were used.*	40	37	92.5%	*
	1. The following evidence-based practices were used in treatment:				
	Adolescent Community Reinforcement Approach (A-CRA)	37	0	0.0%	*
	Beyond Trauma: A Healing Journey for Women	37	0	0.0%	*
	Cognitive Behavioral Therapy (CBT)	37	15	40.5%	*
	Contingency management	37	3	8.1%	*
	Dialectal Behavioral Therapy (DBT)	37	0	0.0%	*
	Helping Women Recover	37	1	2.7%	*
	Matrix	37	16	43.2%	*
	Moral Reconation Therapy (MRT)	37	0	0.0%	*
	Motivational Enhancement/Interviewing Therapy (MET/MI)	37	13	35.1%	*
	Relapse Prevention Therapy (RPT)	37	14	37.8%	*
	Seeking Safety	37	5	13.5%	*
	SMART Recovery	37	2	5.4%	*
	Thinking for a Change	37	0	0.0%	*
	Trauma Recovery and Empowerment Model (TREM)	37	0	0.0%	*
	Trauma-Informed Care (TIC)	37	0	0.0%	*

Case File Review Findings for Measures I–VIII—HCIC				
		DENOMINATOR	# of YES	% of YES	# of NA
	Wellness Recovery Action Plan (WRAP)	37	0	0.0%	*
	Other	37	0	0.0%	*
	B. Medication-assisted treatment	40	4	10.0%	*
1. The following medication was used in treatment:					
	• Alcohol-related				
	Acamprosate (Campral)	4	0	0.0%	*
	Disulfiram (Antabuse)	4	0	0.0%	*
	• Opioid-related				
	Buprenorphine/Subutex	4	0	0.0%	*
	Methadone/ Levo-Alpha-Acetylmethadol (LAAM)	4	3	75.0%	*
	Naloxone	4	1	25.0%	*
	Naltrexone; long-acting injectable (Vivitrol)	4	1	25.0%	*
	Suboxone	4	1	25.0%	*
	C. Was screening for substance use/abuse conducted during the course of treatment?	40	11	27.5%	*
	D. Were peer support services offered as part of the treatment continuum?	33	9	27.3%	7
	E. Were peer support services used as part of the treatment continuum?	9	4	44.4%	*
IV	Treatment/Support Services/Rehabilitation Services				
A. The following services were used in treatment:					
	Individual counseling/therapy	40	31	77.5%	*
	Group counseling/therapy	40	33	82.5%	*
	Family counseling/therapy	40	1	2.5%	*
	Case management	40	35	87.5%	*
	B. Was there evidence of progress or lack of progress toward the identified ISP goals?	39	34	87.2%	1
C. The number of completed counseling/therapy sessions during treatment was:					
	0–5 sessions	40	11	27.5%	*
	6–10 sessions	40	5	12.5%	*
	11 sessions or more	40	24	60.0%	*

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Case File Review Findings for Measures I–VIII—HCIC					
		DENOMINATOR	# of YES	% of YES	# of NA
	D. Documentation showed that the individual reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	No documentation	40	31	77.5%	*
	0 times during treatment	40	3	7.5%	*
	1–4 times during treatment	40	2	5.0%	*
	5–12 times during treatment	40	0	0.0%	*
	13–20 times during treatment	40	1	2.5%	*
	21 or more times during treatment	40	3	7.5%	*
	E. If there was evidence of lack of progress toward the identified goal, did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	10	8	80.0%	30
	F. If the individual was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	12	7	58.3%	28
	G. If the individual was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	16	9	56.3%	24
	H. If the individual was not involved with a meaningful community activity (volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	9	1	11.1%	31
	I. Does the documentation reflect that substance abuse services were provided?	40	39	97.5%	*
V	Gender Specific (female only)				
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	2	1	50.0%	1

Case File Review Findings for Measures I–VIII—HCIC					
		DENOMINATOR	# of YES	% of YES	# of NA
	B. If the female was pregnant, was there documentation of coordination of care efforts with the primary care physician and/or obstetrician?	0	0	---	3
	C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	0	0	---	3
	D. If the female had a child less than 1 year of age, was there evidence that screening was completed for postpartum depression/psychosis?	0	0	---	3
	E. If the female had dependent children, was there documentation to show that child care was addressed?	0	0	---	3
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	2	1	50.0%	1
VI	**Opioid Specific**				
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	40	9	22.5%	*
	B. Was there documentation that the member was provided Medication-Assisted Treatment (MAT) education as a treatment option?	9	4	44.4%	*
	C. If yes to VI B, were they referred to a MAT provider?	4	4	100.0%	5
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	2	2	100.0%	7
	E. If a physical health concern was identified, were alternative pain management options addressed?	0	0	---	9
	F. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or Buprenorphine during the course of pregnancy?	0	0	---	9

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Case File Review Findings for Measures I–VIII—HCIC					
		DENOMINATOR	# of YES	% of YES	# of NA
	G. Was there documentation that the member was provided with relevant information related to overdose, Naloxone education, and actions to take in the event of an opioid overdose?	9	4	44.4%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	9	4	44.4%	*
VII	**Discharge and Continuing Care Planning (completed only if individual completed treatment or declined further services)**				
	A. Was there documentation present that a relapse prevention plan was completed?	39	15	38.5%	*
	B. Was there documentation that staff provided resources pertaining to community supports, including recovery self-help and/or other individualized support services?	39	23	59.0%	*
	C. Was there documentation that staff activity coordinated with other involved agencies at the time of discharge?	26	16	61.5%	13
VIII	**Re-engagement (completed only if individual declined further services or chose not to appear for scheduled services)**				
	The following efforts were documented:				
	A. Was the individual (or legal guardian if applicable) contacted by telephone at times when the individual was expected to be available (e.g., after work or school)?	13	10	76.9%	*
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	4	3	75.0%	9
	C. Were other attempts made to re-engage the individual, such as:				
	Home visit	4	1	25.0%	9
	Call emergency contact(s)	4	1	25.0%	8
	Contacting other involved agencies	5	4	80.0%	8
	Street outreach	2	0	0.0%	11
	Other	3	1	33.3%	9

Note: An asterisk (*) represents a standard for which the "NA" response was not an option.

Measure I—Intake/Treatment Planning

Initial Behavioral Health Assessment

- 87.5 percent of the sampled behavioral health case files contained evidence that a behavioral health assessment was completed within the required time frame of 45 days from the individual's initial appointment.
- The performance scores for the indicators pertaining to the required components of an initial behavioral health assessment (I A.1–7) ranged from 51.4 percent to 100.0 percent.
- 51.4 percent of the behavioral health assessments contained documentation of screening for tuberculosis, hepatitis C, HIV, and other infectious diseases.
- 100.0 percent of the sampled behavioral health case files addressed the substance-related disorder(s).

Individual Service Plan (ISP)

- 97.5 percent of the sampled behavioral health case files contained evidence that an ISP was completed within the required time frame of 90 days from the individual's initial appointment.
- 100.0 percent of the behavioral health case files contained evidence that the ISP was congruent with the individual's diagnosis(es) and presenting concern(s).
- 18.2 percent of the behavioral health case files contained evidence that the ISP was developed with the participation of the family/support network. In 17 cases, there was no family/support network or the individual declined inclusion of others in the service planning process.

Measure II—Placement Criteria/Assessment

- 87.5 percent of the sampled behavioral health case files contained evidence that the ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service.
- 87.5 percent of behavioral health case files contained evidence that the individual received the level of services identified by the placement criteria/assessment.
- 45.0 percent of the sampled behavioral health case files contained evidence that the ASAM Patient Placement Criteria were revised/updated during treatment.
- In 12.5 percent of the sampled behavioral health case files, additional assessment tools were used during the course of treatment.

Measure III—Best Practice

- 92.5 percent of sampled behavioral health case files contained documentation that evidence-based practices were used in treatment. Three behavioral health records lacked sufficient documentation to determine if evidence-based practices were used. The Matrix Model was used in 43.2 percent of the sampled behavioral health case files. The reviewers could select more than one response for Question III.A.1.
- MAT was documented in 10.0 percent of the behavioral health case files. 27.5 percent of sampled behavioral health records contained evidence that screening for substance use/abuse was conducted during treatment.

- 27.3 percent of sampled behavioral health case files contained evidence that peer support was offered as treatment. Seven behavioral health case files contained documentation that peer support was declined by the individual. Of the nine individuals who were offered peer support services, 44.4 percent used the service.

Measure IV—Treatment/Support Services/Rehabilitation Services

- Documentation in the sampled behavioral health records contained evidence that 87.5 percent of individuals received case management services, 82.5 percent received group counseling/therapy, 77.5 percent received individual counseling/therapy, and 2.5 percent received family counseling/therapy. The reviewers could select more than one response to this question.
- 87.2 percent of behavioral health case files contained documentation of progress or lack of progress toward the identified ISP goals. One record had no ISP present or contained documentation that services were recent and there was no change in progress.
- 60.0 percent of the behavioral health case files contained evidence that individuals completed 11 or more counseling/therapy sessions during treatment, 12.5 percent completed six to 10 sessions, and 27.5 percent completed zero to five sessions.
- 77.5 percent of behavioral health case files did not contain documentation of the number of self-help or recovery group sessions completed during the course of treatment.
- If there was evidence of lack of progress toward the identified goal, in 80.0 percent of the sampled behavioral health case files, there was documentation that the provider revised the treatment approach and/or sought consultation to facilitate improvement. In 30 cases, symptomatic improvement was documented in the behavioral health case file.
- If the individual was unemployed at intake, 58.3 percent of behavioral health case files demonstrated evidence that the individual's interest in finding employment was explored. Twenty-eight of the individuals were employed at intake or employment was not relevant to the individual's situation.
- 56.3 percent of behavioral health case files demonstrated evidence that if the individual was not participating in an educational or vocational training program, the individual's interest in participating in such a program was explored. Twenty-four individuals were involved in an educational or vocational training program at the time of intake or it was not relevant to the individual's situation (e.g., the individual was employed).
- 11.1 percent of the behavioral health case files demonstrated evidence that if the individual was not involved with a meaningful community activity, the individual's interest in such an activity was explored. Community activity was not relevant for 31 individuals (e.g., they were employed or engaged in a vocational program).
- 97.5 percent of the behavioral health case files contained evidence that substance abuse services were provided.

Measure V—Gender Specific (female only)

- 50.0 percent of the sampled behavioral health records contained a completed safety plan in cases where there was a history of domestic violence. In one case there were no domestic violence issues.

- There were no pregnant women in the sampled behavioral health cases.
- Evidence of gender-specific treatment services was found in two behavioral health case files. One of the two individuals declined the gender-specific services.

Measure VI—Opioid Specific

- 22.5 percent of the behavioral health case files contained documentation of a diagnosed OUD.
- In 44.4 percent of the behavioral health case files of members diagnosed with OUD, MAT education was presented as a treatment option.
- 100.0 percent of members who accepted MAT as a treatment option were referred to a MAT provider. Five individuals did not have documentation of OUD.
- 100.0 percent of members with withdrawal symptoms were provided a referral and/or intervention with a medical provider. Seven individuals had no documentation of withdrawal symptoms.
- 44.4 percent of members with a diagnosis of OUD were provided information related to overdose, Naloxone education, and actions to take in the event of an opioid overdose.
- 44.4 percent of members who were diagnosed with OUD received education on the effects of polysubstance use with opioids.

Measure VII—Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services)

- 38.5 percent of the sampled behavioral health case files contained evidence that a relapse prevention plan was completed.
- 59.0 percent of behavioral health case files contained documentation that the individual received information pertaining to community supports and other individualized supports.
- 61.5 percent of the behavioral health case files contained evidence of active coordination of care with other involved agencies. Thirteen individuals had no other agencies involved.

Measure VIII—Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services)

- 76.9 percent of the sampled behavioral health case files contained evidence that telephone outreach was conducted at times when the individual was expected to be available.
- 75.0 percent of behavioral health case files contained evidence that a letter requesting contact was mailed to the individuals who were not reachable by telephone. In nine cases, a letter was not mailed as the individual was contacted by other means.
- Other types of outreach conducted to re-engage individuals in treatment included conducting a home visit, documented in 25.0 percent of behavioral health case files; contacting other involved agencies, evident in 80.0 percent of behavioral health case files; and calling the emergency contact, documented in 25.0 percent of behavioral health case files. The reviewer could select more than one response to this question.

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Table 3-4 and Figure 3-2 illustrate the HCIC case file review findings pertaining to Measure IX (NOMs). This table displays the number of "Yes" and the percentage of "Yes" responses for the corresponding NOMs, both at intake and at discharge. Measure D, which measures the individual's arrest history 30 days prior to both intake and discharge, is a reverse measure. Therefore, a lower number of "Yes" responses constitutes a more favorable outcome.

Table 3-4—Health Choice Integrated Care Case File Review Findings for Measure IX
National Outcome Measures

National Outcome Measures	At Intake			At Discharge		
	Denominator	# of Yes	% of Yes	Denominator	# of Yes	% of Yes
A. Employed?	39	25	64.1%	33	27	81.8%
B. Enrolled in school or vocational educational program?	38	1	2.6%	31	1	3.2%
C. Lived in a stable housing environment? (not homeless)	39	38	97.4%	34	32	94.1%
D. Arrested 30 days prior?	36	13	36.1%	33	1	3.0%
E. Abstinent from drugs and/or alcohol?	39	19	48.7%	31	26	83.9%
F. Participated in social support recovery 30 days prior?	28	5	17.9%	21	6	28.6%

Note: Documentation was missing for up to 12 members regarding whether or not selected NOM indicators were completed at program intake.

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Figure 3-2—Distribution of Measure IX
National Outcome Measures: Health Choice Integrated Care

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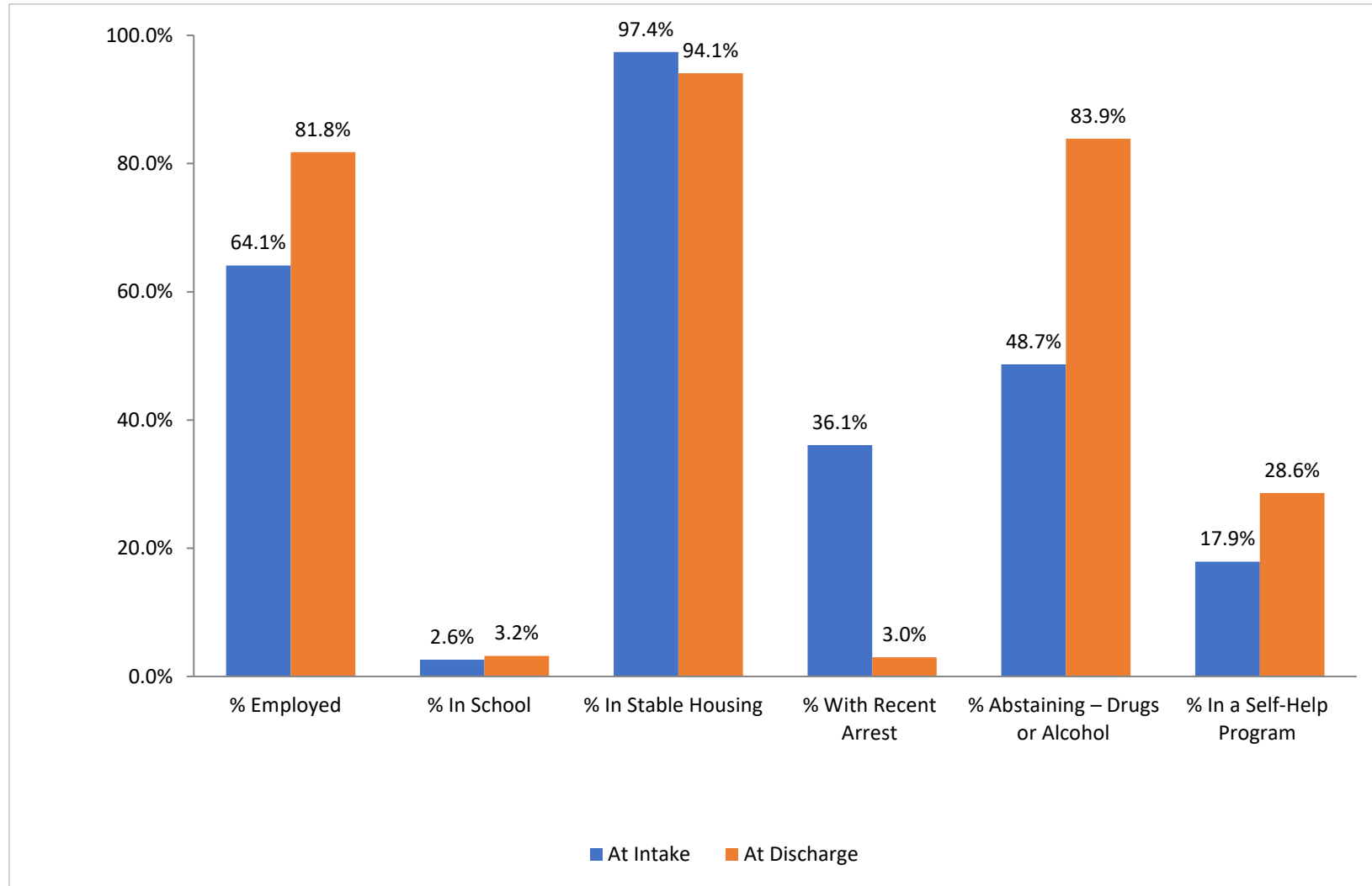
Mercy Maricopa Integrated Care (MMIC)

Table 3-5 represents the aggregate case file review findings for the MMIC sampled behavioral health records.

Due to the denominator sizes of the individual indicators, caution should be used when interpreting the results.

Differences in the number of indicators evaluated were due to some responses not being applicable to all sampled individuals. Questions II.A.1, III.A.1, III.B.1, IV.A, IV.C, IV.D, and VIII.C (other) were for informational purposes and were therefore excluded from scoring. The MMIC results for Measure IX are presented in Table 3-6 and Figure 3-3.

For indicator III.A, "Best Practices": Note that the denominator for indicator III.A includes 12 cases with therapy progress notes, but the documentation was not sufficient to determine if evidence-based practices were used.

Table 3-5—Substance Abuse Prevention and Treatment—Mercy Maricopa Integrated Care

		DENOMINATOR	# of YES	% of YES	# of NA
	**Case File Review Findings for Measures I–VIII—MMIC**				
I	**Intake/Treatment Planning**				
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	94	93	98.9%	0
	Did the behavioral health assessment:				
	1. Address substance-related disorder(s)?	93	93	100.0%	*
	2. Describe the intensity/frequency of substance use?	93	93	100.0%	*
	3. Include the effect of substance use on daily functioning?	93	91	97.8%	*
	4. Include the effect of substance use on interpersonal relationships?	93	87	93.5%	*
	5. Include a completed risk assessment?	93	92	98.9%	*
	6. Document screening for tuberculosis (TB), hepatitis C, HIV, and other infectious diseases?	93	76	81.7%	*

Case File Review Findings for Measures I–VIII—MMIC					
		DENOMINATOR	**# of YES**	**% of YES**	**# of NA**
	7. Document screening for emotional and/or physical abuse/trauma issues.	93	88	94.6%	*
	B. Was there documentation that charitable choice requirements were followed?	0	0	---	94
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	94	93	98.9%	0
	Was the ISP:				
	1. Developed with participation of the family/support network?	32	18	56.3%	61
	2. Congruent with the diagnosis(es) and presenting concern(s)?	93	93	100.0%	*
	3. Developed with measurable objectives and time frames to address the identified needs?	93	92	98.9%	*
	4. Developed to address the unique cultural preferences of the individual?	93	81	87.1%	*
II	**Placement Criteria/Assessment**				
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) Dimensions were used to determine the proper level of care at intake?	94	91	96.8%	*
	1. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
	Level 0.5: Early Intervention	91	0	0.0%	*
	OMT: Opioid Maintenance Therapy	91	1	1.1%	*
	Level I: Outpatient Treatment	91	44	48.4%	*
	Level II: Intensive Outpatient Treatment/Partial Hospitalization	91	16	17.6%	*
	Level III: Residential/Inpatient Treatment	91	30	33.0%	*
	Level IV: Medically Managed Intensive Inpatient Treatment	91	0	0.0%	*
	B. Did the individual receive the level of services identified by the placement criteria/assessment?	94	86	91.5%	*

Case File Review Findings for Measures I–VIII—MMIC					
		DENOMINATOR	**# of YES**	**% of YES**	**# of NA**
	C. Were the American Society of Addiction Medicine (ASAM) Dimensions revised/updated during the course of treatment?	94	57	60.6%	*
	D. Were additional assessment tools utilized during the course of treatment?	94	2	2.1%	*
III	**Best Practices**				
	A. Were evidence-based practices used in treatment? *Note that the denominator for indicator III.A includes 12 cases with therapy progress notes, but the documentation was not sufficient to determine if evidence-based practices were used.*	94	82	87.2%	*
	1. The following evidence-based practices were used in treatment:				
	Adolescent Community Reinforcement Approach (A-CRA)	82	1	1.2%	*
	Beyond Trauma: A Healing Journey for Women	82	1	1.2%	*
	Cognitive Behavioral Therapy (CBT)	82	24	29.3%	*
	Contingency management	82	3	3.7%	*
	Dialectal Behavioral Therapy (DBT)	82	3	3.7%	*
	Helping Women Recover	82	0	0.0%	*
	Matrix	82	19	23.2%	*
	Moral Reconation Therapy (MRT)	82	0	0.0%	*
	Motivational Enhancement/Interviewing Therapy (MET/MI)	82	19	23.2%	*
	Relapse Prevention Therapy (RPT)	82	53	64.6%	*
	Seeking Safety	82	15	18.3%	*
	SMART Recovery	82	5	6.1%	*
	Thinking for a Change	82	3	3.7%	*
	Trauma Recovery and Empowerment Model (TREM)	82	0	0.0%	*

Case File Review Findings for Measures I–VIII—MMIC					
		DENOMINATOR	# of YES	% of YES	# of NA
	Trauma-Informed Care (TIC)	82	0	0.0%	*
	Wellness Recovery Action Plan (WRAP)	82	2	2.4%	*
	Other	82	0	0.0%	*
	B. Medication-assisted treatment	94	15	16.0%	*
	1. The following medication was used in treatment:				
	• Alcohol-related				
	Acamprosate (Campral)	15	0	0.0%	*
	Disulfiram (Antabuse)	15	0	0.0%	*
	• Opioid-related				
	Buprenorphine/Subutex	15	0	0.0%	*
	Methadone/ Levo-Alpha-Acetylmethadol (LAAM)	15	15	100.0%	*
	Naloxone	15	2	13.3%	*
	Naltrexone; long-acting injectable (Vivitrol)	15	0	0.0%	*
	Suboxone	15	0	0.0%	*
	C. Was screening for substance use/abuse conducted during the course of treatment?	94	49	52.1%	*
	D. Were peer support services offered as part of the treatment continuum?	92	25	27.2%	2
	E. Were peer support services used as part of the treatment continuum?	25	25	100.0%	*
IV	**Treatment/Support Services/Rehabilitation Services**				
	A. The following services were used in treatment:				
	Individual counseling/therapy	94	73	77.7%	*
	Group counseling/therapy	94	82	87.2%	*
	Family counseling/therapy	94	1	1.1%	*
	Case management	94	84	89.4%	*
	B. Was there evidence of progress or lack of progress toward the identified ISP goals?	90	86	95.6%	4
	C. The number of completed counseling/therapy sessions during treatment was:				
	0–5 sessions	94	22	23.4%	*
	6–10 sessions	94	20	21.3%	*
	11 sessions or more	94	52	55.3%	*

Case File Review Findings for Measures I–VIII—MMIC					
		DENOMINATOR	# of YES	% of YES	# of NA
	D. Documentation showed that the individual reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	No documentation	94	41	43.6%	*
	0 times during treatment	94	4	4.3%	*
	1–4 times during treatment	94	7	7.4%	*
	5–12 times during treatment	94	4	4.3%	*
	13–20 times during treatment	94	17	18.1%	*
	21 or more times during treatment	94	21	22.3%	*
	E. If there was evidence of lack of progress toward the identified goal, did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	46	30	65.2%	48
	F. If the individual was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	54	34	63.0%	40
	G. If the individual was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	51	12	23.5%	43
	H. If the individual was not involved with a meaningful community activity (volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	46	13	28.3%	47
	I. Does the documentation reflect that substance abuse services were provided?	94	92	97.9%	*
V	**Gender Specific (female only)**				
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	4	4	100.0%	16

Case File Review Findings for Measures I–VIII—MMIC					
		DENOMINATOR	**# of YES**	**% of YES**	**# of NA**
	B. If the female was pregnant, was there documentation of coordination of care efforts with the primary care physician and/or obstetrician?	2	2	100.0%	18
	C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	2	1	50.0%	18
	D. If the female had a child less than 1 year of age, was there evidence that screening was completed for postpartum depression/psychosis?	1	0	0.0%	19
	E. If the female had dependent children, was there documentation to show that child care was addressed?	2	0	0.0%	18
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	20	9	45.0%	0
VI	**Opioid Specific**				
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	94	41	43.6%	*
	B. Was there documentation that the member was provided Medication-Assisted Treatment (MAT) education as a treatment option?	41	16	39.0%	*
	C. If yes to VI B, were they referred to a MAT provider?	16	16	100.0%	25
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	14	12	85.7%	27
	E. If a physical health concern was identified, were alternative pain management options addressed?	7	4	57.1%	34

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Case File Review Findings for Measures I–VIII—MMIC					
		DENOMINATOR	**# of YES**	**% of YES**	**# of NA**
	F. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or Buprenorphine during the course of pregnancy?	0	0	---	41
	G. Was there documentation that the member was provided with relevant information related to overdose, Naloxone education, and actions to take in the event of an opioid overdose?	41	7	17.1%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	41	19	46.3%	*
VII	**Discharge and Continuing Care Planning** **(completed only if individual completed treatment or declined further services)**				
	A. Was there documentation present that a relapse prevention plan was completed?	62	49	79.0%	*
	B. Was there documentation that staff provided resources pertaining to community supports, including recovery self-help and/or other individualized support services?	62	56	90.3%	*
	C. Was there documentation that staff activity coordinated with other involved agencies at the time of discharge?	52	37	71.2%	10
VIII	**Re-engagement** **(completed only if individual declined further services or chose not to appear for scheduled services)**				
	The following efforts were documented:				
	A. Was the individual (or legal guardian if applicable) contacted by telephone at times when the individual was expected to be available (e.g., after work or school)?	58	52	89.7%	*
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	43	35	81.4%	15

Case File Review Findings for Measures I–VIII—MMIC					
		DENOMINATOR	**# of YES**	**% of YES**	**# of NA**
C. Were other attempts made to re-engage the individual, such as:					
	Home visit	38	2	5.3%	20
	Call emergency contact(s)	34	5	14.7%	24
	Contacting other involved agencies	39	20	51.3%	19
	Street outreach	22	0	0.0%	36
	Other	33	1	3.0%	24

Note: An asterisk (*) represents a standard for which the "NA" response was not an option.

Measure I—Intake/Treatment Planning

Initial Behavioral Health Assessment

- 98.9 percent of the sampled behavioral health case files contained evidence that a behavioral health assessment was completed within the required time frame of 45 days from the individual's initial appointment.
- The performance scores for the indicators pertaining to the required components of an initial behavioral health assessment (I A.1–7) ranged from 81.7 percent to 100.0 percent.
- 81.7 percent of the behavioral health assessments contained documentation of screening for tuberculosis, hepatitis C, HIV, and other infectious diseases.
- 100.0 percent of the sampled behavioral health assessments addressed the substance-related disorder(s).
- Charitable choice requirements did not apply in 94 cases.

Individual Service Plan (ISP)

- 98.9 percent of the sampled behavioral health case files contained evidence that an ISP was completed within the required time frame of 90 days from the individual's initial appointment.
- 100.0 percent of the behavioral health case files contained evidence that the ISP was congruent with the individual's diagnosis(es) and presenting concern(s).
- 56.3 percent of the behavioral health case files contained evidence that the ISP was developed with the participation of the family/support network. In 61 cases, there was no family/support network or the individual declined inclusion of others in the service planning process.

Measure II—Placement Criteria/Assessment

- 96.8 percent of the sampled behavioral health case files contained evidence that the ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service.
- 91.5 percent of records contained evidence that the individual received the level of services identified by the placement criteria/assessment.

- 60.6 percent of the sampled behavioral health case files contained evidence that the ASAM Patient Placement Criteria were revised/updated during treatment.
- In 2.1 percent of the sampled behavioral health case files, additional assessment tools were used during the course of treatment.

Measure III—Best Practice

- 87.2 percent of sampled behavioral health case files contained documentation that evidence-based practices were used in treatment. Twelve behavioral health case files lacked sufficient documentation to determine if evidence-based practices were used. RPT was used in 64.6 percent of the sampled behavioral health case files. The reviewers could select more than one response for Question III.A.1.
- MAT was documented in 16.0 percent of the sampled behavioral health case files.
- 52.1 percent of sampled behavioral health case files contained evidence that screening for substance use/abuse was conducted during treatment.
- 27.2 percent of sampled behavioral health case files contained evidence that peer support was offered as treatment. Two behavioral health case files contained documentation that peer support was declined by the individual. Of the remaining 25 individuals who were offered peer support services, 100.0 percent used the services.

Measure IV—Treatment/Support Services/Rehabilitation Services

- Documentation in the sampled behavioral health case files contained evidence that 89.4 percent of individuals received case management services, 87.2 percent received group counseling/therapy, 77.7 percent received individual counseling/therapy, and 1.1 percent received family counseling/therapy. The reviewers could select more than one response to this question.
- 95.6 percent of behavioral health case files contained documentation of progress or lack of progress toward the identified ISP goals. Four behavioral health case files had no ISP present or contained documentation that services were recent and there was no change in progress.
- 55.3 percent of the behavioral health case files records contained evidence that individuals completed 11 or more counseling/therapy sessions during treatment, 21.3 percent completed six to 10 sessions, and 23.4 percent completed zero to five sessions.
- 43.6 percent of behavioral health case files did not contain documentation of the number of self-help or recovery group sessions completed during the course of treatment.
- If there was evidence of lack of progress toward the identified goal, in 65.2 percent of the sampled behavioral health case files, there was documentation that the provider revised the treatment approach and/or sought consultation to facilitate improvement. In 48 cases, symptomatic improvement was documented.
- If the individual was unemployed at intake, 63.0 percent of records demonstrated evidence that the individual's interest in finding employment was explored. Forty of the individuals were employed at intake or employment was not relevant to the individual's situation.

- 23.5 percent of behavioral health case files demonstrated evidence that if the individual was not participating in an educational or vocational training program, the individual's interest in participating in such a program was explored.
- 28.3 percent of the behavioral health case files demonstrated evidence that if the individual was not involved with a meaningful community activity, the individual's interest in such an activity was explored.
- 97.9 percent of the behavioral health case files contained evidence that substance abuse services were provided.

Measure V—Gender Specific (female only)

- 100.0 percent of the sampled behavioral health records contained a completed safety plan in cases where there was a history of domestic violence. In 16 cases, there were no domestic violence issues present.
- 100.0 percent of the records of pregnant females demonstrated coordination of care with the primary care physician and/or obstetrician.
- 50.0 percent of the behavioral health case files contained documentation that the pregnant female received education on the effects of substance use on fetal development.
- Evidence of gender-specific treatment services was found in 45 percent of the behavioral health case files.

Measure VI—Opioid Specific

- 43.6 percent of the behavioral health case files contained documentation of a diagnosed OUD.
- In 39.0 percent of the behavioral health case files of members diagnosed with OUD, MAT education was presented as a treatment option.
- 100.0 percent of members who accepted MAT as a treatment option were referred to a MAT provider.
- 85.7 percent of members with withdrawal symptoms were provided a referral and/or intervention with a medical provider.
- 17.1 percent of members with a diagnosis of OUD were provided information related to overdose, Naloxone education, and actions to take in the event of an opioid overdose.
- 46.3 percent of members who were diagnosed with OUD received education on the effects of polysubstance use with opioids.

Measure VII—Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services)

- 79.0 percent of the sampled behavioral health case files contained evidence that a relapse prevention plan was completed.
- 90.3 percent of behavioral health case files contained documentation that the individual received information pertaining to community supports and other individualized supports.

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- 71.2 percent of the behavioral health case files contained evidence of active coordination of care with other involved agencies.

Measure VIII—Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services)

- 89.7 percent of the sampled behavioral health case files contained evidence that telephone outreach was conducted at times when the individual was expected to be available.

- 81.4 percent of behavioral health case files contained evidence that a letter requesting contact was mailed to the individuals who were not reachable by telephone. In 15 cases, a letter was not mailed as the individual was contacted by other means.

- Other types of outreach conducted to re-engage individuals in treatment included conducting a home visit, documented in 5.3 percent of behavioral health case files; contacting other involved agencies, evident in 51.3 percent of behavioral health case files; and calling the emergency contact, documented in 14.7 percent of behavioral health case files. The reviewer could select more than one response to this question.

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Table 3-6 and Figure 3-3 illustrate the MMIC case file review findings pertaining to Measure IX (NOMs). This table displays the number of "Yes" and the percentage of "Yes" responses for the corresponding NOMs, both at intake and at discharge. Measure D, which measures the individual's arrest history 30 days prior to both intake and discharge, is a reverse measure. Therefore, a lower number of "Yes" responses constitutes a more favorable outcome.

Table 3-6—Mercy Maricopa Integrated Care Case File Review Findings for Measure IX
National Outcome Measures

National Outcome Measures	At Intake			At Discharge		
	Denominator	# of Yes	% of Yes	Denominator	# of Yes	% of Yes
A. Employed?	94	33	35.1%	83	40	48.2%
B. Enrolled in school or vocational educational program?	94	4	4.3%	80	6	7.5%
C. Lived in a stable housing environment? (not homeless)	94	75	79.8%	82	74	90.2%
D. Arrested 30 days prior?	92	10	10.9%	79	3	3.8%
E. Abstinent from drugs and/or alcohol?	94	52	55.3%	78	48	61.5%
F. Participated in social support recovery 30 days prior?	82	12	14.6%	78	34	43.6%

Note: Documentation was missing for up to 12 members regarding whether or not selected NOM indicators were completed at program intake.

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Figure 3-3—Distribution of Measure IX
National Outcome Measures: Mercy Maricopa Integrated Care
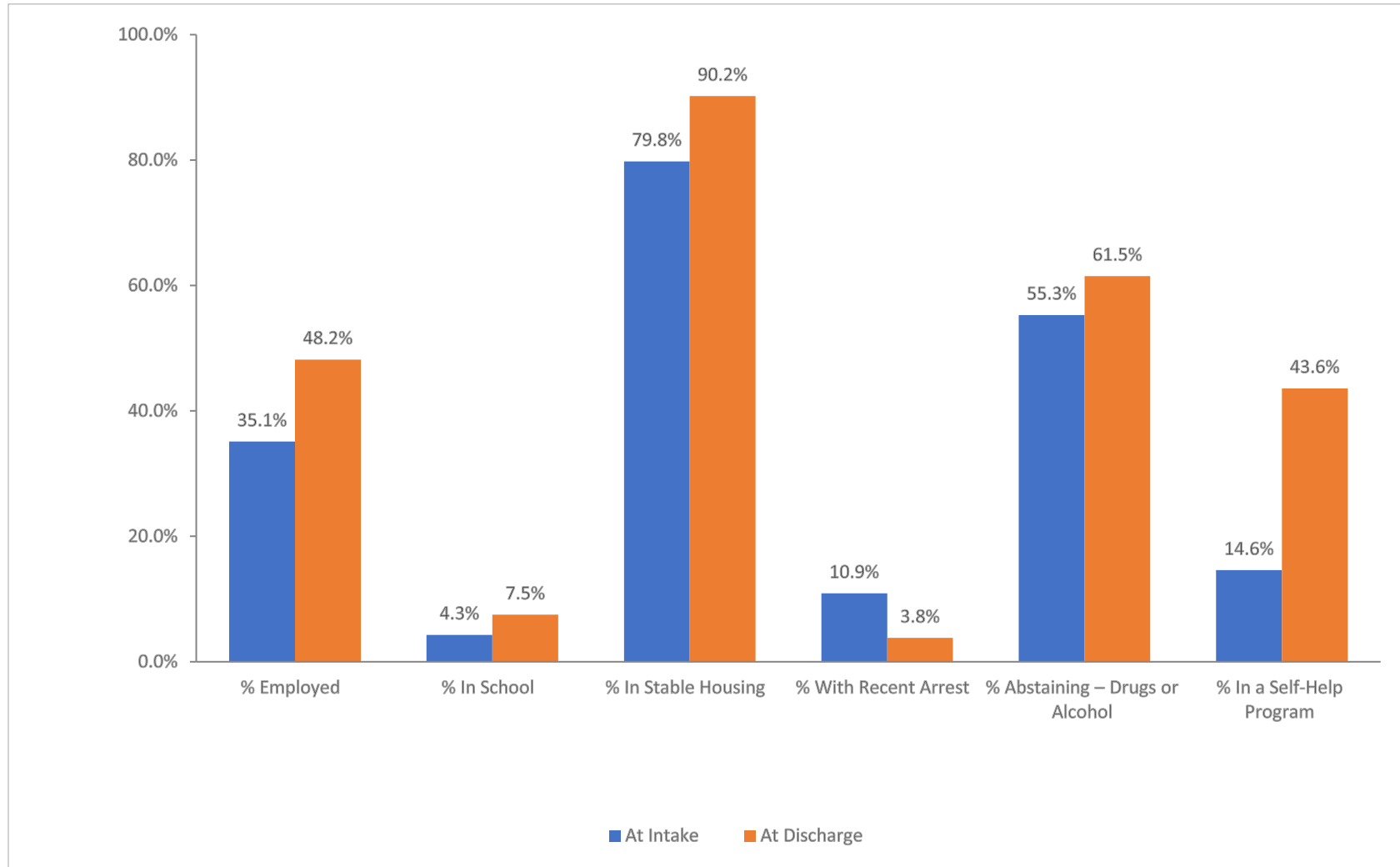
Appendix A, which follows this page, contains the Case File Review Tool and corresponding tool instructions developed by AHCCCS and provided to HSAG.

Substance Abuse Prevention and Treatment Case File Review Findings
State of Arizona

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		Denominator	# of YES	% of Yes	# of NA	# of No Documentation
	Substance Abuse Prevention and Treatment					
	Case File Review Findings for Measures I–VIII					
I	**Intake/Treatment Planning**					
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?					
	Did the behavioral health assessment:					
	1. Address substance-related disorder(s)?					
	2. Describe the intensity/frequency of substance use?					
	3. Include the effect of substance use on daily functioning?					
	4. Include the effect of substance use on interpersonal relationships?					
	5. Was a risk assessment completed?					
	6. Document screening for tuberculosis (TB), Hepatitis C, HIV, and other infectious diseases?					
	7. Document screening for emotional and/or physical abuse/trauma issues.					
	B. Was there documentation that charitable choice requirements were followed?					
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?					
	Was the ISP:					
	1. Developed with participation of the family/support network?					
	2. Congruent with the diagnosis(es) and presenting concern(s)?					
	3. Measurable objectives and timeframes to address the identified needs?					
	4. Addressing the unique cultural preferences of the individual?					
II	**Placement Criteria/Assessment**					
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?					
	1. If the ASAM Patient Placement Criteria were used, the level of service identified was:					
	Level 0.5: Early Intervention					
	OMT: Opioid Maintenance Therapy					

		Denominator	# of YES	% of Yes	# of NA	# of No Documentation
	Substance Abuse Prevention and Treatment					
	Case File Review Findings for Measures I–VIII					
	Level I: Outpatient Treatment					
	Level II: Intensive Outpatient Treatment/Partial Hospitalization					
	Level III: Residential/Inpatient Treatment					
	Level IV: Medically Managed Intensive Inpatient Treatment					
	B. Did the individual receive the level of services identified by the placement criteria/assessment?					
	C. Were the American Society of Addiction Medicine (ASAM) dimensions revised/updated during the course of treatment?					
	D. Were additional assessment tools utilized during the course of treatment? If yes, please list in box below:					
III	**Best Practices**					
	A. Were evidence-based practices used in treatment?					
	1. The following evidence-based practices were used in treatment:					
	Adolescent Community Reinforcement Approach (ACRA)					
	Beyond Trauma: A Healing Journey for Women					
	Cognitive Behavioral Therapy (CBT)					
	Contingency management					
	Dialectal Behavioral Therapy (DBT)					
	Helping Women Recover					
	Matrix					
	Moral Re-conation Therapy (MRT)					
	Motivational Enhancement/Interviewing therapy (MET/MI)					
	Relapse Prevention Therapy (RPT)					
	Seeking Safety					
	SMART Recovery					
	Thinking for a Change					

		Denominator	# of YES	% of Yes	# of NA	# of No Documentation
	Substance Abuse Prevention and Treatment					
	Case File Review Findings for Measures I–VIII					
	Trauma Recovery & Empowerment Model (TREM)					
	Trauma-Informed Care (TIC)					
	Wellness Recovery Action Plan (WRAP					
	Other (please list in box below):					
	B. Medication assisted treatment					
	1. The following medication was used in treatment:					
	• Alcohol-related					
	Acamprosate (Campral)					
	Disulfiram (Antabuse)					
	• Opioid-related					
	Buprenorphine/Subutex					
	Methadone/ Levo-Alpha-Acetylmethadol (LAAM)					
	Naloxone					
	Naltrexone, long-acting injectable (Vivitrol)					
	Suboxone					
	C. Was screening for substance use/abuse conducted during the course of treatment?					
	D. Were peer support services offered as part of the treatment continuum?					
	E. Were peer support services used as part of the treatment continuum?					
IV	**Treatment/Support Services/Rehabilitation Services**					
	A. The following services were used in treatment:					
	Individual counseling/therapy					
	Group counseling/therapy					
	Family counseling/therapy					
	Case management					
	B. Was there evidence of progress or lack of progress toward the identified ISP goals?					
	C. The number of completed counseling/therapy sessions during treatment was:					
	0–5 sessions					
	6–10 sessions					
	11 sessions or more					

		Denominator	# of YES	% of Yes	# of NA	# of No Documentation
header: **Substance Abuse Prevention and Treatment**						

		Denominator	# of YES	% of Yes	# of NA	# of No Documentation
	D. Documentation showed that the individual reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:					
	No documentation					
	0 times during treatment					
	1–4 times during treatment					
	5–12 times during treatment					
	13–20 times during treatment					
	21 or more times during treatment					
	E. If there was evidence of lack of progress towards the identified goal did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?					
	F. If the individual was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?					
	G. If the individual was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?					
	H. If the individual was not involved with a meaningful community activity (volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?					
	I. Does the documentation reflect that substance abuse services were provided?					
V	**Gender Specific (female only)**					
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?					
	B. If the female was pregnant, was there documentation of coordination of care efforts with the primary care physician and/or obstetrician?					

Substance Abuse Prevention and Treatment					
Case File Review Findings for Measures I–VIII					
		Denominator	**# of YES**	**% of Yes**	**# of NA**	**# of No Documentation**
	C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?					
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?					
	E. If the female had dependent children, was there documentation to show that child care was addressed?					
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?					
VI	**Opioid Specific**					
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?					
	B. Was there documentation that the member was provided Medication Assisted Treatment (MAT) education as a treatment option?					
	C. If yes to VI B, were they referred to a MAT provider?					
	D. If withdrawal symptoms were present, were they addressed in a medically appropriate manner?					
	E. If a physical health concern was identified, were alternative pain management options addressed?					
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or Buprenorphine during the course of pregnancy?					
	G. Was there documentation that the member was provided with relevant information related to overdose, Naloxone education, and actions to take in the event of an Opioid overdose?					

		Denominator	# of YES	% of Yes	# of NA	# of No Documentation
	**Substance Abuse Prevention and Treatment**					
	Case File Review Findings for Measures I–VIII					
	H. Was there documentation that the member was provided education on the effects of polysubstance use with Opioids?					
VII	**Discharge and Continuing Care Planning**					
	(completed only if individual completed treatment or declined further services)					
	A. Was there documentation present that a relapse prevention plan was completed?					
	B. Was there documentation that staff provided resources pertaining to community supports, including recovery self-help groups and/or other individualized support services.					
	C. Was there documentation that staff activity coordinated with other involved agencies at the time of discharge.					
VIII	**Re-engagement**					
	(completed only if individual declined further services or chose not to appear for scheduled services)					
	The following efforts were documented:					
	A. Was the individual (or legal guardian if applicable) contacted by telephone at times when the individual was expected to be available (e.g., after work or school)?					
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?					
	C. Were other attempts made to re-engage the individual, such as:					
	Home visit					
	Call emergency contact(s)					
	Contacting other involved agencies					
	Street Outreach					
	Other, *please list in the box below*					

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Measure IX National Outcome Measures						
National Outcome Measures	**At Intake**			**At Discharge**		
	Yes	No	Missing	Yes	No	Missing
A. Employed?						
B. Enrolled in school or vocational educational program?						
C. Lived in a stable housing environment (not homeless)?						
D. Arrested 30 days prior?						
E. Abstinent from drugs and/or alcohol?						
F. Participated in social support recovery 30 days prior?						

The items below correspond to the 2018 SABG Case File Review Tool. Each case file will contain **one treatment segment.** For the purposes of this review, only supporting documentation falling between the **"date of intake"** and the **"date of closure"** for the selected treatment segment will be reviewed. The date of intake and date of closure are pre-populated on the case file review tool. The length of treatment will range from 30 days to 365 days. There must be at least one episode of care.

I. Intake/Treatment Planning

A) Assessment—Review the case file to determine if a **comprehensive** assessment was completed at intake **within 45 days of the initial appointment**. The addendum sections of the Core Assessment are completed based on the needs of the individual; however, a comprehensive assessment allowing for sound clinical formulation and diagnostic impression must be completed within 45 days of the initial appointment. Answer YES if a comprehensive assessment was completed within 45 days of the initial appointment. Answer NO if a comprehensive assessment is not present in the case file or if the assessment was not completed within 45 days of the initial appointment. Answer NA if there is not a comprehensive assessment present and the case closed prior to 45 days from the initial appointment.

For each component related to assessment process below (1–7), consider the information contained in the comprehensive initial assessment completed within 45 days of the initial intake appointment.

1) Review the assessment to determine if it addressed substance-related disorder(s). Answer **YES** if the assessment addressed this component. If the assessment did not address a substance related disorder, answer **NO**.

2) Review the assessment to determine if the assessment described the intensity/frequency of substance use. Answer **YES** if the assessment addressed this component. If the assessment did not describe the intensity/frequency of substance use, answer **NO**.

3) Review the assessment to determine if the assessment included the effect of substance use on daily functioning. Answer **YES** if the assessment addressed this component. If the assessment did not describe the effect of substance use on daily functioning, answer **NO**.

4) Review the assessment to determine if the assessment described how substance abuse affects the interpersonal relationships of the individual. Answer **YES** if the assessment addressed this component. If the assessment did not describe how substance abuse affects the interpersonal relationships of the individual, answer **NO**.

5) Review the assessment to determine if a risk assessment was completed. The risk assessment may be contained within the standardized core assessment or may consist of a comparable RBHA- or provider-specific form, but should be completed as part of the comprehensive assessment within

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45 days of the initial appointment. Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

6) Review the assessment to determine if it contains documentation of screening for tuberculosis (TB), Hepatitis C, HIV, and other infectious diseases. Answer **YES** if the assessment included documentation of screenings for TB, Hepatitis C, HIV, and other infectious diseases screening. If the assessment did not contain documentation of screenings for TB, Hepatitis C, HIV, and other infectious diseases, answer **NO**. Screening may include testing; education; referrals for screening and services; follow-up counseling that addresses identified services; and an evaluation of history, risk factors, and/or screening tools.

7) Review the assessment to determine if it contains documentation of screening for emotional and/or physical abuse/trauma issues. Answer **YES** if the assessment included documentation of screening for abuse/trauma issues. If the assessment did not contain evidence, answer **NO**.

B) Review the assessment to determine if it contains documentation that charitable choice requirements were followed. Answer **YES** if the assessment included documentation that charitable choice requirements were being followed. If the assessment did not contain evidence, answer **NO**. Answer NA if charitable choice did not apply in this case.

C) Individual Service Plan (ISP)—Review the case file to determine if an ISP was completed within **90 days** of the initial appointment. **The interim service plan should not be considered when responding to this question.** Answer **YES** if an ISP was completed within 90 days of the initial appointment. Answer **NO** if an ISP is not present in the case file or if the service plan was not completed within 90 days of the initial appointment. Answer **NA** if there is not an ISP and the case closed prior to 90 days from the initial appointment.

For each component related to the ISP process below (1–3), consider the information contained in the ISP completed within 90 days of the initial intake appointment. Updates to the service plan should not be considered when responding to the questions below.

1) Review the service plan to determine if it was developed with the participation of the individual's **family and/or support network,** when appropriate. If there is evidence that staff made efforts to actively engage the involved family members/support network in the treatment planning process, answer **YES**. If there is evidence that these individuals would have an impact on treatment planning but there is no evidence of staff efforts to engage them, answer **NO**. Answer **NA** if there is no family/support network or if the individual declined inclusion of others in the service planning process. Evidence of engagement attempts may include verbal or written efforts to solicit their input.

2) Review the service plan to determine if the scope, intensity, and duration of services offered was congruent with the diagnosis(es) and presenting concern(s). If the scope, intensity, and duration of services offered were congruent with the diagnosis(es), answer **YES**. If the scope, intensity, and duration of services offered were not congruent with the diagnosis(es), answer **NO**.

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3) Review the service plan to determine if objectives are measurable and identify timeframes for the identified needs to be met. If the objectives are measurable and identify timeframes for the identified needs to be met, answer **YES**. If the objectives are not measurable and do not identify timeframes, answer **NO**.

4) Review the service plan to determine if it addressed the unique cultural preferences of the individual. Cultural preferences may include the influences and background of the individual with regard to language, customs, traditions, family, age, gender, ethnicity, race, sexual orientation, and socioeconomic class. If the unique cultural preferences of the individual were addressed, answer **YES**. If the unique cultural preferences of the individual were not addressed, answer **NO**.

II. Placement Criteria/Assessment

A) Review the case file to determine if the American Society of Addiction Medicine (ASAM) dimensions were used at intake to determine the criteria to identify the appropriate level of care via the Patient Placement Criteria.

If the ASAM tool was completed, answer **YES**. If the ASAM tool was not completed, answer **NO**. Providers are allowed to create their own ASAM document.

    1) If the ASAM tool was completed at intake, select the level of care identified by the tool:
- ☐ Level 0.5: Early Intervention
- ☐ OMT: Opioid Maintenance Therapy
- ☐ Level I: Outpatient Treatment
- ☐ Level II: Intensive Outpatient Treatment/Partial Hospitalization
- ☐ Level III: Residential/Inpatient Treatment
- ☐ Level IV: Medically Managed Intensive Inpatient Treatment

B) Review the case file to determine if the individual received the level of care identified by the ASAM tool. If the individual received the level of services identified by the placement criteria/assessment, answer **YES**. If not, answer **NO**.

C) Review the case file to determine if an ASAM tool was completed during the course of treatment at any time subsequent to intake/assessment. It is not necessary for the ASAM tool result to change if it is considered an updated tool. If an ASAM tool was completed after intake, answer **YES**. If an ASAM tool was not completed after intake, answer **NO**.

D) Review the case file to determine if an assessment tool (can include other multi-dimensional placement criteria tools in lieu of ASAM) was utilized **during** the course of treatment at any time subsequent to intake/assessment. If an additional assessment tool was completed after the intake ASAM, answer **YES**. If answer is **YES**, please list the name of the tool in the box below. If an assessment tool was not completed after the intake ASAM, answer **NO**.

III. Best Practices

A) Review the case file to determine if it contains evidence that evidence-based practices were implemented in treatment. Answer **YES** if the case file contains evidence-based practices. If not, answer **NO**. If there is not sufficient documentation available to verify that evidence-based practice was utilized (e.g., an evidence-based practice was not mentioned in the treatment progress notes), answer **NO DOCUMENTATION**.

1) Identify **each** type of evidence-based practice documented in the case file:
> Adolescent Community Reinforcement Approach (A-CRA)
> Beyond Trauma: A Healing Journey for Women
> Cognitive Behavioral Therapy (CBT)
> Contingency management
> Dialectal Behavioral Therapy (DBT)
> Helping Women Recover
> Matrix
> Moral Reconation Therapy (MRT)
> Motivational Enhancement/Interviewing Therapy (MET/MI)
> Relapse Prevention Therapy (RPT)
> Seeking Safety
> SMART Recovery
> Thinking for a Change
> Trauma Recovery and Empowerment Model (TREM)
> Trauma-Informed Care (TIC)
> Wellness Recovery Action Plan (WRAP)
> Other: Identify other evidence-based practices utilized (*Enter the evidence-based practice in the text box below.*)

B) Medication assisted treatment **(for substance abuse treatment only).** If there was evidence of MAT, answer **YES**. Answer **NO** if there was no documentation of MAT.

1) Identify **each** medication used in the treatment of substance abuse:
- Alcohol-related: ☐ Acamprosate (Campral)   ☐ Disulfiram (Antabuse)
- Opioid-related: ☐ Buprenorphine/Subutex   ☐ Methadone/Levo-Alpha-Acetylmethadol (LAAM)   ☐ Naloxone   ☐ Naltrexone, long-acting injectable (Vivitrol)   ☐ Suboxone

C) Review the case file to determine if it contains evidence that the individual was screened for substance use/abuse during the course of treatment. Answer **YES** if the case file contains evidence that the individual was screened for substance use. Answer **NO** if documentation of screening for substance use was not present in the case file.

D) Review the case file to determine if peer support/coaches (e.g., peer worker) were offered as part of the treatment continuum. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. Answer **NA** if the individual declined peer support services.

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E) Review the case file to determine if peer support/coaches were used as part of the treatment continuum. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**.

IV. Treatment/Support Services/Rehabilitation Services

A) Review the case file to identify which services the individual received during the course of treatment. Answer **YES** next to **each** service received. Answer **NO** next to the services that were not received during the course of treatment.
> Individual counseling/therapy
> Group counseling/therapy
> Family counseling/therapy
> Case management

B) Review the case file to determine if documentation (e.g., progress notes) shows evidence of progress or lack of progress toward the identified treatment goals. If the documentation shows progress or lack of progress toward the identified treatment goals, answer **YES**. If the case file does not show evidence of progress or lack of progress toward the identified ISP goals, answer **NO**. Answer **NA** if there is not an ISP present in the case file. You may also answer **NA** if services provided are recent and there is no change in progress.

C) Review the case file to determine the number of counseling/therapy sessions that the individual attended during the course of treatment. Treatment sessions include individual and group sessions. Select the appropriate response:
> 0–5 treatment sessions
> 6–10 treatment sessions
> 11 sessions or more

D) Review the case file to determine how many self-help or recovery group sessions (e.g., Alcoholics Anonymous, Narcotics Anonymous) the individual reported attending during the course of treatment. Select the appropriate response:
> No documentation (includes those individuals who were referred to self-help groups but did not attend)
> 0 times during treatment
> 1–4 times during treatment
> 5–12 times during treatment
> 13–20 times during treatment
> 21 or more times during treatment

E) If there was evidence of lack of progress toward the identified goal, review the case file to determine if staff revised the treatment approach and/or sought consultation in order to facilitate symptomatic improvement. Answer **YES** if the provider revised the treatment approach and/or sought consultation. If not, answer **NO**. Answer **NA** if symptomatic improvement is present in the case file.

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F) If the individual was **NOT** employed at the time of intake, review the case file to determine if the individual's interest in finding employment was explored. Answer **YES** if there is evidence that the individual's interest in finding employment was explored. If not, answer **NO**. **Answer NA if the individual was employed at the time of intake or employment is not relevant to the individual's situation (e.g., the individual is participating in a vocational program).**

G) If the individual was **NOT** involved in an education or vocational training program at the time of intake, review the case file to determine if the individual's interest in becoming involved in a program was explored. Answer **YES** if there is evidence that the individual's interest in becoming involved in an educational or vocational training program was explored. If evidence is not present, answer **NO**. **Answer NA if the individual was involved in an education or vocational training program at the time of intake or it is not relevant to the individual's situation (e.g., the individual was employed).**

H) If the individual was **NOT** involved in a meaningful community activity (volunteering, caregiving to family or friends, and/or any active community participation) at the time of intake, review the case file to determine if the individual's interest in becoming involved in a community activity was explored. Answer **YES** if there is evidence that the individual's interest in a community activity was explored. Answer **NO** if the individual's interests were not explored. **Answer NA if the individual was involved in a community activity at the time of intake or if it is not relevant to the individual's situation (e.g., the individual was participating in a vocational program or employed).**

I) Review the case file to determine if the documentation reflects that substance abuse services were rendered. If the documentation in the case file reflects that services were provided for the treatment of substance abuse, answer **YES**. Answer **NO** if documentation does not reflect that substance abuse services were rendered.

V. Gender-Specific (Female Only) If the patient is male, this section of the database will be closed. You will not respond to the following Section V questions.

A) Review the case file to determine if it includes a safety plan **where there are domestic violence issues present**. If the case file contains a safety plan, answer **YES**. If the case file does not contain a safety plan, answer **NO**. Answer **NA** if there are no domestic violence issues present.

B) If the individual was pregnant, review the case file to determine if there is evidence that staff coordinated behavioral health care with the physician/obstetrician. If there is evidence in the case file indicating that staff coordinated behavioral health care, answer **YES**. Answer **NO** if staff did not coordinate with the physician/obstetrician. **Answer NA if the service provider does not apply (e.g., the individual was not pregnant).** Since an adult individual has to give permission for release of information, this should be considered when responding. Coordination of care includes verbal or written efforts to solicit their input or share information.

C) If the individual was pregnant, review the case file to determine if there is evidence that staff provided education pertaining to the effects of substance use on fetal development. Answer **YES** if the case file contains evidence. Answer **NO** if evidence is not present. **Answer NA if the individual was not pregnant.**

D) If the individual has a child less than one year of age, review the case file to determine if screening was completed for postpartum depression/psychosis. If evidence is present in the case file, answer **YES.** If evidence is not present in the case file, answer **NO. Answer NA if the individual does not have a child less than one year in age.**

E) If the individual has dependent children, review the case file to determine if child care was addressed. If evidence is present in the case file, answer **YES.** If evidence is not present in the case file, answer **NO. Answer NA if the individual does not have dependent children.**

F) Review the case file to determine if gender-specific treatment services were offered and/or provided (e.g., women's-only group therapy sessions, female peer/recovery support/coaches) as part of the treatment continuum. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. Answer **NA** if the individual declined gender-specific services.

VI. Opioid Specific (only for records that indicate opioid use)

A) Review the case file to determine if it contains evidence that the individual has a **diagnosed Opioid Use Disorder (OUD)**. Answer **YES** if the case file contains evidence that the individual has been diagnosed with OUD. Answer **NO** if documentation an OUD was not present in the case file.

B) Review the case file to determine if it contains documentation that Medication-Assisted Treatment (MAT) education was a treatment option. If there is documentation that the member was offered MAT education as an option, answer **YES**. Answer **NO** if documentation is not present in the case file.

C) If the answer to VI B was **YES**, and there is documentation that a referral was made to a MAT provider, answer **YES**. If the answer to VI B is **YES**, but no referral to a MAT provider was made, answer **NO**. If the answer **to VI B** was **NO**, answer **NA**.

D) Review the case file to determine if there is evidence that the member had withdrawal symptoms that were addressed via referral and/or intervention with a medical provider. If there is evidence that the withdrawal symptoms were addressed via referral and/or intervention with a medical provider, answer **YES**. Answer **NO** if evidence shows that withdrawal symptoms were not addressed via referral and/or intervention with a medical provider. Answer **NA** if no withdrawal symptoms were documented.

E) Review the case file to determine if there is documentation that alternative pain management options were addressed if the member reported a physical health concern. Answer **YES** if alternative pain management options were addressed if the member reported a physical health concern. Answer **NO** if the member reported a physical health concern and there is no evidence that alternative pain management options were addressed. Answer **NA** if there is no evidence of physical health concerns related to pain.

F) If the individual is pregnant, review the case file to determine if there is evidence that staff provided education pertaining to the safety of methadone and/or Buprenorphine during the course of the

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pregnancy. Answer **YES** if the case file contains evidence. Answer **NO** if evidence is not present. **Answer NA if the individual is not pregnant.**

G) Review the case file to determine if there is evidence that the member was provided relevant information related to overdose, Naloxone education, and actions to take in the event of an opioid overdose. Answer **YES** if the case file contains evidence. Answer **NO** if evidence is not present.

H) Review the case file to determine if there is evidence that the member was provided education on the effects of polysubstance use with opioids. Answer **YES** if the case file contains evidence. Answer **NO** if the evidence is not present.

VII. Discharge and Continuing Care Planning (only completed if the individual completed treatment or declined further services)

A) Review the case file to determine if a relapse prevention plan was completed. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**.

B) Review the case file to determine if there is evidence that staff provided resources pertaining to community supports, including recovery self-help groups and/or other individualized support services. If there is evidence that staff provided resource and/or referral information, answer **YES**. A **YES** response indicates that staff provided information and/or referral regarding at least one resource. If evidence is not present, answer **NO**.

C) Review the case file to determine if staff actively coordinated with other involved agencies at the time of discharge. If there is evidence in the case file indicating that staff attempted to coordinate/communicate with other involved agencies, answer **YES**. Answer **NO** if staff did not make efforts to coordinate with other involved agencies at the time of discharge. Answer **NA** if there were no other agencies involved. Since an adult individual must give permission for other involved parties to participate in treatment, this should be considered when responding. Coordination of care includes verbal or written efforts to solicit their input or share information.

VIII. Re-Engagement (only completed if the individual declined further services or chose not to appear for scheduled services, including closure for loss of contact)

Review the case file to determine if the following outreach activities were conducted in an effort to re-engage the individual prior to closure:

A) Contacting the individual (or legal guardian if applicable) by telephone, at times when the person may be expected to be available (e.g., after work or school)—Answer **YES** if telephone contact was attempted. Answer **NO** if telephone contact was not attempted.

B) If telephone contact was unsuccessful, a letter was mailed requesting contact—Answer **YES** if a letter was sent to the individual. Answer **NO** if a letter was not sent to the individual. Answer **NA** if attempts to reach the **member** through other means were successful.

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C) Were other attempts made to re-engage, such as:
    a. Home visit?
    b. Call emergency contact(s)?
    c. Contacting other involved agencies?
    d. Street outreach
    e. Other (please *enter the type of re-engagement in the box below).*

Answer **YES** next to each means of outreach attempted in order to re-engage the individual. Answer **NO** next to each action that was not attempted. If other re-engagement attempts were made that aren't listed, list the other types in the box below. Answer **NA** if attempts to reach the individual by other means of outreach were successful (e.g., the individual was successfully reached via telephone call). NA may also be used if a particular means of outreach was not applicable to the individual (e.g., answer NA for "contacting other involved agencies" if the individual did not have any other agencies involved).

IX. National Outcome Measures (NOM)

For each measure below, answer YES or NO based on the individual's status at the time of intake and at the time of discharge. Answer MISSING if there is no documentation of the NOM at time of intake and/or discharge.

A) Employed at intake?
Employed at discharge?

B) Enrolled in school or vocational educational program at intake?
Enrolled in school or vocational educational program at discharge?

C) Lived in a stable housing environment at intake? (Not homeless)
Lived in a stable housing environment at discharge? (Not homeless)

D) Arrested 30 days prior to treatment?
Arrested 30 days prior to discharge?

E) Was the individual abstinent from alcohol and/or drugs at intake?
Was individual abstinent from alcohol and/or drugs at discharge?

F) Participated in Social Support Recovery 30 days prior to treatment?
Participated in Social Support Recovery 30 days prior to discharge?

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December 28, 2018

The Honorable Douglas A. Ducey
Governor of Arizona
1700 W. Washington
Phoenix, AZ 85007

The Honorable Steve Yarbrough
Arizona State Senate
1700 West Washington
Phoenix, Arizona 85007

The Honorable J.D. Mesnard
Speaker of the House
Arizona House of Representatives
1700 West Washington
Phoenix, Arizona 85007

Dear Governor Ducey, President Yarbrough, and Speaker Mesnard:

Pursuant to A.R.S. §36-2023, please find enclosed AHCCCS Annual Report on Drug Abuse Treatment Programs. Please do not hesitate to contact me if I can answer any questions or provide additional information.

Sincerely,

Thomas J. Betlach,
Director

cc: Christina Corieri, Governor's Office Senior Policy Advisor

Annual Report:
Substance Use Treatment Programs
State Fiscal Year 2018

July 1, 2017 to June 30, 2018

January 2019
Tom Betlach, Director

Background

The Arizona Health Care Cost Containment System, Division of Healthcare Management (AHCCCS/DHCM) has conducted an assessment of its Substance Use Disorder (SUD) treatment programs in accordance with the requirements outlined in Arizona Revised Statutes (A.R.S) §36-2023(C)(6):

Prepare an annual report on drug abuse treatment programs in this state that receive monies from the administration to be submitted by January 1 of each year to the governor, the president of the senate and the speaker of the house of representatives and to be made available to the general public through the Arizona drug and gang prevention resource center. The report shall include:

(a) The name and location of each program.
(b) The amount and sources of funding for each program.
(c) The number of clients who received services during the preceding fiscal year.
(d) A description of the demographic characteristics of the client population served by each program, including age groups, gender and ethnicity.
(e) A description of client problems addressed by the programs, including the types of substances abused.
(f) A summary of the numbers and types of services available and provided during the preceding fiscal year.
(g) An evaluation of the results achieved by the programs.

As a result of administrative simplification, the merger of AHCCCS and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) effective July 1, 2016, AHCCCS acquired responsibility for the Annual Report. AHCCCS reviewed the Reports previously prepared by DBHS and the legislative requirements for this Report, and have updated the methodologies and data sources utilized to better align with the legislative requirements. This 2018 Report reflects those changes. Utilization data used in this Report are for dates of service in State Fiscal Year (SFY) 2018 from July 1, 2017 through June 30, 2018, and were extracted in November 2018. Due to the short four month lag from the last date of service, data may be slightly understated.

In a Special Session of the Legislature, members of the Arizona House and Senate unanimously passed the Arizona Opioid Epidemic Act, which Governor Ducey signed into law on January 26, 2018. The introduction of the Arizona Opioid Epidemic Act followed a thorough effort to engage community stakeholders through approximately 50 meetings held throughout Arizona. Through the input received and conducting a review of national best practices of opioid-related policies, the Arizona Department of Health Services (ADHS) issued an Opioid Action Plan in September 2017, which included recommendations to reduce opioid misuse, promote safe prescribing and dispensing, and improve access to treatment.

The Arizona Opioid Epidemic Act included several key initiatives to combat the opioid epidemic in Arizona. Opioid Use Disorder (OUD) Treatment was enhanced by identifying gaps in and improving access to treatment, including for uninsured or underinsured Arizonans, with a $10 million appropriation to AHCCCS through the legislation. Additionally, access was expanded to the overdose reversal drug Naloxone for law enforcement or corrections officers previously not

authorized to administer it. Pharmacists are now required to check the Controlled Substances Prescription Monitoring Program (CSPMP) prior to dispensing an opioid or benzodiazepine. The Opioid Epidemic Act limited the first-fill of an Opioid prescription to five days for all opioid naïve patients and limiting dosage levels to align with federal prescribing guidelines. These proposals contain important exemptions to protect chronic pain suffers, cancer, trauma or burn patients, hospice or end-of-life patients, and those receiving Medication Assisted Treatment (MAT) for SUD.

The enactment of the Arizona Opioid Epidemic Act in 2018 followed several concentrated steps aimed at addressing the opioid epidemic in Arizona which occurred during 2016 and 2017. These included the Governor's Goal Council 3 Breakthrough Project: Reducing Opioid Deaths, and the Governor's emergency declaration to address the growing number of deaths in Arizona in June, 2017. This was followed by a publication from the ADHS of the Opioid Action Report, which can be accessed on the ADHS website: http://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/opioid-prevention/index.php.

On May 1, 2017, AHCCCS received an Opioid State Targeted Response (STR) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for prevention and treatment activities in the amount of $24.3 million over the course of two years.   The objectives of the grant are to reduce the number of individuals with OUD and the number of opioid-related deaths. State partners include the Governor's Office of Youth, Faith and Family (GOYFF), ADHS, and the Department of Child Safety (DCS). Prevention activities include conducting Screening, Brief Intervention and Referral to Treatment (SBIRT) models; increased access to Naloxone for law enforcement; education and outreach to older adults; and implementation of community-based awareness and education activities. Treatment activities are centered around increasing access, participation and retention in MAT and recovery support services. Activities include 24/7 access to care sites for OUD treatment; increasing peer support networks; incarceration alternative projects; care coordination for individuals re-entering the community from correctional settings; and expanded options for residential services. More information on the grant can be found on the AHCCCS website:
 https://www.azahcccs.gov/Resources/Grants/STR/

Through the use of STR funding, Arizona has stood up five Centers of Excellence (CoE) in areas of high opioid use throughout the state; two of which include MAT CoE and three crisis centers. These facilities have expanded services and hours of operation in an effort to help individuals access treatment 24 hours a day, 7 days a week. The two MAT centers are the first in the country that can provide MAT induction using Methadone, Suboxone, and Vivitrol, in conjunction with psycho-social counseling and medical support 24/7.

The STR grant has made significant steps at improving the prevention and early intervention efforts throughout the state. The state's public universities, including Northern Arizona University, University of Arizona and Arizona State University, have implemented SBIRT trainings for staff campus wide. Campus staff have been trained to screen students for substance use, utilize Motivational Interviewing skills to increase students' motivation to receive treatment services, and have the ability to provide referrals for treatment services. Efforts also include the expansion of community based engagement and collaboration with substance use coalitions and local harm reduction organizations for community Naloxone distribution.

The Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA)_ grant has assisted in expanding education and training in rural locations throughout Arizona in an effort to display clinically effective prevention and treatment strategies to best serve those

impacted by the opioid epidemic. Seminars where held that covered topics including current state initiatives implemented to combat the rapidly emerging crisis. The seminars provided training for MAT providers, SUD treatment providers, physical health providers, harm reduction organizations, justice system partners and interested community members.

On September 19, 2018, Arizona received the State Opioid Response (SOR) grant in the amount of $20.3 million per year for two years to assist in combatting this nationwide epidemic. The project approach includes developing and supporting state, regional, and local level collaborations and service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse and dependency. The funding is geared towards implementing, expanding and sustaining services that support for the full continuum of care for an individual throughout their course of recovery. Additionally, SOR funding will be utilized to sustain the impactful programs that were developed through the STR grant. AHCCCS, as the Single State Agency for SUD Treatment, will administer the grant and work with other state agencies and sub-recipients to implement the following activities:

- Sustaining and enhancing community Naloxone distribution;

- Increasing localized community opioid prevention efforts;

- Stigma reduction and public awareness on the medical model of opioid dependency;

- Expansion of Trauma-Informed prevention, treatment and recovery efforts;

- Expanding navigation and access to MAT through 24/7 access points;

- Expanding access to recovery support services (supportive housing, peer supports, job assistance and supportive recovery programming);

- Increasing public access to real-time prevention, treatment and recovery resources through the "no-wrong door" model;

- Equipping law enforcement and first responders with Naloxone;

- Promoting prescriber education and a statewide chronic pain self-management campaign;

- Collaboration with law enforcement, corrections, first responders and Emergency Departments for diversion and targeted care coordination efforts in high impact sectors;

- Collaborating with justice partners to integrate pre and post booking programs for those involved with the criminal justice system; and

- Targeted focus on treatment and recovery services for pregnant women and parents with OUD.

Lastly, the activities in the SOR program will place a strong emphasis on comprehensive strategies to ensure a full continuum of care for this population. The objectives will be geared towards addressing prevention, treatment and recovery supports for individuals suffering from an opioid use disorder, focusing greater attention to integration efforts and working to deliver services that are clinically indicated as best practices. In addition, to better bolster these efforts,

the providers working within SOR were selected due to their person-centered approach and experience at addressing substance use, underlying and core issues, behavioral health disorders, trauma, family dynamics, lack of motivation and purpose, education or employment, life skills development, aftercare support and housing. Whether this occurs through a continuum of services from a single treatment provider or several providers, the cohesiveness within the SOR model will ensure the provision of appropriate clinical services and have greater impact to retain those in services.

Location of Substance Use Disorder Treatment Programs

The locations of the state's SUD treatment programs are divided in three distinct geographic service areas (GSAs) throughout the state with oversight provided by three Integrated Managed Care Organizations (MCO)/Regional Behavioral Health Authorities (RBHA) and Tribal Regional Behavioral Health Authorities (TRBHA, which may serve more than one GSA).

RBHA and TRBHA	GSA
Health Choice Integrated Care	North
Mercy Maricopa Integrated Care	Central
Cenpatico Integrated Care	South
Navajo Nation	North
Pascua Yaqui Tribe	South
White Mountain Apache Tribe	North & South
Gila River Indian Community	Central & South

The RBHAs and TRBHAs are required to maintain a comprehensive network of behavioral health providers to deliver prevention, intervention, treatment and rehabilitative services to members enrolled in the AHCCCS system. This structure allows communities to provide services in a manner appropriate to meet the unique needs of members and families residing within their local areas. Appendix A lists the names and locations of providers throughout the state who had a Substance Use Treatment Program during SFY 2018. There were approximately 510 SUD programs in the State of Arizona, as summarized below.

RBHA and TRBHA	Number of Programs[1]
Health Choice Integrated Care	84
Mercy Maricopa Integrated Care	172
Cenpatico Integrated Care	126
Gila River Indian Community	25
Navajo Nation	99
Pascua Yaqui Tribe	51
White Mountain Apache Tribe	63

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[1] More than 100 SUD programs serve more than one RBHA or TRBHA thus the data in the table will exceed 510 SUD programs.

Program Funding

During SFY 2018, AHCCCS expended over $385 million in service funding for members and families with SUD. The single largest source of SUD treatment funding was Medicaid as reflected in Table I, followed by Federal Substance Abuse Block Grant (SABG) funds. Additional funding included State appropriated monies, other federal discretionary funds, funds from Maricopa County for local detoxification services, funds available through intergovernmental agreements (IGA) with the City of Phoenix, Substance Use Disorder Services funding (the appropriated monies included in the Arizona Opioid Epidemic Act), and liquor services fees.

Table I: Substance Use Disorder Treatment Funding Summary
SFY 2018 - July 1, 2017 to June 30, 2018

Fund Source[2]	Dollar Amount	Percentage
Medicaid Funding (State Match and Title XIX)	$341,674,687	88.67%
Federal: Substance Abuse Block Grant (SABG)	$33,618,749	8.72%
Federal: Other (Discretionary Funds)	$5,188,470	1.35%
State Appropriated	$2,943,050	0.76%
Substance Use Disorder Services Fund	$248,015	0.07%
Intergovernmental Agreements: Maricopa County; City of Phoenix Central City Addiction Recovery Center	$1,589,871	0.41%
Liquor Fees	$72,500	0.02%
Total Funding:	$385,335,342	100.00%

Enrolled and Served Demographics

AHCCCS policy requires that members with behavioral health needs undergo a clinical assessment, administered by a clinician through a mental health or substance use treatment program. The information gathered during this assessment process includes several identifiable factors, such as race and ethnicity, gender, and reasons for seeking treatment. Members identified in this Report include those with a SUD who were enrolled in AHCCCS and received a service from a SUD program (Appendix A) during SFY 2018.

Tables II and III below detail the demographics of these members by GSA and provide statewide totals. In SFY 2018, there were 63,200 members enrolled in AHCCCS who received

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[2] *Funding in Table I represents payments to TRBHAs/RBHAs, with the exception of the Medicaid Funding data which includes substance use funding for all AHCCCS programs including RBHA, ALTCS/EPD, ACUTE, CRS and the American Indian Health Program. Funding includes administrative components and other amounts that will not be reflected in the provider level substance abuse utilization data in this report (Table VI). The State Appropriated line represents Crisis Services for individuals with a Substance Use Disorder which includes behavioral health services. Federal Discretionary funds include, but are not limited to, the STR grant and the MAT-PDOA grant.*

at least one service from a SUD program. The Central GSA has the largest AHCCCS population in the state and, consistent with its overall AHCCCS membership, represents 50% of those receiving SUD treatment services.

Table II: Members Served with a Substance Use Disorder by GSA
SFY 2018 - July 1, 2017 to June 30, 2018

GSAs	Count	Percentage
North	9,017	14.3%
South	22,599	35.7%
Central	31,584	50.0%
Statewide	**63,200**	**100.0%**

Table III: Demographics of Members Served with a Substance Use Disorder by GSA
SFY 2018 - July 1, 2017 to June 30, 2018

Gender

The percentage of males versus females served is consistent between GSAs and statewide, with the SUD treatment population comprised of more men than women—59.1%versus 40.9%, respectively. This statistic remains consistent with the data reported for the prior year.

Gender[3]	North		South		Central		Statewide	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Male	5,169	57.3%	13,247	58.6%	18,926	59.9%	37,342	59.1%
Female	3,848	42.7%	9,352	41.4%	12,658	40.1%	25,858	40.9%
Totals	**9,017**	**100.0%**	**22,599**	**100.0%**	**31,584**	**100.0%**	**63,200**	**100.0%**

Race and Ethnicity

The majority (65%) of members who were enrolled and received a SUD treatment service in SFY 2018 were White. As the table illustrates, 4.8% of members enrolled and served were African American, 4.9% were American Indian, 1.4% were of multi-race backgrounds, 0.3% were Asian and 0.2% were Native Hawaiian/Pacific Islander. Statewide, 20.2% of members enrolled and served identified as Hispanic/Latino.

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[3] *Data Source: AHCCCS enrollment data set.*

Race/Ethnicity[4]	North		South		Central		Statewide	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
American Indian	1,272	14.1%	956	4.2%	854	2.7%	3,082	4.9%
Asian	20	0.2%	74	0.3%	85	0.3%	179	0.3%
African American	92	1.0%	1,104	4.9%	1,838	5.8%	3,034	4.8%
Native Hawaiian/Pacific Islander	6	0.1%	47	0.2%	90	0.3%	143	0.2%
White	6,647	73.7%	17,818	78.8%	16,633	52.7%	41,098	65.0%
Multi-Racial	170	1.9%	481	2.1%	256	0.8%	907	1.4%
Data Unavailable	810	9.0%	2,119	9.4%	11,828	37.4%	14,757	23.3%
Totals	**9,017**	**100.0%**	**22,599**	**100.0%**	**31,584**	**100.0%**	**63,200**	**100.0%**
Hispanic	951	10.5%	7,263	32.1%	4,572	14.5%	12,786	20.2%
Not Hispanic	7,256	80.5%	13,217	58.5%	15,184	48.1%	35,657	56.4%
Data Unavailable	810	9.0%	2,119	9.4%	11,828	37.4%	14,757	23.3%
Totals	**9,017**	**100.0%**	**22,599**	**100.0%**	**31,584**	**100.0%**	**63,200**	**100.0%**

Age

An aggregate review of the data detailing members' age indicates the vast majority of members with a SUD and served in SFY 2018 were adults, with those between the ages of 25 and 44 accounting for more than half of all members (57.1%). Additionally, 26.7% of members enrolled and served were between the ages of 45 – 64. Approximately three percent of members were under the age of 18. This data is similar to the age distribution reported for SFY 2017.

Age Distribution[5]	North		South		Central		Statewide	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Birth – 4	2	0.0%	0	0.0%	4	0.0%	6	0.0%
5 – 11	3	0.0%	10	0.0%	17	0.1%	30	0.0%
12 – 14	32	0.4%	109	0.5%	134	0.4%	275	0.4%
15 – 17	232	2.6%	674	3.0%	781	2.5%	1,687	2.7%
18 – 20	309	3.4%	792	3.5%	975	3.1%	2,076	3.3%
21 – 24	764	8.5%	1,714	7.6%	2,718	8.6%	5,196	8.2%
25 – 44	4,798	53.2%	12,857	56.9%	18,437	58.4%	36,092	57.1%
45 – 64	2,697	29.9%	6,135	27.1%	8,051	25.5%	16,883	26.7%
65+	180	2.0%	308	1.4%	467	1.5%	955	1.5%
Totals	**9,017**	**100.0%**	**22,599**	**100.0%**	**31,584**	**100.0%**	**63,200**	**100.0%**

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[4] *Data Source: AHCCCS Behavioral Health Demographics & Outcomes data set (DUG data set). Not all members selected for this Report had BH Demographics data: there were also some members with BH Demographic data, but had no race/ethnicity available. AHCCCS is working on streamlining the data and data collection process to improve data submissions.*

[5] *Data Source: AHCCCS Behavioral Health Demographics & Outcomes data set (DUG data set). Not all members selected for this Report have BH Demographics data available, AHCCCS have been working on streamlining the data and data collection process to improve data submissions.*

Substance Use Disorders Addressed by the Programs

Opiates remained the most common substance used statewide by those in treatment in 2018 at 21.1%. Methamphetamines were the second most common substance used statewide by those in treatment in SFY 2018 at 19.1%, followed by alcohol at 18.2%, and marijuana at 17.1%. The least common substance reported was other sedatives/tranquilizers (0.2%).

Similar to the data reported for SFY 2017, the most common substance reported by GSA varied although opiates were the most common in the South and Central GSAs. While alcohol was the most prevalent substance used in the North GSA (29.2%), opiates was the most common in the South GSA (24.1%) and in the Central GSA (20%).

Table IV: Substance Use Type by GSA
SFY 2018 - July 1, 2017 to June 30, 2018

Substance Type[6]	North		South		Central		Statewide	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Opiates	2,484	17.9%	7,385	24.1%	7,686	20.0%	17,555	21.1%
Alcohol	4,068	29.2%	5,934	19.4%	5,108	13.3%	15,110	18.2%
Marijuana/ Hashish	2,824	20.3%	6,179	20.2%	5,212	13.6%	14,215	17.1%
Methamphetamine	2,981	21.4%	6,117	20.0%	6,747	17.6%	15,845	19.1%
Cocaine/Crack	380	2.7%	2,110	6.9%	1,292	3.4%	3,782	4.6%
Other Stimulants	80	0.6%	148	0.5%	165	0.4%	393	0.5%
Benzodiazepines	150	1.1%	372	1.2%	372	1.0%	894	1.1%
Hallucinogens	70	0.5%	90	0.3%	149	0.4%	309	0.4%
Other Sedatives/ Tranquilizers	10	0.1%	45	0.1%	73	0.2%	128	0.2%
All Other	94	0.7%	115	0.4%	190	0.5%	399	0.5%
Null/Missing	788	5.7%	2,055	6.7%	11,425	29.7%	14,268	17.2%
Total	**13,929**	100.0%	**30,550**	100.0%	**38,419**	100.0%	**82,898**	100.0%

Summary of Services

AHCCCS maintains a comprehensive service delivery network providing primary prevention, treatment and rehabilitation programs to children and adolescents with Serious Emotional Disturbances (SED) and/or Substance Use Disorders (SUD), as well as adults with General Mental Health disorders (GMH) and/or SUD, and adults determined to have a Serious Mental Illness (SMI).

With respect to SUD treatment, AHCCCS works diligently with Contractors and TRBHAs to ensure the service delivery network presents individuals with a choice of multiple, highly-

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[6] *Data Source: Data Source: AHCCCS Behavioral Health Demographics & Outcomes data set (DUG data set). Not all members selected for this report had BH Demographics data and there were also members with a BH Demographic, but had no substance use type available. AHCCCS is working on streamlining the data and data collection process to improve data submissions.*

qualified providers, each offering varying levels of care spanning multiple treatment modalities.

Services can primarily be grouped into eight major categories: Inpatient, Support, Medical/Pharmacy, Residential Services, Treatment, Crisis, Behavioral Health Day Programs, and Rehabilitation. Table V (below) details the array of SUD services offered.

Table V: Services Available to Members
**   SFY 2018 - July 1, 2017 to June 30, 2018**

Service Category[7]	Description
Inpatient Services	Inpatient detoxification and treatment services delivered in hospitals and sub-acute facilities, including Level I residential treatment centers that provide 24-hour supervision, an intensive treatment program, and on-site medical services.
Support Services	Case management, self-help/peer support services and transportation.
Medical and Pharmacy	Medications and medical procedures which relieve symptoms of addiction and/or promote or enhance recovery from addiction.
Residential Services	Residential treatment with 24-hour supervision
Behavioral Health Day Programs	Skills training and ongoing support to improve the individual's ability to function within the community. Specialized outpatient substance abuse programs provided to a person, group of persons and/or families in a variety of settings.
Treatment Services	Individual and group counseling, therapy, assessment, evaluation, screening, and other professional services.
Crisis Intervention	Stabilization services provided in the community, hospitals and residential treatment facilities.
Rehabilitation Services	Living skills training, cognitive rehabilitation, health promotion, and ongoing support to maintain employment.

The services listed in Table V are available to all AHCCCS members and are delivered based on need per each member's individualized treatment plan.

As indicated in Table VI (below), on a statewide basis Pharmacy Services were utilized at the highest percentage (27.8%), followed by Inpatient Services (21.4%), whereas Behavioral Health Day Program services were used the least (0.1%). Utilization by service category was consistent across GSAs. Table VI shows utilization of these service categories via the number of claims, and amounts paid to providers, for AHCCCS members served with a SUD. It should be noted that the data in Table VI represents all services included in Table V provided to members with a SUD diagnosis who received at least one paid service from any of the providers in Appendix A.

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[7] *The Service Category Medical and Pharmacy is shown in two rows in Table VI to differentiate the expenditures for the Medical Services compared to the Pharmacy amounts. The Service Category Outpatient Services (UB92) is listed as an additional row in Table VI to represent the Outpatient Hospital Services expenditures.*

Table VI: Utilization by Service Category (Based on Number of Claims and Paid Amount) SFY 2018 - July 1, 2017 to June 30, 2018 [8]

Service Category	North		South		Central		Statewide	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Treatment Services	47,171	$3,100,280	159,129	$11,831,739	323,040	$18,196,398	529,340	$33,128,418
Rehabilitation Services	36,314	$1,078,122	107,192	$3,875,309	117,517	$3,152,120	261,023	$8,105,551
Medical Services	12,147	$277,447	47,092	$1,963,875	223,342	$3,872,583	282,581	$6,113,905
Support Services	180,988	$8,849,648	452,322	$13,121,354	749,938	$21,195,663	1,383,248	$43,166,665
Crisis Intervention Services	4,850	$1,162,464	7,546	$3,557,722	59,608	$13,271,802	72,004	$17,991,988
Inpatient Services	4,102	$21,755,532	4,673	$16,189,800	11,802	$44,577,978	20,577	$82,523,310
Residential Services	32,939	$14,988,233	49,424	$14,844,571	98,201	$30,145,700	180,564	$59,978,505
Behavioral Health Day Programs	82	$64,034	334	$14,159	5,203	$444,124	5,619	$522,317
Outpatient Services (UB92)	17,303	$9,341,342	20,258	$8,247,262	20,235	$9,367,845	57,796	$26,956,449
Pharmacy	205,852	$14,231,102	480,852	$32,641,014	637,582	$60,428,858	1,324,286	$107,300,974
Totals	**541,748**	**$74,848,206**	**1,328,822**	**$106,286,805**	**2,246,468**	**$204,653,071**	**4,117,038**	**$385,788,082**

Summary of Medication Assisted Treatment Services

AHCCCS maintains a comprehensive network of MAT providers throughout the state. These treatment providers use a combination of counseling and ancillary support services with medications for the treatment of OUD. The medications used for OUD treatment are in the form of Methadone, Buprenorphine (Suboxone and/or Subutex) and Naltrexone. AHCCCS maintains a minimum list of medications to ensure the availability of necessary, safe and cost effective medications for persons with behavioral health disorders.

Through AHCCCS' response to the opioid epidemic, efforts have been focused toward enhancing the state's multi-sector strategic plan to address the gaps in prevention, treatment and recovery support. These specific initiatives include; increasing access to OUD treatment, expanding access to MAT, increase public awareness through stigma reduction and education, enlisting new MAT providers, ensuring 24/7 access to care points, increasing access to peer support services and increasing recovery support options.

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[8] *Data Source: AHCCCS Encounter and Claims Data. The data methodology has been improved to more accurately reflect the utilization of SUD services and is not comparable to previous reports. The previous methodology reported all claims for individuals receiving SUD services including claims for physical health services not directly related to SUD diagnoses. The current methodology excludes claims for physical health services not directly related to SUD diagnoses and thus reflects fewer claims and lower payments than prior years.*

A key component of the Arizona strategy for preventing overdose deaths from opioids is through increasing community-based access to Naloxone, the overdose reversal medication. AHCCCS continues to partner with contracted network providers and first responders to enhance statewide Naloxone distribution and accessibility. 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. From January 1, 2017 through October 15, 2018, AHCCCS grant funding enabled local entities to distribute 184,747 doses of Naloxone throughout Arizona.[9]

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 is given to geographic areas identified through epidemiological data as high needs areas.

Table VII: MAT Medication Utilization
SFY 2018 - July 1, 2017 to June 30, 2018

MAT Medication Utilization[10]	North		South		Central		Statewide	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Total	584	5.2%	3,399	30.2%	7,279	64.6%	11,262	100.0%

Table VIII: Services in Conjunction with MAT Medications

Support Services Type	North		South		Central		Statewide	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Inpatient Services	5	1.1%	0	0.0%	1	0.1%	6	0.1%
Support Services	341	76.8%	23,964	63.4%	17,590	22.0%	41,895	35.6%
Residential Services	29	6.5%	3,042	8.0%	5,880	7.4%	8,951	7.5%
Medical Services	6	1.4%	551	1.5%	43,883	55.1%	44,440	37.7%
Treatment Services	47	10.6%	6,217	16.4%	10,676	13.4%	16,940	14.3%
Crisis Intervention Services	16	3.6%	0	0.0%	50	0.1%	66	0.1%
Behavioral Health Day Programs	0	0.0%	0	0.0%	75	0.1%	75	0.1%
Rehabilitation Services	0	0.0%	4,029	10.7%	1,446	1.8%	5,475	4.6%
Totals	444	100.0%	37,803	100.0%	79,601	100.0%	117,848	100.0%

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[9] *With State Targeted Response to the Opioid Crisis (Opioid STR) funding, Arizona Department of Health Services has distributed 29,717 Naloxone doses dispensed in Arizona; With Arizona's Substance Abuse Block Grant (SABG) funding, Sonoran Prevention Works has distributed 155,030 doses throughout Arizona.*
[10] *Data Source: AHCCCS Claims & Encounter data.*

Treatment Outcomes

AHCCCS employs a variety of mechanisms to measure the effectiveness of treatment, including assessing the change in numerous functional outcome indicators for members receiving behavioral health services. SAMHSA has established a set of National Outcome Measures (NOMs) to capture an individual's improvement in the areas of employment, educational participation, abstinence from alcohol or other drugs, criminal activity and homelessness.

Table IX (below) delineates the percentages at admission and discharge, and corresponding change, in each of the outcome domains for those receiving treatment for a SUD. For example, the number of members reducing or abstaining from alcohol at discharge from treatment programs in State Fiscal Year 2018 was 28.0% greater in relation to those abstaining from alcohol at the time of admission to the program.

Participation in self-help programs at discharge was 56.5% greater than at admission. Although this was a significant increase, only a small number of members were participating in self-help programs at the time of admission, resulting in this relative change.

The Table illustrates a negative 7.8% change for individuals having recent involvement with the Criminal Justice System at discharge compared to the time of admission, indicating a reduction in recidivism throughout treatment. Through the TRBHAs and RBHAs, AHCCCS continues its efforts to provide behavioral health services, housing and employment supports to members to improve their stability in the community and positively impact recidivism. In addition, AHCCCS mandated "Reach–In" activities are conducted for individuals prior to release for the purpose of care coordination and timely access to services after release.

Table IX: Treatment Outcomes
SFY 2018 - July 1, 2017 to June 30, 2018

Outcomes[11]	How has participating in the behavioral health system impacted the lives of our members?		
Members with Substance Use:	**Percentage at Admission**	**Percentage at Discharge**	**Percentage Change**
No Alcohol Use	28.9%	37.0%	**+28.0%**
No (Other) Drug Use	25.7%	33.1%	**+28.8%**
Participate in Self-Help Programs During Treatment	2.3%	3.6%	**+56.5%**
Are Not Homeless	90.0%	90.6%	**+0.1%**
Are Competitively Employed Full or Part-Time	24.3%	27.1%	**+11.5%**
Recent Involvement with the Criminal Justice System	11.1%	10.3%	**-7.8%**

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[11] *Data Source: SFY2018 Substance Abuse Prevention and Treatment Block Grant Application, T-Form Data, Performance Measures.*

Summary

AHCCCS continues to implement strategies to maximize the benefit to Arizonans who need treatment for SUD. These efforts have been conducted in partnership with other state agencies, Contractors, providers and stakeholders committed to assisting those seeking assistance in improving their quality of life and success in the community. The comprehensive array of services provided through the funding described in this Report provide opportunity for each member in need of SUD services to be provided with treatment through the use of evidence based practices and individualized treatment planning. Services are available statewide tailored to be clinically and culturally appropriate for all age groups, genders, races, ethnic backgrounds and other areas of diversity.

Moving forward into 2019, AHCCCS is broadening the scope of available services through the integration of the GMH/SUD services through the AHCCCS Complete Care Plans (fully integrated Plans addressing members' physical and behavioral health needs) in addition to the RBHAs and TRBHAs. A holistic approach to treating individuals' SUD needs as well as addressing any co-occurring behavioral or physical health concerns will provide the best potential outcomes and cost savings to Arizonans. AHCCCS is enhancing its focus on Social Determinants of Health (SDoH), and is encouraging access to related resources that support recovery which have shown promise nationally and are foundational in addressing SUD.

The availability of Naloxone and expanded access to MAT has been successful in 2018 and will serve as the foundation in addressing the opioid epidemic going forward in 2019. AHCCCS is committed to serving as a leader in the state and country in reducing stigma associated with SUD, reversing the trend of overdose deaths and utilizing funding in the most cost-effective manner possible to support recovery.

Appendix A:
Name and Location of SUD Programs

Program Name	Service Address	City	State	Zip
A Path of Resilience	1752 East Carter Road	Phoenix	AZ	85042
Amity at Circle Tree Ranch	10500 E. Tanque Verde Rd.	Tucson	AZ	85749
ARIZONA BEHAVIORAL CARE HOMES - GILBERT 3	1101 E. GOLDCREST STREET	Gilbert	AZ	85297
ARIZONA BEHAVIORAL CARE HOMES - GOODYEAR 1	16575 WEST ROOSEVELT STREET	Goodyear	AZ	85338
ARIZONA BEHAVIORAL CARE HOMES - GOODYEAR 3	560 NORTH 159TH LANE	Goodyear	AZ	85338
Arizona Behavioral Care Homes, LLC,dba	16781West Hilton Avenue	Goodyear	AZ	85323
Arizona Behavioral Care Homes, LLC,dba	230 East Frances Lane	Gilbert	AZ	85295
Arizona Behavioral Care Homes, LLC,dba	1469 East Ivanhoe Street	Gilbert	AZ	85295
Arizona Behavioral Care Homes, LLC,dba	1101 East Goldcrest Street	Gilbert	AZ	85297
Arizona Behavioral Care Homes, LLC,dba	1024 North Ridge Circle	Mesa	AZ	85203
Arizona Behavioral Care Homes, LLC,dba	16800 West Roosevelt Street	Goodyear	AZ	85338
Arizona Behavioral Care Homes, LLC,dba	1946 S 174th Lane	Goodyear	AZ	85338
Arizona Center for Change	4205 N 7th Ave	Phoenix	AZ	85013
ARIZONA MENTOR-JASMINE	12502 NORTH 85TH LANE	Peoria	AZ	85381
Ascend Behavioral Health & Wellness	2432 W. Eagle Feather Rd.	Phoenix	AZ	85085
Ascend Behavioral Health & Wellness	35005 N. 27th Lane	Phoenix	AZ	85086
Ascend Behavioral Health & Wellness	27818 N. 24th Lane	Phoenix	AZ	85085
Ascend Behavioral Health & Wellness	512 W. Yearling	Phoenix	AZ	85085
Ascend Behavioral Health & Wellness	33508 N. 27th Ave.	Phoenix	AZ	85085
Aspire/Community Bridges	1012 S. Stapley Dr., Bldg. 5	Mesa	AZ	85204
Aurora Behavioral Health Level I Hospital	6015 W. Peoria Ave	Glendale	AZ	85302
Aurora Behavioral Health Level I Hospital	6350 Maple Ave.	Tempe	AZ	85283
AZ Comfort Home	23832 W TONTO STREET	Buckeye	AZ	85326
BAART	908 A W. Chandler Blvd	Chandler	AZ	85225
Baraka House	3740 W. CARON STREET	Phoenix	AZ	85051
Baraka House IV	7445 W. CHERYL DRIVE	Peoria	AZ	85345
Bayless Healthcare (Therapeutic Wellness)	77 E. Columbus Ave. Ste. 210	Phoenix	AZ	85012
Bayless Healthcare(South Phoenix)	9014 S. Central Ave.	Phoenix	AZ	85042
Bayless Integrated Healthcare	3033 N Central Ave, Ste 700	Phoenix	AZ	85012
Bayless Primary Care	3620 N. 3rd St.	Phoenix	AZ	85012
Bayless Primary Care	2204 S. Dobson Rd., Ste 102/201	Mesa	AZ	85202
Beautiful Beginnings	5321 W. NOVAK WAY	Laveen	AZ	85339
Beautiful Beginnings	2819 S. 73rd DRIVE	Phoenix	AZ	85043
Beautiful Beginnings	7316 W. CORDES ROAD	Phoenix	AZ	85043
Benchmark Valley Behavioral Health	5625 W. EUCLID AVENUE	Laveen	AZ	85339
Benchmark Valley Behavioral Health	5818 W. PADRO LANE	Laveen	AZ	85339
Benchmark Valley LLC, dba	5818 West Pedro Lane	Laveen	AZ	85339
Benchmark Valley LLC, dba	5625 West Euclid Avenue	Laveen	AZ	85339

Program Name	Service Address	City	State	Zip
BENTLEY'S TRANSITIONAL LIVING LLC	6432 SOUTH 23RD AVENUE	Phoenix	AZ	85041
Black Family and Child Services	1522 E. Southern Ave	Phoenix	AZ	85040
Building Blocks Counseling	7725 N 43rd Ave., Ste 522	Phoenix	AZ	85051
CBI/Albert Long Residential Program	993 HERMOSA DR. AREA B	Holbrook	AZ	86025
CBI/Arizona Bridge to Recovery	554 S. BELLVIEW, RM B	Mesa	AZ	85204
CBI/Benson Stabilization & Recovery Unit	646 W. UNION ST.	Benson	AZ	85602
CBI/Case Grande Stabilization & Recovery Unit	675 E. Cottonwood, Suite 104	Casa Grande	AZ	85122
CBI/Central City Addiction Recovery	2770 E. Van Buren	Phoenix	AZ	85008
CBI/East Valley Addiction Recovery Center	560 S. BELLVIEW	Mesa	AZ	85204
CBI/Globe Stabilization & Recovery Unit	5734 E. Hope Lane, Globe	Globe	AZ	85501
CBI/Payson Stabilization & Recovery Unit	803 W. Main St.	Payson	AZ	85541
CBI/West Valley Transition Point	824 N. 99th Ave. Suite 108	Avondale	AZ	85323
CBI/Winslow Stabilization & Recovery	110 E. 2nd STREET	Winslow	AZ	86047
CBI-Renaissance House (Women)	240 Ohara Ave.	Bisbee	AZ	85603
Center for Behavioral Health, Inc.	2123 E. Southern Ave. Ste. 2,	Tempe	AZ	85282
Center for Behavioral Health, Inc.	1501 E. Washington St.	Phoenix	AZ	85034
Center for Hope-Community Bridges	554 Bellview	Mesa	AZ	85204
Chalet House	6633 N. Amahl Circle	Tucson	AZ	85704
Chalet House	6849 S. Tackweed Way	Tucson	AZ	85756
Changepoint Integrated Health	103 N. 1st Ave. Holbrook	Holbrook	AZ	86025
Changepoint Integrated Health	2500 E. Show Low Lake Rd	Show Low	AZ	85901
Changepoint Integrated Health	423 N. Main St.	Snowflake	AZ	85937
Changepoint Integrated Health	1015 E. Second St.	Winslow	AZ	86047
Changepoint Integrated Health	1920 W. Commerce Dr	Lakeside	AZ	85929
Chinle DBHS	PO Drawer 709	Window Rock	AZ	86515
Clean Slate Centers	15255 N 40th Sr., Bldg 5, Ste 135	Phoenix	AZ	85032
Clean Slate Centers	8410 W. Thomas Rd., #124	Phoenix	AZ	85037
Clean Slate Centers	2451 E. Baseline Rd., #430	Gilbert	AZ	85234
CODAC	630 N. Alvernon	Tucson	AZ	85711
CODAC - Broadway - Men's Services	3130 E. Broadway	Tucson	AZ	85716
CODAC - Cobblestone Court	1075 E. Fort Lowell Rd	Tucson	AZ	85719
CODAC- COE	380 E. Fort Lowell Rd	Tucson	AZ	85705
CODAC-Las Amigas (Women)	1600 N. Country Club	Tucson	AZ	85716
Community Bridges	803 W. Main St. Ste. A	Payson	AZ	85541
Community Bridges	648 W. Union St.	Benson	AZ	85602
Community Bridges	5734 E Hope Lane	Globe	AZ	85501
Community Bridges	554 S. Bellview, Room B	Mesa	AZ	85204
Community Bridges	675 E. Cottonwood Lane, Ste. 104	Casa Grande	AZ	85122
Community Bridges	2770 E. Van Buren St., Rooms A,B,D	Phoenix	AZ	85008
Community Bridges	2770 E. Van Buren St.	Phoenix	AZ	85008
Community Bridges	358 E. Javelina Ave., Ste. 102	Mesa	AZ	85210

Program Name	Service Address	City	State	Zip
Community Bridges	358 E. Javelina Ave., Ste. 101	Mesa	AZ	85210
Community Bridges	2950 N. Dodge Blvd.	Tucson	AZ	85716
Community Bridges	560 S. Bellview, Room A	Mesa	AZ	85204
Community Bridges	560 S. Bellview, Room B & C	Mesa	AZ	85204
Community Bridges	250 S. Toole Ave.	Tucson	AZ	85701
Community Bridges	250 S. Toole Ave.	Tucson	AZ	85701
Community Bridges	8324 N. 99th Ave., Ste. 109	Avondale	AZ	85323
Community Bridges	803 W. Main St. Ste. A	Payson	AZ	85541
Community Bridges	675 E. Cottonwood Lane	Casa Grande	AZ	85048
Community Bridges	3250 E. 40th St.	Yuma	AZ	85365
Community Bridges	3250 E. 40th St.	Yuma	AZ	85365
Community Bridges - Arizona Bridge to Recovery	554 S. Bellview	Mesa	AZ	85204
Community Bridges - Aspire	1012 S. Stapley Dr., Bldg. 5	Mesa	AZ	85204
Community Bridges - Aspire	1012 S. Stapley Dr., Bldg. 5	Mesa	AZ	85204
Community Bridges - Casa Grande OSC	675 E. Cottonwood	Casa Grande	AZ	85122
Community Bridges - Center for Hope	554 S. Bellview	Mesa	AZ	85204
Community Bridges - EVARC	560 S. Bellview	Mesa	AZ	85204
Community Bridges - MAT - SUD BHRF	470 S Ocotillo Ave	Benson	AZ	85602
Community Bridges - Scottsdale Outpatient	8541 E Anderson Dr., Ste 105	Scottsdale	AZ	85255
Community Bridges - Scottsdale Unscript	8541 E Anderson Dr., Ste 105	Scottsdale	AZ	85255
Community Bridges 99th Ave ACT	824 n. 99th ave #107	Avondale	AZ	85323
Community Bridges East Valley Addiction Center	560 S. Bellview	Mesa	AZ	85204
Community Bridges East Valley Addiction Center	560 S. Bellview	Mesa	AZ	85204
Community Bridges FACT 1	1125 W Jackson St	Phoenix	AZ	85007
Community Bridges FACT 2	1125 W Jackson St	Phoenix	AZ	85007
Community Bridges FACT 3	1125 W Jackson St	Phoenix	AZ	85007
Community Bridges- Globe SRU	5737 E. Hope Lane	Globe	AZ	85501
Community Bridges- Payson Outpatient	803 W. Main St.	Payson	AZ	85541
Community Bridges- Unscript	8541 E. Anderson Dr.	Scottsdale	AZ	85255
Community Bridges-Access & Transition Point	824 N. 99th Ave.	Avondale	AZ	85323
Community Bridges-Albert Long Residential TX Center	993 N. Hermosa Dr	Holbrook	AZ	86025
Community Bridges-Albert Long Residential TX Center	993 N. Hermosa Dr	Holbrook	AZ	86025
Community Bridges-Central City Addictions Recovery Center	2770 E. Van Buren St.	Phoenix	AZ	85008
Community Bridges-Central City Addictions Recovery Center	2770 E. Van Buren St.	Phoenix	AZ	85008
Community Bridges-Central City Addictions Recovery Center	2770 E. Van Buren St.	Phoenix	AZ	85008
Community Bridges-Detox/ACCESS Point	250 S. Toole Ave.	Tucson	AZ	85701
Community Bridges-Globe Outpatient	5734 E. Hope Lane	Globe	AZ	85501
Community Bridges-West Valley Access & Transition Point	824 N. 99th Ave. Ste 108	Avondale	AZ	85323
Community Bridges-West Valley Access & Transition Point	824 N. 99th Ave. Ste 108	Avondale	AZ	85323
Community Bridges-Winslow Outpatient	110 E. Second St	Winslow	AZ	86047
Community Bridges-Winslow SRU	105 N. Cottonwood Ave	Winslow	AZ	86047

Program Name	Service Address	City	State	Zip
Community Bridges-Winslow SRU	105 N. Cottonwood Ave	Winslow	AZ	86047
Community Health Associates	1773 W. St. Mary's Rd, Suite 105	Tucson	AZ	85745
Community Health Associates	275 W. Continental Rd, Suite 133 A, B, C and D	Green Valley	AZ	85622
Community Health Associates	1923 N. Trekell Rd	Casa Grande	AZ	85122
Community Health Associates	1326 Highway 92, Suite J	Bisbee	AZ	85603
Community Health Associates	1701 North Douglas	Douglas	AZ	85607
Community Health Associates	1516 Ocotillo Avenue	Parker	AZ	85344
Community Health Associates	32 Blvd Del Rey David	Nogales	AZ	85621
Community Health Associates	2851 S. Avenue B Bldg 4 and 11	Yuma	AZ	85364
Community Health Associates	1938 E. Juan Sanchez Blvd. Suite 4	San Luis	AZ	85349
Community Medical Services	3825 N. 24th St.	Phoenix	AZ	85016
Community Medical Services	2301 W. Northern Ave.	Phoenix	AZ	85021
Community Medical Services	6116 E. Arbor Ave. Bldg 1 Ste.104	Mesa	AZ	85206
Community Medical Services	2001 W. Orange Grove Ste 202	Tucson	AZ	85704
Community Medical Services	6626 E. Carondelet Dr.	Tucson	AZ	85710
Community Medical Services	6116 E. Arbor Ave. Bldg 1 Ste.104	Mesa	AZ	85206
Community Medical Services	5002 W Glendale Ave., Ste 101	Glendale	AZ	85301
Community Medical Services - Alpha Medical Services	3825 N. 24th St.	Phoenix	AZ	85016
Community Medical Services - Medication Unit **	102 E. Main St.	Safford	AZ	85546
Community Medical Services - Medication Unit **	440 N. Camino Mercado	Casa Grande	AZ	85122
Community Partners Integrated Healthcare	2039 E. Wilcox Drive Suite A	Sierra Vista	AZ	85635
Community Partners Integrated Healthcare	301 E. 4th Street Suite A	Safford	AZ	85546
Community Partners Integrated Healthcare	1021 S. Kofa Avenue	Parker	AZ	85344
Community Partners Integrated Healthcare	2545 S. Arizona Avenue	Yuma	AZ	85364
Community Partners Integrated Healthcare	3939 South Park Avenue Suite 150	Tucson	AZ	85714
Community Partners Integrated Healthcare	1515 E Osborn Rd	Phoenix	AZ	85014
Community Partners Integrated Healthcare- Children	1010 E. Palmdale Street Suite 150	Tucson	AZ	85714
Connections Health Solutions	3333 N 7th Ave.	Phoenix	AZ	85013
COPE - Craycroft Integrated Care	620 N. Craycroft Rd	Tucson	AZ	85711
COPE - Northwest Integrated Care	5840 N. La Cholla Blvd	Tucson	AZ	85741
COPE - Thrive Youth and Family Center	924 N. Alvernon Way	Tucson	AZ	85711
COPE - Villa Verde	1660 W. Commerce Point Place	Green Valley	AZ	85614
COPE Community Services	5401 E. 5th St.	Tucson	AZ	85712
COPE- La Cholla Clinic	1501 W. Commerce Court	Tucson	AZ	85746
COPE- Lakeside Integrated Care	8050 E. Lakeside Parkway	Tucson	AZ	85730
Corazon	900 E. Florence Blvd	Casa Grande	AZ	85122
Corazon	1891 N. Mastick Way	Nogales	AZ	85621
Corazón-Chicanos por La Causa (Male Program)	3639 W. Lincoln St.	Phoenix	AZ	85009
CPES	4444 E. Grant Rd. #116	Tucson	AZ	85712
CPES	2180 S. 4th Ave, Suite H	Yuma	AZ	85364
CPES- Can also serve Graham/Greenlee	324 S. Ocotillo Ave	Benson	AZ	85602

Program Name	Service Address	City	State	Zip
CPLC Centro Esperanza	310 S. Extension	Mesa	AZ	85210
CPLC Corazon	3630 W Lincoln St	Phoenix	AZ	85009
CPLC Friendship Community Mental Health Center	1107 E Tonto St.,	Phoenix	AZ	85034
CPLC Maryvale	6580 W Indian School Rd	Phoenix	AZ	85033
Crisis Preparation and Recovery	10799 N 90th St., Ste 100	Scottsdale	AZ	85260
Crisis Preparation and Recovery	2120 S. McClintock Dr.	Tempe	AZ	85282
Crossroads - Arcadia	5116 E Thomas Rd.	Phoenix	AZ	85018
Crossroads - East	1845 East Ocotillo Rd.	Phoenix	AZ	85016
Crossroads - Flower	1632 E Flower St.	Phoenix	AZ	85016
Crossroads - Midtown	3702 N 13th Ave.	Phoenix	AZ	85013
Crossroads - Red Mountain	143 S Center St.	Mesa	AZ	85210
Crossroads - West	4201 N 16th St. Ste 110	Phoenix	AZ	85016
CrossRoads INC	141&142 South Center Street	Mesa	AZ	85210
CrossRoads INC	7523 North 35th Avenue	Phoenix	AZ	85051
Crossroads Mission	944 S. Arizona Avenue	Yuma	AZ	85364
Danster LLC	11949 West Alvarado Road	Avondale	AZ	85392
Desert Senita	410 N. Malacate Street	Ajo	AZ	85321
Destiny Behavioral Health	2911 S 87th Drive	Tolleson	AZ	85353
Destiny Behavioral Health ,LLC 5	10313 Hess Street	Tolleson	AZ	85353
Destiny Behavioral Health Residential	8809 West Preston Lane	Tolleson	AZ	85353
Destiny Behavioral Health, LLC 2	8824 West Preston Lane	Tolleson	AZ	85353
Destiny Behavioral Health, LLC 3	3427 South 84th Lane	Tolleson	AZ	85353
Destiny Sober Living	5306 N. 17th Ave	Phoenix	AZ	85015
Destiny Sober Living	11629 S. 43rd Ave.	Laveen	AZ	85339
Destiny Sober Living (Men)	5306 N 17th Ave	Phoenix	AZ	85015
Destiny Sober Living (Women)	11629 S 43rd Ave.,	Laveen	AZ	85339
Devereux Foundation, dba	6436 East Sweetwater Avenue	Scottsdale	AZ	85254
Dilkon DBMHS	PO Box 7072	Winslow	AZ	86047
Eagles Nest Group Home Boys and Girls	1802 East Dobbins Road	Phoenix	AZ	85042
Ebony House	6222 S. 13th St.	Phoenix	AZ	85042
Ebony House (Men)	6222 S. 13th St.	Phoenix	AZ	85042
Ebony House (Women)	8646 S. 14th St.	Phoenix	AZ	85042
Emmarie Behavioral Health	7725 W. Wood Lane	Phoenix	AZ	85043
Emmarie Behavioral Health	3031 W. Burgess Lane	Phoenix	AZ	85041
Emmarie Behavioral Health	5748 W. Wood Lane	Phoenix	AZ	85043
Emmarie Behavioral Health	2926 W. Wayland	Phoenix	AZ	85043
Emmarie Behavioral Home Care	5748 W. Hidalgo Ave.	Phoenix	AZ	85339
Empact Comunidad, Empact/La Frontera	1035 E. Jefferson #A	Phoenix	AZ	85034
Empact- SPC	11518 E. Apache Trail Suite 129	Apache Junction	AZ	85120
Empact Tempe Clinic, Empact/La Frontera	618 S. Madison Dr.	Tempe	AZ	85281
Encompass Health Services	463 S. Lake Powell Blvd	Page	AZ	86040

Program Name	Service Address	City	State	Zip
Encompass Health Services	4103 E Fleet, Ste 100	Littlefield	AZ	86040
Encompass Health Services SRU	32 N. 10th Ave., Ste. 5	Page	AZ	86040
Encompass Health Services-Fredonia Outpatient Services	170 N. Main St	Fredonia	AZ	86022
Eureka Annex Residence	2668 S. Heritage Dr.	Gilbert	AZ	85295
Eureka Imperial Residence	2668 S. Heritage Dr.	Gilbert	AZ	85295
Eureka Imperial Residence	1740 S. Heritage Dr.	Gilbert	AZ	85295
Family Service Agency	2400 N. Central Ave Ste. 101	Phoenix	AZ	85004
Family Service Agency	10220 N. 31st Ave Ste. 103-105	Phoenix	AZ	85051
Family Service Agency	1107 S Gilbert Rd., Ste 104	Mesa	AZ	85204
Flagstaff Medical Center Level I Hospital	1200 North Beaver St.	Flagstaff	AZ	86001
Florence Crittenton Services	715 W Mariposa St	Phoenix	AZ	85013
Focused Family Services	1634 N 19th Ave.	Phoenix	AZ	85009
Fort Defiance DBHS	PO Box 1490	Fort Defiance	AZ	86504
Friendship Community Mental Health Center	1107 E Tonto St	Phoenix	AZ	85034
Gila River Behavioral Health - Oasis D3	291 W. Casa Blanca Road	Sacaton	AZ	85147
Gila River Behavioral Health - Oasis D5	3455 W. Casa Blanca Road	Bapchule	AZ	85339
Gila River Behavioral Health - Oasis D6	4577 W. Pecos Lane	Laveen	AZ	85339
Gila River Behavioral Health - Thwajik Ke	3850 N. 16th Street	Laveen	AZ	85339
Gila River Behavioral Health - Thwajik Ke	3850 N. 16th Street	Laveen	AZ	85339
Golden Cross Healthcare Services	1523 West Colter Street #44	Phoenix	AZ	85015
Helping Associates	1901 N Trekell Suite A	Casa Grande	AZ	85222
Helping Associates	1000 E. Racine PL	Casa Grande	AZ	85122
Helping Associates	1901 N. Trekell Road	Casa Grande	AZ	85122
Hope Behavioral Health Residential Care	132870 W. Woodlands Ave.	Goodyear	AZ	85338
Hope Behavioral Health Residential Care	15985 W. William Street	Goodyear	AZ	85338
Hope Behavioral Health Residential Care LLC	16181 West Madison Street	Goodyear	AZ	85338
Hope Behavioral Health Residential Care LLC	15985 West Williams Street	Goodyear	AZ	85338
HOPE, INC	1200 N. Country Club	Tucson	AZ	85716
HOPE, INC	201 S. 1st Ave	Yuma	AZ	85364
HOPE, INC - ESPERANZA	4067 E. Grant Rd	Tucson	AZ	85712
Horizon Health and Wellness	210 E Cottonwood Lane	Casa Grande	AZ	85122
Horizon Health and Wellness	791 S 4th Ave	Yuma	AZ	85364
Horizon Health and Wellness	478 Hagen Rd	Globe	AZ	85501
Horizon Health and Wellness	478 Hagen Rd	Globe	AZ	85501
Horizon Health and Wellness	3180 E. 40th St.	Yuma	AZ	85365
Horizon Health and Wellness-STOP	625 N. Plaza Dr.	Apache Junction	AZ	85120
Horizons Health and Wellness Peart IV	2271 S. Peart Rd	Casa Grande	AZ	85222
Hu Hu Kam Memorial Hospital	483 Seed Farm Road	Sacaton	AZ	85147
Infinity Group Home 1	12643 N. 22nd. Ave	Phoenix	AZ	85032
Infinity Group Home 2	15111 N. 33rd Place	Phoenix	AZ	85032
Infinity Group Home 3	2146 E. Everette Drive	Phoenix	AZ	85022

Program Name	Service Address	City	State	Zip
Intensive Treatment Systems	4136 N. 75th Ave. Ste. 116	Phoenix	AZ	85033
Intensive Treatment Systems	19401 N. Cave Creek Rd. Ste. 18	Phoenix	AZ	85024
Intensive Treatment Systems	651 W. Coolidge St.	Phoenix	AZ	85013
Intermountain	Tohono Plaza Bia Route 19 Ste 409	Sells	AZ	85634
Intermountain	5055 E Broadway Blvd C104	Tucson	AZ	85711
Intermountain	276 W. Viewpoint Drive	Nogales	AZ	85621
INTERMOUNTAIN Admin Office	994 S Harrison Rd.	Tucson	AZ	85748
Intermountain- Adolescent SUD BHRF	220 S. Avenida Los Reyes	Tucson	AZ	85748
Intermountain Center for Human Development-Angel House	1310 N Speedway Pl	Tucson	AZ	85731
Intermountain Center for Human Development-Kiva Apts	Bld 2 3636 East Lee St	Tucson	AZ	85731
Intermountain Center for Human Development-Kiva House	Bld 1 3626 East Lee Street	Tucson	AZ	85731
Intermountain Center for Human Development-Vida Nueva	3815 East Monte Vista Apt G	Tucson	AZ	85731
Intermountain Health Center	5055 East Broadway C104	Tucson	AZ	85711
Jesa Homes LLC	2328 W. Darrel Rd	Phoenix	AZ	85041
Jewish Family and Children Services	5701 W. Talavi Blvd. Ste. 180	Glendale	AZ	85306
Jewish Family and Children Services	1255 W. Baseline Rd. Ste. B258	Mesa	AZ	85202
Jewish Family and Children Services	1840 N. 95th Ave. Ste. 146	Phoenix	AZ	85037
Jewish Family and Children Services - (Michael R Zent)	3001 N. 33rd Ave.	Phoenix	AZ	85017
Jussamal Manor II	641 S. Karen Drive	Chandler	AZ	85244
Jussamal Manor LLC	1302 W. Kessler Lane	Chandler	AZ	85224
Kaibeto Department of BHS	PO Drawer 709	Window Rock	AZ	86515
Kayenta DBHS	PO Drawer 709	Window Rock	AZ	86515
Konadu Family	40030 W. Coltin Way	Maricopa	AZ	85138
La Frontera	502 W. 29th Street	Tucson	AZ	85713
La Frontera	1141 W. Grant Rd, Suite 100	Tucson	AZ	85705
La Frontera	260 S. Scott Ave.	Tucson	AZ	85701
La Frontera	1900 W. Speedway Blvd.	Tucson	AZ	85745
La Frontera- Broadway Clinic- DUI Services	1101 E. Broadway, Suite 130	Tucson	AZ	85719
La Frontera- East Clinic	4891 E. Grant Rd	Tucson	AZ	85712
La Frontera Empact-Suicide Prevención	11518 E. Apache Trail, Ste. 129	Apache Junction	AZ	85210
La Frontera Empact-Suicide Prevención	2474 E. Hunt Hwy. Ste. C100	San Tan Valley	AZ	85143
La Frontera Empact-Suicide Prevención	4425 W. Olive Ste. 194	Glendale	AZ	85302
La Frontera Empact-Suicide Prevención	618 S. Madison Dr.	Tempe	AZ	85281
La Frontera- Mountain Clinic	3620 N. Mountain	Tucson	AZ	85719
La Frontera- New Life	1082 E. Ajo, Suite 100	Tucson	AZ	85713
La Frontera- Southwest Clinic	1210 E. Pennsylvania St	Tucson	AZ	85714
La Frontera-Casa de Vida	260 S. Scott Ave	Tucson	AZ	85701
La Tonya King	1122 E. Buckeye Rd. # B-1	Phoenix	AZ	85034
Lifewell Behavioral Health	3301 E Pinchot Ave	Phoenix	AZ	85018
Lifewell Behavioral Health	3540 E Baseline Rd ste 150	Phoenix	AZ	85012
Lifewell Behavioral Health	4451 E Oak	Phoenix	AZ	85018

Program Name	Service Address	City	State	Zip
Lifewell Behavioral Health	2715 N 3rd St	Phoenix	AZ	85012
Lifewell Behavioral Health	619 W. Southern Ave.	Mesa	AZ	85210
Lifewell Behavioral Health	621 W. Southern Ave.	Mesa	AZ	85210
Lifewell Behavioral Health	3222 N. 37th St.	Phoenix	AZ	85018
Lifewell Behavioral Health - Beryl	2505 W Beryl Ave	Phoenix	AZ	85021
Lifewell Behavioral Health - Main	6915 E Main St. 2nd Floor	Mesa	AZ	85207
Lifewell Behavioral Health - Mitchell	40 E Mitchell Dr Ste 100 & 200	Phoenix	AZ	85012
Lifewell Behavioral Health - University	262 E University Dr	Mesa	AZ	85201
LIFEWELL BEHAVIORAL WELLNESS, INC - HIGHLAND	119 WEST HIGHLAND	Phoenix	AZ	85013
Little Colorado Behavioral Health Services	50 N. Hopi Dr.	Springerville	AZ	85938
Little Colorado Behavioral Health Services	470 W. Cleveland	St. John	AZ	85936
Live Well Assisted Living, LLC, dba	10258 West Windsor Blvd.	Phoenix	AZ	85037
Live Well Assisted Living, LLC, dba	12634 West Estero Lane	Litchfield	AZ	85340
Loloma House, LLC	7402 W. Shangri Lane	Peoria	AZ	85345
Loloma House, LLC	15259 N. 67th. Drive	Peoria	AZ	85381
Maricopa County Adult Probation	125 S. 1st Ave, 1st Floor	Phoenix	AZ	85003
Maricopa County Adult Probation	111 S. 3rd Ave, WCB 5th Floor	Phoenix	AZ	85003
Maricopa County Adult Probation	6655 W. Glendale Ave	Glendale	AZ	85301
Maricopa County Adult Probation	245 N. Centennial Way	Mesa	AZ	85201
Maricopa County Adult Probation	2445 W. Indianola Ave	Phoenix	AZ	85015
Martha's Group Home, LLC	22958 W. Pima Street	Buckeye	AZ	85326
Mary Group Home, LLC	7136 S. 13th Way	Phoenix	AZ	85042
Mary's Group Home LLC	7136 South 13th Way	Phoenix	AZ	85042
Mary's Mission and Developmental Center	345 Taylor Drive	Sierra Vista	AZ	85635
Mary's Mission and Developmental Center	8360 South Highway 92	Hereford	AZ	85615
Mary's Mission and Developmental Center	736 N. Country Club Drive	Mesa	AZ	85201
MHC Healthcare- Clinica Del Alma	3690 S. Park, Suite 805	Tucson	AZ	85713
MHC Healthcare- Marana Main Health Center	13395 N. Marana Main Street, Bldg B	Marana	AZ	85653
MHC Healthcare- Santa Catalina	16701 N. Oracle Road #135	Catalina	AZ	85739
MHC Healthcare- Wilmot Family Health	899 N. Wilmot Rd, Bldg B	Tucson	AZ	85711
MICHEAL R ZENT HEALTHCARE CLINIC (IHH)	3001 N. 33rd Ave	Phoenix	AZ	85017
MIHS Mesa Riverview	570 W. Brown	Mesa	AZ	85201
Mingus Mountain Estate Residential Center INC	15801 East Don Carlos Drive	Prescott Valley	AZ	86314
Mingus Mountain Estate Residential Center INC	3801 North Robert Road	Prescott Valley	AZ	86312
Mingus Mountain Estate Residential Center INC	100 Dewey Road	Dewey	AZ	86327
Mingus Mountain Estate Residential Center INC	2430 West Whitefeather Lane	Phoenix	AZ	85085
Mohave Mental Health	3505 Western Ave	Kingman	AZ	86409
Mohave Mental Health	3505 Western Ave	Kingman	AZ	86409
Mohave Mental Health Clinics	1145 Marina Blvd.	Bullhead City	AZ	86442
Mohave Mental Health Clinics	1741 Sycamore Ave.	Kingman	AZ	86409
Mohave Mental Health Clinics	151 Rivera Ste. B	Lake Havasu City	AZ	86403

Program Name	Service Address	City	State	Zip
Montevista Hospital	5900 W. Rochelle Ave.	Las Vegas	AZ	89103
Mountain Top Behavioral Health Services, LLC	73190 W. Maldonado Road	Laveen	AZ	85339
Mountain Top Behavioral Health Services, LLC	3331 W. Fraktur Road	Phoenix	AZ	85041
Mountain Top Behavioral Health Services, LLC	3838 W. Dunbar Drive	Phoenix	AZ	85041
MUCO Behavioral Health Residential Home,LLC	7216 West Ironwood Drive	Peoria	AZ	85345
MUCO Behavioral Health Residential Home,LLC-2	9010 North 63rd Drive	Glendale	AZ	85302
Mwangaza Residential Care	2234 E. Calle Sierra Del Manantial	Tucson	AZ	85706
Mwangaza Residential Care	2226 N. Avenida el Capitan	Tucson	AZ	85705
Mwangaza Residential Care	4449 E. Elmwood St.	Tucson	AZ	85711
Mwangaza Residential Care, LLC.	8421 East Collete Street	Tucson	AZ	85711
National Council on Alcoholism and Drug Dependence (NCADD)	4201 N 16th St., Ste 140 and 280	Phoenix	AZ	85016
Native American Community Health	4041 E. Central Ave Building C	Phoenix	AZ	85012
Native American Community Health Center	4041 N. Central Ave. Bldg. C	Phoenix	AZ	85012
Native American Community Health Center	2423 W Dunlap	Phoenix	AZ	85021
Native American Connections	337 E. Virginia Ave.	Phoenix	AZ	85004
Native American Connections	4520 N. Central Ave., Ste. 100 & 200	Phoenix	AZ	85012
Neema	6607 E. Hawk Dr.	Tucson	AZ	85730
Neema LLC, BH Residential Facility	6607 E. Hawk Drive	Tucson	AZ	85730
New Casa de Amigas (Women)	1648 W. Colter Suite 8	Phoenix	AZ	85015
New Hope Behavioral Health Center	215 S. Power Rd. Ste 114	Mesa	AZ	85206
New Hope Behavioral Health Center	215 S. Power Rd. Ste 114	Mesa	AZ	85206
New Horizon Youth Homes	PO Box 2754	Chandler	AZ	85244
New Horizons Behavioral Health	6871 E. Nelson Dr.	Tucson	AZ	85730
New Horizons Behavioral Health	5849 E. 5th St.	Tucson	AZ	85711
Oasis Behavioral Health Hospital	2190 N. Grace Blvd.	Chandler	AZ	85225
Oasis Home LLC	78 East Via Teresita	Sahuarita	AZ	85629
Oasis Home LLC	845 West Calle Barbitas	Sahuarita	AZ	85269
Pastalino Manor, LLC-2	1393 West Kesler Lane	Chandler	AZ	85224
Pastalino Manor, LLC-3	2264 Olive Way	Chandler	AZ	85248
Pastinlino Manor, LLC-1	1383 West Kesler Lane	Chandler	AZ	85224
Pathways	3295 W. Ina Rd, Suite 150	Tucson	AZ	85741
Pathways	1161 N El Dorado Place #103	Tucson	AZ	85715
Patina Wellness Center	337 E. Virginia Ave.	Phoenix	AZ	85012
People Empowering People of AZ	2428 E. Apache Blvd. Ste. 123	Tempe	AZ	85281
Phoenix Shanti	2345 W. Glendale Ave.	Phoenix	AZ	85021
Pima Prevention Partnership/SIN PUERTAS	924 N. Alvernon Way	Tucson	AZ	85711
Pinal Hispanic Council	107 E. 4th Street	Eloy	AZ	85131
Pinal Hispanic Council	556 S. Arizona Blvd	Coolidge	AZ	85128
Pinal Hispanic Council	1940 11th Street	Douglas	AZ	85607
Pinal Hispanic Council	275 N. Grand Court Plaza	Nogales	AZ	85621
PIR Arrowhead	5625 W. Bell Road	Glendale	AZ	85308

Program Name	Service Address	City	State	Zip
PIR East Valley	4330 E. University Dr.	Mesa	AZ	85205
PIR GATEWAY (IHH)	5222 E Baseline Rd Suite 101	Gilbert	AZ	85234
PIR HASSAYAMPA	811 N. Tegner #121	Wickenburg	AZ	85390
PIR MEDICAL ACT	9150 W. Indian School Rd Suite 130	Phoenix	AZ	85037
PIR METRO	10240 N. 31st Ave., #200	Phoenix	AZ	85051
PIR West Valley	11361 N. 99th Ave #601	Peoria	AZ	85345
PPEP Integrated Care	901 E. 46th Street	Tucson	AZ	85713
PRATS - Ak'ei House	3205 E Sunny Side Lane	Phoenix	AZ	85032
PRATS - Bah Hozoh Hooghan	13401 N. 30TH Street	Phoenix	AZ	85032
PRATS - Dine' House	3014 E Emile Zola	Phoenix	AZ	85032
PRATS - Nizhoni House	13437 North 30th Street	Phoenix	AZ	85032
PRATS - Shik Is House	13603 North 30th Street	Phoenix	AZ	85032
PRATS - Ta'Chinii Ni House	1113811 North 38th Street	Phoenix	AZ	58032
Presidential Mansioncare, LLC	1647 S. 170th Ave.	Goodyear	AZ	85338
Pronghorn Psychiatry	5940 E. Copper Hill Dr.	Prescott Valley	AZ	86314
PSA Behavioral Health - ICC	3271 E Queen Creek Rd. Bldg 2, Ste 101	Gilbert	AZ	85297
PTL Behavioral Health	10839 E. Sonrisa Ave.	Mesa	AZ	85212
Recovery Innovations of Arizona	2701 N. 16th Street	Phoenix	AZ	85006
Red Mountain Behavioral Health	2915 E Baseline Rd, Ste. 115	Gilbert	AZ	85234
Rehoboth LLC, dba	19436 North Smith Drive	Maricopa	AZ	85138
Rehoboth Residential Facility, LLC	19436 N. Smith Drive	Maricopa	AZ	85139
RI International	2701 N. 16th St. Ste. 316	Phoenix	AZ	85006
Richlin Regal Residency LLC	7872 South Abbey Lane	Gilbert	AZ	85298
Richlin Regal Residency ABBEY	7872 S. Abbery Lane	Gilbert	AZ	85298
Richlin Regal Residency-BELLERIVE	2864 E. Bellerive Drive	Gilbert	AZ	85298
Roxbury Commons Residential LLC, dba	3847 West Port Royal Lane	Phoenix	AZ	85053
Safeway House Youth Facility, LLC,dba	1469 East Laurel Drive	Casa Grande	AZ	85122
Salter House	9834 W. Salter Drive	Peoria	AZ	85382
Salter House 2	1634 W. Andora Drive	Phoenix	AZ	85029
SEABHS	1430 E. Fort Lowell Rd, Appt Only	Tucson	AZ	85719
SEABHS	10A Ward Canyon Road	Clifton	AZ	85533
SEABHS	590 S. Ocotillo Street	Benson	AZ	85602
SEABHS	404 Rex Allen Dr	Wilcox	AZ	85643
SEABHS	4755 Campus Dr	Sierra Vista	AZ	85635
SEABHS	1615 S. 1st Ave	Safford	AZ	85548
SEABHS	1891 N. Mastick Way	Nogales	AZ	85621
Sequal Care of AZ	9435 Smoki Trail	Dewey	AZ	86327
Sequal Care of AZ	14410 E. Blue Ridge Rd	Dewey	AZ	86327
Sequal Care of AZ	8800 N. Marys Drive	Flagstaff	AZ	86004
Sequal Care of AZ - Hualapai Mountain	3240 Hualapai Mountain Rd	Kingman	AZ	86401
Sequal Care of AZ - Kaitlin Ranch	6070 North Treadway Trail	Flagstaff	AZ	86004

Program Name	Service Address	City	State	Zip
Sequal Care of AZ - Prescott House	8070 East Prescott Road	Prescott Valley	AZ	86314
Sequal Care of AZ - TGH	4001 N. Catherine Drive	Prescott Valley	AZ	86314
Sequal Care of AZ - Transitions	3160 North Pine View Drive	Prescott Vally	AZ	86314
Sequel Care of Arizona LLC,dba	3170 Stillwater Drive	Prescott	AZ	86305
Sequel Three Springs Inc. - Chinle	Westside Presbyterian Church Navajo	Chinle	AZ	86503
Sequel Three Springs Inc. - Kayenta	E. HWY 163 Kayenta Mobile Park#84	Kayenta	AZ	86033
Sequel Three Springs Inc. - Saint Michaels	1/4 Mile S. of HWY 264 Across Chapter	Saint Michaels	AZ	86511
Sequel Three Springs Inc. - Tuba City	Maloney & Spur St. KFC Facility	Tuba City	AZ	86045
Shannon Seyedan	2722 S. 186th Drive	Goodyear	AZ	85338
Sonora Behavioral Health Hospital	6050 N. Corona Rd	Tucson	AZ	85339
Southeastern Arizona Behavioral Health Services (SEABHS)	996 N. Broad St.,Ste. 9&10	Globe	AZ	85501
Southwest Behavioral Health Services	1424 S. 7th Ave. Bldg. C	Phoenix	AZ	85007
Southwest Behavioral Health Services	7600 E. Florentine Rd. Ste. 201	Prescott Valley	AZ	86314
Southwest Behavioral Health Services	1424 S. 7th Ave. Bldg. C	Phoenix	AZ	85007
Southwest Behavioral Health Services	26428 W. US Hwy 85	Buckeye	AZ	85326
Southwest Behavioral Health Services	2632 E. Thomas Rd.	Phoenix	AZ	85016
Southwest Behavioral Health Services	1255 W. Baseline Rd. Ste. 138	Mesa	AZ	85202
Southwest Behavioral Health Services	11221 N. 28th Dr. Bldg. E	Phoenix	AZ	85029
Southwest Behavioral Health Services	4420 S. 32nd St.	Phoenix	AZ	85040
Southwest Behavioral Health Services	1515 E. Cedar Ave., Ste. E2	Flagstaff	AZ	86004
Southwest Behavioral Health Services	7600 E. Florentine Rd. Ste. 101	Prescott Valley	AZ	86314
Southwest Behavioral Health Services	7763 E. Florentine Rd, Ste. 101	Prescott Valley	AZ	86314
Southwest Behavioral Health Services	2580 Highway 95 #119	Bullhead City	AZ	86442
Southwest Behavioral Health Services	404 W. Aero Dr.	Payson	AZ	85541
Southwest Behavioral Health Services	809 Hancock Rd., Ste.1	Bullhead City	AZ	86422
Southwest Behavioral Health Services	2215 Hualapai Mountain Rd. Ste H & I	Kingman	AZ	86401
Southwest Behavioral Health Services	1845 McColloch Blvd. Ste. B1	Lake Havasu City	AZ	86403
Southwest Behavioral Health Services - Crisis Stabilization Unit	1301 W. Beale St.	Kingman	AZ	86401
Southwest Behavioral Health Services - Marina Pointe	401 Emery St	Bullhead City	AZ	86442
SOUTHWEST BEHAVIORAL HEALTH SERVICES, INC - STAR	313 EAST WILLETTA	Phoenix	AZ	85003
Southwest Center for HIV/AIDS	1101 N. Central Ave., Ste. 200	Phoenix	AZ	85004
Spectrum Healthcare	452 Finnie Flat Rd.	Camp Verde	AZ	86322
Spectrum Healthcare	651 W. Mingus Ave	Cottonwood	AZ	86326
Spectrum Healthcare	8 E. Cottonwood St. (BLD A)	Cottonwood	AZ	86326
Spectrum Healthcare	8 E. Cottonwood St. (BLD C)	Cottonwood	AZ	86326
Spectrum Healthcare	2880 Hopi Dr.	Sedona	AZ	86336
Spectrum Healthcare (Women's World)	8 E. Cottonwood St.	Cottonwood	AZ	86327
St. Luke's Hospital	1800 E. Van Buren	Phoenix	AZ	85006
Star Oaks Behavioral Home	17644 N 19th Street	Phoenix	AZ	85022
Star Oaks Behavioral Home	2016 E. Rockwood Drive	Phoenix	AZ	85024
Starks Homes LLC, dba	2873 East Lucca Lane	Vail	AZ	85610

Program Name	Service Address	City	State	Zip
Sunrise Behavioral Health LLC	8913 North 114th Drive	Peoria	AZ	85345
Sunrise Behavioral Health LLC	9280 W. Sunnyslope Lane	Peoria	AZ	85345
Suzy Najera	25190 S. 190th St	Queen Creek	AZ	85242
SWBH Community Resilience Center	5717 N 7th St	Phoenix	AZ	85014
SWN Mesa Heritage (formerly Hampton)	460 N Mesa Drive Suite 201	Mesa	AZ	85201
SWN Osborn	3640 W. Osborn #1	Phoenix	AZ	85019
SWN Royal Palm, (formerly Bethany Village)	2311 W. Royal Palm Rd	Phoenix	AZ	85021
SWN Saguaro	3227 E. Bell Rd Suite 170	Phoenix	AZ	85032
SWN San Tan Clinic	1465 W. Chandler Blvd Bldg A	Chandler	AZ	85224
Tender Loving Care Home	7232 E. Montecito Dr.	Tucson	AZ	85710
Tender Loving Care Home	6010 E. Seneca St.	Tucson	AZ	85712
Terros	1111 S. Stapley Dr.	Mesa	AZ	85204
Terros - Broadway OP Clinic	1232 E. Broadway Rd., Ste. 120	Tempe	AZ	85282
Terros - FQHC	3864 N 27th Ave,	Phoenix	AZ	85008
Terros - Ladder Program	1111 S. Stapley Dr	Mesa	AZ	85206
Terros - Ladder Program	4909 E McDowell Rd	Phoenix	AZ	85008
TERROS - Maverick House-Male Only	5801 N. 51st Ave.	Glendale	AZ	85301
Terros - OP Clinic	4909 E. McDowell Rd.	Phoenix	AZ	85008
Terros - OP Clinic	10220 N. 31st. Ave Ste. 120	Phoenix	AZ	85051
Terros - OP Clinic	4425 W. Olive Ave.., Ste 200	Glendale	AZ	85302
Terros - OP Clinic	2400 W. Dunlap Ave. Ste. 300	Phoenix	AZ	85021
Terros - OP Clinic	12835 N. 32nd St.	Phoenix	AZ	85032
Terros 51st Ave, (formerly West McDowell)	4616 N 51st Avenue, Ste #108	Phoenix	AZ	85031
Terros Enclave	1642 S. Priest Dr #101	Phoenix	AZ	85281
Terros FQHC	3864 N. 27th Ave	Phoenix	AZ	85017
Terros Townley 1	8836 N. 23rd Ave Ste B1	Phoenix	AZ	85021
The Chalet House	6633 N. Amahl Circle	Tucson	AZ	85704
The Chalet House	6849 S. Tackweed Way	Tucson	AZ	85756
The Guidance Center	2187 N. Vickey St.	Flagstaff	AZ	86004
The Guidance Center	220 W. Grant St.	Williams	AZ	86046
The Guidance Center	2187 N. Vickey St.	Flagstaff	AZ	86004
The Guidance Center - Crisis Stabilization Unit	2187 N. Vickey St.	Flagstaff	AZ	86004
The Guidance Center (CD Residential)	2697 E. Industrial Dr.	Flagstaff	AZ	86004
The Guidance Center (CD Residential)	2187 N. Vickey St.	Flagstaff	AZ	86004
The Haven	2601 N. Campbell Rd.	Tucson	AZ	85719
The Haven	1017, 1025 and 1107 E. Adelaide Dr.	Tucson	AZ	85719
The Haven	2601 N. Campbell Ave., Ste. 105	Tucson	AZ	85719
The Haven (Women)	1107 E. Adelaide Dr.	Tucson	AZ	85719
The Potters House	4220 N. 20th Ave Ste. 100	Phoenix	AZ	85015
Touch Angels, LLC	5045 S. Tatum Lane	Gilbert	AZ	85298
Transitional Living Center	1340 S 4th Ave	Yuma	AZ	85364

Program Name	Service Address	City	State	Zip
Transitional Living Center	117 E 2nd Street	Casa Grande	AZ	85222
Tuba City DBHS	PO Drawer 709	Window Rock	AZ	86515
UnHooked at the Heights	152 N. 56th St.	Mesa	AZ	85205
Unhooked at the Heights	5801 E. Main St.	Mesa	AZ	85205
UnHooked Recovery	215 S Power Road, Bldg 1251	Mesa	AZ	85206
Valle del Sol	509 S. Rockford Dr.	Tempe	AZ	85281
Valle del Sol	4135 S. Power Rd. Ste. 108	Mesa	AZ	85212
Valle del Sol	1209 S. 1st Ave.	Phoenix	AZ	85003
Valle del Sol	1209 S. 1st Ave.	Phoenix	AZ	85003
Valle del Sol	10320 W. McDowell	Avondale	AZ	85392
Valle del Sol	3807 N. 7th St.	Phoenix	AZ	85014
Valle del Sol - RED MOUNTAIN (IHH)	1209 S. 1st Avenue	Phoenix	AZ	85003
Visions of Hue, LLC	11826 W. Lupine Ave	El Mirage	AZ	85335
Wellbeing Institute	3615 N. Prince Village Place Suite 121	Tucson	AZ	85719
West Yavapai Guidance Clinic	3345 N. Windsong Dr.	Prescott Valley	AZ	86314
West Yavapai Guidance Clinic	642 Dameron Dr.	Prescott	AZ	86301
West Yavapai Guidance Clinic	625 Hillside Ave	Prescott	AZ	86301
West Yavapai Guidance Clinic	555 W. Road 3 North	Chino Valley	AZ	86323
West Yavapai Guidance Clinic - Crisis Stabilization and SubAcute	8655 E. Eastridge Dr.	Prescott Valley	AZ	86314
West Yavapai Guidance Clinic (CD Residential)l	642 Dameron Dr.	Prescott	AZ	86301
Wind Haven Psychiatric Hospital	3347 Windsong Dr.	Prescott Valley	AZ	86314

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.

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

Footnotes:

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.

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

for their health care delivery systems.

* 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:

* 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).

i* 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 six, 24/7 access points 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:

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.

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[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 Arizona Health Care Cost Containment System (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.

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 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/family support 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/family 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/family support plays in recovery. As a result, providers within the ACC network have incorporated peer/family 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.

Footnotes:

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?

   The Arizona Health Care Cost Containment System (AHCCCS) serves as the single state authority (SSA) to provide coordination, planning, administration, regulation, and monitoring of all facets of the state public behavioral health services.

   AHCCCS receives multiple grants from the Substance Abuse and Mental Health Service Administration (SAMHSA) to help Arizona reduce opioid deaths. 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.

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. With completion of the emergency response deliverables, and the implementation of the Opioid Action Plan and the Arizona Opioid Epidemic Act, Governor Ducey officially called an end to the public health emergency on May 29, 2018. While the official emergency has ended, the fight to save lives and turn the tide on the opioid epidemic continues. Find out more about Arizona emergency response.

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 56,156 naloxone kits distributed and over 15,925 reported naloxone doses administered according to Arizona Department of Health Website.

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 Managed Care Organizations 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 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.

AHCCCS has recognized the important role medication-assisted treatment (MAT) plays in the treatment of SUD targeted MAT Symposiums across the State, presenting to Arizona Department of Corrections, along with other conferences/symposiums. The MAT Symposiums were provided at no-cost to attendees and included attendees from treatment providers, corrections, and probation,

Lastly, AHCCCS, and other community stakeholders to educate and raise awareness within the community regarding what MATs are, the services provided within the MAT setting, facility locations, and their availability throughout the state. As the SSA, AHCCCS continues to cite research about the importance of utilizing evidence-based MAT treatment in the community and have contract terms that require the Managed Care Organizations to maintain a network of MAT providers for their geographic service areas (GSAs).

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.

Footnotes:

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.

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[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

    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 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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Footnotes:

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:

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.

Lastly, recovery and support services for children with Serious Emotional Disturbance (SED) are available, and follow the Arizona Vision and 12 Guiding Principles. By collaborating with the child and family and others, Arizona provides accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. These services are tailored to the child and family and are provided in the most appropriate setting, in a timely fashion, and in accordance with best practices

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 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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Footnotes:

What is a Peer-Run Organization?

Peer-run organizations are service providers owned, operated and administrated by persons with lived experiences of mental health and/or substance use disorders. These organizations are based in the community and provide support services.

AHCCCS members have the right to request services provided by and/or participate in programs at a peer-run organization.

Here are some of the things you can find at a peer-run organization:

- 1-on-1 peer support
- Daily support groups
- Social outings
- Meals
- Employment programs
- Learning opportunities

- Health and exercise programs
- Creative arts
- Resources
- Advocacy
- Volunteer opportunities
- Youth and young-adult programs

- Meeting new people
- Personal development, and
- Empowerment
- Extended hours and/or weekends

How to Access Services from a Peer-Run Organization

1. Contact a peer-run organization in your area to learn what services they offer.

2. Request the service be added to your service plan at the peer-run organization of your choice. Once the service has been requested, services should be initiated within 45 days.

Recovery Empowerment Network
Phoenix
renaz.org
602.248.0368

Helping Ourselves Pursue Enrichment
(HOPE), Inc.
Tucson, Yuma
hopetucson.org
520.770.1197

Northern Arizona Consumers Advancing Recovery by Empowerment (NAZCARE)
Prescott, Benson, Globe, Show Low, Bullhead City, Kingman, Eagar, Parker, Yuma, Casa Grande, Apache Junction, Cottonwood
nazcare.org
928.442.9205

Center for Health Empowerment Education Employment Recovery Services (CHEEERS)
Phoenix
cheeers.org
602.246.7601

Stand Together and Recover (STAR) Centers
Avondale, Phoenix, Mesa
thestarcenters.org
602.231.0071

Hope Lives/Vive La Esperanza
Phoenix, Flagstaff
vivehopelives.org
1.855.747.6522

Wellness Connections
Sierra Vista, Douglas, Safford, Nogales
wellness-connections.org
520.452.0080

Coyote TaskForce – Our Place Clubhouse /Café 54 and Truck 54
Tucson
ourplaceclubhouse.org
520.884.5553

Transitional Living Center Recovery (TLCR)
Yuma, Casa Grande
tlcrecoveryaz.com
928.261.8668

The Arizona Health Care Cost Containment System (AHCCCS) is committed to ensuring the availability of timely, quality behavioral health care. If you know of an AHCCCS member who is unable to access behavioral health services, or if you have a concern about the quality of care, please call your AHCCCS health care plan's Member Services number. If your concern is not resolved, please call AHCCCS Clinical Resolution Unit at 602-364-4558, or 1-800-867-5308.

If you are having difficulty accessing timely services at the peer-run organization of your choice, please contact your assigned AHCCCS Health Plan listed on the next page.

AHCCCS Health Plan Contacts

AHCCCS ACUTE CARE/INTEGRATED HEALTH PLANS		
Arizona Complete Health Customer Service 1-888-788-4408 www.azcompletehealth.com/completecare	Mercy Care Customer Service 1-800-624-3879 www.mercycareaz.org	Magellan Complete Care Customer Service 1-800-424-5891 www.mccofaz.com
Care 1st Health Plan Customer Service 1-866-560-4042 www.care1staz.com	Banner – University Family Care Customer Service 1-800-582-8686 www.bannerufc.com/acc	Steward Health Choice Arizona Customer Services 1-800-322-8670 www.stewardhealthchoiceaz.com
Department of Economic Security Division of Developmental Disabilities (DES/DDD) Customer Service 1-844-770-9500 www.azdes.gov/ddd/	Comprehensive Medical Dental Program 602-351-2245 or 1-800-201-1795 dcs.az.gov/cmdp	United Healthcare Community Plan Customer Service 1-800-348-4058 www.uhccommunityplan.com

LONG TERM CARE HEALTH PLANS (PROGRAM CONTRACTORS)	
Banner – University LTC Customer Service 1-833-318-4146 www.bannerufc.com	Mercy Care Long Term Care (ALTCS) Customer Services 1-800-624-3879 www.mercycareaz.org
United Healthcare LTC Customer Service 1-800-293-3740 www.uhccommunityplan.com	LTC DD DES Customer Service 1-800-770-9500 www.azdes.gov/ddd/

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.

    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 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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Footnotes:

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

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

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[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.)

Arizona has the well-established Child and Family Team (CFT) practice, which continues to be an important tool to continued improvement in outcomes for children and youth when they transition from hospitals to community based care. In the Children's System, the CFT 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,
- Making sure our children are moving towards becoming stable, productive adults.

The 12 Principles further outlines Arizona's System of Care Values and closely align with the 13 System of Care Principles described by Robert Friedman, PhD and Shelia Pires in the SAMSHA sponsored "System of Care" approach. Adherence to these 12 Principles serve as the foundation, and are universally applied, when working with all enrolled children and their families through the use of the Child and Family Team (CFT) practice. This is evident through the shared concepts of the 12 Principles with the 10 Principles of Wraparound:
1. Family Voice And Choice

2. Team-Based
3. Natural Supports
4. Collaboration
5. Community Based
6. Culturally Competent
7. Individualized
8. Strengths Based
9. Unconditional
10. Outcome Based

In the CFT model it is the child's and family's complexity of needs that drive the development, integration, and individualization of service delivery. The level of complexity is determined individually with each child and family. A child's and family's overall health status also contributes to their complexity of needs and subsequent level of service intensity. For children with a serious emotional disturbance (SED) and/or chronic physical condition, symptoms associated with their physical or behavioral health condition can impact their level of functioning in multiple life domains and may result in the use of medications that are monitored through a primary care physician and/or other qualified professional. 9Thus, the intensity of service integration through CFT practice is dependent on the level of coordination necessary to support the child and family in making progress toward identified goals in their AHCCCS Service Plan.

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 High Needs Case Manager (HNCM). The 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 and 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.

Arizona holds a distinction in the United States for promoting various family roles in relation to the AHCCCS System of Care. The involvement of families is credited as making a significant contribution in improving the service system. Collaboration with the Child and Family is the foundation for the mandate that all children served by the Children's AHCCCS System of Care have a CFT. Through the team process, parents/caregivers and youth are treated as full partners in the planning, delivery and evaluation of services. The team process is most effective when the family is welcomed (access), empowered to have a strong voice (voice) and has a thorough sense of commitment to the plan that they have created (ownership). Even though this participation is only on an individual basis, it is an example of family involvement, which brings about quality service for the child and family. Effective CFTs have a broader system impact by serving as an example for other CFTs. Through the CFT process with respect to service planning, families are able to access services tailored to their unique needs and circumstances based on the families' individual culture which goes beyond race and ethnicity. They are not expected to fit their needs into a list of categorical services. The CFT honors and gives careful consideration and weight to the family's preference to end one service and/or request another.

Currently, one of AHCCCSs strongest collaborative efforts is with the Department of child Safety (DCS), Arizona's Child Welfare System. AHCCCS staff is working with DCS 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 foster children tend to suffer through. 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 their 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 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 rolled out in July 2007. MMWIA is designed to increase 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 children 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 provides guidance on how best to utilize these services.

High Needs Case Managers (HNCMs) were established to facilitate CFTs 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. For a full FTE (1.0), the case load ratio of high needs children and youth not less than 1:8 and not more than 1:20, with 1:15 being the desired target in order to work with the most complex child and family needs. The caseload cap is 20 to allow for continuity of care for children who have been receiving high needs case management, but are now ready to begin transition from that level of care and for high needs case management of siblings. There are currently over 450 of these skilled CFT practitioners serving children and families in Arizona. AHCCCS monitors the statewide policies and activities to codify these System of Care initiatives and they are written into the Managed Care Organizations (MCOs) including the Regional Behavioral Health Authorities (RBHAs) lines of business.

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 MCOs including the RBHAs. Additionally, for over ten 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, 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. Over the past few years, the SOCPR Tool has been mostly focused on Children in the foster care system.

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 MCO and 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 MCO, 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. Some of the MCO, (including the RBHAs) co-locate and agency-specific liaison roles further enhance collaboration in the provision of children's services. Also, MCOs including the RBHA line of business and their providers maintain co-located positions at juvenile courts and 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, adolescents, and their families through contracts. Annual Network Inventories are submitted by the MCOs, including the RBHA line of business, 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". 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)".

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

Technical assistance is not being requested at this time.

Footnotes:

Arizona's Children's System of Care Practice Review
Fiscal Year 2017 Statewide Report

Debra Mowery, PhD, Wei Wang, PhD, & Linda Callejas, PhD
University of South Florida

Kevin Flynn, LCSW
Arizona Health Care Cost Containment System

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EXECUTIVE SUMMARY

BACKGROUND

Research has identified that outcome evaluation is key to achieving and sustaining transformation initiatives in Systems of Care (Hodges, Hernandez, Nesman, & Lipien, 2002). The System of Care Practice Review (SOCPR) was implemented in FY2009-2010 as the Arizona Health Care Cost Containment System (AHCCCS) practice review method of choice in Arizona. It was developed at the University of South Florida (USF) by Dr. Mario Hernandez, Ph.D. Research has demonstrated high inter-rater reliability in the use of the tool, which is based on face to face interviews with multiple informants as well as file/record reviews (Hernandez et al., 2001). A total of 170 reviews were conducted across Arizona in FY2016-2017. Because the sampling emphasis was placed on children and families involved with the Department of Child Safety (DCS) system, the outcomes of this year's SOCPR report will include two separate analyses and results sections: ALL Cases and DCS Cases.

METHODOLOGY

Interviews were drawn from a sample of children and families identified as having high/complex levels of need. For FY2016-2017, the sampling emphasis was placed on children and families involved with the DCS system. Therefore, the sample pool of cases contained all children and youth age 6 –18 years who had scores of 4 or higher on the Child and Adolescent Service Intensity Instrument (CASII). Children aged 0-5 were included if they met one or more of the following criteria: other agency involvement (Arizona Early Intervention Program [AZ EIP], Department of Child Safety [AZ DCS], Department of Developmental Disabilities [AZ DDD]); out of home placement (within past 6 months); psychotropic medication utilization (2 or more medications); and/or CGAS of ≤50. In addition, selected cases had to be enrolled in services at least 90 days, and be currently active at the time the sample was drawn. In addition, if multiple siblings were receiving services from the same agency only one child was included in the sample. For each agency under review, a case manager could have no more than two (2) of their cases identified for the SOCPR review.

The SOCPR uses a case study methodology informed by caregivers, youth, formal providers, informal supports, and extant documents related to service planning and provision. The SOCPR tool itself is comprised of four (4) domains and 13 subdomains and areas:
- *Child-Centered, Family-Focused (CCFF)*
  - *Individualized, Full Participation, and Case Management*

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- *Community Based (CB)*
  - *Early Intervention, Access to Services, Minimal Restrictiveness, and Integration and Coordination*
- *Culturally Competent (CC)*
  - *Awareness, Sensitivity and Responsiveness, Agency Culture and Informal Supports*
- *Impact (IMP)*
  - *Improvement and Appropriateness*

SOCPR results include a combination of quantitative and qualitative data. Quantitative data are scored on a scale of 1–7. Scores from 1–3 represent lower implementation of a system of care principle, and scores from 5–7 represent enhanced implementation of a system of care principle. A score of 4 indicates a neutral rating, meaning a lack of support for or against implementation. Qualitative data are analyzed for themes that are identified in at least half of examined cases.

SUMMARY RESULTS ALL CASES

Quantitative Data Summary

During FY2016-2017, a total of 170 cases were sampled from three Regions in Arizona. In addition to results related to the four domains, other areas of analysis included: *demographics, service system involvement*, and *receipt of services or treatments*. The demographic profile for ALL Cases showed that males were more commonly represented, in almost 56% of the sample, with the overall average age at 8.6 years. With regard to race/ethnicity, half of the sample was White (51%), almost 29% was Latino/Hispanic, and almost 11% was multi-racial. The remaining 10% of the sample consisted of Black and Native American racial origins. Almost 96% of the sample spoke English as their primary language, with an additional 2.4% listing Spanish as their primary language. From a total range of 0-6 systems, the average number of child-serving systems involved per child was 2.02. For the 170 ALL Cases 99% were recorded as showing behavioral health system involvement. A review of the services or treatments utilized showed that almost 98% of the children received Support Services, with Case Management being received by almost 97% of the families. Treatment Services were utilized by over 76% of youth while about 47% the families utilized Medical Services. The average number of services used per child or youth was 4.24.

Scores range from a low of 1 to a high of 7, with scores 5 and higher representing *enhanced implementation* of the item of interest. For the statewide sample of 170 ALL Cases, mean scores ranged from 5.05 to 5.44 for the four SOCPR domains, with an overall case mean score of 5.19.

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SOCPR Overall Domain Mean Scores ALL Cases

REGION	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
Statewide (N=170)	5.19 (0.95) Min 2.04 Max 6.72	5.22 (1.08) Min 1.25 Max 6.89	5.44 (0.82) Min 2.38 Max 6.88	5.05 (1.06) Min 1.58 Max 6.47	5.07 (1.37) Min 1.25 Max 7.00

In Arizona, provider agencies performed best at including the Community Based system of care values when serving children and families followed by Child-Centered Family-Focused. Providers were most tested in the Impact and Culturally Competent domains.

For FY2016-2017, all of the SOCPR domain, subdomain, and area scores for the ALL Cases fell in the mid 4 to high 5 range. All four SOCPR *domain* mean scores fell within the 5 range (representing enhanced implementation of a system of care principle). In the domain of Community Based all subdomains and areas except for the subdomain of Early Intervention (4.88), scored in the low to high 5 range, with the area of Appropriate Language scoring highest (5.96). High scoring *subdomains* included Access to Services (5.78) and Minimal Restrictiveness (5.75) from the Community Based domain. High scoring *areas* included Appropriate Language (5.96) and Convenient Times (5.86) both in the Community Based domain. Other subdomain scores in the 5 range included two scores from Child-Centered, Family-Focused (Full Participation 5.39 and Case Management 5.34) and one score from Community Based (Integration and Coordination 5.34). Other area scores in the 5 range included Convenient Locations (5.51) from Community Based domain and Awareness of Cultural Dynamics (5.34) from the domain of Culturally Competent. These scores represent strengths in the Arizona's Children's System of Care as reviewed through these 170 SOCPR ALL Cases.

Because of the geographic re-alignment within the state of Arizona, Region sample sizes were large enough to calculate, analyze, and provide data, which might be statistically meaningful. Therefore, this report presents statewide SOCPR data for most levels of the instrument, including the total case mean score, SOCPR Domain scores, SOCPR Subdomain scores, and SOCPR Area scores for each Region (North-7, South-8, and Central-6) for ALL Cases. Briefly the overall mean scores for each Region were in the low 5 range (5.38 for North 7; 5.22 for Central 6; and 5.04 for South 8).

A series of variables of interest were tested to identify if there was a statistically significant relationship to the outcome of the SOCPR results. There were a variety of significant associations in SOCPR case and domain scores across the variables examined. Associations were both positive and negative. Some of each of the demographics, service systems, and services measured showed significant differences.

Receiving Treatment Services (specifically Family Counseling and Substance Abuse Counseling), Family Support, and Other were significantly associated with Region. Gender, Age, Educational Services, Child Safety, and Total Systems were associated with higher SOCPR case scores and domain scores for children and youth.

Summary of Qualitative Analysis

The Qualitative Analysis section presents a review of data compiled from responses to Summative Questions that SOCPR reviewers use to summarize and integrate the information gathered throughout the Document Review and a series of interviews completed with a particular child/youth and family to address each of the four SOCPR domains. The Summative Questions call for the reviewer to provide a rating for each statement and to give a brief narrative in support of that rating. Individual ratings serve as indicators of the extent to which the subdomain elements (e.g., individualized services, full family participation) or SOC principles are being implemented within the System of Care under review. The narrative portion of each Summative Question response provides evidence for a given rating and is used to determine the presence or absence of system of care principles for each subdomain. Where an overall summative rating relates to a reviewer's determination of completion of a thorough assessment, for instance, qualitative analysis examines the evidence provided to explain the rating.

In the final analysis, ratings for each item are clustered and considered in conjunction with the respective brief narrative provided to determine a general assessment for each subdomain. The compiled narratives for ALL Cases Summative Questions were coded and sorted to assess the degree to which System of Care principles were implemented in each SOCPR domain area (N=170). The frequency of Summative Question responses were examined and analyzed for emerging patterns/trends. In order to be considered a trend, at least of half of the responses associated with a particular rating had to provide similar information related to a given measurement and/or subdomain area. Trends in each subdomain are then reviewed together to provide an overall assessment for the larger domain area. This report section also highlights particular successes and challenges with regard to implementation of System of Care principles for each of the SOCPR Domain Areas.

Some notable strengths that were identified for ALL Cases included active participation by families, providers, and informal helpers in services and service planning; verbal communication and written documentation are in the preferred language of youth and families; awareness of cultural dynamics in working with families, and improvements in child/youth functioning. Opportunities for improvement were also identified. Some of these include ensuring that service plans are integrated across all providers, ensuring that the needs of

families are clarified early, and increasing identification of youth and family's concepts of health and family

SUMMARY RESULTS DEPARTMENT OF CHILD SAFETY (DCS) CASES

Quantitative Data Summary

Of the 170 SOCPR cases sampled during FY2016-2017, the state of Arizona was also interested in only those cases where the children and families had Department of Child Safety (DCS) involvement. The 97 DCS Cases (57%) completed during FY2016-2017 were sampled from all three Regions. In addition to results related to the four domains, other areas of analysis included: *demographics, service system involvement, and receipt of services or treatments.* The demographic profile showed that males and females were equally represented (49.5%) , with the overall average age at 6.82 years. With regard to ethnicity/race, half of the sample was White (49.5%), almost 29% was Latino/Hispanic, and over 10% identified as Multiracial. The remaining 11% of the sample consisted of Black and Native American racial origins.. Almost 96% of the sample spoke English as their primary language, while 1% of the sample spoke Spanish as their primary language. From a total range of 0-5 systems, the average number of child-serving systems involved per child was 2.32. For the 97 DCS Cases, 99% were recorded as showing behavioral health system involvement. A review of the services or treatments utilized showed almost 97% of the children received Support Services, with Case Management being received by almost 95% of the families. Treatment Services were utilized by over 73% of youth while Medical Services were utilized by a third of the families. The average number of services used per child or youth involved with DCS services was 3.73.

Scores range from a low of 1 to a high of 7, with scores 5 and higher representing enhanced implementation of the item of interest. For the sample of 97 DCS Cases, mean scores ranged from 4.85 to 5.16 for the four SOCPR domains, with an overall case mean score of 5.00.

SOCPR Overall Domain Mean Scores DCS Cases

REGION	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
Statewide (N=97)	5.30 (0.84) Min 2.88 Max 6.49	5.34 (0.94) Min 2.22 Max 6.85	5.51 (0.73) Min 3.42 Max 6.88	5.10 (0.99) Min 2.43 Max 6.47	5.27 (1.24) Min 2.00 Max 7.00

In Arizona, provider agencies performed best at including the Community Based system of care value when serving children and families who had department of child safety involvement. The domains of Child-Centered Family-Focused and Impact followed next. Providers were most tested in the Culturally Competent domain.

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For FY2016-2017 SOCPR DCS Cases scores by Region ranged from the mid 4s to high 5s. All four SOCPR *domain* scores fell within the 5 range (representing enhanced implementation of a system of care principle). In the Community Based domain, all subdomains and areas scored in the mid to high 5 range with the exception of the subdomain of Early Intervention (4.97). The area of Appropriate Language had the highest mean score (5.99). High scoring *subdomains* included Minimal Restrictiveness (5.80) and Access to Services (5.79) from the Community Based domain. High scoring *areas* included Appropriate Language (5.99) and Convenient Times (5.95) both in the Community Based domain. Other subdomain scores in the 5 range included Case Management (5.48) and Full Participation (5.41) in the Child-Centered, Family-Focused domain and Integration and Coordination (5.46) from the Culturally Competent domain. Other area scores in the 5 range included Convenient Locations (5.44) and Awareness of Cultural Dynamics (5.43) from the domains of Community Based and Culturally Competent respectively. These scores represent strengths in the Arizona's Children's System of Care as reviewed through these 97 SOCPR DCS Cases.

A series of variables of interest were tested to identify if there was a statistically significant relationship to the outcome of the SOCPR results. There were a variety of significant differences in SOCPR case and domain scores across the variables of interest examined. Associations were both positive and negative. Some of each of the demographics, service systems, services categories, and services measured showed significant differences.

Receiving Treatment Services (specifically Individual Counseling and Family Counseling) were significantly associated with Region. Primary Language, Gender, and Total Number of Services were associated with higher SOCPR case scores and domain scores for children and youth.

Summary of Qualitative Analysis

The Qualitative Analysis section presents a review of data compiled from responses to Summative Questions that SOCPR reviewers use to summarize and integrate the information gathered throughout the Document Review and the series of interviews completed with a particular child/youth and family to address each of the four SOCPR domains. The Summative Questions call for the reviewer to provide a rating for each statement and to give a brief narrative in support of that rating. Individual ratings serve as indicators of the extent to which the subdomain elements (e.g., individualized services, full family participation) or SOC principles are being implemented within the System of Care under review. The narrative portion of each Summative Question response provides evidence for a given rating and is used to determine the presence or absence of system of care principles for each subdomain. Where an overall summative rating relates to a reviewer's determination of completion of a thorough

assessment, for instance, qualitative analysis examines the evidence provided to explain the rating.

In the final analysis, ratings for each item are clustered and considered in conjunction with the respective brief narrative provided to determine a general assessment for each subdomain. The compiled narratives for DCS Cases Summative Questions were coded and sorted to assess the degree to which System of Care principles were implemented in each SOCPR domain area (N=97). The frequency of Summative Question responses were examined and analyzed for emerging patterns/trends. In order to be considered a trend, at least of half of the responses associated with a particular rating had to provide similar information related to a given measurement and/or subdomain area. Trends in each subdomain are then reviewed together to provide an overall assessment for the larger domain area. This report section also highlights particular successes and challenges with regard to implementation of System of Care principles for each of the SOCPR Domain Areas.

Some notable strengths that were identified for DCS Cases include strengths of youth and family are identified consistently, communication with youth and family is in their primary language, providers are aware of the cultural dynamics essential to working collaboratively with families, and services and services and supports are meeting the needs of children/youth. Opportunities for improvement were also identified, including adequately documenting needs of family, ensuring timely identification and clarification of youth and family needs, understanding youth and families' concepts of health and family, and consistently documenting the impact of services and supports for families.

BACKGROUND

Arizona's Behavioral Health Care System

In 2016, at the request of the Governor, the Arizona Legislature mandated that the State's public healthcare system undertake an administrative simplification process. As a result of this process, it was determined that the Division of Behavioral Health Services (DBHS) would be consolidated with the State's Medicaid agency to create the Arizona Health Care Cost Containment System (AHCCCS). On July 1, 2016, DBHS and AHCCCS officially merged in order to fully integrate the oversight and implementation of physical and behavioral healthcare for the state.

The Arizona Health Care Cost Containment System (AHCCCS) is responsible for administration of Arizona's publicly funded behavioral health service system for individuals, families, and communities. As such, AHCCCS provides services both to populations eligible for federal entitlement programs such as Title XIX and Title XXI of the Social Security Act, as well as those receiving State funding only. AHCCCS funding is derived from a variety of sources: Title XIX (Medicaid), TXXI (Kids Care), federal block grants, state appropriations, and intergovernmental agreements.

Additionally in 2016, there was a change in the way RBHAs provided coverage in the state of Arizona. In contrast to the previous six (6) Geographic Service Area (GSA) system, there are now three (3) Regions, which are designated as follows: North-7, South-8, and Central-6. See additional detailed information beginning on page 12.

In 2014, the state of Arizona reorganized the State's Child Protective Agency (CPS), resulting in a new administrative structure and new designation as the Department of Child Safety. In previous iterations of this SOCPR reporting, the agency had been generically referred to as Child Welfare. Since 2014, the agency has been referred to as The Department of Child Safety (DCS).

Service Provision

AHCCCS' mission includes providing services to children and adults with substance use and/or general mental health disorders. Sub-populations include children with a serious emotional disturbance and adults with a serious mental illness. Children's Behavioral Health Services in the State of Arizona are delivered in accordance with the 12 principles of the Children's System of Care (see Appendix A), and delivered via the "Arizona Practice Model".

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This "System of Care" approach to service delivery in Arizona developed in response to the JK class action lawsuit, as part of the settlement agreement between AHCCCS and the plaintiffs in the case.

The Arizona Practice Model is based on the "wrap-around" model (VanDenBerg, 2003), and includes formation of Child and Family Teams as a means of organizing and directing care. The Child and Family Team may be composed of family members, behavioral health service providers, and representatives of other child-serving agencies, as well as other identified helpers and "natural supports". Teams are typically facilitated by a case manager or other behavioral health representative, and are responsible for identifying the strengths and needs of children and families and identifying and monitoring treatment goals and tasks. Teams are also responsible for obtaining any and all covered behavioral health services *not* requiring prior authorization by the Regional Behavioral Health Authority (RBHA). Teams may also request services requiring prior authorization, which will be subject to medical necessity determination by the RBHA. Services requiring prior authorization include out of home care and psychological testing. Other AHCCCS Covered Services include (for a comprehensive list refer to the AHCCCS Covered Behavioral Health Services Guide):

- Treatment Services – behavioral health counseling and therapy
- Medical Services – medication services and laboratory
- Rehabilitation Services – living skills training
- Support Services – case management, home care training, respite, and transportation
- Crisis Intervention – AHCCCS also oversees a statewide crisis system including crisis phones, warm lines, mobile teams, and inpatient psychiatric and detoxification facilities, which operate seven (7) days a week.

AHCCCS also oversees provision of prevention programs for children and adults. These services are funded separately, and are not included as Medicaid covered services.

In Arizona, services for children and adults have separate funding streams, and state law prohibits children's services from being funded with adult monies and vice versa. For purposes of this report, the focus will be on children/youth under the age of 18 (and their families) served by AHCCCS. Quality improvement and evaluation activities related to services provided to adult populations are considered to be outside the scope of this report.

Contracting Process

Contracts are bid on a 3–5 year competitive cycle. Currently three (3) Regional Behavioral Health Authorities (RBHAs) serve the three Regions. In addition there are five (5) Tribal Intergovernmental Agreements (IGAs), which include three (3) Tribal Regional Behavioral Health Authorities (TRBHAs).

Each T/RBHA contracts with various provider agencies to deliver the full array of covered behavioral health services to children and families within its Region. Augmenting the efforts of these service providers are Family Run Organizations (FROs), who partner with AHCCCS and the T/RBHAs to promote family involvement as well as family and youth voice and choice across the system. In addition, FROs are also providers of services to support youth and families.

Geographic Coverage

Beginning in FY2016-2017, there was a consolidation of the RBHA system in Arizona. In the new RBHA structure, the previous system of four RBHAs administering behavioral health services in six geographical service areas (GSAs) covering the state was altered, and is now composed of three RBHAs which encompass those GSAs. These three RBHAs serving their respective regions are designated as follows: North-7, South-8, and Central-6. For purposes of consistency with past reporting, and maintaining geographic distributions of providers, this report will continue to categorize reviews according to the original 6 Geographic Service Area divisions, now encompassed by the three RBHA "regions" noted above.

For the most part, the geographic delineations of the previous GSAs by county are maintained in the new 3-Region RBHA structure. The exception is in what was formerly GSA 4, consisting of Gila and Pinal counties. This former GSA (consisting of two counties) was "split" between the North and South RBHAs, with each RBHA incorporating one county. In the new structure, Gila County is included in the "North" RBHA (Region 7), and Pinal County is assigned to the "South" RBHA, (Region 8). To reflect current boundaries, in this report, reviews in the formerly unified GSA 4 will now be referenced as occurring either in GSA IV-P (Pinal) or GSA IV-G (Gila). This is the only instance of a GSA with this type of cross-RBHA split.

Prior GSA Designations	Current RBHA Regions
GSA I GSA IV-G (Gila)	North-7
GSA II GSA III GSA IV-P (Pinal) GSA V	South-8
GSA VI	Central-6

Coordination of Care

AHCCCS works in tandem with a variety of potential stakeholders on behalf of youth and families. Child and Family Teams may include one or more of these stakeholders in addition to behavioral health system providers. These include:

- Physical healthcare providers
- Arizona Department of Economic Security (including):
  - Department of Developmental Disabilities
  - Rehabilitation Services Administration
  - Department of Child Safety
- Department of Juvenile Corrections
- Administrative Office of the Courts
- Arizona Department of Housing
- Arizona Department of Corrections
- Arizona Department of Education

Since Child Safety, Developmental Disabilities, Education, and Juvenile Justice are funded separately in Arizona, a mixture of cooperative agreements and contractual relationships have been defined. Of the stakeholder organizations, only the Department of Developmental Disabilities has established a contract with AHCCCS to provide behavioral health services for its eligible members. All other stakeholder agencies operate with collaborative agreements developed individually with each T/RBHA. These agreements define how the respective agencies are to work together to provide services such as counseling, crisis intervention, and residential treatment on behalf of individuals and families "shared" by the systems. Each T/RBHA has regular meetings with representatives of these stakeholder agencies to coordinate their collaborative efforts. In addition, AHCCCS maintains communication and collaboration through ongoing meetings involving stakeholders and state-level leadership.

Research has identified that outcome evaluation is key to achieving and sustaining transformation initiatives in Systems of Care (Hodges, Hernandez, Nesman, & Lipien, 2002). This is illustrated by a five-year study of children's mental health sponsored by the University of South Florida. In the study, researchers identified key elements for accomplishing goals and sustaining theory-based efforts at system change. These included the finding that organizations must have methods to ensure that service implementation is consistent with underlying theory, "regardless of the information source". According to the authors, it is important that organizations have a means to confirm that their theory-based strategies are actually serving intended recipients, are providing intended services and supports, and are producing desired results. Finally, the authors conclude that as a consequence of such outcome evaluation, decision makers are better equipped to identify and to anticipate challenges to implementation and sustainability.

For AHCCCS, research findings underscoring the need for outcome measures coincided with requirements of the settlement agreement entered into by AHCCCS with plaintiff's counsel in the Jason K. class action lawsuit. Under the terms of this agreement, AHCCCS committed to undertake development of a process to evaluate the quality of practice throughout the state. The J.K. Settlement Agreement, provision VIII, under "Quality Management and Improvement System", indicates that the measurement process will include as an integral component, "an in-depth case review of a sample of individual children's cases that includes interviews of relevant individuals in the child's life". In response to this agreement, in its 5th Annual JK Action Plan, AHCCCS established twelve objectives. One of these pertained to the implementation of the Practice Improvement Review process, and stipulated that AHCCCS would settle on a practice review instrument for use statewide.

As of June 2007, the practice review method in use by AHCCCS was the Wraparound Fidelity Assessment Scale (WFAS), developed by Dr. Eric Bruns of the University of Washington. The WFAS, as implemented in Arizona, consisted of two components; the Wraparound Fidelity Index (WFI), and the Document Review Measure (DRM). The WFAS was used to evaluate the degree to which services were being delivered according to the 12 Principles, and in keeping with Child and Family Team Practice. In October 2008, AHCCCS implemented a taskforce to evaluate the efficacy of the WFAS as a performance improvement measure for Arizona's System of Care. This taskforce, chaired by the AHCCCS Medical Director for Children's Services, included representatives from a number of AHCCCS functional areas including Children's System of Care, Children's Networks, Quality Management, and Clinical Practice Improvement.

The taskforce recommendations included: 1) Finalizing the Arizona-developed "Low Needs Tool", (henceforth referred to as the Brief Practice Review), and 2) Combining what had been separate moderate and high needs reviews into one process, to be referred to as the Practice Review for Children with Complex Needs. For purposes of implementing a practice review tool, AHCCCS determined that it was not practicable to employ the same method for reviewing cases with a high level of complexity/acuity as for those with a lower level of complexity. The Child and Adolescent Service Intensity Instrument (CASII) was identified as a mechanism for providers to rate levels of need/acuity on a scale from 0-6, with 6 representing the greatest intensity of need. Thus, the initial sample pool of cases deemed "high complexity" contained all children and youth age 6-18 years who had scores of 4 or higher on the CASII. Children ages 0-5 were also included if they had met the criteria of being involved in two or more child-serving systems; i.e., being involved in Behavioral Health plus an additional service such as Department of child safety, Juvenile Justice, or the Department of Developmental Disabilities. All other children not meeting these criteria were included in the sample for the Brief Practice Review.

In response to the taskforce's first recommendation, a workgroup was formed, and subsequently developed "The Practice Review for Children with Standard Needs". This tool, consisting of 15 questions, was to be administered telephonically with a child's primary caregiver. To address the second objective, the taskforce consulted with a number of local and national experts in practice review and survey development, including Mario Hernandez, Ph.D., of the University of South Florida. Ultimately, the Committee determined that the System of Care Practice Review (SOCPR) methodology developed by Dr. Hernandez would satisfy its requirements for the Complex Needs review process in Arizona. Subsequently, the SOCPR was adopted by AHCCCS as its practice review methodology with implementation beginning in FY2009-2010.

SOCPR and Quality Management/Practice Improvement

SOCPR results constitute one of the many data sources utilized by the AHCCCS Quality Management (QM) Department. These results are intended to be used as a mechanism to provide feedback to the Behavioral Health System regarding areas of strength and areas where improvement is needed in System of Care implementation. The feedback/improvement process occurs at two levels. The first is the individual provider agency level, where SOCPR feedback is utilized to develop individualized performance improvement plans. Second, as trends and common themes are identified across the state, these are incorporated into the AHCCCS System of Care Planning and Development process as goals and objectives for the T/RBHAs for the coming year.

METHODOLOGY

SOCPR Introduction

The System of Care Practice Review (SOCPR) collects and analyzes information regarding the process of service delivery to document the service experiences of children and their families, and then provides feedback and recommendations for improvement to the system. The process yields thorough, in-depth descriptions that reveal and explain the complex service environment experienced by children and their families. Feedback is provided through specific recommendations that can be incorporated into staff training, supervision, and coaching, and may also be aggregated across cases at the Regional or system level to identify strengths and areas in need of improvement within the system of care. In this manner, the SOCPR provides a measure of how well the overall system is meeting the needs of children and their families relative to system of care values and principles.

The reliability of the SOCPR has been evaluated, and high inter-rater reliability has been reported in its use (Hernandez et al., 2001). The validity of the protocol is supported through triangulating information obtained from various informants and document reviews. The SOCPR was found to distinguish between a system of care site and a traditional services site. Moreover, Hernandez et al. (2001) found in their study that the SOCPR identified system of care sites as being more child-centered and family-focused, community based, and culturally competent than services in a matched comparison site offering traditional mental health services. System of care sites were more likely than traditional service systems to consider the social strengths of both children and families and to include informal sources of support such as extended family and friends in the planning and delivery of services. In addition, Stephens, Holden, and Hernandez (2004) found that the SOCPR ratings were associated with child-level outcome measures. In their comparison study, Stephens and colleagues (2004) discovered that children who received services in systems that functioned in a manner consistent with system of care values and principles compared with traditional services had significant reductions in symptomatology and impairment one year after entry into services, whereas children in organizations that did not use system of care values demonstrated less positive change. The study also found that as system of care-based practice increased, children's impairments decreased.

SOCPR Method

The SOCPR relies on data gathered from interviews with multiple informants, as well as through case files and record reviews. Document reviews precede interviews and provide an understanding of the family's service history, including the presence and variety of services from sectors outside of behavioral health care systems. These reviews also provide the chronological context of service delivery and help to orient the reviewer to the child and family's strengths, needs, and involvement with services.

The interviews are based on a set of questions intended to obtain the child and family's perceptions of the services they have received. Questions related to accessibility, convenience, relevance, satisfaction, cultural competence, and perceived effectiveness are included. These questions are open-ended and designed to elicit both descriptive and explanatory information that might not be found through the document review. The questions provide the reviewer with the opportunity to obtain information about the everyday service experiences of the child and family and thereby gain a glimpse of the life experience of a child and family in the context of the services they have received.

The SOCPR uses a case study methodology informed by caregivers, youth, formal providers, informal supports, and extant documents related to service planning and provision. The unit of analysis is the *family case*, with each case representing a test of the extent to which the system of care is implementing its services in accordance with system of care values and principles. The family case consists of the child involved in the system of care, the primary caregiver (e.g., biological parent, foster parent, relative), the primary formal service provider (e.g., behavioral health case manager, therapist), and if present, a primary informal helper (e.g., extended family member, neighbor, friend).

Domains

The SOCPR assesses four domains relevant to systems of care: 1) Child-Centered, Family-Focused, 2) Community Based, 3) Culturally Competent, and 4) Impact.

Domain I, Child-Centered Family-Focused, is defined as having the needs of the child and family dictate the type and combination of services provided by the system of care. It is a commitment to adapt services to children and families, as opposed to expecting children and families to conform to pre-existing service configurations. Domain I has three subdomains: 1) Individualized, 2) Full Participation, and 3) Case Management.

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Domain II, Community Based, is defined as having services provided within or close to the child's home community in the least restrictive and most appropriate setting possible, and coordinated and delivered through linkages between a variety of providers and service sectors. This domain is composed of four subdomains: 1) Early Intervention, 2) Access to Services, 3) Minimal Restrictiveness, and 4) Integration and Coordination.

Domain III, Culturally Competent, is defined by the capacity of agencies, programs, services, and individuals within the system of care to be responsive to the cultural, racial, and ethnic differences of the population they serve. Domain III has four subdomains: 1) Awareness, 2) Sensitivity and Responsiveness, 3) Agency Culture, and 4) Informal Supports.

Domain IV, Impact, examines the extent to which families believe that services were appropriate and meeting their needs and the needs of their children. This domain also examines whether services are seen by the family to produce positive outcomes. This domain has two subdomains: Improvement and Appropriateness.

Taken individually, these measures allow for assessment of the presence, absence, or degree of implementation of each of the domains and subdomains. Taken in combination, they speak to how close a system's services adhere to the values and principles of a system of care. The findings can also highlight which aspects of system of care-based services are in need of improvement. Ultimately, results provide the basis for feedback, thus allowing a system's stakeholders to maintain fidelity to system of care values and principles.

Organization of the SOCPR

The SOCPR is organized into four major sections: Demographics. Document Review, Interview Questions, and Summative Questions.

Section 1: Demographics includes vital and social characteristics of the child, family, and formal provider and a snapshot of the child's current array of services.

Section 2: Document Review organizes the case records review and comprises the Case History Summary and the Current Service/Treatment Plan. The Case History Summary requires the reviewer to provide a brief case history based on a review of the file. It also provides information about all of the service systems with which the child and family are involved (e.g., special education, behavioral health, juvenile justice, department of child safety). It summarizes major life events, persons involved in the child's history and current life, outcomes of interventions,

and the child's present status. Review of the Individualized Service Plan provides information about the types and intensity of the services received, integration and coordination, strengths identification, and family participation. The Document Review is completed prior to any interview so that the information gathered through the documents can inform and strengthen the interviews.

Section 3: Interviews Questions consists of the interview questions organized by the type of informant (primary caregiver, youth, formal service provider, informal helper). The interviews are designed to gather information about each of the four identified domains (Child-Centered Family- Focused, Community Based, Culturally Competent, and Impact). Questions for each of the four domains are divided into subdomains that define the domain in further detail and represent the intention of the corresponding system of care core value. Questions in each of the subdomains are designed to indicate the extent to which core system of care values guide practice. Data are gathered through a combination of closed-ended questions (i.e., quantitative) that produce ratings and explanatory responses from participants through more open-ended questions and narrative responses (i.e., qualitative). The open-ended questioning provides an opportunity for the reviewer to probe issues related to specific questions so that answers are as complete as possible. In addition, direct quotes from respondents are recorded whenever appropriate and possible.

Section 4: Summative Questions consists of the summative questions in which reviewers record their ratings and the evidence derived from the file review and interviews to support the reviewer rating for each summative question. These ratings represent the reviewer's belief of the extent to which system of care values and principles are actualized.

Training of the Interview Team

Training for the SOCPR follows strict procedural guidelines, which are outlined below. These steps were implemented and followed by the AHCCCS review team. Before data collection begins, the team conducting the SOCPR must be identified and trained. Case reviews may be conducted using single reviewers or paired review teams. The use of single reviewers allows for more cases to be reviewed at a lower cost. Pairing reviewers provides the advantage of being able to validate and discuss what is being learned through the review process. The use of paired reviewers is obviously more costly and may not always be feasible. However, when individual reviewers are conducting the SOCPR, it is recommended that reliability checks be conducted with another reviewer.

The didactic training includes a review of the values and principles of systems of care, an

orientation regarding the purpose and objectives of the SOCPR, and practice sessions for interviewing and rating the summative questions within the SOCPR. In addition, because much of the useful information about a family is collected through interviews, it was important to train reviewers in the proper methods for conducting interviews and documenting information from the responses that emerge during the review. Without this part of the training, reviewers may not probe adequately, or they may overlook information that helps with both the summative ratings and with the feedback that is later provided to the system of care. In addition, interview training was important so that the reviews are respectful, effective at ensuring that all questions are answered, and able to create a comfortable experience for informants.

During the training of reviewers, it is recommended that each trainee be shadowed by the trainer or another person with experience using the SOCPR protocol. This hands-on training includes the shadowing of a trainee by an experienced reviewer who participates in all aspects of the case review. The trainee conducts the interviews and leads the case review, and the shadow is available to provide support, clarify procedures, answer questions, and complete a separate set of ratings for comparison. Once a training case is completed, the trainee and shadow debrief about the case. It is essential that the debriefing include a discussion of why the ratings were given and the ways in which the notes resulting from the review will be used to give feedback to system stakeholders. Trainees, shadows, and the primary trainer typically meet together for group debriefing.

The coaching/shadowing of two cases per trainee allows for an examination of the trainee's ability to conduct the SOCPR in an appropriate and reliable manner. The reliability of a trainee can be examined through the calculation of three different measures: 1) the percentage of summative question ratings that were exact matches between the trainee and the shadow; 2) the percentage of summative question ratings that were scored in the same direction (i.e., positive or negative scores) by the trainee and the shadow; and 3) the discrepancy value between the trainee and shadow scores displayed as a percentage.

Selecting Cases and Informants

Implementing the SOCPR involves the selection of cases for review and the selection of the key informants for interviews. The number and type of cases to be examined is determined by the agency or system of care using the SOCPR and should be tailored to meet the specific needs and interests of that agency or system. Cases are selected based on characteristics such as the child's age, gender, and the service sector with which the child is involved. For example, an agency or system may be interested in assessing its service delivery for young children who are

not yet in school or for youth involved within the juvenile justice sector. A system of care should be purposeful in its approach to sampling to ensure the usefulness of the results. If a few cases are drawn from too large a pool of services and programs, it will be difficult to understand the results and to later know to whom and in what manner feedback should be provided. Determining the number of cases to be examined and the system's reason for implementing the SOCPR is critical to the usefulness of the results.

Arizona's sample of SOCPR cases could not be guided by examples from other communities who have used the SOCPR, as Arizona is the first state to implement the SOCPR in a systematic statewide manner. Therefore, the sample pool of cases contained all children and youth age 6 –18 years who had scores of 4 or higher on the Child and Adolescent Service Intensity Instrument (CASII). Children aged 0-5 were included if they met one or more of the following criteria: other agency involvement (Arizona Early Intervention Program [AZ EIP], Department of Child Safety [AZ DCS], Department of Developmental Disabilities [AZ DDD]); out of home placement (within past 6 months); psychotropic medication utilization (2 or more medications) and/or CGAS of ≤50. In addition, selected cases had to be enrolled in services at least 90 days, and be currently active at the time the sample was drawn. In addition, if multiple siblings were receiving services from the same agency only one child was included in the sample. For each agency under review, a case manager could have no more than two of their cases identified for the SOCPR review.

The next step involved examining the number of children who met this complexity designation at each Provider Network Organization or service agency in the state. No cases were chosen for the SOCPR from agencies who served fewer than 25 children who met the eligibility criteria. For agencies who served 25 to 400 eligible children, five cases from the agency were chosen for the SOCPR. For agencies who served more than 400 children who met the criteria, 10 cases were chosen. Agencies were contacted and asked to pull a random oversample based on the criteria described above. This oversampling was intended to provide substitute cases where families were not able to be located, chose not to participate in the process, or who upon review were found not to meet the "high complexity" designation. This process resulted in a total of 170 cases being completed in FY2016-2017.

SOCPR Data Analysis and Reporting

The analysis of the SOCPR follows a sequential process, in which data are coded, sorted, rated, and examined. Data are integrated, and ratings are determined for each question, embedded within a subdomain of one of the four main domains, with higher scores indicating that a family's experiences are more consistent with system of care principles. All of the interview

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questions in the SOCPR are organized into a predetermined coding scheme. This allows for questions to be sorted by interview (e.g., primary caregiver, child, formal provider) and by domain. Once all of the required data for the protocol have been collected, the information is integrated to rate the summative questions, each relating to a specific domain. The ratings specified for each subdomain are averaged to provide a global rating for that domain. In addition, the summative questions for each domain are clustered, with their average rating representing a measurement of the individual components in each domain. Finally, reviewers support their final ratings with a brief explanation and direct quotes from the interviews.

The SOCPR produces findings such as mean ratings that reveal the extent to which the services and/or system under review adhere to the system of care philosophy (i.e., the extent to which services are child-centered and family-focused, community based, culturally competent, and impactful). A mean rating is also completed that assesses the impact of services on children and their families. The ratings are supported and explained by reviewer's detailed notes and direct quotes from respondents to provide objective, evocative, and in-depth feedback. The findings are used to document the specific components of service delivery that are effective or that need to be further developed and improved to increase fidelity to the system of care approach. One of the strengths of the SOCPR derives from its production of both quantitative and qualitative data. The mean ratings provide a discrete number to indicate the level of system of care values and principles implementation that is present within the family case. The file review data, interview contents, and reviewer reasoning to support summative question ratings provide the "why" to support the mean ratings scores. In addition, overall themes can be gleaned from these writings to provide information about larger systemic issues, community resources or needs, or other unique events that affect system of care values implementation.

TIBCO Spotfire S+® 8.2 (2010) was used to analyze the quantitative data. The results of the SOCPR are organized and presented on the basis of the four domains: Child-Centered Family-Focused, Community Based, Culturally Competent, and Impact. Each summative question is rated on a scale of –3 (disagree very much) to +3 (agree very much). These scores are then transformed on a scale from 1 (disagree very much) to 7 (agree very much) to eliminate the – and + signs. Thus, –3 is transformed to 1; –2 to is transformed to 2; –1 is transformed to 3, and so forth.

Hence, a rating ranging from 1–7 is derived for each of the domains and their embedded measurements. Scores from 1–3 represent lower implementation of a system of care principle, and scores from 5–7 represent enhanced implementation of a system of care principle. A score of 4 indicates a neutral rating, meaning a lack of support for or against implementation of system of care values and principles. Because a rating of 4 does not provide any evidence, raters are trained to use it as sparingly as possible when rating items.

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Means were calculated for the overall case, domains, subdomains, and individual items. The range of scores, minimum and maximum values, and standard deviations for each data point were also examined. The total set of cases as well as groups of cases determined by Region were "slices" of data used to examine the relationship between SOCPR scores and a variety of demographic variables, including age, gender, race/ethnicity, child's primary language, service systems utilized, specific services accessed, and length of services at the agency. SOCPR quantitative score comparisons among Regions were not made, as each Region encompasses a unique set of children and families receiving services, and provider agencies providing services. Data are reported to provide state-level information to guide AHCCCS planning and to assist provider agencies within a specific Region to improve their services to best serve their children and families.

The qualitative analysis reports a summary of qualitative data compiled from responses to Summative Questions that SOCPR reviewers use to summarize and integrate the information gathered as a means of assessing the degree to which System of Care values and principles are implemented in four SOCPR domains. These domains are further divided and include a total of 13 subdomains. The SOCPR review includes a Document Review and a series of interviews completed with one or more service providers, as well as a particular child/youth and caregiver that are involved with the department of child safety system. The Summative Questions call for the reviewer to provide a rating for each of 41 statements and to provide a brief narrative in support of each rating. Individual ratings serve as indicators of the extent to which subdomain elements (e.g., *individualized services*, *full participation*) are being implemented. In the final analysis, ratings for each item were clustered and considered in conjunction with the respective reviewers' narrative to determine a general assessment for each subdomain and an overall rating for each domain indicating the extent to which each subdomain was achieved. The compiled narratives for all Summative Questions were coded and sorted to assess the degree to which System of Care principles were implemented in each SOCPR domain area and an explanation for the evidence provided. The frequency of Summative Question responses were examined and analyzed for emerging patterns/trends. Where an overall summative rating relates to a reviewer's determination of completion of a *thorough assessment*, for instance, qualitative analysis examines the evidence provided to explain a particular rating.

In order to be considered a trend, at least of half (50%) of the responses associated with a particular rating had to provide similar information related to a given measurement and/or subdomain area. Trends in each subdomain are then reviewed together to provide an overall assessment for the larger domain area.

Initial verification of data from SOCPR reports were conducted by the contractor who reviewed submitted SOCPR instruments, and identified any omissions or other obvious errors in recording. Subsequently, data were forwarded to AHCCCS for entry into the SOCPR database. The quality of the SOCPR data was checked again as data entry was completed for each provider agency. A summary of each provider's quantitative data was produced and reviewed again for errors. If errors were found, clarification was sought from the data collection team leader and corrected in the database. Quantitative data were also compared by reviewer and provided to the data collection team leader in order to ensure accuracy. As part of preparation for provider feedback sessions, data from each provider agency review were assembled into a report format, which was forwarded to the Children's System of Care Bureau Chief and staff to review prior to sending to the contractor for final report preparation. Annually, various data reports were completed as part of the quality check process to assist with training and ensure continued data integrity needs were addressed.

Qualitative data derived from Summative Questions were monitored as follows. Summaries were reviewed for clarity and edited for consistency in of use of terms, spelling, jargon, and identifying information. Additionally, a sample of responses from each rater was reviewed for consistency between the rating and the narrative summary by the Project Manager with the individual rater. The scope and quality of these brief narrative responses can vary, though initial reviewer training and ongoing training and supervision are implemented to promote consistency.

Because the sampling emphasis for FY2016-2017 was again placed on children and families involved with the Department of Child Safety system, results of this year's SOCPR report (both quantitative and qualitative) is divided into 2 sections: Results ALL Cases and Results DCS Cases. This will provide an opportunity for side-by-side comparison of the whole sample (of children and families identified as having high/complex levels of need) and the sample of interest (children and families involved with the Department of Child Safety).

RESULTS ALL CASES

Demographics ALL Cases

The 170 SOCPR cases completed during FY2016-2017 were sampled from all three Regions in Arizona. A summary of the demographic characteristics is presented in Table 1. Due to the sampling scheme employed by AHCCCS (previously described in the Methodology section), different numbers of cases were completed in each Region. The most populous Region, Central-6, provided the greatest number of cases for the sample (N=70). South-8 provided 60 cases while North-7 had the fewest cases (40).

Table 1. Demographic Characteristics ALL Cases

Demographic Characteristic	Statewide N=170	NORTH-7 (I & IV-G) N=40	SOUTH-8 (II, III, IV-P, & V) N=60	CENTRAL-6 (VI) N=70
Age (years)	8.61	7.48	8.68	9.19
Gender (Male)	55.9%	60.0%	60.0%	50.0%
Race:				
White	50.6%	70.0%	45.0%	44.3%
Black	4.7%	0.0%	5.0%	7.1%
Latino/Hispanic	28.8%	15.0%	31.7%	34.3%
Native American	5.3%	12.5%	1.7%	4.3%
Multi-racial	10.6%	2.5%	16.7%	10.0%
Primary Language:				
English	95.9%	97.5%	96.7%	94.3%
Spanish	2.4%	0.0%	3.3%	2.9%

As shown in Table 1, the overall mean age for the 170 cases was 8.61 years. The means for age across Regions ranged from 7.48 years to 9.19 years. Statewide almost 56% of the sample was male, ranging from 50% in Central-6 to 60% in both North-7 and South-8. Of the sample, almost 51% was White, almost 29% was Latino/Hispanic, and almost 11% identified as Multi-racial. The remaining 10% of the sample was Black and Native American. Statewide, almost 96% of the children and youth in the sample spoke English as their primary language. English was the only language reported in North-7. Spanish was also identified as a primary language (2.4%) in South-8 and Central-6. Chi-square analyses were used to look for demographic differences in cases by Region, with age bands, gender, race, and primary language under consideration.

Service System Involvement ALL Cases

Five different child-serving systems and an "Other" category were used to capture service system involvement as part of the services profiles of children and youth whose cases were chosen as part of the sample. Almost all 170 cases (99.4%) indicated having behavioral health system involvement, as shown in Table 2. The SOCPR protocols documented that a little over 57% of the cases had child safety involvement, followed by educational services involvement (21%). Juvenile justice, developmental disabilities, and "Other" rounded out service system involvement. The "Other" system category was documented by 4.7% of the Regions. The five services included Arizona Early Intervention Program (AZEIP), Children's Rehabilitative Services (CRS), Department of Economic Security/Rehabilitation Services Administration (DES/RSA), Group Home Therapeutic, and Probation.

Table 2. Service System Involvement ALL Cases

Service System	Statewide N=170	NORTH-7 (I & IV-G) N=40	SOUTH-8 (II, III, IV-P, & V) N=60	CENTRAL-6 (VI) N=70
Behavioral Health	99.4%	100.0%	100.0%	98.6%
Child Safety	57.1%	57.5%	53.3%	60.0%
Juvenile Justice	8.2%	5.0%	10.0%	8.6%
Educational Services	21.2%	20.0%	18.3%	24.3%
Developmental Disabilities	11.8%	10.0%	11.7%	12.9%
Other	4.7%	0.0%	10.0%	2.9%

The results of the 170 cases were plotted by histogram to explore the distribution of cases for total number of systems involved. The results are seen in Figure 1. The horizontal axis displays the total number of services, while the vertical axis represents the number of cases with that total number of services. The 170 cases represent children and youth who either were receiving behavioral health system services or had recently completed services from the behavioral health system. In addition, cases were only chosen for SOCPR review if the youth was identified as having complex needs.

Overall, cases identified a range of 0 – 6 for the possible number of service system involvement, with the mean being 2.02. The amount of service system involvement documented ranged from 1 – 5. The shape of the histogram resembles a normal distribution but is slightly skewed. One might expect that children and youth in this sample to be involved in a significant number of child-serving systems and thus expect the shape/distribution to skew to the right, towards a greater number of service systems. Explanations for this finding might include inadequate record documentation, differences in

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reviewer interpretations of how to record service system involvement, or data entry errors.
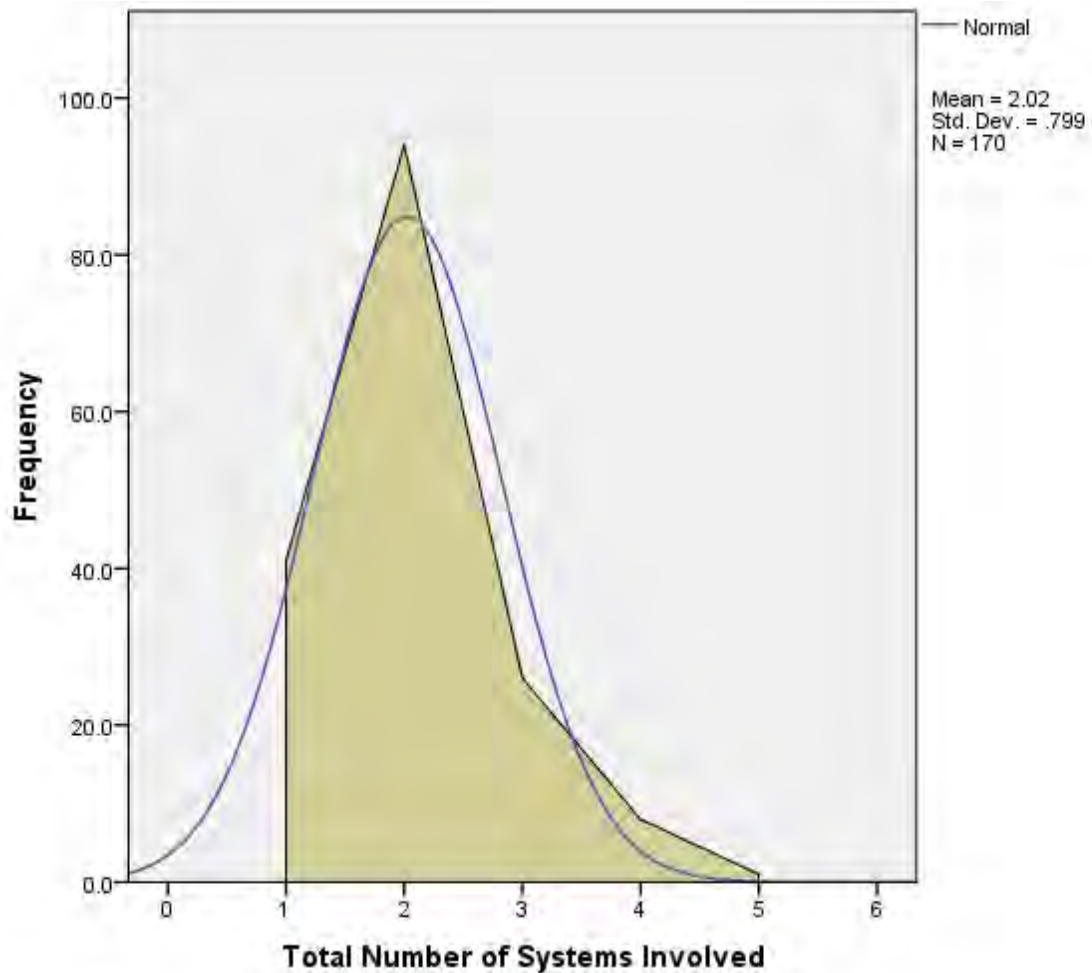
Figure 1. Histogram of child-serving system involvement ALL cases.

Receipt of Services or Treatments ALL Cases

Similar to child-serving systems, the kinds of services or treatments children and youth in the sample received were also calculated. Fifteen named types of services as well as an "Other" category (see Appendix B) were used to identify categories of service or treatment provision. These service types are shown in Table 3.

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Table 3. Services or Treatments Received by Children and Youth ALL Cases

Services or Treatment	Statewide N (%)	NORTH-7 (I & IV-G) N=40 N (%)	SOUTH-8 (II, III, IV-P, & V) N=60 N (%)	CENTRAL-6 (VI) N=70 N (%)
Treatment Services	**130 (76.5)**	**23 (57.5)**	**49 (81.7)**	**58 (82.9)**
•Individual Counseling	113 (66.5)	22 (55.0)	39 (65.0)	52 (74.3)
• Family Counseling	63 (37.1)	3 (7.5)	29 (48.3)	31 (44.3)
• Group Counseling	22 (12.9)	3 (7.5)	9 (15.0)	10 (14.3)
• Substance Abuse Counseling	4 (2.4)	3 (7.5)	0 (0.0)	1 (1.4)
Medical Services				
•Psychiatric Medication	80 (47.1)	14 (35.0)	26 (43.3)	40 (57.1)
Support Services	**166 (97.6)**	**40 (100.0)**	**58 (96.7)**	**68 (97.1)**
• Family Support	66 (38.8)	15 (37.5)	32 (53.3)	19 (27.1)
• Peer Support	10 (5.9)	2 (5.0)	5 (8.3)	3 (4.3)
• Respite Support	22 (12.9)	4 (10.0)	11 (18.3)	7 (10.0)
• Home Care Training	12 (7.1)	3 (7.5)	3 (5.0)	6 (8.6)
• Case Management	164 (96.5)	40 (100.0)	57 (95.0)	67 (95.7)
• Skill Development & Training	84 (49.4)	22 (55.0)	35 (58.3)	27 (38.6)
Inpatient Services	**7 (4.1)**	**0 (0.0)**	**3 (5.0)**	**4 (5.7)**
•Psychiatric Hospitalization	6 (3.5)	0 (0.0)	3 (5.0)	3 (4.3)
• Level I Residential	2 (1.2)	0 (0.0)	0 (0.0)	2 (2.9)
Residential Services	**9 (5.3)**	**1 (2.5)**	**3 (5.0)**	**5 (7.1)**
• Level II Residential	8 (4.7)	1 (2.5)	3 (5.0)	4 (5.7)
• Level III Residential	1 (0.6)	0 (0.0)	0 (0.0)	1 (1.4)
Other	**64 (37.6)**	**20 (50.0)**	**25 (41.7)**	**19 (27.1)**

Across the state the most utilized service or treatment provision category was Support Services (97.6%) followed by Treatment Services (76.5 %). Inpatient Services (4.1%) was the least used service or treatment provision. More specifically, the most widely utilized service or treatment statewide, based on percentage of cases using the service, was Case Management (97 %) followed by Individual Counseling (67 %), Skill Development and Training (49%), and Psychiatric Medication (47 %). Level III Residential (0.6%), Level I Residential (1.2%), Substance Abuse Counseling (2.4%), and Psychiatric Hospitalizations (3.5%) were the least utilized services or treatments statewide. Across all three Regions, Case Management was utilized in at least 95% of the cases in each Region. Level III Residential was utilized in only one Region (Central-6, 1 case).

Support Services was the most extensively utilized service or treatment category with all three Regions utilizing them in over 98% of the cases. As mentioned earlier in this report one

specific Support Service, Case Management, was received by families 97% in all three Regions. Treatment Services was documented as the next most frequently utilized service with over 76% of cases. Inpatient Services and Residential Services were utilized the least in all three Regions. North-7 had the smallest number of cases as a part of the overall statewide sample using services in all service provision categories except Inpatient Services.

Usage of some services *appears* to be unusually high; therefore, because Regions vary widely in the number of SOCPR cases completed, both number of cases and percentage need to be examined. For example, 50% of cases in North-7 had "Other" services, which represents 20 youth, as only 40 total SOCPR cases were completed for this Region. Likewise, South-8 utilized about 42% of "Other" services which accounted for 25 families. Statewide, about 38% (N=64) of the treatment or service provisions reported were identified as "Other". Several of the services variables differed significantly by Region and are shown in Table 4. Only statistically significant chi-square statistics are reported.

Table 4. Significant Associations between Region and Specific Services ALL Cases

Treatment	Chi-Square Statistic
Treatment Services • Individual Counseling • Family Counseling • Group Counseling • Substance Abuse Counseling	X^2 (2, N=170)= 10.488, p-value = 0.005 X^2 (2, N=170)= 19.820, p-value = 0.000 X^2 (2, N=170)= 6.318, p-value = 0.042
Medical Services • Psychiatric Medication	
Support Services • Family Support • Peer Support • Respite Support • Home Care Training (HCTC) • Case Management • Skills Development and Training	X^2 (2, N=170)= 9.369, p-value = 0.009
Inpatient Services • Psychiatric Hospitalization • Level I Residential	
Residential Services • Level II Residential • Level III Residential	

Other	X^2 (2, N=170)= 6.304, p-value = 0.043

Statewide for ALL Cases, a statistically significant relationship between Region and specific services received was shown for the category of Treatment Services, and within the categories of Support Services and Other. Specifically, Family Counseling, Substance Abuse Counseling, Family Support, and Other were found to show strong significant associations with Region.

In order to examine the breadth of services used by children and youth in the sample, a simple summation was calculated for the 16 potential service categories. Thus, the possible range for this variable was from 0 to 16 services utilized. For the total of 170 ALL cases in the sample, the range of services used was 0 to 10. These data are displayed via histogram to examine the distribution of total number of services used. The results are displayed in Figure 2. The histogram closely resembles a normal distribution, with a mean of 4.24 services per child or youth recorded. The number of services used during the time a case is open could vary greatly, depending on the needs of the child and family, the array of services that are available, and the length of time the case is open.
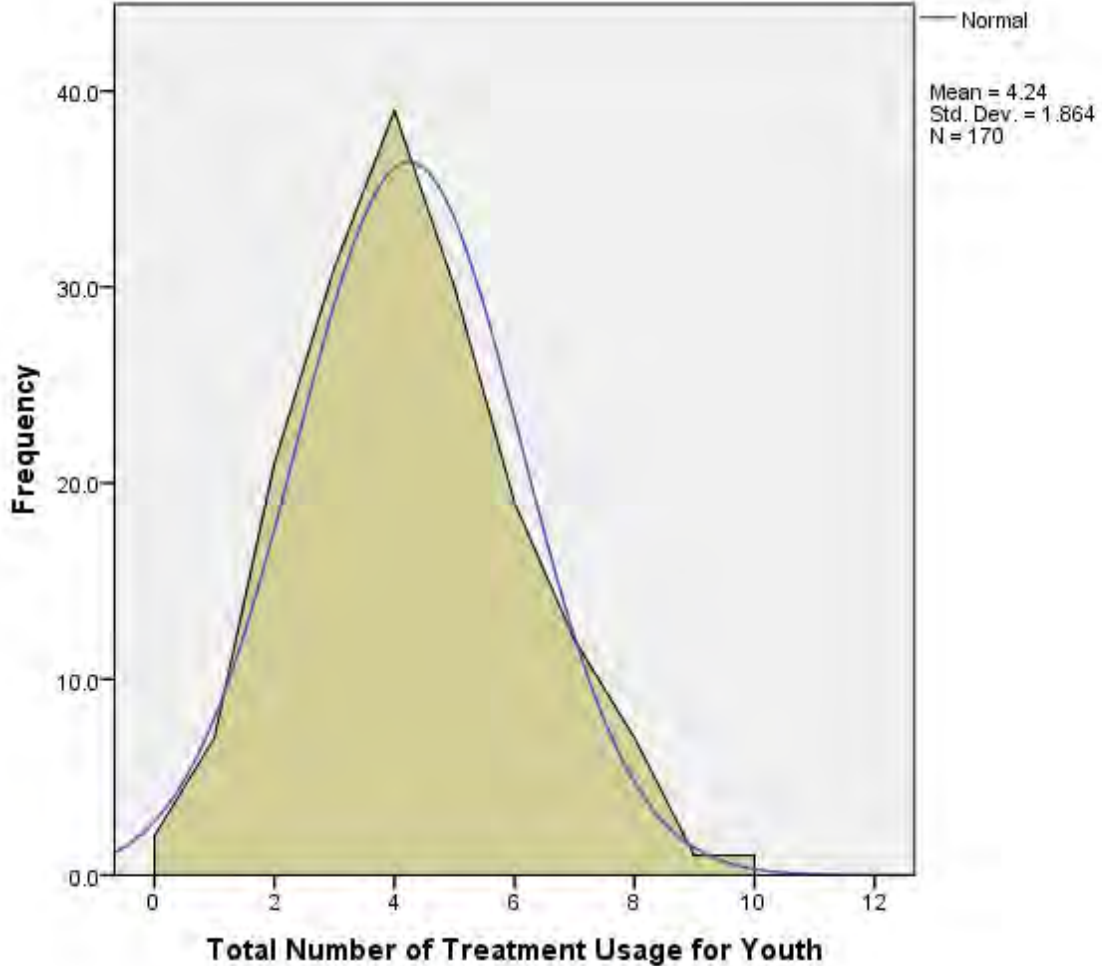
Figure 2. Histogram of service or treatment usage for youth ALL cases.
Quantitative Analysis ALL Cases

SOCPR Scores – Overall Case and SOCPR Domains ALL Cases

Mean scores were computed for the Overall case, as well as for each of the four SOCPR domains (Child-Centered Family-Focused, Community Based, Culturally Competent, and Impact). In addition, mean scores were computed for those subdomains contained within the domains. Finally, each summative question was examined individually. In general, the mean score for each item of interest was an important statistic to be examined. In addition, the minimum and maximum scores, as well as the standard deviation for each item of interest, were examined. Using these four statistics, an understanding of the range of scores, the average score, as well as an indication of the variability from case to case, could be examined. This section will report on the overall findings, and then report on specific items of interest, which demonstrate extreme scores.

Table 5 shows the Overall case scores as well as those for each SOCPR domain for the entire statewide sample of 170 cases, indicated by individual Region. As explained in the Methodology section, SOCPR scores range from a low of 1 to a high of 7. Scores from 1–3 represent lower implementation of a system of care principle, and scores from 5–7 represent enhanced implementation of a system of care principle. A score of 4 indicates a neutral rating, meaning a lack of support for or against implementation. At the statewide level, SOCPR mean scores ranged from 5.05 to 5.44 with an overall case mean score of 5.19. While the SOCPR scores for the case and domains are not normally distributed and so the standard deviation is a less useful statistic, in conjunction with minimum and maximum scores, a more complete picture of the data emerges. The statewide overall case score suggests that, like all of the SOCPR domains, great variability exists across cases. The minimum and maximum scores are to their greatest possible extremes, representing exemplary cases of good and poor system of care values implementation. The means range from the high 4s to mid 5s, showing generally enhanced implementation of system of care values. The scores indicate that across the state, behavioral health provider agencies included in the sample performed best at including the Community Based system of care values in service planning and provision. Behavioral health provider agencies were most challenged by providing culturally competent care as well as providing services and supports that were impactful to children and families.

Table 5.0 SOCPR Case and Domain Scores ALL Cases

REGION	Overall Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
Statewide (N=170)	5.19 (0.95)	5.22 (1.08)	5.44 (0.82)	5.05 (1.06)	5.07 (1.37)
	Min 2.04	Min 1.25	Min 2.38	Min 1.58	Min 1.25
	Max 6.72	Max 6.89	Max 6.88	Max 6.47	Max 7.00
North-7 (N=40)	5.38 (0.93)	5.48 (1.01)	5.49 (0.78)	5.18 (1.10)	5.36 (1.29)
South-8 (N=60)	5.04 (1.00)	5.02 (1.15)	5.33 (0.84)	4.91 (1.06)	4.91 (1.51)
Central-6 (N=70)	5.22 (0.91)	5.24 (1.04)	5.51 (0.83)	5.10 (1.03)	5.04 (1.30)

Minimum and maximum values are not presented for individual Regions, as they are a subset of the statewide scores. At the state level, the highest scoring SOCPR domain was Community Based (Mean = 5.44). This was followed by Child-Centered Family-Focused (Mean = 5.22), Impact (Mean = 5.07) and Culturally Competent (Mean = 5.05). Data for North-7 and South-8 show similar patterns when compared with statewide scores; however, Central-6 deviated from the statewide pattern.

The state of Arizona was also interested in an analysis on caseload and its impact on SOCPR scores. The variable caseload can be described as the number of cases that a service provider is concerned with/responsible for at one time or over a period of time.

Table 5.1 provides a summary of the results of ALL SOCPR scores by caseload. Among the 170 respondents, the minimum caseload was 10 and the maximum was 108 with a median of 23 and mean of 32.7. The standard deviation of the caseload was 22.4. The distribution substantially skews to the right with a skewness measure of 1.55. In total there are six missing responses of caseload including one zero value recoded to missing.

Table 5.1. SOCPR Case and Domain Scores and Caseload Impact ALL Cases

Domains	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
CL: 10-15 (n=19)	5.64 (0.56)	5.61 (0.77)	5.67 (0.55)	5.60 (0.69)	5.68 (0.62)
CL: 16-20 (n=40)	5.24 (0.72)	5.37 (0.69)	5.43 (0.60)	5.20 (0.95)	4.98 (1.27)
CL: 21-25 (n=44)	5.21 (1.06)	5.28 (1.19)	5.45 (0.93)	4.99 (1.19)	5.12 (1.46)
CL: 26+ (n=60)	5.09 (1.04)	5.03 (1.24)	5.44 (0.90)	4.87 (1.10)	5.02 (1.49)
p-value	.19	.21	.46	.06	.28

To understand the impact of caseload on SOCPR scores for ALL cases, the values were collapsed into four categories: 10 to 15; 16 to 20; 21 to 25; and 26 and above. The counts were 19, 40, 44, and 61 respectively. Additionally, Kruskal-Wallis tests were conducted to associate Case and Domain scores with categorized caseload values. No significant associations were found. However, there was an overall trend with some exceptions: the higher the caseload, the lower the SOCPR

domain scores and the higher the variability as seen in Table 5.1.

Histograms were drawn at the statewide level to better demonstrate the range of SOCPR scores for the overall case and the four SOCPR domains. These results are displayed in Figures 3 – 7. Scrutiny of these graphs shows a similar pattern for the overall average and each SOCPR domain. The data are not normally distributed and are skewed slightly towards the right, toward higher scores.
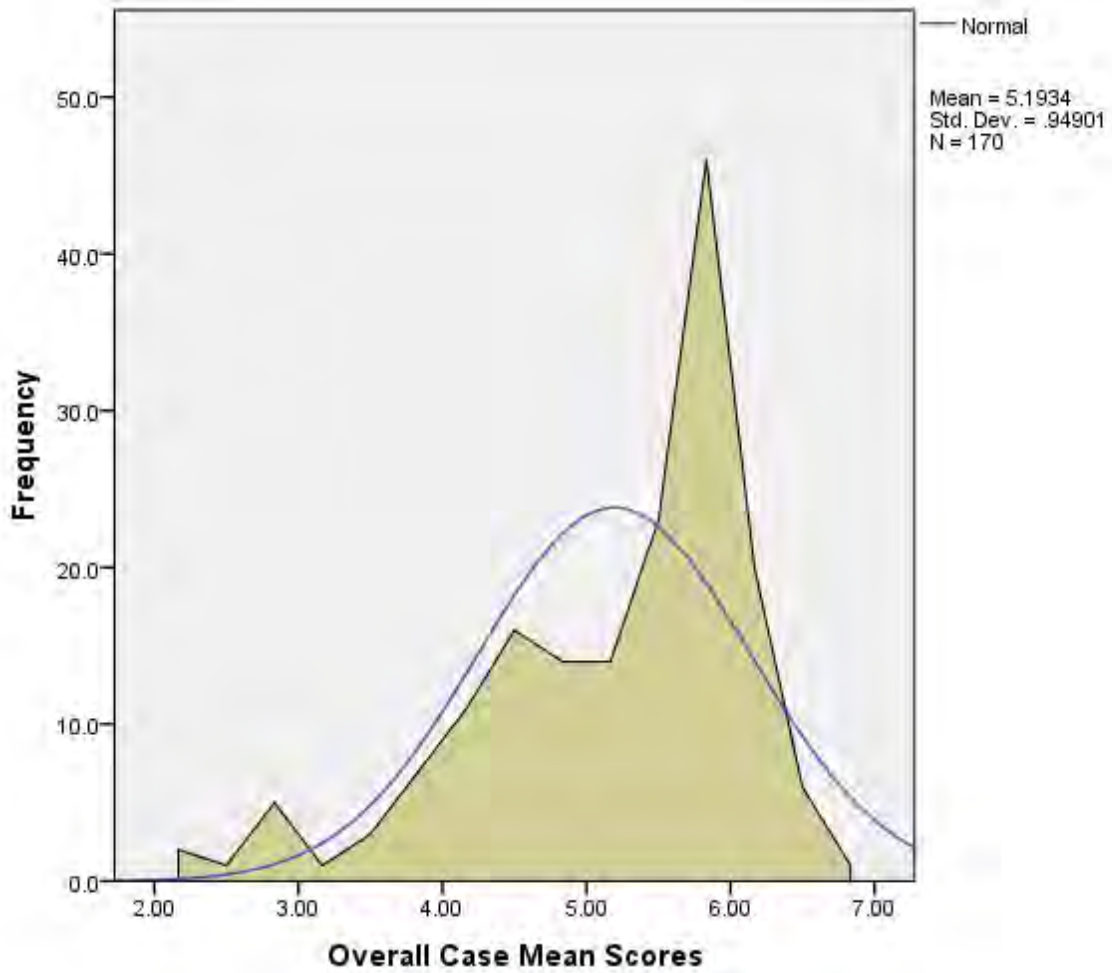
Figure 3. Histogram of SOCPR Overall case mean scores ALL cases.
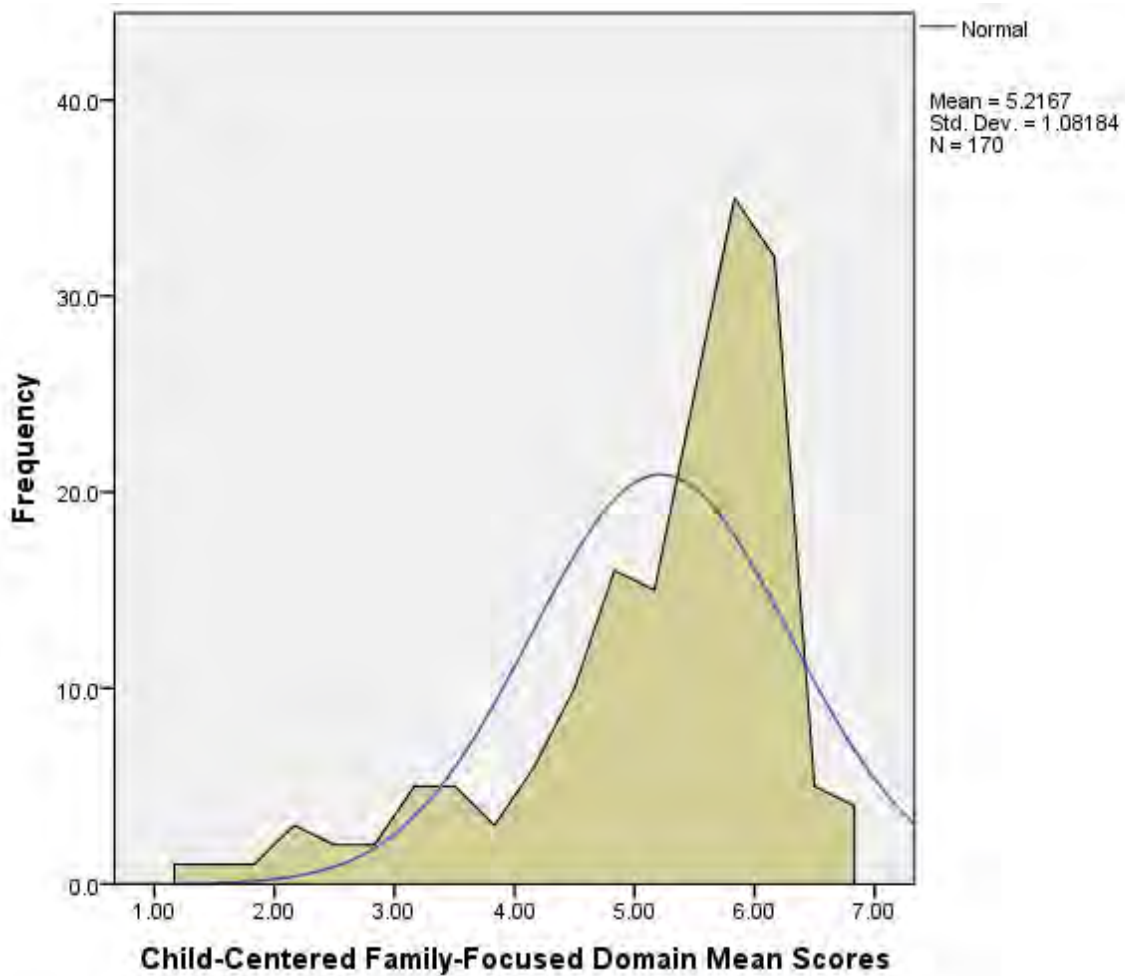
Figure 4. Histogram of SOCPR Child-Centered Family-Focused domain mean scores ALL cases.
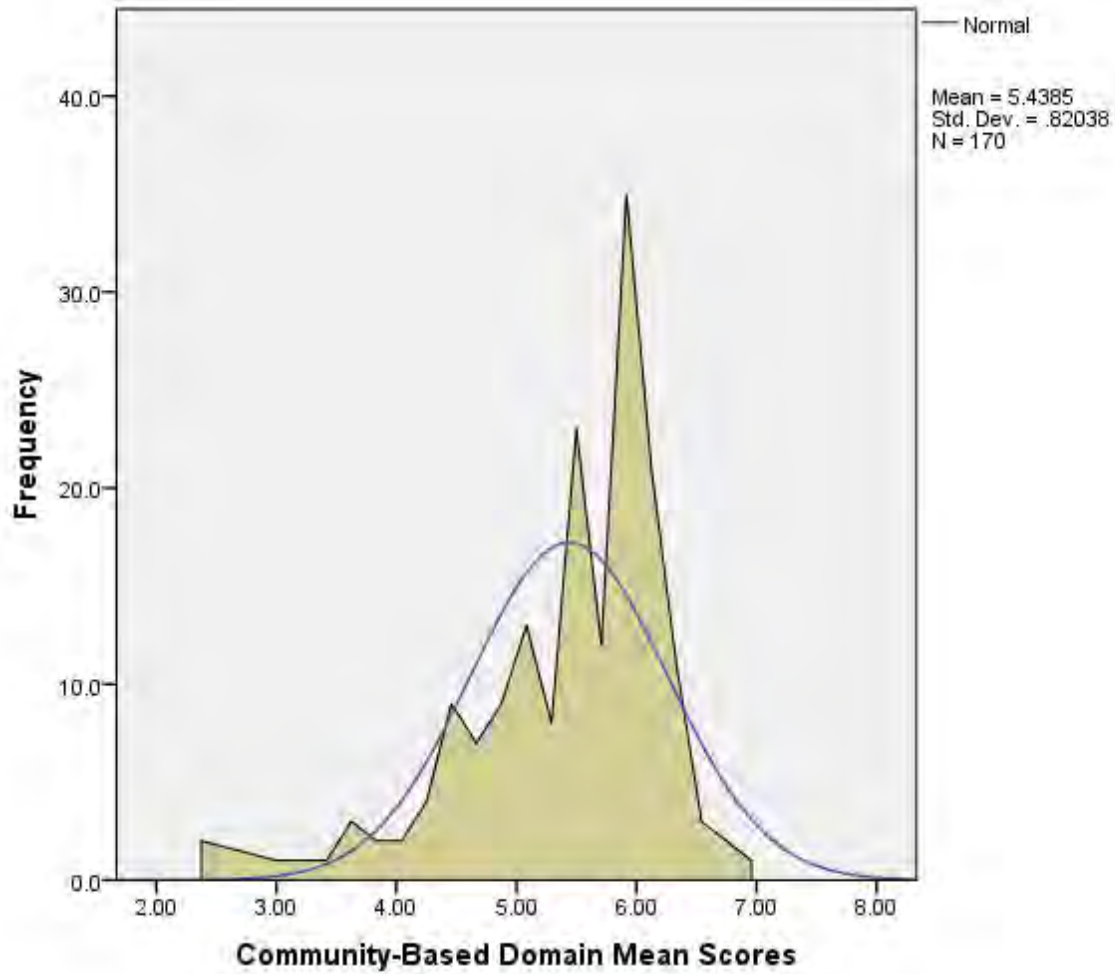
Figure 5. Histogram of SOCPR Community Based domain mean scores ALL cases.
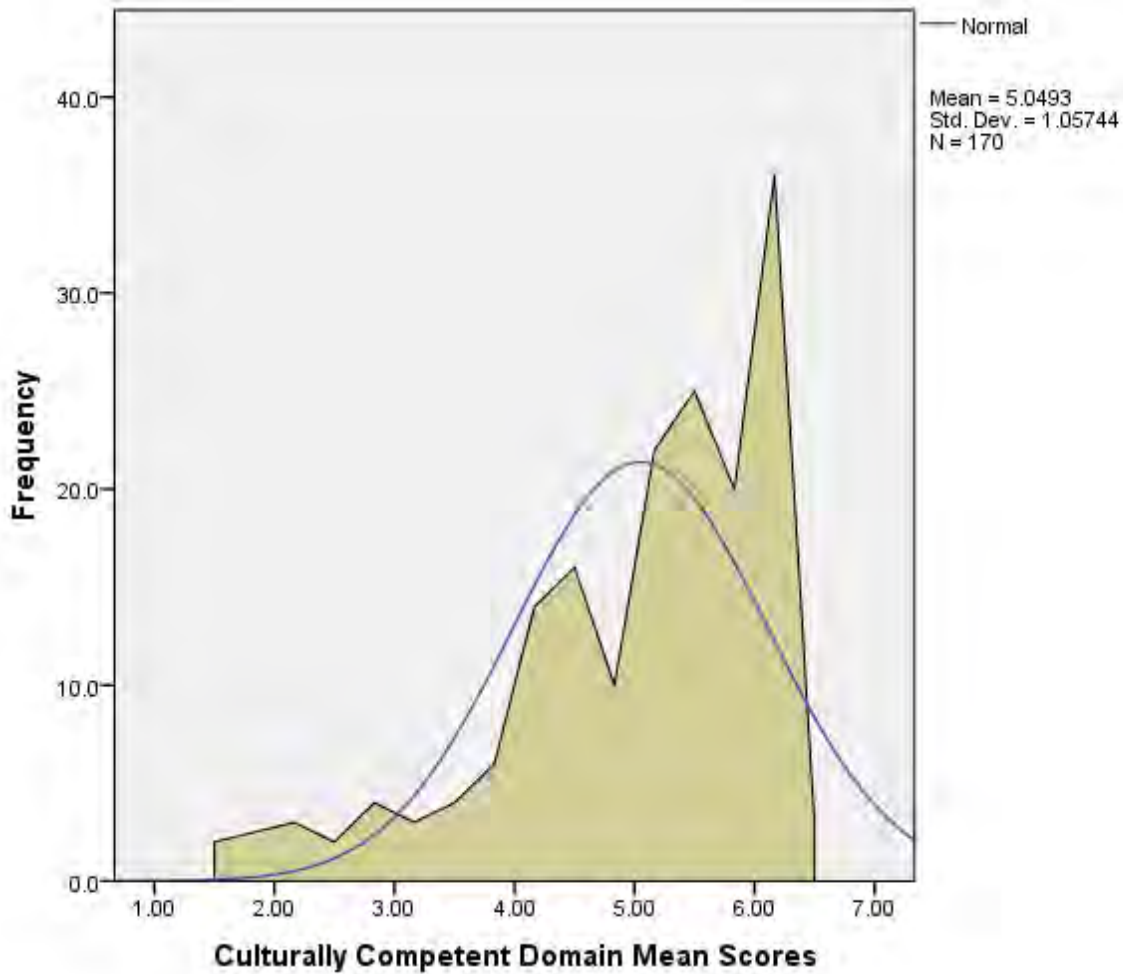
Figure 6. Histogram of SOCPR Culturally Competent domain mean scores ALL cases.
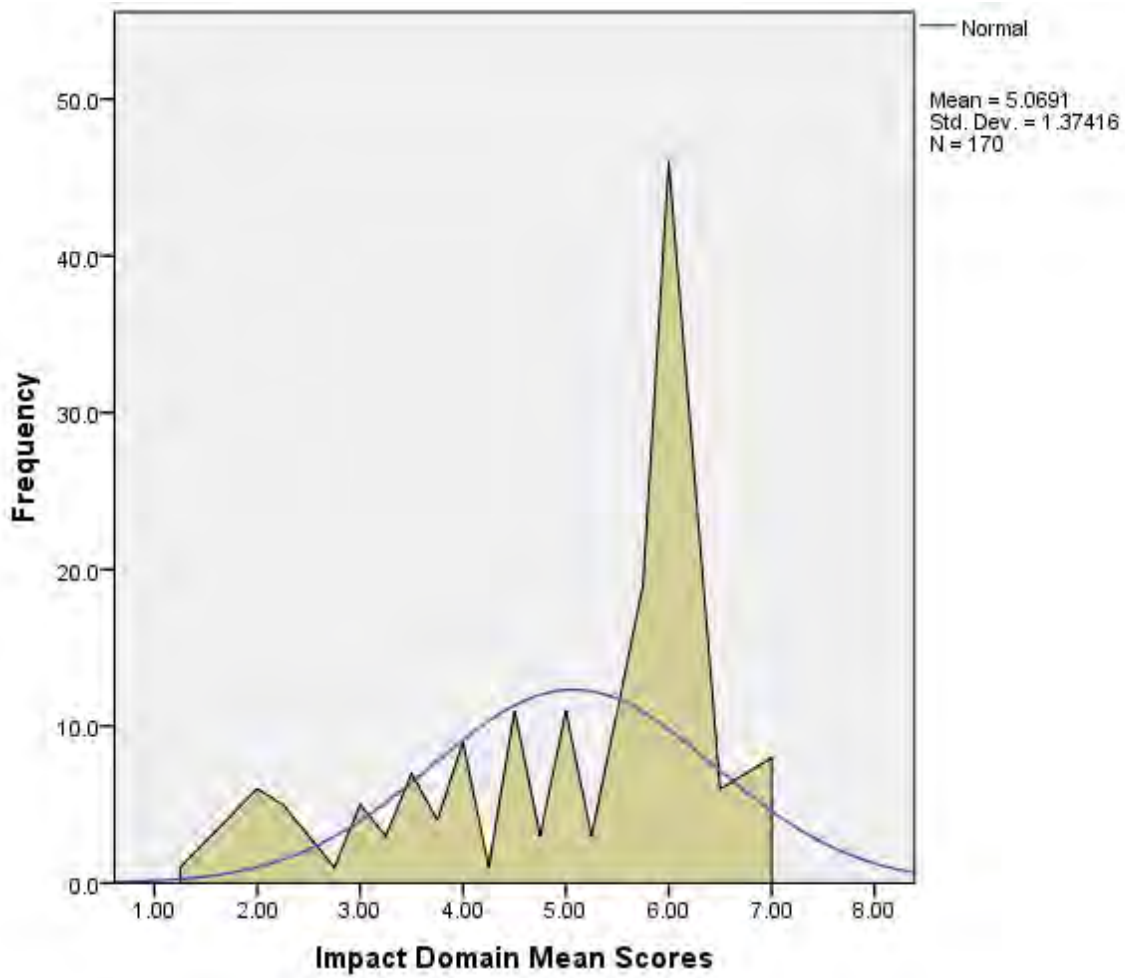
Figure 7. Histogram of SOCPR Impact domain mean scores ALL cases.

SOCPR Scores – SOCPR Domains, Subdomains, and Areas ALL Cases

Table 6.0 presents statewide SOCPR data for most levels of the instrument, including the total case or Overall mean score, SOCPR Domain scores, SOCPR Subdomain scores, and SOCPR Area scores. Because of the geographic re-alignment, Region sample sizes are now large enough to provide data, which are statistically meaningful.

Table 6.0. Statewide SOCPR Scores: Overall, Domain, Subdomain, and Area ALL Cases

Overall Score – ALL cases: 5.19 (0.95)			
	Domain Mean (SD)	Area Mean (SD)	Subdomain Mean (SD)
Domain I: Child-Centered Family-Focused	**5.22 (1.08)**		
Individualized			4.92 (1.21)
Assessment/Inventory		5.07 (1.27)	
Service Planning/Delivery		4.83 (1.26)	
Types of Services/Supports		4.90 (1.59)	
Intensity of Services/Supports		4.89 (1.68)	
Full Participation			5.39 (1.16)
Case Management			5.34 (1.36)
Domain II: Community Based	**5.44 (0.82)**		
Early Intervention			4.88 (1.43)
Access to Services			5.78 (0.74)
Convenient Times		5.86 (1.11)	
Convenient Locations		5.51 (1.27)	
Appropriate Language		5.96 (0.58)	
Minimal Restrictiveness			5.75 (0.88)
Integration and Coordination			5.34 (1.28)
Domain III: Culturally Competent	**5.05 (1.06)**		
Awareness			4.96 (1.13)
Awareness of Child/Family's Culture		4.48 (1.50)	
Awareness of Providers' Culture		5.08 (1.38)	
Awareness of Cultural Dynamics		5.34 (1.24)	
Sensitivity and Responsiveness			4.99 (1.48)
Agency Culture			5.17 (1.30)
Informal Supports			5.06 (1.59)
Domain IV: Impact	**5.07 (1.37)**		
Improvement			5.09 (1.37)
Appropriateness			5.05 (1.50)

As reported previously, the highest scoring SOCPR domain statewide was Community Based, followed by Child-Centered Family-Focused, Impact, and finally Culturally Competent. All of the SOCPR domain, subdomain, and area scores fell in the mid 4 (neutral) to high 5 (enhanced implementation of a system of care principle) range. Appropriate Language, in the subdomain of Access to Services had the highest mean score (5.96).

In the Community Based domain all subdomains and areas except for the subdomain of Early Intervention (4.88), scored in the low to high 5 range. Further, the highest subdomain mean scores were Access to Services and Minimal Restrictiveness (5.78 and 5.75 respectively). All three areas in the subdomain of Access to Services had mean scores in the mid to high 5 range: Appropriate Language (5.96), Convenient Times (5.86), and Convenient Locations (5.51). These subdomain and area scores indicate that services and service planning are provided in the primary language of the family. The available services and supports are scheduled at times that are convenient for the family, and they take place in the least restrictive setting within the home community of the child and family. These represent strengths in Arizona's Children's System of Care, as reviewed through these 170 SOCPR ALL cases.

Two additional subdomain scores (Full Participation and Case Management) within the Child-Centered, Family-Focused domain were in the low 5s. The same was true for the area of Awareness of Cultural Dynamics in the subdomain of Awareness within the domain of Culturally Competent. These scores showed that children and families, formal providers, and informal supports actively participated and influenced the service planning process. Service providers successfully coordinated and delivered culturally competent services which were responsive to the needs of the children and families.

Two subdomains, Agency Culture (5.17) and Informal Supports (5.06), and one area, Awareness of Provider's Culture within Culturally Competent (5.08), scored in the low 5s. Additionally, both subdomains in Impact scored in the low 5s: Improvement (5.09) and Appropriateness (5.05).

The data for the remaining subdomains and areas revealed scores in the mid to high 4s. Although these scores indicate neither support for nor against implementation of system of care values and principles, they may stress the need for additional attention or support. These scores may indicate that although services are provided early and in an individualized manner, providers may be challenged by developing a service plan that reflects the needs and strengths of the child and family as well as integrates both the appropriate types and intensity of services and supports. Further, providers need to keep in mind the culture, values, and beliefs of the families and utilize these formally in both the planning and delivery of services.

Based on the information received from the overall and statewide data, individual analyses were conducted for each of the three Regions. These data are presented in Tables 6.1 – 6.3.

Table 6.1 presents Region North-7 data for SOCPR Overall, Domain, Subdomain, and Area mean scores.

Table 6.1. Region North-7 SOCPR Scores: Overall, Domain, Subdomain, and Area ALL Cases

Overall Score – North-7 ALL Cases: 5.38 (0.93)			
	Domain Mean (SD)	Area Mean (SD)	Subdomain Mean (SD)
Domain I: Child-Centered Family-Focused	**5.48 (1.01)**		
Individualized			5.28 (1.05)
Assessment/Inventory		5.32 (1.21)	
Service Planning/Delivery		5.28 (1.03)	
Types of Services/Supports		5.28 (1.40)	
Intensity of		5.22 (1.64)	
Full Participation			5.58 (1.07)
Case Management			5.59 (1.35)
Domain II: Community Based	**5.49 (0.78)**		
Early Intervention			5.15 (1.25)
Access to Services			5.74 (0.79)
Convenient Times		6.00 (1.09)	
Convenient Locations		5.22 (1.56)	
Appropriate Language		6.00 (0.30)	
Minimal Restrictiveness			5.65 (1.06)
Integration and Coordination			5.40 (1.17)
Domain III: Culturally Competent	**5.18 (1.10)**		
Awareness			5.07 (1.08)
Awareness of Child/Family's Culture		4.52 (1.55)	
Awareness of Providers' Culture		5.18 (1.48)	
Awareness of Cultural Dynamics		5.52 (1.04)	
Sensitivity and Responsiveness			5.16 (1.48)
Agency Culture			5.35 (1.22)
Informal Supports			5.15 (1.69)
Domain IV: Impact	**5.36 (1.29)**		
Improvement			5.41 (1.24)
Appropriateness			5.30 (1.44)

For Region North-7, similar to Statewide Cases, the highest scoring SOCPR domain region-wide was Community Based, followed by Child-Centered Family-Focused, Impact, and finally Culturally Competent. All of the SOCPR domain, subdomain, and area scores fell in the mid 4 (neutral) to 6 (enhanced implementation of a system of care principle) range. Appropriate Language (6.00) and Convenient Times (6.00), in the subdomain of Access to Services had the highest mean scores.

In the Community Based domain all subdomains and areas scored in the low 5 to 6 range. Further, the subdomains of Access to Services and Minimal Restrictiveness had the highest mean scores (5.74 and 5.65 respectively). All three areas in the subdomain of Access to Services had mean scores in the low 5 to 6 range: Appropriate Language (6.00), Convenient Times (6.00), and Convenient Locations (5.22).

All subdomain and area scores for Child-Centered, Family-Focused were in the low to mid 5s. Similarly all subdomain scores for both Culturally Competent and Impact were in the low to mid 5s. Two of the three areas score in Culturally Competent scored in the low to mid 5s. These data indicate that service providers are aware of and utilize families' culture, beliefs, and values within service planning and provision. Service providers assist families and their informal supports in navigating the service system process towards improving their situations.

The data also revealed one score in the mid 4s. Although these scores indicate neither support for nor against implementation of system of care principles, they may stress the need for additional attention or support. Within the domain of Culturally Competent, the area score for Awareness of Child/Family's Culture was 4.52.

Table 6.2 presents Region South-8 data for SOCPR Overall, Domain, Subdomain, and Area mean scores.

Table 6.2. Region South-8 SOCPR Scores: Overall, Domain, Subdomain, and Area ALL Cases

Overall Score – South-8 ALL Cases: 5.04 (1.00)			
	Domain Mean (SD)	Area Mean (SD)	Subdomain Mean (SD)
Domain I: Child-Centered Family-Focused	**5.02 (1.15)**		
Individualized			4.82 (1.27)
Assessment/Inventory		4.95 (1.29)	
Service Planning/Delivery		4.76 (1.37)	
Types of Services/Supports		4.92 (1.60)	
Intensity of		4.67 (1.74)	
Full Participation			5.11 (1.23)
Case Management			5.12 (1.42)
Domain II: Community Based	**5.33 (0.84)**		
Early Intervention			4.64 (1.54)
Access to Services			5.63 (0.76)
Convenient Times		5.68 (1.10)	
Convenient Locations		5.49 (1.23)	
Appropriate Language		5.72 (0.72)	
Minimal Restrictiveness			5.68 (0.87)
Integration and Coordination			5.36 (1.20)
Domain III: Culturally Competent	**4.91 (1.06)**		
Awareness			4.88 (1.10)
Awareness of Child/Family's Culture		4.41 (1.42)	
Awareness of Providers' Culture		5.08 (1.18)	
Awareness of Cultural Dynamics		5.15 (1.33)	
Sensitivity and Responsiveness			4.97 (1.47)
Agency Culture			5.02 (1.35)
Informal Supports			4.75 (1.62)
Domain IV: Impact	**4.91 (1.51)**		
Improvement			4.92 (1.49)
Appropriateness			4.89 (1.59)

For Region South-8, the highest scoring SOCPR domain region-wide was Community Based, followed by Child-Centered Family-Focused. The mean scores for the domains of Impact and Culturally Competent were the same. All of the SOCPR domain, subdomain, and area scores fell in the mid 4 (neutral) to high 5 (enhanced implementation of a system of care principle) range. Appropriate Language (5.72), in the subdomain of Access to Services had the highest mean score.

In the Community Based domain all subdomains and areas except for the subdomain of Early Intervention (4.64) scored in the low to mid 5 range. Further, the subdomains of Minimal Restrictiveness and Access to Services had the highest mean scores (5.68 and 5.63 respectively). All three areas in the subdomain of Access to Services had mean scores in the mid to high 5 range: Appropriate Language (5.72), Convenient Times (5.68), and Convenient Locations (5.49).

Other low 5 mean scores included the subdomains of Integration and Coordination (5.36), Case Management (5.12), Full Participation (5.11) and Agency Culture (5.02). Two area mean scores Awareness of Cultural Dynamics and Awareness of Providers' Culture were also in the low 5s. These data indicate that services are provided and delivered seamlessly through the coordination of a single person. Families actively participate in both the planning process and services through the navigation assistance of service providers.

The data also revealed scores in the mid to high 4s. Although these scores indicate neither support for nor against implementation of system of care principles, they may stress the need for additional attention or support. For example, the domains of Impact and Culturally Competent scored in the high 4 range (4.91). Both subdomains of Impact, Improvement and Appropriateness, scored in the high 4s (4.92 and 4.89, respectively). Other high 4 subdomains included Individualized, Awareness, Sensitivity and Responsiveness, and Informal Supports.

Other mid to high 4 mean scores included all area scores within the domain of Child-Centered Family-Focused and one area score with in the Culturally Competent domain.

Table 6.3 presents Region Central-6 data for SOCPR Overall, Domain, Subdomain, and Area mean scores.

Table 6.3. Region Central-6 SOCPR Scores: Overall, Domain, Subdomain, and Area ALL Cases

Overall Score – Central-6 ALL Cases: 5.22 (0.91)			
	Domain Mean (SD)	Area Mean (SD)	Subdomain Mean (SD)
Domain I: Child-Centered Family-Focused	**5.24 (1.04)**		
Individualized			4.81 (1.23)
Assessment/Inventory		5.04 (1.27)	
Service Planning/Delivery		4.64 (1.23)	
Types of Services/Supports		4.67 (1.66)	
Intensity of		4.89 (1.65)	
Full Participation			5.52 (1.13)
Case Management			5.38 (1.29)
Domain II: Community Based	**5.51 (0.83)**		
Early Intervention			4.93 (1.41)
Access to Services			5.92 (0.67)
Convenient Times		5.93 (1.13)	
Convenient Locations		5.69 (1.10)	
Appropriate Language		6.15 (0.50)	
Minimal Restrictiveness			5.87 (0.76)
Integration and Coordination			5.30 (1.41)
Domain III: Culturally Competent	**5.10 (1.03)**		
Awareness			4.98 (1.20)
Awareness of Child/Family's Culture		4.53 (1.55)	
Awareness of Providers' Culture		5.01 (1.50)	
Awareness of Cultural Dynamics		5.39 (1.27)	
Sensitivity and Responsiveness			4.91 (1.52)
Agency Culture			5.21 (1.32)
Informal Supports			5.29 (1.48)
Domain IV: Impact	**5.04 (1.30)**		
Improvement			5.04 (1.33)
Appropriateness			5.04 (1.46)

Region Central-6's ranking of domains was dissimilar to Statewide Cases. The highest scoring SOCPR domain region-wide was Community Based, followed by Child-Centered Family-Focused, Culturally Competent, and lastly Impact. All of the SOCPR domain, subdomain, and area scores fell in the mid 4 (neutral) to low 6 (enhanced implementation of a system of care principle) range. Appropriate Language, in the subdomain of Access to Services had the highest mean score (6.15).

In the Community Based domain, all subdomains and areas except for the subdomain of Early Intervention (4.93) and the area of Appropriate Language scored in the low to high 5 range. Further, the subdomains of Access to Services and Minimal Restrictiveness had the highest mean scores (5.92 and 5.87 respectively). All three areas in the subdomain of Access to Services had mean scores in the mid 5 to low 6range: Appropriate Language (6.15), Convenient Times (5.93), and Convenient Locations (5.69).

Both subdomain scores in the domain of Impact (5.04) were in the low 5 range. Additionally, two subdomain scores in Culturally Competent (Agency Culture and Informal Supports) and two in Child-Centered, Family-Focused (Full Participation and Case Management) were in the low to mid 5 range. Three area scores were in the low 5 range: Awareness of Cultural Dynamics (5.39), Assessment/Inventory (5.04), and Awareness of Providers' Culture (5.01). These data indicate that service providers are not only assisting families navigate the system but they include informal and formal supports as part of the service planning process. Service providers ensure that service plans are appropriate for meeting the needs of the youth and family and help improve their current situation.

The data also revealed scores in the mid to high 4s. Although these scores indicate neither support for nor against implementation of system of care principles, they may stress the need for additional attention or support. For example, within the domain of Child-Centered, Family-Focused one domain score (4.81) and three area scores (4.89, 4.67, and 4.64) were in the mid to high 4 range. Similarly, Culturally Competent had two subdomains (Awareness and Sensitivity and Responsiveness) and one area (Awareness of Child's/Family's Culture) in the 4 range.

SOCPR Scores and Tests of Significant Differences ALL Cases

Because the SOCPR Overall and Domain scores do not fit the pattern of a normal distribution, nonparametric statistical tests were performed to examine the data for differences between groups within a specific variable in relation to SOCPR scores. SOCPR scores are continuous data, while most of the other variables were categorical data. Thus, for statistical tests in which the variable to be examined in relation to SOCPR scores consisted of more than 3 groups, such as race, the Kruskal- Wallace test was performed. For variables with only two groups, such as gender, the Mann-Whitney U test was performed. Age was transformed into an Age Band variable with three groups: 0 through 5, 6 to 12, and 13 to 18. Table 7 shows the results of these statistical tests for a variety of variables. A value of .05 or lower indicates a significant difference between groups for the variables involved in the statistical test, with lower scores indicating a higher likelihood of true significant differences.

Table 7. SOCPR Scores and Significant Differences with Variables of Interest ALL Cases

Variable	Overall	CCFF	CB	CC	IMP
Demographics					
Age Bands				0.040	0.020
Gender					0.032
Race					
Primary Language					
Region					
Case Longevity					
Service Systems					
Behavioral Health					
Child Safety					0.034
Juvenile Justice					
Educational Services				0.029	
Developmental Disabilities		0.033			
Total Systems					0.022
Services Categories					
Treatment Services					
Medical Services					
Support Services					
Inpatient Services					
Residential Services					
Services					
Individual Counseling					0.035
Family Counseling					
Family Support					
Respite Support					
Case Management					
Psychiatric Hospitalization					0.040
Total Number of Services					0.018

There were a variety of significant associations in SOCPR overall case and domain scores across the variables examined. Some of each of the service systems, services categories, and services measured showed significant associations.

Findings indicate that demographically, females had significantly higher Impact scores than males. Age was positively associated with Culturally Competent but negatively associated with Impact. Children and youth who received Educational Services were associated with higher Culturally Competent scores. Additionally, children and youth with Child Safety and Total Systems were associated with higher Impact domain scores. However, Individual Counseling, Psychiatric Hospitalization, and Total Services were associated with lower Impact scores.

SOCPR Scores – FY2015-2016 and FY2016-2017 Comparison ALL Cases

Table 8 shows a comparison of overall, domain, subdomain, and area scores across two administrations of the SOCPR. Overall, scoring differences across all case, domain, subdomain, and area scores indicate a positive trend from FY2015-2016 to FY2016-2017. All except one of the statistically significant changes were in a positive direction. The majority of significant changes were in the Community-Based domain.

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Table 8. SOCPR Score Comparisons between FY2015-2016 and FY2016-2017 ALL Cases

	2015-2016		2016-2017		Change	p-value[1]
	Mean	(SD)	Mean	(SD)		
Overall Score	4.98	(1.06)	5.19	(0.95)	0.22	0.04*
Domain I: Child-Centered, Family-Focused	4.92 (1.23)		5.22 (1.08)		0.29	0.01*
Individualized	4.80 (1.22)		4.92 (1.21)		0.13	0.32
Assessment/Inventory	5.22 (1.11)		5.07 (1.27)		-0.15	0.24
Service Planning/Delivery	4.69 (1.31)		4.83 (1.26)		0.14	0.29
Types of Services/Supports	4.70 (1.63)		4.90 (1.59)		0.20	0.24
Intensity of Services/Supports	4.58 (1.71)		4.89 (1.68)		0.31	0.08
Full Participation	5.18 (1.21)		5.39 (1.16)		0.21	0.09
Case Management	4.79 (1.61)		5.34 (1.36)		0.54	0.00**
Domain II: Community Based	5.15 (0.99)		5.44 (0.82)		0.28	0.00**
Early Intervention	5.06 (1.34)		4.88 (1.43)		-0.18	0.21
Access to Services	5.60 (0.86)		5.78 (0.74)		0.18	0.03*
Convenient Times	5.44 (1.41)		5.86 (1.11)		0.42	0.00**
Convenient Locations	5.55 (1.16)		5.51 (1.27)		-0.04	0.75
Appropriate Language	5.80 (0.79)		5.96 (0.58)		0.16	0.02*
Minimal Restrictiveness	5.39 (1.18)		5.75 (0.88)		0.37	0.00**
Integration and Coordination	4.57 (1.55)		5.34 (1.28)		0.77	0.00**
Domain III: Culturally Competent	4.85 (1.17)		5.05 (1.06)		0.20	0.08
Awareness	5.00 (1.15)		4.96 (1.13)		-0.03	0.77
Awareness of Child/Family's Culture	4.81 (1.33)		4.48 (1.50)		-0.33	0.03*
Awareness of Providers' Culture	5.01 (1.30)		5.08 (1.38)		0.07	0.63
Awareness of Cultural Dynamics	5.18 (1.32)		5.34 (1.24)		0.16	0.23
Sensitivity and Responsiveness	4.98 (1.39)		4.99 (1.48)		0.02	0.91
Agency Culture	4.95 (1.44)		5.17 (1.30)		0.22	0.12
Informal Supports	4.46 (1.68)		5.06 (1.59)		0.61	0.00**
Domain IV: Impact Domain Score:	4.98 (1.38)		5.07 (1.37)		0.09	0.52
Improvement	5.06 (1.36)		5.09 (1.37)		0.03	0.82
Appropriateness	4.90 (1.54)		5.05 (1.50)		0.15	0.33

[1] p-values were obtained through a two-sided two independent samples t-test.

The changes in ALL mean scores from FY2015-2016 and FY2016-2017 reflect an overall improvement, although the ranking of domain scores was not consistent. The overall score as well as two of the four domain scores showed statistically significant improvement from last year. The highest scoring SOCPR domain was Community Based across both administrations and the lowest scoring was Culturally Competent. The subdomains of Access to Services and Minimal Restrictiveness both scored high across both administrations of the SOCPR, as did the areas of Appropriate Language, Convenient Times, and Convenient Locations.

Improvement in Arizona's Children's System of Care for this year can overwhelmingly be seen in the domain of Community Based. Almost all domain, subdomain, and area mean scores show a positive trend from FY2015-2016 to FY2016-2017, with five of the seven improvements being statistically significant. Additionally, the domain of Child-Centered, Family-Focused showed significant improvement as did the subdomain of Case Management and the area of Intensity of Services. Lastly, one subdomain in Culturally Competent (Informal Supports) showed significant improvement.

These positive trends indicate that services are accessible to families and are being provided in the least restrictive and most coordinated manner as possible. These results also show that service plans and services are coordinated by one person who ensures that the intensity of services are responsive and reflect the needs and strengths of the youth and family. Lastly, service providers actively utilized informal supports in all aspects of service provision.

Qualitative Analysis ALL Cases

This section reports a summary of qualitative data compiled from responses to Summative Questions that SOCPR reviewers use to develop a case summary for a particular child and her/his family. Each case summary integrates information gathered through a document review and a series of interviews completed with the child, a caregiver, and a provider, to address each of the four SOCPR domains. The Summative Questions call for a reviewer to provide a rating for each statement and to give a brief narrative in support of that rating. Individual ratings serve as indicators of the extent to which system of care subdomain elements (e.g., individualized, full participation) are being implemented. In the final analysis, ratings for each measurement are clustered and considered in conjunction with reviewers' narratives to determine an overall rating for each domain, indicating the extent to which each subdomain was achieved. The narrative portion of each Summative Question response is used to assess the degree to which SOCPR items tied to each domain were met and an explanation for the evidence provided. Where an overall summative rating relates to a reviewer's

determination of completion of a *thorough assessment*, for instance, qualitative analysis examines the evidence provided to explain the rating.

The compiled narratives for all Summative Questions were coded and sorted to assess the degree to which System of Care principles were implemented in cases examined, in each SOCPR domain area (N=170). The frequency of Summative Question responses was examined and analyzed for emerging patterns/trends in the 13 subdomains and 10 areas which correspond to the four large SOCPR domains: Child-Centered Family-Focused, Community - Based, Culturally Competent, and Impact. In order to be considered a trend, at least half of the cases reviewed had to provide similar information for a given subdomain area. Identified trends are then reported for the entire domain. The qualitative findings section also highlights successes and opportunities for growth related to each of the SOCPR Domain Areas as reported in responses to Summative Questions.

Qualitative Findings

Domain 1: Child-Centered Family Focused Services

The first domain of the SOCPR is designed to measure whether the needs of the child/youth and family determine the types and mix of services provided within the System of Care. This domain reflects a commitment to adapt services to the child and family rather than expecting them to conform to preexisting service configurations. The review reflects the effectiveness of the site in providing services that are individualized, that families are included as full participants in the treatment process, and that the type and intensity of services provided is monitored through effective case management.

Overall, scores and descriptive comments provided by SOCPR raters suggest that providers within the System of Care are generally providing child-centered and family-focused services. For FY2016-2017, the review of cases indicated that services for children and families were Child-Centered Family-Focused. This was evident by the individualization of services based on the needs and strengths of the child and family. Children and families fully participated in the service planning process. Planning and delivery of services was successfully coordinated by a single person. Scores indicated that the strengths of the child and family were informally acknowledged via service delivery and planning. The data also show that not only were the child and family actively participating in the planning process, but formal providers and informal helpers were as well.

When considering whether children/youth and family received *Individualized Services* within the System of Care, reviewers noted that in most cases families' strengths were informally acknowledged in the service planning process. Raters also indicated that the

strengths of both the child/youth and the family were identified; however, there was minimal acknowledgment of the families' strengths in the service planning process. A challenge related to this subdomain was evident in documents reviewed that related to the primary service plan reflecting the needs and incorporating the strengths of the child and family. Generally, the needs and strengths of the child/youth were a part of the service plan goals, but documents indicated that the needs and strengths of the family were in some instances almost nonexistent. Records showed that service plan goals failed to address the needs of the family in about 58 percent of cases with a rating of "5" (Agree Slightly) and lower. Additionally, documents noted that service plan goals lacked integration of family strengths into service plan goals in about 53 percent of these cases. Moreover, when the strengths and needs of both the child and family were noted, they were vague and minimal at best. Reviewers commented that at times it was difficult to determine the strengths from the documents in the case file. These findings provide an opportunity for growth for providers to not only address but also clearly document the needs and strengths of the family to ensure that the appropriate types and mix of services and supports are provided.

Another challenge related to this subdomain was reflected in documents related to the primary service plan being integrated across providers. Records indicated that in about 41 percent of the cases, service plans did not reflect all services and supports that were being provided to the child and family. In some cases, services were listed for only one agency/provider. In other cases plans were lacking information such as signatures, roles and responsibilities, staff, or services that were being delivered. Although these findings do not constitute a trend, as defined for the purposes of analysis, they provide another opportunity for growth and training of providers to improve service plan documentation and integration.

Overall, reviews indicated that there was *Full Participation* on the part of children/youth and families in the development, implementation, and evaluation of service plans. Families and youth were full, active participants in the planning process along with their formal providers and informal helpers. Their active participation allowed them to provide input to help determine what types of services they would receive, and the level of intensity of those services and supports. In addition, records indicated that youth and families not only seemed to be actively participating in services and supports, interviews indicated that they seemed to understand the service plan. Despite overall ratings of "5" (Agree Slightly) and greater related to understanding the service plan, reviewers noted a lack of documentation when it came to recording an understanding of the service plan across all team members. Some raters noted even with discussions at team meetings and explanations of the service plan to caregivers, youth, and formal providers, understanding was still uncertain/unclear. This is evident in missing signatures on plans, team members "not sure" if they received copies of the service plan, and even absence of participants at team meetings.

With regard to the *Case Management* subdomain*,* data indicated that generally there was a single person responsible for coordination of the services and supports outlined in the service plan. Additionally, the service plan was responsive to the ever changing needs of the youth and family. Overall, service plans appear to be updated in response to the emerging and changing needs of the child/youth and family.

System Successes in the Provision of Child-Centered Family-Focused Services
- Children and families fully participate in the service planning process
- Formal providers and informal helpers participate in service planning
- Case managers successfully coordinate services
- Families actively participate in services
- Strengths of youth and family are informally acknowledged by providers
- Caregivers generally understand service plans
- Assessments of children/youth conducted across multiple domains
- Strengths and needs of the child/youth are identified
- Service planning is responsive to changing needs and plan is updated accordingly

Opportunities for Growth and/or Training in Domain 1
- Service plans may not always be integrated across all providers serving children and families
- Service plan goals do not consistently reflect the needs of the family
- Child and/or family strengths are not always incorporated into the service plan goals
- Lack of documentation regarding understanding of the service plan across caregivers, youth, and providers

Domain 2: Community Based Services

The second SOCPR domain is designed to measure whether services are provided within or close to the child/youth's home community, in the least restrictive setting possible, and moreover, that services are coordinated and delivered through linkages between public and private providers. The subdomains in this area are used to evaluate how effective the system is at identifying needs and providing supports early, facilitating access to services, providing less restrictive services, and integrating and coordinating services for families.

When assessing whether child/youth and families received *Early Intervention* related to their identified needs, reviewers overwhelmingly reported that the needs of youth and family are clarified at intake and services and supports are provided in appropriate combinations based on the needs of the child/youth and family. Although the data indicated that services and supports are community-based, the system at times failed families by not offering coordinated services and support as soon as they entered the service system. A small number of cases

indicated that at times there were lags in services. Sometimes there were stops and starts to services; other times there were gaps of weeks - even months - between services. Reviewers even noted no contact between formal providers and families. This challenge may indicate a need for providers to clarify the needs of families more efficiently so there is a decrease in the time between intake and services beginning.

Overall, reviewers indicated that case files demonstrated that the System of Care was ensuring *Access to Services* for children/youth and families. Scores for FY2016-2017 overwhelmingly showed that services and supports were provided in the home community of the child and family. This indicated that services and supports were easily accessible to families. Reviewers indicated agreement between caregivers, formal providers, and records when it came to services and supports being provided at convenient times and in convenient locations for youth and families. Records also showed that services were conveniently scheduled to fit the daily routines of families. Location of services were either close to where the families lived or supports such as transportation were viable options being provided to families to increase access to where services were being provided. When service providers communicate with the child and family, they are communicating both verbally and in writing in the preferred language of the family.

When assessing for *Minimal Restrictiveness* in service delivery, raters reported agreement between all that services were provided in comfortable environments that appeared to be the most appropriate and least restrictive for the child and family. Overwhelmingly, there was documented information that provided insight about the comfort level, appropriateness, and/or restrictiveness of settings where services were provided.

With regard to *Integration and Coordination* of services, reviewers generally found that there appeared to be ongoing two-way communication among and between all team members, including child/youth and family members. Additionally, they noted that linking the child/youth and family to additional services was a smooth and seamless process. However, in about 13 percent of cases, reviewers indicated challenges with the process to link the child and family with additional services. Caregivers noted that there were "hiccups" when trying to link to additional services and that it was a timely process with many delays. Providers agreed that obtaining additional services was timely and that external referrals were more difficult to obtain. This might indicate a need to provide additional training for providers to work to improve the transition and timeliness of the linkage process to additional services and supports for children and families.

System Successes in the Provision of Community Based Services
- Services and supports are provided in appropriate combinations based on needs of child and family
- Services are generally provided at convenient times and within or close to the child and family's home community
- Service providers verbally communicate in the primary language of the child/youth and family
- Written documentation regarding services and service planning is in the preferred language of the child and family
- Services are provided in environment(s) that are comfortable, the least restrictive, and the most appropriate to the child/youth and family
- There is ongoing communication between formal service providers and family members

Opportunities for Growth and/or Training in Domain 2
- Needs of families are not always clarified early so system can begin addressing them
- Linking children and families to additional services is not always a smooth and seamless process
- Linkage process is time consuming especially to external referrals

Domain 3: Culturally Competent Services

The third domain of the SOCPR is intended to measure whether services are attuned to the cultural, racial, and ethnic background and identity of the child/youth and family. Ratings provided in each subdomain are meant to evaluate the level of cultural awareness of the service provider, whether evidence shows that efforts are made to orient the family to an agency's culture, whether sensitivity and responsiveness is shown for the cultural background of families, and whether informal supports are included in services.

Reviewers assessing for *Cultural Awareness* noted that providers are attuned to the cultural values, beliefs, and lifestyles of the child and/or the family with which they work. They are also aware of the dynamics that are involved with working with families whose culture is different from their own. Generally, providers understand how culture influences the way they work and interact with families, but it continues to be an area of growth. One area that provided difficulty was documentation of a child and family's ideas of health and/or family. About 42 percent of the cases rated "5" (Agree Slightly) and lower provided minimal to no evidence in the case record on the subject especially their ideas of health. Ideas of health typically included physical health. Ideas of health from caregivers and providers included "hugs make the kids feel better"; "sports, staying active"; "problem behavior and mental capacity"; and "drugs make you sick and living right is healthier". The idea of family, when it was documented, was defined as "family first"; "family is very important"; "family is a high priority";

and "having dinner together and create a culture of encouragement and positivity". In some of the cases, providers were unsure of families' ideas of health and family. This might indicate a need to provide additional training for providers to provide adequate documentation of relevant information for cases.

Scores indicated that providers were minimally able to recognize the need to view the child/youth and family within the context of their community. Additionally, reviewers noted some evidence of provider awareness related to how cultural beliefs and values of families influenced their decision-making. Although ideas of culture, values, and beliefs may not have adequately been documented, providers indicted that the decision making process of families typically focused on the child. Providers may want to increase their documentation about cultural awareness because knowledge about cultural, neighborhood, and community context may provide important information about a child and family's identity.

When evaluating the *Sensitivity and Responsiveness* of the System, raters noted that information was minimally documented regarding the cultural values and beliefs of the child/youth and family. However, many caregivers stated in interviews that they feel providers consider and are responsive to their culture. As one provider stated, "she understands that she needs to listen to the family, let them feel heard and believes that the family is the expert when it comes to what they need." Moreover, caregivers felt that providers were responsive to their culture by adapting services whenever possible.

Reviewers generally gave high ratings to the subdomain *Agency Culture* suggesting that service providers generally offered families information to help them better understand their agency's rules and expectations and offered additional assistance, resources, or supports as needed. Providers also appeared to provide families with assistance in understanding and navigating the larger service system.

With regard to *Informal Supports*, reviewers found inconsistent documentation in case files that families were asked whether they would like to include informal or natural supports in services or service planning. However, reviewers found that families declined to include natural support (e.g., supportive friends or community members/resources) involvement in about 15 percent of cases.

<u>System Successes in the Provision of Culturally Competent Services</u>
- Providers have some awareness of their own culture and the cultural dynamics involved when working with families whose culture may be different from their own
- Providers are attuned to the culture, values, and beliefs of the child and/or the family

- Providers offered families information to help them understand system/agency rules and expectations
- Providers were minimally able to recognize the need to view the child/youth and family within the context of their community
- Providers have some awareness related to how cultural beliefs and values of families influenced their decision-making.

Opportunities for Growth and/or Training in Domain 3
- Limited documentation of youth and family's concepts of health and family
- Reviewers noted that providers did not always clearly document ideas of culture, values, and beliefs
- Limited evidence of incorporating family culture into action
- Inconsistent documentation related to availability of informal supports

Domain 4: Impact

The final SOCPR domain evaluates whether services have produced positive outcomes for the child and family. This domain includes two subdomains: *Improvement* and *Appropriateness of Services*, which are meant to determine whether services have had a positive impact on the child/youth and family and if so, whether these services met their identified needs.

In general, reviewers found that services and supports provided to children and families positively affected their situation. Scores indicated that services and supports also met the needs of both the children and the families. Evidence provided for this domain indicates some disagreement among the files, caregivers/family members, and providers about the amount of improvement or degree of progress made by families. A review of most cases, though, suggested that some level of improvement was made on the part of the youth and family. Raters also generally indicated that supports and services provided to children/youth and families had been appropriate because they were found to have adequately met identified needs. Overall, the services provided through the System of Care appear to have produced positive outcomes for the children and families served. An opportunity for growth and training with regard to documentation may be to establish guidelines that clarify levels of improvement or progress and have discussions of these guidelines with providers and caregivers.

System Successes
- Reviewers generally agree that the services provided to children/youth have provided some level of improvement

- Reviewers generally agree that the services provided to families have provided some level of improvement
- Reviewers generally agree that the services and supports provided to children/youth have adequately met their needs
- Reviewers generally agree that services and supports provided to families have adequately met their needs

Overall, qualitative analysis of responses to Summative Questions suggest that the Statewide System of Care has achieved some success in its effort to implement System of Care values and principles in its service delivery to children/youth and families in FY2016-2017. Some recommendations have been made to help build on these successes by encouraging the work of providers and reviewers through ongoing training and coaching.

RESULTS DCS CASES

Demographics DCS Cases

The state of Arizona was also interested in only those cases where the children and families had Department of Child Safety involvement. During FY2016-2017, 97 DCS Cases (57%) were sampled from all three Regions from the 170 SOCPR ALL Cases. A summary of the demographic characteristics are presented in Table 9. Due to the sampling scheme employed by AHCCCS (previously described in the Methodology section), different numbers of cases were completed in each Region. The most populous Region, Central-6, provided the greatest number of cases for the sample (N=42). South-8 provided 32 cases while North-7 had the fewest cases (23).

Table 9. Demographic Characteristics DCS Cases

Demographic Characteristic	Statewide N=97	NORTH-7 (I & IV-G) N=23	SOUTH-8 (II, III, IV-P, & V) N=32	CENTRAL-6 (VI) N=42
Age (years)	6.82	4.43	6.81	8.14
Gender (Male)	49.5%	52.2%	56.2%	42.9%
Race:				
White	49.5%	69.6%	43.8%	42.9%
Black	6.2%	0.0%	6.2%	9.5%
Latino/Hispanic	28.9%	21.7%	31.2%	31.0%
Native American	5.2%	8.7%	3.1%	4.8%
Multi-racial	10.3%	0.0%	15.6%	11.9%
Primary Language:				
English	95.9%	95.7%	100.0%	92.9%
Spanish	1.0%	0.0%	0.0%	2.4%

As shown in Table 9, the overall mean age for the 97 cases was 6.82 years. The means for age across Regions ranged from 4.43 years to 8.14 years. Statewide almost 50% of the sample was male, ranging from almost 43% in Central-6 to over 56% in South-8. Of the sample, almost 50% was White, almost 29% was Latino/Hispanic, and a little over 10% identified as Multi-racial. The remaining 11% of the sample was Black or Native American. Statewide, almost 96% of the children and youth in the sample spoke English as their primary language. English was the only language reported in North-7 and South-8. Spanish was also identified as a primary language in Central-6 (2.4%). Chi-square analyses were used to look for demographic differences in cases by Region, with age bands, gender, race, and primary language under consideration.

Service System Involvement DCS Cases

In addition to Department of Child Safety, four different child-serving systems and an "Other" category were used to capture service system involvement as part of the services profiles of children and youth whose cases were chosen as part of the sample. Almost all 97 DCS Cases (99%) were recorded as showing behavioral health system involvement, the system with the greatest participation across all three Regions, as shown in Table 10. The SOCPR protocols documented that 15.5% of the cases had educational services involvement, followed by juvenile justice, developmental disabilities, and "Other". The "Other" system category was documented by over 4% of the Regions. The four services included Arizona Early Intervention Program (AZEIP) (n=3) and Department of Economic Services/Rehabilitation Services Administration (DES/RSA).

Table 10. Service System Involvement DCS Cases

Service System	Statewide N=97	NORTH-7 (I & IV-G) N=23	SOUTH-8 (II, III, IV-P, & V) N=32	CENTRAL-6 (VI) N=42
Behavioral Health	99.0%	100.0%	100.0%	97.6%
Juvenile Justice	8.2%	0.0%	12.5%	9.5%
Educational Services	15.5%	13.0%	15.6%	16.7%
Developmental Disabilities	5.2%	8.7%	3.1%	4.8%
Other	4.1%	0.0%	9.4%	2.4%

The results of the 97 DCS Cases were plotted by histogram to explore the distribution of cases for total number of systems involved. The results are seen in Figure 8. The horizontal axis displays the total number of services, while the vertical axis represents the number of cases with that total number of services. The 97 DCS cases represent children and youth who were involved with the department of child safety system and who were receiving behavioral health system services or had recently completed services from the behavioral health system. In addition, cases were only chosen for SOCPR review if the youth was identified as having complex needs.

Overall, cases identified a range of 0 – 5 for the possible number of systems involvement, with the mean being 2.32, and the number of systems involved for this sample ranged from 1 – 5. The shape of the histogram is symmetrical, resembling a normal distribution. One might expect that children and youth in this sample to be involved in a significant number of child-serving systems and thus expect the shape/distribution to skew to the right, towards a greater number of service systems. Explanations for this finding might

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include inadequate record documentation, differences in reviewer interpretations of how to record service system involvement, or data entry errors.
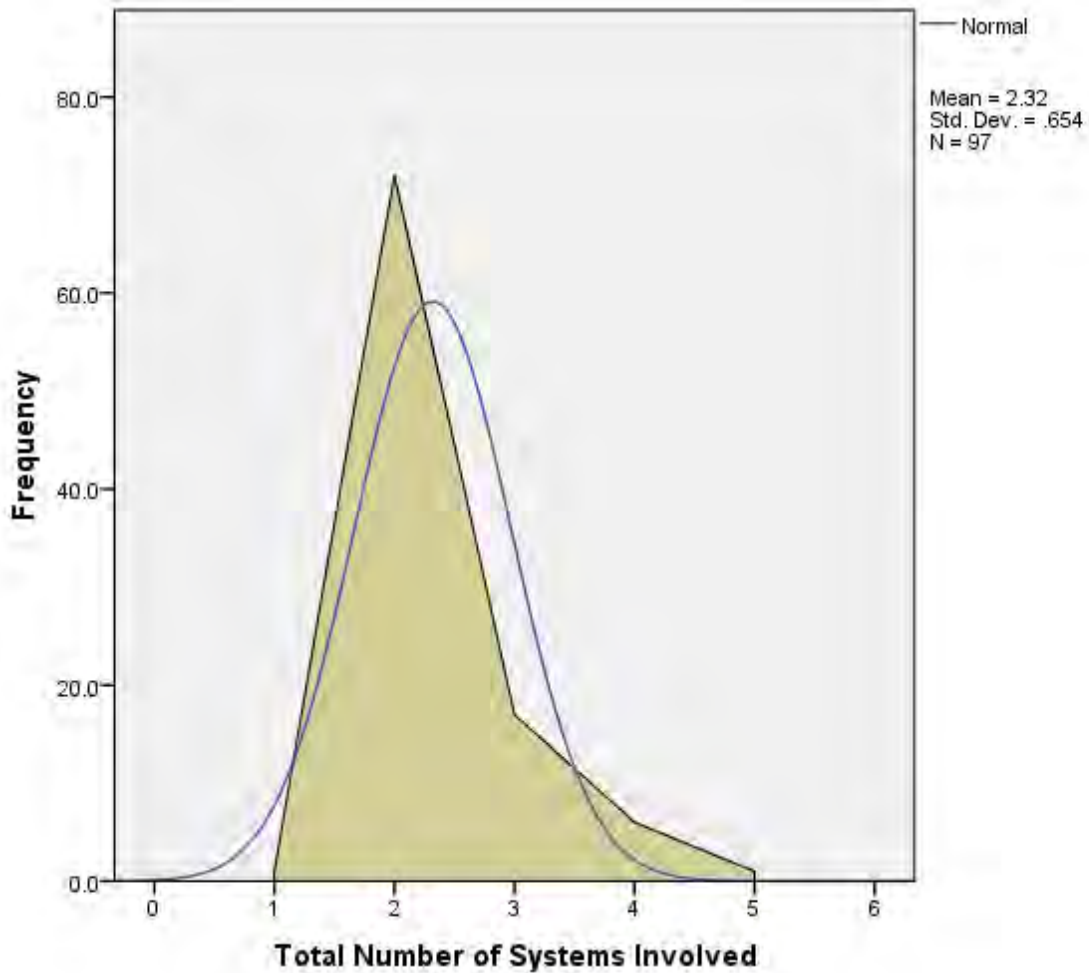
Figure 8. Histogram of child-serving system involvement DCS cases.

Receipt of Services or Treatments DCS Cases

Similar to child-serving systems, the kinds of services or treatments children and youth in the sample received were also counted. Fifteen named types of services as well as an "Other" category (see Appendix C) were used to identify service provision. These service types are shown in Table 11.

Table 11. Services or Treatments Received by Children and Youth DCS Cases

Services or Treatment	Statewide N=97 N (%)	NORTH-7 (I & IV-G) N=23 N (%)	SOUTH-8 (II, III, IV-P, & V) N=32 N (%)	CENTRAL-6 (VI) N=42 N (%)
Treatment Services	**71 (73.2)**	**9 (39.1)**	**28 (87.5)**	**34 (81.0)**
•Individual Counseling	59 (60.8)	8 (34.8)	21 (65.6)	30 (71.4)
• Family Counseling	35 (36.1)	1 (4.3)	18 (56.2)	16 (38.1)
• Group Counseling	7 (7.2)	0 (0.0)	3 (9.4)	4 (9.5)
• Substance Abuse Counseling	3 (3.1)	2 (8.7)	0 (0.0)	1 (2.4)
Medical Services				
•Psychiatric Medication	32 (33.0)	4 (17.4)	9 (28.1)	19 (45.2)
Support Services	**94 (96.9)**	**23 (100.0)**	**31 (96.9)**	**40 (95.2)**
• Family Support	32 (33.0)	7 (30.4)	15 (46.9)	10 (23.8)
• Peer Support	5 (5.2)	0 (0.0)	3 (9.4)	2 (4.8)
• Respite Support	8 (8.2)	3 (13.0)	3 (9.4)	2 (4.8)
• Home Care Training	6 (6.2)	2 (8.7)	1 (3.1)	3 (7.1)
• Case Management	92 (94.8)	23 (100.0)	30 (93.8)	39 (92.9)
• Skill Develop & Train	38 (39.2)	8 (34.8)	16 (50.0)	14 (33.3)
Inpatient Services	**3 (3.1)**	**0 (0.0)**	**1 (3.1)**	**2 (4.8)**
• Psychiatric Hospitalization	2 (2.1)	0 (0.0)	1 (3.1)	1 (2.4)
• Level I Residential	1 (1.0)	0 (0.0)	0 (0.0)	1 (2.4)
Residential Services	**5 (5.2)**	**0 (0.0)**	**1 (3.1)**	**4 (9.5)**
• Level II Residential	4 (4.1)	0 (0.0)	1 (3.1)	3 (7.1)
• Level III Residential	1 (1.0)	0 (0.0)	0 (0.0)	1 (2.4)
Other	**37 (38.1)**	**12 (52.2)**	**12 (37.5)**	**13 (31.0)**

Across the state the most utilized service or treatment provision category was Support Services (96.9%) followed by Treatment Services (73.2%). Inpatient Services (3.1%) was the least used service or treatment provision. More specifically, the most widely utilized service or treatment statewide, based on percentage of cases using the service, was Case Management (95%) followed by Individual Counseling (61%), Skills Development & Training (39%), Other (38%), and Family Counseling (36%). Level III Residential (1.0), Level I Residential (1.0), Psychiatric Hospitalization (2.1%), and Substance Abuse Counseling (3.1%), were the least utilized services or treatments statewide. Across all three Regions, Case Management was utilized in a minimum of 92% of the cases in each Region.

Support Services were utilized in all three Regions with North-7 utilizing them in 100% of the cases. As mentioned earlier in this report one specific support service, Case Management, was received by a minimum of 92% of families across all three Regions. Treatment Services was documented as the next most frequently utilized service with over 73% of cases. Inpatient Services and Residential Services were utilized the least. Inpatient Services and Residential

Services were not utilized in North-7 nor was Peer Support or Group Counseling. Level I Residential and Level III Residential were only utilized in Central-6. South-8 did not utilize Substance Abuse Counseling services. .

Usage of some services *appears* to be unusually high; therefore, because Regions vary widely in the number of SOCPR cases completed, both number of cases and percentage need to be examined. For example, 52% of cases in North-7 had "Other" services, which represents only 12 youth, as only 23 total SOCPR cases were completed for this Region. Statewide, a little over 38% (n=37) of the treatments or services utilized were identified as "Other". Several of the services variables differed significantly by Region and are shown in Table 12. Only statistically significant chi-square statistics are reported.

Table 12. Significant Associations between Region and Specific Services DCS Cases

Treatment	Chi-Square Statistic
Treatment Services • Individual Counseling • Family Counseling • Group Counseling • Substance Abuse Counseling	X^2 (2, N=97) = 18.229, p-value = 0.000 X^2 (2, N=97) = 8.838, p-value = 0.012 X^2 (2, N=97) = 15.761, p-value = 0.000
Medical Services • Psychiatric Medication	
Support Services • Family Support • Peer Support • Respite Support • Home Care Training (HCTC) • Case Management • Skills Development and Training	
Inpatient Services • Psychiatric Hospitalization • Level I Residential	
Residential Services • Level II Residential • Level III Residential	
Other	

Statewide for DCS cases, a statistically significant relationship between Region and services received was shown only for the category of Treatment Services. Specifically within this category, Individual Counseling and Family Counseling were found to show strong significant

associations with Region.

In order to examine the breadth of services used by children and youth in the sample, a simple summation was calculated for the 15 potential service categories. Thus, the possible range for this variable was from 0 to 15 services utilized. For the total 97 DCS cases in the sample, the range of services used was 0 to 8. These data are displayed via histogram to examine the distribution of total number of services used. The results are displayed in Figure 9. The histogram closely resembles a normal distribution, with a mean of 3.73 services per child or youth recorded. The number of services used during the time a case is open could vary greatly, depending on the needs of the child and family, the array of services that are available, and the length of time the case is open.
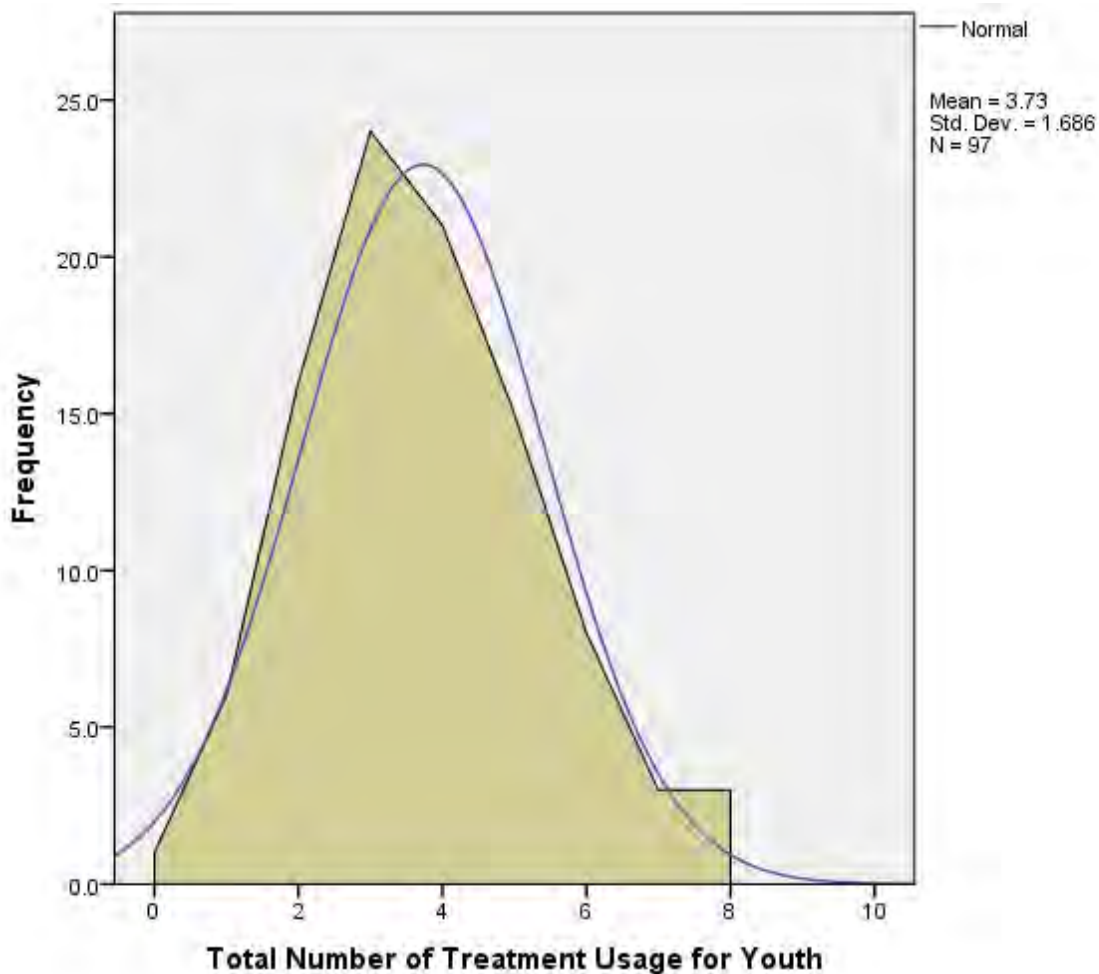
Figure 9. Histogram of service or treatment usage for youth DCS cases.

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SOCPR Scores – Overall Case and SOCPR Domains DCS Cases

Mean scores were computed for the overall case, as well as for each of the four SOCPR domains (Child-Centered Family-Focused, Community Based, Culturally Competent, and Impact). In addition, mean scores were computed for those subdomains contained within the domains. Finally, each summative question was examined individually. In general, the mean score for each item of interest was an important statistic to be examined. In addition, the minimum and maximum scores, as well as the standard deviation for each item of interest, were examined. Using these four statistics, an understanding of the range of scores, the average score, as well as an indication of the variability from case to case, could be examined. This section will report on the overall findings, and then report on specific items of interest, which demonstrate extreme scores.

Table 13.0 shows the overall case scores as well as those for each SOCPR domain for the department of child safety sample of 97 DCS cases, indicated by individual Region As explained in the Methodology section, SOCPR scores range from a low of 1 to a high of 7. Scores from 1–3 represent lower implementation of a system of care principle, and scores from 5–7 represent enhanced implementation of a system of care principle. A score of 4 indicates a neutral rating, meaning a lack of support for or against implementation. At the statewide level, SOCPR DCS mean scores ranged from 5.10 to 5.51 with an overall case mean score of 5.30. While the SOCPR scores for the case and domains are not normally distributed and so the standard deviation is a less useful statistic, in conjunction with minimum and maximum scores, a more complete picture of the data emerges. The DCS overall case mean score suggests that, like all of the SOCPR domains, great variability exists across cases. The minimum and maximum scores are to their greatest possible extremes, representing exemplary cases of good and poor system of care values implementation. The means are all in the low to mid 5 range, showing an enhanced implementation of system of care values. The scores indicate that across the state, behavioral health provider agencies included in the DCS sample performed best at including the Community Based system of care value in service planning and provision. Behavioral health provider agencies were most challenged by providing Culturally Competent care that was child and family focused.

Table 13.0. SOCPR Case and Domain Scores DCS Cases

REGION	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
Statewide (N=97)	5.30 (0.84)	5.34 (0.94)	5.51 (0.73)	5.10 (0.99)	5.27 (1.24)
	Min 2.88	Min 2.22	Min 3.42	Min 2.43	Min 2.00
	Max 6.49	Max 6.85	Max 6.88	Max 6.47	Max 7.00
North-7 (N=23)	5.39 (0.89)	5.50 (0.85)	5.49 (0.77)	5.17 (1.09)	5.40 (1.30)
South-8 (N=32)	5.17 (0.90)	5.15 (1.04)	5.39 (0.74)	4.89 (1.04)	5.23 (1.32)
Central-6 (N=42)	5.36 (0.78)	5.39 (0.92)	5.61 (0.69)	5.22 (0.88)	5.21 (1.18)

Minimum and maximum values are not presented for individual Regions, as they are a subset of the statewide scores. At the state level, the highest scoring SOCPR domain was Community Based (Mean = 5.51). This was followed by Child-Centered, Family-Focused (Mean = 5.34), Impact (Mean = 5.27), and lastly, Culturally Competent (Mean = 5.10). Data for all three Regions deviated from the statewide pattern.

The state of Arizona was also interested in an analysis of caseload and its impact on SOCPR scores. The variable caseload can be described as the number of cases that a service provider is concerned with/responsible for at one time or over a period of time.

Table 13.1 provides a summary of the results of DCS SOCPR scores by caseload. Among the 97 respondents, the minimum caseload was 10 and the maximum was 103 with a median of 25 and mean of 35.5. The standard deviation of the caseload was 23.5. The distribution skews to the right with a skewness measure of 1.30. In total there were three missing responses resulting in 94 respondents in the analysis.

Table 13.1. SOCPR Case and Domain Scores and Caseload Impact DCS Cases

Domains	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
CL: 10-15 (n=8)	5.67 (0.59)	5.65 (0.72)	5.64 (0.67)	5.65 (0.76)	5.75 (0.53)
CL: 16-20 (n=20)	5.16 (0.86)	5.28 (0.86)	5.37 (0.72)	4.96 (1.18)	5.03 (1.27)
CL: 21-25 (n=26)	5.50 (0.63)	5.49 (0.84)	5.68 (0.53)	5.24 (0.88)	5.57 (0.95)
CL: 26+ (n=40)	5.24 (0.96)	5.26 (1.07)	5.51 (0.82)	5.00 (0.99)	5.18 (1.44)
p-value	.43	.55	.56	.40	.37

To understand the impact of caseload to SOCPR scores for the DCS cases, the values were collapsed into four categories: 10 to 15; 16 to 20; 21 to 25; and 26 and above. The counts were 8, 20, 26, and 40. Additionally, Kruskal-Wallis tests were conducted to associate Case and Domain scores with categorized caseload values. No significant associations were found, and there was not an overall monotonic trend like was found in the ALL cases analysis. Those of caseload between 10 and 15 or 21 and 25 seemed to have higher scores as seen in Table 13.1.

Histograms were drawn at the statewide level to better demonstrate the range of SOCPR scores for the overall case and the four SOCPR domains. These results are displayed in Figures 10 – 14. Scrutiny of these graphs shows a similar pattern for the case and each SOCPR domain. The data are not normally distributed but are skewed slightly towards the right, toward higher scores.
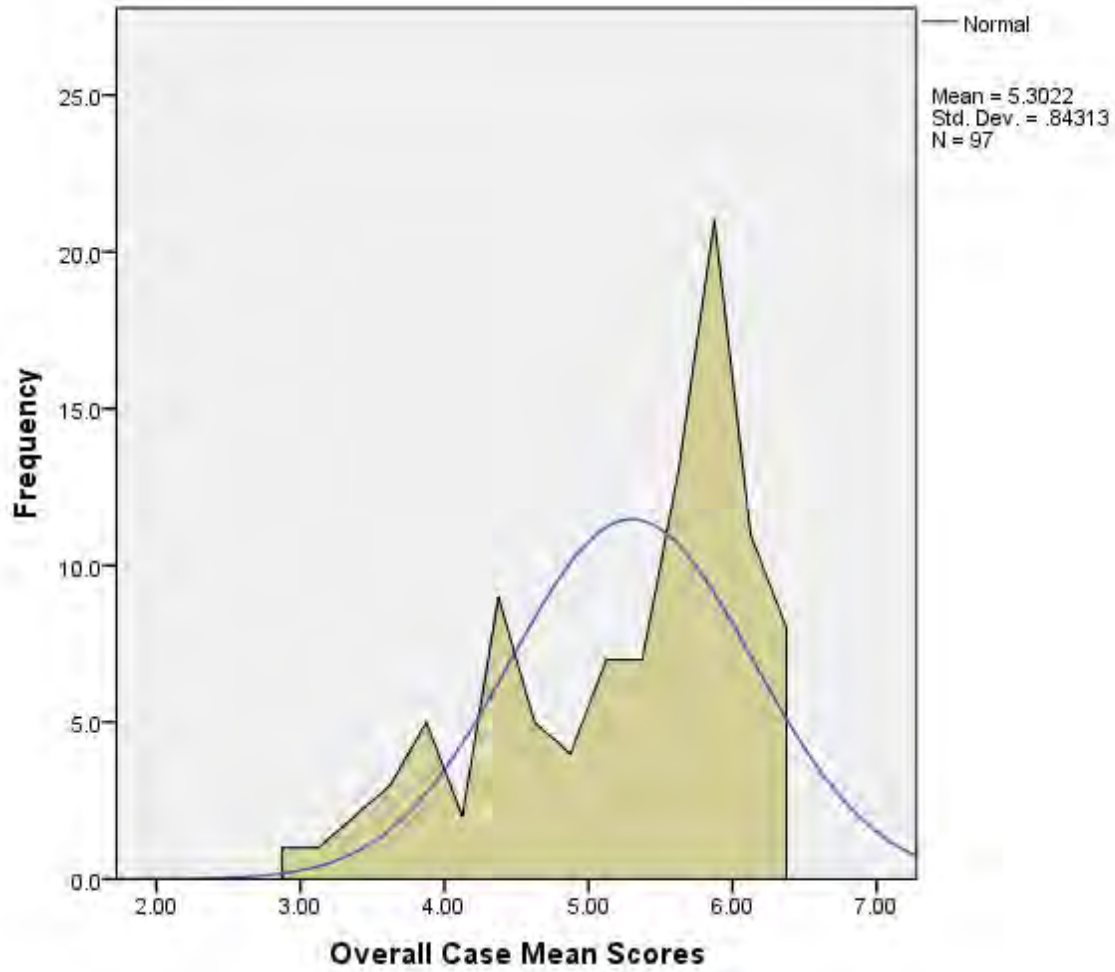
Figure 10. Histogram of SOCPR Overall case mean scores DCS cases.
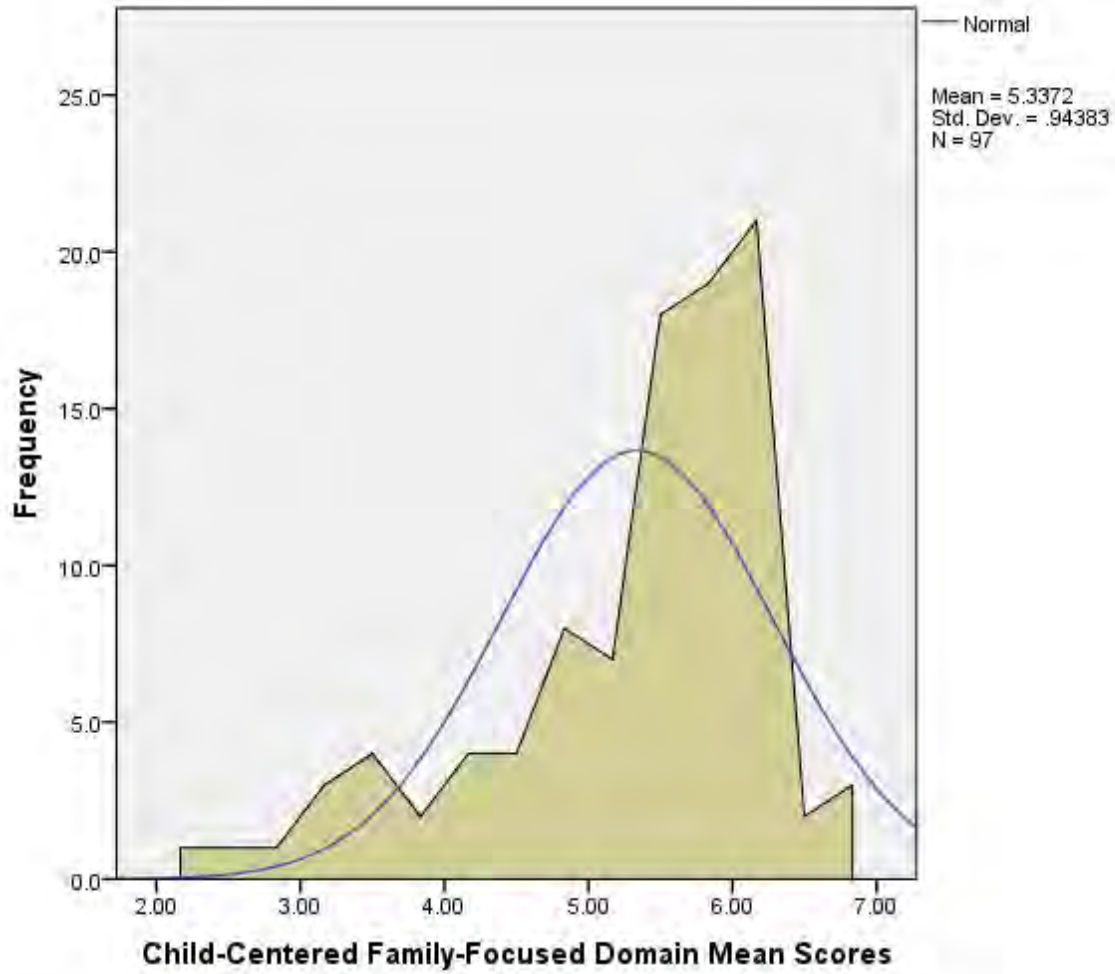
Figure 11. Histogram of SOCPR Child-Centered Family-Focused domain mean scores DCS cases.
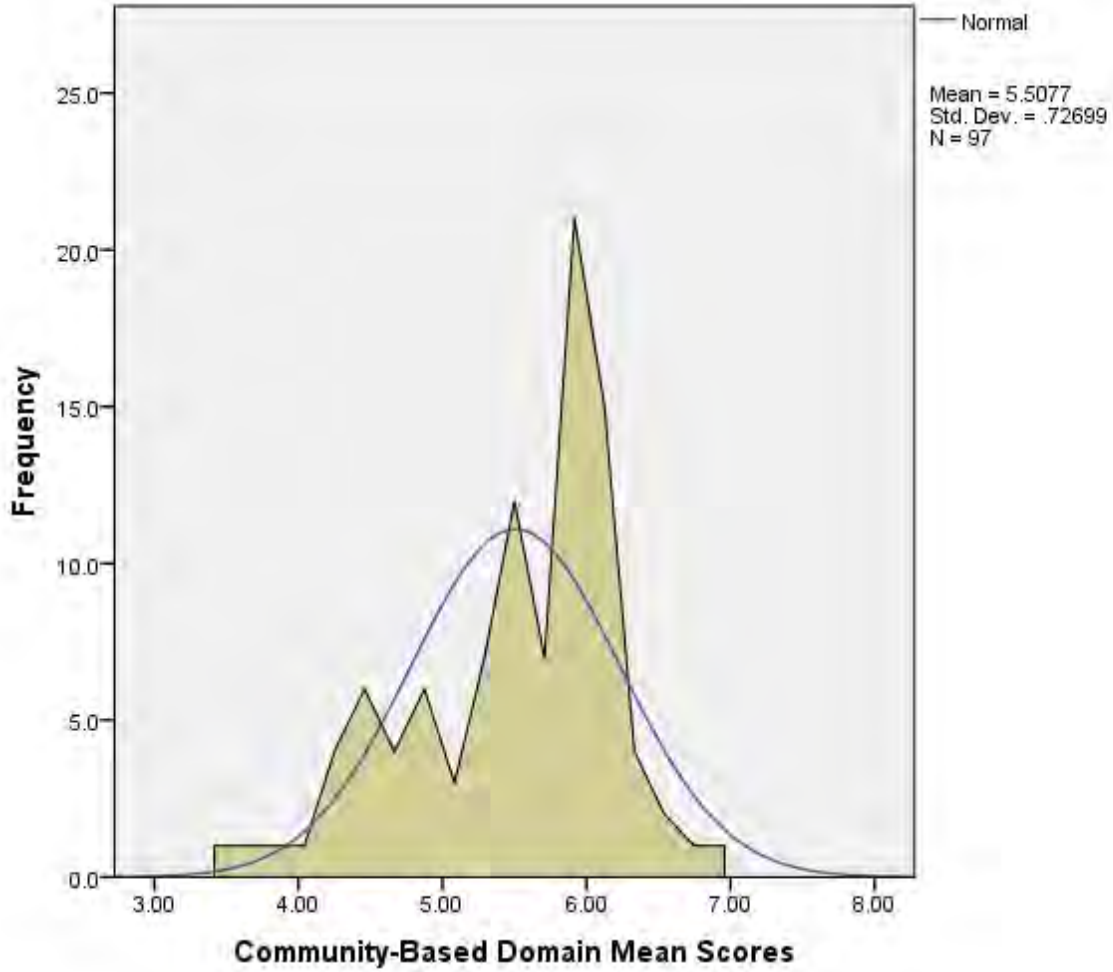
Figure 12. Histogram of SOCPR Community Based domain mean scores DCS cases.
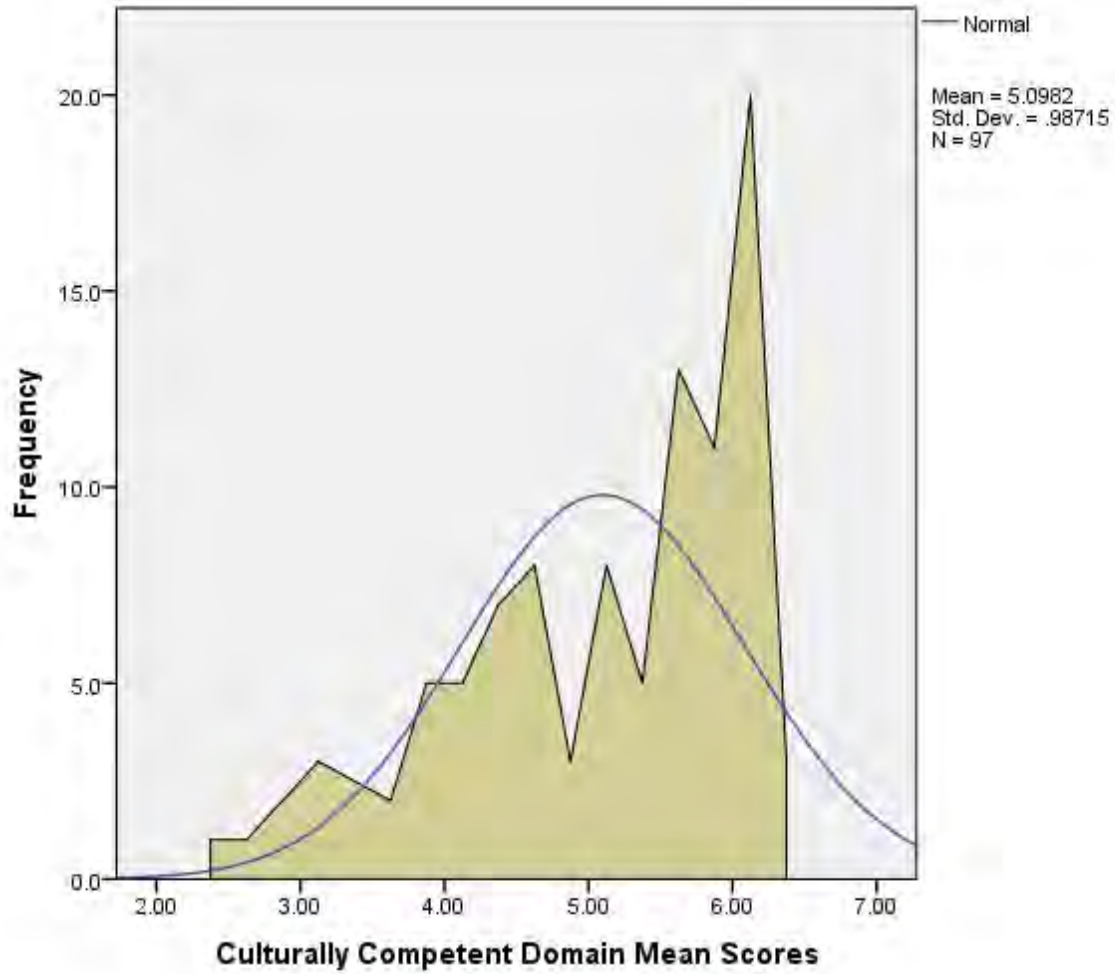
Figure 13. Histogram of SOCPR Culturally Competent domain mean scores DCS cases.
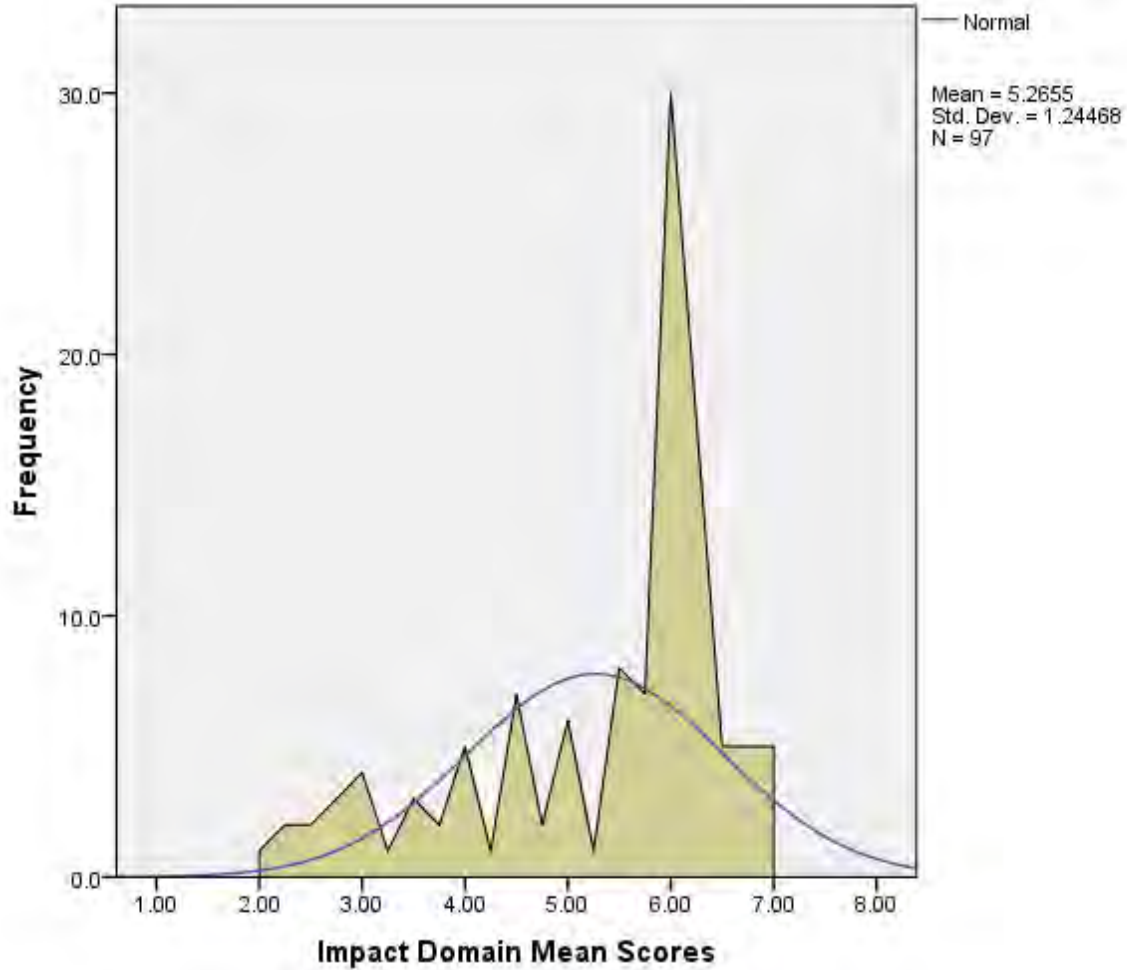
Figure 14. Histogram of SOCPR Impact domain mean scores DCS cases.

SOCPR Scores – SOCPR Domains, Subdomains, and Areas DCS Cases

Table 14 presents statewide DCS SOCPR data for most levels of the instrument, including the total case or overall mean score, SOCPR domain mean scores, SOCPR subdomain mean scores, and SOCPR area mean scores. Because the Regions may have small DCS sample sizes, the standard deviation data are not statistically meaningful; consequently, SOCPR subdomain and area mean scores are not reported at the Region level.

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Table 14. Statewide SOCPR Scores: Overall, Domain, Subdomain, and Area DCS Cases

Overall Mean Score – DCS cases: 5.30 (0.84)			
	Domain Mean (SD)	Area Mean (SD)	Subdomain Mean (SD)
Domain I: Child-Centered Family-Focused	**5.34 (0.94)**		
Individualized			5.12 (1.05)
Assessment/Inventory		5.19 (1.17)	
Service Planning/Delivery		4.92 (1.11)	
Types of Services/Supports		5.15 (1.43)	
Intensity of Services/Supports		5.22 (1.44)	
Full Participation			5.41 (1.10)
Case Management			5.48 (1.29)
Domain II: Community Based	**5.51 (0.73)**		
Early Intervention			4.97 (1.30)
Access to Services			5.79 (0.67)
Convenient Times		5.95 (0.95)	
Convenient Locations		5.44 (1.34)	
Appropriate Language		5.99 (0.44)	
Minimal Restrictiveness			5.80 (0.80)
Integration and Coordination			5.46 (1.17)
Domain III: Culturally Competent	**5.10 (0.99)**		
Awareness			5.05 (1.11)
Awareness of Child/Family's Culture		4.63 (1.51)	
Awareness of Providers' Culture		5.09 (1.47)	
Awareness of Cultural Dynamics		5.43 (1.20)	
Sensitivity and Responsiveness			5.05 (1.45)
Agency Culture			5.22 (1.23)
Informal Supports			5.07 (1.56)
Domain IV: Impact	**5.27 (1.24)**		
Improvement			5.25 (1.24)
Appropriateness			5.28 (1.37)

As previously reported, the highest scoring SOCPR domain was Community Based, followed by Child-Centered Family-Focused, Impact, and finally Culturally Competent. All DCS case mean scores were in the mid 4 (neutral) to high 5 (enhanced implementation) range. The area of Appropriate Language, in the subdomain of Access to Services, had the highest mean score (5.99), while the area of Awareness of Child/Family Culture in the subdomain of Awareness had the lowest mean score (4.63).

In the Community Based domain, the Minimal Restrictiveness subdomain was the highest scoring subdomain (5.80) with the subdomain of Access to Services just slightly behind with a mean score of 5.79. Within the subdomain of Access to Services, all three area mean scores [Appropriate Language (5.99), Convenient Times (5.95), and Convenient Locations (5.44)] scored at the enhanced implementation of a system of care principle level. These subdomain and area mean scores indicate that services and communications (both verbal and written) are being provided to youth and families in their primary language. Additionally, coordinated services are scheduled at times that are most convenient for families and are delivered in locations, which are accessible and comfortable like the youth's home community whenever possible. These represent strengths in Arizona's Children's System of Care, as reviewed through these 97 SOCPR DCS cases.

Other low to mid 5 subdomain mean scores included Full Participation (5.41) in the domain of Child-Centered, Family-Focused, Appropriateness (5.28) and Improvement (5.25) in Impact, and Agency Culture (5.22) in Culturally Competent. Children and families are actively participating not only in services but also in the service planning process. They are informed consumers about the services and the agencies that provide the services. They are an integral part of the decision making process. The services provided are appropriate and have improved the lives of youth and families served.

The data also revealed scores in the 4 (neutral) range. Although these scores indicate neither support for nor against implementation of system of care principles, they may emphasize the need for increased attention or support. For example, the scores for the areas of Awareness of Child/Family Culture and Service Planning and the subdomain of Early Intervention were in the mid to high 4 range. These scores may indicate an increased need for service providers to take note of how culture may affect families' decision-making, service plans may need to be improved to reflect both the needs and the strengths of both the child and the family, and an improved response time for providing integrated and coordinated services as soon as families begin experiencing issues.

SOCPR Scores and Tests of Significant Differences DCS Cases

Because the SOCPR DCS case and domain scores do not fit the pattern of a normal distribution, nonparametric statistical tests were performed to examine the data for differences between groups within a specific variable in relation to SOCPR scores. SOCPR scores are continuous data, while most of the other variables were categorical data. Thus, for statistical tests in which the variable to be examined in relation to SOCPR scores consisted of more than 3 groups, such as race, the Kruskal-Wallace test was performed. For variables with

only two groups, such as gender, the Mann-Whitney U test was performed. Age was transformed into an Age Band variable with three groups: 0 through 5, 6 to12, and 13 to 18. Table 15 shows the results of these statistical tests for a variety of variables. A value of .05 or lower indicates a significant difference between groups for the variables involved in the statistical test, with lower scores indicating a higher likelihood of true significant differences.

Table 15. SOCPR Scores and Significant Differences with Variables of Interest DCS Cases

Variable	Case	CCFF	CB	CC	IMP
Demographics					
Age Bands				0.008	
Gender	0.026			0.006	
Race					
Primary Language	0.021	0.021		0.031	0.026
Region					
Case Longevity					
Service Systems					
Behavioral Health					
Juvenile Justice					
Educational					0.008
Developmental Disabilities					
Total Systems					
Services Categories					
Treatment Services					
Medical Services					
Support Services					
Inpatient Services					
Residential Services				0.041	
Services					
Individual Counseling					
Family Counseling					
Family Support					
Respite Support					
Case Management					
Psychiatric Hospitalization					
Total Number of Services	0.005		0.012	0.00	0.046

There were significant associations found for the measures of demographics, service systems, services categories, and services.

Findings indicate that Primary Language and Gender of the child contributed to significant associations. Females had significantly higher Case and Culturally Competent scores than males. English speakers had significantly higher scores in case and all domains except

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Community-Based. Total Number of Services was positively associated with case and all domains except Child Centered and Family Focused.

SOCPR Scores – FY2016-2017 Comparison DCS Cases and Non-DCS Cases

Table 16 shows a comparison of overall, domain, subdomain, and area scores across two sub-samples of the FY2016-2017 SOCPR administration: DCS Cases (N=97) and Non-DCS Cases (N=73). DCS Cases included children and families involved with the Department of Child Safety system while Non-DCS Cases included children and families identified as having high/complex levels of need. Overall, scoring differences are not significant with DCS mean scores generally positive.

Table 16. SOCPR Score Comparisons between DCS Cases and Non-DCS Cases

	DCS Cases	Non-DCS Cases	Difference	p-value[1]

[1] p-values were obtained through a two-sided two independent samples t-test.

	Mean	(SD)	Mean	(SD)		
Overall Score	5.30	(0.84)	5.05	(1.06)	0.25	0.10
Domain I: Child-Centered Family-	5.34	(0.94)	5.06	(1.23)	0.28	0.11
Individualized	5.12	(1.05)	4.66	(1.36)	0.46	0.02*
Assessment/Inventory	5.19	(1.17)	4.93	(1.38)	0.26	0.20
Service Planning/Delivery	4.92	(1.11)	4.71	(1.44)	0.22	0.29
Types of Services/Supports	5.15	(1.43)	4.56	(1.72)	0.59	0.02*
Intensity of Services/Supports	5.22	(1.44)	4.45	(1.89)	0.76	0.00**
Full Participation	5.41	(1.10)	5.36	(1.25)	0.05	0.79
Case Management	5.48	(1.29)	5.14	(1.43)	0.34	0.12
Domain II: Community Based	5.51	(0.73)	5.35	(0.93)	0.16	0.22
Early Intervention	4.97	(1.30)	4.75	(1.58)	0.22	0.33
Access to Services	5.79	(0.67)	5.76	(0.83)	0.04	0.75
Convenient Times	5.95	(0.95)	5.74	(1.29)	0.21	0.25
Convenient Locations	5.44	(1.34)	5.60	(1.17)	-0.16	0.40
Appropriate Language	5.99	(0.44)	5.92	(0.72)	0.07	0.47
Minimal Restrictiveness	5.80	(0.80)	5.68	(0.98)	0.12	0.40
Integration and Coordination	5.46	(1.17)	5.19	(1.39)	0.27	0.19
Domain III: Culturally Competent	5.10	(0.99)	4.98	(1.15)	0.11	0.50
Awareness	5.05	(1.11)	4.85	(1.16)	0.20	0.25
Awareness of Child/Family's Culture	4.63	(1.51)	4.28	(1.47)	0.35	0.13
Awareness of Providers' Culture	5.09	(1.47)	5.05	(1.28)	0.04	0.86
Awareness of Cultural Dynamics	5.43	(1.20)	5.21	(1.29)	0.23	0.24
Sensitivity and Responsiveness	5.05	(1.45)	4.92	(1.53)	0.12	0.60
Agency Culture	5.22	(1.23)	5.11	(1.40)	0.11	0.59
Informal Supports	5.07	(1.56)	5.05	(1.64)	0.02	0.94
Domain IV: Impact	5.27	(1.24)	4.81	(1.50)	0.46	0.04*
Improvement	5.25	(1.24)	4.87	(1.51)	0.38	0.08
Appropriateness	5.28	(1.37)	4.75	(1.62)	0.53	0.03*

Overall, SOCPR DCS mean scores are higher than Non-DCS mean scores when compared across all four domains. Consistent with other sample comparisons, the domain of Community Based scored highest across both samples followed by Child-Centered, Family-Focused.

Results indicated that of the comparisons across all domain, subdomain, and area levels

DCS scores were higher than Non-DCS scores, and there were five that scored significantly

	2015-2016	2016-2017	Change	p-value[1]

higher.

In all but one of the domain, subdomain, and area mean scores, DCS cases scored higher when compared to Non-DCS cases. Five of these comparisons showed significant increases. Within the domain of Child Centered, Family-Focused the subdomain score of Individualized and the area scores of Types of Services/Supports and Intensity of Services/Supports had significantly higher mean scores. Additionally, the domain of Impact and the subdomain of Appropriateness each had the same results.

The area mean score for Convenient Locations in the subdomain of Access to Services within the domain of Community Based was the only score that showed a lower though not significant different mean score when comparing DCS to non-DCS cases. Overall, domain, subdomain, and area comparisons indicate that DCS cases scored higher than non-DCS cases.

SOCPR Scores – FY2015-2016 and FY2016-2017 Comparison DCS Cases

Table 17 shows a comparison of overall, domain, subdomain, and area mean scores across two administrations of the SOCPR. Overall, scoring differences indicate a positive trend from FY2015-2016 to FY2016-2017 among DCS Cases. Some of these were statistically significant. A few of the comparisons show a downturn. All mean scores in the domain of Impact showed improvement.

	Mean	(SD)	Mean	(SD)		
Overall Score	5.00	(1.13)	5.30	(0.84)	0.31	0.03*
Domain I: Child-Centered Family-Focused	4.96	(1.29)	5.34	(0.94)	0.38	0.02*
Individualized	4.87	(1.24)	5.12	(1.05)	0.25	0.13
Assessment/Inventory	5.31	(1.03)	5.19	(1.17)	-0.13	0.41
Service Planning/Delivery	4.70	(1.35)	4.92	(1.11)	0.22	0.20
Types of Services/Supports	4.85	(1.63)	5.15	(1.43)	0.31	0.16
Intensity of Services/Supports	4.63	(1.75)	5.22	(1.44)	0.58	0.01**
Full Participation	5.18	(1.29)	5.41	(1.10)	0.23	0.17
Case Management	4.83	(1.64)	5.48	(1.29)	0.65	0.00**
Domain II: Community Based	5.16	(1.07)	5.51	(0.73)	0.34	0.01**
Early Intervention	5.12	(1.35)	4.97	(1.30)	-0.15	0.43
Access to Services	5.56	(0.94)	5.79	(0.67)	0.23	0.04*
Convenient Times	5.44	(1.47)	5.95	(0.95)	0.51	0.00**
Convenient Locations	5.41	(1.33)	5.44	(1.34)	0.03	0.86
Appropriate Language	5.83	(0.70)	5.99	(0.44)	0.16	0.05
Minimal Restrictiveness	5.30	(1.23)	5.80	(0.80)	0.50	0.00**
Integration and Coordination	4.67	(1.56)	5.46	(1.17)	0.79	0.00**
Domain III: Culturally Competent	4.85	(1.23)	5.10	(0.99)	0.25	0.12
Awareness	4.94	(1.14)	5.05	(1.11)	0.11	0.48
Awareness of Child/Family's Culture	4.77	(1.32)	4.63	(1.51)	-0.13	0.50
Awareness of Providers' Culture	4.93	(1.33)	5.09	(1.47)	0.16	0.42
Awareness of Cultural Dynamics	5.12	(1.35)	5.43	(1.20)	0.31	0.08
Sensitivity and Responsiveness	5.00	(1.37)	5.05	(1.45)	0.05	0.80
Agency Culture	4.97	(1.53)	5.22	(1.23)	0.25	0.20
Informal Supports	4.50	(1.75)	5.07	(1.56)	0.57	0.01*
Domain IV: Impact	5.01	(1.48)	5.27	(1.24)	0.26	0.18
Improvement	5.08	(1.46)	5.25	(1.24)	0.18	0.35
Appropriateness	4.94	(1.62)	5.28	(1.37)	0.33	0.11

Table 17. SOCPR Score Comparisons between FY2015-2016 and FY2016-2017 DCS Cases

[1] p-values were obtained through a two-sided two independent samples t-test

      The changes in mean scores from FY2015-2016 and FY2016-2017 reflect an overall improvement, although the ranking of domain scores was not consistent. The overall score as

well as two of the four domain scores showed statistically significant improvement from last year. The highest scoring SOCPR domain was Community Based across both administrations and the lowest scoring was Culturally Competent. The subdomains of Access to Services and Minimal Restrictiveness both scored high across both administrations of the SOCPR, as did the areas of Appropriate Language, Convenient Times, and Convenient Locations.

Improvement in Arizona's Children's System of Care for this year can overwhelmingly be seen in the domain of Community Based. Almost all domain, subdomain, and area mean scores show a positive trend from FY2015-2016 to FY2016-2017, with five of the seven improvements being statistically significant. Additionally, the domain of Child-Centered, Family-Focused showed significant improvement as did the subdomain of Case Management and the area of Intensity of Services. Lastly, one subdomain in Culturally Competent (Informal Supports) showed significant improvement.

These positive trends indicate that services are accessible to families and are being provided in the least restrictive and most coordinated manner as possible. These results also show that service plans and services are coordinated by one person who ensures that the intensity of services is responsive and reflect the needs and strengths of the youth and family. Lastly, service providers actively utilized informal supports in all aspects of service provision.

Qualitative Analysis DCS Cases

This section reports a summary of qualitative data compiled from responses to Summative Questions that SOCPR reviewers use to develop a case summary for a particular child and her/his family. Each case summary integrates information gathered through a document review and a series of interviews completed with the child, a caregiver, and a provider, to address each of the four SOCPR domains. The Summative Questions call for a reviewer to provide a rating for each statement and to give a brief narrative in support of that rating. Individual ratings serve as indicators of the extent to which system of care subdomain elements (e.g., individualized, full participation) are being implemented. In the final analysis, ratings for each measurement are clustered and considered in conjunction with reviewers' narratives to determine an overall rating for each domain, indicating the extent to which each subdomain was achieved. The narrative portion of each Summative Question response is used to assess the degree to which SOCPR items tied to each domain were met and an explanation for the evidence provided. Where an overall summative rating relates to a reviewer's determination of completion of a *thorough assessment*, for instance, qualitative analysis examines the evidence provided to explain the rating.

The compiled narratives for all Summative Questions for this sub-sample of 97 cases were coded and sorted to assess the degree to which System of Care principles were implemented with children and families involved in the Department of Child Safety (DCS) system, by SOCPR domain area. The frequency of Summative Question responses was examined and analyzed for emerging patterns/trends in 13 subdomains and 10 areas which correspond to the four large SOCPR domains. In order to be considered a trend, at least half of the cases reviewed had to provide similar information for a given subdomain area. Identified trends are then reported for the entire domain. The qualitative findings section also highlights successes and opportunities for growth related to each of the SOCPR Domain Areas as reported in responses to Summative Questions.

Qualitative Findings

Domain 1: Child-Centered Family Focused Services

The first domain of the SOCPR is designed to measure whether the needs of the child/youth and family determine the types and mix of services provided within the System of Care. This domain reflects a commitment to adapt services to the child and family rather than expecting them to conform to preexisting service configurations. The review reflects the effectiveness of the site in providing services that are individualized; that families are included as full participants in the treatment process; and that the type and intensity of services provided is monitored through effective case management.

Overall, scores and descriptive comments provided by SOCPR raters suggest that providers within the System of Care are generally providing child-centered and family-focused services to children and families involved within the department of child safety system. The review of cases using the measures associated with *Child-Centered Family-Focused Services* suggests that children and their families are generally receiving services and supports that are adapted to their individual strengths and needs, that families actively participate in the service delivery process, and that the type and intensity of services is monitored through effective case management.

When considering whether children/youth and families received *Individualized Services* within the System of Care, reviewers indicated that needs and strengths were identified and the types and intensity of services were appropriate for the needs of the youth and families. In a majority of cases reviewers noted that children and families obtained assessments across all life domains; however, scores indicated that there were some barriers when it came to service planning and delivery. In about 31 percent of cases rated "3" (Disagree Slightly) and under primary service plans showed minimal evidence of integration across all providers and agencies. Additionally, the service plan goals failed to reflect the needs of the children and families

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adequately, and they did not incorporate the strengths of the youth and families in an adequate manner. Although this does not constitute a trend, providers may take this as an opportunity for growth and training to improve documentation of the primary service plan.

Overall, reviewers indicated that there was *Full Participation* on the part of children/youth and families in this DCS sample, in the development, implementation, and evaluation of service plans. Scores indicated that families as well as providers and informal helpers had active roles not only in the service planning process but also in participation of services and supports. Overwhelmingly, reviewers indicated agreement between caregivers, providers, and records. In addition, families had input in the service planning process, and they had a general understanding of the service plan.

With regard to the Case Management subdomain, over 85% of the reviewers reported overall high ratings ("5" through "7"- Agree Slightly to Agree Very Much) indicating successful coordination of services planning and delivery, that was responsive to the emerging and changing needs of children and families. In general, evidence indicated that one person coordinated services and supports and facilitated team meetings. Additionally, raters indicated that although service plans were regularly reviewed, they might not be updated or revised when new services were added.

Opportunities for Growth and/or Training in Domain 1
System Successes in the Provision of Child-Centered Family-Focused Services
- Strengths of youth and family are identified consistently
- Thorough assessment across all life domains was conducted
- Children and families are receiving individualized services
- Types and intensity of services and supports were appropriate for the needs of the family
- Child/youth and family appear to understand service plans and actively participate in services
- Service providers and informal helpers participated in the service planning process and were active participant in services and supports
- Services for children and families are successfully coordinated by one person

Opportunities for Growth and/or Training in Domain 1
- Service plan goals do not reflect the needs of the children and families adequately
- Minimal evidence of integration across all providers and agencies
- Service plans were not updated or revised on a regular basis
- Goals of service plan did not incorporate strengths of youth and family

Domain 2: Community Based Services
The second SOCPR domain is designed to measure whether services are provided within

or close to the child/youth's home community, in the least restrictive setting possible, and moreover, that services are coordinated and delivered through linkages between public and private providers. The subdomains in this area are used to evaluate how effective the system is at identifying needs and providing supports early, facilitating access to services, providing less restrictive services, and integrating and coordinating services for families.

When assessing whether child/youth and families within the Department of Child Safety received *Early Intervention*, case files indicated that families were able to obtain the services and supports they needed in the appropriate combinations as soon as they entered into the system. Their needs were identified promptly and were clarified in an efficient manner. However, in about 21 percent of cases, reviewers noted lags between referral, intake, assessment, and receipt of services and supports. Cases records show that these gaps ranged from a couple of weeks to months. Reviewers also noted that in some of the cases during these gaps there was no documentation of any services being provided to families. This challenge provides an opportunity for growth and training of providers to ensure that the needs of youth and family are identified and clarified in a timely manner so that services and supports can begin as soon as possible.

Overall, reviewers noted that the System was ensuring *Access to Services* for children/youth and families involved in DCS. Almost 99 percent of raters noted that verbal and written communications between providers and families were in the primary language of the child and family. However, preferred language was not always noted on the service plan. Some challenge to this was voiced by families when they stated that acronyms got in the way of them understanding service plans.

Additionally, case records indicated that support for access to services was discussed, and generally, families stated they did not require additional assistance with transportation. The majority of rater indicated that providers were respectful of children and families by scheduling appointments at times and in locations that were convenient typically within their neighborhood or home community. In about 11% of cases challenges were noted around supports for transportation for families to services. Some of these challenges included what is written in the case file, what the family needs, and what they receive.

When assessing for *Minimal Restrictiveness* in service delivery, scores showed that services and supports were provided in environments that were the least restrictive for youth and families. Raters indicated that families felt that the locations where they obtained services were welcoming and inviting, appropriate and comfortable.

With regard to *Integration and Coordination* of services, reviewers generally found that there was productive and successful communication among and between all team members, including formal service providers, family members and informal supports. In addition, over 80 percent of reviewers noted that in general there are smooth and seamless processes for linking children/youth and family to additional services. In about 23 percent of the cases, reviewers noted that there was a difference of opinion between the file, caregiver, and provider around the issue of being a smooth and seamless proves linking the child and family with additional services. The disagreement was varied, but some challenges included follow-up, services not occurring, providers changing often, location of child to service providers, and time delays.

System Successes in the Provision of Community Based Services
- Service providers verbally communicate in the primary language of the child/youth and family
- Written documentation regarding services/service planning is in the primary language of the child and family
- Access to services is convenient for youth and families
- Services are generally provided at convenient times and in locations that are close to youth's' home community
- Services are provided in environment(s) that feel comfortable to the child/youth and family
- Communication is productive and successful among and between all team members
- Process for linking children/youth and family to additional services is smooth

Opportunities for Growth and/or Training in Domain 2
- Services provided to children and families were not always provided in a timely manner
- The process for linking children and families to additional services is not always a seamless one
- Gaps between referral, intake, assessment, and receipt of services and supports
- Child and family needs were not always clarified by the system in a timely manner

Domain 3: Culturally Competent Services
The third domain of the SOCPR is intended to measure whether services are attuned to the cultural, racial, and ethnic background and identity of the child/youth and family receiving services. Ratings provided in each subdomain are meant to evaluate the level of cultural awareness of the service provider, whether evidence shows that efforts are made to orient the family to an agency's culture, whether sensitivity and responsiveness is shown for the cultural background of families, and whether informal supports are included in services.
Reviewers assessing for *Cultural Awareness* in this DCS sample indicated that providers generally recognize and understand the youth and family's culture and community. However,

understanding the family's concepts of health and family, and how their culture influenced the decision making process proved to be a challenge. In about one third of the cases rated "3" (Disagree Slightly) and below raters indicated that there was limited documentation or discussion amongst team members regrading either of these topics. As one record indicated, "Culture is not documented". Although these findings do not constitute trends, they provide an opportunity for growth and training of providers to improve the documentation of culture within case files. Overall, raters reported evidence that providers are aware of the dynamics of working with families whose culture is different but were able to provide integrated and coordinated services and supports appropriately. Service providers also assisted families in not only understanding agencies they represent but also helping them navigate the entire service system successfully.

When evaluating the *Sensitivity and Responsiveness* of the system, raters noted that respondents provided some evidence that providers translated awareness of family culture into action within the planning process and the service plan and that services and supports were responsive to the culture, values, and beliefs of the youth and family. However, in about a quarter of the case, there was limited evidence of this subject in the documentation.

In the subdomain of *Agency Culture* reviewers generally noted that providers are assisting families in understanding and navigating the service systems in which they are involved. Families generally agreed that service providers take their cultures and values into account when they are planning and providing services. Service providers seemed to understand that families would participate in services if they understood what agencies expected of them and when they were able to successfully navigate the system.

With regard to *Informal Supports*, reviewers generally found evidence that informal supports were discussed and offered to families. However, in about 31 percent of cases, there was little to no documentation in the service plan of natural supports or community-based activities being incorporated into the service planning and delivery process. Some cases indicated that there were discussions between providers and caregivers about community resources and informal supports, but there was little to no documentation to support that the team helped expand the child and family's community and natural support connections. Even when families indicated that natural supports were available or were noted in the service plan, they declined to include these natural supports (e.g. supportive friends or community members) in services.

System Successes in the Provision of Culturally Competent Services
- Providers generally recognize and understand the youth and family's culture and

community

- Providers are aware of the dynamics of working with families whose culture is different
- Services and supports were responsive to the culture, values, and beliefs of the youth and family
- Providers are assisting families in understanding and navigating the service systems
- Informal supports and community resources were discussed and offered to families

Opportunities for Growth and/or Training in Domain 3

- Reviewers identified limited documentation or discussion amongst team members regrading understanding the family's concepts of health and family
- Limited evidence of documentation of how the family's culture influenced the decision making process
- Raters noted minimal documentation in the service plan of natural supports or community-based activities being incorporated into the service planning and delivery process

Domain 4: Impact

The final SOCPR domain evaluates whether services have produced positive outcomes for the child and family. This domain includes two subdomains: *Improvement* and *Appropriateness of Services*, which are meant to determine whether services have had a positive impact on the children/youth and families and if so, whether these services met their identified needs.

The majority of raters found evidence that services and supports provided to both children and families produced positive impacts on their situations and had met their needs. In general, raters noted that in about 85 percent of the cases providers and caregivers indicated some improvement on the part of the child/youth, while about 87 percent indicated a little improvement for families. Similarly, reviewers indicated that providers generally were able to appropriately serve youth and meet their needs; however, raters noted that the services and supports provided did not seem to be assisting the family. This may provide an opportunity for growth and training of providers to ensure that the needs of families are documented and appropriate services and supports are provided to adequately meet their needs.

System Successes

- Reviewers generally agree that services provided to children/youth and families have improved their situation to some degree
- Reviewers generally agree that the services and supports provided to children/youth and families has adequately met their needs
- Raters noted that services and supports had a positive impact on youth and families

<u>Opportunities for Growth and/or Training in Domain 4</u>

- Inconsistent documentation in the case files related the needs of families being met appropriately

Overall, qualitative analysis of responses to Summative Questions suggest that the Statewide System of Care has achieved some success in its effort to implement System of Care values and principles in its service delivery to children/youth and families with DCS involvement in FY2016-2017. Some recommendations have been made to help build on these successes by encouraging the work of providers and reviewers through ongoing training.

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TECHNICAL APPENDICES

APPENDIX A

Twelve Principles of the Children's System of Care

Arizona Vision and 12 Principles of the Children's System of Care

In collaboration with the child, family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency and become stable and productive adults. Services will be tailored to the child and family, provided in the most appropriate setting, in a timely fashion, and in accordance with best practices, while respecting the child and family's cultural heritage.

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

APPENDIX B

"Other" Category of Treatments and Services ALL Cases

Almost 38% of the service provision treatments reported for ALL Cases were identified as "Other". Below is a list and frequency of the 23 treatments or services identified as "Other".

"Other" Category Treatments and Services ALL Cases	N
Assessment	5
Assessment, transportation	1
Behavior coach	2
Behavioral health education services	1
CFT meeting	1
Evaluations (B-5 screenings)	1
Family group support (other agency)	1
Interpreter services	1
Job training	1
Med monitoring	1
Monthly assessments	1
Out of home placement	1
Psychiatric evaluation	1
Psychiatric evaluation transportation	1
Speech therapy	1
Speech therapy from DDD	1
Transportation	37
Transportation, Great Aunt	1
Transportation, assessments	1
Transportation, Behavior. Inter. Services	1
Transportation, CFSS	1
YAP – Young Adult Program, transportation	1
Youth/Family specialist, behavior coaching	1
TOTAL	**64**

APPENDIX C

"Other" Category of Treatments and Services DCS Cases

Over 38% of the service provision treatments reported for DCS Cases were identified as "Other". Below is a list and frequency of the 15 treatments or services identified as "Other".

"Other" Category Treatments and Services DCS Cases	N
Assessment	5
Assessment, transportation	1
CFT meeting	1
Evaluations (B-5 screenings)	1
Family group support (other agency)	1
Interpreter services	1
Monthly assessments	1
Out of home placement	1
Psychiatric evaluation	1
Transportation	19
Transportation, Great Aunt	1
Transportation, assessments	1
Transportation, Behavior. Inter. Services	1
YAP – Young Adult Program, transportation	1
Youth/Family specialist, behavior coaching	1
TOTAL	**37**

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CHILD AND FAMILY TEAM PRACTICE TOOL

Effective Date: 10/01/16

I. GOAL/WHAT DO WE WANT TO ACHIEVE THROUGH THE USE OF THIS PRACTICE TOOL?

A. To describe universal Child and Family Team (CFT) practice in the AHCCCS System of Care.
B. To describe indicators that contribute to a child and family's complexity of needs.
C. To describe how the essential CFT practice activities are implemented on a continuum based on individualized needs.
D. To describe how the Child and Adolescent Service Intensity Instrument (CASII) is utilized in the AHCCCS System of Care.

II. BACKGROUND

The Arizona Vision as established by the Jason K. Settlement Agreement in 2001, states, "In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's and family's cultural heritage".

The Twelve Principles for Children's Service Delivery (12 Principles) are:

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

The 12 Principles serve as the foundation, and are universally applied, when working with all enrolled children and their families through the use of CFT practice. Arizona's CFT practice model was created from the tenets of Wraparound a nationally recognized team process. This is evident through the shared concepts of the 12 Principles with the 10 Principles of Wraparound: family voice and choice, team-based, natural supports, collaboration, community based, culturally competent, individualized, strengths based, unconditional, and outcome based (Bruns, E. J., Walker, J. S., & The National Wraparound Initiative Advisory Group. (2008). 10 principles of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health).

"It has been over twenty years since the term 'wraparound' was used to define an intervention approach that surrounds a youth and family with customized services and supports. Since that time perhaps no other term used in the field of mental health has been more praised or embraced, redefined or misunderstood." (Blau, G. (2008). Foreword. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health)

In the CFT model it is the child's and family's complexity of needs that drive the development, integration, and individualization of service delivery. The level of complexity is determined individually with each child and family.

One variable that is considered when determining complexity of needs for children is the involvement of other child-serving agencies, such as Juvenile Justice (Probation or Parole), Division of Developmental Disabilities (DDD), Department of Child Safety (DCS), and Education (Early Intervention or Special Education). The number of system partners involved and invited to participate in CFT practice by the child and family will contribute to the level of service coordination required, as well as consideration by team members of the individual mandates for each agency involved.

A child's and family's overall health status also contributes to their complexity of needs and subsequent level of service intensity. For children with a serious emotional disturbance (SED) and/or chronic physical condition, symptoms associated with their physical or behavioral health condition can impact their level of functioning in multiple life domains and may result in the use of medications that are monitored through a primary care physician and/or other qualified professional. 9Thus, the intensity of service integration through CFT practice is dependent on the level of coordination necessary to support the child and family in making progress toward identified goals in their AHCCCS Service Plan.

The presence of environmental stressors/risk factors is another variable to be considered by the CFT when reviewing the child's and family's level of complexity. The identification of potential environmental stressors is addressed during the comprehensive assessment; examples include changes in primary care giver, inadequate social support of the family, housing problems, mental health or substance use concerns in family members, etc. Other variables for consideration include children in an out-of-home setting (group home, therapeutic foster care, etc.) and use of crisis or inpatient services.

Another method for determining complexity of needs and intensity of service delivery is through the application of the CASII for children age six to 18. This instrument consists of six dimensions for assessment of service intensity: risk of harm, functional status, co-occurrence of conditions, recovery environment, resiliency and/or response to services, and involvement in services as referenced in the CASII Implementation Guide.

The application of CFT practice will vary depending on the child's and family's individualized level of need and complexity. Frequency of CFT meetings, location and nature of meetings, intensity of activity between CFT meetings, and level of involvement by

formal and informal supports necessary to adequately support children and families will vary depending on:

1. The preferences of the child and family,
2. The size of the team including the number of agencies/systems involved,
3. The coordination efforts required,
4. The ability of the CFT to work effectively together,
5. The number of distinct services and supports necessary to meet the needs of the child and family,
6. The frequency of CFT meetings necessary to effectively develop a plan, track progress and make modifications when needed,
7. The severity of mental health and/or physical health symptoms,
8. The effectiveness of services,
9. Stressors currently affecting the child and family, and
10. Rural versus metropolitan location.

As the child's and family's level of complexity varies, the level of service intensity required to meet their needs also changes. "In a continuum based on the principles of the wraparound process described by the National Wraparound Initiative, the children and families with the most complex needs will have the most integrated and individualized services and supports, although all children and youth with behavioral health needs at any level must have individualized services and supports." (VanDenBerg, J. (2008). Reflecting on wraparound: Inspirations, innovations, and future directions. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health) All children receiving public behavioral health services in Arizona are served according to the 12 Principles through CFT practice along a continuum of care based on their complexity of needs as illustrated through the example in Figure 1.

FIGURE 1
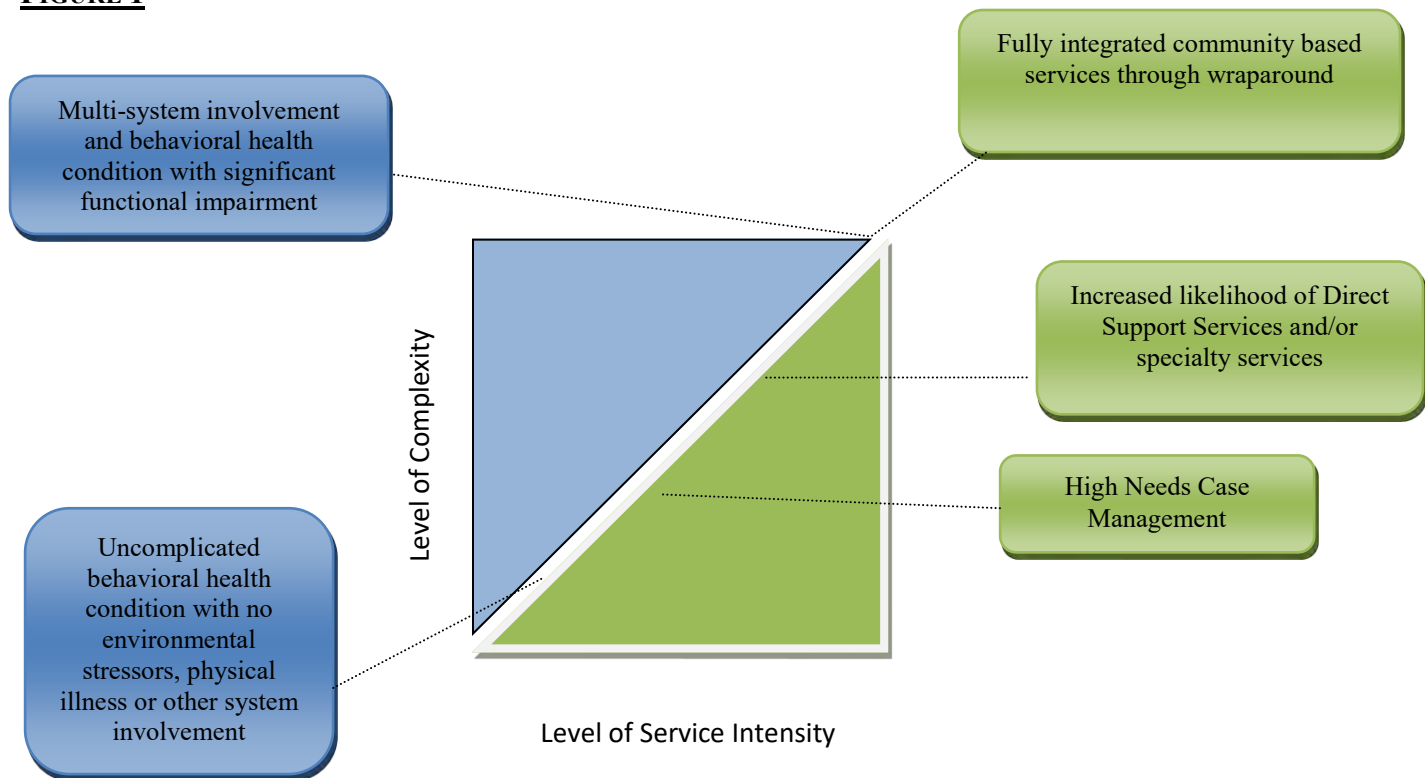
See also Attachment A, Guidelines for Strengths, Needs and Culture (SNCD)Discovery Domains; Attachment B, Arizona's Child and Adolescent Service Intensity Instrument Children/Adolescents Age 6 through 17 Scoring Sheet, and Attachment C, Attachment C, CASII Implementation Guidelines for CFT Practice Nin Essential Activities

A. PROCEDURES

CFT practice consists of nine activities which will be described in further detail in this Practice Tool:

1. Engagement of the Child and Family,
2. Immediate Crisis Stabilization,
3. Strengths, Needs and Culture Discovery (SNCD),
4. CFT Formation/Coordination of CFT Practice,
5. Service Plan Development,
6. Ongoing Crisis Planning,
7. Service Plan Implementation,
8. Tracking and Adapting, and
9. Transition.

These activities of CFT practice are addressed in the order, frequency, and duration necessary depending on the child's and family's individualized needs.

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ACTIVITY 1 - ENGAGEMENT OF THE CHILD AND FAMILY

"The perspective or orientation with which providers enter into service relationships will have a major impact on the outcomes achieved through those relationships."(Franz, J. (2008). ADMIRE: Getting practical about being strength-based. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health) Engagement is the foundation of CFT practice beginning with the first contact between the child/family and the behavioral health system and continuing throughout their involvement in the treatment relationship. Engagement is the active development of a trusting relationship based on empathy, respect, genuineness and warmth to facilitate moving toward an agreed upon outcome (See AMPM Policy 1040).

The initial conversations with the child and family provide opportunities for the behavioral health provider to learn and understand the child's and family's concerns. Primary needs may require quick action such as immediate crisis stabilization (see Activity 2). However, conversational dialogue partnered with an active listening style, rather than a structured interview, supports the development of a trusting relationship between the behavioral health provider and the child and family. During this initial engagement period, it is important for the behavioral health provider to gain a clear understanding of the needs that led the child and family to seek help from the behavioral health system and to explore how peer and family-run organizations can provide additional support.

Any accommodations that may be indicated, including scheduling/location of appointments, interpretation services, child care or transportation needs are addressed during the initial engagement period. It is important to brainstorm with the child and family to identify the most convenient meeting location and times. For example, meetings can be held at the family's home, school, library, community center, or another location that is identified by the child and family. When meeting in public places, please ensure compliance with confidential requirements as outlined in AMPM Policy 550. Scheduling appointments or CFT meetings during school classroom hours should be avoided whenever possible.

A description of Arizona's CFT practice model is provided to the child and family during the initial engagement period by the behavioral health provider. The behavioral health provider then assists the child and family with identification and participation of additional family members, close family friends, and other persons who may become part of the CFT. If DCS is involved with the child and family, dialogue occurs with the DCS case manager regarding any barriers to involvement of potential CFT members. To the extent possible, the attorney and Guardian ad Litem (GAL) should attend meetings or provide input to the CFT (see Administrative Order No. 2011-16 and The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS Practice Tool.

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Subsequent contacts between the child/family and the behavioral health provider continue to reinforce engagement. This may be accomplished by using a variety of approaches such as: avoiding the use of professional/system jargon and acronyms, active listening, and responsiveness to the individualized needs as identified by the child and family. For example, responsiveness to phone messages from a child's family regarding when a service will be delivered helps reinforce a working relationship that is built on trust.

ACTIVITY 2 - IMMEDIATE CRISIS STABILIZATION

A behavioral health risk assessment is one of the minimum elements of a comprehensive clinical assessment as referenced in AMPM Policy 320-O. This includes the identification of any immediate crisis that requires intervention to maintain the safety of the child, family, and/or community. The AHCCCS definition of crisis is "[A]n acute, unanticipated, or potentially dangerous behavioral health condition, episode or behavior". Examples of crisis situations include suicidal or homicidal behaviors/intentions or the imminent risk of a child's removal from his/her home.

For a child or family experiencing a crisis situation, immediate stabilization takes precedence over all other assessment and planning activities. When the development of a crisis stabilization plan is indicated, crisis intervention services which work in conjunction with the child's and family's strengths are identified and secured. Family support, respite, or in-home services that may assist in crisis stabilization are identified and secured in a timely manner to maintain the least restrictive environment possible to provide for the child's and family's safety and well-being.

ACTIVITY 3 - STRENGTHS, NEEDS AND CULTURE DISCOVERY (SNCD)

Service planning and delivery for children and families is based on a comprehensive assessment of the child's and family's needs, as well as an understanding of their strengths and unique family culture. The minimum elements of the comprehensive behavioral health assessment for children include information related to the child's/family's medical history, social history, educational history and status, employment history and status, housing status, legal history and status, and involvement with other child-serving agencies (See AMPM Policy 320-O).

For children with complex needs, as indicated through an individualized assessment (See Background Section in this document) and/or a CASII score of four and higher for children age 6 to 18, the development of a document that reflects the strengths, needs and culture of the child and family provides a foundation for future planning. The written Strengths, SNCD summarize information on a broad range of life domains of the child and of the family and includes the following elements:

1. Identification of strengths, assets and resources that can be mobilized to address the child and family's need for support,
2. Exploration and understanding of the unique culture of the family to ensure that the Service Plan will be a plan that the child and family will support and utilize,

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3. Attention to aspects of family culture influenced by family relationships, rituals, social relationships, living environment, work environment, spiritual focus, health, financial situation, and other factors;
4. Recording of the child's and family's vision of a desired future, and
5. Identification of the needs and areas of focus that must be addressed in order to move toward this desired future.

Family members are central participants in the development of the SNCD. Information used in developing the SNCD is acquired through conversations that begin at the time of initial engagement and continue over the course of service delivery. The discovery process begins with identifying presenting concerns and prioritized needs that the child and family select to be addressed in-depth through the service planning process. The SNCD identifies extended family members, friends, and other individuals who are currently providing support to the child and family or who have been supportive in the past. By gaining a clear understanding of the child's and family's prioritized needs, the CFT can begin focusing on the integration of natural supports along with formal services.

Before finalizing the SNCD, the behavioral health provider reviews the document with the child and family to ensure that they are in agreement with the content. Revisions are made as needed to reflect the child and family's feedback. The family is provided with a copy of the completed SNCD document, and then, if the family agrees, copies are provided to other CFT members. The SNCD is updated as additional needs, strengths, and cultural elements are identified over the course of service delivery. Families are asked to review any changes to the document for accuracy and to ensure that the contents reflect their view of the family.

ACTIVITY 4 - CFT FORMATION/COORDINATION OF CFT PRACTICE

In conjunction with the family, the behavioral health provider facilitates the identification, engagement and participation of additional family members, close family friends, professionals, partner agency representatives (e.g., DCS, DDD, juvenile justice and education), and other potential members on the CFT. One of the goals is to strengthen or help build a natural and community based social support network for the family.

The size, scope and intensity of the involvement of CFT members are driven by the needs of the child and family. The CFT may consist of the child, a parent and the identified behavioral health provider or may involve additional participants if the child and family are involved with other systems, have complex needs, an extensive natural support system, or are involved with multiple support providers. When working with older youth, the CFT respects the young person's wishes around team formation. When DCS is the identified guardian, inclusion of the child's family members on the CFT, is critical and is not limited to only those situations when reunification is the identified goal. Membership of the CFT is adjusted as the needs and strengths of the child and family change over time.

The frequency of CFT meetings is individualized and scheduled in relation to the child and family's situation, preferences, and level of need. Policy that establishes a set time frame for frequency of CFT meetings is avoided in order to support this individualized approach. Though AHCCCS does not establish specific guidelines, Contractors are encouraged to supply guidelines that support consistent team meetings based on level of need.

Behavioral health providers who serve as the facilitator of CFT practice have the specialized training and skill set to effectively implement the activities of this practice model. For a child and family with complex needs, a CFT facilitator with the appropriate background and training is assigned.

Upon initial formation of the CFT, the facilitator provides team members with an overview of CFT practice and clarifies the member's role and responsibilities as a team member. As appropriate, in rural areas where getting members together physically may be challenging, the facilitator utilizes alternative modes of communication. Facilitators assist CFT members with establishing ground rules for working together, identify their priority concerns, work proactively to minimize areas of potential conflict, and acknowledge the mandates of other involved child-service systems. CFT facilitators utilize consensus-building techniques, such as compromise, reframing, clarification of intent, and refocusing efforts while keeping the best interests of the child and family in mind. In addition, the CFT facilitator informs the child and family of their rights and ensures all necessary consents and releases of information are obtained.

Depending on the level of complexity of the child's and family's needs, increasing CFT membership through the inclusion of informal supports may be beneficial for the child and family. This is accomplished by periodically inquiring whether there is anyone else the family would like to participate in CFT practice (friends, extended family, neighbors, faith community, etc.) and the nature of their participation (attend meetings, be utilized as a resource in their crisis plan, etc.). In addition, family or peer support services may be needed to assist the child and family with exercising their voice. Refer to the Family and Youth Involvement in Child Behavioral Health Services Practice Tool and AMPM Policies 961-A and 961-B.

Decisions which affect the child and family occur with the family's full participation. Likewise, decisions affecting substantive changes in service delivery are made with the participation of the full CFT. CFT practice is flexible and, when necessary, adapts to accommodate parallel processes such as Team Decision Making (TDM), Family Group Decision Making (FGDM), or permanency planning (DCS), Person Centered Planning (DDD) and Individualized Education Program (IEP) planning.

ACTIVITY 5 – SERVICE PLAN DEVELOPMENT

The identification of the child and family's preferences, strengths, and culture begins at the time of initial assessment and continues through the development of the Service Plan. CFT members engage in brainstorming options and identify creative approaches, including the use of informal supports, for meeting the individualized needs of the child and family.

The Service Plan includes a long-term family vision which identifies what the youth and family would like to occur, as a result of services; the vision should be in the family's words to the extent possible. The Service Plan also includes goals which pertain to what needs to happen in order to obtain the identified family vision, as well as measurable objectives for each identified goal so that progress can be measured and assessed throughout the process. Therefore, the effectiveness of the services and supports can be evaluated over time, as well as revised as needs change, as progress is made, or if they are ineffective.

When the family has multi-agency involvement, every effort is made to collectively develop a single, unified plan that addresses the needs and mandates of all the parties involved. If a parent and/or other family member has needs that pertain to the child's goals, these needs can be incorporated into the goals and measurable objectives on the Service Plan. In instances when a parent and/or family member may have individualized needs, the CFT facilitator provides information on available resources.

The assessment, SNCD and Service Plan development are ongoing based on the changing needs of the child and family; this results in plans that are continually updated to obtain desired outcomes. At a minimum, the assessment and Service Plan are updated on an annual basis as referenced in AMPM Policy 320-O. When changes in the provision of services (e.g. frequency, duration, provider agencies) or changes in identified needs occur, the Service Plan is updated.

ACTIVITY 6 - ONGOING CRISIS PLANNING

CFT practice includes ongoing assessment and planning for crisis situations. The decision of whether or not a crisis plan is needed is made by the CFT based on the assessment of the child's and family's needs. A crisis plan is required for children, youth, and young adults under the age of 21 with complex needs who are receiving services through the children's behavioral health system as indicated by an individualized assessment (see Background Section) and/or a CASII score of four and higher for children age six to 18.

If potential crisis situations are identified, the CFT members then develop a plan to prevent these potential crisis situations from occurring, as well as an approach for responding most effectively if one of these situations occurs. Crisis planning includes recognizing when a situation is escalating and how to best defuse the situation or obtain assistance to prevent further escalation. Services such as mobile crisis teams and urgent

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care centers, as well as police intervention, are utilized as a final intervention when the situation surpasses the ability of the CFT to maintain the child's and family's safety.

As illustrated in Figure 2, crisis planning is composed of:

Predict: What is the worst thing that could happen or what is most likely to go wrong, that would divert the CFT from successfully implementing the Service Plan?

1. Anticipates crises based on knowledge of past behavior as an indicator of future behavior
2. Researches past crises to identify for each situation: the preceding behaviors and behavioral responses/consequences.

Functional Assessment: What events, behaviors or behavioral sequences are associated with the initial, middle and ending phases of the actual crisis?

1. Identifies the specific triggers of a crisis situation.
2. Describes what happens when the crisis occurs.
3. Identifies the consequences of the crisis.
4. Identifies what works to calm the child when he/she is in crisis.
5. Identifies the best people to intervene and their response actions.

Prevent: What can be changed or added to the daily routine to prevent the crisis?

Encompasses the bulk of the plan by identifying the options, drawn primarily from the child's and family's strengths and community supports, which can be used to mitigate the triggers, events or behaviors associated with the crisis situation.

Plan: What are the effective or ineffective interventions? What are the steps to be initiated based on the severity level of the crisis?

1. Anticipates a 24-hour crisis response.
2. Triages the intensity of response actions to align with the severity level of the crisis situation.
3. Clearly defines roles of the CFT members, including family members and other natural supports.
4. Includes specific names, agency represented (if applicable), and phone numbers.
5. Contains clear behavioral benchmarks.
6. Evaluates the management of the crisis and effectiveness of the plan once the crisis has stabilized.
   a. Utilizes input from the child and family.
   b. Information obtained from evaluation is utilized to update the plan.

FIGURE 2

A specific type of crisis plan, sometimes called a safety plan, may be required when there is an immediate concern regarding the safety of others or when there is evidence of prior unsafe behavior toward others that threatens the child's ability to remain or return to living in his/her community. This type of planning identifies interventions to be implemented and the persons responsible for each intervention when the unwanted behavior is attempted or occurs. This type of planning:

1. Clearly describes the situation,
2. Clarifies the goals,
3. Defines inappropriate and appropriate behaviors,
4. Establishes family and community rules,
5. Is proactive about educating siblings and others,
6. Plans for community safety,
7. Plans for the 24 hour day,
8. Has a back-up plan,
9. Creates a plan for negative community reactions, and
10. Supports and builds the family through teaching healthy alternatives through the CFT practice.

ACTIVITY 7 – SERVICE PLAN IMPLEMENTATION

Based on the decisions of the CFT, the behavioral health provider and/or case manager is responsible for overseeing and facilitating the implementation of the Service Plan. Effective implementation includes the provision of covered behavioral health services within an appropriate timeframe (see ACOM Policy 417). For example, when a child needs to be evaluated by a BHMP as indicated in the Service Plan, the child is scheduled for an appointment within a timeframe that ensures:
1. The child does not run out of any needed psychotropic medications; or

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2. The child is evaluated for the need to start medications so that the child does not experience a decline in his/her behavioral health condition.

Specific services on the Service Plan may require prior authorization (See AMPM Policy 1110). Services requiring prior authorization include:

1. Non-emergency admission to and continued stay in a Behavioral Health Inpatient Facility (BHIF),
2. Admission to and continued stay in a Behavioral Health Residential Facility (BHRF),
3. Admission to and continued stay in treatment for Home Care Training to Home Care Client (HCTC) services,
4. Non-emergency services outside the geographic service area of the Contractor.

Other than services from agencies, Service Plan may include interventions provided by the child's/family's natural supports or participation in activities within their community. For example, an intervention may outline specific ways of interacting with the child to reinforce a particular behavior or the child's involvement with a community arts or sports program to support his/her social skills development with peers.

Some services or interventions may require the completion of specific tasks by assigned CFT members in order to support the implementation of the Service Plan. Between meetings, CFT members make reasonable efforts to carry out their assigned tasks within the agreed upon timeframes. If barriers arise and a task cannot be completed or a service cannot be provided, the CFT member contacts the CFT facilitator to brainstorm solutions. If unsuccessful in addressing these barriers, the CFT facilitator explores options for resolution with the team, supervisors, or other resources. When an activity, support or service cannot be secured in a timely manner, even with such assistance, or the barrier is a system's issue, the behavioral health provider elevates the issue within the children's behavioral health system for additional assistance and resolution.

Coaching Facilitators of Child and Family Team Practice

As part of their training, CFT Facilitators are provided coaching from individuals who have achieved a high level of expertise regarding the facilitation of Child and Family Team Practice. These individuals may have various job titles (CFT Coach, Team Coach, Provider Mentor, Supervisor, etc.) but they each perform the same role when it comes to coaching. After an employee completes the initial required CFT training, the Coach/Supervisor works with that individual to make sure they are competent facilitators of CFT practice. This work may entail shadowing, modeling, observation, group coaching, one on one debriefing, and other methods aimed at supporting the facilitator's growth and development. In addition to the initial coaching to achieve competency, the coaches are available to support and guide experienced facilitators when they encounter situations where they may request or require additional assistance.

ACTIVITY 8 - TRACKING AND ADAPTING

During subsequent meetings, the CFT evaluates the effectiveness of the Service Plan; this includes celebrating successes and addressing crises, challenges and/or barriers. CFT activities are documented and the Service Plan is updated and modified to reflect positive changes or when progress has not occurred. The frequencies of ongoing meetings are individualized and scheduled based on the child's and family's needs, level of progress, and/or the Service Plan's target dates.

Between meetings, the behavioral health provider continues to engage the child, family and other team members to determine if:
1. Services being implemented are achieving expected results, and
2. Tasks are being completed. The CFT is responsible for tracking and monitoring outcomes related to goals/objectives in the Service Plan. A lack of progress towards meeting the goals and/or objectives can indicate that certain strategies or interventions need to be reevaluated. The behavioral health provider assists the CFT in refining existing strategies or developing new interventions. As indicated in Activity 6, Ongoing Crisis Planning, the CFT also tracks the effectiveness of crisis planning interventions and implements modifications when needed.

   In summary, tracking and adapting for all children and families includes:
   a. Tracking progress and outcomes, keeping the child's and family's vision of the future in mind,
   b. Adapting the Service Plan as necessary to address barriers, lack of progress, or new situations,
   c. Monitoring timelines for activities,
   d. Anticipating and addressing transitions,
   e. Reviewing and updating the CASII every six months, and
   f. Tracking task assignments and their completion.

ACTIVITY 9 – TRANSITION

Child and Family Teams develop plans that support the child and family to maintain positive outcomes throughout periods of transition. Examples of potential types of transitions are illustrated in Figure 3.

FIGURE 3

CHANGE IN LIVING ENVIRONMENT | CHANGE IN RELATIONSHIPS | CHANGE IN SCHOOL SETTING | CHANGE IN INTENSITY OF SERVICES

TRANSITIONING TO ADULT BEHAVIORAL HEALTH SYSTEM | SUCCESSFUL COMPLETION OF GOALS AND DISCONTINUATION OF BEHAVIORAL HEALTH SERVICES | OTHER TRANSITIONS

B. CHANGE IN LIVING ENVIRONMENT, RELATIONSHIPS OR SCHOOL SETTING

For children and teenagers, moving to new neighborhoods, leaving friends, and changing schools or even just changing grade level can be very stressful and cause great anxiety. These transitions, especially when a youth has existing behavioral health issues, may result in increased academic problems, social/emotional difficulties, isolation, lower motivation, and decreased school attendance. There are numerous resources available for the family and CFT to help them prepare for these common transitions, including Helping Your Child with Transitions and Successful Transitions for High Conflict Families.

C. CHANGE IN INTENSITY OF SERVICES

Transitions between various levels of service intensity can be extremely challenging for youth and their families or caregivers. This is especially true when the young person is moving from high intensity services to less intense services. An extreme example of this would be when a youth returns to their family after a period of treatment in an out-of-home facility (see Child Out of Home Services Practice Tool) but less extreme examples, such as reducing the amount of contact a child has with their therapist, case manager, or direct service provider can also be stressful. Paradoxically, these reductions in intensity are generally a function of the child and/or family making progress towards their treatment goals but it is important for the team to recognize the potential for regression during these periods and plan accordingly.

D. TRANSITIONING TO ADULT BEHAVIORAL HEALTH SYSTEM

Planning for transition into the adult behavioral health system must begin for any child involved in behavioral health care when the child reaches the age of 16 (see Transition to Adulthood Practice Tool). However, if the CFT determines that planning should begin

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prior to the youth's 16th birthday, the team may proceed with transition planning earlier (e.g., as young as age 14) to allow more time for the youth to acquire the necessary life skills, while the team identifies the supports that will be needed. A request to determine eligibility as a person with a Serious Mental Illness (SMI) can occur at age 17 (for eligibility criteria, refer to AMPM Policy 320-P, Serious Mental Illness Eligibility Determination). The young adult, in conjunction with other involved family members, caregivers or guardian, may, in many cases, request to retain his/her current CFT until the youth turns 21. If the CFT is not retained when the youth turns 18, an Adult Recovery Team (ART) is created to support the individual. ART membership may change based on the needs of the young adult as they mature out of the children's system. If a new provider will be involved with the young adult who is transitioning to the adult behavioral health system, key professionals from the adult service system are invited to join the CFT in order to facilitate a smooth transition and support the continuity of team practice.

For additional information related to transition, planning that will assist youth in acquiring the skills necessary for self-sufficiency and independence in adulthood refer to Transition to Adulthood Practice Tool. For resources related to transition planning refer to Transition to Adulthood Resources.

E. **SUCCESSFUL COMPLETION OF GOALS AND DISCONTINUATION OF BEHAVIORAL HEALTH SERVICES**

One goal of service planning that involves transition is building independence. Youth and families who have assumed some or all responsibility for facilitating their CFTs and are close to successful completion of their goals may be approaching readiness to transition out of the behavioral health service system. Advocates or mentors can provide additional natural support during times of transition. If needed, a plan outlining the specific steps necessary to reconvene the CFT and the re-establishment of behavioral health services and supports is completed by the CFT prior to any child's/youth's disenrollment. Indicators that show a family may no longer need the support of the behavioral health system may include:

   a. The presence of a high percentage of CFT members who are from the family's own informal support system,
   b. The family notes they no longer need the same level of assistance,
   c. The majority of their supports and services are from resources within their own family and community rather than paid and professional services,
   d. Frequency of meetings have decreased,
   e. There are no longer major safety or crisis concerns, and/or
   f. Successful completion of the child's and family's goals.

F. **OTHER TRANSITIONS**

When a youth is adjudicated and sentenced to the Arizona Department of Juvenile Corrections (ADJC) they are ineligible for services through our public behavioral health system while in the juvenile facility. This transition requires careful planning to ensure

information is shared with ADJC regarding the youths mental health needs including any medications the youth may be prescribed. Likewise, when the youth returns to the community, transition planning is crucial in order to enhance the individual's chances of success by providing strong support of the behavioral health system. Another significant transition is a child entering or leaving the custody of DCS. For children removed from their family, the planning needs are more obvious but it is also important to understand that a child leaving DCS custody, in and of itself, is not a reason to end collaborative practice through the CFT. Often times, the end of involvement from DCS can mean that a child and family need more support from the CFT in order to maintain successful outcomes. One transition which commonly occurs due to the way Arizona structures the delivery of behavioral health services, is when a youth moves from one geographic region to another (see). Again, this type of transition requires careful planning by the CFT in order to maintain necessary behavioral health services.

For additional information related to transition, planning that will assist youth in acquiring the skills necessary for self-sufficiency and independence in adulthood refer to Transition to Adulthood Practice Tool. For resources related to transition planning refer to Transition to Adulthood Resources.

G. TRAINING AND SUPERVISION EXPECTATIONS

Contractors shall establish their own process for ensuring that all clinical and support service agencies' staff working with children and adolescents implements the practice elements as outlined in this document. Staff will be trained on the elements of this Practice Tool within 90 days of their hire date as outlined in AMPM Policy 1060.

Behavioral health staff must also participate in AHCCCS designated CASII training, education, and technical assistance. This six to eight hour training must be completed prior to the administration of the CASII. Only persons who have attended a two-day training containing a "teach back" method are authorized to train the CASII through the American Academy of Child and Adolescent Psychiatry (AACAP). These "master trainers" can then train other staff on the use and implementation of the CASII, as well as train new trainers by having them participate in two, one-day training sessions that include a "teach back" component.

Contractors are required to provide documentation, upon request from AHCCCS, demonstrating that all required network and provider staff have been trained on the practice elements in this Practice Tool. Whenever this Practice Tool is updated or revised, Contractors must ensure their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes. The supervision for implementation of this Practice Tool is to be incorporated into other supervision processes which Contractors and their subcontracted network and provider agencies have in place for direct care clinical staff.

H. ANTICIPATED OUTCOMES
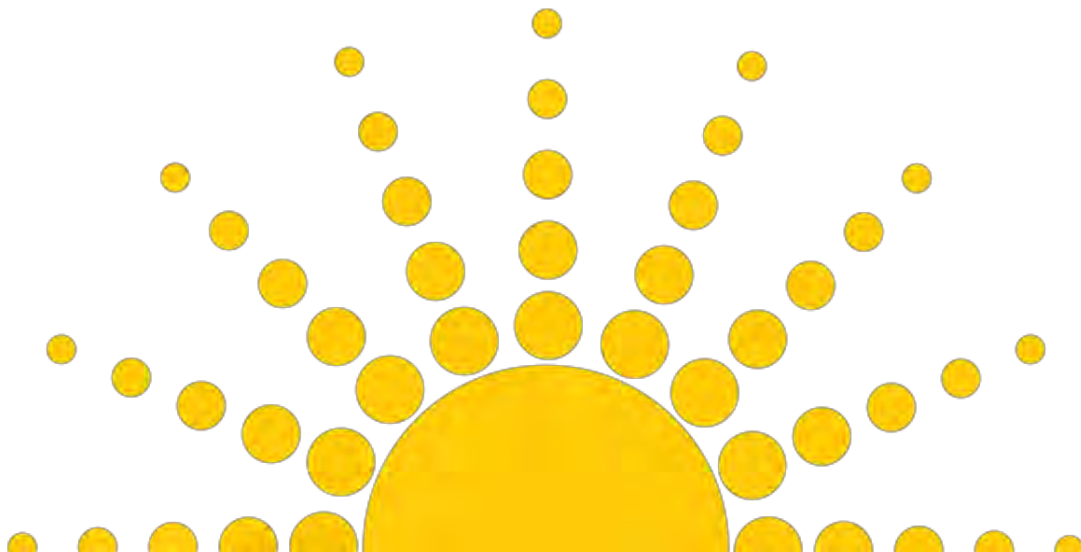
Anticipated outcomes include:

1. Increased statewide practice in accordance with the 12 Principles for Children's Service Delivery,
2. Improved functional outcomes for children,
3. Improved engagement and collaboration in service planning between children, families, community providers and other child serving agencies,
4. Improved identification and incorporation of strengths and cultural preferences into planning processes, and
5. Coordinated planning for seamless transitions.

FAMILY AND YOUTH INVOLVEMENT IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM

Effective Date: 10/01/16

I. **GOAL (WHAT DO WE WANT TO ACHIEVE THROUGH THE USE OF THIS PRACTICE TOOL?)**

1. To define quality family involvement as a necessary and effective component to the AHCCCS System of Care.

2. To define roles that are uniquely intended for parents/caregivers of children receiving services; youth and young adults who receive or have received services.

3. To describe the roles that family-run organizations play in optimizing family involvement and roles for parents/caregivers, youth and young adults who receive or have received services.

4. To set the expectation for culturally and linguistically responsive practice.

5. To present a wide array of family involvement opportunities.

6. To prepare and enable the AHCCCS System of Care to build and sustain the infrastructure and culture to support and involve family members at all levels of the system.

II. **BACKGROUND**

Arizona holds a distinction in the United States for promoting various family roles in relation to the AHCCCS System of Care. The involvement of families is credited as making a significant contribution in improving the service system. This Practice Tool presents a review of the various roles that families may and do play within the AHCCCS System of Care.

This Practice Tool is organized around three roles for families:

1. First, families are encouraged and supported to participate as active and respected members of their child's Child and Family Team (CFT). In that capacity, families influence the development and implementation of a Service Plan that will respond to the unique strengths and needs of the child and family.

2. Second, families participate in various activities that influence the local, regional and state service system. This type of activity is commonly called "Family Involvement". Family members have first-hand experience and are able provide a unique perspective and insight. In addition, in Arizona family members have representation on boards, advisory committees and policymaking groups, and are partners in the development and implementation of programs and policy to improve the AHCCCS System of Care.

3. Third, family members may work in a professional capacity in the AHCCCS System of Care. In this capacity, family members offer a special type of support (peer-

delivered) to the families and children that they serve. Further, families who work in the system may also influence the service system in which they are a part by contributing the family perspective to the service environment.

Refer also to Attachment A, Family and Youth Involvement in Children's Behavioral Health System Desktop Guide.

A. RECOMMENDED PROCESS/PROCEDURES

This Practice Tool discusses how families can be supported successfully in their assumption of the general roles listed above. The following is a more detailed listing of roles for families in the Children's AHCCCS System of Care:

1. Family Participation in Service Planning:
   a. In accordance with the Arizona Vision and 12 Principles as outlined in AMPM Policy 430, the first Principle, Collaboration with the Child and Family is the foundation for the mandate that all children served by the Children's AHCCCS System of Care have a CFT. Through the team process, parents/caregivers and youth are treated as full partners in the planning, delivery and evaluation of services. The team process is most effective when the family is welcomed (access), empowered to have a strong voice (voice) and has a thorough sense of commitment to the plan that they have created (ownership). Even though this participation is only on an individual basis, it is an example of family involvement, which brings about quality service for the child and family. Effective CFTs have a broader system impact by serving as an example for other CFTs.
   b. Through the CFT process with respect to service planning, families must be able to access services tailored to their unique needs and circumstances based on the families' individual culture which goes beyond race and ethnicity. They should not be expected to fit their needs into a list of categorical services. Special care and attention needs to be paid to the families' readiness to receive potential services being offered, and should be explored before putting services and supports in place.
   c. The CFT must honor and give careful consideration and weight to the family's preference to end one service and/or request another. Families should feel free to express their concerns without consequences.

2. Challenges or considerations for this family role: Historically in AHCCCS System of Care, the implementation of the first of the 12 Principles, collaboration with the child and family, has often not been as full and complete as desired. Even now, while recognizing the benefits of this collaboration, our system sometimes struggles as professionals learn to embrace this approach. This is for a variety of reasons:
   a. Staff members, including supervisors and leadership, may vary in their understanding of what constitutes true collaboration between professionals and families. Although a basic tenant for the AHCCCS System of Care, this Principle is not taught consistently in educational settings for behavioral health staff receiving professional training. Where there is not consistent understanding to the

principle of partnership with the parent and child, the experience of the parent, child and team can suffer,

b. Families vary in their capacity to know what they need and to communicate these needs effectively. This can happen for a variety of reasons. The youth's challenges can be complex and the family situation can also be complex. In addition, the environment the family comes from (family, community, work situation, school, etc.) can create an unfair burden of guilt and self-blame, which can lead parents/caregivers, children and youth to feel that many of their challenges are their "fault". When the family feels the challenges are their fault, they have a harder time asking for resources to assist with these challenges,

c. When they encounter individuals within the AHCCCS System of Care who do not appear to embrace this Principle, families may not know where to go to express their concerns or may be uncomfortable expressing their concerns,

d. Some CFTs include a Family Support Partner (FSP)/Parent Partner (PP) (see below) who can assist the parent with their participation. Although some families are very capable to express their perspectives, others cannot. When this is the case, some type of adjustment in the CFT process, either through staffing or through the role of the facilitator, is needed, and

e. When individuals do not recognize the value of family-professional partnerships, including paying particular attention to shared power in the relationship, joint decision making, problem solving and mutual accountability.

3. Family Involvement in Local, Regional and State Systems
   a. Family involvement opportunities should be available throughout the AHCCCS System of Care. Family leaders will represent the family perspective as participants in system transformation activities, including but not limited to:
      i. Policy and program advisory committees,
      ii. Trainings for families and professionals,
      iii. System monitoring,
      iv. Leading focus groups, conducting satisfaction interviews and other new initiatives related to family involvement and family support,
      v. Identifying, developing and supporting, coaching and mentoring emerging and existing family leaders,
      vi. Distributing information about resources to families.
   b. Generally, family member roles are within formal structures reflected in procedures and policies. They are formalized in documents such as contracts or agreements within in the service system, (articles of incorporation, by-laws, founding documents, Memorandums of Understanding, etc. These elements assure family involvement continues even when there are disagreements in perspectives. An important element is that the structures created for family involvement reflect a value placed on the family perspective; which include:
      i. A range of persons who are engaged in Family Involvement activities (parents, caregivers, extended families, siblings and youth, and other natural supports).
      ii. A budget for family involvement is clearly identified. For example, family members are compensated for their time and travel, there are funds dedicated

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to the training and support of family members who participate in various family involvement activities, etc.

    iii. Opportunities are in a form that indicate that the organization values family involvement (participants are provided information about the topic, meetings are in-person, family input is incorporated in final decisions, meeting times and places agreed upon by families).

    iv. There are multiple venues for family involvement. For example, families may advise on or deliver a training program; they may participate in a quality management review body; and they may participate in a children's services policymaking group).

c. When there are multiple opportunities for family involvement, there is greater expectation that the family perspective will be heard and reflected in the operation of the organization.

d. Challenges or considerations for this family role: Family Involvement calls for real change in the way organizations and the system functions. It means power is genuinely shared with family members. For genuine family involvement to occur:

    i. Decision making needs to be shared with families.

    ii. Organizations need to be able to partner with families and have an open line of communication with them. This may simply mean that systemic jargon is discarded and the issues are discussed in everyday language.

    iii. There are sometimes costs associated with the involvement of family members within the above scope. These can include such things as time, travel and preparation. While compensation paid to a family member when performing these role(s) is not mandatory, it can often be beneficial especially when all parties at the table are compensated.

    iv. Problem solving and negotiation for a solution shall be part of the process.

e. Families requiring assistance often need training on the following, including but not limited to:

    i. The terms used in the work,

    ii. How to read financial statements or quality management reports,

    iii. Background on policies or programs, and

    iv. Organizational structure and decision making process.

f. Family-Run Organizations are often a resource to families to train and support them in these roles. In order for families to be truly independent and significant contributors to the system, they need to have a safe and supportive place where they can receive assistance in carrying out this role. In addition, families are strengthened in their Family Involvement role when they can connect with other family members to interact and exchange views. Family-Run Organizations are a place where this can happen.

4. Family Work Roles in the Children's AHCCCS System of Care

The AHCCCS System of Care offers many opportunities for parents/caregivers, youth and young adults to participate at all levels as family and system resources. As stated above, the AHCCCS System of Care has been enriched through the array of contributions that family members have made in their work within the system. Some

roles for family members involve full-time or part-time employment, while others may offer stipends for participation. Flexibility and sensitivity are essential in determining how to best compensate the family member for their contribution.

The following is a brief list describing the functions or roles:

FSP/PP - This is a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance use concerns. The FSP/PP will assist the parent/caregiver of a child, who is receiving services, to identify needs and communicate those needs to the team so that the family's perspective is well represented in the child's Service Plan. Part of this role may be to exercise non-adversarial advocacy to assure that the family's needs are addressed in planning. On behalf of the family, the unique role of the FSP/PP may involve assisting the family in sharing their perspective to meet their needs that are addressed in the plan. The FSP/PP will further assist the family to assure that the plan is implemented and progress is made. Finally, the FSP/PP will assist the family to achieve self-efficacy resulting in decreased reliance on the formal system.

Youth Partner - This is a young adult who has received services in the AHCCCS System of Care. The Youth Partner provides support and services to youth who are receiving services from the system. This role is used primarily for work with older teens who are transitioning to the adult AHCCCS System of Care.

Greeter (Connector) - This is a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance use needs. This person's role is to welcome a new family during the time of intake to the AHCCCS System of Care. Since this can often be an intimidating time, the Greeter can offer support and information to the family by telephone or in person to give reassurance during this difficult time. Another supportive resource for families is other parents/caregivers who also have a child receiving behavioral health services. Often this connection is made through parent support groups. The Greeter can help the parent to become involved in such a group.

Navigator - This is a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance abuse needs. The Navigator is sometimes called an advocate and often works through telephonic support. This person assists the parent/caregiver in working their way through various child serving systems including behavioral health, Child Protective Services, Juvenile Justice or the school system. This person's knowledge of the child serving system and relationships can be a resource to help the parent of the child receiving services to understand the expectations of the applicable system. This knowledge can often be a resource for families to obtain answers or services in areas beyond behavioral health.

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Telephone Support - This is a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance abuse needs. Families in the AHCCCS System of Care often need advice or direction in the many challenges they face. Through telephone support, families can often get the help they need. This support may vary including:

a. Coaching on how to make an initial contact to obtain behavioral health services
b. Provision of information about a behavioral health diagnosis
c. Provision of information about benefits or resources for treatment or medication
d. Information about special education or other school issues

Family Interviewer - This is a family member having had at least one year of experience with the Child and Family Team process. With the implementation of the Practice Improvement Reviews in the AHCCCS System of Care, there are now opportunities for parents/caregivers to be employed to conduct interviews. The parent perspective is a valuable asset to this role. It is a good example of how parents/caregivers add value to the system.

Family Trainer - This is a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance abuse needs. The Family Trainer provides training to staff and to parents/caregivers on various behavioral health topics. There are numerous topics in the AHCCCS System of Care where parents/caregivers or youth can offer a fresh and rich perspective on the topics. Example topics include: Child and Family Teams, Direct Support Services, and various parent work roles such as Family Support Partner and Parent Partner.

Community and Family Integration Coordinator/Consultant - This is a family member who promotes family access, voice and choice at all levels of the system. This individual creates opportunities for youth and families to partner with professionals, welcomes and engages families, and encourages their partnership in the sharing of ideas and connection to community resources. In addition, the Community and Family Integration Coordinator/Consultant collaborate with local family-run organizations to promote family voice, family-driven care and family involvement at the local, state and national levels.

Family Members/Youth/Young Adults Serving on Task Forces, Committee Groups, Etc.- These family/youth members bring a unique perspective and out-of-the-box thinking, along with their personal life expertise, to the decision-making process in conjunction with professionals who bring their technical expertise to the table. The collaboration and interaction within this group create an authentic family-professional partnership in which both are treated as equals and collaboratively bring an enriched understanding of the needs of families as well as establishing meaningful family involvement.

NOTE: In smaller providers, these parent roles may be combined and assumed by one person. In larger providers, there may be much more specialization.

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These roles are described to give an impression of the types of functions family members can play. This is not meant to imply that each role must be assumed by a separate individual.

5. Parent/Caregiver/Youth/Young Adult Delivered Support or Service Considerations for family members working within the system*

As noted in the section above, there are many roles for families within the system. Not all of them are direct support roles, as delineated in the Family Involvement section of this Practice Tool, but those that are direct support have common characteristics. Please note for the purposes of this section, this role will be called Parent/Youth Partner.

As direct support staff Family Support Partners/Parent Partners and Youth Partners share the following characteristics.
a. Provide direct person to person work with family members or youth receiving services. This is a range of roles/functions including; providing support, helping people learn new skills, accessing resources and providing family education.
b. Using personal experience to enhance the relationship: Parent/Youth partners have to be prepared to share their personal story or experiences when appropriate. Extension of self is one way that peer support roles differ fundamentally from other supportive system roles. Training will be readily available to Parent/Youth Partners to validate the optimal way to offer their experience as a resource.
c. Collaborative model of problem solving: There is no expert in a parent-to-parent support role. The decision making model is a shared model in which the peer parent and the family jointly make decisions that blend the information the Partner brings to the table with the family's expertise on their own situation,
d. Shared first-person system experience: Parent/Youth Partners have first-person system experience and are able to share, compare and connect with the experience of the family as they are going through the system,
e. Support to hold a different perspective: Parent/Youth Partners bring a different perspective to the way services and systems operate. Effective Parent/Youth Partners are sustained by an organizational commitment that demonstrates the ability to appreciate different perspectives. In other words, family members can hold different opinions.

Parent/Youth Partners can flourish when the provider demonstrates coherence with the role and unique perspective of that position. This means that the organization, in addition to demonstrating a commitment to family involvement, also demonstrates the organizational capacity to support the uniqueness of this role administratively and programmatically. Examples of this include:
a. Administrative Supports: Ability to recruit parents/caregivers and young adults who have first-person experience as well as providing orientation, necessary tools etc. Other administrative supports may include:
   i. Ability to connect with others who have first-person experience: Persons in these roles benefit from an ability to network with others, both inside and

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outside their organization, in similar circumstances. Organizations employing Parent/Youth Partners should build the capacity for these connections to happen.

ii. Promotes choice for advancement: Parent/Youth Partner roles shall have opportunities to advance while not giving up their ability to contribute their unique perspective in their work. This means that in order to get promoted the worker should not have to change job roles (such as moving into a case management role) but is able to move ahead while staying in a family/youth partner role. On the other hand, if the employee desires moving into other types of roles the organization should create solid career paths for that to happen.

iii. Values Personal Experience: The organization shall demonstrate an organizational commitment to the personal experience of family members. This means that salary scales are based on more than formal training but also have the capacity to take into account first-person experience in setting salary ranges.

iv. Accommodations for Personal Experience: The organization shall demonstrate a commitment to the personal experience of parents, grandparents, caregivers and young adults employed in these roles by offering flexible schedules, unique employee assistance options for people in the Parent/Youth Partner roles, flexible family leave policies and, in the case of families with youth/children in the system, flexibility for sons/daughters to be welcomed into the workplace.

b. Programmatic Supports: Supports in this category reflect the willingness to blend perspectives and to value first-person experience along with formal training. These may include:

i. Appreciative Capacity of Supervisor: Supervisor shall be able to demonstrate a sincere and authentic strength based appreciation of the Parent/Youth Partner. The supervisor must support growth and development of each Parent/Youth Partner to help them realize their professional goals. Often the most successful supervisors of Parent/Youth Partners are those who are also a parent/caregiver of a youth who is receiving or has received services in the AHCCCS System of Care.

ii. Strong commitment to protect the integrity of the role: Organizational supervision, management and leadership shall demonstrate a commitment to preserve the integrity of the role and the unique perspective brought by first person experience.

iii. Ongoing commitment to assuring equal status: Those who come into paid roles within the formal system may run the risk of being seen as secondary players. The provider should demonstrate the ability to insure this position is as valued as those positions that represent formal training versus personal experience.

iv. Meaningful and Independent Roles: Programmatically, these positions are involved in providing direct support to a parent/caregiver or youth which may include education, resource access and development, non-adversarial advocacy or skills development delivered in a group, individual or family setting. The provider will demonstrate the ability to allow these roles to play a meaningful role with families.

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B. FAMILY-RUN ORGANIZATIONS

For decades Family-Run Organizations have offered parents/caregivers of children with behavioral health challenges a range of services and supports. Inherent in the identity of Family-Run Organizations is the natural ability and necessary environment to link families with individuals in their communities who share similar experiences in their life's journey. Without these peer connections to other families, stigma may create isolation, self-blame and other unneeded barriers that prevent families from reaching out and connecting with available supports and services. The growth of the family's natural support network is an important means for achieving higher levels of community integration and decreasing reliance on formal services. An important benefit of this informal family-driven network of support is the opportunity to build sincere, authentic lifetime connections.

In Family-Run Organizations, parent/youth support happens in a variety of ways and through a variety of strategies. It is recommended that each family be connected with a Family-Run Organization as soon as they are enrolled, to receive informal support and to learn how to access the type of support that is meaningful for them; for instance, some families experience healing through connection with other families in a support group format. Other families find resiliency, recovery, and balance through connection with an individual who has a similar story to tell. Some discover their own capacity for resilience in fellowship with others in a social or training setting, or may need one-on-one support to achieve a specific outcome as identified by the Child and Family Team within the context of individual cultural environments and needs.

Family-Run Organizations are seen as "safe places" in the community for parents and youth to process/discuss their challenges and to seek solutions through services or through systems change. It is a place where families learn how the behavioral health and other child-serving systems work; how they can articulate the issues that concern them, and parents and youth who participate in committees or boards are able to obtain on-going support to continue and grow in this role.

Family-Run Organizations provide a leadership role in, not only building family support and involvement, but in system development or transformation at all levels. Through leadership and technical assistance activities on systems transformation, Family-Run Organizations assist in developing and connecting the "authentic" family voice to shape sustainable systems transformation. This technical support and leadership is instrumental in the family-professional partnerships throughout the systems. By building a mutual partnership, which is characterized by interdependence and cooperation, family members and behavioral health professionals are able to improve service, the quality of opportunities available, and change the values and attitudes of society toward children with emotional, behavioral and mental disorders. Family Run Executive Director Leadership Association (FREDLA) serves as the national representative and advocate for family-run organizations. FREDLA acts as the Family Engagement Hub for the Network, providing resources, training, and technical assistance to federally funded System of Care communities/states and non-funded communities/states.

National research indicates there are nine key components and characteristics of effective and sustainable family-run organizations. These are described by the Research and Training Center for Children's Mental Health at the University of Southern Florida as follows:

1. **Values** – The value of family partnership is evident, with families and youth involved in all aspects of the system in a variety of capacities, including setting policies, developing programs, delivering services, providing training and technical assistance to enhance/expand family partnerships across the AHCCCS System of Care.

2. **Leadership Development** – Family-Run Organizations recruit, engage, and nurture diverse family leaders and nurture their development as a leader to interface effectively with the AHCCCS System of Care in a variety of capacities

3. **Partnerships** – Families and youth are encouraged, supported and paid to participate in all operations of the AHCCCS System of Care, including setting policies, developing programs, delivering services, providing training and technical assistance and assessing the impact of AHCCCS System of Care on children, youth and families served, agencies and systems and the community.

4. **Access and Referrals** – Family-Run Organizations are adequately funded and supported to develop and sustain a diverse group of families who collectively and effectively are the "family voice" in shaping their community's response to children with mental health needs and their families. In order to accomplish this goal, Family-Run Organizations must make themselves accessible to all families.

5. **Meeting Family Needs** – The primary role and responsibility is to meet the needs of families. They do so by helping families in a peer support role to access services, by addressing requests of all families about their systems of care community, by helping families have direct connections to mental health providers and other child serving agencies; and by helping develop skills and knowledge of families in changing policy.

6. **Productive Working Relationships** – Family-Run Organizations have productive working relationships with state and local agencies and with providers in order to strengthen policy commitment and service delivery to children with mental health needs.

7. **Sustainability and Growth** – Mechanisms are in place to sustain a Family-Run Organization. Funding and in-kind support from multiple and varied sources are important to the sustainability of these organizations.

8. **Youth Involvement** – The development of youth leadership opportunities and organizations. Youth are encouraged and supported to participate in all operations of the AHCCCS System of Care, including setting policies, developing programs, delivering services, and assessing the impact of the AHCCCS System of Care on children, youth, and families served.

9. **Organizational Progress Chart** – This is a tool to guide the growth and progress of the Family-Run Organization to review the challenges/barriers at the various levels of development.

Throughout the country, Family-Run Organizations provide an important function in systems development by supporting, mentoring and connecting parents and youth to become spokespersons and leaders.

Through the Family-Run Organizations, parents and youth receive education and training about the organization and availability of services, funding, data collection, quality improvement initiatives, and policy or legal considerations that affect how families and youth with behavioral health needs are served. Family members serving in these roles are increasingly recognized as valued and necessary partners in working with leadership at all levels to bring positive change to the AHCCCS System of Care. Similarly, the Family-run Organizations are providing increased technical assistance and leadership on family support, family involvement and systems transformation topics at the local, state and national levels.

1. How families grow in their capacity to become involved or to be a service provider:

   Parents/Caregivers who are raising a child with behavioral health challenges often travel a journey of personal growth and change. At points along this journey, parents/caregivers may feel ready to take advantage of opportunities to become involved in the AHCCCS System of Care through participation in family involvement activities or through employment in the AHCCCS System of Care. Keys for Networking, a Family-Run Organization in Kansas, developed a 10 step tracking system measuring each parent's growth as they are supported and face new challenges with their child. This system illustrates how parents/caregivers grow, change and become candidates for family involvement or family employment opportunities. It also illustrates the role a Family-Run Organization plays in helping each parent along this journey.

   The following is a list of the ten steps associated with the process:

   Step 1: Seeks Information,
   Step 2: Initiates additional contact,
   Step 3: Commits to address problem,
   Step 4: Works on the problem,
   Step 5: Resolves initial problem/feels success/accomplishment,
   Step 6: Takes on new problems,
   Step 7: Offers to help others,
   Step 8: Completes training to help others,
   Step 9: Helps others,
   Step 10: Impacts local, state, national policy.

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Parents/caregivers move through these steps at different paces based on differences in their personal and family circumstances. At each step, the Family-Run Organization can offer parents/caregivers opportunities for growth. In addition, the Organization has an obligation to offer support and reassurance at each step as families face each day's challenges. As parents/caregivers grow in their mastery over the struggles they face, they often grow in their motivation to assist and support other parents in their journey. This motivation is a rich potential resource to the Children's AHCCCS System of Care. Great payoff can be gained from these families when they are able to work in a context where they are valued and supported.

2. Capacity Expectations

Because family involvement and family support are critical to systems transformation, the number of Parent Partner and Family Support Partner positions should increase as the system builds capacity. In a fully developed system, additional family roles should be incorporated in the staffing requirements to build and sustain family involvement. Providers should hire a diverse cadre of staff that is reflective of the community they are serving.

3. Anticipated Outcomes

Anticipated outcomes include:
a. To define quality family involvement as a necessary and effective component to AHCCCS System of Care,
b. To define roles that are uniquely intended for parents/caregivers of children receiving services; youth and young adults who receive or have received services.
c. To describe the roles that Family-Run Organizations play in optimizing family involvement and roles for parents/caregivers, youth and young adults who receive or have received services.
d. To set the expectation for culturally and linguistically responsive practice.
e. To present a wide array of family involvement opportunities,
f. To prepare the AHCCCS System of Care to build and sustain the infrastructure and culture to support and involve family members at all levels of the system, and
g. Increased statewide practice in accordance with the Arizona Vision and 12 Principles.

TRANSITION TO ADULTHOOD PRACTICE TOOL

Effective Date: 10/01/16
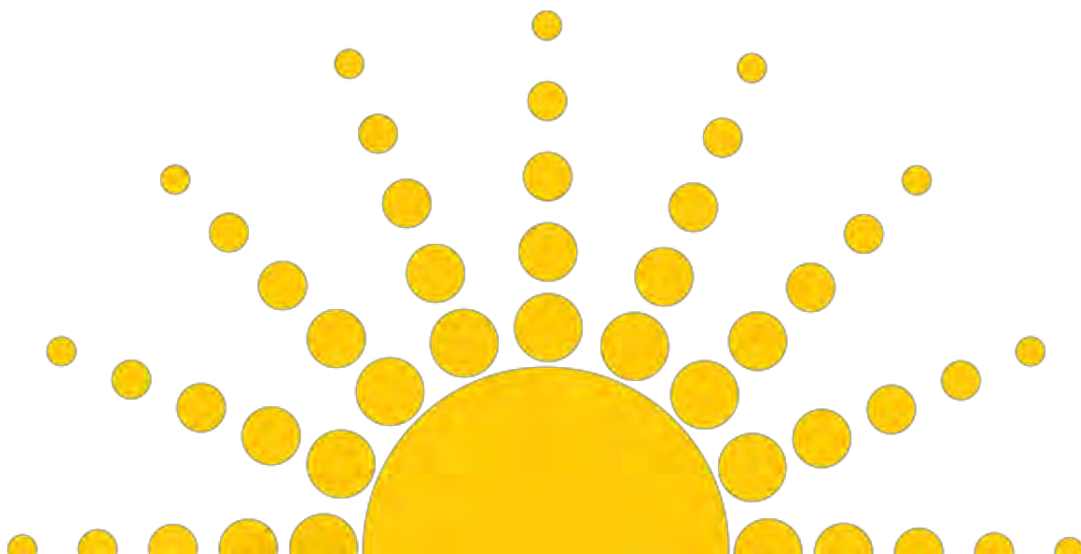
I. GOAL (WHAT DO WE WANT TO ACHIEVE THROUGH THE USE OF THIS PRACTICE TOOL)?

1. To strengthen practice in AHCCCS System of Care and promote continuity of care through collaborative planning by:
   a. Supporting individuals transitioning into early adulthood in ways that reinforce their recovery process,
   b. Ensuring a smooth and seamless transition from the AHCCCS Children System of Care to the AHCCCS Adult System of Care, and
   c. Fostering an understanding that becoming a self-sufficient adult is a process that occurs over time and can extend beyond the age of eighteen.

II. BACKGROUND

The psychological and social development of adolescents transitioning into young adulthood is challenged by the economic, demographic, and cultural shifts that have occurred over several generations. Sociologist researcher, Frank F. Furstenberg, Jr., as Network Chair of the Network on Transitions to Adulthood stated: "Traditionally, early adulthood has been a period when young people acquire the skills they need to get jobs, to start families, and to contribute to their communities. But, because of the changing nature of families, the education system, and the workplace, the process has become more complex. This means that early adulthood has become a difficult period for some young people, especially those who are not going to college and lack the structure that school can provide to facilitate their development."[*] While some individuals adapt well as they transition into the responsibilities of adulthood, others experience challenges such as those youth who have mental health concerns.

In 2002, one study found that about three-fourths of young adults with a diagnosable mental health condition at the age of 26 had first been diagnosed while in their teens.[†] Adolescents with mental health concerns are at a higher risk of dropping out of high school, not finishing college, using drugs or alcohol, having unplanned pregnancies, being unemployed, and are more likely to have a criminal past. Approximately 24 to 39 percent of adolescents with mental health disorders experience at least one of the above noted outcomes compared to 7 to 10 percent of their peers without disorders.[‡] Among 18-25 year olds, the prevalence of serious mental health conditions is high, yet this age group shows the lowest rate of help-seeking behaviors.[§]

As the transition to adulthood has become more challenging, youth with mental health needs struggle to achieve the hallmarks of adulthood such as finishing their education, entering the labor force, establishing an independent household, forming close relationships, and potentially getting married and becoming parents.[**] While these may be considered the trademarks of adulthood from a societal viewpoint, some studies suggest that youth may conceptualize this transition in more "intangible, gradual, psychological, and individualistic terms."[††] Top criteria endorsed by youth as necessary for a person to be considered an adult emphasized features of individualism such as accepting "responsibility for the consequences

of your actions," deciding one's "own beliefs and values independently of parents or other influences," and establishing "a relationship with parents as an equal adult."[‡‡]

Oftentimes, youth who successfully transition to adulthood are those that acquire a set of skills and the maturational level to use these skills effectively. Transition planning can emphasize interpersonal skill training through a cognitive-behavioral approach to help youth develop positive social patterns, assume personal responsibility, learn problem-solving techniques, set goals, and acquire skills across various life domains.[§§]

With transition to adulthood occurring at later ages and over a longer span of time, many young people in their 20's may still require the support of their families. Involving families in the transition planning process and identifying the individual support needs of their children recognizes the diversity that is needed when accessing services and supports. Youth who have been enrolled in government programs due to family hardship, poverty, physical, or mental health challenges are often the least prepared to assume adult responsibilities. For others, such as youth leaving foster care, they must acquire housing without the financial support of a family.[***]

Eligibility for public programs, such as Medicaid, Social Security, and vocational rehabilitation, as well as housing and residential services, may engender planning for changes at the age of 18. Youth who have disabilities that significantly impact their ability to advocate on their own behalf may require a responsible adult to apply for guardianship. Other youth may benefit from a referral to determine eligibility for services as an adult with a Serious Mental Illness (SMI). Thus, it is the responsibility of the behavioral health system to ensure young adults are provided with the supports and services they need to acquire the capacities and skills necessary to navigate through this transitional period to adulthood.

III. PROCEDURES

The purpose of this Practice Tool will be to address the recommended practice for transitioning youth from the AHCCCS Children System of Care to the AHCCCS Adult System of Care with a focus on the activities that will assist youth in acquiring the skills necessary for self-sufficiency and independence in adulthood. Contractors or TRBHAs and their subcontractors are expected to follow the procedures clearly outlined in AMPM Chapter 500, *Care Coordination Requirements,* which require that transition planning begins when the youth reaches the age of 16. However, if the Child and Family Team (CFT) determines that planning should begin prior to the youth's 16th birthday, the team may proceed with transition planning earlier to allow more time for the youth to acquire the necessary life skills, while the team identifies the supports that will be needed. Age 16 is the latest this process should start. For youth who are age 16 and older at the time they enter the AHCCCS System of Care, planning must begin immediately. It is important that members of the CFT look at transition planning as not just a transition into the AHCCCS Adult System of Care, but also as a transition to adulthood.

When the adolescent reaches the age of 17 and the CFT believes that the youth may meet eligibility criteria as an adult designated as having a SMI, the Contractor or TRBHA and their subcontracted providers must ensure the young adult receives an eligibility determination as outlined in AMPM Policy 320-P. If the youth is determined eligible, or likely to be determined eligible for services as a person with a SMI, the adult behavioral health services case manager is then contacted to join the CFT and participate in the transition planning process. After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services case manager to upcoming planning meetings. When more than one Contractor or TRBHA and/or behavioral health service provider is involved, the responsibility for collaboration lies with the provider who is directly responsible for service planning and delivery.

If the young adult is not eligible for services as a person with a SMI, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult general mental health provider. Whenever possible, it is recommended that the young adult and his/her family be given the choice of whether to stay with the children's provider or transition to the adult behavioral health service provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the person's identified behavioral health category assignment (SMI, General Mental Health, Substance Abuse). The children's behavioral health provider should be persistent in its efforts to make this occur.

Requirements for information sharing practices, eligible service funding, and data submission updates are outlined in the following policies:

1. Prior to releasing treatment information, the CFT, including the adult service provider, will review and follow health record disclosure guidelines per AMPM Chapter 500, *Care Coordination Requirements*.

2. If the young adult is not Medicaid eligible, services that can be provided under Non-Medicaid funding will follow policy guidelines per AMPM Policy 320-T, Non-Discretionary Federal Grants and ACOM Policy 431, Copayment.

3. The behavioral health provider will ensure that the behavioral health category assignment is updated along with other demographic data consistent with the AHCCCS Technical Interface Guidelines.

Youth, upon turning age 18, will be required to sign documents that update their responsibilities with relation to their behavioral health treatment as an adult. Some examples include a new consent to treatment and authorizations for sharing protected health information to ensure that the team members can continue as active participants in service planning. A full assessment is not required at the time of transition from child to adult behavioral health services <u>unless</u> an annual update is due or there have been significant

changes to the young adult's status that clinically indicate the need to update the Assessment or Individual Recovery Plan (IRP).

Refer also to Attachment A, Transition to Adulthood Resources.

A. KEY PERSONS FOR COLLABORATION

1. Team Coordination

   When a young person reaches age 17 it is important to begin establishing team coordination between the child and adult service delivery systems. This coordination must be in place no later than four - six months prior to the youth turning age 18. In order to meet the individualized needs of the young adult on the day s/he turns 18 a coordinated effort is required to identify the behavioral health provider staff who will be coordinating service delivery, including the services that will be needed and the methods for ensuring payment for those services. This is especially critical if the behavioral health provider responsible for service planning and delivery is expected to change upon the youth's transition at the age of 18.

   Orientation of the youth and his/her family to potential changes they may experience as part of this transition to the AHCCCS Adult System of Care will help minimize any barriers that may hinder seamless service delivery and support the youth's/family's understanding of their changing roles and responsibilities. It might be helpful to engage the assistance of a liaison (e.g., family and/or peer mentor) from the adult system to act as an ambassador for the incoming young adult and his/her involved family and/or caregiver.

   As noted in the CFT Practice Tool, the young adult, in conjunction with other involved family members, caregivers or guardian, may request to retain his/her current CFT until the youth turns 21. Regardless of when the youth completes his/her transition into the AHCCCS Adult System of Care, the CFT will play an important role in preparing the Adult Recovery Team (ART) to become active partners in the treatment and service planning processes throughout this transitional period. Collaboration between the child and adult service provider for transition age youth is more easily facilitated when agencies are dually licensed to provide behavioral health service delivery to both children and adult populations.

2. Family Involvement/Cultural Considerations

   Family involvement and culture must be considered at all times especially as the youth prepares for adulthood. Although this period in a young person's life is considered a time for establishing his/her independence through skill acquisition, many families and cultures are interdependent and may also require a supportive framework to prepare them for this transition. With the assistance of joint planning by the child and adult teams, families can be provided with an understanding of the

increased responsibilities facing their young adult while reminding them that although their role as legal guardian may change, they still remain an integral part of their child's life as a young adult. It is also likely that the youth's home and living environment may not change when they turn 18 and are legally recognized as an adult.

During this transitional period the role that families assume upon their child turning 18 will vary based on:
a. Individual cultural influences,
b. The young adult's ability to assume the responsibilities of adulthood,
c. The young adult's preferences for continued family involvement, and
d. The needs of parents/caregivers as they adjust to upcoming changes in their level of responsibility.

Understanding each family's culture can assist teams in promoting successful transition by:
a. Informing families of appropriate family support programs available in the AHCCCS Adult System of Care,
b. Identifying a Family Mentor who is sensitive to their needs to act as a "Liaison" to the AHCCCS Adult System of Care,
c. Recognizing and acknowledging how their roles and relational patterns affect how they view their child's movement toward independence, and
d. Addressing the multiple needs of families that may exist as a result of complex relational dynamics or those who may be involved with one or more state agencies.

Some youth involved with DCS may express a desire to reunite with their family from whose care they were removed. In these situations it is important for the CFT to discuss the potential benefits and challenges the youth may face.

B. SYSTEM PARTNERS

Coordination among all involved system partners promotes collaborative planning and seamless transitions when eligibility requirements and service delivery programs potentially change upon the youth turning 18. Child welfare, juvenile corrections, education, developmental disabilities, and vocational rehabilitation service delivery systems can provide access to resources specific to the young adult's needs within their program guidelines. For example, students in special education services may continue their schooling through the age of 21. Youth in foster care may be eligible for services through a program referred to as the Arizona Young Adult Program (AYAP) or Independent Living Program (ILP)[†††] through the Arizona Department of Child Safety (DCS).

System partners can also assist young adults and their families/caregivers in accessing or preparing necessary documentation, such as:

1. Birth certificates,
2. Social security cards and social security disability benefit applications,
3. Medical records including any eligibility determinations and assessments,
4. Individualized Education Program (IEP) Plans,
5. Certificates of achievement, diplomas, GED[‡‡‡] transcripts, and application forms for college,
6. Case plans for youth continuing in the foster care system,
7. Treatment plans,
8. Documentation of completion of probation or parole conditions,
9. Guardianship applications, and
10. Advance directives, etc.

C. NATURAL SUPPORT

Maintaining or building a support structure will continue to be important as the youth transitions to adulthood and has access to new environments. This is especially relevant for young adults who have no family involvement. For some youth, developing or sustaining social relationships can be challenging. The child and adult teams can assist by giving consideration to the following areas when planning for transition:

1. Identify what supports will be needed by the young adult to promote social interaction and relationships,
2. Explore venues for socializing opportunities in the community,
3. Determine what is needed to plan time for recreational activities, and
4. Identify any special interests the youth may have that could serve as the basis for a social relationship or friendship.

D. PERSONAL CHOICE

Although young adults are free to make their own decisions about treatment, medications, and services, they are generally aware that their relationships, needs, and supports may not feel different following their 18th birthday. They may require assurance that their parents are still welcomed as part of their support system, that they still have a team, rules still apply, and that information will be provided to assist them with making their own treatment decisions. However, some young adults may choose to limit their parent's involvement, so working with youth in the acquisition of self-determination skills will assist them in learning how to speak and advocate on their own behalf. This may involve youth developing their own understanding of personal strengths and challenges along with the supports and services they may need. When planning for transition, teams may also need to provide information to young adults on how the behavioral health service delivery systems operate in accordance with the following:

1. Arizona Vision and 12 Principles for Children's Service Delivery , and

2. Nine Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems.

E. CLINICAL AND SERVICE PLANNING CONSIDERATIONS

AHCCCS supports clinical practice and behavioral health service delivery that is individualized, strengths-based, recovery-oriented, and culturally sensitive in meeting the needs of children, adults, and their families. Transitioning youth to adulthood involves a working partnership among team members between the children's behavioral health service system and the AHCCCS Adult System of Care. This partnership is built through respect and equality, and is based on the expectation that all people are capable of positive change, growth, and leading a life of value. Individuals show a more positive response when there is a shared belief and collaborative effort in developing goals and identifying methods (services and supports) to meet their needs.

F. CRISIS AND SAFETY PLANNING

The team is responsible for ensuring that crisis and safety planning is completed prior to the youth's transition as outlined in the CFT Practice Tool. For some youth, determining potential risk factors related to their ability to make decisions about their own safety may also need to be addressed. Collaboration with the adult case manager and/or ART will ensure that the transitioning young adult is aware of the type of crisis services that will be available through the AHCCCS Adult System of Care and how to access them in his/her time of need.

G. SPECIAL EDUCATION PLANNING

The Individuals with Disabilities Education Act of 2004 (hereafter referred to as IDEA)[§§§] ensures that all children with disabilities have available to them a "free appropriate public education" (FAPE) that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living. Per IDEA, school districts are required to assist students with disabilities to make the transition from school to work and life as an adult. This postsecondary transition must be addressed not later than the student's first IEP to be in effect when the youth turns 16, or younger if determined appropriate by the IEP team. Measurable postsecondary goals for education/training, employment, and independent living, when appropriate, include a coordinated set of activities that addresses the following areas:

1. Instruction,
2. Daily living skills,
3. Related services,
4. Functional evaluation,
5. Post school adult living,
6. Community experiences, and

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7. Employment.

While IDEA mandates services and programs while the youth with disabilities remains in school (which can be up to the age of 22), there are no federal mandates once the individual leaves the school system.

For any youth who is currently being served under an IEP, collaboration with the IEP team**** in transition planning is imperative to ensure the alignment of IEP goals with the goals contained in the behavioral health IRP. The CFT, in conjunction with the adult service provider, would consult with the minor's parent/legal guardian or the young adult, if age 18 or older, to obtain their permission to participate in the IEP meeting for the purpose of coordinating transition planning and services between the behavioral health and education systems. For young adults, age 18 and older, where legal guardianship has been established or the right to make educational decisions has been delegated to another responsible person, permission to participate in IEP meetings is obtained from the student's identified legal representative.

H. TRANSITION PLANNING

The length of time necessary for transition planning is relevant to the needs, maturational level, and the youth's ability to acquire the necessary skills to assume the responsibilities of adulthood. When planning for the young person's transition into adulthood and the adult behavioral health system, a transition plan that includes an assessment of self-care and independent living skills, social skills, work and education plans, earning potential, and psychiatric stability must be incorporated into the Service Planning. Living arrangements, financial, and legal considerations are additional areas that require advance planning.

1. Self-care and Independent Living Skills

   As the youth approaches adulthood the acquisition of daily living skills becomes increasingly important. Personal care and hygiene can include grooming tasks such as showering, shaving (if applicable), dressing, and getting a haircut. Learning phone skills, how to do laundry and shop for clothes, cleaning and maintaining one's personal living environment, use of public transportation or learning how to drive are other suggested areas for transition planning. Acquisition of various health-related skills includes fitness activities such as an exercise program, nutrition education for planning meals, shopping for food, and learning basic cooking techniques. Planning around personal safety would address knowing their own phone number and address, who to contact in case of emergency, and awareness of how to protect themselves when out in the community.

Effective Date: 7/01/16

2. Social and Relational Skills

    The young adults' successful transition toward self-sufficiency will be supported by their ability to get along with others, choose positive peer relationships, and cultivate sustainable friendships. This will involve learning how to avoid or respond to conflict when it arises and developing an understanding of personal space, boundaries, and intimacy. Some youth may require additional assistance with distinguishing between the different types of interactions that would be appropriate when relating to strangers, friends, acquaintances, boy/girlfriend, family member, or colleague in a work environment. For example, teams may want to provide learning opportunities for youth to practice these discrimination skills in settings where they are most likely to encounter different types of people such as a grocery store, shopping mall, supported employment programs, etc. Planning for youth, who have already disclosed to the behavioral health service provider their self-identity as gay, lesbian, bisexual, or transgender, may include discussions about community supports and pro-social activities available to them for socialization. Adolescents who do not have someone who can role model the differing social skills applicable to friendship, dating, and intimate relationships may need extra support in learning healthy patterns of relating to others relevant to the type of attachment.

3. Vocational/Employment

    An important component of transitioning to adulthood includes vocational goals that lead to employment or other types of meaningful activity. While a job can provide financial support, personal fulfillment, and social opportunities, other activities such as an internship or volunteering in an area of special interest to the young adult can also provide personal satisfaction and an opportunity to engage socially with others. The CFT along with involved system partners work together to prepare the young adult for employment or other vocational endeavors. It is imperative that a representative from the adult behavioral health system be involved in this planning to ensure that employment related goals are addressed before, during, and after the youth's transition to adulthood.

    Service planning that addresses the youth's preparation for employment or other meaningful activity can include:
    a. Utilizing interest inventories or engaging in vocational assessment activities to identify potential career preferences or volunteer opportunities,
    b. Identifying skill deficits and effective strategies to address these deficits,
    c. Determining training needs and providing opportunities for learning through practice in real world settings,
    d. Learning about school-to-work programs that may be available in the community and eligibility requirements,
    e. Developing vocational skills such as building a resume, filling out job applications, interviewing preparation, use of online job sites, etc. and
    f. Learning federal and state requirements for filing annual income tax returns.

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Youth involved in school based work activities (paid or non-paid) are able to "test the waters" of the work world, develop a work history, better understand their strengths and weaknesses, explore likes and dislikes, and begin to develop employment related skills necessary for their success in competitive work settings. School based work activities can start as early as middle school yet should begin no later than the youth's freshman year of high school. Once youth reach the age of 17, they can be given work experience in the community, whether it is through a volunteer or internship experience. It is best for school and community-based work experience to be short term, so that youth can experience a variety of employment settings and perform different job duties in more than one vocation to assist them in identifying possible career choices. These work related opportunities will assist teams in determining where the youth excels or struggles in each type of work undertaken, the types of supports that might be needed, and what the best "job match" might be in terms of the youth's personal interests and skill level.

As youth narrow their career focus, it is useful to tour employment sites, job shadow, and interview employers and employees who work in the youth's chosen fields of interest. It may be necessary to plan for on-going support after a job has been obtained to assist the young adult in maintaining successful employment. Identifying persons in the job setting who can provide natural support such as supervisors and co-workers, as well as employer related accommodations may be necessary to ensure that the young adult can continue to perform his/her job duties.

4. Vocational/Employment Considerations for Youth with Disabilities

For youth who have a disability, regardless of whether or not they are in Special Education, may be eligible for services through the Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) under a Vocational Rehabilitation (VR) program[††††] when transitioning from school to work. The high school can refer youth with a disability to the VR program within two years before they leave school, if VR and the school have jointly funded programs, or within one year following the youth's exit from school if the provision of VR services is expected to occur after the youth leaves school. Planning for employment is done in conjunction with the youth's VR counselor through the development of an Individual Plan of Employment (IPE). Including the VR counselor in the school's IEP planning that might involve VR services is necessary since only VR personnel can make commitments for ADES/RSA program services. Refer to ADES/RSA[‡‡‡‡] for information on the VR process regarding intake/eligibility, planning for employment, services, and program limitations.

5. Education

Collaboration between the CFT and the education system is helpful with preparing youth and their parents/caregivers in developing an understanding of what happens as young adults transition from secondary education to adult life. In 2008, the Arizona

State Board of Education approved Education and Career Action Plans (ECAP) for all Arizona students in grades 9-12. The ECAP reflects a student's current plan of coursework, career aspirations, and extended learning opportunities in order to develop the young adult's individual academic and career goals. Asking the youth to share his/her ECAP with the rest of the team may provide information to assist with transition planning.

6. Education Considerations for Youth with Disabilities

Section 504 of the Rehabilitation Act of 1973[§§§§] protects the civil rights of individuals with disabilities in programs and activities that receive federal funds. Recipients of these funds include public school districts, institutions of higher education, and other state and local education agencies. This regulation requires a school district to provide adjustments that can be made by the classroom teacher(s) and other school staff to help youth benefit from their education program through a 504 Plan that outlines these services and accommodations.

While youth are in secondary education, IDEA requires public schools to include transition plans for each student with a disability beginning with the IEP that is in effect when the youth reaches the age of 16. These transition plans are required to include the following eight components:
   a. Measurable Postsecondary Goals (MPGs) in the areas of:
      i. Education/Training,
      ii. Employment, and
      iii. Independent living (if needed),
   b. MPGs are updated annually,
   c. Age appropriate transition assessment,
   d. Coordinated activities,
   e. Course of study,
   f. Annual goals that are aligned to the MPGs,
   g. Student invitation to these meetings is required, and
   h. Outside agency participation with prior consent from the family or student that has reached the age of majority.

7. Transfer of Rights' Requirement for Public Education Agencies

Under Arizona State law, a child reaches the age of majority at 18. The right to make informed educational decisions transfers to the young adult at that time.

According to IDEA,[*****] "beginning not later than one year before the child reaches the age of majority under State law, a statement that the child has been informed of the child's rights under this title, if any, that will transfer to the child on reaching the age of majority under section 615(m)"[†††††] must be included in the student's IEP. This means that schools must inform all youth with disabilities on or before their 17th birthday that certain rights will automatically transfer to them upon turning age 18.

In order to prepare youth with disabilities for their transfer of rights, it is necessary for parents/caregivers to involve their child in educational decision making processes early. The CFT or ART, in conjunction with the adult behavioral health provider, can assist the youth/parent/caregiver with the following:

a. Having the youth actively participate in IEP and transition planning to ensure his/her voice is heard,

b. Assisting the youth in developing positive relationships with involved school personnel and other service providers,

c. Discussing potential decisions before IEP meetings so the youth is informed and can actively participate in advocating for his/her wishes, and

d. Including the youth in decisions that impact his/her life inside and outside the school setting.

"A student with a disability, between the age of 18 and 22 who has not been declared legally incompetent and has the ability to give informed consent may execute a Delegation of Right to Make Educational Decisions. The Delegation of Right allows the student to appoint his/her parent or agent to make educational decisions on his/her behalf. The student has the right to terminate the agreement at any time and assume his/her right to make decisions."[‡‡‡‡‡] Additional information pertaining to a special education transfer of parental rights and an example of a Delegation of Right to Make Educational Decisions form is provided in the Arizona Center for Disability Law's Legal Options Manual.

For additional information related to special education transitions refer to the publications posted by the ADE.[§§§§§]

8. Summary of Performance

A Summary of Performance (SOP)[******] is completed for every young adult whose special education eligibility terminates due to graduation from high school with a regular diploma or due to exceeding the age eligibility for FAPE[††††††] under State law. A public education agency (PEA) must provide the youth with a summary of his/her academic achievement, functional performance, and recommendations on how to assist in meeting the young adult's postsecondary goals.

9. Postsecondary Education Considerations

When postsecondary education is the goal for young adults, transition planning may include preparatory work in the following areas:

a. Identify academic strengths to assist with matching the young adult's interests with the right school,

b. Determine the best fit between the young adult's needs and the type of postsecondary setting (e.g., university, community college, technical or trade school, etc.),

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c. Assist in the identification of and application process for various financial resources (e.g., scholarships, financial aid, student loans, etc.),

d. Discover the types of proficiency testing or assessments that are required for admission such as the Scholastic Aptitude Test (SAT) or American College Testing (ACT),

e. Assist with skill development to ensure the young adult is able to organize school assignments, manage his/her time, identify and set priorities, and break projects down into manageable steps,

f. Consider potential summer school courses or other options to determine an area of study or vocational interest,

g. Attend informational meetings at a local college and network with current students, and

h. Promote the development of the young adult's self-advocacy skills to support his/her success in a postsecondary setting.

10. Medical/Physical Healthcare

    Planning can include assisting the youth with:
    a. Transferring healthcare services from a pediatrician to an adult health care provider, if pertinent,

    b. Applying for medical and behavioral health care coverage, including how to select a health plan and a physician,

    c. Preparing an application for submission at age 18 to AHCCCS for ongoing Medicaid services[‡‡‡‡‡‡],

    d. Obtaining personal and family medical history (e.g., copies of immunization records, major illnesses, surgical procedures, etc.)[§§§§§§],

    e. Information on advance directives, as indicated in the Policy 640, Advanced Directives,

    f. Methods for managing healthcare appointments, keeping medical records, following treatment recommendations, and taking medication,

    g. How to identify healthcare concerns, address questions during appointments, and consult with doctors regarding diagnosis, treatment, and prognosis, and

    h. Assuming responsibility for understanding and managing the symptoms of their mental illness and obtaining knowledge of the benefits, risks, and side effects of their medication.

11. Living Arrangements

    Where young adults will live upon turning age 18 could change based on their current housing situation (e.g., living at home with family, with a relative, in a Behavioral Health Inpatient or Residential Facility (BHIF/BHRF), other out of home treatment setting, etc.) or whether or not they decide to choose housing on-site while pursuing their postsecondary education. Youth who do not have the support of their parents or extended family, or who may be under the care and custody of the child welfare system, may require intensive planning to evaluate their ability to live independently,

identify the level of community supports needed, and match the type of living environment to their individual personality and preferences. Each situation will require planning that specifically uses the young adult's strengths in meeting his/her needs and addresses any personal safety concerns. The most common types of living situations range from living independently in one's own apartment with or without roommates to a supported or supervised type of living arrangement. If needed, the team may assist the young adult with completing and filing applications for public housing or other subsidized housing programs. Refer to Arizona 2-1-1 for further information on housing options, state and federally funded programs, and other areas for consideration when addressing housing needs.

Youth living in a BHIF at the time they turn age 18 can continue to receive residential services until the age of 22 if they were admitted to the facility before their 21st birthday and continue to require treatment. AMPM Policy 1110, Prior Authorization, Notification and Concurrent and Retrospective Review provide procedural information and criteria for services that require authorization.

Licensed residential agencies may continue to provide behavioral health services to individuals age 18 or older if the following conditions are met per A.A.C. R9-10-318 (B)

a. Person was admitted before his/her 18th birthday and is completing high school or a high school equivalency diploma, or is participating in a job training program, is not 21 years of age or older, or
b. Through the last day of the month of the person's 18th birthday.

12. Financial

Assessing the financial support needed will include identifying how much money is required to support the young adult's living situation and how s/he will obtain it. This will include determining whether the income from employment will pay the bills or if Social Security disability programs (SSDI[*******] or SSI[††††††]), food stamps, or other emergency assistance will cover the young adult's financial responsibilities. Depending on the special needs of the young adult, arranging for a conservator or guardian may also be necessary.

Together, the team should review and update any federal and/or state financial forms to reflect the young adult's change in status to ensure there is no disruption in healthcare or financial assistance services. Youth who are eligible for SSI benefits as a child will have a disability redetermination during the month preceding the month when they attain age 18. This determination will apply the same rules as those used for adults who are filing new applications for SSI benefits.[‡‡‡‡‡‡‡] The team can assist the young adult and his/her family/caregiver with identifying any changes related to Social Security benefits, including opportunities for Social Security Work Incentives.[§§§§§§§]

Young adults who learn about financial matters prior to age 18 have a better opportunity to acquire the skills necessary for money management. Skill development can include:

a. Setting up a simple checking and/or savings account to learn how it can be used to pay bills, save money, and keep track of transactions;

b. Identifying weekly/monthly expenses that occur such as food, clothes, school supplies, and leisure activities and determining the monetary amount for each area;

c. Learning how to monitor spending and budget financial resources;

d. Education on how credit cards work and differ from debit cards, including an understanding of finance charges and minimum monthly payments; and

e. Understanding the short and long term consequences of poor financial planning (e.g., overdrawn account [Non-Sufficient Funds fee], personal credit rating, eligibility for home and/or car loans, potential job loss, etc.).

13. Legal Considerations

Transition planning that addresses legal considerations ideally begins before the youth turns 18 to ensure the young adult has the necessary legal protections upon reaching the age of majority. This can include the following:

14. Document Preparation

Some families/caregivers may decide to seek legal advice from an attorney who specializes in mental health, special needs and/or disability law in planning for when their child turns 18 if they believe legal protections are necessary. Parents, caregivers or guardians may choose to draw up a will or update an existing one to ensure that adequate provisions have been outlined for supporting their child's continuing healthcare and financial stability. Other legal areas for consideration can include:

a. Guardianship,

b. Conservator,

c. Special needs trust, and

d. Advance directives (e.g., living will, powers of attorney).

15. Legal Considerations for Youth with Disabilities

Persons with developmental disabilities, their families and caregivers may benefit from information about different options that are available when an adult with a disability needs the assistance of another person in a legally recognized fashion to help manage facets of his/her life. Refer to the *Arizona Center for Disability Law's Legal Options Manual* for access to information and forms. This publication also addresses tribal jurisdiction in relation to the guardianship process for individuals who live on a reservation. While this resource is focused on planning for individuals with disabilities, teams can utilize this information to gain a basic understanding of the legal rights of individuals as they approach the age of majority.

Effective Date: 7/01/16

16. Transportation

    A training program, whether a formal or informal one, may be useful in helping the young adult acquire the skills necessary for driving or when using public transportation. Planning can include assisting the youth with test preparation and acquiring a driver's permit. Use of a qualified instructor, family member, or other responsible adult can provide the youth with "behind the wheel" driving experience including how to read maps or manage roadside emergencies. If obtaining a driver's license is not feasible, skill training activities for using public transportation can include reviewing bus schedules, planning routes to get to a designated location on time, and learning how to determine the cost and best method of transportation for getting to and from work or scheduled appointments.

    When transitioning to the adult behavioral health system, educate the family and young adult on the transportation options available through the adult service delivery system. This will help support the young adult's continued attendance at behavioral health treatment appointments, as well as assist the team with identifying and planning for other transportation needs that are not necessarily associated with accessing medical or behavioral health services.

17. Other Considerations

    Some young adults may need assistance with acquiring proof of personal identification if they have not done so by the age of 18. Additionally, young adults may require further information explaining the mandatory and voluntary registrations that become effective at the age of majority.

18. Personal Identification

    The team can assist the youth with acquiring a State issued identification (ID) card in situations where the young adult may not have met the requirements for a driver's license issued by the Arizona Motor Vehicle Division.******** An identification card is available to all ages (including infants), however, the youth may not possess an Arizona identification card and a valid driver's license at the same time.

19. Mandatory and Voluntary Registrations

    Selective Service registration†††††††† is required for almost all male U.S. and non-U.S. citizens who are 18 through 25 years of age and residing in the United States. Registration can be completed at any U.S. Post Office and a Social Security number is not needed. When a Social Security number is obtained after registration is completed, it is the responsibility of the young adult male to inform the Selective Service System.

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Upon turning age 18 the young adult can register to vote. Online voter registration is available through Arizona's Office of the Secretary of State.‡‡‡‡‡‡‡‡

20. Resources

Refer to Transition to Adulthood Resources for access to additional information that may assist the CFT and adult behavioral health service provider with transition planning activities.

I. TRAINING AND SUPERVISION RECOMMENDATIONS

This Practice Tool applies to Contractors, TRBHAs and their subcontracted network and provider behavioral health staff who participate in assessment and service planning processes, provide case management and other clinical services, or who supervise staff that provide service delivery to adolescents, young adults and their families. Each Behavioral Health Contractor or TRBHA shall establish their own process for ensuring that all staff have been trained and understand how to implement the practice elements as outlined in this document. Whenever this Practice Tool is updated or revised, Contractors and TRBHAs must ensure their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes. Each Contractor or TRBHA, upon request from AHCCCS, is required to provide documentation demonstrating that all required network and provider staff have been trained on this Practice Tool. In alignment with A.A.C. R4-6-212 Clinical Supervision requirements, the supervision of this Practice Tool is to be incorporated into other supervision processes which the Contractor or TRBHA and their subcontracted network and provider agencies have in place for direct care clinical staff.

J. ANTICIPATED OUTCOMES

1. Coordinated planning for seamless transitions from the AHCCCS Children System of Care to the AHCCCS Adult System of Care.

2. Active collaboration between CFTs and ARTs for the purpose of transition planning.

3. Increased opportunities for youth to acquire the necessary skills to assume the responsibilities of adulthood.

4. Engagement of families in the transition planning process that recognizes the diversity that is needed in identifying the individual support needs of their young adult.

5. Improved self-advocacy skills in transition age youth.

[*] Furstenberg, F. The Network on Transitions to Adulthood. Retrieved November 25, 2009, from http://www.transad.pop.upenn.edu/about/index.html

[†] J. Kim-Cohen et al. (2002). Prior Juvenile Diagnoses in Adults with Mental Disorder. *Archives of General Psychiatry, 60*, 709-17.

[‡] Osgood, D. Wayne, Foster, E. Michael, Flanagan, Constance & Ruth, Gretchen R., editors. (2005). *On Your Own without a Net: the Transition to Adulthood for Vulnerable Populations* (Chapter 10, J. Heidi Gralinski-Bakker et al., and Chapter 11, Phillip M. Lyons, Jr. & Gary B. Melton).

[§] Retrieved from http://www.whatadifference.samhsa.gov/

[**] Osgood et al. (2005). *On Your Own without a Net: the Transition to Adulthood for Vulnerable Populations* (Chapter 10, J. Heidi Gralinski-Bakker et al., and Chapter 11, Phillip M. Lyons, Jr. & Gary B. Melton).

[††] Arnett, Jeffrey Jensen. (1997). Young People's Conceptions of the Transition to Adulthood. *Youth & Society*, 29(1), 3-23.

[‡‡] Ibid.

[§§] Osgood, D. Wayne, Foster, E. Michael, Flanagan, Constance & Ruth, Gretchen R., editors. (2005). *On Your Own without a Net: the Transition to Adulthood for Vulnerable Populations* (Chapter 3, He Len Chung, et al., and Chapter 4, David Altschuler).

[***] Osgood, D. Wayne, Foster, E. Michael, Flanagan, Constance & Ruth, Gretchen R. (February 2005, Issue 18). Network on Transitions to Adulthood Policy Brief. *Programs and Policy Goals for Helping Vulnerable Youth as They Move into Adulthood*.

[†††] Refer to https://dcs.az.gov/services/young-adult/independent-living-program-and-young-adult-program for eligibility requirements, services, and resources.

[‡‡‡] Commonly referred to as a General Education Diploma or General Equivalency Diploma.

[§§§] http://idea.ed.gov/

[****] http://idea.ed.gov/explore/view/p/%2Croot%2Cdynamic%2CTopicalBrief%2C9%2C

[††††] https://www.azdes.gov/main.aspx?menu=32&id=1300

[‡‡‡‡] https://des.az.gov/services/employment/rehabilitation-services/vocational-rehabilitation-vr/vr-frequently-asked

[§§§§] http://www2.ed.gov/about/offices/list/ocr/docs/edlite-FAPE504.html

[*****] Federal law dealing with the education of children with disabilities.

[†††††] Per IDEA Part B Sec. 614(d)(1)(A)(i)(VIII)(cc) at: http://idea.ed.gov/download/statute.html

[‡‡‡‡‡] http://www.azed.gov/special-education/files/2011/08/prepare-your-child-brochure1.pdf

[§§§§§] http://www.azed.gov/ess/SpecialProjects/transition/

[******] http://www.azed.gov/search-results/?q=summary%20of%20performance

[††††††] Free appropriate public education (FAPE)

[‡‡‡‡‡‡] Youth at age 18 who remain in foster care are enrolled in Young Adult Transitional Insurance through the Arizona Division of Children, Youth, and Families, rather than being enrolled in Medicaid services through AHCCCS.

[§§§§§§] For youth in foster care, teams work with Department of Child Safety's personnel to obtain personal and family medical history as this information will be requested at future medical appointments.

[*******] Social Security Disability Insurance

[†††††††] Supplemental Security Income

[‡‡‡‡‡‡‡] http://www.socialsecurity.gov/ssi/text-cdrs-ussi.htm

[§§§§§§§] http://www.ssa.gov/disabilityresearch/wi/generalinfo.htm

[********] http://www.azdot.gov/mvd/

[††††††††] http://www.sss.gov/

[‡‡‡‡‡‡‡‡] http://www.azsos.gov/election/voterregistration.htm

YOUTH INVOLVEMENT IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM PRACTICE TOOL

Effective Date: 10/01/16

I. GOAL (WHAT DO WE WANT TO ACHIEVE THROUGH THE USE OF THIS PRACTICE TOOL?)

A. To define youth involvement as a necessary and effective component to AHCCCS System of Care.

B. Promote understanding of the benefits of youth involvement in their own recovery and within the AHCCCS System of Care.

C. Support the development and implementation of youth involvement throughout all levels within the AHCCCS System of Care.

II. BACKGROUND

Youth leaders in Arizona advocated for the development of a Practice Tool outlining guidance for how to improve youth involvement in the use and delivery of behavioral health services. This recommendation was enthusiastically embraced by the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) because active youth involvement is congruent with evidence based practice, promotes resiliency and hastens recovery. This Practice Tool describes a variety of steps AHCCCS System of Care can take to increase youth involvement at all levels.

Youth involvement serves the dual purpose of developing the resiliency of individual youth while simultaneously bringing about improvements in systems and communities (Viner RM, Barker M. [2005] Young people's health: the need for action. BMJ; 330: 901-3). Meaningful youth involvement promotes the development of knowledge, skills, confidence, self-efficacy, and pride (Matarese, M., McGinnis L., & Mora M. (2005) Youth Involvement in Systems of Care: A Guide to Empowerment). It also provides youth with opportunities for success by identifying and building on their strengths. This focus on talents as opposed to deficits promotes hope and optimism which in turn promotes resiliency, recovery, wellness and empowerment (Klau, M. (2006), Exploring youth leadership in theory and practice. New Directions for Youth Development, 2006: 57–87; Viner RM, Barker M. (2005) Young people's health: the need for action. BMJ; 330: 901-3; Gyamfi, P., Keens-Douglas, A., & Medin, E. (2007). Youth and youth coordinators' perspectives on youth involvement in systems of care. Journal of Behavioral Health Services and Research, 34, 382–394). An important element of youth involvement is the acquisition of social skills and leadership abilities above and beyond what might be achieved through professionally-driven services alone.

There are various levels and types of youth participation. This Practice Tool encourages Arizona's behavioral health organizations to develop meaningful roles and opportunities that enhance youth involvement, including:

A. Meaningful youth involvement in their own recovery,

B. Utilizing formal and informal peer support services,

C. Establishing and participating in youth leadership groups, and

D. Facilitating youth participation in community coalitions, as well as provider and Contractor committees.

Refer also to Attachment A, Youth Involvement in the Children's Behavioral Health System practice Tool – Youth Tip Sheet.

III. RECOMMENDED PROCESSES /PROCEDURES

A. MEANINGFUL YOUTH INVOLVEMENT IN THEIR OWN RECOVERY

1. Meaningful Youth Involvement in Recovery

    Treatment is an important component of the recovery process. Meaningful youth involvement in recovery entails active youth participation in decisions affecting all aspects of their care and the delivery of treatment services. This level of involvement means that youth share the role of expert in their own treatment. Their responsibilities as experts include selecting their own goals and deciding how those goals will be achieved. To promote this level of involvement, every person involved in a youth's treatment must seek and respect the young person's input. Each behavioral health professional, medical provider, and others involved in the recovery process should make the effort to listen to the youth regarding his or her opinions and preferences, and be prepared to involve the youth in the decision making process. The benefit of this approach is that it promotes autonomy and prepares each youth to take responsibility for guiding their recovery and life.

2. Child and Family Teams

    The Child and Family Team (CFT) is one example of a process in which youth involvement may be central to recovery outcomes. A CFT is a defined group of people that includes at a minimum, the child/youth and his/her family, a behavioral health representative, and any individuals important in the young person's life that are identified and invited to participate. Please refer to the AHCCCS Child and Family Team Practice Tool. The level of participation of youth as part of their own CFT will vary depending on individual factors, however all youth are expected to have the opportunity to participate.

    Youth should be involved in selecting the membership and guiding the work of their CFT. Natural supports, such as extended family members, friends, coaches, community service providers, and spiritual/religious representatives should be engaged in partnership with the youth to balance the presence of "formal" service providers. Meetings of the CFT should be scheduled to promote participation of

youth, which includes avoiding scheduling CFTs during school hours, as defined in A.R.S. §§ 8-527, 36-3435 subsection B (2011).

Development of youth voice at the CFT level can be fostered according to the following phases:
a. Advocating for the youth,
b. Assisting the youth in developing their own voice and self-advocacy skills, and
c. Assuring that other CFT members are respecting and hearing the youth's voice.

Though this process is described in three discrete phases, these are not actually rigid sequential steps. Instead, they are overlapping phases that, in many circumstances, may be occurring simultaneously and to varying degrees.

3. Youth Advocacy Development

The primary function of advocacy development is to help ensure that the youth's needs are being heard by the behavioral health provider, as well as other CFT members. Youth should be supported in advocating for the services they have determined will meet their needs, as well as in participating in identifying the goals and strategies in their service plans. Through this process, youth are able to experience an active voice in the service planning process.

This process requires that engagement and trust are established with the youth, and models the relationship building that is necessary among all CFT members. Mentoring youth to effectively advocate for themselves may be accomplished through a variety of methods, including one-on-one coaching, modeling, de-briefing after CFT meetings, and role playing. Skills acquired by young people during this phase may include:
a. Advocating for CFT membership/participation
b. Planning skills,
    i.   Advanced preparation of questions or statements,
    ii. Drafting portions of the agenda,
c. Learning effective communication strategies, and
d. Building team consensus.

4. Co-facilitation

When performing advocacy functions, youth begin assuming many of the roles eventually associated with co-facilitation. Each youth transitions to the co-facilitation role at a pace that is appropriate and comfortable for him/her, while maintaining the potential for immediate assistance of adults through natural or formal supports. Though the function of the CFT facilitator remains largely unchanged during co-facilitation, the process supports opportunities for ongoing skill building on the part of youth. As co-facilitators, youth take an active role in planning their services, while also learning ways to build team consensus.

Acquiring co-facilitation skills requires support and collaboration on the part of all CFT members. Without this consensus, young people may experience challenges fulfilling their roles, and the functioning of the CFT may be adversely affected. Such situations may require intervention by the CFT facilitator to create alignment among team members by reinforcing the importance of the youth's active involvement.

Ongoing responsibilities of the youth role during this phase also include scheduling or rescheduling one's own CFT meetings, drafting the majority of the CFT meeting agenda, and determining CFT membership.

5. Supporting Youth

    As a young person begins to develop his/her ability to self-advocate, it is important for the CFT facilitator to continuously reinforce the benefits of this empowerment to the youth and adult CFT members. This can be difficult if the youth's efforts are regularly met with resistance or disingenuous responses from other CFT members. The CFT facilitator can address this by:
    a. Supporting the youth in his/her self-advocacy,
    b. Helping to reinforce or reframe the youth's message,
    c. Modeling for other adults how to effectively interpret youth voice, and
    d. Meeting with other stakeholders outside of the CFT to hear any possible concerns or assist them in understanding the youth's needs.

    While it is exercised and practiced during CFT meetings, much of the work associated with developing an effective youth voice is done outside of meetings through mentoring partnerships with natural or formal support providers. When a youth is in a remote out-of-home setting, someone in the youth's immediate area may be identified as a support person for the youth and may consent to be coached to support the purpose, goals and strategies for development of youth voice in the CFT.

    Youth involved with Department of Child Safety (DCS), constitute a unique population, deserving special recognition and consideration. In those instances where DCS is the legal guardian, The CFT should work closely with DCS representatives regarding the participation of biological family members in the planning and implementation of behavioral health services. Please refer to the Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS Practice Tool. To the extent possible, the CFT should carefully consider all decisions about biological family involvement with the youth.

    In summary, a CFT is built to help support and guide each youth to meet their unique needs. Encouraging expression of youth voice during CFT meetings demonstrates that others place value on, and desire a better understanding of each youth's perspective. This can lead to greater engagement on the part of young people while increasing their sense of self-efficacy, and resulting in more positive outcomes overall.

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Refer also to Youth Involvement in the Children's Behavioral health System Practice Tool Youth Tip Sheet.

B. UTILIZING FORMAL AND INFORMAL PEER SUPPORT SERVICES

Youth peer support has been shown to aid in the process of recovery from mental health and substance use disorders in multiple ways. It assists individuals to develop a better understanding and acceptance of their circumstances, and also provides opportunities to engage with others who are in recovery (Catalano, R.F., Berglund, M.L., Ryan, J.A.M., Lonczak, H.S., & Hawkins, J.D. (2002) Positive Youth development in the United States: Research findings on evaluations of positive youth development programs. Prevention & Treatment, 5, Article 15). The Arizona Practice Model supports the philosophy that youth who employ healthy self-care and self-management techniques are capable of being helpful to others in a peer support context.

Peer support occurs in both formal and informal contexts. With formal peer support, peers are hired to provide Medicaid reimbursable services such as life skills training and home care training family services (family support). Peer support can also occur in less formal contexts. In these instances, sources of "informal" support may be drawn from the youth's relational network.

1. Informal Peer Support

   In many instances, "traditional" behavioral health services for youth have been provided on an individual basis or in the context of specific therapy groups in clinic settings. These approaches often offered youth limited opportunities to be full participants in creating their own behavioral health service plans, and also afforded minimal opportunities for engagement and socialization with other youth.

   An alternative approach has been introduced among a number of providers in Arizona, which offers a greater level of youth involvement, including increased opportunities for informal support. These programs provide opportunities for youth not only to act as co-authors of their service plans, but also to join with their peers in flexible group settings. Service provision utilizing such non-traditional models allows youth to engage in a manner that feels more natural to them, and also helps reduce the potential for stigma associated with involvement in behavioral health services.

   Structured group settings can also expand opportunities for youth to acquire social skills and develop supportive peer relationships in an informal context. As an example, participants in these groups are able to regularly "check in" regarding each other's wellbeing. As a result, when concerns are identified, participants can readily communicate them to program staff, averting potential crises. In addition, because participants include youth at all levels of functioning and developmental stages, there

are ample opportunities for modeling positive peer interaction. This provides opportunities to shape and reinforce individual strengths, and to facilitate acquisition of adaptive social behaviors in an "informal" and safe setting.

2. Formal Supports: Peer Support

    Formal peer support services are based on the assumption that individuals learn best by observing the actions of others with similar characteristics (Hill, W. [1990]. Learning A Survey of Psychological Interpretations Harper Collins Publishers, New York, New York). Formal peer support services typically involve an older or more experienced youth in a therapeutic relationship with one or more younger or less experienced youth. In these contexts, peer-facilitated education can be a highly effective method for young people to learn new life skills. This is especially true when a peer has experienced similar life challenges, as a result of which they may be better able to relate to and guide the younger person. This peer-to-peer relationship is a key benefit of youth involvement, and may be particularly important for youth who are in the process of transitioning to adulthood.

    Historically, developing formal peer support for youth has been a challenging endeavor within the behavioral health system. Examples of these challenges include the capability to identify, recruit and train qualified individuals. Other barriers include contractual and licensing limitations prohibiting many behavioral health providers from employing youth under twenty one years of age.

    Once youth are trained and prepared to function in peer support roles, they may be employed by providers in a variety of roles. These include:
    a. Functioning as qualified trainers in the provision of Peer Support Services,
    b. As direct providers of peer support services in both individual and group contexts, and/or
    c. As Youth Peer Mentors, whose intended role is to assist youth with socialization and developing life skills. These attributes contribute to increasing self-sufficiency, and become increasingly important as young people begin the transition to adulthood.

C. **Establishing and Supporting Youth Leadership Groups**

Youth development can be defined as a deliberate process of providing youth with the support, relationships, experiences, resources, and opportunities needed to become successful and competent adults.

Youth leadership groups support young people in contributing to the resolution of social and behavioral health issues in their community. This includes working to prevent substance use and to reduce stigma associated with behavioral health services. Youth who become involved in making positive change are more likely to feel a sense of pride and ownership regarding their communities. Furthermore, engaging in, and being

recognized for pro-social activities has also been shown to contribute to the development of resiliency (Catalano, R. F., Berglund, M. L., Ryan, J. A. M., Lonczak, H. S., & Hawkins, J. D. [2002]. Positive youth development in the United States: Research findings on evaluations of positive youth development programs. Prevention & Treatment, 5, Article 15). In this context, resiliency may be defined as the ability to rebound from adversity, trauma, tragedy, threats, and other stresses, and to proceed with life with a greater sense of mastery, competence, and hope (New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Executive Summary. DHHS Pub. No. SMA-03-3831. Rockville, MD: 2003).

Through involvement in youth leadership development, young people are able to contribute to their communities, gain experience in decision making, and form important youth-adult partnerships. These partnerships provide them with the tools and support to be more successful in their lives. Over the past decade, youth leaders in Arizona have achieved a variety of important outcomes. These include successfully developing substance use prevention curricula, as well as participating in the design of prevention programs. Youth leaders also provided trainings to other youth and adults across the state. In addition, they have participated in writing grants which were subsequently awarded, as well as in drafting legislation which was enacted into law. Youth leaders have also acted as co-chairs in multiple community coalitions and committees.

1. Universal capacity for leadership development

   By definition, youth leadership programs are inclusive, and are accessible to any youth who wishes to participate. An additional principle of youth leadership groups is the belief that no young person should be denied membership because of a behavioral health condition. In fact, an operating assumption of youth leadership groups is that diversity makes these groups stronger and the experience of participants richer. Also, since research shows that prolonged involvement in youth leadership programs has the potential to increase positive outcomes, (Gorman, D.M. (2007). Changing Service Systems for High Risk Youth Using State Level Strategies. American Journal of Public Health, 97 (4) Refer to: http://ajph.aphapublications.org/cgi/reprint/97/4/595) youth should be provided opportunities to grow into more advanced leadership roles as they mature.

2. Structure

   Young people participate in groups because doing so can provide them with an increased sense of well-being. This gain is an intangible reward which stimulates intrinsic motivation, as well as the perception that the information and skills provided are worth learning. At the same time, group involvement fulfills a number of important developmental needs. These include the feeling of doing something positive for others, satisfying curiosity, as well as providing opportunities to have fun, build friendships and get support (Gorman, D.M. [2007]. Changing Service Systems for High Risk Youth Using State Level Strategies. American Journal of Public

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Health, 97 (4) Refer to: http://ajph.aphapublications.org/cgi/reprint/97/4/595). Youth leadership groups constitute a unique opportunity to utilize these intrinsic rewards to further the goals of recovery and promote a heightened sense of self-worth among young people.

While youth leadership programs may reflect a high level of flexibility in their make-up, the one aspect which should remain consistent across all groups is their leadership structure. Given that a primary function of these groups is to aid in development of leadership skills, the organization and operation of each group should be managed by the youth themselves.

Another important aspect of youth leadership groups is the timing of scheduled meetings. Regular meeting times are beneficial, as is avoiding conflicts with other important life activities such as school attendance and family routines. As an aid to participation, youth leadership groups held at meal times should include healthy food or snacks. Also, since maintaining regular communication among participants is also important for sustaining groups, phone calls, e-mail, texts, etc., are recommended as a means of reminding participants about the group and of supporting continued interest and involvement.

The intent of youth leadership groups is developing the skills, insight, and confidence to address social issues in the community, while also maintaining a focus on personal and group wellness. The goal of increased wellness is supported by the development of positive relationships between members. These positive peer relationships can provide a base of acceptance and emotional support to help youth become more focused and motivated in developing their individual strengths. To facilitate this development, leadership groups should include a strong social component, making groups both positive and fun, and utilizing humor as a key element.

As a final comment on the structure of youth leadership groups, it is worth noting that the approach to development of urban and rural youth leadership groups can differ greatly. When youth live great distances from the community's center, attention should be given to the scheduling, frequency and location of group meetings. Scheduling meetings around already occurring community activities such as school or sports can make it easier for youth to participate.

3. Youth leadership groups are supported by committed adults

Adults too can have a role in youth leadership groups. Ideally, they can be collaborators who share equally with youth in decision-making power. Adults are also helpful in overcoming barriers to participation which can include providing safe transportation and moderating potential conflicts with other important life activities.

The skills and attitudes of the adults who provide ongoing support to youth leaders are critical to the success and sustainability of youth leadership groups. These adults

should understand and respect youth culture, youth development and love working with young people. Additionally, they should approach all youth with the assumption that each has innate intelligence, resiliency, talent and capacity for success. One of the most important things an adult leader can do is to help each youth to find his or her strengths and learn how to use those strengths and talents to their own best advantage.

The role of an adult engaged in supporting a youth leadership group also includes the responsibility to act as a role model and exemplify positive, healthy living and behavior. This includes maintaining professional boundaries, and following strict ethical standards both in and outside of work. Adults who work in rural communities where there is little anonymity need to be especially aware of how their behaviors outside of the work setting can influence the youth with whom they work.

D. **FACILITATING YOUTH PARTICIPATION IN COMMUNITY COALITIONS, AS WELL AS PROVIDER AND CONTRACTOR COMMITTEES**

Youth involvement in committees, boards, and community coalitions can be of great benefit to the AHCCCS System of Care. In part, this is because youth bring a different perspective to issues and can generate creative solutions that are relevant for their age group. Through this participation, youth who received services within the public behavioral health system have the ability to have a positive influence on the services received by their peers.

Some examples of participation include:

1. Participation in Behavioral Health/Stakeholder meetings,

2. Operating as consultants to the foster care system regarding services to transition-age youth,

3. Participating in RBHA/Contractor Governance Boards on Youth issues, and

4. Community substance use prevention coalitions.

Genuine Youth involvement is potentially of great benefit to the AHCCCS System of Care when youth have a meaningful role in the work of committees, boards or coalitions. Meaningful involvement means more than just having "a seat at the table". In practice it means shared power and decision making, as well as participation as an equal partner with equal voice. Positive adult-youth partnerships build leadership skills through mentoring and sharing power (Libby, M., Sedonaen, M. and Bliss, S. (2006), The mystery of youth leadership development: The path to just communities. New Directions for Youth Development, 2006: 13–25).

Youth need support from adults to be successful in this role and to ensure they have an equal voice. Simultaneous involvement with adults in a youth leadership group can support a young person's development of the skills necessary to effectively interact with others. This can include learning how to be persuasive and how to ensure their voices are heard. Debriefing with a supportive adult after events and meetings can help a young person review what worked well as well as identifying ways they could improve these skills. When appropriate, adults should be ready to speak on behalf of youth with other adults on committees, boards, or coalitions. This helps to ensure power is shared fully and youth are treated with equal respect and dignity.

E. TRAINING AND SUPERVISION RECOMMENDATIONS

Contractors shall establish processes for ensuring that all staff has been trained and understand how to implement the practice elements as outlined in this document. Whenever this Practice Tool is updated or revised, Contractors must ensure their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes. Contractors, upon request from AHCCCS, are required to provide documentation demonstrating that all required network and provider staff have been trained on this Practice Tool.

F. ANTICIPATED OUTCOMES

1. Increased youth participation in CFTs as measured by the System of Care Practice Review (SOCPR) and/or other review processes.

2. Increased peer support roles within the AHCCCS System of Care.

3. Improved services and systems for youth and young adults.

4. Increase in the number of youth participating in leadership groups.

5. Increased awareness by behavioral health staff of the importance of youth involvement.

6. Improved treatment outcomes.

7. Increased number of youth involved in community advocacy.

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.

AHCCCS has been involved in the Mayor's Challenge since 2015. We work alongside other state agencies and community partners to collaborate in efforts to reduce suicides among Arizona's veterans and their family members. More information about the Be Connected campaign can be found here: https://beconnectedaz.org/

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.

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

Footnotes:

An End to Suicide in Arizona
2019 State Plan

EXECUTIVE SUMMARY

According to officials at the World Health Organization (WHO), more than 800,000 people die by suicide each year globally; many more make an attempt. Suicide remains the second leading cause of death among 15-29 year olds worldwide; a suicide happens once every 20 seconds. It is estimated for every completed suicide, there are 20 others who have attempted.

In Arizona, an average of 1350 people die by suicide annually. The majority of these suicides were by gun.

Suicide is not just a behavioral health concern. Suicide may be linked to depression and other illnesses, but the majority of those who have a behavioral health illness do not commit suicide. Suicide touches every family and community in Arizona, regardless of diagnoses, zip codes, ethnicities, or faith.

Suicide is the second leading cause of "years of potential life lost" in our state for American Indians. Also of grave concern are suicides among our increasing populations of retirees and veterans.

The 2019 state plan is a guideline for activities to prevent suicide in Arizona. This plan has been created with guidance from community stakeholders, including the Arizona Coalition for Suicide Prevention.

2019 STATE PLAN

The *2019 End to Suicide in Arizona State Plan* provides recommendations including strategic directions, objectives and strategies specific to our state. The four strategic directions are the same as those given in the National Strategy with the goals, objectives, and strategies closely following the national plan. The statewide strategies identified in the plan are those that can be directly supported by the Arizona Suicide Prevention Coalition and AHCCCS.

This plan was submitted to the Arizona Coalition for Suicide Prevention and other community partners for comment and final review. As such, this plan is presented in collaboration with the Coalition, on behalf of the citizens of Arizona. Together, our mission is to improve the health and wellbeing of all Arizonans by eliminating suicide.

KEY COMPONENTS

Suicide prevention should be community-based; the effort to reduce stigma associated with suicide, and/or asking for help to address mental illness needs to be communal. Key mental health and suicide prevention terms used in this document follow definitions in the National Strategy for Suicide Prevention:
http://www.surgeongeneral.gov/library/reports/national-strategy-suicide- prevention/full_report-rev.pdf

STRATEGIC DIRECTIONS:
1. Healthy individuals and communities
2. Ready access to prevention resources for clinicians and communities
3. Treatment and support services available to clinicians, communities, survivors
4. Continued evaluation and monitoring of prevention programming

A 2019 calendar is included in the index with a preliminary list of activities related to the following goals, objectives, and immediate points of action. As the year progresses, updates will be available on the

AHCCCS blog.

GOALS:

1. Reduce the number of suicides in Arizona through coordinated prevention activities, including developing broad-base support for the Zero Suicide model
2. Reduce stigma related to suicide, including promoting responsible media reporting of suicide
3. Promote efforts to reduce access to lethal means of suicide
4. Promote suicide prevention as a core component of health care services
5. Provide care and support to individuals affected by suicide deaths or suicide attempts and implement community best practice-based prevention, intervention and postvention strategies
6. Increase the timeliness and usefulness of national, state, tribal, and local surveillance systems relevant to suicide prevention and improve 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 findings

GOAL 1. Reduce the number of suicides in Arizona through coordinated prevention activities, including developing strong, multidisciplinary support for the Zero Suicide model

OBJECTIVES 1.1: Integrate zero suicide prevention into the core values, culture, leadership, conversation and work of a broad range of organizations and programs with a role to support suicide prevention activities—including AHCCCS and contracted managed care organizations.
OBJECTIVE 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state, county, tribal, and local levels.
OBJECTIVE 1.3: Sustain and strengthen collaborations across agencies (state, county, tribal, municipal) and community-based organizations to advance suicide prevention.

GOAL 2. Reduce stigma related to suicide, including promoting responsible media reporting of suicide

OBJECTIVE 2.1: Promote effective programs and practices that increase protection from suicide risk.
OBJECTIVE 2.2: Reduce prejudice, discrimination, or stigma associated with suicidal behaviors, and mental health and substance use disorders.
OBJECTIVE 2.3: Promote the understanding that recovery from mental health illness and substance use disorders is possible for all.
OBJECTIVE 2.4: Encourage and recognize news and online organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.
OBJECTIVE 2.5: Encourage and recognize news and online organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.

GOAL 3: Promote efforts to reduce access to lethal means of suicide

OBJECTIVE 3.1: Encourage providers who interact with individuals and groups at risk for suicide to routinely assess for access to lethal means.

OBJECTIVE 3.2: Partner with firearm dealers, gun owners, concealed handgun trainers and law enforcement to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

OBJECTIVE 3.3: Encourage the implementation of safety technologies to reduce access to lethal means.

GOAL 4. Promote suicide prevention as a core component of health care services
OBJECTIVE 4.1: Provide training to community groups in the prevention of suicide and related

behaviors.

OBJECTIVE 4.2: Provide training to all health care providers, including mental health, substance abuse and behavioral health, on the recognition, assessment, and management of risk factors, warning signs, and the delivery of effective clinical care for people with suicide risk.

OBJECTIVE 4.3: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.
OBJECTIVE 4.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.
OBJECTIVE 4.5: Develop and implement protocols, programs, and policies for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

GOAL 5: Provide care and support to individuals affected by suicide deaths or suicide attempts and implement community best practice-based prevention, intervention and postvention strategies

OBJECTIVE 5.1: Support current LOSS teams and research funding options to expand work statewide.

OBJECTIVE 5.2: Provide suicide prevention information in Spanish.

OBJECTIVE 5.3: Provide evidence-based best practice information regarding postvention strategies.

GOAL 6. Increase the timeliness and usefulness of national, state, tribal, and local surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action
OBJECTIVE 6.1: Strengthen relationships with state, county partners to improve access to suicide data.

GOAL 7. Evaluate the impact and effectiveness of suicide prevention interventions and systems and disseminate findings

OBJECTIVE 7.1: Evaluate the effectiveness of suicide prevention interventions in Arizona
OBJECTIVE 7.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions in Arizona.
OBJECTIVE 7.3: Examine how suicide prevention efforts are implemented in different states/counties and communities to identify the types of delivery structures that may be most efficient and effective.

What Can You Do to Prevent Suicide?

Research shows there are protective factors that keep individuals from dying by suicide. Individuals, neighborhoods, cities, etc… can accomplish the following to strengthen their communities and prevent future suicides.

1. Build strong, positive relationships with family and friends.
2. Become involved in your community. Mentor youth. Volunteer at a food bank. Join a faith or spiritual community. Check on your neighbors, especially those who are older and live alone.
3. Learn the signs and symptoms of suicide and suicidal behaviors and how to reach out to those who may be at risk.
4. Store firearms locked and unloaded. Store ammunition in a different location, also locked.
5. Dispose of unwanted medications.
6. Learn when to contact treatment providers or emergency services for loved ones who are at risk for suicide.
7. Provide appropriate follow up support to family members who have been discharged from an ED or inpatient for suicidal thoughts or attempts.
8. Ask your community leaders about suicide prevention. Does your local library have flyers on how to access behavioral health services? Are your children's teachers receiving suicide prevention training? Does your church know how to respond if someone in the congregation is suicidal?
9. Participate in local coalitions. For information about the Arizona Suicide Prevention Coalition, visit: https://www.azspc.org/
10. Encourage your neighborhood newsletter, or city, to convey messages of help, hope, and resiliency. Use your voice for prevention by writing a letter to your editor. Does your Senator know about suicide prevention efforts in your community?

Reference: 2012 National Strategy for Suicide Prevention

RESOURCES:

2012 National Strategy for Suicide Prevention -
http://www.surgeongeneral.gov/library/reports/national- strategy-suicide-prevention/ .
After a Suicide: A Toolkit for Schools
https://www.afsp.org/coping-with-suicide-loss/education-training/after-a-suicide-a-toolkit-for- schools
Assessing and Managing Suicide Risk (AMSR)
http://www.sprc.org/training-institute/amsr
Best Practices Registry, Suicide Prevention Resource Center
http://www.sprc.org/bpr
Counseling on Access to Lethal Means Project (CALM) *http://www.hsph.harvard.edu/means-matter/examples-of-means-restriction- programs/* Center for Elimination of Disproportionality and Disparities *http://www.hhsc.state.tx.us/hhsc_projects/cedd/*
Chronological Assessment of Suicide Events (CASE approach - *www.suicideassessment.com*), Clinical Workplace Preparedness and Comprehensive Blueprint for Workplace Suicide Prevention
http://actionallianceforsuicideprevention.org/task-force/workplace/cspp/training Collaborative Assessment and Management of Suicidality (CAMS) *http://psychology.cua.edu/faculty/jobes.cfm*
Columbia Suicide Severity Rating Scale (CSSRS) *http://www.cssrs.columbia.edu/*) Framework for Successful Messaging *www.SuicidePreventionMessaging.org*
LOSS Team Postvention Workshops and Trainings *http://www.lossteam.com/About-LOSSteam-2010.shtml* Means Matters, Harvard School of Public Health
http://www.hsph.harvard.edu/means-matter/examples-of-means-restriction-programs/
National Registry of Evidence-Based Prevention Programs
http://nrepp.samhsa.gov
National Suicide Prevention Lifeline, 1-800-273-8255
http://www.suicidepreventionlifeline.org
Preventing Suicide: A Toolkit for Schools
http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669
Recommendations for Reporting on Suicide
http://reportingonsuicide.org
Self-Directed Violence Surveillance Uniform Definition and Recommended Data Elements
http://www.cdc.gov/violenceprevention/pdf/self-directed-violence-a.pdf. Suggested Guidelines for Implementation of a Trauma-informed Approach
http://www.samhsa.gov/traumajustice/traumadefinition/guidelines.asp x
The Way Forward - Pathways to hope, recovery, and wellness with insights from lived experience
http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/T he- Way- Forward-Final-2014-07-01.pdf
Zero Suicide in Health and Behavioral Health Care

2019 CALENDAR OF EVENTS:

Arizona Suicide Prevention Coalition: Second Tuesday of the month JFCS
2033 N. 7th St. Phoenix, AZ
Dial in: 1-619-326-2772 #5131264

Survivors of Suicide Support Group Last Tuesday, monthly
8:30 pm
Christ Lutheran Church 25 Chapel Rd
Sedona, AZ 86336

September:
Suicide Prevention Month

December:
Out of Darkness Suicide Prevention walk, Phoenix

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 a reepreentative of the AHCCCS Executive Team. 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 Arizona Department of Housing, the Governor's Office of Youth, Faith and Family, 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

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.

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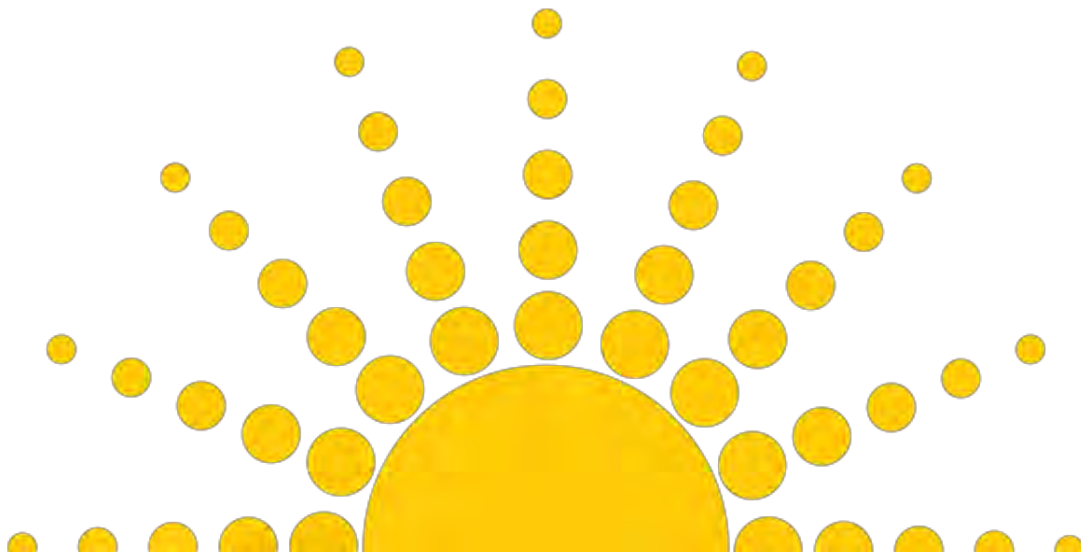
Footnotes:

UNIQUE BEHAVIORAL HEALTH SERVICES FOR NEEDS OF CHILDREN, YOUTH AND FAMILIES INVOLVED WITH DEPARTMENT OF CHILD SAFETY PRACTICE TOOL

Effective Date: 10/01/16

I.   GOAL (WHAT DO WE WANT TO ACHIEVE THROUGH THE USE OF THIS PRACTICE TOOL?)

1. To provide an understanding of the unique behavioral health service needs of children involved with the Department of Child Safety (DCS) and to provide guidance to Child and Family Teams (CFTs) in responding to those needs,

2. To outline the clinical considerations for serving children involved with DCS, their families, and other caregivers,

3. To delineate the Rapid Response procedures that must be followed when a child is removed from their home by DCS see ACOM Policy 449.

II.   BACKGROUND

During the past 40 years, a growing body of research has identified some of the risk factors that predispose children and adults to behavioral health issues.[a] Risk factors are those characteristics, variables, or hazards that, if present, make it more likely an individual will develop a disorder than someone selected at random from the general population. Risk factors can reside in the individual (such as a genetic vulnerability) or within the family, community, or institutions that surround the individual. Some risk factors play a causal role while others merely mark or identify the potential for a disorder. The degree of risk – and the likelihood of developing a behavioral health issue – is also shaped by the accumulation and timing of risk factors across the lifespan of the individual.

An adverse childhood exposure or a biologic vulnerability may increase the risk for certain behavioral health issues, such as substance use, depression, and juvenile conduct disorder; however, other risk factors may also be necessary for the illness to be expressed. Studies of conduct disorder have consistently confirmed that as the numbers of adverse conditions accumulate, the risk of disorder onset increases proportionately; however, certain risk factors, such as low income, are a more significant predictor in children aged four to 11 than in older adolescents.

Finally, understanding the complex interrelationships of individual, family, and community risk factors in the onset of a behavioral health issue is also shaped by the presence of protective factors – personal qualities, familial rituals and relationships, and social/peer group norms among other variables − that contribute to individual resilience or the capacity to cope with significant stressors.

Across the two most common behavioral health issues in the U.S. today – depression and alcohol abuse/dependence − situational stressors and adverse family conditions including a significant loss, traumatic exposure, and family conflict or violence are significantly associated with later onset of the condition, particularly in children whose close biologic relatives also suffer depression or alcoholism.[b] In a survey testing for associations between adverse childhood experiences and health risk behaviors and chronic disease among 9,500 adults at a large California HMO, the study's authors found a strong association between individuals exposed to a variety of negative environmental risk factors as children and the likelihood of smoking, suffering chronic pulmonary disease, use of illicit drugs, and attempting suicide as adults.[c] The categories of exposure reviewed included experiencing emotional, physical, or sexual abuse, witnessing domestic violence, parental

separation, or divorce, living in a household characterized by substance use, or with an adult with mental illness, and incarceration of one or more parents.[d]

While any child might experience trauma, loss, or anxiety, children in the child welfare system tend to be exposed to an accumulation of adverse childhood experiences and life transitions to which children from other families may never be exposed. The mission of the child welfare system and DCS is to ensure children experience safety, permanency, and wellbeing. This mandate can be supported through strong partnerships between DCS and AHCCCS System of Care to provide prompt behavioral health assessment, treatment, and services for referred families that may also reduce the risk of future behavioral health issues among children experiencing abuse or neglect.[e]

Refer also to Attachment A, Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with DCS − Desktop Guide.

A. PROCEDURES

1. Working in Partnership

   Efforts to meet the unique service needs of children and families referred by DCS are best supported when all involved Contractors and DCS work collaboratively through a unified service planning process that upholds the Arizona Vision-and 12 Principles for Children Service Delivery as outlined in AMPM Policy 430. Partner agencies may include a variety of health, social service, and justice system organizations, including the AHCCCS System of Care, DCS, juvenile justice, DDD, and allied service providers (including pediatricians and day care providers). The CFT provides the platform for unified assessment, service planning, and delivery based on the individual needs of the children and other family members. Other child-serving agencies, such as the DCS caseworker and Juvenile Justice probation officer (if the child is a dual ward/dually adjudicated) should be invited as members of the team where indicated to align efforts of the CFT with the child welfare case plan or other agency Service Plans. The CFT must strive to fully understand the unique needs of each child and family. Continuity of team membership and its clinical representative(s) is particularly important during the child's transitions and subsequent placement. Integrated Service Plans among child-serving agencies involved with the child should be developed by the CFT and jointly implemented.

   Referrals from the child welfare system can be initiated through an urgent, rapid, or crisis behavioral health response after a child's removal from his/her home, or by referral from DCS (e.g., as part of an in-home intervention plan or when behavioral health needs of removed children and/or family members warrant re-assessment and potential intervention). In all cases, the AHCCCS System of Care shall begin to address the child and family's need for behavioral health treatment and service at the earliest moment as specified in A.R.S. §8-512.01, and ACOM Policy 449 in order to understand, shape, and align with the child welfare case plan. For example, if the child is removed from his/her family of origin with a case plan focused on reunification, behavioral health services are expected to support that plan by providing services directed toward the behavioral health treatment needs of the child. For children under the age of three and their siblings, A.R.S. §§8-113, 8-553, 8-824,

8-829, 8-847, 8-862 reduces the time in care requirement to six months; this highlights the need for timely behavioral health services as part of the reunification plan through DCS. Services should also be provided to the parent(s), when necessary, to help them address their own behavioral health treatment needs. This may require separate enrollment of the parent(s) in the AHCCCS System of Care when eligible. If the child is placed with temporary caregivers (e.g. an uncle, out-of-home placement or adoptive parent(s) and families), behavioral health services should support the child's stability with those caregivers by addressing the child's treatment needs; identifying any risk factors for placement disruption and providing support to minimize the risk; and anticipating crises that might develop and indicating specific strategies and services to be employed if a crisis occurs. Behavioral health services must be designed to help the child remain stable in the temporary, out-of-home placement to minimize or eliminate the risk of placement disruption and to avoid the involvement of the police and the criminal justice system. In particular, behavioral health services must anticipate and plan for transitions in the child's life that may create additional stressors, such as transitions to new schools or transitions to a permanent family living situation.

The AHCCCS System of Care is expected to support the DCS caseworker by:
a. Establishing a CFT to identify and describe the strengths, needs, and important cultural considerations of the child and family,
b. Using the CFT to assess clinical risks, symptoms, and behaviors indicating a need for extended assessment or more intensive treatment services for both children and adults,
c. Using the CFT to develop a Service Plan, crisis plan, and to present recommendations and options to the court as appropriate, and
d. Furnishing information and reports about the provision of behavioral health services to child serving agencies, including DCS and the juvenile court.

2. <u>Addressing Needs in the Context of Each Child's Family</u>

The involvement of DCS indicates the presence of significant safety and risk concerns within the family unit. The family circumstances that lead to involvement by DCS can be expected to create needs for behavioral health treatment for most children and may also reflect behavioral health treatment needs of other family members. It is important that the CFT understand these concerns and their clinical implications and explore opportunities where behavioral health services can help to mitigate them. This can be accomplished through assessment and referral of adult family members for substance use and behavioral health services and by identifying those strengths and resources within the family and community that can fortify the child's abilities to cope with problems and adapt to change. Together, DCS, AHCCCS System of Care and other involved agencies should identify resources to support the needs of both family and child.

Families – whether the child's family of origin, an out-of-home placement or adoptive parent(s) and families, a relative, a friend providing kinship care, or an adoptive family giving legal guardian -- can be supported through the individual Service Plan of the child with services and/or interventions such as respite, family support, peer support, living skills

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training, or family counseling to address the child's treatment needs. The CFT may recommend behavioral health services that can help to stabilize the child's family situation and address behavioral health and substance use needs of family members without removing the child from the home. Parents and others in the home, including siblings, may also need specific individualized treatment, and it may be necessary to refer those family members for enrollment in the AHCCCS System of Care Service Plans for family members should be coordinated with those of the child to make them compatible and mutually reinforcing. Without diminishing the needs that may exist for individual interventions, the CFT should participate in an overall plan that makes sense to the family and is consistent with the goals of DCS and the juvenile court.

3. <u>When the Child Remains with His/Her Own Family</u>

Children involved with DCS often live in family homes where DCS is actively monitoring identified concerns relating to safety, security, or basic needs. In these situations, adults and siblings living in the home may be the primary focus of AHCCCS System of Care involvement through provision of treatment and support services to parents that also reduce risks to the children. Service providers working with families who are involved with DCS must remain alert to common emotional responses of children that may indicate a need for further assessment or referral to the AHCCCS System of Care If a CFT has convened, such considerations should be factored into developing the Service Plan. Common responses can include:
a. Disturbed parent-child and child-sibling relationships,
b. Disrupted capacity for trust and attachments,
c. Anxiety,
d. Developmental delays or compromised learning,
e. Dysfunctional coping skills,
f. Behavioral disturbances,
g. Post-traumatic stress disorder (PTSD),[f]
h. Mood disturbances, and/or
i. Physical complaints or symptoms like headaches, abdominal pain, or bedwetting.

Some of these responses might be associated with – or indicate potential need for – involvement in primary health care, juvenile justice, special education, and/or developmental disabilities systems. The AHCCCS System of Care must furnish behavioral health services to address critical behavioral health needs, ideally as part of a collaborative intervention with DCS, the juvenile court, and other child-serving systems. Behavioral health treatment can be most effective when provided prior to a child's removal.

A child remaining at home with a family involved with DCS may need to develop or strengthen supportive relationships with family and others – both peers and adults. To meet these unique needs, behavioral health services with most families will need to be intensive, comprehensive, and delivered quickly in order to maximize engagement with the family and to strengthen their existing support systems. When DCS services are also in place, behavioral health professionals and other providers should work in concert with those services.

Parents should be helped to learn/know how to manage their child's unique needs, and to anticipate and respond to those needs as they change. A key challenge for many parents and family members in this situation is the need to advance their own recovery from behavioral health conditions or substance use disorder while remaining responsive and attentive to the needs of their child. Behavioral health services provided to such families must be designed to impart skills and confidence to the parents – both in their role as caregivers and their role as a person entering recovery. Siblings and other family members should be incorporated in service planning and delivery, and advised of choices they may exercise in the process.

The behavioral health representative must ensure the provision of covered behavioral health services identified and recommended by the CFT that address the child's treatment needs, including coordination with services for parents and promotion of the child's ability to live and thrive in his/her own family home, with safety and stability.

4. <u>When the Child Is Removed to Out-Of-Home Placement</u>

The presence of serious safety concerns may require DCS to remove children from their family home to an out-of-home placement (shelters, receiving homes, relative ["kinship"] placements, family foster homes, or group homes). A child who may already have been seriously neglected or abused (physically, sexually, and/or emotionally) within the family home will very likely be affected not only by the neglect or abuse that precipitated removal, but also by the removal itself. The child may experience trauma, disorientation, and uncertainty related to such a drastic change in his/her life circumstances[g,h]. A Team Decision Meeting (TDM) can be scheduled by DCS when there is consideration of removal of a child or when removal has occurred. The meeting is typically held within a very short time frame to address the potential removal. Behavioral health representative(s) may be invited to participate in these meetings in order to provide insight into the AHCCCS System of Care and the services that may be provided to the child, family or relatives.

AHCCCS considers the removal of a child from his/her family home to the protective custody of DCS to be an urgent behavioral health situation. In these situations, the Contractor shall ensure timely provision of all behavioral health services including crisis services, 72-hour rapid response, urgent need response, and ongoing behavioral services, including screening and evaluation. See ACOM Policy 449.

The behavioral health service provider is expected to consider an extended assessment period (e.g., over 30 to 45 days) to more accurately identify any emerging/developing behavioral health treatment needs that are not immediately apparent following the child's removal. When children are placed in DCS custody, the child and family shall be referred for ongoing behavioral health services for a period of at least six months unless services are refused by the guardian or the child is no longer in Department of Child Safety custody. Children in out-of-home placement who do not initially demonstrate behavioral health symptoms may still require active therapeutic intervention, including family-focused services and continued close observation to address any potential effects of their removal and to support placement stability. The behavioral health service provider identifies areas

which may require further assessment during the period of time the child is enrolled. While identifying and arranging the behavioral health services needed for a child, the CFT is also expected to support familial relationships, such as visitations with their siblings and other members of their birth families as arranged by DCS. When there is multi-agency involvement, every effort is made by the CFT to collectively develop a single, unified Service Plan that addresses the needs and mandates of all the parties involved. If after receiving behavioral health services for at least six months a child is adjusting well and no longer exhibiting signs and symptoms of behavioral health concerns receiving such services that child may be dis-enrolled from those behavioral health services. The child can still be referred for future services, including re-assessment, should a need arise. The behavioral health service provider must work collaboratively with DCS caseworkers to establish a process for a subsequent referral to the AHCCCS System of Care should those clinical symptoms manifest and a need for services arise in the future.

AHCCCS and DCS established mechanisms to implement the rapid response requirements. Rapid Response for children entering out-of-home placement is intended to:

a. Identify immediate behavioral health needs and presenting problems of children removed from their homes, to stabilize crises, enroll the child in the AHCCCS System of Care and offer the immediate services and supports each given child may need,

b. Provide direct (therapeutic) support to each child removed from their home as appropriate, intending to reduce stress or anxiety the child may be experiencing.

c. Provide direct support to each child's new caregiver as appropriate, including guidance about how to respond to the child's immediate behavioral health needs,

d. Identify a point of contact within the AHCCCS System of Care,

e. If a CFT is not already in place, initiate the development of a CFT, and

f. Provide the DCS Specialist with findings and recommendations, related to the behavioral health needs of each child, within five to seven days of the referral or prior to the Preliminary Protective Hearing, whichever occurs first.

Out-of-home placement or adoptive parent(s) and other protective caregivers must be recognized as significant, knowledgeable members of the CFT. They should experience well-integrated coordination among, and clear communication from, all involved systems, beginning immediately upon placement of the child. Out-of-home placement or adoptive parent(s) and other protective caregivers will need guidance and support to raise children experiencing the trauma of neglect/abuse and subsequent removal from their family homes. The caregivers will need guidance to better understand each child's adjustment, how to respond to the coping mechanisms the child may demonstrate in his/her new situation, and how to seek outside assistance and/or recommendations to support any treatment.

When children are removed to out-of-home placement their parents may also benefit from behavioral health services, either as included in the treatment plan for the child or through separate enrollment in the adult AHCCCS System of Care. Parents may need assistance in order to:

a. Learn how to better analyze and solve problems in relation to the safety needs of the child and other family members, and

b. Be engaged (or possibly re-engaged) to participate in assessment, service planning, and delivery processes for their children and themselves.

The AHCCCS System of Care is expected to assist DCS Specialists, judges, attorneys, Court-Appointed Special Advocates (CASAs), and others to understand how behavioral health services, as well as their own respective relationships with the child, impact the child's overall treatment progress and functional outcomes.

Children who have been removed by DCS from their family homes because of neglect or abuse might experience the following emotional responses:
a. Disrupted parent-child and child-sibling relationships,
b. Disrupted capacity for trust and attachments,
c. Anxiety,
d. Developmental delays or compromised learning,
e. Dysfunctional coping skills,
f. Behavioral disturbances,
g. Running away,[i]
h. Post-traumatic stress disorder,
i. Mood disturbances,
j. Substance abuse,[j] and/or
k. Physical complaints or symptoms like headaches, abdominal pain, or bedwetting.

In addition, some children may need specially informed treatment to address their victimization by sexual abuse, including specific interventions for such children who act out in a sexually aggressive manner.

Any child who has experienced a removal by DCS is at risk for negative emotional consequences and future behavioral health disorders. When DCS initiates a removal of the child, specific requirements for behavioral health contractors are identified ACOM Policy 417.

5. <u>When the Child Returns to His/Her Family of Origin from Out-of-Home Placement</u>

Children who have been living apart from their families of origin have had time to adapt to new expectations, interactions, roles, and experiences. Coping skills and behavioral response patterns have likely been adapted to the dynamics of the protective caregivers, and these may be distinct from those of their own families. At the same time, their families of origin will likely have adapted to new daily realities that have not included the child.

Consequently, visitation and contact must be promoted with family members and other anchoring relationships (e.g., friends, extended family, and teachers) to the greatest extent possible. The CFT must work collaboratively with DCS caseworkers to identify opportunities for therapeutic support during episodes of visitation and other family contact and to promote practicing the new skills and behaviors that successful reunification requires. All involved parties will need to understand how to optimize the transition process

according to the child's age, developmental level, and specific circumstances, including how to support productive transition strategies.

Each CFT member/partner agency should contribute knowledge, skills, appropriate services, and resources to the reunification plan. In spite of the planning and work undertaken to prepare for the child's return home, reunification will likely be stressful and difficult.[k] Issues relating to neglect, abuse, abandonment, fear, and mistrust may resurface. Negative feelings, memories, and traumatic stress symptoms can be triggered by re-exposure to the home environment. Familiar but dysfunctional family coping patterns may return and threaten to replace recently learned adaptive patterns. The CFT must focus on preparing both the child and the family for reunification by ensuring that appropriate Service Plans (including crisis plans) are in place as needed.

Children and family members may require additional assessment and individualized behavioral health services during the period of reunification based on new or recurrent behavioral health needs. Behavioral health providers and child welfare professionals on the CFT must work collaboratively to promote:
a. A strong recovery environment for the family,
b. The child being embraced, re-accepted, and not blamed (e.g., for the initial removal) by his or her reunified families,
c. Family engagement and permanency,
d. Evidence that the family will put the child's needs first, and
e. Confidence that the child's stay with the family will last.

6. <u>When the Child Achieves Permanency through Adoption or Guardianship</u>

Children who leave out-of-home placement for other permanent situations (such as adoption or guardianship) may experience significant feelings of loss at the same time their permanency is viewed as a success by DCS, the juvenile court, their new families, and even by themselves. Many adopted children experience feelings of isolation and being different. They may feel irreversibly abandoned by their families of origin, engendering anger, feelings of guilt, and even self-blame. The adopted child may experience the loss of not only both natural parents, but also of extended family, cultural and genealogical heritage, a sense of connectedness, former social status, and personal identity. Such losses are rarely recognized in the context of adoption, and few supports have been made available to children experiencing them. The CFT must draw upon the expertise and resources of participating agencies to identify supports for children in this stage of transition.

The same children may strive for, and be integrating, new feelings of gratitude, inclusion, and acceptance. Children entering new ties through adoption or guardianship are likely to strive to gain a new sense of identity and belonging – a feeling of "fitting in" – in their new home and community. Given their prior losses, they are likely to need reassurance that "I am wanted, no matter what I do or how I act". Many will choose to test limits repeatedly to try the strength of their new ties as they adjust. Children in adoptive or guardianship situations need to know that their past will be considered by others and included in their futures.

These emotional responses may occur on top of existing issues such as: abuse and neglect, the trauma of separation, the adaptation challenge posed to the child by his/her removal from family to out-of-home placement, and the additional transitions the child most likely endured within out-of-home placement. All children eligible for the Adoption Subsidy program remain categorically eligible for Title XIX behavioral health services for the duration of their childhoods.

The CFT must organize to meet the many needs of the child in their new home. Adoptive parents, child welfare, and behavioral health professionals must work together to help the child understand what adoption/guardianship means, and to name and manage confusing feelings. The team may identify the need for such feelings to be addressed in the context of individual, family, or group therapy or identify behavioral health services that prepare the child for success in the new family situation. Minimally, the family should receive information on how to access additional assistance if concerns arise.

The CFT must recognize that the child's new family may also need adequate preparation and support to successfully welcome and incorporate a new family member. Every member of the child's new family will be affected by the changing relationships within the family system. They may need to be prepared for complex emotional and behavioral issues often presented by children out-of-home placement, and to anticipate that the older the child, and the longer he/she has been in out-of-home placement, the more challenges and limit-testing will be likely.[1] Supportive services provided by the child welfare system, behavioral health services, and other individualized services must be readily available, consistently provided, and sufficiently tailored to meet the unique needs of the child and the adoptive family. Adoptive parents will feel the need to be fully recognized as the child's parent, and reassured that they will know what to do when faced with the child's adjustment issues over time.

"Safe" people from the child's family of origin or past support system, who are important to the child, should remain involved in the child's life as much as possible. This dimension may also require assistance by the behavioral health provider to ensure that the child and his/her new family can have positive connections to the child's past. The CFT should continue involving those safe people in the ongoing planning and treatment process.

7. Special Considerations for Infants, Toddlers, and Preschool-Aged Children

The CFT can contribute to the well-being of infants, toddlers, and young children by helping other involved partners to view the child holistically. Clinicians are expected to facilitate the special assessment approach prescribed by AHCCCS in the Psychiatric Guidelines for Children Birth to Five Practice Tool which supports this holistic perspective. The behavioral health expertise they bring to the CFT must:
a. Help family members to appreciate the impact of their interactions on young children (most therapeutic work at this age is likely to focus on those dyadic interactions and relationships, as individual interventions with such young children are rarely indicated),

b. Recognize signs, symptoms, and indicators of other needs (e.g., speech delays, sensory challenges, secondary effects of maternal substance abuse) that may impact children's social and emotional development (and, for children below age three, initiate referrals for early intervention services [Arizona Early Intervention Program (AzEIP)] when indicated by developmental screenings), and

c. Work closely with family members, pediatricians, and other early intervention partners to recognize and address such needs.

Parents, out-of-home placement or adoptive parent(s), and other protective caregivers must be given guidance and support to understand the strong sensory base to an infant's experience of interactions with people and the world in general. Pediatricians, parent aides, behavioral health clinicians, or early interventionists must educate caregivers to recognize indicators of the young child's adjustment through observable behavior (e.g., an infant's eating, sleeping, and other bodily functions). They must be helped to understand that, as children make gains with receptive and expressive language and with cognitive development,[m] they will have increasing capacity to identify and describe how they are reacting to or coping with new situations, how it feels, and perhaps what might help them to feel better.

8. Preparing the Adolescent for Independent Living

Behavioral health service needs of children reaching the age of majority while in protective state custody can be multi-dimensional. Some individuals may continue to have behavioral health needs that can be addressed through enrollment in services for adult General Mental Health, Substance Abuse, and/or Serious Mental Illness.[n] Studies demonstrate that problems that tend to surface in adolescence (e.g., alcohol and drug use, truancy) will be more common among adolescents in the child welfare system. In addition, in order to become stable and productive adults, they may require transitional financial assistance (including but not limited to DCS independent living subsidy) and budget management skills. Added challenges of moving to adulthood include assistance in locating and securing housing, connecting to a first job, and/or beginning pursuit of higher education. Employment, higher education, and housing issues will pose significant challenges for many young people.

Some young adults continue their involvement with DCS on a voluntary basis during this period. DCS independent living and young adult programs offer opportunities to gradually develop skills necessary for stable, productive adult living. Many young adults, understanding they are now fully responsible for making their own decisions, opt to forego such opportunities and cut ties with the system that may have, in their view, been "controlling my life" before now. Because youth former in out-of-home placement frequently experience poor outcomes,[o] behavioral health counseling may assist them in realizing their decision-making power without "proving it" by cutting ties with this important lifeline.

Many young people who have been in the DCS system have expressed the recurring theme of stigma, of an overwhelming desire to be free of it, and to be seen in the world as competent, self-sufficient, and independent. Many young adults will still have – or will strive to re-establish – close connections with others from their past, such as siblings,

family, friends, educators, and faith communities. The behavioral health provider, in collaboration with DCS personnel, must:

a. Respond quickly to meet any identified behavioral health needs,
b. Solicit input from the young adult to determine their needs,
c. Involve the young adult's own support system,
d. Plan adequately to address their needs,
e. Stay involved in their lives, and
f. Help them transition to adulthood by teaching them the skills they need to thrive and to meet their ongoing needs, including behavioral health issues that may continue into adulthood, or which may emerge over time.

The CFT must anticipate the need to help a young person prepare for the transition to adulthood beginning at age 16. The AHCCCS Transition to Adulthood Practice Tool provides specific guidance and required service expectations to support the CFT in thorough planning and preparatory activities.

While this Practice Tool describes many likely emotional responses of children and adolescents, it is not exhaustive. Children and youth may manifest a wide variety of psychological, social and even medical problems in combination. The Contractors and their providers are expected to recognize and appropriately address the unique behavioral health needs of children involved with DCS, their families, and caregivers through the CFT process as specified in AMPM Policy 510.

B. TRAINING AND SUPERVISION EXPECTATIONS

Contractors shall establish their own process for ensuring all clinical and support services staff working with children and adolescents understands the required service expectations and implements the practice elements as outlined in this document.

Whenever this Practice Tool is updated or revised, Contractors must ensure their subcontracted network is notified and required staff is retrained as necessary on the changes. In alignment with A.A.C. R9-20-205, Clinical Supervision requirements, the supervision for implementation of this Practice Tool is to be incorporated into other supervision processes which the Contractor and their subcontracted network have in place for direct care clinical staff.

C. ANTICIPATED OUTCOMES

1. Anticipated outcomes include:
   a. Improved engagement and collaboration in service planning between children, families, community providers and Department of Child Safety.
   b. Improved functional outcomes for children involved with Division of Child Safety
   c. Improved identification and incorporation of strengths and cultural preferences into the planning processes
   d. Increased statewide practice in accordance with the Arizona Vision and -12 Principles for Children Service Delivery

    e. Coordinated planning between behavioral health and Department of Child Safety to ensure seamless transitions for children involved with DCS

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[a] National Academy of Sciences. *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. (1994)

[b] Ibid.

[c] Anda, RF, Croft JB, Felitti VJ, et al. "Adverse Childhood Experiences and Smoking During Adolescence and Adulthood." *Journal of the American Medical Association*. 1999. 282:1652-1658.

[d] Felitti, Vincent J., MD, The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead," in: *Praxis der Kinderpsychologie and Kinderpsychiatrie* (2003), 52: 547-559 [English translation].

[e] See *J.K. v. Eden et al.,* No. CIV 91-261 TUC JMR (6/26/01), Paragraph 21.

[f] *Saltzman, W.R., Pynoos, R.S., Layne, C.M. et al. (2001), Trauma- and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment tool. Group Dynamics: Theory, Research and Practice, 5(4):291-303:* When failing adolescent students with severe PTSD symptoms were recognized and treated for trauma, their symptoms were markedly reduced, they required no further discipline, and their grade point averages went up significantly.

[g] Landsverk, Garland & Leslie (2002), *Mental health services for children reported to Child Protective Services*, APSAC Handbook on Child Maltreatment (Sage Publications), 487-507. In Great Smoky Mountain Study, 80% of children in contact with child welfare (n = 234) met criteria for DSM-IV diagnosis, functional impairment or both; as well as 78% of children (n = 132) who had ever been in foster care.

[h] Landsverk, J, *National Study of Child and Adolescent Well-Being,* 2003 (Washington, DC: U.S. DHHS Administration for Children and Families): In San Diego Children's Hospital study, 40-50% of children in out-of-home care ages 4-17 demonstrate significant behavioral problems; and 42% (n = 426) of children in out-of-home care ages 6-17 met criteria for DSM-IV disorders with moderate impairment (POC).

[i] *Deborah Bass, "Study of Runaway Youths Finds One-Third Were In Foster Care," St. Louis Post-Dispatch, (January 19, 1992).* [results of a survey of 170 runaway shelters.]

[j] *Clark, H.W., McClanahan, T.M. & Sees, L.K. (Spring 1997), Cultural aspects of adolescent addiction and treatment. Valparaiso University Law Review, Vol.31(2).* Adolescents with alcohol dependence are six to 12 times more likely to have a childhood history of physical abuse, and 18 to 21 times more likely to have a history of sexual abuse than those without substance abuse problems.

[k] National Child Welfare Resource Center for Family-Centered Practice, 2003. "The problems of these children are not likely to disappear once they are adopted or reunified with their families. Therefore children and parents need post-adoptive or post-reunification services to help them deal with lifelong effects of abuse, neglect and separation."

[l] A recent survey of 375 Maine families who had adopted children from foster care an average of six years earlier *[John Levesque and MichaelLahti, Maine Adoption Guides Project, "Maine Post-Adoption Legalization Survey: Child and Family Needs and Services," DHHS IV-E Demonstration Project, January 2002]* reported the following problems persisting in at least half of those children: Sudden

changes in mood or feelings (82%); argues too much (75%); difficulty concentrating (75%); impulsive, acts without thinking (75%); disobedient at home (74%), stubborn, sullen (71%); cheats or tells lies (70%); high-strung, tense or nervous (61%); has trouble getting along with other children (60%); very strong temper, loses it easily (60%); restless, overly active (59%); does not seem to feel sorry after misbehaving (57%); fearful or anxious (55%); disobedient at school (53%); not liked by other children (52%); has obsessions (52%); and easily confused (51%). These problems were identified within stable adoptive families of relatively long standing. Yet even after an average of six years since finalization of the adoptions, 38% of parents rated the child's current adjustment as "somewhat difficult," and 12% as "very difficult."

[m] Lederman, C., Osofsky, J & Youcha, V, *Meeting the unique needs of infants and toddlers in juvenile and family court*, (2005), Zero to Three, "Almost 80% of young children (below age 5) in foster care have been prenatally exposed to maternal drugs. Developmental delay among these children is four to five times greater than for children in the general population. More than half suffer from serious physical health problems." See also, Landsverk, op. cit., "50-65% of children in out-of-home placements ages 0-6.4 years screen positive for developmental problems."

[n] Chapin Hall Center for Children (2004), "Midwest sample of youth transitioning out of foster care to adulthood found: 12.9% with major depression, 25.1% PTSD, 21.1% substance use disorders. *Northwest Fpster Care Alumni Study* (2005) of 479 young adults in Oregon and Washington, "PTSD incidence among former foster children is twice as high as for U.S. war veterans. Foster care alumni experienced over seven times the rate of drug dependence and nearly two times the rate of alcohol dependence experienced in the general population."

[o] *Northwest Foster Care Alumni Study*, op.cit., "Between age 20 and 33, 1/3 of the study group lived below the poverty level, 1/3 lacked health insurance, and ¼ had experienced periods of homelessness." A survey of 113 former foster care youth (Wisconsin, 1998) found that, 12-18 months after leaving foster care, 39% were unemployed, 32% were on public assistance, and 27% of men and 10% of women had been incarcerated at least once.

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?

    Arizona Health Care Cost Containment System (AHCCCS) Response:
    The Behavioral Health Planning Council was involved in the development and review of the State Plan by reviewing the plan and providing feedback to AHCCCS that was incorporated into the final draft of the plan.

    The Behavioral Health Planning Council has held community forums with stakeholders to identify topics to be addressed in the planning, implementation and process improvement for the behavioral health services through AHCCCS. The Council has worked collaboratively with AHCCCS to address the topics, provide clarification, and work with contractors to make changes to improve service delivery and health outcomes.

    Arizona Behavioral Health Planning Council addition to response:
    These services are provided through contracts with individual local organizations.

    Health Plans in Arizona seeking to provide Substance Use Treatment and Recovery Services submitted proposals in response to a Request for Proposal from AHCCCS. Through this process, AHCCCS selected organizations with winning bids. These services are monitored within the context of the submitted proposals and terms of the Request for Proposals.

    Draft of The Request for Proposals were subject to public comment and within that context, the Planning Council may comment on these documents and the plan for 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.

    Arizona Health Care Cost Containment System (AHCCCS) Response:
    Council members represent Arizona's mental health population including General Mental Health/Substance Use (GMH/SU), Substance Use Disorders, and individuals who are diagnosed a serious mentally illness (SMI). The Council regularly collaborates with AHCCCS on program funding matters, access to care, and quality improvement recommendations. The Council holds

meetings and community forums in locations around the state for the purpose of offering opportunities for people in various communities to speak about their concerns, have their voices heard, and have actions taken by the state to address their concerns. The Council and AHCCCS partnered to identify stakeholders representing the Department of Corrections, Department of Education, and a replacement council member for the Department of Economic Security to gain perspective from partnering state agencies.

Arizona Behavioral Health Planning Council addition to response:
The Council alternates its meeting locations from being in Phoenix at the AHCCCS office where program and funding information is provided to the Council. Other Council meetings are held in locations around the state for the purpose of offering opportunities for people in various communities to speak about their concerns, have their voices heard and have actions taken by the state to address their concerns. Information obtained in both contexts guides the Council to form recommendations and feedback about service and system needs.

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

Technical assistance is not being requested at this time.

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

Footnotes:

Community Partners (HEAplus) (/Resources/CommunityPartners/HEAPlus.html)

Pharmacy (/Resources/GuidesManualsPolicies/pharmacyupdates.html)

Arizona Behavioral Health Planning Council

The mission of the Arizona Behavioral Health Planning Council shall be to advise the state in planning and implementing a comprehensive community based system of Behavioral Health and Mental Health Services.

The formation of this Council was mandated by the "State Comprehensive Mental Health Services Act of 1986" (P.L.99-660) and amended by "Mental Health Amendments of 1990" (P.L. 101-639) and "ADAMHA Reorganization Act of July 19, 1992" (P.L. 102-321) to perform the following duties:

- To review plans provided to the Council by the State of Arizona and to submit to the State any recommendations of the Council for modifications to the plans;·
- To serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems;
- To monitor, review and evaluate not less than once each year the allocation and adequacy of mental health services within the State.

Please email us (mailto:ali.delatrinidad@azahcccs.gov) with any comments.

- Behavioral Health Membership Application (/Resources/Grants/CMHS/BehavioralHealthMembershipApplication.aspx)
- CMHS Block Grant FAQs (/Resources/Downloads/Grants/FrequentlyAskedQuestions.pdf)
- Substance Abuse Prevention and Treatment (SAPT) Block Grant (/Resources/Grants/SAPT/)
- 2018 Substance Abuse and Mental Health Block Grant Combined Behavioral Health Assessment an Plan (/AHCCCS/PublicNotices/SA-MHBG.html)

Agendas and Minutes

2019   2018   2017

2019

August 21, 2019

Agenda (/Resources/Downloads/BehavioralHealthPlanningCouncil/2019/August212019BHPCAgenda.pdf)

August 16, 2019

Agenda (/Resources/Downloads/BehavioralHealthPlanningCouncil/2019/August2019BHPCAgenda.pdf)

ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
PLANNING COUNCIL MEETING
August 17, 2018
9:00am – 2:00pm

MEETING LOCATION	CONFERENCE CALL AVAILABILITY
AHCCCS 701 E. Jefferson St. Phoenix, AZ 85034	Call in number: **1-877-820-7831** **Participant Code: 679145#**

	AGENDA ITEM	FACILITATOR	ANTICIPATED ACTION
9:00 AM			
I.	**Welcome and Introductions**	Dan Haley, Chair	Action
9:05 AM			
II.	**Approval of Council Minutes (May)**	Council	Action
9:10 AM			
III.	**Prospective Committee Member- DCS**		Discussion
9:15AM-11:30AM			
IV.	**Council review SABG Application, Plan Workflow and Draft Letter**		Discussion/Review/Action
1:00PM-2:30PM			
V.	**SABG Application Presentation**	Michelle Skurka	Action
VI.	**Call to the Public**	Public	Discussion
VII.	**Next Meeting- September 21, 2018-**		Review
VIII.	**Adjournment**	Dan Haley	Action

"...to advise, review, monitor, and evaluate all aspects of the development of the State Plan"
(Public Laws 99-660, 100-639, and 102-321)

ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
PLANNING COUNCIL MEETING
September
10:00am – 12:00pm

MEETING LOCATION	CONFERENCE CALL AVAILABILITY
White Mountain Apache	1-877-820-7831 ███████████ **Participant Code 679145**

<u>Town Hall Community Meeting</u>

10:00 am – 12:00 pm

	AGENDA ITEM	FACILITATOR	ANTICIPATED ACTION
I.	**Welcome and Introductions**	Dan Haley, Chair	Action
II.	**Approval of Council Minutes (August)** Council		Action
III.	**Topic**	Dan Haley, Chair	
IV.	**Next Meeting**		

- **October 19, 2018- Phoenix (AHCCCS)**

V.	**Adjournment**	Dan Haley	Action

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(Public Laws 99-660, 100-639, and 102-321)

Tour of _____

September 21, 2018

1:30pm-2:30pm

Write up on the facility-------

Let me know if you will be attending the Tour…Dan

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ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
PLANNING COUNCIL
MEETING OF October 19, 2018
10:00am – 2:00pm

MEETING LOCATION	TELEMED AVAILABILITY
AHCCCS **701 E. Jefferson, Grand Canyon Room, 701-4**	None
Call In Number Moderator Code/Participant Code **1-877-820-7831**- participant code **906422#**	

10:00-10:15	**Call to Order/ Introductions**
10:15 – 10:30	**Reminders about travel forms/ Webex transition**
10:30 – 11:00	**Discussion about committees/ committee chairs**
11:00 – 11:30	**Discussion about attendance records/ maintaining membership status**
11:30 – 12:45	**Lunch**
12:45- 1:30	**Presentation/discussion on provider feedback after ACC transition** **Discussion on member feedback, if any**
1:30 – 2:00	**Update on how OIFA is embracing and interacting with the new plans since the ACC transition**
2:00	**Adjourn**

AGENDA ITEM		FACILITATOR	ANTICIPATED ACTION
I.	Call to Order & Introductions	Dan Haley, Chair	Action
II.	Reminders	Dan Haley, Chair	Discussion
III.	Committees/committee chairs	Dan Haley, Chair	Discussion
IV.	Member Attendance	Dan Haley, Chair	Discussion/Action
V.	ACC provider impact	Kathy Bashor	Discussion
VI.	Update on OIFA	Susan Junck	Discussion
VII.	Adjournment	Dan Haley, Chair	Action

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ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
Open Community Meeting
MEETING OF November 30, 2018

10:00am – 12:00pm

MEETING LOCATION	TELEMED AVAILABILITY
AHCCCS **701 E. Jefferson, Gold Room, 701-3**	None
Join Via Webex (information in the Outlook calendar invite) or call in at: **1-(240)-454-0879**	

10:00-10:15	**Introductions**
10:15 – 10:30	**Discussion on the purpose of this meeting**
10:30 – 11:30	**Presentation on the Mental Health and Substance Abuse Block Grants**
11:30 – 12:00	**Open Discussion about member voice & choice**
12:00	**Adjourn**

AGENDA ITEM	FACILITATOR	ANTICIPATED ACTION
I. Introductions	Dan Haley, Chair/ All	Action
II. Discussion on the goal of this meeting	Dan Haley, Chair	Discussion
Presentation on SABG/MHBG	Michelle Skurka/ Alex Demyan	Presentation/ Q&A
III. Open Discussion	All	Discussion
IV. Adjournment	Dan Haley, Chair	Action

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![AHCCCS logo - Arizona Health Care Cost Containment System]

ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
MEETING OF December 21, 2018
10:00am – 2:00pm

MEETING LOCATION	TELEMED AVAILABILITY
AHCCCS **701 E. Jefferson, Gold Room, 701-3**	None
Join Via Webex (information in the Outlook calendar invite) or call in at: **1-(240)-454-0879** Meeting Number: 809 328 920	

Time	Agenda
10:00-- 10:15	**Call to order/ Introductions**
10:15 – 10:20	**Minutes Approval**
10:20 – 10:40	**Introduction/Voting for new members/ Chair, Vice Chair Elections**
10:40 – 11:15	**MHBG/SABG Updates**
11:15--12:15	**Lunch**
12:15-- 1:00	**Financial Report Presentation**
1:00—1:45	**Prevention Efforts Presentation**
1:45—2:30	**Secret Shopper Final Update**
2:30	**Adjourn**

AGENDA ITEM	FACILITATOR	ANTICIPATED ACTION
I. Introductions	Dan Haley, Chair/ All	Action
II. Minutes approval	Dan Haley, Chair	Action
III. Introduction/Voting of new members/Elections	Dan Haley, Chair/Alex Demyan	Action
IV. MHBG/SABG Updates	Michelle Skurka/Dan Greenleaf	Presentation/ Q&A
V. Lunch	All	N/A
VI. Financial Report Presentation	Mary Mason/Weiwen Stockton	Presentation/ Q&A
VII. Prevention Efforts Presentation	Alex O'Hannon	Presentation/Q&A
VIII. Secret Shopper	Alex/Dana	Presentation/Q&A
IX. Adjournment	Dan Haley, Chair	Action

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ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
MEETING OF January 18, 2019
10:00am – 12:30pm

MEETING LOCATION	TELEMED AVAILABILITY
AHCCCS **701 E. Jefferson, Grand Canyon Room, 701-4**	None
Join Via Webex (information in the Outlook calendar invite) or call in at: **1-(240)-454-0879**-Meeting Number: 809 328 920	

10:00-- 10:10	**Call to order/ Introductions**
10:10 – 10:15	**Minutes Approval**
10:15 – 10:30	**Voting in new members/Cleaning up member roster**
10:30 – 10:50	**Legislative updates**
10:50—11:40	**Review Bylaws**
11:40—12:00	**Establish 2019 Calendar**
12:00—12:15	**AHCCCS update**
12:15—12:30	**OIFA Update**
12:30	**Adjourn**

AGENDA ITEM	FACILITATOR	ANTICIPATED ACTION
I. Introductions	Kathy Bashor, Chair/ All	Action
II. Minutes approval	Kathy Bashor, Chair	Action
III. Voting on new members/Member roster clean-up	Kathy Bashor, Chair	Action
IV. Legislative Updates	Kristina Sabetta	Presentation/ Q&A
V. Review Bylaws	All	Consensus
VI. Establish 2019 calendar	All	Action
VII. AHCCCS Update	Dana Hearn/CJ Loiselle	Presentation/Q&A
VIII. OIFA Update	Susan Junk	Presentation/Q&A
IX. Adjournment	Dan Haley, Chair	Action

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ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
MEETING OF February 15, 2019
10:00am – 12:30pm

MEETING LOCATION	TELEMED AVAILABILITY
AHCCCS **701 E. Jefferson, Grand Canyon Room, 701-4**	None
Join Via Webex (information in the Outlook calendar invite) or call in at: **1-(240)-454-0879**-Meeting number (access code): 288 088 637 Meeting password: e66YHzfq	

10:00-- 10:10	**Call to order/ Introductions**
10:10 – 10:15	**Minutes Approval**
10:15 – 10:25	**Call to the Public**
10:25 – 10:30	**Adjourn regular meeting/ Call executive meeting to order**
10:30—10:50	**Review Bylaws**
10:50—11:10	**Review Membership (New Members and Current Members)**
11:10—12:00	**Finalize BHPC 2019 calendar (with take-away items)**
12:00—12:30	**Discuss committee assignments**
12:30	**Adjourn**

AGENDA ITEM	FACILITATOR	ANTICIPATED ACTION
I. Call to order/Introductions	Kathy Bashor, Chair/All	Action
II. Minutes approval	Kathy Bashor, Chair	Action
III. Call to the Public	Kathy Bashor, Chair/Non-Members	Discussion
IV. Adjourn regular/call executive to order	Kathy Bashor, Chair	Action
V. Review Bylaws	All	Consensus/Action
VI. Review Membership	All	Action
VII. Finalize BHPC 2019 Calendar	All	Discussion/Action
VIII. Discuss Committees	Kathy Bashor, Chair/All	Discussion
IX. Adjournment	Kathy Bashor, Chair	Action

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Advocacy Committee Meeting
MEETING OF March 15, 2019
9:00am – 10:00 AM

MEETING LOCATION	
AHCCCS **701 E. Jefferson, Grand Canyon Room, 701-4**	None
Join Via Webex (information in the Outlook calendar invite) or call in at: **1-(240)-454-0879**-Meeting number (access code): 288 088 637 Meeting password: e66YHzfq	

9:00 – 9:45   **Advocacy committee updates & information sharing**

9:45 – 10:00   **Discuss Council committee recruitment**

Behavioral Health Planning Committee Meeting
MEETING OF March 15, 2019
10:00am – 12:30 PM

10:00 – 10:20   **Call to order/ Introductions**

10:20– 10:30   **Approval of minutes**

10:30 – 11:00   **State Agency updates**

11:00 – 11:40   **Review 2019 Meeting Calendar for BHPC**
- **Identify agency/organizations to invite to future BHPC meetings**
- **Discuss changing April 19th meeting date**
  - **BHPC meeting in Prescott**
    - **Identify topics/speakers**

11:40 – 12:00   **Council Committee Workgroups**
- **Identify workgroups**
  - **Leads**
  - **Members**

12:00 – 12:10   **Review need to update Council Member Notebooks**

12:10 – 12:30   **Wrap Up: Discuss committee assignments, establish due date for submitting**
                                information for April meeting

12:30   **Adjourn**

"...to advise, review, monitor, and evaluate all aspects of the development of the State Plan"
(Public Laws 99-660, 100-639, and 102-321)

AGENDA ITEM	FACILITATOR	ANTICIPATED ACTION
I. **Call to order/Introductions**	**Kathy Bashor, Chair/All**	**Action**
II. **Approval of minutes**	**Kathy Bashor, Chair**	**Action**
III. **State Agency updates**	**Kathy Bashor, Chair**	**Action/Discussion**
IV. **Review 2019 Meeting Calendar**	**Kathy Bashor, Chair/Non-Members**	**Discussion/Action**
V. **Council Committee Workgroups**	**Kathy Bashor, Chair**	**Discussion/Action**
VI. **Review Member Notebooks**	**Kathy Bashor, Chair**	
VII. **Wrap Up:**	**Kathy Bashor, Chair**	**Discussion/Action**

- **Committee assignments**
- **April Meeting**

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BEHAVIORAL HEALTH PLANNING COUNCIL MEETING
Friday, May 17, 2019
Care 1st Health Plan Arizona
432 N 44th Street Gateway Phoenix, AZ 85008
Please park on the surface lot - no parking validation required
10:30am – 12:30pm
Call in Number: 1-669-234-1179 Passcode: 712277815#

Agenda		
I.	Welcome	Council Chair Kathy Bashor
II.	Introductions of Members	ALL
III.	Review April meeting summary	ALL
Agency & Organization Updates		
IV.	Discussion with Mercy Care	
V.	State Agency Updates	
VI.	Committee Workgroup Updates	
VII.	Call to the Public	Council Chair Kathy Bashor
VIII.	Topics for Future Agenda Items	ALL
IX.	Executive Session	
X.	Adjourn	Next Meeting June 21, 2019 Sierra Vista/WebEx Location TBD

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NOTES
May 17, 2019

BEHAVIORAL HEALTH PLANNING COUNCIL MEETING
Friday, June 21, 2019
Sierra Vista, AZ 85635
12:30 – 1:00 PM

Agenda	
MEETING LOCATION	**CALL IN AVAILABILITY**
Easter Seals Blake Foundation 55 S. 5th St. Sierra Vista AZ. 85635	To join by phone **+1-415-655-0003 US Toll** **Access code: 808 717 354** **There is NO ID number** After you enter the access code **press #** The automated voice asks for attendee **ID#** You don't have one, **just press #**
I. Welcome and Introductions	Council Chair Kathy Bashor
II. Minutes from March & May Council Meetings	Council Members

III.   Council Updates
    • Council Calendar review
    • August grant review
    • AHCCCS website resources
	Council Chair Kathy Bashor

IV. Call for public input	
V. Adjourn at 1:00pm	Next Council Meeting July 2019 Flagstaff, Arizona Location TBD

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AHCCCS
Arizona Health Care Cost Containment System

BEHAVIORAL HEALTH PLANNING COUNCIL MEETING
Friday, July 19, 2019
10:00 AM – 12:00 PM

Agenda	
MEETING LOCATION	**CALL IN AVAILABILITY**
AHCCCS 701 East Jefferson Phoenix, AZ 85034 Saguaro Conference Rm	**1-415-655-0003** **Access Code 800 906 523**
I. Welcome, Introductions, Ensure Quorum and Call Meeting to Order	Council Chair Kathy Bashor
II. Minutes from March & May Council Meetings	Council Members
III. Council Updates • Current Events • Council Calendar Review • August: Grant Review • Open Meeting Law Training • New Applications for BHPC	Council Chair Kathy Bashor
IV. Call To The Public	Council Chair Kathy Bashor
V. Adjourn at _____	Next Council Meeting August 16 AHCCCS 701 E. Jefferson Street HRD Training Room 3rd Floor

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BEHAVIORAL HEALTH PLANNING COUNCIL MEETING
Friday, August 16, 2019
8:30 AM – 5:00 PM

Agenda	
MEETING LOCATION	**CALL IN AVAILABILITY**
AHCCCS 701 East Jefferson Phoenix, AZ 85034 HRD Training Conference Rm 3rd Floor	**1-415-655-0003** **Access Code 805 251 199**
I. Welcome, Introductions, Ensure Quorum and Call Meeting to Order	Council Chair Kathy Bashor
II. Council Updates • Grant Review • Open Meeting Law Training 10-1130 in the Grand Canyon Conference Room • New Applications for BHPC	Council Chair Kathy Bashor
III. Call To The Public	Council Chair Kathy Bashor
IV. Adjourn at _____	Next Council Meeting September 20, 2019 AHCCCS 701 E. Jefferson Street HRD Training Room 3rd Floor

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BEHAVIORAL HEALTH PLANNING COUNCIL

BHPC Monthly Meeting	Date: August 17 2018	Called to Order: 9:11 Adjourned: 2:18

Members Present:	Kathy, Dan, Dave D, Amy, Vicky, Stacy, Akia (phone) Alita
Members Absent:	
Non-Members Present:	Susan, Alex , Michelle, Valerie
Guests:	
Next Meeting:	**September 21, 2018**

Agenda Item	Notes	Follow-up/Next Steps
I. Welcome and Introductions	• Call to order	
II. Approval of Council Minutes (May)	• Minutes from last meeting voted to approve- 9:13	

III. Prospective Committee Member (DCS)	• New member is: Amy Hodgson
	  • DCS on the policy side
	  • Runs statewide prevention program
	  • Was appointed
	
	• Dan explained purpose of council
	• Explained oversight
	• Explained planning, future planning	

IV. Council review SABG application
 	
Discussion with Michelle Skurka
	• Question regarding title and nature of the application being combined SABG/MHBG
	• Question regarding non-direct services- pg. 45
	• Question regarding BHPC $5000 line item
	• Question regarding table on pg.35
	• Council wants to know what specifically is BG being spent on (within each priority
	• Question surrounding how gov. office interacts w/ SABG prevention funding (how are the funds allocated/managed
	• What if the provider does not spend all of their money?
		• **Michelle:**
		  • Discussed prevention needs assessment
		  • Explained the grant app being combined
		  • Explained how prevention dollars are allocated
		  • Explained how dollar projections within application are retrieved/ compiled.
		  • Explained how all BG are staying with RBHAs
		  • Addressed $5000 BHPC line item

		• Explained that if the council wants more, they need to submit a proposal in writing, and then it will be evaluated. • Reviewed gov. office expenditure report landscape • Offered for Cielo to come give a prevention presentation to the council • DBF has not yet completed 100% of the tables on the application • DHCM finance continues to monitor what providers are over/under spending and trying to work with network to make sure all dollars are being utilized.
	• For items to be addressed/presented on during council meeting, item needs to be included in agenda at least 2 weeks beforehand • BHPC would like to see/review RBHA's expenditure plans for n-TXIX dollars	
V. Draft SABG application letter	• Alex D presented a high level overview of secret shopper calls thus far • Need to change text of number 1 on page 47 • Council needed to receive full question of 1-b on pg. 47 • BHPC will decide what reports they want to supplement the application every year and request them prior to reviewing application. • Will do the same with 12/1 report. • Will request this documentation in writing ahead of time and add to agenda ahead of time • BHPC would like a geo map of all n-TXIX providers/SABG funded providers. •	• Alex to send pg. 47 text exits to Dan G/Michelle for edits on final application • Alex found full question fro 1-b
VI. Call to Public	•	
VII. Meeting Adjournment **Items council wants addressed on next agenda**	• Adjourned- 2:18	• **Dan to email Alex regarding agenda items he would like included for the next council meeting.**

BEHAVIORAL HEALTH PLANNING COUNCIL

Advocacy and Legislation Committee	Date: October 19, 2018	Called to Order: 10:10 Adjourned for Lunch: 11:42 Called to Order: 12:47 Adjourned: 1:34

Members Present:	Dan Haley, Kathy Bashor, Vicki Lynn Johnson, Alida Montiel, John Lea Bird, Jane Kallal, Lisa St. George,
	On the phone: Dawn Abbot, Amy Hodgson, David Delawder,
Members Absent:	
Non-Members Present:	Alex Demyan, Evelyn Kelley, Michelle Skurka
Guests:	
Next Meeting:	**November 30, 2018**

Agenda Item	Notes	Follow-up/Next Steps
I. Call to order and Introductions	Call to order and introductions made around the room and on the phone at 10:10 am.	**NA**
II. Reminder about Travel forms/ Webex Transition	- Alex reminded the council of the 30 day window to get travel reimbursement forms submitted. Also noted the administrative difficulties of receiving the forms after the 30 days. - Some council members still need to fill out travel form to identify the vehicle they are using. - Some council members have a hard time filling out the form online due to lack of internet access - Alex noted AHCCCS' change to Webex for online meetings/ phone conferences.	- **Evelyn /Yisel to help council members fill out travel reimbursement form before they leave from the meeting if need be.** - **Alex to send out the appropriate forms in the week following the meeting. (302.2 form + one other)**
III. Discussion about committees/ committee chairs	- Dan H apologized about not having his head in the council over the past few months. - Dan H considering not running for chair during the next election cycle. - Noted he still wants to remain on the council. - Dan H stated that the sub-committees need to become more instrumental in the functions of the BHPC meetings. - Jane and the Council thanked Dan H for all of his efforts in recruiting. - Dan H noted that he appreciated the	

	collaboration with AHCCCS. - Dan H spoke about the need for a membership committee that monitors the attendance and participation of BHPC members so that there is an accurate record of attendance and real-time recruiting for needed roles on the council. - Dan spoke about the Legislative Action Committee, and the other historic sub-committees. Spoke about the need for new leadership in these committees.	
IV. Discussion about membership records/ maintaining membership status	- Motion to suspend electing sub-committee leadership until after recruiting new members. - Approved - Dan H to draft letters directed toward peer and family runs to recruit new BHPC members. - Other BHPC members to send out the letter to their networks of providers. - Dan to look into the current member roster and purge non-active members. - BHPC to focus on rural recruitment - Alida to send the letter to her tribal contacts - Need to focus recruiting on transition-age youth and their parents. - Alex stated that AHCCCS has sent out a letter to the Arizona Education Department recruiting a new representative since the previous two stepped down. - Council stated that AHCCCS needs to send out a letter recruiting a new representative from the housing department since their representative stepped down. - Dan H plans to send out correspondence to members who are not actively attending letting them know that they are in danger of being removed from the council. - Decision made to hold council meeting in November on 11/30/18 in gold room. Council wants this to be an open format geared toward recruiting new members. Hope to have attendance as a result of Dan's letter	- **Alex to send out recruitment letter to Arizona Housing Department.** - **Dan to send out correspondence to members who are not actively attending meetings.** - **Alex to reserve Gold room for November meeting and send out new appointment to BHPC mailing list.** - **Council requested to have Secret Shopper added as a topic for the November meeting.** - **BHPC requested to have Governor's office come and do a presentation on how they are spending their prevention dollars. Requested this for the December meeting.** - **BHPC requested a general presentation on the block grants for the November meeting.** -
V. Ad-hoc review of SAMHSA's 2017 core review	- Reviewed the sections of the report that were specific to the BHPC. - Discussion about the 50% SMI/Family member requirement.	- **Alex to re-send link to the BHPC page on the AHCCCS website.**

	- Long discussion clarifying Block grant structure - Adjourn for Lunch: 11:42	
VI. Kathy presentation on ACC provider feedback and OIFA updates.	- Call to order- 12:47 - Kathy discussed the meetings that OIFA has been attending with providers and contractors - There are not OIFA offices/representatives in all 7 plans. (required by contract) - Kathy went over the ACC transition and detailed the small issues that have come up thus far. Stated that there have not really been any large issues. - Council brought up transportation as an issue they have been hearing about. - Pharmacy services identified as a potential issue - Employment rates of peers are very low, even though there are a lot of community members being trained. - Kathy stated now peer support trainings have been abused in the community. Stated that OIFA is looking into it. - Council brought up that there has been a lack of SMI peer referrals in Tucson. Expressed the need for males. - Discussed the crisis system in Arizona and why it has stayed with the RBHAs. - Long discussion on tribal concerns w/ ACC transition including referral sources, prior authorization, and the fact that the tribes will be sending a letter to the director voicing their concerns.	
VII. August minutes approval	- Minutes voted on and approved	
VI. Adjournment	- Adjourned at 1:34	

BEHAVIORAL HEALTH PLANNING COUNCIL

Advocacy and Legislation Committee	Date: November 30, 2018	Called to Order: 10:04 Adjourned: 12:03

Members Present:	Dan, Kathy, Vicki, Alida, John, Brenda, Stacy,
	On the phone: Jane
Members Absent:	
Non-Members Present:	Justin, NAMI person
Guests:	Alex, Michelle, Yisel, Evelyn
Next Meeting:	**12/21/18**

Agenda Item	Notes	Follow-up/Next Steps
I. Call to order and Introductions	- Dan called the meeting to order at 10:04 am - Dan introduced Justin Ashley, the new prospective member from ADOE	- **Justin's membership will need to be voted on after he attends three BHPC meetings**
II. Discussion on the purpose of this meeting	- Dan explained that the purpose of this meeting was to recruit new members. - Dan stated how disappointed he is with the turnout - Discussion on how to better recruit was put on hold at request of council for the following presentation.	
III. Presentation on SABG/MHBG	- Michelle Skurka/Alex Demyan presented on SABG/MHBG respectively - Presentation was held in an open-discussion format, with questions throughout. - Michelle gave clarification about OUD vs SA with other drugs - BHPC asked for a timeline with their responsibilities as it relates to the block grants - Michelle explained that this had already been sent out, but we will resend. - Clarifications around child care for priority population- how this benefit must be accessed/monitored. - The need for a standardized tool was recognized - Clarification provided on how the council can provide feedback to SAMHSA- the	

	BHPC letter submitted with the block grant application. - *Alex to send out the block grant presentation to the BHPC mailing list.* - *Alex to send out link to 320-T* - Recommended that the council review 320-T and discuss council suggestions as an agenda item at a future meeting - Council requested participation in internal AHCCCS policy meetings- council was advised this is probably not possible, however AHCCCS will look into possible avenues for participation. - Discussion on FEP services as part of the 10% MHBG set aside. - Clarification given on why the BHPC oversees and gives input on both block grants. - AHCCCS offered to give these presentations at any venues, tribal or otherwise.	
IV. Open Discussion	- Kathy asked what the council members from ADOC and ADOE thought about the knowledge of block grants in their respective agencies. - Limited knowledge from both. - Stacy recommended that the council come up with a standard agenda, and focus on one issue at a time. Stated that too many topics get discussed in the meetings, and no solutions ever seem to arise.	
VI. Adjournment	- Dan adjourned the meeting at 12:03	

Advocacy and Legislation Committee	Date: December 21, 2018	Called to Order: 10:00 Adjourned: 3:20

Members Present:	Dan, Kathy, Vicki, John, Jane, Brenda, Lisa, Stacy,
	On the phone: Alida, Dave
Members Absent:	Amy, Alicia, Akia, Leon, Mary
Non-Members Present:	Justin, Susan
Guests:	Yisel, Evelyn, Alex O'Hannon, Dana, Alex, Michelle, Mary
Next Meeting:	1/18/19

Agenda Item	Notes	Follow-up/Next Steps
I. Call to order and Introductions	- Dan called the meeting to order at 10:00 am	-
II. Minute Approval	- Committee reviews minutes	-Vicki makes motion to approve meeting minutes as presented. -Jane seconds motion, all members vote in favor.
III. Introduction/Voting of new members	- Chair position open - Vice Chair Position open - AHCCCS representative position open	-Dan makes a motion to accept Kathy Bashor as Chair of the Behavioral Health planning council -Dan makes a motion to accept Vicki Johnson as Vice Chair of the Behavioral Health planning council -Dan makes a motion to accept Susan Junck as member of the council as the AHCCCS representative -Committee members all vote in favor

IV. MHBG/SABG Updates	- AHCCCS Submitted the SAMHSA Block Grants Application on 12/3/18;
	- The Arizona Statewide Substance Use Needs Assessment will be ready for release to the public by the end of January.
	- Kathy identified issues from the north she has been hearing in various meetings with Vicki
	  o Justice system not knowing about bg
	  o Some providers still not doing "no wrong door."
		-Requests that a one pager for non-title19 funds be completed by next meeting to roll out to the community.

	- Dana suggested using alternate language other than "block grant" when asking about this funding
	    ○ Alternate funding
	    ○ Non-title 19 funding
	- Council Recommended that a cheat sheet be given to front key staff
	    ○ Council recommends that this resource be rolled out to all areas of the system (courts, juvenile, providers, etc)
	    ○ Dana/Alex let council know this is already being implemented
	- Discussion on crisis timeframes from Alida
	    ○ Dana offered to review any tribal resources that were presented.
	    ○ Alex clarified title vs non titled timeframes
	    ○ AHCCCS offered to do trainings if need be.	

V. Financial Report Presentation	- Mary Mason provided an overview of the RBHA Block Grants for the State Fiscal Year Ended 2018. Revenue and Expenses related to SABG, MHBG SED and MHBG SMI were discussed.
	- The BHPC was particularly interested in provider-level expenses related to Family Support and Peer Support. The Council does not believe enough block grant funding is being expended in these areas.
	    ○ Council has requested that AHCCCS provide an encounter report on a regular basis
	    ○ Want to know how many people were served
	    ○ Want an SABG breakdown of codes on services (peer and family supports)
	        ▪ How many people were served
	        ▪ How many dollars were spent on a specific code
	    ○ What kind of providers do they come from Ask about the 50/50 SED/SMI split
	    ○ Clarified how BG dollars are utilized.
	    ○ Council thanked Mary for her efforts.
	-
		Alex (not sure who was speaking) agreed to gather additional information related to Family Support and Peer Support, such as the number of people served and type of agency.

| VI. Prevention Efforts Presentation | - Alex O'Hannon presented on prevention efforts
- Substance abuse block grant, GOYFF receives $5,906,300 SABG per year from AHCCCS
- Funds used as follows;
- $900,000 Healthy Families and Healthy Youth
- Piloted in September 2016 and expanded for 2 years in September 2017
- Focused on 7th grades-2500 participated
- $300,000 School Superintendents
- $125,000 Arizona State University
- $3,262,199 High School Health and Wellness
- Piloted in May 2017 in 38 high schools in six counties
- Programs to prevent use of drugs and alcohol
- Fosters the development of social and physical environments that promotes a healthier life style
- More than 40,000 students are impacted annually through this program
- $200,000 Department of Liquor Licensing and Control
- Program educates community businesses that are licensed to sell liquor on underage buying trends
- Train covert underage buyers
- Collaborate with coalitions to educate communities on social host ordinances and conduct outreach
- Educate schools
- Aid in development and distribution of educational materials
- Alex O's role with the SABG include; Collaboration with GOYFF and AHCCCS; Oversight of HFHY, HSHW and DLLC programs; Epidemiology work group; Liaison between GOYFF and AHCCCS; Attends SABG funded/related events; Provides technical assistance for internal and external stakeholders; Promotes evidence based practices; Other duties as assigned | Alex O will respond to requests made by the council in the next couple of weeks. |
| **VII. Secret Shopper Final update** | - Alex reported the second round is coming soon
- Dana thanked the council for their efforts on this | Dana to send FAQ on crisis to Alida

Dana reminds group ACC training is available |

		Dan H would like to what agency types did monies come from and a breakdown of codes based on the funding, Alex will look into and see if a report can be generated
		If available committee will review and see if report meets their needs
VIII. Adjournment	- Dan adjourned the meeting at 3:20	

BEHAVIORAL HEALTH PLANNING COUNCIL

	Date: January 18, 2019	Called to Order: 10:09 Adjourned: 12:34

Members Present:	John Baird; Lisa St. George; Jane Kallal; Kathy Bashor; Alida Montiel; Brenda Vittatoe; Vicki Johnson; Stacy Paul; Susan Junck; Justin Ashley; Tamaria Gammage
	On the phone: Dan Haley; Dave Delawder
Members Absent:	Amy Hodgson; Alicia Ruiz; Akia Compton; Leon Canty; Mary Page; Leon Canty
Non-Members Present:	Tony Smith; Kristina Sabetta;
Guests:	Alex Demyan; Michelle Skurka; Chaz Longwell; Judith Walker; Evelyn Kelley; Yisel Sanchez;
Next Meeting:	2/15/19

Agenda Item	Notes	Follow-up/Next Steps
I. Call to order and Introductions	- Kathy called the meeting to order at 10:09 am	-
II. Minute Approval	- Committee reviews minutes - Vicki asks that language change in section V. Financial Report Presentation. First bullet point includes language that states "thinks", will change to state "request". - Council agrees to utilize the request form for formal requests moving forward	-Vicki makes a motion to accept meeting minutes with revisions -Jane seconds motion, all members vote in favor.
III. Voting of new members	- Council has two members that are up for approval today 1) Justin Ashley 2) Tamaria Gammage - Kathy shares additional nominations submitted. - Andrew Real recommended as a representative from DOH. Has not attended any meetings, Alex will follow-up on status and or another representative. - Chair shares other members who are on the council but have not attended for months and should be removed. - Kathy asks that a motion be made to remove Leon Canty - Kathy will contact others on the current roster and provide update at February meeting	-Vicki makes a motion to accept Justin Ashley and Tamaria Gammage as member of the council. -Lisa St. George seconds the motion. -Committee members all vote in favor -Alex will reach out to Andrew Real -Vicki makes motion to remove Leon Canty from the committee. -Lisa St. George sends the motion -All vote in favor
IV. Legislative Update	- Kristina Sabetta provide legislative update - Shared MHA's legislative priority list. - Priorities for MHA	-Alex to send out any additional resources along with meeting minutes.

	1). SUICIDE PREVENTION AND MENTAL HEALTH TRAINING IN SCHOOLS
	Schools are a key setting for suicide prevention. Teachers, mental health providers, and all other school personnel who interact with students can play an important role in keeping them safe. MHA AZ is advocating for teachers, counselors and other school staff who work with children in grades 6-12 receive evidence-based training in suicide.
	   - Prevention, warning signs and intervention and referral techniques.
	   - Shared link Here to the form to register for RTS - this will allow folks to get registered if they can't make it to the capitol to do so.
	   - Shared a few helpful videos that are great in learning how to have a voice as well as use Arizona's legislative system.
	
	2) SUICIDE INTERVENTION
	2-1-1 information line transforms lives by linking individuals and families to vital community resources throughout Arizona, yet it currently receives zero dollars in state funding. We are asking for state appropriated funding for 2-1-1 which will provide a 24/7 safety net for Arizonans, reducing the need for high cost ER, housing and crisis services across the state.
	
	3) RESTORATION OF THE STATE HOUSING TRUST FUND
	The Arizona Housing Trust Fund was enacted in 1988, and created a funding source to assist in meeting the housing needs of low-income families. This dedicated source of funding included 35% of revenues received from the sale of unclaimed property, which increased to 55% in 1998 with additional resources dedicated to rural Arizona. Due to the 2009 recession, state budgetary cuts forced the State Housing Trust Fund, which should have received almost $40 million, to be capped at $2.5 million in 2010; with the balance then being appropriated to the state's general fund. We ask the legislature to lift the $2.5 million cap on revenue from unclaimed property sales and restore those funds back to the State Housing Trust Fund to support unmet housing needs.
	
	4) PROTECT KIDS CARE
	AHCCCS offers health insurance through KidsCare for eligible children (under age 19) who are not eligible for other AHCCCS health insurance. MHA AZ advocates to protect the key provisions of the Affordable Care Act that effect access to mental	

	health services, which includes measures that prevent an automatic freeze on KidsCare when federal funding dips below 100%. MHA AZ proposes that a supplemental funding source be allocated to prevent this automatic freeze of health insurance for thousands of Arizona's children. • View archived webinar, "How to Become an Empowered Advocate for Public Policy" provided by Empowerment Systems in partnership with the Arizona Rural Health Association • View this youtube video showing you how to register in the AZ legislative system and how to find bills. We strongly encourage anyone unfamiliar with the system to watch this video and register. - Council can sign up for our action alerts here. - Shared link here for an action alert for SB 1011.	
V. Review of Bylaws	- Discussion on how the bylaws need to be updated annually. - Council was shown language in bylaws that specifies the above. - Council recounted that the bylaws worked on in April, 2018, were completed, but not voted on due to lack of quorum. - Council decided to utilize this draft version, to add new language they would like included. - Discussion on option to draft changes, and approve a final version during Feb. meeting. - Decision made finalize edits, vote on bylaws during this meeting. - Council revisited historical context of T/RBHA representation/participation on the council - Discussion about the potential conflicts of having RBHA employees as voting members - Council still wants RBHAs to attend meetings as members of the public - Discussion about utilizing the inter-tribal council to gather the best way for tribal input to the council - New language includes Article IV: 1) The State OIFA Advisory Council shall annually nominate a person to represent the AHCCCS Contracted health plan community. This nominee shall become a voting member of the BHPC, with	- Vicki motioned to approve bylaws - John 2nd Vicki's motion - Council voted 12-1 in favor of approving Bylaws - Alex to send the council bylaws

	all included responsibilities and requirements. Any person representing the OIFA Advisory Council may serve in this role for a maximum of 2 consecutive years. 2) Due to the oversight responsibilities of the BHPC and potential conflict of interest, no person who is an employee of an AHCCCS Contracted health plan may be permitted as a voting member of the BHPC. - Removed language includes: 1) The Directors of an urban and rural Regional Behavioral Health Authority (RBHA) in the state shall propose a representative from their service area who is knowledgeable about behavioral health services in the geographic area they represent. One member from each RBHA shall be proposed. 2) The Director of one Tribal Regional Behavioral Health Authority (TRBHA) shall be appointed. 3) Where more than one urban or rural RBHA or TRBHA wish to be represented on the Council, representation will be rotated among the RBHAs or TRBHA to ensure that one representative is available to the Council on a continual basis. - Kathy requested a motion to approve bylaws with identified changes	
VI. Establish 2019 Calendar	- Council needs to establish a BHPC calendar for 2019 - Every other month BHPC will meet with AHCCCS at AHCCCS - Alternating months will be community-based meetings - Council decided that members should not be penalized for not attending community meetings - Certain months the BHPC will need to be in Phoenix at AHCCCS to fulfill council requirements (i.e. review Block Grant Application & reports) - Reserve August meeting to review BG application - Reserve November meeting to review the BG report - Council would like to reserve one month specific for a meeting in a tribal community. - Feb meeting will be at AHCCCS for planning the remainder of the year & other council	- Council to finalize and vote on the 2019 calendar during the February meeting - Council would tentatively like leadership to present in May - Alex to explore quarterly AzSH update feasibility - Council to discuss language to go out on the OIFA Newsletter - Alex will organize DFSM presentation once 2019 calendar is set.

	business.	
	- "Community Meetings" do not require AHCCCS presence outside of the voting state Medicaid rep, and clerical - Council would like to establish discussions from AHCCCS leadership once or twice per year. - Possible DFSM presentation on block grants - Council would like to explore bringing back AzSH updates as a standing agenda item. - Kathy requested that verbiage go out about the council on the OIFA newsletter - Discussion began about re-starting the committees. - Council agreed to discuss this further at Feb meeting, as it was not an agenda item - Since membership is currently a pressing issue, Lisa, John, Vicki, and Kathy to look over new applications and make recommendations on how to proceed at Feb. meeting.	
VII. AHCCCS Update	- Dana gave a presentation on the new AHCCCS organizational changes & other post-ACC initiatives - Presented on the waiver approval. - Alex to send out Dana's presentation and other resources.	- Alex to send out resources.
VIII. OIFA Update	- Susan presented on peer and family run organizations and AHCCCS' involvement - Susan presented on OIFA's DRAFT one-pager on SABG funds	- Alex to send out OIFA presentation - Alex to send out one pager upon OIFA publishing final draft.
IX. Call for public comment	- Kathy makes a call to the public. - No response	
X. Adjournment	- Kathy asks for a motion to adjourn at 12:34 pm	-Dan makes motion to adjourn meeting. -John Baird seconds motion. -All vote in favor.

BEHAVIORAL HEALTH PLANNING COUNCIL

	Date: February 15, 2019		Called to Order: 10:08am Adjourned: 12:40 pm

Members Present:							
Justin Ashley		John Baird	X	Kathy Bashor	X	Akia Compton	
Dave Delawder	X -Phone	Tamaria Gammage	X Phone	Daniel Haley	X Phone	Any Hodgson	X
Vicki Johnson	X	Jane Kallal	X	Alida Montiel	X	Mary Page	
Stacy Paul		Andrew Real		Alicia Ruiz	X-Phone	Lisa St. George	X
Brenda Vittatoe		Susan Junck/ **Judie Walker**	X				
Non-Members Present: None							
Guests: None							
Next Meeting: Town Hall Meeting, April 12, 2019							

Agenda Item	Notes	Follow-up/Next Steps
I. Call to order and Introductions	- Kathy called the meeting to order at 10:08 am	
II. Minute Approval	- Committee reviews minutes - Council reaffirmed to use request form for formal requests	**-**Vicki makes motion to accept meeting minutes -Jane Kallal seconds motion, all members vote in favor.
III. Review of Calendar and upcoming council events	-	
IV. Updates	- Judie shared information on the AHCCCS website including FAQ's related to AHCCCS Works, Accessing Behavioral Health Services in Schools, questions related to American Indian Members, CRS and Crisis services. - - AHCCCS will offer the opportunity for council members to participate in Open Meeting Law training in the coming month	Open meeting law training was scheduled for May 14, 2019
V. Call for public comment	- Council members, ACC health plan and agency representatives discussed the idea of hosting council meetings outside of AHCCCS.	April meeting to be in Prescott Location to be determined
VI. Adjourn regular/call executive to order	- Call to Executive Session	

BEHAVIORAL HEALTH PLANNING COUNCIL

	Date: March 15, 2019	Called to Order: 10:10 am Adjourned: 12:40 pm

Members Present:

Justin Ashley		John Baird	X	Kathy Bashor	X	Akia Compton	
Dave Delawder	X – Phone	Tamaria Gammage	X	Daniel Haley	X Phone	Any Hodgson	X
Vicki Johnson	X	Jane Kallal	X	Alida Montiel	X	Mary Page	
Stacy Paul		Andrew Real		Alicia Ruiz	X-Phone	Lisa St. George	X
Brenda Vittatoe		Susan Junck	X				

Non-Members Present: Judie Walker, Colleen McGregor, Debra Jorgensen, Dawn McReynolds

Guests:

Next Meeting: Town Hall Meeting, April 12, 2019 to be in Prescott Valley 10:30am – 12:30pm(site to be determined)

Agenda Item	Notes	Follow-up/Next Steps
I. Call to order and Introductions	- Kathy called the meeting to order at 10:10 am	
II. Minute Approval	- Committee reviews minutes	-Vicki makes motion to accept meeting minutes -David seconds motion, all members vote in favor.
III.	- State Agency Updates	-New DCS representative Cathy Hasenberg requested information re: AFF and AHCCCS Liaison will report updates at 3.22.19 AFF Meeting. Cathy plans to talk to Mike Faust to get additional information on any changes. It was suggested Cathy may want to meet/work with Dan Greenleaf/AHCCCS for information regarding current AHCCCS treatment parameters since DCS is now starting prep work & will be re-soliciting it in the near future.

IV. Review 2019 Meeting Calendar	- April Town Hall will be held in Prescott area - Recommendation to have more meetings in the community	-April 12, 2019 Town Hall location to be determined. Potential topics: Northern AZ issues re: Health Homes, training on Grievance and Appeals Discussion regarding future community locations for BHPC meetings tabled until public comment
V. Follow up from February meeting	- In previous meeting there was discussion regarding attendance by OIFA representatives. Recommendation was to limit number of representatives. - Information provided on Accessing Behavioral Health Services in School. - ADE provided additional information on emergency preparedness also taking place at schools and discussions around children identified as SED. - Suggestion to create template for council and partners to identify and report on community issues/concerns to be shared during monthly meetings. - Suggestion to create a small committee to review old member notebooks to identify potential updates/additional information -	-The only limitation for their attendance is related to council membership, not attendance to the open meeting. -Information located on AHCCCS website. https://www.ahcccs.gov Under AHCCCS Initiatives/Behavioral Health Services -Kathy will follow up -Council members will contact Judie if interested
V. Call for public comment	- Council members, ACC health plan and agency representatives discussed the idea of hosting council meetings outside of AHCCCS. -	April 12th Town Hall will be held in Prescott Valley, location to be determined. May 17th meeting will be hosted by Care 1st at Care 1st location. Meeting locations and updated calendar will be sent out once sites are determined.
VI. Adjourn regular/call executive to order	- Call to Executive Session	

BEHAVIORAL HEALTH PLANNING COUNCIL

	Date: May 17, 2019	Called to Order: 10:31 am Adjourned: 12:36 pm

Members Present:							
Kathy Bashor, Chair	X	Vicki Johnson	X	John Baird	X	Akia Compton	X
Alida Montiel	X	Tamaria Gammage	X	Daniel Haley	X-Phone	Jane Kallal	X
Alicia Ruiz	X	Susan Junck	X	John Barrett	X	Richard Brubaker	X

Non-Members Present: None

Public: Michelle Skurka & Judie Walker (AHCCCS), Tony S, Matthew Gioia, Tarva G, Eddie Sisson, Nadine Smith, Targa Bedoit, Mary Lou C, Joshua Bangle, Maurcio R, Deb Jorgenson, Dr. Matt Joyner, Cathy Romans

Next Meeting: June 21, 2019

Location: Sierra Vista (site to be determined)

Agenda Item	Notes	Follow-up/Next Steps
I. Call to order and Introductions	- Council Chair Kathy B called meeting to order at 10:31 AM - Kathy/Chair identified her recent participation in Open Meeting Law training and the need for the council to follow the requirements. - Thank you to Care 1st & Deb Jorgenson for hosting the meeting at their facility and for her work to increase the role of peer and family members in the community. - Handouts from the AHCCCS website included the AHCCCS Works Fact Sheet, OIFA administrators list, and the AHCCCS Initiatives. Also provided was a copy of the page where the documents are located on the AHCCCS website and the link. https://www.azahcccs.gov/	- Upcoming trainings & resources are available on the Arizona Ombudsman – Arizona State Legislature website. https://www.azoca.gov/open-meeting-and-public-records-law/training/

II. Minute Approval	- Dan H and Kathy B reviewed the 4-12-19 Town Hall summary notes with the committee and discussed the issues brought up during the Town Hall meeting. Notes to be included in the update section of meeting notes. - Dan identified that he will call a workgroup meeting to continue a discussion off-line on how to present the concerns from the Town Hall meeting and also to describe other issues with AHCCCS.	- Request from Council Chair to include issues identified in the 4-12-19 town hall meeting in the minutes from 5-17-19.
III. Updates	- Participants in the Town Hall Peer/Family Run programs expressed concern that members are not getting referred to their programs. - Peer/Family run programs have been told by members they are not receiving information about their programs. Organization representatives identified families/members expressed they were not told of the Peer/Family run programs or if they were, not told how to access them. - Town Hall participants identified another issue facing members and Peer/Family run programs in the Northern part of the state. The member requested a specific therapy program by a community provider but was denied by their Health Home. The Health Home stated they could provide the service; however Town Hall participants identified that the Health Home in question does not have a certified Therapist for the program. - Additional issues identified regarding the lack of referrals by Health Homes. The meeting participants shared examples of members requesting services and were denied by Health Home, who identified they could provide them; however the sites were not at the location or by the provider the members preferred.	- Follow up to Town Hall meeting: - Dan will schedule workgroup meeting to discuss ideas and strategies to increase the visibility of the Peer/Family run programs. - Kathy/Chair will request a meeting with AHCCCS leadership to discuss and address the issues identified in the Town Hall meeting. - The council will invite a Steward Health representative to attend the July BHPC meeting in Flagstaff.
	- Matthew Gioia, Clinical Operations Administrator, Mercy Care provided a presentation on the Mental Health and Substance Abuse Block Grants Mercy Care manages. He also provided frequently asked questions (FAQ's) from the AHCCCS website.	- Mental Health and Substance Abuse Block Grants https://www.mercycareaz.org/wellness/grants - AHCCCS Website: FAQ's https://www.azahcccs.gov/Resources/Downloads/Grants/FrequentlyAskedQuestions.pdf Block Grants.pptx

IV. Call for public comment	- A family member in attendance shared an overview of her son's situation and the strengths and weaknesses of the site providing his services. The housing voucher reasonable accommodations paperwork has been at the clinic for over 2 weeks and the clinical team cannot locate it. There is turnover of case managers. Mercy Care OIFA Representative, Ernie Pinder was present and will talk with family member to obtain contact information and more details of the described issues.	- Mercy Care OIFA Representative, Ernie Pinder obtained contact information for family member and will work with family to file a grievance and assist with the criminal and medical issues facing the member.
V. Adjourn Council meeting	- **Call to Adjourn Council Meeting at 12:36 PM**	Next Behavioral Health Planning Council Meeting: June 21, 2019 Sierra Vista – Site to be determined

ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
701 E. Jefferson St. MD 6500
Phoenix, AZ 85034

August 22, 2019

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)
Division of State and Community Systems Development (DSCSD)
5600 Fishers Lane
Station 14E26C
Rockville, MD 20857

Dear Sir or Madam,

The Arizona Behavioral Health Planning Council is required by Public Law 103-321 to review Arizona's Mental Health and SABG Services Plan for Children and Adults for Fiscal Year 2019. This must occur before it is submitted to the U.S. Department of Health and Human Services (DHHS) so that Arizona may receive the Federal Mental Health Block Grant and the Federal SABG for 2020. On August 16, 2019, the Council met with representatives from the Arizona Health Care Cost Containment System (AHCCCS) to review the 2020 Plan. Through this meeting, the Council was able to comment on and recommend changes. The Planning Council is submitting this letter to the Center for Mental Health Services to provide information regarding our role and activities.

The Planning Council has included integrated representation between mental health and substance abuse since 1999, with the participation of substance abuse providers. In addition, the Council has strong representation by persons experienced in substance abuse treatment, persons with personal experience or who have a family member with substance abuse challenges.

The Council's membership reflects the diverse cultures in Arizona. Currently, the Council has one American Indian individual, who is the family member of an adult with a Seriously Mentally Ill (SMI) diagnosis, and also includes representation by African American members- one who is a mother of a child with SED. Also, there are older adults, and individuals with SMI designation in the behavioral health system, family members of young children and adults with SMI. Additionally, the Council recruits and retains individuals throughout the state, including individuals from Tucson, Southern Arizona (San Manuel), and Northern Arizona (Prescott). At this time, the Council has members from all required state agencies. A chart that details the Council representation is attached.

During the past year, the Council has returned to a meeting schedule that includes periodic meetings around the state where input can be solicited from local system participants. In March, 2019 there was a meeting in Prescott (Northern Arizona) and in June,2019 there was a meeting in Sierra Vista (Southern Arizona). Also, in May, 2019, there was a Council meeting in Phoenix for the purpose of soliciting issues and concerns from Maricopa County. From these meetings concerns were raised

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(Public Laws 99-660, 100-639, and 102-321)

about access to services and transportation to services. The Council is seeking to follow-up on these concerns. In addition to the opportunity to hear concerns, the meetings in Prescott and Sierra Vista also included a presentation on the Grievance and Appeal process available to Medicaid eligible behavioral health service recipients. In both meetings, this information was presented in order to assist persons with a means to address concerns they may be having in obtaining the services/support they are seeking.

The Planning Council is charged with the mission of:
- Reviewing plans and submitting to the State any recommendations for modification;
- Serving as an advocate for adults with a serious mental illness and children who are seriously emotionally disturbed, including individuals with mental illnesses or emotional problems;
- Monitoring, reviewing, and evaluating, not less than once per year, the allocation and adequacy of mental health services in the State; and Participating in improving mental health services within the State.

The Arizona Behavioral Health Planning Council meets monthly.

The **Planning and Evaluation Committee** has been working to obtain reports on the block grants and Arizona public behavioral health services in general. There have been barriers in obtaining this information, and this has hindered the Council's ability to carry out its duties. One type of report on the Mental Health Block Grant expenditures was received during the past year. A presentation on the use of SABG prevention dollars was received but further information requested on this program area has not been received. Recently representatives from the Council met with persons from AHCCCS to request data and to better understand the process to request data that had not been clarified. Hopefully this information will be forthcoming resulting in the Council better executing its oversight role over the block grants and behavioral health services in general. The entire August 16, 2019 meeting of the Council was devoted to work of the **Planning & Evaluation Committee** for the purpose of reviewing the Block Grant application. The Council submitted suggested language changes on the plan to AHCCCS. In addition, during the process of the plan review the Council identified a number of system concerns and questions that are listed below according to sections in the plan:

-**Strengths/Needs Assessment**
--Transition from State Hospital: The Council would like the plan format to include information about Peer and Family Support work in this area.
-**Unmet needs**: Areas of concern in this section include:
--Persons who are homeless experience significant barriers in accessing services.
--A common problem with the system is that the point of entry to the system is often through a receptionist who is not trained on the various funding sources and ways that persons may access services. This may result in persons being turned away unnecessarily. A Mystery Shopper program may better define this problem, but then, a training program for frontline staff would be needed to correct the issue.
--AHCCCS collects data on unmet needs from RBHAs. Unfortunately, RBHAs have an interest in reporting that needs are being met. This may skew data that AHCCCS receives.

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-The Health Care System, Parity and Integration-Health Parity: AHCCCS needs to assist with the creation of a definition of "medical necessity" so that persons who receive behavioral health services through private insurance could have better access to covered services

-Evidence Based Practices for Early Interventions to Address Early Serious Mental Illness (10% set aside): Decisions about expenditure of these funds have been made by the RBHAs and in some cases, these decisions were not optimal. The Council would like to have a more active role in this process.

-Program Integrity: The Planning Council would like to assist in monitoring program expenditures to assure that Block Grant funds are used appropriately.

-Tribes: The Planning Council notes that important concerns were addressed at the AHCCCS Tribal Consultation sessions, especially with regard to the transition to the new AHCCCS Complete Care system on October 1, 2018. Care coordination issues between the Indian Health Service, Tribal and Urban Indian behavioral health programs and TRBHA's that engage with ACC health plans and RBHA's were identified. Further the state is trying to educate AHCCCS registered providers that they may accept American Indians and Alaska Native patients who are enrolled in the American Indian Health Program (AIHP). Tribes have seen more denials since the transition.

-Primary Prevention: These dollars are being dedicated to teens and young adults. The Council would like to see a portion of these funds to also serve older age groups.

Also, as stated above, the Council would like to review financial and performance data on the Prevention component of the SABG. At this point, this data has not been available.

-Statutory Criterion for MHBG--Incidence of SMI and SED- Data in the 20-21 plans shows a significant increase in persons with these diagnoses over the numbers listed in the 18-19 plan. The Council would like to know why there is such an increase.

-Criminal Justice: The Planning Council agreed that a significant problem in this area is poor coordination between various systems such as Criminal Justice, Behavioral Health, Housing, Department of Economic Security, Education (for youth) etc. Existing methods that are intended to coordinate services are not being utilized. Another area of concern is poor access to services in rural, sparsely populated areas of the state.

-Medication Assisted Treatment: Rural areas need more access to this resource.

-Suicide Prevention: There is reference to "Mayors Challenge". The Council would like to receive more information about this.

-Community Living and the Implementation of Olmstead: Especially prompted by recent legislation to redirect Housing dollars to creation of secure settings for adults with SMI and who are resistant to treatment, the Council is interested in reviewing the Olmstead plan, and it has not been able to locate the current plan.

Through its **Advocacy and Legislative Committee**, the Council is active in reviewing and tracking state and federal legislation pertaining to mental health services. This year the Council has been responding to new Arizona legislation that allocated funds to the Department of Housing to develop or build secure facilities for programs directed toward persons with Serious Mental Illness and who are resistant to treatment.

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The **Community Advisory Committee** convenes the meetings the Council holds that are away from AHCCCS. As stated earlier, these meetings serve to inform the Council about challenges and concerns experienced by persons who receive AHCCCS behavioral health services.

The Council meetings at AHCCCS include staff who are directly involved in the statistical and financial data collection, and subsequent Block Grant development. The participation of these persons in Council meetings results in better coordination and communication between the Council and AHCCCS.
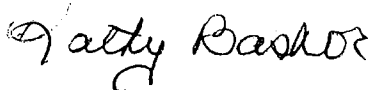
The Planning Council has focused on several areas of concern during 2019:
- Access to services. In Northern Arizona, coordinating agencies called "Health Homes" have deprived some service recipients from obtaining services they seek.
- . Transportation. In Southern Arizona, some service recipients are being denied access to transportation to AHCCCS funded services. This is especially problematic during the summer months when the heat can be oppressive.
- The new legislation on secure residential programs for persons with SMI who are resistant to treatment is an interest and concern of the Council.

When more data is provided to the Council, we anticipate that more topics or areas of concern will be identified.

Thank you for the opportunity to provide comment on the State Mental Health and SABG Plan. The Council continues to review, monitor and evaluate all aspects of the development of this plan and of the Arizona Behavioral Health System in general.

Sincerely,

Kathy Bashor

Kathy Bashor
Chair, Arizona Behavioral Health Planning Council

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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)
David Delawder	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Susan Junck	State Employees	Arizona Health Care Cost Containment System (AHCCCS)		
Jane Kallal	Parents of children with SED/SUD			
John Baird	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kathy Bashor	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Richard Brubaker	Providers	Canyon Pediatrics		
Akia Compton	Parents of children with SED/SUD			
Teresa Fleming	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Tammaria Gammage	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Daniel Haley	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Cathy Hasenberg	State Employees	Arizona Department of Child Safety		
Alida Montiel	Representatives from Federally Recognized Tribes			
Stacy Paul	State Employees	Arizona Department of Corrections		
Aayna Rispoli	State Employees	Arizona Department of Education		
Alicia Ruiz	State Employees	Arizona Department of Economic Security		

Lisa St George	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Brenda Vittatoe	Parents of children with SED/SUD			

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

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Footnotes:

Arizona is actively recruiting for a State Housing Agency representative.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020   End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**18**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	3	
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	1	
Total Individuals in Recovery, Family Members & Others	**11**	**61.11%**
State Employees	5	
Providers	1	
Vacancies	1	
Total State Employees & Providers	**7**	**38.89%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**3**	
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:

          https://www.azahcccs.gov/AHCCCS/PublicNotices/SA-MHBG.html

   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.

April 8, 2019

Grants Management Specialist
Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Grants Management Specialist:

Due to the recent retirement announcement of Director, Thomas J. Betlach, I am designating Shelli Silver, Deputy Director of Health Plan Operations, at the Arizona Health Care Cost Containment System (AHCCCS) to serve as the role of the Single State Authority (SSA) for Arizona. I am also designating signature authority for the Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG), Project for Assistance in Transition from Homelessness (PATH) and discretionary grants during my term as Governor of Arizona, the signature authority includes the signing of any standard federal forms such as Assurances, and Certification and Disclosure of Lobbying Activities.

If you have any questions, please contact Michelle Skurka at Michelle.Skurka@azahcccs.gov or (602) 364-2111.

Sincerely,

Douglas A. Ducey
Governor
State of Arizona