Substance Abuse and Mental Health Services Administration (SAMHSA)
Emergency COVID-19 Grants
Progress Report Template

Grantee Name/Grant Number: 1H79FG000250-01

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Date Submitted: January 19, 2021

Period Covered: April 20, 2020 – December 19, 2020

Progress Updates

Instructions: Please describe successes, challenges and obstacles overcome in meeting the objectives. Note evidence-based practices being facilitated and use quantitative & qualitative data to show outcomes and progress for the following activities:

1. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the implementation of your evidence-based mental and/or SUD treatment services for individuals with SMI/SED or Co-Occurring; including, telehealth services. (70% of services)**
   The overarching goal of the Arizona Emergency COVID-19 Project is to address the increased need for substance abuse, mental health, and crisis support services to Arizonans that have been impacted by the COVID-19 pandemic. The first phase of the project included planning to inventory resources available to Arizonans, including the Arizona AHCCCS Emergency COVID-19 funding. The first phase also included ensuring service gaps, barriers, and potential overlap were addressed before project implementation. These steps were critical to ensuring available resources were being coordinated appropriately to address the substance use and mental health needs cohesively in the state. Planning included identifying and outreaching Regional Behavioral Health Authorities (RBHA), Tribal Regional Behavioral Health Authorities (TRBHA), and local service providers, conducting the steps necessary to subcontract, and obtaining SAMHSA budgetary approvals needed to begin service implementation. AHCCCS contracted for program evaluation, and the evaluation team developed data collection protocols, electronic GPRA data collection tools, and tracking logs. Final budget approvals were provided by SAMHSA in July and October, with AHCCCS finalizing the allocation letters for all Contractors in October. Multiple trainings in data collection and GPRA administration were conducted with the RBHAs and providers throughout the months of October and November, which launched service implementation.

   The total number of program intakes as of December 19, 2020, was 112. The GPRA intake coverage rate was 37.3%. Eighty-one (81) enrollments, making up 72% of the total enrollments, were for individuals with SMI/SED or Co-occurring disorders. Initially, providers reported barriers surrounding medical coding for claims and issues around workflow management. AHCCCS, the RBHAs and providers utilized a team approach to

identify these barriers and develop tools and strategies to resolve these challenges. For example, AHCCCS and the RBHAs developed a medical coding and claims process specific to individuals enrolling in this program, triggered by eligibly determination at the provider level. Workflow challenges were discussed with each provider and technical assistance was provided to ensure processes were in place to enroll and conduct GPRA intakes with eligible individuals in an integrated systems approach manner. The integration of COVID-19 processes and services into the existing system of care and process was determined to be critical for program sustainability.

Providers identified several challenges serving individuals with SMI/SED or Co-occurring disorders including identifying/outreaching potentially eligible individuals, and once enrolled, the need to provide expanded case management, check-ins, and psychiatric services/access to services for individuals with these diagnoses. Identifying individuals that are not AHCCCS/ Title XIX eligible has been one of the biggest challenges faced by providers. The RBHAs addressed this challenge through the development of guidance in determining eligibility by adding grant eligibility into the providers' existing decision tree matrix used to trigger GPRA intakes. Tribal providers worked with their tribal health/behavioral health departments to secure lists of individuals with diagnoses that are not AHCCCS/ Title XIX eligible and began outreaching for potential COVID-19 program enrollment. All providers created outreach materials specific to their local programs and distributed that information across their communities.

In serving individuals with SMI/SED or Co-occurring disorders, providers identified the need to expand program services to include case management and psychiatric services and have included these services for eligible individuals. One provider's substance use disorder team assesses patient needs during the intake process to include determining if client's circumstances have been exacerbated due to stressors and social determinants of health related to COVID-19, and services, resources, and referrals, are put in place to address identified needs. Another provider gives enrolled individuals with SMI/SED or Co-occurring disorders consistent outreach/check-ins, support services, and brief counseling. This provider found that continuous check-ins help to engage individuals in services. Providers use a combination of face to face, virtual telehealth, and phone calls to meet patient needs.

2. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the implementation of evidence-based and population appropriate treatment services. (10% of services for Healthcare professionals)**
   As of December 19, 2020, four (4) enrollments, making up 4% of the total enrollments, were for healthcare professionals. The planning for and implementation of evidence-based and population appropriate treatment services for healthcare professionals has been the biggest challenge to date. Initial discussions with RBHA contract administrators revealed numerous perceived challenges in serving healthcare professionals included:
   - The need to ensure that healthcare professionals can enroll in services anonymously so as not to have to report mental health treatment to medical licensing boards;
   - The need to address this through policy at the state level;

- The requirement of conducting a full GPRA intake
- The need to identify healthcare professionals willing to come forward and participate in services; and
- The need to set up programs for healthcare professionals that include single encounter services. RBHAs and providers noted that stigma is associated with healthcare professionals seeking behavioral health treatment. To combat these concerns, AHCCCS allowed for single encounter services for healthcare professionals to be provided under this grant and has tasked the RBHAs with developing methods for ensuring anonymity when enrolling. AHCCCS and Wellington Group Consulting modified the GPRA intake process for healthcare professionals and obtained approval from SAMHSA to do so in order to help reduce stigma and increase anonymity; all providers were given additional/modified guidance for enrolling healthcare professionals in November 2020.

Since making enrollment modifications one provider enrolled four healthcare professionals indicating barriers have been reduced. AHCCCS obtained information from the providers on the processes used for enrolling the healthcare professionals and has shared the successful strategies with the other RBHAs and providers to support them in outreaching and enrolling healthcare professionals. The successful strategies included targeted marketing to healthcare professionals utilizing social media and providing access to outreach/check-in and treatment services after normal business hours. Another provider developed a wellness program targeting their healthcare employees and will provide virtual anxiety and stress relief classes. This provider is currently working with vendors outside the organization that have experience in facilitating these types of programs remotely to ensure quality of virtual services and to support employee confidentiality. Another provider is planning to offer wellness services to their healthcare employees through the implementation of Jorgensen Brooks Employee Assistance Program (EAP). Currently, this program is sending out information on staying safe and attending telehealth trainings and self-care events. It is expected that healthcare professionals in these programs will be forthcoming in the new year. Finally, AHCCCS is planning to obtain technical assistance in policy development to reduce stigma associated with healthcare professionals accessing mental health services, as well as identifying new areas for technical assistance opportunities.

3. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the implementation of evidence-based and population appropriate treatment services. (20% of services for population with less than SMI)**
As of December 19, 2020, 27 enrollments, making up 24% of the total enrollments, were for individuals with mental health diagnosis less severe than SMI or general mental health disorders. Providers reported barriers surrounding medical coding for claims and issues around workflow management. AHCCCS, the RBHAs and service providers utilized a team approach to identify barriers and develop tools and strategies to resolve these challenges. One provider began identifying and outreaching eligible individuals through assessment during their Fastrack intake process. When patients are identified as being impacted by COVID-19 the patient is informed of the grant services that are available. If the patient is interested an appointment is set up for GPRA intake interview. Another

provider is continuing to outreach potential participants via phone and through direct outreach at community events. The Pascua Yaqui Tribe distributed program information including program flyers during a community resource fair held during Halloween promoting COVID-19 safety and recovery month. The Pascua Yaqui Centered Spirit Program conducted a virtual presentation for recovery month in September for SAMHSA with over 300 participants.

4. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the screening and assessing clients for mental, SUD & Co-Occurring disorders and develop appropriate treatment approaches, as needed.**

The screening and assessment process includes members participating in a comprehensive assessment with emphasis on the unique qualities and culture of the individual. The following elements outlined in the AHCCCS Medical Policy Manual (AMPM), Behavioral Health Assessments and Treatment/Service Planning policy are followed: *the model shall be strength-based, member-centered, family-friendly, culturally and linguistically appropriate, and clinically supervised. The model incorporates the concept of a "team," established for each member receiving behavioral health services*. The AMPM policy, Serious Mental Illness Eligibility Determination, is adhered to when assessing individuals for a SMI determination. This policy also outlines requirements associated with referral for a SMI Evaluation and SMI Eligibility. Behavioral health providers are required to assist individuals with applying for the following:

- Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance),
- Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D "Extra Help with Medicare Prescription Drug Plan Costs" low income subsidy program,
- Verification of U.S. citizenship/lawful presence prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services.

All Contractors adhere to AMPM, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits.

One of the biggest challenges providers have faced is identifying individuals that are not AHCCCS/Title XIX eligible. To address this challenge, the RBHAs developed guidance to support providers in determining eligibility for the COVID-19 grant by adding grant eligibility into their existing decision tree matrix, which triggers GPRA intakes. Tribal providers worked with their tribal health/behavioral health departments to secure lists of individuals with diagnoses that are not AHCCCS/Title XIX eligible and began outreaching for potential COVID-19 program enrollment. Providers have created outreach materials specific to their local programs and are distributing that information across communities. AHCCCS and the RBHAs developed a medical coding and claims process specific to individuals enrolling in this program, triggered by eligibility determination at the provider level. As of December 19, 2020, the number of program intakes was 112, a 37.3% GPRA intake coverage rate.

Providers noted that most participants were eager to engage and actively participated in the assessment process, which includes the development of person-specific treatment plans. Therapists are able to determine best practice approaches for individual treatment plans. Substance use disorder staff assess patient needs during the intake process, which includes a comprehensive biopsychosocial assessment including screening for social determinants of health barriers, and an ASAM and Guide Right Assessment (GRA) for substance use disorders. Services, resources and referrals are determined during the screening and assessment process.

A challenge experienced by Health Choice Arizona (HCA), a contracted RBHA in northern Arizona, was the recruitment of local service providers interested in adding COVID-19 services to their existing menu of services and processes as the grant requires adding additional screening and assessment. AHCCCS and Wellington provided guidance to this contractor; however, local providers were not interested in conducting GPRA in addition to their standard screening and assessment processes. Some local services planned to provide recovery housing/rapid rehousing rental assistance under the Emergency COVID-19 funding, but when this item was removed from budgets per SAMHSA guidelines some local providers determined the project was not a good fit for their agency. At this time, HCA is working to identify and recruit providers interested in conducting services utilizing grant funds and implementing grant processes including GPRA. AHCCCS has issued a contractual concern to HCA in an effort to resolve this issue.

Other providers have conducted screening and assessment during this reporting period. Arizona Complete Health (AzCH), a RBHA in southern Arizona, has contracted COPE Community Services as their local provider. COPE implemented the Pandemic Outreach Project (POP), which screened and enrolled 68 clients including 48 with SMI/SED or Co-occurring disorders, 12 individuals with general mental health disorders, and four health care practitioners. AHCCCS has asked AzCH to provide technical assistance to other RBHAs that are struggling to outreach, screen, and assess clients under this project.

5. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the implementation of recovery support services (nutrition services, peer support, childcare, educational/housing, etc.) Ensure ability to provide virtually as needed.**

Current providers are well connected within their communities and are currently charged with ensuring there is a complete continuum of services and care being provided to their members. Case management services are utilized to manage all aspects of a members' care, ensure all services are being provided according to the members' needs, and to ensure services are being provided in a comprehensive manner. Individuals who may not be in need of direct substance abuse, mental health, and crisis services, but who may be in need of recovery support services or general assistance services due to COVID-19 such as housing, food assistance, and utility assistance, are connected with support service entities throughout the state. Once an enrollee's GPRA intake is completed, the client is referred to all services identified in their assessment, treatment plan and GPRA intake. One provider connects client's to rehabilitation specialists, peer support specialists, care

coordinators, and counselors for all identified services. The Pascua Yaqui tribal COVID-19 program has assisted tribal members with food boxes and is utilizing recovery support services for recruitment and engagement in program services including the GPRA data collection. Other programs have found that recovery support services have been well received by participants, as they seem to enjoy the assistance they are receiving in the community. The participants have been able to access basic needs through the assistance of peer support certified outreach workers. These outreach workers have attended primary care and specialist appointments with clients helping them obtain groceries and access additional community resources.

6. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the implementation of crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, meditation admin, and crisis stabilization.**

AHCCCS ensures the provision of an array of short-term crisis stabilization and behavioral health services across Arizona's urban, rural and frontier communities. Crisis services are available to all individuals in Arizona at any time irrespective of Medicaid eligibility status. Crisis services include a full continuum of crisis intervention services including, but not limited to 24/7/365 crisis telephone services, mobile crisis response teams, and 24-hour substance use disorder/psychiatric crisis receiving and stabilization settings. Arizona's robust network of crisis providers ensures that individuals experiencing a behavioral health emergency are served quickly and appropriately within their communities. Interventions are solution- and recovery-oriented. They are focused on stabilizing the individual within their community and returning them to their baseline of functioning, while simultaneously ensuring receipt of appropriate follow-up services to mitigate future emergencies through preventive treatment or connection to community services. Arizona's crisis system is a national leader and "best-practice" state in the provision of crisis care.

One COVID-19 provider in Maricopa County, Valle del Sol, has a licensed clinician on call seven days a week to handle any emergencies that may arise after hours. Enrolled clients have access to the after hours on-call system. A crisis plan is developed, which includes crisis contact numbers in Maricopa County including the warm line. Valle Del Sol clients who experience a crisis situation that results in an emergency room or inpatient stay get visited by a member of the clinical team. Staff outreach patients again post discharge to schedule a follow up appointment with a Crisis Transition Navigator to support patients.

At this time, providers have not reported the need to implement crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, meditation admin, and crisis stabilization for clients enrolled in this project, but processes are in place should the need arise.

Data Collection

1. **Requirement: Each grantee must collect and report client-level data at intake, every six months after and at discharge using GPRA. (Admin & Data Collection must not exceed 20% of budget)**

   Total # Of Clients Served Between 4/20/20 – 12/19/21: # 112

   SMI/SUD and/or Co-occurring: # 81

   Healthcare Professionals # 4

   Less than SMI: # 27

   Children 11 Years and Younger: # N/A

2. **Does SPARS accurately reflect the total intake and follow-up rates reported? (Y/N)**
   At this time, SPARS accurately reflects the total intake and follow-up rates reported in this document.

   If no, please explain: Not Applicable

3. **How is data being used for Quality Improvement?**
   The program Evaluation team, Wellington Consulting Group, developed an online GPRA tracking tool for each provider to assist them in identifying enrolled clients, 6-month follow-up interview due dates, follow-ups completed, GPRA discharges, and their GPRA completion rate. Ongoing and continuous support in GPRA implementation has been employed across providers. The Evaluator provides GPRA data updates at monthly meetings with AHCCCS, RBHAs, and providers. Providers report monthly on program updates, success, challenges, barriers, and actions to overcome barriers. Reports are reviewed by the AHCCCS Project Director, RBHA contract managers, and the Evaluation team. Reported challenges and barriers are discussed during monthly meetings in order to identify any quality improvement issues that need to be addressed with a focus on disparities in access/use/outcomes. Content analyses of monthly process narratives are utilized to identify characteristics of recruitment/retention plans, factors that facilitate /hinder implementation, and challenges and barriers experienced, and resolutions. The monthly meetings allow for quick identification and resolution of challenges/barriers and planning for technical assistance needs.

Key Personnel & Budget

1. The project is overseen by a project director at 80% level of effort. **Please note in progress if there have been any key staff changes or level of effort.**

   There have been no key staff changes or level of effort.

2. **Have you met the stated timeline and budget proposed in the original application (or any changes in scope submitted)**
   The AHCCCS AZ Emergency COVID-19 Program has finalized contracts with the Evaluation team and the subcontractors. The program has worked with subcontractors to finalize implementation plans and set up monthly meetings to track implementation progress. The Evaluation team developed data collection protocols and developed and deployed a web-based GPRA tool and data collection system. The Evaluation team trained all providers on data collection processes and requirements including GPRA administration. SAMHSA provided final TRBH budget approvals in July and RBHA budget approvals in September. Official allocation letters were finalized between AHCCCS and subcontractors in service implementation began in October and November and includes GPRA data collection, monthly reporting, and monthly meetings. AHCCCS continues to work with providers to spend the original approved budgets.

   Each month, all Contractors must submit a Contractor Expenditure Report (CER) with backup documentation in order to get reimbursed for providing services. Each CER is reviewed by AHCCCS Program and Financial staff to ensure funds are allowable. Additionally, each Contractor is expected to submit a monthly progress report to our Evaluator Wellington Group Consulting detailing progress, successes, and challenges.

Outcomes, Challenges & Successes:

1. **What obstacles has your program encountered and what steps did you take to overcome these obstacles?**
   Providers are working through implementation plans and identifying and enrolling eligible individuals. To support providers, a web-based GPRA tool and data collection system were created, and all providers were trained prior to implementation. As of December 19, 2020, there were 112 program intakes:
   - 81 enrollments (72% of total enrollments) SMI/SED or Co-occurring disorders,
   - 4 enrollments (4% of total enrollments) healthcare professionals,
   - 27 enrollments (24% of total enrollments) mental health diagnosis less severe than SMI or general mental health disorders.

   Each provider is working towards outreach and enrollment. COPE Community Services' Pandemic Outreach Project (POP) developed a social media outreach campaign utilizing Facebook, Instagram, and LinkedIn to recruit new individuals with a specific emphasis on healthcare professionals.

Challenges included delays in budget approvals resulting in delays in implementation, medical coding for claims, and workflow processes/management. AHCCCS, the RBHAs and providers utilized a team approach to identify this issue, and the RBHAs developed tools and strategies to resolve these challenges. Workflow challenges were discussed with each provider and technical assistance was provided to ensure processes were put in place to specifically enroll and conduct GPRA intakes with eligible individuals using an integrated systems approach manner. Health Choice Arizona (HCA) were challenged in the recruitment of local service providers adding COVID-19 services and the required GPRA administration to their existing menu of services and processes. Other providers planned to use funding to conduct recovery housing/rapid rehousing rental assistance and when this disallowed, some providers determined the funding was not a good fit for their agency. HCA is working to identify and recruit providers interested in conducting services utilizing grant funds and processes including GPRA. AHCCCS has issued a contractual concern to HCA in an effort to resolve this issue.

2. **Please provide three (3) examples that demonstrate your program's successes in achieving the goals and objectives stated in the grant application, and ensure that one of these examples highlights a person served in each of the target populations (SMI/SUD, Healthcare Practitioner, Other than SMI).**

    - **Serving Healthcare Practitioners:** The Pandemic Outreach Project is an outreach-based program from COPE Community Services (subcontractor) that leverages social media (Facebook, Instagram, and LinkedIn) to recruit new individuals. The program has enrolled four healthcare professionals. Outreach workers support individuals with multiple needs and conduct continuous check-ins. Services are provided after work hours to ensure accessibility. In November, COPE reported the following success story regarding the enrollment of a health care professional. A healthcare practitioner called to enroll in services. Before his intake occurred, he was terminated from his employment. His initial response was that he no longer wanted to be a part of the program and wanted to cancel his intake. However, after speaking to the outreach worker who explained the support services available to him through the POP, the individual agreed to continue with the intake process. The individual is currently enrolled and is receiving services including support in obtaining employment.

    - **Serving individuals with SMI/SED or Co-Occurring Disorders:** AHCCCS and the RBHAs developed a medical coding and claims process specific to individuals enrolling in the COVID-19 grant program, which is triggered by eligibility determination at the provider level. Efforts to include COVID-19 processes and services into the existing system of care processes is critical for program sustainability. To date 81 individuals have been enrolled and are receiving services. One success story was provided by the Valle Del Sol program regarding an individual with an SMI diagnosis who was enrolled in the COVID-19 program due to extreme anxiety related to COVID-19. The client was able to obtain needed counseling services and has since reported a decrease in his symptomology.

- **Serving individuals with disorders less severe than SMI:** AHCCCS, the RBHAs, and the local providers created implementation plans to identify and enroll eligible individuals into the COVID-19 program. To date, 27 individuals have been enrolled. The providers enrolled individuals presenting with depression and anxiety related to COVID-19. Clients have been connected to both individual and group therapy services as needed. Providing support services has helped ensure clients feel connected to services. The GPRA intakes and other assessments have helped determine a variety of needed community services/resources.

3. **Please indicate any innovations or promising practices from your program that you would like to share with SAMHSA and your peers.**

The Arizona AHCCCS Emergency COVID-19 providers developed various local policies and procedures for identifying and assessing individuals affected by the pandemic and in need of treatment services utilizing technology such as Zoom. The providers are using Zoom to provide education and outreach workshops for the Healthcare Workers and conduct program advertising. COPE Community Services developed the Pandemic Outreach Project under this funding and is leveraging social media (Facebook, Instagram, and LinkedIn) to outreach and enroll individuals into services. Continuous marketing through social media assisted the POP program in disseminating program information and outreaching enrollees. The POP program targets health care practitioners with its social media outreach campaign and is the only program to have successfully enrolled healthcare practitioners. To date, the POP program has over 1,000 views, more views than any other program at COPE Community Services. On November 12, 2020, the POP Program Director conducted a Facebook Live interview where she discussed available services through POP and how to access them. COPE also reached out to other provider organizations in Pima County and local schools to provide them program information and to develop a system of referrals for individuals potentially eligible for the POP. The Evaluation team developed the online GPRA tool and tracking system for each provider to assist them in identifying enrolled clients, 6-month follow-up interview dates and follow-up status, GPRA discharge status, and GPRA completion rates. Ongoing and continuous support in GPRA implementation has been employed across providers.

4. **Any other information you would like to share with SAMHSA regarding your program?**

Valle Del Sol noted that this program has supported patients experiencing domestic violence in accessing services. With more adults and children staying home because of federal and state guidelines to slow the spread of COVID-19, many nonprofits in Arizona have reported a rise in domestic violence and an increase in services to meet the demand. The Phoenix Police Department reported homicides involving domestic violence saw a 140% increase in the first half of this year.

Optional Attachment(s)

Specify attachments (associated with the grant project) submitted with the progress report, such as:

- Evaluation report, workplan, statewide plan, minutes/summaries of meetings

  See Attachment 1: AHCCCS Az Emergency COVID-19 Mid-Point Evaluation

- Proclamations, awards, or citations

  Not applicable

- Press releases or Media Coverage

  See Attachment 2: AHCCCS Az Emergency COVID-19 Press Release

- Publications (e.g., internal newsletters, professional journals, and presentations)

  Not applicable

Attachment 1:

AHCCCS AZ EMERGENCY COVID-19 PROJECT MID-POINT EVALUATION

(4/20/2020 – 12/19/2020)

Presented to:
Arizona Health Care Cost Containment System

By:
Jane Dowling, PhD
Samantha Martin, PhD

Wellington Consulting Group, Ltd.

January 2021

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Introduction

The Arizona Emergency COVID-19 project addresses the increased need for substance abuse, mental health, and crisis support services to Arizonans impacted by the COVID-19 pandemic. This project prioritizes outreach services utilizing the existing substance use, mental health, and crisis system to ensure individuals are met where they are and to increase overall service utilization. Case management services manage all aspects of a member's care, ensures all services are provided according to members' needs, and ensures services are provided in a comprehensive manner. Individuals who do not need of direct substance abuse, mental health, and crisis services, but do need recovery support services or general assistance services due to COVID-19 are connected with support service entities throughout the state.

The Arizona Emergency COVID-19 project began on April 20, 2020. During the initial planning period, AHCCCS completed an inventory of resources available to Arizonans to identify service gaps, barriers, and potential overlaps before implementing the Arizona Emergency COVID-19 funding. The work completed during the planning period facilitated the development of a plan that addresses Arizona's specific needs for substance use, mental health and crisis services during the pandemic. Service delivery began in October and November 2020 when AHCCCS sent the allocation letters to the Regional Behavioral Health Authorities (RBHAs) for signatures. This report covers the period of April 20 through December 19, 2020.

Data Sources and Evaluation Overview

The Arizona Emergency COVID-19 project is funded by SAMHSA's Center for Substance Abuse Treatment (CSAT) and uses the CSAT Government Performance and Results Act (GPRA) data collection tool at specific time points as a funding requirement. GPRA data collection occurs as part of the client's enrollment in the program with a second data collection point occurring six months later. The third data collection interval occurs when the client is discharged from the program. Changes in drug alcohol use, family and living conditions, crime and criminal justice status, and social connectedness are measured by comparing the data collected at intake with data collected during the six-month follow-up.

Providers working with clients complete the GPRA and submit the completed forms to the evaluation team as paper copies or through a web portal created by the evaluation team. The evaluation team submits the GPRA data to SAMHSA using the SPARS data system. The web portal collects additional information on the services a client receives and referrals. A monthly process narrative on program implementation is completed by the providers each month. This additional information is utilized to address the following process and outcome evaluation questions developed for the Arizona Emergency COVID-19 project:

Process Evaluation Questions:

1. How many individuals were reached through the project?
2. Is the project serving the target population adequately and appropriately?
3. How closely did implementation match the plan?
4. What types of changes were made to the original plan?

5. What effect did the changes have on the planned intervention and performance assessment?

Outcome Evaluation Questions:

1. What was the effect of intervention on key outcome goals?
2. What factors were associated with outcomes?
3. Was the intervention effective in maintaining the project outcomes at the six-month follow-up?
4. What program factors were associated with increased access to and enrollment in treatment services?
5. What was the effect of the AZ Emergency COVID-19 Project on the level of collaboration between the integrated care system, recovery support services, and healthcare system on key outcome goals?

This evaluation report presents information related to the process and outcome evaluation questions using the intake GPRA interview data. Counts, frequencies, and means are shown for available data. As follow-up and discharge data is collected from clients, additional forms of analysis will include effect size and percent change. Follow-up data collection is scheduled to begin in March 2021 and will enable the answering of the outcome evaluation questions.

Evaluation Results

Service providers began identifying and enrolling clients in October and November 2020. Once a client is identified as eligible for the Arizona Emergency COVID-19 project, an Intake interview is completed. Service delivery begins following the completion of the intake interview and is tracked through the data collection web portal created by the evaluation team. Limited outcome data is available on the services provided through December 19, 2020. Services were initiated with clients only after the allocation letters were distributed and signed in October and November 2020. The data included in this evaluation report was collected from intake interviews conducted between October 2020 and December 19, 2020. Future reports will include data collected from six-month follow-up and discharge interviews to measure changes over time.

Process Evaluation Results

<u>Process Evaluation Question 1:</u> How many individuals were reached through the program?

This process evaluation questions is measured using several items from the intake interviews. The following table presents demographics through December 19, 2020 for 112 eligible Arizona Emergency COVID-19 participants. The six-month follow-up data collection window has not been reached for any clients. The first six-month follow-up interviews will begin in March 2021. No clients have been discharged. Data collection for the project will continue through August 2021.

Demographic variables	Intake (n = 112)
1. Co-occurring Screen (%)	
Yes	72%
2. Co-occurring positive screen status (%)	
Yes	23%
3. Average Age in years	
Range 15 – 84 years old	48.6
4. Gender (%)	
Males	51%
Females	49%
5. Race & Ethnicity (%)	
Hispanic	33%
American Indian	8%
Alaska Native	1%
Asian	0%
Black	1%
Native Hawaiian	2%
White	75%
Refused or Unknown	13%
6. Education (%)	
6th Grade	0.9%
8th Grade	0.9%
9th Grade	2.7%
10th Grade	4.4%
11th Grade	5.3%
12th Grade/HS diploma/equivalent	28.6%
College or University/1st year completed	13.4%
College or University/2nd year completed Associates Degree (AA/AS)	16.1%
College or University/3rd year completed	4.4%
Bachelor's Degree	17.9%
Voc/Tech Program with no diploma	0.9%
Voc/Tech Program diploma	3.6%
Don't know	0.9%
7. Ever served in the military? (%)	
Yes	7%

Nearly three-quarters of clients (72%) were screened for a co-occurring disorder with 23% having a positive result indicating a co-occurring disorder. With a mean age of 48.6, slightly more participants were male (51%) than female (49%). Three-quarters of clients identified as white and one third (33%) are Hispanic/Latino. Approximately 29% completed grade 12 with a high school diploma or a GED equivalent and nearly 18% of clients indicated a Bachelor's degree.

The GPRA included a section on Behavioral Health Diagnoses using the International classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). Up to three diagnoses could be selected with the option to identify the diagnosis as Primary, Secondary, or Tertiary. The following section presents the results for 112 intake interviews. Of the 112 clients, 107 individuals (96%) had a primary behavioral health diagnosis, 62 individuals (55%) also had a secondary diagnosis, and 22 individuals (20%) had a tertiary diagnosis. Four individuals (3%) had at least one behavioral health diagnosis that was not ranked as primary, secondary, or tertiary. One individual had more than one behavioral health diagnosis that was not ranked; consequently, the table below shows five behavioral health diagnoses in the "No Ranking" column.

8. Behavioral Health Diagnosis	**# Primary**	**# Secondary**	**# Tertiary**	**No Ranking**
F10.10 – Alcohol use disorder, uncomplicated, mild	5	2	0	1
F10.11 – Alcohol use disorder, mild, in remission	1	1	0	0
F10.20 – Alcohol use disorder, uncomplicated, modern/severe	1	4	4	0
F10.21 – Alcohol use, disorder, moderate/severe, in remission	1	2	1	0
F10.9 – Alcohol use, unspecified	1	1	0	0
F11.10 – Opioid use disorder, uncomplicated mild	1	0	0	0
F11.11 – Opioid use disorder, mild, in remission	0	1	0	0
F11.20 – Opioid use disorder, uncomplicated, moderate/severe	2	0	1	0
F11.21 – Opioid use disorder, moderate/severe, in remission	0	0	0	1
F12.10 – Cannabis use disorder, uncomplicated, mild	0	1	0	0
F12.11 – Cannabis use disorder, mild, in remission	0	0	1	0
F12.20 – Cannabis use disorder, uncomplicated, moderate/severe	0	0	1	0
F14.20 – Cocaine use disorder, uncomplicated, moderate/severe	0	0	2	0
F14.21 – Cocaine use disorder, moderate/sever, in remission	1	0	1	0
F15.20 – Other stimulant use disorder, uncomplicated, moderate/severe	0	1	0	0
F15.21 – Other stimulant use disorder, moderate/severe, in remission	0	3	0	0
F15.9 – Other stimulant use, unspecified	0	1	0	0
F18. 20 – Inhalant use disorder, uncomplicated, moderate/severe	1	0	0	0
F19.20 – Other psychoactive substance use disorder, uncomplicated, moderate/severe	0	0	1	0
F20 - Schizophrenia	2	1	0	0
F22 – Delusional disorder	1	0	1	0
F25 – Schizoaffective disorders	13	0	0	0
F29 – Unspecified diagnosis not due to a substance or known physiological condition	2	0	0	0
F31 – Bipolar disorder	26	2	0	0
F32 – Major depressive disorder, single episode	4	0	0	0
F33 – Major depressive disorder, recurrent	21	4	0	1
F40 – F48 – Anxiety, dissociative, stress-related,	13	35	2	1

8. Behavioral Health Diagnosis	# Primary	# Secondary	# Tertiary	No Ranking
somatoform, and other nonpsychotic mental disorders				
F50 – Eating disorders	1	1	0	1
F51 – Sleep disorders not due to a substance or known physiological condition	0	0	1	0
F60.3 – Borderline personality disorder	1	1	2	0
F60.0, F60.1, F60.4 – F69 – Other personality disorders	5	1	2	0
F90 – Attention-deficit hyperactivity disorders	2	0	2	0
F91 – Conduct disorders	2	0	0	0
Total	**107**	**62**	**22**	**5**

Two items were also asked regarding whether or not a client was diagnosed with an opioid use disorder (OUD) or an alcohol use disorder (AUD). Additional items identified if the client was prescribed a U.S. Food and Drug Administration (FDA)-approved medication for the treatment of the OUD or AUD. These questions were completed at intake.

The following table presents the data for past 30-day diagnosis of an opioid use disorder for those individuals having an intake interview. Three individuals had an OUD diagnosis. Two of the three individuals received OUD treatment in the past 30 days using an FDA-approved medication. One client indicated they did not receive an FDA-approved medication.

9. OUD Treatment	# Received in Past 30 Days	Average # of Days Received	Range of Days
Methadone	0	0	0
Buprenorphine	2	15.5	1 to 30
Naltrexone	0	0	0
Extended-release naltrexone	0	0	0
Client did not receive an FDA-approved medication for an opioid use disorder	1	0	0

The next table presents the data for past 30-day diagnosis of an alcohol use disorder. Twelve clients were identified with an AUD. One person indicated receiving FDA-approved treatment in the past 30 days, and three people did not know what medication they were prescribed. Eight individuals reported they did not receive an FDA-approved medication for their AUD diagnosis.

10. AUD Treatment	# Received in Past 30 Days	Average # of Days Received	Range of Days
Naltrexone	1	1	1
Extended-release naltrexone	0	0	0
Disulfiram	0	0	0
Acamprosate	0	0	0
Client did not receive an FDA-approved medication for an alcohol use disorder	8	0	0
Did not know what medication they were prescribed	3	0	0

Process Evaluation Question 2: Is the project serving the target population adequately and appropriately?

Contractors agreed to serve 842 unduplicated individuals by August 19, 2021. In accordance with funding requirements, 70% of clients (590 individuals) should be persons with SMI/SUDs, 10% (84 individuals) should be healthcare practitioners, and 20% (168 individuals) should be individuals with less than SMI.

The 112 intake interviews (13% of the 842 target) indicate that the Arizona Emergency COVID-19 project is progressing toward the specified target population and subpopulation percentages. Of the 112 intakes, 72% were for individuals with SMI/SED or co-occurring disorders, 24% were individuals with less than SMI, and 4% were for healthcare practitioners. These percentages will be updated as enrollment continues. Providers will provide additional attention on enrolling healthcare practitioners to bring this population in closer alignment with target goals.

Process Evaluation Question 3: How closely did implementation match the plan?

Process Evaluation Question 4: What types of changes were made to the original plan?

Process Evaluation Question 5: What effect did the changes have on the planned intervention and performance assessment?

Service delivery began in October and November 2020 once allocation letters were distributed to and signed by contractors. Future reports will address the three evaluation questions related to implementation and changes to the original plan.

Outcome Evaluation Results

Outcome Evaluation Question 1: What was the effect of intervention on key outcome goals?

The following tables present baseline data for the 112 clients who completed an intake interview prior to December 19, 2020. The percent change between intake interview data and the six-month interview will be reported after follow-up data collection begins in March 2021.

Risk factor variables

Current employment status is reported at the time of the intake interview. The percent change of participants who increased full time or part time employment at follow-up will be reported and reductions in the percentage of individuals who are unemployed, but looking for work will also be documented as follow-up interviews are completed. Approximately 28% of the clients reported being employed. The largest percentage (38%) of individuals were unemployed and disabled.

11. Current employment status (%)	Intake (n = 112)
Employed, Full Time	20%
Employed, Part Time	8%
Unemployed, looking for work	9%
Unemployed, disabled	38%
Unemployed, retired	13%
Unemployed, not looking for work	9%
Intake Other (n=4)	3%
On medical leave (2)	
Incarcerated (2)	

The next table presents the housing data at intake. The majority of participants (95%) were in permanent housing at the intake interview. Among those in permanent housing, more than 80% of individuals own/rent their own apartment, room, or house.

12. In the past 30 days, where have lived most of the time? (%)	Intake (n = 112)
Shelter	0%
On Street/Automobile	1%
Institution	4%
Permanent Housing	95%
Permanent Housing: Own/Ren apartment, room, or house	*83%*
Permanent Housing: Someone else's apartment, room, or house	*12%*
Permanent Housing: Halfway house	*3%*
Permanent Housing: Residential treatment	*1%*
Permanent Housing: Other – Motel	*1%*

Participants were asked to indicate their satisfaction with the conditions of their living space on a five-point scale with "1" being Very Dissatisfied and "5" being Very Satisfied. Approximately 75% of the participants indicated they were either Satisfied (42%) or Very Satisfied (33%) with their living space. Another 19% said they were either Very Dissatisfied (6%) or Dissatisfied (13%) with their living space. The remaining 6% of participants were neither satisfied nor dissatisfied.

A reduction in client's substance use is another intended outcome of the Arizona Emergency COVID project. The intake interview established clients' baseline use of alcohol and illegal drugs. The following table presents the percentage of the clients at intake who reported substance use. Clients were able to report in more than one category.

13. Substance use variables: In past 30 days	Intake (n = 112)	Average # of Days	Range of Days
Any alcohol use (n=33)	29%	7.3	1 to 30
Use of alcohol for intoxication (5+ drinks in 1 sitting) (n=14)	13%	3.3	1 to 10
Use of alcohol for intoxication (4 or fewer) and felt high (n=16)	14%	6.4	1 to 30
Used illegal drugs (n=14)	13%	17.3	2 to 30
Used both alcohol and drugs (n=3)	3%	3.7	1 to 6

Illegal drug use by individual substance at intake is shown in the following table. The percentage of individuals responding that they had used an illegal substance at least one day in the past 30 days is shown. At intake, marijuana was the most frequently used substance with 11% of participants reporting use at intake and using on the average of 15.4 days in the past 30 days. As medical marijuana is legal in Arizona, it is not surprising that this substance has the highest rate of use among clients. A few clients also reported using methamphetamine and benzodiazepine at intake. Changes in substance use will be reported when discharge and six-month follow-up data becomes available. Clients were able to report on more than one substance.

14. Illegal Drug Use: In past 30 days	Intake (n = 112)	Avg. # Days	Range of Days
Cocaine/Crack	0%	0	0
Marijuana/Hashish (N=12)	11%	15.4	2 to 30
Heroin	0%	0	0
Morphine	0%	0	0
Diluadid	0%	0	0
Demerol	0%	0	0
Percocet	0%	0	0
Codeine	0%	0	0
Tylenol 2,3,4	0%	0	0
Oxycontin/Oxycodone	0%	0	0
Non-prescription methadone	0%	0	0
Hallucinogens/Psychedelics	0%	0	0
Methamphetamine. (N=1)	1%	10	10
Benzodiazepines (N=1)	1%	30	30
Non-prescription GHB	0%	0	0
Ketamine	0%	0	0
Other tranquilizers, downers, sedatives, or hypnotics	0%	0	0
Inhalants	0%	0	0
Other illegal drugs	0%	0	0

Participants were also asked to rate the impact of their use of alcohol or other drugs on a scale from 1 to 4 with "1" being "Not at all" to "4" being "Extremely". The following table shows the intake ratings of the impact on stress levels, activities, and emotional problems for 38% of the participants; 62% of the clients indicated "not applicable" when asked to rate the impact of alcohol or drug use. The ratings regarding of alcohol or other drugs on their emotional problems will be compared to the intake values after the six-month interviews are conducted. The intake values indicate that clients using alcohol and/or drugs felt little impact of their use of alcohol or other drugs when asked during the intake interview.

15. In the past 30 days	**Intake Mean (n = 42)**
How stressful have things been for you because of your use of alcohol or other drugs? (n=41)	1.56
Has your use of alcohol or other drugs caused you to reduce or give up important activities? (n=41)	1.44
Has your use of alcohol or other drugs caused you to have emotional problems? (n=42)	1.38

The baseline for mental and behavioral health issues was established for the 109 of the 112 clients. Three clients refused to answer the questions. The most frequently reported issues were "experienced anxiety" and "experienced serious depression" with 77% of clients reporting the first and 62% reporting the second.

16. Mental and Behavioral Health: Past 30 days	**Intake (n = 109)**	
	"% Yes"	**Avg. # Days**
Experienced serious depression	62%	14.7
Experienced anxiety	77%	16.7
Experienced hallucinations	12%	17.8
Experienced and/or had trouble understanding, concentrating, or remembering	60%	21.1
Experienced and/or had trouble controlling violent behavior	6%	10
Attempted suicide	1%	1
Were prescribed medications for psychological/emotional problems	58%	27.7

The intake interviews indicated clients had low levels of crime in the past 30 days. Use of illegal substances is considered a crime even if the person is not arrested. Thirteen individuals reported committing a crime 195 times in the past 30 days. Data collection for the six-month follow-ups will begin in March 2021; changes between baseline and follow-up data will be reported in subsequent reports.

17. Crime and recidivism: In past 30 days	
Number of times arrested	1 time (n=1)
Number of times arrested for drug offenses	1 time (n=1)
Number of nights spent in jail and/or prison	50 nights (n=2)
Number of times committed a crime	195 (n=13)

Protective factor variables

Social connectedness was measured by attendance at self-help groups and interaction with family/friends as support for recovery. The percentage of participants who identified attending a self-help group or support group at intake was low. Clients who participated in these groups went between twice a week (8 to 8.5 times in the past 30 days) and three times a week (12.8 times). Nearly three out of four clients reported interacting with family/friends who are supportive of recovery in the past 30 days. The number of interactions with supportive family/friends in the past 30 days is not measured by the data collection tool.

Protective factor variables	**Intake (n = 112)**	
18. Social Connectedness: In past 30 days	**% "yes"**	**Average # of Times**
Attended voluntary self-help groups	12%	12.8
Attended religious/faith-based self-help groups	7%	8.0
Attended any other support groups	5%	8.5
Interacted with any family/friends that are supportive of recovery	74%	

Mental and Physical Health Outcome Variables

Mental and physical health outcomes were measured with self-report of health status and whether or not treatment was received in the past 30 days. During the intake interview, 53% of participants ranked their health status as good, very good, or excellent. The highest percentage of clients reported receiving outpatient mental treatment with an average of 3.4 times in the past 30 days. Inpatient alcohol or substance use had the highest average number of nights due to the small number of clients who received this treatment in the past 30 days. No clients reported receiving treatment for alcohol or substance use in the ER in the past 30 days.

19. Self-reported health status	**Intake (n = 112)**	
Excellent	5%	
Very Good	15%	
Good	33%	
Fair	33%	
Poor	14%	
20. Received treatment in past 30 days	**% Yes**	**Average # of nights/times**
Inpatient Physical	3%	5.7
Inpatient Mental	2%	5
Inpatient Alcohol or Substance abuse	2%	18.5
Outpatient Physical	22%	2.3
Outpatient Mental	40%	3.4
Outpatient Alcohol or Substance abuse	4%	4.4
ER Physical	3%	1

ER Mental	1%	1
ER Alcohol or Substance abuse	0%	0

Arizona Emergency COVID participants were asked to rate their perception of several components of their mental and physical health on a scale from 1 to 5 with "5" being the preferred response. The items had a mean ranging from 3.1 to 3.4. The lowest mean was reported on having enough energy for everyday life (3.1) while being satisfied with themselves and their quality of life had the highest mean (3.4).

21. Ratings of Mental and Physical Health (Scale 1 to 5–Mean 5.0 preferred)	**Intake Mean**
Quality of life	3.4
Satisfaction with health	3.2
Enough energy for everyday life	3.1
Satisfaction with ability to perform daily activities	3.3
Satisfied with yourself	3.4

Outcome Evaluation Question 2: Was the intervention effective in maintaining the project outcomes at the six-month follow-up?

Six-month follow-up interviews will begin in March 2021. No clients have been discharged from the Arizona Emergency COVID-19 project. Changes in key items, such as abstinence and reductions in substance use, criminal activity and recidivism, and mental and physical health outcomes will be reported once additional data is collected from clients.

Planned Services

During the intake interview, program staff identified the services planned for the client. The planned services and the services provided are documented in the data collection web portal. The actual services clients received will be included in future reports. Case management services were planned for all 112 clients. Individual counseling was the next most commonly planned service with 74 clients identified followed by Outreach (65 clients), Peer coaching or mentoring (63), and Transportation (61). The following table summarizes the planned services identified during the intake interview.

22. Planned Services	**Number of Clients**
Case Management	112
Day Treatment	6
Inpatient/Hospital (Other Than Detox)	0
Outpatient	25
Outreach	65
Intensive Outpatient	11
Methadone	2
Residential/Rehabilitation	1
Detoxification – Hospital Inpatient	0
Detoxification – Free-Standing Residential	0

22. Planned Services	Number of Clients
Detoxification – Ambulatory Detoxification	0
After Care	13
Recovery Support	24
Other Modality – Specified:	4
Peer Support	*1*
Therapy	*1*
Employment	*1*
Counseling	*1*
Screening	50
Brief Intervention	14
Brief Treatment	1
Referral to Treatment	26
Assessment	55
Treatment/Recovery Planning	29
Individual Counseling	74
Group Counseling	25
Family/Marriage Counseling	3
Co-Occurring Treatment/Recovery Services	3
Pharmacological Interventions	17
HIV/AIDS Counseling	0
Other Clinical Services – Specified:	5
SMI Determination	*1*
Food Assistance	*1*
DUI Education	*2*
Anger Management Education	*1*
Family Services (Including Marriage Education, Parenting, Child Development Services)	3
Child Care	0
Employment Service – Pre-Employment	11
Employment Service – Employment Coaching	8
Individual Services Coordination	51
Transportation	61
HIV/AIDS Service	0
Supportive Transitional Drug-Free Housing Services	2
Other Case Management Services – Specify:	16
Remote learning support	*1*
Facilitation of ESL classes	*1*
Food Boxes	*1*
Coordination with legal system	*8*
Help with groceries/errands	*1*
Facilitation with getting medicines	*1*
Group therapy	*1*
Possible housing or additional resources based on treatment	*1*

22. Planned Services	Number of Clients
Coordination of care	*1*
Medical Care	20
Alcohol/Drug Testing	2
HIV/AIDS Medical Support and Testing	2
Other Medical Services – Specify: Support for appts.	1
Continuing Care	22
Relapse Prevention	5
Recovery Coaching	7
Self-Help and Support Groups	10
Spiritual Support	6
Other After Care Services – Specify:	1
Support for divorce	*1*
Substance Abuse Education	13
HIV/AIDS Education	1
Other Education Services – Specify:	15
ESL classes	*1*
Support for remote learning	*1*
Physical exercise and nutrition	*1*
Medication management	*10*
Case Management	*1*
Budgeting	*1*
Peer Coaching or Mentoring	63
Housing Support	13
Alcohol- and Drug-Free Social Activities	8
Information and Referral	24
Other Peer-to-Peer Recovery Support Services – Specify:	8
Organizational help	*1*
Physical activity	*1*
Social support for divorce	*1*
Food assistance (food box)	*1*
Personal care	*3*
Helping with groceries	*1*

Outcome Evaluation Question 3: What factors were associated with outcomes?

Outcome Evaluation Question 4: What program factors were associated with increased access to and enrollment in treatment services?

Outcome Evaluation Question 5: What was the effect of the Arizona Emergency COVID-19 project on the level of collaboration between integrated care system, recovery support services, and healthcare system on key outcome goals?

Future reports will address these three outcome evaluation questions as follow-up and discharge data becomes available.

Conclusion

At the end of this reporting period, the Arizona Emergency COVID-19 project has completed the planning period and initiated client services. A total of 112 individuals were enrolled in the project and completed the intake GPRA interview. The baseline data shows that a slight majority (51%) of the clients are male and are predominantly white (75%). A small number of participants reported using drugs in the past 30 days (12%) with marijuana being the most commonly used substance. Alcohol use was reported at a similar level with 13% of clients reporting binge drinking (5 or more drinks in one sitting) in the past 30 days, and 14% of clients reporting drinking to intoxication (4 or fewer drinks) in the past 30 days. Ninety-six percent of clients had a primary behavioral health diagnosis with the most common diagnosis being bipolar disorder (26 clients) followed by major depressive disorder, recurrent (21 clients).

The addition of follow-up data scheduled to begin in March 2021 will provide additional insight into the impact of the Arizona Emergency COVID-19 project on participants. The additional data collection interval will allow for the comparison of data over time and the measurement of changing behaviors.

Recommendations

The first recommendation is for the evaluation team, AHCCCS, and the RBHAs to develop and implement quality control procedures related to data collection on enrolled clients in the Arizona Emergency COVID-19 project. The RBHAs and providers have implemented procedures for identifying when clients should complete an intake GPRAs. Now that these procedures are in place, quality control steps need to be implemented to monitor client data entry in the web portal. Quality control measures should ensure that all necessary information about enrolled clients is completed by providers. Additionally, the quality control reviews should ensure that only clients who completed an intake GPRA and enrolled in the Arizona Emergency COVID-19 project are entered into the web portal. These quality control reviews will ensure that providers are completing necessary data collection on clients enrolled in the program and receiving related services.

ATTACHMENT 2:

AHCCCS Az Emergency COVID-19 Press Release

AHCCCS
Arizona Health Care Cost Containment System

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Arizona Emergency COVID-19 Project

Background

The purpose of this program is to provide crisis intervention services, mental and substance use disorder treatment, and other related recovery support for children and adults impacted by the COVID-19 pandemic. The purpose of this program is specifically to address the needs of individuals with serious mental illness, individuals with substance use disorders, and/or individuals with co-occurring serious mental illness and substance use disorders. Additionally, the program focuses on meeting the needs of individuals with mental disorders that are less severe than serious mental illness, including those in the healthcare profession.

Resources

- Frequently Asked Questions for AZ Emergency Covid-19 Project (Updated 10/02/2020)
- Project Narrative
- Press Release

For additional questions please contact the grantsmanagement@azahcccs.gov email address.

April 22, 2020

AHCCCS Receives $2 Million for Mental Health Services

The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded a $2 million grant to AHCCCS on April 16, 2020 to increase behavioral health services in response to the COVID-19 national emergency. The agency's application, submitted on April 10, requested the grant funding in order to increase treatment services and improve service infrastructure in order to help meet increased community needs statewide.

AHCCCS will distribute the grant funding through the three Regional Behavioral Health Authority (RBHA) contractors, Health Choice in the Northern Region, Mercy Care in the Central Region, and Arizona Complete Health in the Southern Region. In turn, the RBHAs will use these funds to serve individuals with Serious Mental Illness (SMI) designations, individuals with Substance Use Disorders (SUD), and/or individuals with co-occurring serious mental illness and substance use disorders.

The grant identifies specific direct service funding requirements: 70 percent must be used to provide direct services to those with co-occurring SMI and SUD needs, 10 percent must be used for healthcare workers with mental health needs (less severe than SMI) requiring mental health care as a result of COVID-19, and 20 percent must be used for all other individuals with mental health needs less severe than SMI. Grant funding will support direct treatment services, and/or recovery support services, wrap around support services for individuals diagnosed with COVID-19 (short term) being released from an inpatient facility not able to return to family, residential, etc, recovery housing based on AHCCCS established rates, and personal protective equipment for staff charged to the grant.

Questions may be directed to GrantsManagement@azahcccs.gov