

Arizona

UNIFORM APPLICATION

FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND
PLAN

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

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 12/20/2017 2:10:33 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 2018

End Year 2019

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 Thomas

Last Name Betlach

Agency Name Arizona Health Care Cost Containment System

Mailing Address 801 East Jefferson MD

City Phoenix

Zip Code 85034

Telephone 602-417-4711

Fax

Email Address tom.betlach@azahcccs.gov

State CMHS DUNS Number

Number 805346798

Expiration Date

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

Agency Name Arizona Health Care Cost Containment System

Organizational Unit Division of Health Care Management

Mailing Address 701 East Jefferson MD6500

City Phoenix

Zip Code 85034

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

First Name Thomas

Last Name Betlach

Agency Name Arizona Health Care Cost Containment System (AHCCCS)

Mailing Address 801 E Jefferson

City Phoenix

Zip Code 85034

Telephone 602-417-4711

Fax

Email Address tom.betlach@azahcccs.gov

III. Third Party Administrator of Mental Health Services

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 8/31/2017 5:03:44 PM

Revision Date 12/20/2017 2:09:13 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

Footnotes:

Arizona utilizes Regional Behavioral Health Authorities (RBHAs) as Managed Care Organizations for the SABG and MHBG as Sub-Recipients. Arizona does not pass the funds to the RBHAs to manage the administrative responsibilities of the funds.

State Information

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

Fiscal Year 2018

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
 Title 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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Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: 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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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 (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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: Thomas J. Betlach

Signature of CEO or Designee¹: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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Fiscal Year 2018

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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.
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1. CERTIFICATION REGARDING LOBBYING

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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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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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: Thomas J. Betlach

Signature of CEO or Designee¹: 

Title: Director

Date Signed: 08-09-2017

mm/dd/yyyy

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

Footnotes:

State Information

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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
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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.
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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 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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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 (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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: Thomas J. Betlach

Signature of CEO or Designee¹: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2018

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
 Title 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

Note: 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).
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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: Thomas J. Betlach

Signature of CEO or Designee¹: 

Title: Director

Date Signed: 08-09-2017

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.
Printed: 7/19/2017 12:18 PM - Arizona

Footnotes:



STATE OF ARIZONA
OFFICE OF THE GOVERNOR

DOUGLAS A. DUCEY
GOVERNOR

EXECUTIVE OFFICE

February 26, 2016

Grants Management Specialist
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Grants Management Specialist:

Arizona has a long history of implementing significant and innovative initiatives related to integration and care coordination in the provision of services. As of July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (DBHS) and the Arizona Health Care Cost Containment System (AHCCCS) will merge to fully integrate the implementation and oversight of behavioral and physical care services. The coming together of DBHS and AHCCCS builds a stronger and better informed Medicaid leadership and builds greater awareness of behavioral health services in the Medicaid program.

This merger requires the transition of the oversight of Substance Abuse and Mental Health Services Administration (SAMHSA) grants. As such, I am designating Tom Betlach, Director of AHCCCS, as the signature authority for the Substance Abuse Block Grant (SABG), Projects for Assistance in Transition from Homelessness Grant (PATH), and Mental Health Block Grant (MHBG) as well as for any discretionary grant. This authority includes the signing of any standard federal forms such as Assurances, Certifications and Disclosure of Lobbying Activities and shall have such authority during my term as Governor of Arizona. In addition, I am designating Director Betlach as the Single State Authority (SSA) for Arizona.

If you have any questions, please contact Kelly Charbonneau, Division of Health Care Management at (602) 364-1356.

Sincerely,

Douglas A. Ducey
Governor
State of Arizona

1700 WEST WASHINGTON STREET, PHOENIX, ARIZONA 85007

602-542-4331 • www.azgovernor.gov

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

Thomas J. Betlach

Title

Director

Organization

Arizona Health Care Cost Containment System

Signature:

Date:

Footnotes:

State Information

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

[Standard Form LLL \(click here\)](#)

Name

Thomas J. Betlach

Title

Director

Organization

Arizona Health Care Cost Containment System

Signature: 

Date:

08-09-2017

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health 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 SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health 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 gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Arizona has a long history of implementing significant and innovative initiatives related to integration and care coordination in the provision of physical and behavioral health services. Through an administrative initiative to integrate the management of physical and behavioral health services as of July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the Arizona Health Care Cost Containment System (AHCCCS) merged in order to integrate the implementation and oversight of federally funded behavioral and physical care services. Since 1982, when it became the first statewide Medicaid managed care system in the nation, AHCCCS has operated under a federal 1115 Research and Demonstration Waiver that allows for a public-private partnership in the operation of a mandatory managed care model. As of January 1, 2017, AHCCCS provides coverage to approximately 1.9 million members in in three distinct geographical service areas (GSAs) throughout Arizona. The integration of ADHS/DBHS and AHCCCS builds stronger and better informed delivery of behavioral and physical health services through Arizona's Medicaid and SAMHSA programs.

In addition to overseeing the managed care organizations that provide Medicaid-funded physical health care services, AHCCCS serves as the Single State Authority on substance abuse. AHCCCS will be the agency responsible for matters related to behavioral health and substance abuse and will provide oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona. Through this integration the staff responsible for the application, implementation, and oversight of SAMHSA block and discretionary grants remain in one unit for coordination of care. These positions include the State Opioid Treatment Authority/Opioid Treatment Network, Women's Treatment Network, National Prevention Network and National Treatment Network representatives in the System of Care and Grant Unit within Division of Health Care Management. The integration of physical and behavioral health services in one state agency puts AHCCCS in position to improve treatment outcomes for members in Arizona.

AHCCCS currently contracts with three Regional Behavioral Health Authorities (RBHAs) to administer integrated managed care delivery services in three distinct geographic service areas (GSAs) throughout the State. This regionalized system allows local communities to provide services in a manner appropriate to meet the unique needs of members and their families. AHCCCS requires RBHAs to maintain a comprehensive network of behavioral health providers that deliver prevention, intervention, treatment, and rehabilitative services to a variety of populations including children and adolescents, adults with Serious Mental Illnesses (SMI), adults with General Mental Health Disorders (GMH), and persons with Substance Use Disorders (SUD/SA).

Divided into three GSAs, Arizona's RBHAs serve the following areas:

- Mercy Maricopa Integrated Care: Maricopa County

- Health Choice Integrated Care: Mohave, Coconino, Apache, Navajo, Gila and Yavapai Counties
- Cenpatico Integrated Care: Pima, La Paz, Yuma, Greenlee, Graham, Cochise, Santa Cruz, Gila and Pinal Counties

In addition to RBHAs, the state has Intergovernmental Agreements (IGAs) with five of Arizona's American Indian Tribes to deliver behavioral health services to persons living on and off the reservation. Gila River Indian Community, Navajo Nation, Pascua Yaqui Tribe, and the White Mountain Apache Tribe of Arizona each have an IGA for both Medicaid and state subsidized services. Colorado River Indian Tribe has an IGA for state subsidized services only. The American Indians/Alaska Natives (AI/AN), may choose to receive services through either the contracted health plans or the American Indian Health Program (AIHP), and members who, as required by federal law, qualify for Federal Emergency Services (FES), which provides only emergency services.

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

Additionally, AHCCCS has developed a collaborative partnership with multiple state agencies to increase the effectiveness of behavioral health treatment and prevention services across the state. Some of the state agencies include the Governor's Office of Youth, Faith, and Family (GOYFF), the Department of Economic Security (DES), the Arizona Criminal Justice Commission (ACJC), etc.

In addition to the RBHAs and tribes receiving prevention funding 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, Middle School and High School Programs, etc.

Continuum of Care

As a leader in the public behavioral health field, Arizona's approach to managed care and service delivery is nationally recognized. AHCCCS focuses its efforts and energies toward providing leadership in activities designed to integrate and adapt the behavioral health system to meet the needs of those we serve.

AHCCCS Covered Behavioral Health Services Guide (<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/covered-bhs-guide.pdf>) outlines the comprehensive array of services to assist, support, and encourage each eligible member to achieve and maintain the highest possible level of health and self-sufficiency. The goals that influenced how covered services were developed include:

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

Arizona also has a Demographic User Guide (DUG) (<https://www.azahcccs.gov/PlansProviders/Downloads/GM/Demographics/DUG81FINAL.pdf>) to provide detailed information for the completion and submission of the demographic data set, a set of data elements Tribal and Regional Behavioral Health Authorities (T/RBHAs) are required to collect and submit AHCCCS. The demographic data set is gathered and recorded in the AHCCCS Client Information System (CIS), and used for the following:

- Monitor and report on members' outcomes;
- Comply with federal, state, and/or grant requirements to ensure continued funding for the behavioral health system;
- Assist with financial-related activities such as budget development and rate setting;
- Support quality management and utilization management activities, and;
- Inform stakeholders and community members.

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



AHCCCS MEDICAL POLICY MANUAL

POLICY 300, EXHIBIT 300-2B,

AHCCCS COVERED SERVICES BEHAVIORAL HEALTH NON-TITLE XIX/XXI PERSONS

SERVICES		NON-TITLE XIX/XXI PERSONS DETERMINED TO HAVE AN SMI*	NON-TITLE XIX/XXI PERSONS RECEIVING SERVICES THROUGH SABG	NON-TITLE XIX/XXI JUVENILE'S WITH SED RECEIVING SERVICES THROUGH MHBG
Behavioral Health Counseling and Therapy	Individual	X	X	X
	Group and Family	X	X	X
Assessment, Evaluation and Screening Services	Screening, Evaluation, Assessment, and Testing	X ⁱ	X ⁱ	X ⁱ
Other Professional	Alcohol and/or drug services: Intensive Outpatient (Treatment Program that operates at least three hours/day and at least three hours/day week and is based on an individualized treatment plan) including assessment, counseling, crisis intervention and activity therapies or education	N/A ⁱⁱ	X	N/A ⁱⁱ
	Multisystemic Therapy for Juveniles	N/A	N/A	X
	Mental Health Services (formerly Traditional Healing)	**	**	**
	Auricular Acupuncture	**	**	**



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AHCCCS COVERED SERVICES BEHAVIORAL HEALTH NON-TITLE XIX/XXI PERSONS

SERVICES	NON-TITLE XIX/XXI PERSONS DETERMINED TO HAVE AN SMI*	NON-TITLE XIX/XXI PERSONS RECEIVING SERVICES THROUGH SABG	NON-TITLE XIX/XXI JUVENILE'S WITH SED RECEIVING SERVICES THROUGH MHBG
Skills, Training and Development, and Psychosocial Rehabilitation Living Skills Training	X	X	X
Cognitive Rehabilitation	X	NA	X
Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)	X	X	X
Psycho Educational Services and Ongoing Support to Maintain Employment	X	X	X
Medical Services ***	***	X ⁱⁱⁱ	***
Laboratory, Radiology, and Medical Imaging	X	X ^{iv}	X
Medical Management	X	X ⁱⁱⁱ	X
Electro-Convulsive Therapy	N/A	NA	NA
Case Management	X	X	X
Personal Care Services	X	X	X
Home Care Training Family (Family Support)	X	X	X
Self-Help/Peer Services	X	X	X
Home Care Training to Home Care Client (HCTC)	N/A	N/A	N/A
Unskilled Respite Care ^v	**	**	**
Supported Housing**	**	**	**
Sign Language or Oral Interpretative Services ^{vi}	X	X	X
Transportation	Emergency	X	N/A
	Non-Emergency	X	X
Crisis Intervention Services	(Mobile Community Based)	X	X
	(Stabilization, Facility Based)	X	X
	(Telephone)	X	X
Hospital	N/A	N/A	NA
Subacute Facility	**	X	X
Residential Treatment Center	**	X	X



AHCCCS MEDICAL POLICY MANUAL

POLICY 300, EXHIBIT 300-2B,

AHCCCS COVERED SERVICES BEHAVIORAL HEALTH NON-TITLE XIX/XXI PERSONS

SERVICES	NON-TITLE XIX/XXI PERSONS DETERMINED TO HAVE AN SMI*	NON-TITLE XIX/XXI PERSONS RECEIVING SERVICES THROUGH SABG	NON-TITLE XIX/XXI JUVENILE'S WITH SED RECEIVING SERVICES THROUGH MHBG
Behavioral Health Residential Facility (Without Room and Board)	**	X ^{vii}	X
Mental Health Services NOS (Room and Board)*	**	X ^{viii}	X ^{vi}
Supervised Behavioral Health Treatment and Day Programs	X	X	X
Therapeutic Behavioral Health Services and Day Programs	X	X	X
Community Psychiatric Supportive Treatment and Medical Day Programs	X	NA	X

LIMITATIONS:

This category refers to services funded through allocations for persons determined to have an SMI, including State General Funds,

- * MHBG, and County Funds. Each service may not be available through each line of funding. Refer to allocation schedule for further funding detail.
- ** Provided based upon available funding
- *** See the Behavioral Health Drug List for further information on covered medication.

See the AHCCCS Covered Behavioral Health Services Guide for restrictions, scope and time limitations, provider requirements and eligibility limitations for Title XIX and Title XXI behavioral health services.

Services under this area allowable with some exceptions. Refer to Financial Reporting Guide for RBHA Contractors for details
 Non-Title XIX members in need of substance use services could be eligible for SUD services under SABG
 Per AMPM 320-T, medications through SABG are limited to those identified by AHCCCS as SABG approved
 Limited to services related to MAT
 No more than 600 hours of respite care per contract year (October 1st through September 30th) per person
 Contractors are to use administrative dollars before Non-Title XIX funding for these services
 Limited to Residential treatment for substance use disorders
^{viii} Refer to SABG FAQs for coverage limitations

Arizona has a long history of implementing significant and innovative initiatives related to integration and care coordination in the provision of physical and behavioral health services. Through an administrative initiative to integrate the management of physical and behavioral health services as of July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the Arizona Health Care Cost Containment System (AHCCCS) merged in order to integrate the implementation and oversight of federally funded behavioral and physical care services. Since 1982, when it became the first statewide Medicaid managed care system in the nation, AHCCCS has operated under a federal 1115 Research and Demonstration Waiver that allows for a public-private partnership in the operation of a mandatory managed care model. As of January 1, 2017, AHCCCS provides coverage to approximately 1.9 million members in in three distinct geographical service areas (GSAs) throughout Arizona. The integration of ADHS/DBHS and AHCCCS builds stronger and better informed delivery of behavioral and physical health services through Arizona's Medicaid and SAMHSA programs.

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 and mental health. AHCCCS will be the agency responsible for matters related to behavioral health and substance abuse and will provide oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona. Through this integration the staff responsible for the application, implementation, and oversight of SAMHSA block and discretionary grants remain in one unit for coordination of care. These positions include the State Opioid Treatment Authority/Opioid Treatment Network, Women's Treatment Network, National Prevention Network and National Treatment Network representatives in the System of Care and Grant Unit within Division of Health Care Management. The integration of physical and behavioral health services in one state agency puts AHCCCS in position to improve treatment outcomes for members in Arizona.

AHCCCS currently contracts with three Regional Behavioral Health Authorities (RBHAs) to administer integrated managed care delivery services in three distinct geographic service areas (GSAs) throughout the State. This regionalized system allows local communities to provide services in a manner appropriate to meet the unique needs of members and their families. AHCCCS requires RBHAs to maintain a comprehensive network of behavioral health providers that deliver prevention, intervention, treatment, and rehabilitative services to a variety of populations including children and adolescents, children with serious emotional disturbances (SED), adults with Serious Mental Illnesses (SMI), adults with General Mental Health Disorders (GMH), and persons with Substance Use Disorders (SUD/SA). Services are delineated by system of care for adult MHBG members in the SMI population and the children SED population members as outlined in the AHCCCS Medical Policy Manual (AMPM) 300 – Exhibit 2B (see attached).

Divided into three GSAs, Arizona's RBHAs serve the following areas:

- Mercy Maricopa Integrated Care: Maricopa County
- Health Choice Integrated Care: Mohave, Coconino, Apache, Navajo, Gila and Yavapai Counties
- Cenpatico Integrated Care: Pima, La Paz, Yuma, Greenlee, Graham, Cochise, Santa Cruz, Gila and Pinal Counties

In addition to RBHAs, the state has Intergovernmental Agreements (IGAs) with five of Arizona's American Indian Tribes to deliver behavioral health services to persons living on and off the reservation. Gila River Indian Community, Navajo Nation, Pascua Yaqui Tribe, and the White Mountain Apache Tribe of Arizona each have an IGA for both Medicaid and state subsidized services. Colorado River Indian Tribe has an IGA for state subsidized services only. The American Indians/Alaska Natives (AI/AN), may choose to receive services through either the contracted health plans or the American Indian Health Program (AIHP), and members who, as required by federal law, qualify for Federal Emergency Services (FES), which provides only emergency services.

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

Additionally, AHCCCS has developed a collaborative partnership with multiple state agencies to increase the effectiveness of behavioral health treatment and prevention services across the state. Some of the state agencies include the Governor's Office of Youth, Faith, and Family (GOYFF), the Department of Economic Security (DES), the Arizona Criminal Justice Commission (ACJC), etc.

In addition to the RBHAs and tribes receiving prevention funding 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, Middle School and High School Programs, etc.

Continuum of Care

As a leader in the public behavioral health field, Arizona's approach to managed care and service delivery is nationally recognized. AHCCCS focuses its efforts and energies toward providing

leadership in activities designed to integrate and adapt the behavioral health system to meet the needs of those we serve.

AHCCCS Covered Behavioral Health Services Guide (<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/covered-bhs-guide.pdf>) outlines the comprehensive array of services to assist, support, and encourage eligible members with SED and SMI 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.

AHCCCS' Behavioral Health System Practice Tools (<https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/>) provide guidance on how providers are to work with children with SED. Services available in the Covered Behavioral Health Service Guide (CBHSG), which include early intervention, crisis services, inpatient, residential, and outpatient services are to be provided in an individualized manner based on assessment and treatment planning in accordance with the guidance within the tools.

As quoted in the Children and Family Team (CFT) guidance tool, services provided to children with 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 provide 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. Peer-Run Organizations such as Stand Together and Recover Centers (STAR) have been working in the state hospital providing peer support training/credentialing to patients. STAR trains at no cost to the state or the trainees. When the members transition out of Arizona State Hospital (AzSH), they then have a credential making it easier to obtain a job as a Peer/Recovery Support Specialist.

Employment and education support consists of connecting the members with the Rehabilitation Services Administration (RSA) Vocational Rehabilitation (VR). If the member is determined SMI and enrolled with the RBHA, then they would fall under the parameters of the Interagency Services Agreement (ISA) that AHCCCS has with RSA/VR, which includes, but is not limited to VR counselors who have specialized caseloads consisting of members with psychiatric disabilities. RSA/VR has assigned one of their offices to work with any referrals coming out of the State Hospital.

Additional information:

- AHCCCS and RSA/VR work together to provide specialty employment services RBHA-enrolled members who have been determined as having a SMI.
- The purpose of the ISA is to increase the number of employed people with psychiatric disabilities who are successful and satisfied with their vocational roles and environments using the combined talents, commitments, and resources from RSA/VR and AHCCCS.
- The VR program provides a variety of services to persons with disabilities, with the ultimate goal to prepare for, enter into, or retain employment. The VR program is a public program funded through a Federal/State partnership and administered by the RSA, which is part of the Arizona Department of Economic Security (ADES)
- A team of RSA/VR and AHCCCS staff presented to the Forensic Unit at the State Hospital in the end of Calendar Year (CY) 2016 on both RSA services and AHCCCS employment services.

In Maricopa County there are three Forensic Assertive Community Treatment (FACT) teams. 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.

AHCCCS contracts with RBHAs to ensure that 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 SMI and identify as being a part of an identified group with norms not always addressed through traditional treatment modalities, including, but not limited to veterans, LGBT, elderly, homeless, rural, and diverse populations. The RBHAs utilize Cultural Diversity Specialists and Community Liaisons who work with providers and communities through training, education, and technical assistance to ensure implementation and monitoring of the appropriate programs and services.

Arizona also has a Demographic User Guide (DUG) (<https://www.azahcccs.gov/PlansProviders/Downloads/GM/Demographics/DUG81FINAL.pdf>) to provide detailed information for the completion and submission of the demographic data set, a set of data elements Tribal and Regional Behavioral Health Authorities (T/RBHAs) are required to collect and submit AHCCCS. The demographic data set is gathered and recorded in the AHCCCS Client Information System (CIS), and used for the following:

- Monitor and report on members' outcomes;
- Comply with federal, state, and/or grant requirements to ensure continued funding for the behavioral health system;
- Assist with financial-related activities such as budget development and rate setting;
- Support quality management and utilization management activities, and;
- Inform stakeholders and community members.

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

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 behavioral health 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 behavioral health 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.

The state's priorities and goals must be supported by a data-driven process. 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](#), the annual [State and National Behavioral Health Barometers](#), 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.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's population- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. 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](#)¹ 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.

¹ <http://www.healthypeople.gov/2020/default.aspx>

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 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, and; the Systems of Care plans. Additionally, Network Management utilizes the System of Care plans as one of the avenues to monitor network adequacy and sufficiency. Each RBHA utilizes the plan created by AHCCCS and individualizes their approach to meet the specific needs of their network. Each RBHA provides quarterly updates on their progress in meeting goals and objectives.

Substance Abuse – Assessing the Need for Prevention and Treatment Services

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. Formerly, this was done to complete Forms 4 and 5 of the SABG plan. The results outlined treatment need based on race/ethnicity, gender, and age group for the state as a whole, and then for each county and/or sub-state planning area. In Arizona, in Fiscal Year (FY) 2014, there were over 221,000 members enrolled in the public behavioral health system. Of those, 24,749 or 11.2 percent received substance abuse treatment services.

The Substance Abuse Epidemiology Work Group (SEOW) was originally created in 2004 as a requirement of the Strategic Prevention Framework State Incentive Grant (SPF SIG). Later the SEOW was formalized as a subcommittee of the Arizona Substance Abuse Partnership (ASAP). The membership roster includes statisticians, data analysts, academics, holders of key datasets, other stakeholders from various state and federal agencies, tribal entities, private and non-profit substance abuse-related organizations, and universities. This group is tasked with providing communities, policymakers and local, state and tribal officials with data on the use of alcohol and illicit, over-the-counter, and prescription drugs to inform their substance abuse prevention and intervention strategies. The primary responsibilities of the Epidemiology Workgroup include:

- Compiling and synthesizing information and data on substance abuse and its associated consequences and correlations, including mental illness and emerging trends, through a collaborative and cooperative data-sharing process;
- Assessing substance abuse treatment service capacity in Arizona and detail gaps in service availability;
- Serving as a resource to the ASAP 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; and
- Identifying data gaps and address them in order to provide Arizona with a comprehensive picture of substance abuse in the state.

The SEOW seeks to develop the capacity of community coalitions, policy advisors, and other key stakeholders to make policy and data informed decisions. The development of the Community Data Project (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. 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 populations. 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, and;

- Prescription drug abuse and related consequences have been increasing for the past five years.

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 regards to AHCCCS' Prevention System, 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, 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 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 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. One recommendation is to address Prevention workforce development to address capacity building. This can advance strategic efforts toward the provision of training and facilitation for networking opportunities for existing prevention providers and newly hired prevention professionals.

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.

AHCCCS Prevention System strives to eliminate substance use and misuse rates, as well as, Opioid Prescription Drug addiction and overdose of prescription medications in Arizona. In an effort to support integrated care systems, AHCCCS Prevention Contractors will work in partnerships with existing Federally Qualified Community Health Centers (FQHC) in their regions to address prevention of Opioid Prescription's addiction. Some of the strategies will include the provision of educational materials and trainings to FQHC key staff, parents, youth, seniors, pregnant women. In addition, members who receive Opioid medications will learn about their prescription's restrictions to prevent potential addiction and/or overdose if not taken accordingly to the Treatment center recommendations. In addition, substance abuse coalitions will provide community outreach and awareness initiatives to promote nontoxic disposal of medications. For example, coordinating with law enforcement drop-off boxes events, turning in expired and/or no longer needed medications, health fair events to disseminate information about prescription drugs and Opioids addiction, etc.

In order to integrate AHCCCS Prevention System and Contractors' efforts to reduce and eliminate substance use and misuse issues, it is recommended that the creation of a comprehensive statewide Strategic Prevention Framework (SPF) Plan be created in coordination to the needs assessment outcomes. The proposed SPF Plan will include goals, activities, outcomes, data resources, timelines, and the overall structure intended to address substance use prevention high needs. Another important component is the ability to measure Prevention's efforts and accomplishments based on the outcomes identified. The Statewide SPF Plan will serve as a guidance tool for Contractors to implement effectively the preventive strategies at the local levels.

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

The following section details the current instruments and methodology used for assessing service needs; identified strengths, and programmatic initiatives within Arizona's service delivery system, and; the Systems of Care plans. Additionally, Network Management utilizes the System of Care plans as one of the avenues to monitor network adequacy and sufficiency. Each RBHA utilizes the plan created by AHCCCS and individualizes their approach to meet the specific needs of their network. Each RBHA provides quarterly updates on their progress in meeting goals and objectives.

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The Substance Abuse Epidemiology Work Group (SEOW) was originally created in 2004 as a requirement of the Strategic Prevention Framework State Incentive Grant (SPF SIG). Later the SEOW was formalized as a subcommittee of the Arizona Substance Abuse Partnership (ASAP). The membership roster includes statisticians, data analysts, academics, holders of key datasets, other stakeholders from various state and federal agencies, tribal entities, private and non-profit substance abuse-related organizations, and universities. This group is tasked with providing communities, policymakers and local, state and tribal officials with data on the use of alcohol and illicit, over-the-counter, and prescription drugs to inform their substance abuse prevention and intervention strategies. The primary responsibilities of the Epidemiology Workgroup include:

- Compiling and synthesizing information and data on substance abuse and its associated consequences and correlations, including mental illness and emerging trends, through a collaborative and cooperative data-sharing process;
- Assessing substance abuse treatment service capacity in Arizona and detail gaps in service availability;
- Serving as a resource to the ASAP 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; and
- Identifying data gaps and address them in order to provide Arizona with a comprehensive picture of substance abuse in the state.

The SEOW seeks to develop the capacity of community coalitions, policy advisors, and other key stakeholders to make policy and data informed decisions. The development of the Community Data Project (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. 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 populations. 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, and;

- Prescription drug abuse and related consequences have been increasing for the past five years.

Additionally, AHCCCS prepares the Uniform Reporting System (URS) tables to provide MHBG demographic and corresponding utilization data to assess service provision, members served, and unmet needs. The data is combined reports from the RBHAs based on their monitoring and reports received from providers serving those with SMI, SED, and ESMI. From the data available there are few unmet needs identified largely because of the robust integrated care provided through expanded Medicaid services, state general funds, and the MHBG funding available.

An area of improvement has been identified related to the implementation of First Episode Psychosis (FEP) services for adolescents and young adults in Arizona experience an initial psychotic episode within the past two years. These services are being developed and the infrastructure is being built, but the utilization of services and expenditure of funds does not represent the data on the known need for these services. AHCCCS is partnering with the RBHAs and FEP service providers to identify areas for targeted interventions to reach those members who meet the FEP eligibility criteria and engage them in EBP services to best meet their needs. There are currently efforts taking place to provide outreach and awareness to communities, entities, and families who may come into contact with a member who had or may in the near future experience a psychotic episode.

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 regards to AHCCCS' Prevention System, 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, 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 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 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. One recommendation is to address Prevention workforce development to address capacity building. This can advance strategic efforts toward the provision of training and facilitation for networking opportunities for existing prevention providers and newly hired prevention professionals.

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.

AHCCCS Prevention System strives to eliminate substance use and misuse rates, as well as, Opioid Prescription Drug addiction and overdose of prescription medications in Arizona. In an effort to support integrated care systems, AHCCCS Prevention Contractors will work in partnerships with existing Federally Qualified Community Health Centers (FQHC) in their regions to address prevention of Opioid Prescription's addiction. Some of the strategies will include the provision of educational materials and trainings to FQHC key staff, parents, youth, seniors, pregnant women. In addition, members who receive Opioid medications will learn about their prescription's restrictions to prevent potential addiction and/or overdose if not taken accordingly to the Treatment center recommendations. In addition, substance abuse coalitions will provide community outreach and awareness initiatives to promote nontoxic disposal of medications. For example, coordinating with law enforcement drop-off boxes events, turning in expired and/or no longer needed medications, health fair events to disseminate information about prescription drugs and Opioids addiction, etc.

In order to integrate AHCCCS Prevention System and Contractors' efforts to reduce and eliminate substance use and misuse issues, it is recommended that the creation of a comprehensive statewide Strategic Prevention Framework (SPF) Plan be created in coordination to the needs assessment outcomes. The proposed SPF Plan will include goals, activities, outcomes, data resources, timelines, and the overall structure intended to address substance use prevention high needs. Another important component is the ability to measure Prevention's efforts and accomplishments based on the outcomes identified. The Statewide SPF Plan will

serve as a guidance tool for Contractors to implement effectively the preventive strategies at the local levels.

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.

Footnotes:

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

AHCCCS incorporates member demographic and service utilization data into its daily management, administrative and oversight operations. AHCCCS encourages data-driven decision making throughout all levels of the provider network to improve the quality and timeliness of service delivery.

The most significant limitation encountered at present 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 members, as it pertains to members who do not qualify for Medicaid Coverage, AHCCCS is not readily able to specifically identify which funding source was used to provide services to each member.

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

Enrollment and Eligibility

All members who receive 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 members – based on a HIPAA-compliant 834 submission. The database allows AHCCCS to determine, and subsequently report, the number of enrolled Medicaid eligible members, compared to those who would otherwise be funded through other means, including State General Funds, or Federal Block Grants (for more information please see the Client Information System File Layout Manual, available at

<https://www.azahcccs.gov/PlansProviders/Downloads/GM/ClientInformationSystems/cis-manual.pdf>).

Demographics

AHCCCS policy requires all behavioral health members who remain enrolled in the system for at least 45 days undergo a clinical assessment, administered by a clinician at the provider level. Among the data gathered during this process are several identifiable factors, such as date of birth, race and ethnicity, gender, ICD-10 Diagnoses, National Outcome Measures (NOMs), and reasons for seeking treatment. Updates to member information occur annually, at a minimum, or upon a significant change in the member's life - such as gaining employment, or reporting an extended period of substance use abstinence. Lastly, a final assessment of the member is required upon completion of the treatment episode (for more information please see the Demographic and Outcome Data Set User Guide, available at

<https://www.azahcccs.gov/PlansProviders/Downloads/GM/Demographics/DUG81FINAL.pdf>).

Service Encounters

AHCCCS requires the provider network to report all member service encounter data within 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 member received in a unique session (typically based on 15 minute increments, or per-diem, depending on service type), the total dollar value for the service session, and the provider offering the service. This reporting standard allows AHCCCS to measure service utilization, prescription drug utilization, by service type and provider, at the member level. In other words, AHCCCS can report the precise number of service units, and the corresponding dollar value, each member received, or each agency provided, within a given timeframe. The data housed within CIS is vital to AHCCCS' ongoing efforts to ensure the contracted health plans and providers are offering services designed to achieve programmatic goals in a manner that is both effective and resource efficient, ensuring our members are moving towards recovery.

As of 10/1/2010 all Medicaid-eligible members are enrolled in the public behavioral health system and may access services without the need of a separate 834-HIPAA enrollment.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
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 who 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:

The Regional Behavioral Health Authorities (RBHAs) will continue efforts to promote access to substance abuse treatment services for adolescents during meetings with providers and collaborators, and through school and community-based trainings. Trainings provided by the RBHAs have included components screening for substance abuse in the adolescent population, and effective substance abuse treatment such as Adolescent Community Reinforcement Approach (ACRA) and other evidence-based practices targeting the adolescent population. Block grant funds will be available for treatment services while the State Youth Treatment (SYT) grant funds are utilized in this final year for sustainability of the infrastructure created through previous year activities.

Additionally, providers continue to utilize substance abuse screening tools, including American Society of Addiction Medicine (ASAM) and Car, Relax, Alone, Forget, Friends, and Trouble (CRAFT). Arizona Health Care Cost Containment System (AHCCCS) will monitor enrollment number of youth diagnosed with a substance use diagnosis within the system of care.

The RBHAs 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 RBHAs will provide and promote access to substance abuse training initiatives available to child/adolescent providers including those employed through other agencies such as the Department of Child Safety (DCS) and Juvenile Justice agencies.

AHCCCS and the RBHAs will educate treatment providers, prevention providers, and coalitions on how to engage community stakeholders in identifying and referring youth to early intervention and substance abuse treatment services. AHCCCS will ensure the availability of a standardized, parent-friendly, screening tool to identify substance use/abuse in children and adolescents.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement: In Fiscal Year 16, 8.9% 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 2018), 9.2%
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), 9.5%

Data Source:

CIS enrollment numbers/data.

Description of Data:

CIS data can be stratified by age group, diagnosis, and services received. CIS captures all elements needed to measure outcomes for this population.

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Priority #: 2
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 RBHAs 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. Block grant funds will be available for treatment services to supplement the targeted efforts of Opioid State Targeted Response (STR) to address the growing population of people over the age of 55 with an Opioid Use Disorder as well as all other substances that are more traditionally associated with this population.

Additionally, providers continue to utilize SA 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 RBHAs will continue to collaborate and meet regularly with providers to share information on substance abuse screening, trends and best practices. AHCCCS and the RBHAs will provide and promote access to substance abuse training initiatives available to Arizona Long Term Care System (ALTCs) providers.

AHCCCS and the RBHAs 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: Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement: In Fiscal Year 16, 13.1% 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 2018), 13.3%
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), 13.5%

Data Source:

CIS enrollment data.

Description of Data:

CIS data can be stratified by age group, diagnosis, and services received. CIS captures all elements needed to measure outcomes for this population.

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

Priority #: 3
Priority Area: Suicide Rate
Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Reduce the Arizona Suicide Rate to 19.0% per 100,000 by the end of calendar year (CY) 2018.

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 CY15 was 19.4 per 100,000 population 1320 suicide deaths/6,818,000 population.
First-year target/outcome measurement:	First-year target/outcome measurement (Progress to end of CY 2018), 19.0 per 100,000
Second-year target/outcome measurement:	Second-year target/outcome measurement (Final to end of CY 2019), 18.6 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 complete calendar year (i.e. CY 2018 data will be made available in Fall 2019). 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 identified.

Priority #: 4

Priority Area: IV Drug Users

Priority Type: SAT

Population(s): PWID, Other

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 and members on MAT Options.

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 success on a yearly basis.

Baseline Measurement: 2016 measurement of members who report IVDU who received MAT services.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2018), 54%

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), 55%

Data Source:

Client Information System (CIS) data.

Description of Data:

CIS report on the number of IVDU members with a SUD receiving MAT services out of number of members receiving MAT services.

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Priority #: 5

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:

AHCCCS and the RBHAs will collaborate on ways to expand public awareness campaigns directed towards the priority populations. AHCCCS and the RBHAs 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 RBHAs will monitor 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. SFY15 was 3.9%.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2018), 4.2%

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), 4.5%

Data Source:

Client Information System (CIS) data.

Description of Data:

CIS enrollment data on the number of pregnant and parenting women with dependent children receiving SA treatment is capable of stratifying data by gender, diagnosis, service received, number of children, pregnancy, etc.

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Priority #: 6
Priority Area: Use of Prescription Drugs without a Doctor's Recommendation
Priority Type: SAP
Population(s): 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 who do not perceive use of prescription drugs without a doctor's recommendation as being harmful from the current level of 13.3% of those in the 8th grade, 9.7% of those in the 10th grade, and 11.3% of those in the 12th grade, as measured by the 2016 Arizona Youth Survey.

Objective:

Utilize the media and outreach to schools to increase youth perception of risk related to prescription drug use without a doctor's recommendation.

Strategies to attain the objective:

Conduct youth driven media campaigns to promote positive youth values and community pride. Campaigns will include: youth developed social messaging (radio; PSA poster contests; billboards; murals as well as information on prescription drug abuse).

- Collect samples of youth created posters with anti-drug messages.
- Host a statewide youth prevention media display and recognition event.
- Verify that all prevention programs incorporate education on perception of harm into their prevention programs.

Implement afterschool and leadership programs for youth.

- Host annual statewide and regional conferences/retreats/youth camps.
- Develop a statewide venue for recognition of youth prevention projects and other successes.

Implement an adult targeted media campaign to educate parents about risks.

- Community media campaign
- Proper disposal of medication education
- Resources to safely store and dispose of medications

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement: The current percentage of youth who do not perceive use of prescription drugs without a doctor's recommendation as being harmful from the current level of 13.3% of those in the 8th grade, 9.7% of those in the 10th grade, and 11.3% of those in the 12th grade, as measured by the 2016 Arizona Youth Survey.
First-year target/outcome measurement: Reduce the percentage of youth who do not perceive use of prescription drugs without a doctor's recommendation as being harmful to 13.0% of those in the 8th grade, 9.4% of those in the 10th grade, and 11.0% of those in the 12th grade, as measured by the 2018 Arizona Youth Survey.
Second-year target/outcome measurement: Reduce the percentage of youth who do not perceive use of prescription drugs without a doctor's recommendation as being harmful to 12.7% of those in the 8th grade, 9.1% of those in the 10th grade, and 10.7% of those in the 12th grade, as measured by the 2020 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.

Priority #: 7
Priority Area: TB Screenings
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 screenings for TB and related services.

Strategies to attain the objective:

Focus on developing mechanisms to document and verify TB screening of those entering substance abuse treatment that were implemented this past year.

Strategies that providers are and will continue implementing include: integrating education on TB (along with other communicable diseases) into member orientations, providing educational materials on TB to members, providing members with referral handouts for TB and HIV testing at specified locations, as well as including elements to capture TB screening documentation in contractors' audit tools.

In addition, AHCCCS will provide guidance to the RBHAs regarding accurate documentation on screening and referrals for TB services. Communications on block grant CFR requirements related to TB are more specific to RBHAs and providers.

In addition, AHCCCS will provide guidance to the Regional Behavioral Health Authorities (RBHAs) regarding accurate documentation on screening and referrals for TB services. Block grant CFR requirements related to TB is being communicated more specifically to RBHAs and providers.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement:	FY16 data on the number of members receiving substance abuse treatment with documentation of TB services documented in their chart. Current baseline is 24.6%
First-year target/outcome measurement:	First-year target/outcome measurement (Progress to end of SFY 2018), 25.6%
Second-year target/outcome measurement:	Second-year target/outcome measurement (Final to end of SFY 2019), 26.6%

Data Source:

Independent Case Review

Description of Data:

A random sample of charts will be pulled and scored based on pre-determined elements that include documented evidence of screenings and referrals for TB services.

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Priority #: 8
Priority Area: 8
Priority Type: MHS
Population(s): SMI, SED, ESMI

Goal of the priority area:

Increase the number of members served with FEP EBPs.

Objective:

Improve the health outcomes for those who have recently experienced their first episode of psychosis by providing them access to services specifically geared to address their mental health care needs, improve quality of life, and stability in the community.

Strategies to attain the objective:

AHCCCS will work collaboratively with RBHAs, Behavioral Health Service Providers, and communities to assist in increasing knowledge related to FEP and the resources available for treatment following a FEP. Strategies will include but are not limited to: social media messaging, social market/public awareness, provider outreach, strategic partner identification, improved data surveillance, and ongoing collaboration with stakeholders and 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 utilization and expenditure rates for SFY 2017.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2018), by increasing utilization and expenditure rates by 2% above SFY 2017 rates.

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), by increasing utilization and expenditure rates by 2% above SFY 2018 rates.

Data Source:

CIS data and RBHA reports.

Description of Data:

CIS data is collected related to demographics and expenditures, which will be cross-referenced with reports that are due from the RBHAs annually.

Data issues/caveats that affect outcome measures::

No data related issues identified.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

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	\$60,166,650		\$555,698,204	\$27,514,512	\$9,868,951	\$3,079,742	\$0
a. Pregnant Women and Women with Dependent Children**	\$7,001,554		\$0	\$0	\$0	\$0	\$0
b. All Other	\$53,165,096		\$555,698,204	\$27,514,512	\$9,868,951	\$3,079,742	\$0
2. Primary Prevention	\$16,044,440		\$0	\$0	\$0	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$7,130	\$0	\$0
4. Early Intervention Services for HIV	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary							
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
10. Administration (Excluding Program and Provider Level)	\$4,011,110		\$0	\$1,059,697	\$7,200	\$0	\$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	\$80,222,200	\$0	\$555,698,204	\$28,574,209	\$9,883,281	\$3,079,742	\$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:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

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							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$163,999	\$734,025,651	\$0	\$34,675,599	\$22,352,231	\$0
7. Ambulatory/Community Non-24 Hour Care		\$16,235,857	\$3,298,534,545	\$0	\$155,823,791	\$100,445,543	\$0
8. Mental Health Primary*		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		\$1,929,396	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$964,698	\$0	\$274,725	\$1,295,446	\$3,060,000	\$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	\$0	\$19,293,950	\$4,032,560,196	\$274,725	\$191,794,836	\$125,857,774	\$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 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	3059	1442
Women with Dependent Children	17699	5317
Individuals with a co-occurring M/SUD	30078	10328
Persons who inject drugs	10671	7487
Persons experiencing homelessness	6953	4873

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

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	\$30,083,325
2 . Primary Substance Abuse Prevention	\$8,022,220
3 . Tuberculosis Services	\$0
4 . Early Intervention Services for HIV [*]	\$0
5 . Administration (SSA Level Only)	\$2,005,555
6. Total	\$40,111,100

* 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 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.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	\$314,625
	Selective	\$54,539
	Indicated	\$1,068,565
	Unspecified	\$0
	Total	\$1,437,729
Education	Universal	\$879,963
	Selective	\$233,375
	Indicated	\$986,234
	Unspecified	\$0
	Total	\$2,099,572
Alternatives	Universal	\$131,644
	Selective	\$10,500
	Indicated	\$881,920
	Unspecified	\$0
	Total	\$1,024,064
Problem Identification and Referral	Universal	\$35,117
	Selective	\$17,832
	Indicated	\$213,326
	Unspecified	\$6,760
	Total	\$273,035

Community-Based Process	Universal	\$209,382
	Selective	\$29,500
	Indicated	\$826,068
	Unspecified	\$0
	Total	\$1,064,950
Environmental	Universal	\$52,690
	Selective	\$3,000
	Indicated	\$347,586
	Unspecified	\$0
	Total	\$403,276
Section 1926 Tobacco	Universal	\$60,000
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	Total	\$60,000
Other	Universal	\$0
	Selective	\$18,000
	Indicated	\$1,000
	Unspecified	\$0
	Total	\$19,000
Total Prevention Expenditures		\$6,381,626
Total SABG Award*		\$40,111,100
Planned Primary Prevention Percentage		15.91 %

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

Footnotes:

The 20% set-aside amount that will be expended for FFY18 is \$8,022,220. The amount of Non-Direct Services/System Development that will be expended on Primary Prevention is \$1,640,594. This amount added to the total at the bottom of Table 5a equals \$8,022,220 thus satisfying the

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	
Universal Indirect	
Selective	
Indicated	
Column Total	\$0
Total SABG Award*	\$40,111,100
Planned Primary Prevention Percentage	0.00 %

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

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

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems			\$84,840	
2. Infrastructure Support			\$49,000	
3. Partnerships, community outreach, and needs assessment			\$500,543	
4. Planning Council Activities (MHBG required, SABG optional)	\$5,000		\$0	
5. Quality Assurance and Improvement			\$355,540	
6. Research and Evaluation			\$405,108	
7. Training and Education			\$245,563	
8. Total	\$5,000	\$0	\$1,640,594	\$0

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

Footnotes:

The funds outlined for the Planning Council activities represent state travel reimbursement for eligible members to attend monthly meetings.

Environmental Factors and Plan

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

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁵ 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.²⁶ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁷

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.²⁸ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁹ 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.³⁰

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health 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.³¹ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³² 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 behavioral health include: developing models for inclusion of behavioral health 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.³³ 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 behavioral health 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 homes³⁴ and ACOs³⁵ may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health 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.³⁶ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁷

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁸ 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.³⁹ 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.⁴⁰ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.⁴¹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health 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.⁴² 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 behavioral health 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.⁴³ 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.⁴⁴ 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.

²⁵ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:1027-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 527-77

²⁶ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁷ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁸ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

²⁹ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

³⁰ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

³¹ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³² Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

- ³³ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>
- ³⁴ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>
- ³⁵ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx
- ³⁶ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>
- ³⁷ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>
- ³⁸ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>
- ³⁹ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>
- ⁴⁰ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. *Health Affairs*. 2014; 33(4): 700-707
- ⁴¹ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, *JAMA Psychiatry*. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, *JAMA Psychiatry*. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. *JAMA Psychiatry*. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. *Annals of Emergency Medicine*. 2011; 58(2): 218
- ⁴² Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. *Health Affairs*, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>
- ⁴³ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>
- ⁴⁴ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

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.

Currently, Arizona Health Care Cost Containment System (AHCCCS) collaborates with behavioral health partners to create a more streamlined system that reduces barriers to care for members and also increases accountability of the Regional Behavioral Health Authorities (RBHAs), for managing the "whole health" of persons with serious mental illness (SMI) and substance use disorder (SUD). This initiative is part of Arizona's intention to integrate both behavioral and physical health throughout the state by 2018. To implement this new approach, RBHAs throughout the state monitor the delivery of physical and, behavioral health services, To enhance care coordination and broaden accessibility of health care through AHCCCS, individuals determined to have a SMI, and who do not reside in the designated RBHA Global Service Area (GSA) are enrolled in one health plan for both their physical and behavioral health care needs. Depending on where they live, members are reassigned to, or can choose an integrated health plan with a RBHA network provider. Members whose enrollment changed to one of the integrated health plans were sent letters informing them of their new enrollment options.

In recent integration initiatives, the health care plan an individual chooses will manage the provider network for all of the individual's health care services, including their medical care (physical) as well as any behavioral health services. Under these initiatives, instead of navigating two separate networks for medical and behavioral services, all providers will be under one network, managed and funded by the single health care plan. Historically, prior efforts to integrate service delivery were cumbersome due to a system comprised of two distinct regulators, each with different cultures, program goals, and rules. Plans, providers, and enrollees report the consolidated administration has resulted in faster resolution of problems and other streamlined processes. As an example, having a direct line of communication to AHCCCS allows behavioral health providers opportunity to raise concerns about rates not reflecting the time and resources needed for true integrated care delivery.

As a result of these integration efforts, AHCCCS has been able to establish more comprehensive care models, including blending

Medicaid and non-Medicaid funding streams. As part of its efforts to address the opioid epidemic, the AHCCCS formulary now includes injectable Naloxone, as well as FDA approved medications for treatment of opioid and alcohol use disorders. Additionally, the agency promotes education to prevent overdoses, and is currently using federal block-grant funding to expand community-based outreach. The inclusion of non-Medicaid funds has enabled AHCCCS to address social determinants of health, and supports an array of services needed to improve overall enrollee health and well-being.

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.

AHCCCS endeavors to ensure eligible members have access to behavioral health, physical health, and substance disorder services through the oversight of its contractors. Contractors collect and analyze data on their providers' ability to provide urgent and regularly scheduled services and report the data to AHCCCS on a quarterly basis. The Division of Health Care Management (DHCM), which is comprised of AHCCCS' Clinical Quality Management (CQM), Operations, Data Analysis & Research (DAR), Medical Management (Mercy Maricopa), System of Care & Grants (SOC) 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 Network Management and Geo-Mapping activities. These processes allow DHCM to determine the availability of services (by provider type) within the members' geographical area. Contractors are also required to report changes that may impact their network prior to the change occurring.

AHCCCS' efforts to communicate effectively to all T/RBHAs and contractors to enlist their feedback have now become a permanent part of its program operations. Behavioral health representatives along with enrollees, family members, and peer support providers currently sit on AHCCCS' Medicaid policy committee, resulting in a more collaborative approach to policymaking. AHCCCS also incorporates the Division of Health Care Advocacy and Advancement (DHCAA), which is responsible for interfacing with enrollees, families, peers, and other stakeholders.

Healthcare integration, including Medicaid expansion, has offered the Arizona system of care additional resources to address a number of system challenges. As an example, a significant number of youth and adults transitioning out of correctional facilities and into communities are in need of services for behavioral health and physical health conditions. AHCCCS has partnered with state and county agencies to improve coordination with the justice system and create more cost effective and efficient ways to transition back into the community.

AHCCCS is engaging the justice system on several fronts to reduce the prevalence of SMI and SUD among members reentering the community, improve their health care, and reduce unnecessary use of emergency departments and hospital beds. These efforts in turn, have improved recidivism rates among the criminal justice population.

To facilitate this transition, AHCCCS is engaged with the Arizona Department of Corrections (ADOC) (including Arizona counties covering the majority of the State's population), in a data sharing agreement that allows AHCCCS to 'suspend' Medicaid eligibility at the point of incarceration, rather than terminate coverage. This data exchange also allows ADOC and county facilities to send discharge information electronically to behavioral health providers simplifying the process of transitioning into care. Through this enrollment suspension process, county jails or prisons can coordinate care prior to the time of discharge. To support this transition process, all RBHAs are contractually required to have a justice systems liaison to facilitate a connection to needed behavioral health services. 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 attention or present potential public health concerns.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid? Yes No
4. Who is responsible for monitoring access to M/SUD services by the QHP? Yes No
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? Yes No
6. Do the behavioral health providers screen and refer for:
- a) Prevention and wellness education Yes No
 - b) Health risks such as
 - i) heart disease Yes No
 - ii) hypertension Yes No
 - viii) high cholesterol Yes No
 - ix) diabetes Yes No
 - c) Recovery supports Yes No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? Yes No
8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? Yes No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?
10. Does the state have any activities related to this section that you would like to highlight?
None at this time.
Please indicate areas of technical assistance needed related to this section
None at this time.

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴⁵, [Healthy People, 2020](#)⁴⁶, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁷, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health 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)⁴⁸.

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."⁴⁹

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 status⁵⁰. 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 populations⁵¹. 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, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health 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.

⁴⁵ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴⁶ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁷ <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁴⁸ <http://www.thinkculturalhealth.hhs.gov>

⁴⁹ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

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, LGBT, 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 behavioral health 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) standard? Yes No
6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? Yes No
7. Does the state have any activities related to this section that you would like to highlight?

AHCCCS contracts with RBHAs to provide cultural competency trainings. The RBHAs are responsible for developing a plan and providing the trainings to the providers receiving block grant funding to ensure they are treating individuals in their region in the most culturally competent manner possible. Additionally, a statewide workforce development plan, completed by the end of the current calendar year, will enhance the training and utilization of culturally competent employees and practices to continue to address health disparities.

Please indicate areas of technical assistance needed related to this section

None at this time.

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the 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 behavioral health 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 behavioral health 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. NREPP 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. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

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 General⁵², The New Freedom Commission on Mental Health⁵³, the IOM⁵⁴, and the NQF⁵⁵. 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."⁵⁶ 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 behavioral health 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](#))⁵⁷ are best practice guidelines for the SUD treatment. The CSAT 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](#))⁵⁸ was developed to help move the latest information available on effective behavioral health 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 behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, 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.

⁵² 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

⁵³ 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.

⁵⁴ 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.

⁵⁵ National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵⁶ <http://psychiatryonline.org/>

⁵⁷ <http://store.samhsa.gov>

⁵⁸ <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.

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.

Footnotes:

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 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 outcome 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.

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). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). 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 CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the 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 implemented its first program to address Early Serious Mental Illness (ESMI) in adolescents and young adults in 2014.

Arizona currently has four ESMI programs in three Global Service Areas (GSAs) that are in early stages of development and will target First Episode Psychosis (FEP). Two of the four programs are located in the Central GSA, Maricopa County while the Southern and Northern GSAs each have one. The Regional Behavioral Health Authority (RBHA) in each GSA manages the program in their area. Studies show treating members early in the course of their illness correlates with better outcomes and improved ability to meet the demands of day to day life and do so with a greater sense of self-direction and belonging in the social spectrum. Arizona's FEP programs incorporate a focus on a whole health model for the member. In three of the four programs, they target those who are 15-35 and who have experienced a first episode of psychosis within the past two years.

Arizona's evidence-based practices for ESMI / FEP programs engage members in an array of services including, but not limited to medication management, individual and/or group therapy, case management, social interaction, supportive education, supportive employment, cognitive behavioral therapy (CBT), acute care services, and supported housing.

3. How does the state promote the use of evidence-based practices for individuals with a 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 a three RBHA system to cover the three main

GSA. 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 a 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.

With the increase from a 5% set-aside to 10% recently, the Mental Health Block Grant (MHBG) has allowed for opportunities to increase evidenced based practices, which would benefit individuals who have recently experienced a first episode of psychosis (FEP), and are between the ages of 15 – 25 years of age, at an earlier point in treatment. The increase along with the recent transition to an integrated care model throughout the state has allowed for acute care services to be added to the list of services available for individuals with ESMI.

AHCCCS supports four FEP programs currently throughout the state. Each of the Early Psychosis Intervention Center (EPICenter) locations including the Fast Forward EPICenter in Flagstaff, the Institute for Mental Health Research (IMHR) EPICenter in Phoenix, and the Tucson EPICenter all follow the Dr. Nicholas Breitborde model in early intervention strategies. These programs are modeled from the Recovery After an Initial Schizophrenia Episode (RAISE) project and incorporate Coordinated Specialty Care (CSC) treatments in their program.

As with the EPICenters, the Maricopa Integrated Health System's (MIHS) First Episode Center in Phoenix is founded on the Recovery After an Initial Schizophrenia Episode (RAISE), NAVIGATE system of coordinated specialty care, following the OnTrack New York Model. MIHS incorporates Evidenced Based Practices (EBPs) in their program including, Cognitive Enhancement Therapy (CET), Cognitive Behavioral Therapy (CBT), recover coaching, individual, group and family therapy, medication treatment, and school and employment supports.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

AHCCCS' ESMI programs are in their early stages of development. All four of the ESMI / FEP models will fully implement their respective programs in each RBHA covering 15 counties throughout the state within the upcoming Federal Fiscal Year (FFY18).

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 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. Due to the relatively new nature of the programs the data will be submitted to AHCCCS in October 2017. 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.

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).

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

None at this time.

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

None at this time.

Footnotes:

SUMMARY OF FEP CONTRACTOR NARRATIVES

Cenpatico Integrated Care

Approximately 100,000 adolescents and young adults in the U.S. will experience a first episode of psychosis each year. The peak onset of first episode psychosis (FEP) typically occurs between 15 to 25 years of age. Early psychosis intervention (i.e., comprehensive psychosocial and pharmacological treatment within 5 years of an individual's first experience of psychotic symptoms) has repeatedly demonstrated to be more effective and less costly than routine or community care. If untreated, the long-term negative impact on physical and mental health for the individual, as well as the direct and indirect financial burden on the individual's family and community is significant.

With path-breaking innovation, the University of Arizona's Department of Psychiatry in collaboration with the Department of Family and Community Medicine inaugurated a fully integrated primary care/behavioral health clinic in February 2016. This program, Banner University Medicine's Whole Health Clinic, includes the well-established Early Psychosis Intervention Center (EPICenter), a distinct outreach component for early psychosis intervention. This 5-year program provides evidence-based intensive treatment and wrap-around services for young patients (aged 15 to 35) experiencing the early stages of a psychotic illness.

EPICenter offers members three core functions: (a) Early detection, (b) Acute care during and immediately following a psychiatric crisis, and (c) Long-term recovery-focused care, featuring multi-modal interventions to enable young people to maintain or regain their social, academic, and career trajectory during the critical first 2-5 years following the onset of illness. The service is state-of-the-art in terms of inter-professional integration, patient-centeredness, and population health orientation.

The EPICenter in Tucson, AZ proudly stands as one of the earliest of a growing number of FEP intervention programs across the United States. It is one of the longest running centers and is the only program of its kind in Southern Arizona. In the past two years, additional support services were added to the integrated care setting; as a result, EPICenter is at the forefront of comprehensive care for persons with early psychosis and their families.

For the past 7 years, EPICenter has served as the cornerstone of clinical training for both licensed professionals and emerging clinicians, through the College of Medicine Psychiatry Residency Program and the APA-approved Clinical Psychology Internship Program. As a result, more than 30 new and seasoned clinicians have learned specific intervention strategies for this high needs/ high risk population. Additionally, since the inception of the Whole Health Clinic in February 2016, staff at all levels have taken part in a variety of training opportunities provided by the expert clinicians at EPICenter.

In response to the growing and continued unmet need for early psychosis intervention, with the support of Cenpatico Integrated Care, EPICenter is prepared to implement a strategic program that will expand and improve the community's capacity to serve individuals in the early stages of psychotic illness. A specific two-year strategy geared toward workforce development, capacity building, innovative outreach, and education is proposed and outlined below.

Health Choice Integrated Care

Health Choice Integrated Care, LLC (HCIC) will implement an evidence-based program to address first episode psychosis in adolescents and young adults through community-based treatment teams. The plan will describe how Mental Health Block Grant (MHBG) funds allocated for first episode psychosis (FEP), will be used to develop the Fast Forward Program for members who have experienced a first episode of psychosis.

The goals of the Fast Forward program are to decrease cost and utilization of high-cost services, increase the number of members engaged in services, improve overall quality of life for members and increase the number of individuals employed or achieving higher education. The program also aims to increase the number of transition-aged youth engaged in services and promote successful transitions to adulthood.

There are several evidence-based models that address first episode psychosis. The RAISE Early Treatment Program, developed by the National Institute of Mental Health (NIMH), found statistically improved outcomes for individuals with first episode psychosis. The RAISE project focused on evaluating the impact of Coordinated Specialty Care (CSC) on first episode psychosis. Coordinated Specialty Care is a recovery-oriented treatment model, which offers family education/support, psychotherapy, medication management, vocational and educational assistance, and case management.

HCIC's Health Home model uses a community treatment approach similar to CSC. Assertive Community Treatment (ACT) teams, and Child and Family Teams (CFTs) are community treatment models, which offer person-centered, recovery-based treatment to individuals and their families.

Integrating Fast Forward into current Health Home treatment teams will expand capacity of the Health Home to provide services to adolescents and young adults who have experienced first episode psychosis. Additionally, this will provide a mechanism to engage young members in services and ensure a successful transition to adulthood. The Fast Forward program will utilize existing community treatment teams to provide:

- Supported education/employment
- Psychosis focused family psychoeducation (individual and group)
- Medication management
- Nursing and wellness strategies
- Individual skills training
- Individual psychosis focused therapy

The Fast Forward program will be implemented as an auxiliary service aiming to enhance existing community treatment services by adding a specialized Case Manager and Nurse to the

Health Home, and by providing specific training on first-episode psychosis to the following members of the community treatment teams:

- Fast Forward Case Manager
- Behavioral Health Medical Professional (BHMP)
- Vocational Coordinator
- Fast Forward Nurse

The Fast Forward team will be responsible for providing services to all individuals meeting criteria ages 15-25.

Mercy Maricopa Integrated Care

About 100,000 young people experience first-episode psychosis each year, according to the National Institute of Mental Health. Research shows that early intervention and treatment helps them and their families learn to understand, manage, and reduce symptoms of psychotic disorders, increasing the chances of successful recovery and reducing the likelihood of future psychotic episodes. Both First Episode Centers target prompt detection of psychosis, acute care during or following periods of crisis, and recovery-oriented services over a 2-3 year period following psychosis onset. There are only two providers in the service area of Maricopa County targeting this population.

The majority of individuals with serious mental illness, such as schizophrenia, bipolar disorder, and major depression, experience the first signs of illness during adolescence or early adulthood. Within the current behavioral health treatment system, there are often long delays between symptom onset and the receipt of evidence-based interventions.

The Phoenix EpiCenter went live in October 2016. IMHR EpiCenter looks to incorporate the Individual Placement Supported (IPS) Employment Model into practice to adhere to evidenced based practices of FEP and evaluate program fidelity.

IPS supported employment is defined below:

- Inclusion of all clients who want to work
- Integration of vocational and clinical services
- Focus on competitive employment
- Rapid job search and no required prevocational skills training
- Job development by the employment specialist
- Attention to client preferences about desired work and disclosure of mental illness to prospective employers
- Benefits counseling and follow-along supports after employment is obtained

Evidence has shown how employment can alleviate poverty, reduce hospitalization, and improve quality of life. Unfortunately, according to the 1997 National Health Interview Survey (NHIS) reports, employment rates for people with a wide range of mental disorders was last recorded to be 37.1 percent (Harris et al., 2005; New Freedom Commission on Mental Health, 2003).

Employment rates for people with schizophrenia and related disorders are 22 percent (Jans, et al., 2004). With the inclusion of Supported Employment, the clients EpiCenter serves will increase

employment outcomes and achieve recovery. IMHR EpiCenter is requesting to initiate the expansion of Evidenced Based Practice of Supported Employment. The MIHS First Episode Intervention Clinic went live in late December 2016. They are working to continue their efforts to engage individuals in a specific array of services immediately after their first episode of psychosis.

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 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, 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.

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

In the children's behavioral health system, Arizona utilizes the Child and Family Team (CFT) practice, which is a child/youth centered and family driven planning process.

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."

These processes are based on the same principles as Person Centered Planning (PCP). In Arizona, PCP is the planning process utilized in the Department of Developmental Disabilities. In addition, Arizona has Clinical Guidance Tools outlining the State's expectations around the planning practice in our children's behavioral health system. The Guidance Tools include "Child and Family Team Practice," "Family and Youth Involvement in the Behavioral Health System," and "Transition to Adulthood," (see all three attached). These documents are incorporated in our contracts.

AHCCCS has an Office of Individual and Family Affairs (OIFA) staffed by individuals having lived experience involving mental health. This office actively works with Family/ Peer Run agencies, advocacy groups, and other stakeholders in our communities to develop strategies intended to enhance member and family engagement in the recovery process. OIFA also communicates policy and contract expectations to the community to improve communication and understanding of State expectations as far as planning and service delivery. OIFA regional offices are a contractual requirement of the Regional Behavioral Health Authorities (RBHAs), and fulfill similar roles on a local level.

In addition, the AHCCCS System of Care/Grants Office 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 members and their families.

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

In Arizona's children's system, we use Child and Family Team (CFT) Practice as our Person Centered Planning Process. This process, described in detail is in the attached document, "Child and Family Team Practice Tool" (see attached).

In the adult system, the Adult Recovery Team (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. The ART, facilitated by behavioral health staff responsible for working with the member to identify who the member would like to participate on the Team, 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.

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

The AHCCCS Covered Behavioral Health Services Guide (CBHSG), partly due to Arizona's 1115 Medicaid Waiver, 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 member while addressing the identified needs.

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

None at this time.

Footnotes:

THE 12 ARIZONA PRINCIPLES

The Arizona Vision 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 12 Arizona 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 Arizona Principles serve as the foundation and are universally applied when working with all enrolled children and their families through the use of Child and Family Team (CFT) practice. Arizona’s CFT practice model was created from the tenets of wraparound. This is evident through the shared concepts of Arizona’s 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. “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.”



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 unless 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

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.

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.

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.),

- 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.

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.

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.azed.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>



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

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.

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.

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

- 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.

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.

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.



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. Thus, 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.

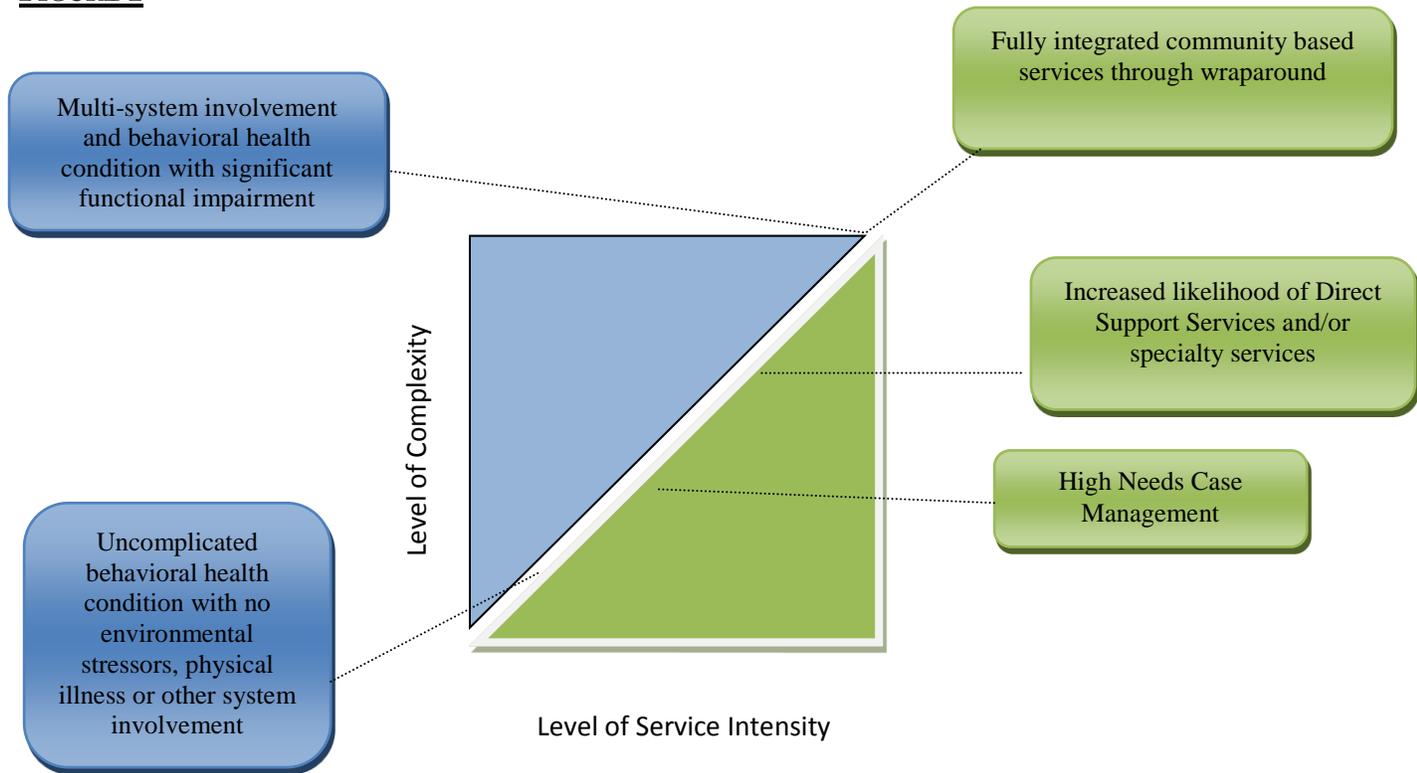
The application of CFT practice will vary depending on the child’s and family’s individualized level of need and complexity. Frequency of CFT meetings, location and nature of meetings, intensity of activity between CFT meetings, and level of involvement by

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, 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.

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.

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,

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

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. Triage 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

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



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

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.

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? Yes No
2. Are there any concretely planned initiatives in our state specific to self-direction? Yes No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

- a) How is this initiative financed?
- b) What are the eligibility criteria?
- c) How are budgets set, and what is the scope of the budget?
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
- e) What, if any, research and evaluation activities are connected to the initiative?
- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

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

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. 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 behavioral health 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 behavioral health 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 behavioral health 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 programs requirements, including quality and safety standard? Yes No
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 an established comprehensive corporate compliance program and plan to achieve the goals of deterring and detecting fraud and program abuse. The plan aims to ensure compliance with applicable laws, rules, regulations, and contract requirements. Additionally, the plan is used for guides and manuals related to program integrity. The Program Integrity Plan is updated annually and proposes a variety of strategies designed to promote program integrity throughout all AHCCCS operations and ensure the best possible use of limited resources.

Within the Division of Health Care Management (DHCM) at AHCCCS, many divisions including Clinical Quality Management (CQM), Data Analysis and Research (DAR), Finance (DFM), Medical Management, and Office of Individual and Family Affairs (OIFA) participate and contribute to ensure compliance with block grant requirements and program integrity. AHCCCS reviews the Tribal and Regional Behavioral Health Authorities' (TRBHAs') compliance with the federal program requirements. Contracts are completed with each of the three RHBA's which outlines in detail the expectations that are required of the RHBA's along with the detailed contractual requirements of the subcontractors whom are the providers for direct care services and treatment. Contracts are updated using amendments as needed. Working with the various divisions, AHCCCS will continue to introduce new topics and initiatives and leverage cross program Subject Matter Experts (SMEs) to enhance and improve the subject matter topics for the Compliance Officer Networking Group.

RHBAs' subcontract with providers in their Geographic Service Area (GSA) or regions in order to ensure members are able to access

services within their own communities. Reviewing bi-annually, auditors follow a pre-established audit program designed to determine if the contractor has adequate controls in place to ensure the efficient and effective use of SABG and MHBG funds. This includes monitoring of sub-recipient's activities to ensure that Federal awards are used for the four (4) authorized purposes and that performance goals are achieved. AHCCCS oversees an annual Independent Case Review (ICR) to meet the Peer Review requirement of the block grant. An ICR interdisciplinary team from an independent agency completes case reviews. The review is completed of all three RHBAs' and focuses on the quality of services members receive while in treatment along with treatment and program outcomes. The priority population of focus for this review can change year to year; therefore AHCCCS has determined that the ICR for FY 2017 will include additional information on individuals receiving treatment for opioid use disorder.

In addition to the RHBA contracts, DHCM has created multiple policy manuals to assist RHBAs in their communication with subcontractors. Two priority manuals are the AHCCCS Contractor Operations Manual (ACOM) and the AHCCCS Medical Policy Manual (AM/PM). Policies written with input from multiple DHCM divisions at AHCCCS are within the manuals. All policies are required to be available for public comment. RHBAs', subcontracted providers, and members have full access to the policy manuals located on the AHCCCS website. Amendments are completed as needed. Individualized communication with T/RHBAs' formally occurs in person during quarterly and semi-annual meetings to review issues, concerns, and new information. If an improvement plan is established, oversight and communication from AHCCCS occurs more frequently. RHBAs' hold quarterly meetings with their substance abuse community providers.

Prevention services, which are not billed through encounters, can be monitored through a variety of mechanisms. Each T/RBHA submits an annual plan to the state no later than May 1st. to allow time for review before the beginning of the next state fiscal year (SFY). The plan shows how to allocate prevention funds for the upcoming SFY to each program including a breakdown by strategy. AHCCCS staff review and approve or deny the proposed allocations. The state conducts annual prevention site visits to each T/RBHA; these site visits include a review of financial information.

To ensure providers have adopted policies and processes that promote compliance with program requirements as well as include quality and safety standards, the RHBAs conduct at least one visit to each prevention site or provider each year. Additional visits occur as needed. Site visits include interview(s) with program staff, observation of program activity, and review of training and supervision records. Supervision records consist of documentation that prevention specialists receive regular and on-going supervision. T/RHBAs must participate in site visits at the request of AHCCCS. Before it is used, AHCCCS must approve the program monitoring protocol of each T/RBHA. T/RHBAs submit their program monitoring protocol with their program descriptions each year for the following SFY.

September 1st or two months following the close of the SFY, each T/RBHA and prevention program submits a description of expended funds by strategy. Non T/RBHA contractors submit monthly or quarterly contractor expenditure reports and/or invoices to detail the expended funds in order to receive payment for services rendered.

The RHBAs are required to submit monthly, quarterly, & annual financial statements. Monthly and quarterly statements are due 30 days after month-end or quarter-end; and 40 days after the last quarter of the contract year. In addition, T/RHBAs are required to submit quarterly year-to-date Revenue and Expense Reports 45 days after quarter-end. Draft audited financial statements are due 75 days after contract year-end and final audited financial statements are due 100 days after contract year-end.

DHCM continues to advance the program integrity plans and policies throughout the state of Arizona. As mentioned above, the SFY 17ICR is collecting additional information on opioid use populations. DHCM is crafting a block grant monitoring tool in order to provide uniformity across all T/RHBAs. Utilizing a "secret shopper" method of monitoring will also ensure access to care, quality of treatment providers and outcomes. Continued collaboration efforts include regularly scheduled meetings held to share information with T/RHBAs regarding their corporate compliance plan that includes all program integrity activities.

Please indicate areas of technical assistance needed to this section

Deferred until receiving recommendations from SAMHSA following the site visit in May of 2017.

Footnotes:

Environmental Factors and Plan

8. 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](#)⁵⁹ 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.

⁵⁹ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?

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

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

9. 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:

- **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;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **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;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **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
 - Data on consequences of substance using behaviors
 - Substance-using behaviors
 - Intervening variables (including risk and protective factors)
 - Others (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)

Social indicators (determinants) measure the prevalence of protective and risk factors, and the social problems based on archival data from records collected and maintained by RBHAs and provider agencies. These indicators provide an overall representation of trends associated to substance use within a specified geographic area. Social indicators consist of data from communities throughout the state establishing rates of underage drinking, crime rates, deaths related to substance use, and maternal use of alcohol and/or other drugs during pregnancy.

Additional social indicator data sources include government publications/reports, online resources, public databases, and surveys conducted by organizations relevant to target populations. Social indicator data is often referred to as archival data on various web sites.

Member interviews are a fundamental component in developing culturally based prevention programs. The community needs assessment include community members and cultural resources that are significant to create tailored and meaningful prevention strategies respective to the community.

Focus Group consists of an interview of a small group of people who have common characteristics. Group members have to be representative of the target population, and are preferable to experts regarding the target group. The focus group interview is based on standardized questions related to perceptions of conditions, needs, and potential resources within the community.

- 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)

Arizona Youth Survey (AYS)

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

If yes, (please explain)

AHCCCS 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 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.

Data collected in the needs assessment includes:

1. The prevalence and trends of substance use in each county of the region served. Data is broken down by communities within counties.
2. Regional statistics informing the needs of diverse and minority populations.
3. Prioritized the highest substances used and related consequences for each region.
4. Prioritized topmost substances used and related behaviors or tendencies contributing to consequences in each region.
5. Prioritized intervening variables/causal factors (risk and protective factors) related to substance use targeted by the T/RBHA in each region.
6. Identified existing resources in targeted community to address local problems and causal factors.
7. Identified prevention service gaps concerning highest needs and resources.
8. Gathered input and feedback directly from stakeholder, program members, coalition members, and providers including social

determinants, focus groups and/or key informant interviews.

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

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

None at this time.

Please indicate areas of technical assistance needed related to this section

Deferred until receiving recommendations from SAMHSA following the site visit in May of 2017.

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:

- **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;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **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;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **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

AHCCCS is committed to advancing Arizona's Prevention System. 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

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 change those factors contributing to substance use problems. Prevention efforts are purposefully designed to meet the communities' needs.

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

None at this time.

Please indicate areas of technical assistance needed related to this section

Deferred until receiving recommendations from SAMHSA following the site visit in May of 2017.

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:

- **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;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **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;
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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
 AHCCCS' current strategic planning process includes the creation of a comprehensive plan with goals, objectives, and strategies aimed at both the individual and community level, in response to the primary substance use problem and related consequences faced by a targeted community. This plan is a collaborative effort including the Governor's Office of Youth, Faith and Family (GOYFF), T/RBHAs, Coalitions, and stakeholders. In order to develop an effective strategic plan, AHCCCS is addressing the documented strengths, needs, and resources in the communities throughout Arizona. The plan establishes goals with measurable objectives that strategically address the contributing factors to the substance use problem identified in the current needs assessments and epidemiological data. Additionally, it will identify benchmarks for deliverables to monitor in addition to the evaluation methods in order to carry out each step in the prevention system.
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

N/A, answered No to #5, but this field was still required.

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

None at this time.

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

Deferred until receiving recommendations from SAMHSA following the site visit in May of 2017.

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:

- **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;
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- **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.

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)

AHCCCS has partnerships with GOYFF, and the T/RBHAs to address Substance Use and Misuse Prevention Services. The RBHAs are separated into three regions:

- Mercy Maricopa Integrated Care (MMIC): Maricopa County;
- Greater Arizona Health Choice Integrated Care (HCIC): Northern Arizona; and
- Cenpatico-Integrated Care (C-IC): Southern Arizona.

Contracts are separated into two documents:

- o Title XIX (Medicaid)
- o Non-Title XIX (State and Grant funds) contracts.

Contractors shall operate in accordance with AHCCCS' Program Administrators to oversee the Request for Grant Applications (RFGAs) procurement processes.

AHCCCS' Prevention system recognizes the 10 domains for National Outcome Measures (NOMs) proposed by the Substance Abuse and Mental Health Services Administration (SAMHSA) for the purpose of inclusion in the Public Mental Health Services and Substance Abuse Prevention and Treatment Block Grants. The NOMs are connected to prevention and treatment measures. The following domains and efforts are applicable to prevention:

- Abstinence: 30-day substance use (non-use/reduction in use). Perceived risk of use; age of first use; perception of disapproval;
- Employment/Education: Alcohol, Tobacco, and Other Drugs (ATOD) suspensions and expulsions; workplace Alcohol and

Other Drugs (AOD) use and perception of workplace policy;

- Crime and Criminal Justice: drug-related crime; alcohol-related car crashes and injuries;
- Access/Capacity: number of persons served by age, gender, race, and ethnicity;
- Retention: total number of evidence-based programs (EBPs) and strategies;
- Cost Effectiveness: increase services provided within cost bands within universal, selective, and indicated programs; and
- Use of Evidence Based Practices: Total number of EBPs and strategies.

AHCCCS' prevention system strives to apply the domains in order to decrease the prevalence and severity of substance use problems through community initiatives and strategies. Contractors are required to conduct a needs assessment on an annual basis and evaluate plans for programs implanted by providers and coalitions receiving prevention funding to identify and develop prioritized programs based on the NOMs. Block Grant Prevention funds are strategically allocated and utilized to address the needs identified in the assessment to achieve positive outcomes. The needs assessment process includes community surveys, town hall meetings, focus groups, and other information which is used to make programmatic decisions and policy advancements.

In addition, each T/RBHA shall develop a regional strategic plan identifying the goals and objectives for each geographic service area (GSA). T/RBHAs submit an annual strategic prevention plan addressing the NOMs, risk and protective factors, data sources, and other indicators.

The T/RBHAs analyze data from the following sources NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, the Arizona Youth Survey, Vital Records, and Emergency Department (ED) records. Through this process, T/RBHAs are able to identify the types of primary prevention services necessary in their regional services area. T/RBHAs are provided technical assistance from AHCCCS throughout the process. T/RBHAs may host local strategic planning sessions for stakeholders where substance use related issues are considered.

AHCCCS aims to fund a variety of primary prevention strategies across the state. Please see below for a description of each primary prevention strategy, which identifies some of the supported activities. Activities will differ across the state based on need. Some of the strategies for primary prevention efforts implemented across Arizona are presented in the answers to Question 2 a-f below.

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 T/RBHAs' 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, healthy eating, and to support information dissemination across the state. Information related to evidence-based approaches and safe effective messages enhance social media campaigns, and promote knowledge on current drug trends as well as national, state and local data. Coalitions also address strategies including promoting proper disposal methods and adding permanent drop boxes for prescription medications, developing and disseminating local marketing campaigns to increase awareness (print materials, PSAs, billboards, theatre advertisements, etc.), outreaching physicians, and pharmacists to encourage them to participate in the "Sign Up to Save Lives" campaign, and providing community education workshops on RX360 for youth, adults, and the community. In addition, an Opioid Task Force was developed focused on provider and prescriber education, and information. The following are some of the specific tasks:

- Design a member follow-up electronic survey.
- Develop two online and/or paper fidelity checklists for peers.
- Collect the retrospective paper surveys in-person at 15 sites.
- Collect the fidelity checklists data.
- Email the electronic survey to school administrators to send to members; this follow-up survey will be emailed to as many members as the schools can contact at a period approximately 3 months after the initial survey data is collected.
- Tabulate and analyze the data.
- Write the report(s).
- Expand to 60 additional middle schools.
- Develop/revise evaluation instruments.
- Complete pre, post, and 90 day follow-ups.

An additional prevention strategy is marketing materials for underage drinking and drug use campaigns. One of the public campaign/communication platforms provides resources and materials for the "It Matters" campaign to participate in communication addressing three main issues: marijuana use, prescription drug abuse, and underage drinking.

b) Education:

Type of Activities: the following educational strategies implemented by T/RBHAs 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 ®.

Moreover, implementation of youth groups at local schools, and the Boy & Girls clubs are in place; hosting of town hall education events; education for police departments, and law enforcement staff on how to engage them in coalitions, referral process, and Prescription Drug-Take Back efforts.

Prevention Coordinators attained Applied Suicide Intervention Skills Training (ASIST) and some of the prevention specialists, coalition members, and young leaders attended Community Anti-Drug Coalitions of America (CADCA) training, as well as conferences to strengthen coalitions across the state. T/RBHAs provided training to providers and coalitions on the Strategic Prevention Framework (SPF) 101, as a brief training drawn from Substance Abuse Prevention Skills Training (SAPST) data which highlights Wellness, Logic Models, SPF Components, Prevention Basics, and Creating / Mobilizing Community Support.

Culturally appropriate programs are in place such as The Safe Out program addressing LGBTQ specific communities for education related to substance use prevention amongst LGBTQ youth/young adults. In addition, various prevention staff attended LGBT + MSM ATTC Center for Excellence Training of Trainers (ToT) for new evidenced based curricula in working with LGBT individuals. Some T/RBHAs hosted gender specific events including Girl Scouts to engage young girls in preventative education activities. Life skills training is provided for youth in grades 5 through 12. Younger youth participate in prevention messaging through cultural efforts incorporated into puppet shows.

Additional education strategies involve SAPST Training, designed to help prevention practitioners develop the knowledge and skills needed to implement effective, data-driven prevention that reduces behavioral health disparities and improves wellness.

Paul Quinnett implemented the curriculum Question, Persuade and Refer (QPR), as an emergency mental health intervention for suicidal individuals created in 1995. The training involves three steps anyone can learn to help save a life from suicide. Helping to save thousands of lives each year, Prevention Providers trained in QPR learn how to recognize the warning signs of a suicide crisis and how to pose a question, persuade, and refer someone to help in a timely manner.

Part of Statewide Prevention Programs includes contract agreements with County Superintendents Office for Middle School Substance Abuse Prevention Education programs. In addition, the scope includes an evaluation process conducted by a State Contractor for the Middle School Program. Through a Request for Grant Application (RFGA) process, selected High Schools as Sub-Grantees participate in the Substance Abuse Prevention Education Program. In accordance to the SABG Grant Sub-Grantees shall operate in accordance with policies and procedures as required by SAMHSA and AHCCCS respectively.

c) Alternatives:

Type of Activities: T/RBHA 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. Providers participated in Valley of Sun United Way community clean up and garden space clearing. Community gardens and coalition driven initiatives are designed across the state to engage neighborhoods and schools in promoting healthy habits and coordinate events for members and their families in need of access to healthy foods, while learning about prevention of alcohol and drug use.

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 number of youth participation identified with a diagnosis of substance use disorder (SUD) in outpatient services; implementing programs including education, referrals, and monitoring for reduction of drug use in the GSAs; collaborations established to coordinate with community providers and share information on SUD data, screenings, trends, and services available.

Provide access to SUD training in community settings including schools, adult and juvenile correctional facilities each year; and continue collaborations with law enforcement to share information and data in regard to referrals, trends, and services available. As well as, identifying coalition participants for timely referrals made for early intervention and

coordination of treatment services.

Some of the problems identified within senior communities include helping men and women over the age of 55 who are at risk for depression and misuse of prescription drugs/medications due to loneliness and solitude due to lack of family and/or community support systems. Primary prevention focuses on reducing the use and misuse of prescription drugs in seniors 55 and older by promoting referrals and education about the harmfulness of prescription drug abuse and/or misuse. The strategies are to increase the social interactions with family and/or friends through Peer Support members. Also, to reduce the level of depression by partnering with peer support members, and coordinate depression screenings regularly.

Another relevant system-level approach is coordinating the community readiness for referral process through coalitions and prevention providers for reductions in Youth 30-Day Use of AOD and decreases in Adult Attitudes Favorable to Underage Drinking in Arizona.

In addition, qualified staff coordinators oversee the Healthy Families programs as a resource for families at the school who can direct students and/or parents through the school year to local community coalitions, and non-profit organizations.

e) Community-Based Processes:

Types of Activities: 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.

The Strategic Prevention Framework serves as the foundation for the coalitions and array of services. Coalition members and staff train on the framework annually. The needs assessment, presented in the community, provides information to make programmatic decisions, and the plan to implement a comprehensive approach for prevention that ensures the entire community has access to prevention services and resources.

Prevention providers' use a comprehensive evaluation protocol, which includes both process and outcome components. Review of the evaluation data ensures goals and objectives are met and improvements to programs are made as needed. Numerous evidenced-based curricula and programs are in place including: Botvin's Life Skills, Active Parenting, ASIST, and SOS (including youth screening), Safe Talk, QPR, Safe Out (community education curriculum for substance use prevention among LGBTQ youth/young adults),

In regards to youth development programs, a large focus is placed on equipping foster children with pro-social life skills, which will allow them to avoid risky behaviors. An evidence-based program tested in Europe by Patricia Conrad of the University of Montreal focuses on how a child's temperament drives his or her risk for drug use. Conrad's research found correlations between five specific traits (sensation-seeking, impulsiveness, anxiety, sensitivity, and hopelessness) and drug addiction. In order to provide successful prevention strategies the community and providers work closely together to complete initiatives that promote foster youth well-being and connectedness through social activities and peer support groups committed to work toward solutions for preventing the negative effects of foster care (substance abuse, homelessness, mental health issues etc.).

Additional evidence community-based programs have been considered for delivery and AHCCCS is committed to continuing to build a strong prevention platform that includes community involvement, engagement, environmental approaches, and engaging youth, parents, and community members through learning opportunities.

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. Some of the programs in Arizona include, but are not limited to Native American communities use themed presentations, and sessions from the Botvin's Life Skills which targets parents/guardians in a variety of settings including the residential treatment centers, adult detention centers, domestic violence shelters, and community settings. Community events are coordinated for the opportunity of prevention staff, community members, and youth to receive information about important substance use and suicide prevention strategies. These events occur in a variety of settings and locations throughout the state.

AHCCCS prevention services ensure the delivery of strategies through community involvement in order to improve outcomes. Some of the programs include implementing social norms campaigns at the local Middle Schools by engaging teachers in a cooperative manner to collect pre-and-post surveys to evaluate the youth programs. T/RBHAs have programs coordinated with community-based coalitions, which is an integral part of implementing its strategic plan and produce environmental level changes. Coalition members help to develop the plan, participate in implementation, activities, and

provide guidance as well as oversight to ensure its successful implementation. The coalitions are comprised of stakeholders from the 12 community sectors, as well as members of the program's target population (youth, older adults, women, etc.).

Some coalitions have community meetings with the local City officials, Parks and Recreational centers, and partner in order to have youth drug trends presentations to their youth council. In some communities, the community centers and/or parks are identified as the places where youths' consumption of drugs may occur.

Programs at GOYFF consist of High School Prevention Education Sub-grantees and have ongoing communication and engagement with faculty, staff, and facilitators at each school.

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

The Institute of Medicine (IOM) model describes three types of populations a prevention program may target: universal, selected, and indicated. A universal prevention program targets the entire population regardless of degree of risk for developing a behavioral health problem. A selected prevention program targets persons with specific risk factors. Indicated prevention programs target persons at high risk for behavioral health problems, but who do not have a diagnosable behavioral health problem. AHCCCS utilizes the IOM model as a guide to classify primary prevention programs that are funded through SABG dollars for services not funded through other prevention efforts.

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

None at this time.

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

Deferred until receiving recommendations from SAMHSA following the site visit in May of 2017.

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:

- **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;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **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;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

Evaluation

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

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

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

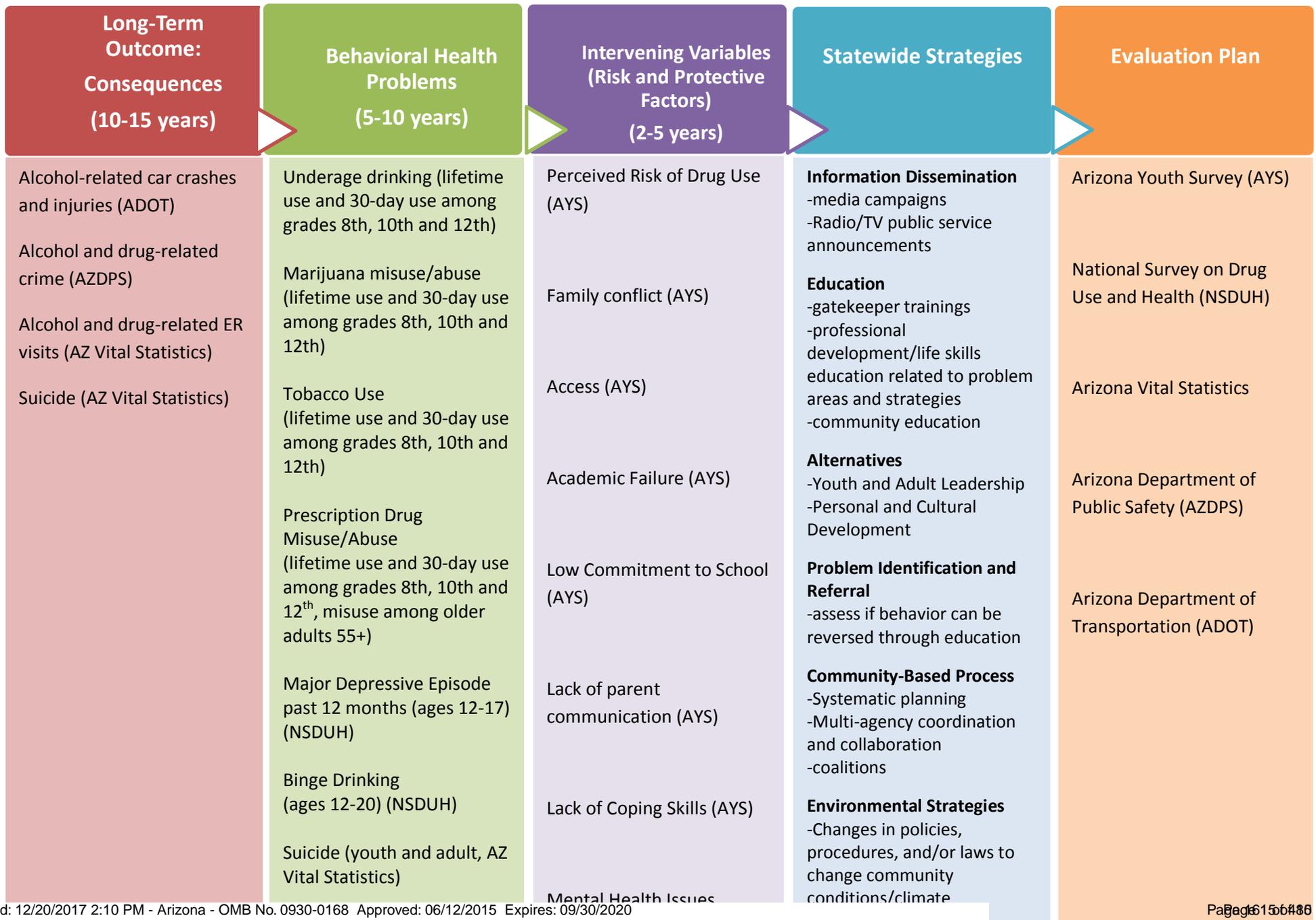
- f) Demographic information
- g) Other (please describe):

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:

Arizona Health Care Cost Containment System State Plan Logic Model



Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required 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-occurring 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.

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

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

Please describe 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.

In addition, the Block Grant covers acupuncture and traditional healing, which are not covered services by Medicaid for both Medicaid and Non-Medicaid members.

3. Describe your state's case management services

Arizona contracts with the Tribal and Regional Behavioral Health Authorities (T/RBHAs) 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 each RBHA 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) consistent with Substance Abuse and Mental Health Services Administration's (SAMHSA) Assertive Community Treatment (ACT) teams statewide. The RBHAs monitor the teams to fidelity to the service delivery programs annually using the AHCCCS adopted measurement instrument.

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

Arizona defines case management as a supportive service provided to enhance treatment goals and effectiveness within the Covered Behavioral Health Service Guide (CBHSG). Activities may include:

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

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

AHCCCS requires the RBHAs 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 determination of the medical necessity for ongoing hospitalization. RBHAs and providers are able to review all requirements and guidelines in the AHCCCS Medical Policy Manual (AMP). 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 following appointments with PCP or specialist within 7-10 days, prescription medications, referrals to appropriate community resources, and a follow up well-being call to the member.

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 behavioral health 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	40,292	0.71%
2.Children with SED	40100	0.64%

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 through the RBHAs.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

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

Describe your state's targeted services to rural and homeless populations and to older adults

The State of Arizona has a State Homeless Coordination Office who plans and coordinates strategic activities aimed at ending homelessness in the State of Arizona. Services for homeless and near-homeless individuals and families throughout the state are provided through contracts with community based organizations and local agencies. A combination of state, federal, and donated funds are used to support local efforts to provide community-based services such as street outreach, emergency shelter, rapid re-housing, homeless prevention, and case management.

AHCCCS' contracts with the RBHAs require each have a housing team. Staff members work with the local US Department of Housing and Urban Development (HUD) continuum of care to coordinate activities and funding to meet the needs of their communities.

In southern Arizona, the RBHA has fully integrated their housing wait list with the coordinated entry process. They have provided more than 30 homeless management information system (HMIS) licenses to community housing providers, and have worked to ensure all community housing providers are using the Vulnerability Index (VI) and Service Prioritization Decision Assistance Tool (SPDAT) (VI-SPDAT).

In northern Arizona, the RBHA recently partnered with the Arizona Department of Housing to also provide HMIS licenses to housing providers. This will improve the communication between those working to end homelessness in the region. We anticipate the northern RBHA will also work to integrate their housing waitlist with the continuum of care.

In Maricopa County, the RBHA works closely with the continuum of care 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. Like many communities in the United States, Maricopa County was hit hard by the affordable housing crisis. There are an estimated 220 individuals moving to the county daily making Maricopa County the fastest growing county in the nation.

This puts additional pressure on the housing waitlist. Vacancy rates are less than 3%. As such, the RBHA is 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.

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.

AHCCCS works with its state partners and contractors to provide needed services to homeless individuals. 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 2017 street count broken out by each county within Arizona.

County Unsheltered: Number of Households

- Apache 11
- Cochise 58
- Coconino 28
- Gila 21
- Graham 6
- La Paz 42
- Maricopa 2020
- Mohave 199
- Navajo 23
- Pima 384
- Pinal 66

Santa Cruz 5
Yavapai 102
Yuma 70

AHCCCS announced the award of contracts for its Arizona Long Term Care System (ALTC) program for members who are Elderly and/or have a Physical Disability (E/PD) to Managed Care Organizations (MCOs) beginning October 1, 2017. The MCOs will provide services to over 26,000 AHCCCS members who are elderly (65 and over), blind, or disabled and at risk of institutionalization.

ALTC 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 ALTC 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.

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.

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 SMI or SED designation. RBHAs 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 EIS/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:



Arizona Commission on
Homelessness and Housing

ENDING HOMELESSNESS

ARIZONA PLAN TO END HOMELESSNESS



MISSION

Arizona will develop housing options, service systems and prevention solutions in order that no one in the State of Arizona will have to sleep in places not meant for human habitation.



GUIDING PRINCIPLES

- Encourage collaborations
- Emphasize shared information
- Communication at all levels
- Utilize National and local “Best Practices” to inform planning process

GOAL – End Chronic Homelessness by 2016

OBJECTIVES

- Move 300 chronically homeless individuals or families into permanent housing each year for the next 5 years
- Adopt and implement statewide use of a common assessment tool to prioritize housing placement based on vulnerability by December 2012
- Support, monitor and assess all pilots for Centralized Intake to prioritize chronic homeless individuals for placement and to evaluate outcomes by December 2013
- Develop a statewide shared database of Permanent Supportive Housing, Affordable Housing and Tax Credit supported housing options by July 2013

CHRONICALLY HOMELESS

Adopt and implement statewide use of a common assessment tool to prioritize housing placement based on vulnerability by December 2012



GOAL – Prevent and End Veteran Homelessness by 2015

OBJECTIVES

- Adopt and implement use of a common assessment tool to identify the most vulnerable and chronically homeless veterans by December 2012
- Insure all mainstream and community resources identify veteran status and connect veterans to additional veteran resources by July 2013
- Target and prioritize use of HUD VASH housing vouchers towards chronically homeless veterans

HOMELESS VETERANS

Target and
prioritize use of
HUD VASH
housing vouchers
towards
chronically
homeless
veterans



GOAL - Continue Work to Prevent and End Homelessness for Families, Youth and Children by 2021

OBJECTIVES

- Develop common reporting standards for family units vs. beds to determine housing needs by December 2013
- Adopt common definition of “Homeless Youth” by July 2013
- Add 300 units of Permanent Supportive Housing to the housing system each year for the next 10 years
- Develop a statewide shared database of Permanent Supportive Housing, Affordable Housing and Tax Credit supported housing options by July 2013

HOMELESS FAMILIES, YOUTH AND CHILDREN

Add 300 units of
Permanent
Supportive
Housing to the
housing system
each year for the
next 10 years



GOAL – Develop Measurement Standards, Data Collection and Accurate Reporting Systems by 2013

OBJECTIVES

- Organize comprehensive statewide street and shelter survey to establish baseline data for future comparisons and research by summer 2012
- Establish common definitions, methodology, measurement tools and reporting standards to be compiled into standardized reports to the Commission by the Continuums of Care by July 2013
- Develop a statewide shared housing stock database of Permanent Supportive Housing, Affordable Housing and Tax Credit supported housing options by July 2013

ACCURATE REPORTING

Organize
comprehensive
statewide street
and shelter survey
to establish
baseline data for
future
comparisons and
research by
summer 2012



GOAL - Move From the Current System of Homeless Management to a Homeless Prevention System by 2021

OBJECTIVES

- Expand Centralized Intake system to become Housing Options Centers with access to all forms of affordable housing, rental assistance and emergency housing solutions by July 2021
- Implement a statewide re-entry process for jail and prison inmate release to prevent release to homelessness by December 2015

HOMELESS PREVENTION

Expand
Centralized Intake
system to become
Housing Options
Centers with
access to all forms
of affordable
housing, rental
assistance and
emergency
housing solutions
by July 2021



STRATEGIES

- Encourage use of common methodology, definitions and measurement tools throughout reporting systems
- Prioritize Housing First Model
- Encourage state and local Public Housing Authorities to prioritize a percentage of all housing vouchers for homeless individuals
- Focus on development of Permanent Supportive Housing
- Encourage development of Affordable and Permanent Supportive Housing through the Low Income Housing Tax Credit Program
- Fund “Bridge Housing” for immediate placement of most vulnerable veterans

STRATEGIES

- Expand available prevention activities through emergency assistance for rent, mortgage, utility payments, etc.
- Emphasize Centralized Intake for client centered triage and data quality
- Adopt an assessment tool to prioritize housing placement based on vulnerability.
- Prioritize prevention and/or permanent housing whenever possible
- Balance community resources across Emergency Shelter, Transitional Housing and Permanent Supportive Housing
- Prioritize and/or develop funding streams for supportive services “Navigators” to include housing follow-up for stability and retention

Standing Committees to Oversee Plan Execution

- **Data Management Committee** – Ted Williams Arizona Behavioral Health Corporation
- **Housing Committee** – Michael Trailor, Director, Arizona Department of Housing
- **Homeless Services Committee** – Darlene Newsom, UMOM New Day Center
- **Studies and Surveys Committee** – Brian Spicker, Valley of the Sun United Way

ENDING HOMELESSNESS

Together we can end homelessness in Arizona!



Data Management Committee

- Establish common definitions, methodology, measurement tools and reporting standards to be compiled into standardized reports to the Commission
 - Measurement criteria
 - Common definitions and measurement tools
 - Consistent reporting format and measurement criteria
 - Identify existing data resources
 - Identify gaps in information

Housing Committee

- Develop a statewide shared housing stock database of Permanent Supportive Housing, Affordable Housing, Public Housing, Vouchers and Tax Credit supported housing options
 - Identify targeted populations to be served through housing stock database
 - Assess housing options and availability goals by county
 - Identify housing needs by county for future development
 - Target and prioritize use of housing choice vouchers

Homeless Services Committee

- Adopt and implement statewide use of a common assessment tool for housing placement and to quantitatively track and measure homeless system outcomes
 - Explore national “Best Practices” and existing local tools to develop recommended model
 - Recommend tools for assessment, and measurement
 - Work towards Centralized Intake to monitor implementation
 - Develop data collection and reporting requirements

Studies and Surveys Committee

- Organize comprehensive statewide street and shelter survey to establish baseline data for future comparisons and research
 - Establish special street and shelter survey methodologies and gain commitment
 - Identify community organizations who can provide and coordinate volunteers, training and organization in each county
 - Reach out to businesses and philanthropy organizations
 - Recommend and plan additional surveys

THANK YOU



Arizona Commission on Homelessness and Housing

**For more information contact the
State Homeless Coordination Office At 602-542-4446**

Environmental Factors and Plan

11. 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) Are you considering any of the following:

Targeted services for veterans Yes No

c) Expansion of services for:

- (1) Adolescents Yes No
- (2) Other Adults Yes No
- (3) Medication-Assisted Treatment (MAT) Yes No

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. Either directly or through an arrangement with public or private non-profit entities make perinatal care available to PWWDC receiving services? 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. Are you considering 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, custody issue 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.

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. Each RBHA 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 (CBHSG) geared toward prevention, treatment, and recovery for both adults and children.

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 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).

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 into the Provider Manual in July 2010. This is in all contracts between AHCCCS and the RBHAs. 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 ACOM 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.

AHCCCS receives an email in real time whenever a member is added to the waitlist. A designated member of the System of Care 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.

AHCCCS will be using SABG funding to provide life skills such as parenting skills, anger management, etc., for parent(s)/families when someone is registered in a program receiving funds and it is documented as such an authorized activities to prevent and or treat substance use disorder.

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-syndromeresearch.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

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. Are you considering 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 (military families, veterans, adolescents, older adults) Yes No
3. States are required to monitor program compliance related to activities 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 CBHSG 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.

During the past Fiscal Year, AHCCCS joined the RBHAs in conducting site visits to monitor SUD block grant funded providers serving the priority populations. Since the exit conference following SAMHSA's site visit of AHCCCS, the State has employed several strategies to address the recommendations for advancing oversight and monitoring of the RBHAs/provider networks. RBHAs now provide additional education and technical assistance based on the recommendations. The specific block grant codes are being incorporated into contract amendments and policies.

The State added a SABG training requirement into the Provider Manual in July 2010, which is referenced in all contracts with the RBHAs. 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 ACOM 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 Substance Use Disorder, and 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 timeframes specified in ACOM.

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.

AHCCCS will be using SABG funding to provide life skills such as parenting skills, anger management, etc., for parent(s)/families when someone is registered in a program receiving funds and it is documented as such an authorized activities to prevent and or treat substance use disorder.

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. Are you considering 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 in high-risk substance users.

Pursuant to the 45 CFR Part 96 Sect. 127, AHCCCS is required to routinely make available tuberculosis services as defined in §96.121 to each individual receiving treatment for substance use, implement infection control procedures including the screening of members, and identify those individuals who are at high risk of becoming infected. In addition, AHCCCS is required to maintain State expenditures of non-Federal amounts for such services at a level that is consistent with the base established in 1993.

SABG targets special population and interim services for pregnant women/women with dependent children/intravenous drug users (Non-Title XIX/XXI only) is established. The purpose of interim services is to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease.

The documentation of interim services must be in the member's chart and reported to the Capacity Management online waitlist. Interim services are available for Non-Title XIX/XXI priority populations who are on an actively managed waitlist.

The minimum required interim services include education that covers: prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C and other communicable diseases; effects of substance use on fetal development; risk assessment/screening; referrals for HIV, Hepatitis C, and TB screening and services; and referrals for primary and prenatal medical care.

As of July 1st, 2016, the Division of Behavioral Health Services, Arizona Department of Health Services (ADHS/DBHS) transitioned to AHCCCS, which is now the SSA of the SABG. An Interagency Service Agreement (ISA) is in place between ADHS/DBHS, and AHCCCS.

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

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

2. Are you considering 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 Yes No

Exchange) Program?

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?

Yes No

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

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. Are you considering 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 members, 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 service 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. Are you considering 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, e.g. 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. Are you considering any of the following:
 - a) Notice to Program Beneficiaries Yes No
 - b) Develop an organized referral system to identify alternative providers Yes No
 - a) Develop 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. Are you considering 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. Are you considering 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 Request for Proposal (RFP) was issued for an independent entity to complete the Independent Peer Review process in compliance with the block grant requirements. The contract was awarded to a third party with expertise in behavioral health, substance use disorder, clinical audits, and research methodology.

There are currently 250 cases randomly selected from the statewide provider network to represent at least 5% of the providers in the network, which are included in the peer review process. Of the 250 cases, no less than 200 will be reviewed to allow for cases to be removed due to not being appropriate for the review and to ensure adequate representation of the provider agencies. Professionals within the behavioral health field who are not affiliated with the providers being reviewed review these cases. The review looks at the full spectrum of the treatment process and addresses clinical appropriateness; member centered care, and associated NOMs with each case. A report is generated and shared with the RBHAs/provider network so lessons can be learned and systemic improvements can be implemented.

The data pull, contract language, and guidelines are being updated. The peer review process and instrument is being evaluated and refined by a group of subject matter experts prior to the next review. The changes will enhance AHCCCS' ability to ensure block grant requirements and priorities are met by this activity.

3. Are you considering 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) Develop 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, e.g., 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. Are you considering 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 opportunity 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) Performance-based accountability Yes No
 - d) Data collection and reporting requirements Yes No
2. Are you considering 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

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, which govern the Mental Health and Substance Use Disorder Programs.

<http://www.azleg.gov/arsDetail/?title=36>

Footnotes:

Under Criteria 4-6, Questions 1 and 2 (a-c) for Early Intervention Services for HIV are marked no because Arizona is not a designated state and there is not an option to change the answers to not applicable.

Criterion 2

Improving Access and Addressing Primary Prevention

As a grantee of the Substance Abuse Block Grant (SABG), Arizona's Health Care Cost Containment System (AHCCCS) requires that the allocation of funding for Primary Prevention implementation and services be determined according to the priority needs revealed in regional needs assessments conducted by contractors. A prevention service includes early interventions to prevent, eliminate, and/or reduce drug use/misuse, underage drinking, prescription drugs, etc. Special populations are main focus including, but not limited to pregnant women, women with dependent children drug use, and intravenous drug use.

In the past, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) Prevention Services required Tribal/Regional Behavioral Health Authorities (T/RBHAs) to participate at a Statewide Strategic Prevention Planning session and planning development coordinated through a facilitation process.

The strategic plan was effective for a 3 to 5 year term including the following: each T/RBHA was mandated to develop a Strategic Plan within their regional service areas and coordinate with subcontractors and providers as well; providers must perform approved prevention activities for the target community as it was detailed in Strategic Plan and Logic Model, by means of CSAP Prevention Strategies; providers must develop their Strategic Plan and collaborate with the designated coalition, and address the activities and sustainability plan to ensure the permanence of efforts beyond the scope and maturation of the contracts. The Strategic Plan included the following components:

- a. Long Term Outcome: Consequence (10-15 years): data driven strategies, collected alcohol related car accidents and injuries (ADOT); Alcohol and Drug related Crime (AZDPS); Alcohol and Drug Related Visits to Emergency Departments (EDs) (AZ Vital Records Statistics); and completed suicides (AZ Vital Records Statistics).
- b. Behavioral Health Problems (5-10 years): Underage Drinking, Tobacco Use, Prescription Drugs, Marijuana misuse/abuse, Major Depression Episodes, Binge Drinking, and Suicide Risk.
- c. Intervening Variables (Risk and Protective Factors): Social Determinants on health, perceived risk of drugs, family conflicts, academic failure, mental health, coping skills, etc.
- d. Statewide Strategies: Information Dissemination, Education, Community Based Process, referral process, environmental strategies addressed through policies. Evaluation: Arizona Youth Survey (AYS), National Survey on Drug Use and Health (NSDUH), Arizona Department of Public Safety (AZDPS), AZ Department of Transportation (ADOT).

In regard to improving access, it is recommended that a more comprehensive approach to Prevention is implemented; ensuring communities in the State of Arizona have access to prevention services, and resources regardless of the regions in which they live.

AHCCCS prevention contractors, the T/RBHAs, and the Governor's Office of Youth, Faith and Family (GOYFF) aim to increase awareness and knowledge on issues and resources related to substance use and misuse in the communities. Social media campaigns, school or community-based social skill development, and parenting empowerment programs increase parent-involvement and healthy growth for families.

The focus of the prevention providers contracted with the T/RBHAs is to address specific issues in their respective communities by developing research-based and evidence based strategies in order to improve outcomes for individuals and families vulnerable to mental and physical health disparities.

As the Single State Authority (SSA) and State Prevention Structure and Organization, AHCCCS monitors and ensures that program specific requirements meet the terms with all contractual, intergovernmental agreements (IGAs), and collaborative protocols, including but not limited to:

- Comply with all relevant MH/SABG requirements.
- Abide by AHCCCS' strategic plan for prevention services.
- Abide by T/RBHA's Provider Manuals and Policies and Procedures Manuals.
- Cooperate with and participate in T/RBHA evaluation process to assess progress toward reducing substance use, and substance-related consequences in communities.
- Participate in mandatory site visits, meetings, and trainings as required by AHCCCS, including cultural competency trainings.
- Comply with any additional requirements set forth by AHCCCS during the duration of the contract period.
- Follow the Strategic Prevention Framework (SPF) to reduce substance abuse and substance abuse related consequences within a targeted population.
- Collaborate with a community based coalitions to implement data-driven initiatives that enhance community capacity to implement sustainable, evidence-based programming
- Apply culturally competent environmental strategies to engage target populations, create community system-based transformation, and positive outcomes.
- The term of the contract shall be from the date the service agreement is signed through the end of AHCCCS' Prevention Fiscal Year. The AHCCCS Prevention Fiscal Year is from July 1st of a calendar year through June 30th of the following year.
- Contracts may be renewed on an annual basis contingent upon the availability of funds, program delivery, and/or financial performance.

- Contractors shall implement approved prevention activities and programs for the identified communities as defined in the strategic plan, and in accordance with CSAP Prevention Strategies.
- Contractors shall develop and/or collaborate with selected coalitions (i.e. suicide prevention, substance abuse prevention, LGBT, underage drinking prevention, faith based, seniors, etc.) in their service areas to support substance use prevention activities
- Contractors' sustainability plans are necessary to ensure ongoing efforts beyond the scope and duration of the contract.
- Contractors shall develop policies for early intervention, referral processes, as well as, tools to monitor, and report referrals as needed.
- In the event prevention providers and coalitions are not the same legal entity, however both are incorporated as legal entities in the State of Arizona, providers shall secure a memorandum of understanding among the provider and the coalition defining the expected relationship and mutual responsibilities under the terms of the contracts with AHCCCS.
- Conduct and update community level needs assessments once a year or as required.

Formerly, ADHS/DBHS Prevention Services utilized a process to determined evidenced based programs that support prevention efforts in the community. The SAHMSA National Registry of Evidence Based Programs and Practices (NREPP) served as the foundation for the EBP process developments. In addition, ADHS/DBHS Prevention Team developed a comprehensive evaluation tool, which included both SAMHSA's EBP criteria and regional adaptations to meet the needs of the communities. ADHS/DBHS developed a process for evaluation including a review panel consisting of 5 members representing T/RBHAs, Governor's Office for Youth, Faith, and Family (GOYFF), DBHS staff, community members, coalition members, peers, and youth as available.

The process began with a call for applications conducted annually around the state to ensure the completion of goals and objectives, and to make necessary adjustments to EBPs, while still maintaining fidelity to the models (i.e. adaptations for culturally appropriate services and addressing language barriers). The T/RBHAs staff, providers, coalition members, promotors, and peer support staff were trained on the framework and other curricula delivered for Prevention Services.

In regard to improving the use of EBPs, AHCCCS will consider developing a process in collaboration with T/RBHA prevention administrators to support EBPs across the state to maximize and enhance efforts to reduce substance use in high risk regions. Prevention programs and coalitions utilize a variety of evidenced based strategies that support prevention efforts in the community as described below:

- Strategic Prevention Framework (SPF) is the foundation for prevention services, coalition members and staff are trained on the framework with updated trainings annually.
- The Community Needs Assessment helps identify the most current needs for substance use prevention and helps prioritize programs' decisions. A comprehensive community based approach ensures allocation of funding specifically to access prevention services and resources.
- A comprehensive evaluation process is required in order to monitor the effectiveness of programs and expected outcomes. Evaluation data is revised regularly to ensure the goals and objectives are met. In addition, the evaluation tools address the potential improvements of programs on an ongoing basis.
- AHCCCS' Prevention System in Arizona is committed to continue building a strong platform for the reduction of alcohol, marijuana, and prescription/Opioid medication misuse and abuse.
- AHCCCS implemented a variety of approaches and initiatives to increase substance use prevention and public awareness including, but are not limited to: targeting priority populations like pregnant women, women with dependent children, and intravenous drug users; community event involvement and engagement; environmental approaches engaging youth, parents, and seniors; and community members at large through learning opportunities, media campaigns, engaging school settings, implementing evidence-based programs, trainings and dissemination of information.

AHCCCS is committed to address Primary Prevention priorities in all regions as emphasized in the needs assessments, and in the evaluation of programs within providers and coalitions. The information and data collected statewide validate the allocation and utilization of funding based on the outcomes and needs for Prevention Services. Some of the fundamental components included in the needs assessment process are community surveys, town hall meetings, focus groups, stakeholder interviews, data sources, and other information, which is used to make programmatic decisions and policy advancements.

Environmental Factors and Plan

12. 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 2016-FFY 2017? Yes No

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

Not at this time.

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

Not at this time.

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma⁶⁰ 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 behavioral health 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 behavioral health. 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 behavioral health 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 behavioral health 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 Trauma⁶¹ paper.

60 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.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health 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 behavioral health providers? Yes No
3. Does the state have a plan to build the capacity of behavioral health 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.

At present, the Arizona Health Care Cost Containment System (AHCCCS) does not have a policy requiring providers to screen members for instances of trauma, however AHCCCS recognizes the importance of Trauma Informed Care (TIC), and has included its promotion and expectations in contracts with Regional Behavioral Health Authorities (RBHAs). AHCCCS currently contracts with three RBHAs to provide direct services and AHCCCS requires that a RBHA's treatment networks include services that are culturally appropriate, maximize personal and family voice and choice, and incorporate a TIC approach into all treatment modalities.

AHCCCS requires the RBHAs annually submit a provider network management plan that includes a description of specialty service providers, including providers with expertise to deliver services to children, adolescents, and adults with developmental or cognitive disabilities; sexual offenders; sexual abuse trauma victims; members with substance use disorders (SUDs); members in

need of Dialectical Behavior Therapy (DBT); and infants and toddlers under the age of five (5) years. RBHAs are required to provide updated needs assessments, which help identify needed trainings to ensure therapies are evidence based and trauma inclusive.

AHCCCS has identified two high priority areas of focus: behavioral health needs of children and families involved in Department of Child Safety (DCS) and birth to 5. These two areas have been identified as high risk because without intervention they can result in immediate trauma, have lasting effects, and be precursors of mental health problems later in life. Assessments such as the Adverse Childhood Experience (ACE) Questionnaire, Connor's Early Childhood Assessment (CECA), Trauma-Attachment Belief Scales (TABs), and others create awareness of untreated mental health issues reflected through physical symptoms, aggressive behavior, and social-emotional development. Implementation of best practices to address the needs of the children are including but not limited to Preschool Cognitive Behavioral Therapy (P-CBT), Child-Parent Psychotherapy (CPP), DBT, and Eye Movement Desensitization and Reprocessing (EMDR) are implemented throughout the state.

Access to therapy has traditionally been a barrier for children and youth to receive appropriate care when needed. Access to behavioral health therapy while in foster care added an extra challenge while the level of trauma increases with removal from their biological home and at times, multiple foster care placements. In March 2016, Governor Ducey signed Jacob's Law, HB 2442, to ensure quicker and easier access for children in the foster care system and their families. This bill allows for children in DCS custody to obtain an intake within seven days and/or clinically necessary services within 21 days. This is monitored through the Child and Family Team (CFT) process, a team of formal and informal supports for the child. If deemed that a child does not need trauma-focused and/or behavioral health intervention at that time, the need is re-assessed for the next six months.

AHCCCS requires the RBHAs to provide trainings to develop and promote the implementation of TIC throughout the state in the RBHA's contracts. The RBHAs develop, implement, and submit annual training plans that provide information and documentation of all trainings. The training plan and training curricula are submitted annually, 45 days after fiscal year end as specified in the RBHA's contract. AHCCCS and the RBHAs have outlined a plan for staff training and trauma-related trainings using three approaches. Currently all provider staff are required to participate in New Employee Orientation within 90 days of hire. RBHAs continue to refine the teachings of TIC into the format of base training, advanced and specialized programs, and finally, differing education needs. Base training relates to what provider staff needs to know to get started. Advanced and specialized programs take content further to develop skills and abilities consistent with growth within specific jobs. While differing education focuses on Training, Coaching, Supervision, and Mentoring. In addition, the RBHAs support their workforce by providing training related to secondary trauma.

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

None at this time.

Footnotes:

Environmental Factors and Plan

14. 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.⁶²

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.⁶³

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 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.

⁶² 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, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

⁶³ <http://csjjusticecenter.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 behavioral health 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, behavioral health 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 behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health 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 behavioral health 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 SSA's leadership at AHCCCS, there has been active involvement in the joint activities between the behavioral health, acute care, long-term care, and Arizona's criminal and juvenile justice systems. Annually updated Collaborative Protocols and System of Care Plans provide structure for the agencies to work together. Regularly occurring meetings take place at the state and local levels to focus on policy development, implementation, improving communication, identifying system barriers, and problem solving. Collaborative development activities such as Drug Courts, Mental Health Courts, and Juvenile Detention Alternatives Initiative (JDAI) are examples of some of the work occurring in Arizona.

In our Children's Behavioral Health System, there are representatives from both juvenile corrections and juvenile probation sitting on the Arizona Children's Executive Committee (ACEC). The ACEC brings together multiple state and government agencies, community advocacy organizations, and family members of children/youth with behavioral health needs to collectively ensure behavioral health services are being provided to children and families according to the Arizona Vision and 12 Principles.

While Arizona does not have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions, screening and treatment are provided prior to adjudication and/or sentencing for individuals with mental

health, substance use, or co-occurring disorders. Both the State Department of Corrections and the Counties' Detention Centers provide mental health and substance use disorder (SUD) screening as a part of their intake protocols.

The Regional Behavioral Health Authorities (RBHAs) 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 and SUD treatment needs assessed, addressed, relevant issues communicated, and coordinated with the judiciary and justice personnel. RBHAs maintain co-located staff at both Juvenile and Adult Courts and Detention Centers in order to provide coordination of care between the 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 mental health or 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 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 RBHAs 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, Pima County has established an Intergovernmental Agreement (IGA) to allow coverage for an individual on the day of their release from the detention center. To work on this problem throughout the state, the Arizona Behavioral Health Planning Council composed and distributed letters to each county describing the issue, Pima County's IGA, and the benefits of this agreement. AHCCCS will continue to work with the counties to encourage collaboration to reduce lapses in coverage when members are released from incarceration.

In order to increase capacity of personnel working with members with behavioral health issues involved in the system, RBHAs 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 behavioral health topics as requested by the courts in their coordination meetings. In addition, the JDAI in Arizona has facilitated cross-system training and collaboration, most recently around the issues specific to Trauma-Informed Care (TIC).

Finally, peer and family support is a priority of the state as well as the RBHAs, and currently there are peer workers embedded within SUD treatment facilities, as well as dedicated peer-run organizations to ensure a comprehensive peer support network throughout the state. In addition, many peer support agencies have developed cross-agency collaboration initiatives and collaborate with jails to assist individuals who are released with enrolling in/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 peer support plays in recovery. As a result, providers within the RBHA network will incorporate Peer Support throughout the continuum of care, making it available at all levels and intensity of service.

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

None at this time.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

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) Buprenorphine, 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 system. The Department contracts with Regional Behavioral Health Authorities (RHBAs) to administer behavioral health services. Each RHBA contracts with a network of service providers similar to health plans to deliver a range of behavioral health care services, treatment programs for adults with substance abuse disorders (SUD), adults with serious mental illness (SMI), and children with serious emotional disturbance (SED). Currently, the RHBAs maintain provider directories to ensure all substance abuse treatment program information is located in one area that is accessible to mental and medical providers and the public. Currently there are Community Liaisons/Coordinators employed by RHBAs that go to meetings and various behavioral health events in the community and promote services available under the Substance Abuse Block Grant (SABG). Additionally, there are outreach workers employed by RHBAs that promote services available under SABG in the community in efforts to engage and refer people into services. Currently within the RHBAs there are requirements in place for providers (including outpatient, residential, and Opioid Treatment Programs (OTPs)) that receive SABG funds to have annual outreach strategies that identify what community coalitions they interact with, how often they are working with coalitions, and their outreach goals (i.e. increase use of SABG funded services, treatment for at-risk/underserved populations, and improving community partnership collaborations). RHBAs host community forums to present services available through SABG funding to community stakeholders (including community members, probation, corrections, and a variety of interested state and county agencies).

AHCCCS has recognized the important role medication-assisted treatment (MAT) plays in the treatment of SUD, and has collaborated with Arizona State University's Center for Applied Behavioral Health Policy to host MAT Symposiums across the state. The MAT Symposiums were provided at no-cost to attendees and included attendees from treatment providers, corrections,

probation, 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 RHBAs to maintain a network of MAT providers for their geographic service areas (GSAs). AHCCCS continues to maintain an open dialogue with the RHBAs regarding barriers to expanding MAT services and provides technical assistance to overcome barriers.

Currently, there is list of preferred behavioral health medications that are to be used by all contractors responsible for the administration of behavioral health pharmacy benefits, including but not limited to Long Term Care, Children's Rehabilitative Services, and RBHAs. This drug list is limited to federally and state reimbursable behavioral health medications supported by current evidence-based medicine. The AHCCCS Behavioral Health Drug List encourages the use of safe, effective, clinically appropriate, and cost-effective behavioral health medications. Through AHCCCS funding, certain medications are covered to make them more accessible to the population. The current medications covered are in the form of opioid agonists (Buprenorphine, Buprenorphine/Naloxone, and Methadone) and opioid antagonists (Naloxone and Naltrexone). Funds also cover additional medications to treat alcohol use disorder (AUD) such as; Acamprosate and Disulfiram.

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

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. The team is actively managing the project for success, adhering to weekly work schedules, routinely tracking performance, and reporting progress to the Governor's Office. 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.

Legislative movements such as, the passing of House Bill 2355 has contributed to combatting overdose related deaths in Arizona. House Bill 2355 allows a pharmacist to dispense Naloxone without a prescription to a person at risk of experiencing an opioid related overdose, a family member, or a community member to assist that person. Currently, initiatives implemented throughout the state are focused on Naloxone distribution and accessibility. Providers in these programs are also contracted to have no less than one year experience with harm-reduction based overdose prevention in the community; a history of conducting Naloxone trainings across the medical and community sectors; experience with direct service Naloxone distribution into the community, and the ability to contract directly with pharmaceutical companies for Naloxone kits.

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

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 in regards to the following:

- Number of trainings
- Number of kits distributed
- Number of people reached with trainings and kit distribution

To date, between January 2017 and July 2017 there have been a total of 11,594 kits distributed and over 1,224 reported reversals.

Please indicate areas of technical assistance needed to this section.

None at this time.

**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

16. 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 behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.⁶⁴ 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 behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁶⁵,

"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 behavioral health 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. Please check those that are used in your state:

⁶⁴<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶⁵Practice Guidelines: Core Elements for Responding to Mental Health Crisis. 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 respond to the following items:

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) WRAP Post-Crisis
- b) Peer Support/Peer Bridgers
- c) Follow-up Outreach and Support
- d) Family-to-Family Engagement

- e) Connection to care coordination and follow-up clinical care for individuals in crisis
- f) Follow-up crisis engagement with families and involved community members
- g) Recovery community coaches/peer recovery coaches
- h) Recovery community organization

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

Arizona Health Care Cost Containment System (AHCCCS) integrates crisis services into three Regional Behavioral Health Authority (RBHA) contracts and crisis services, described in the AHCCCS Covered Behavioral Health Services Guide (CBHSG), support a coordinated system of entry into crisis services that are community based, recovery oriented, and member focused. The improvement of collaboration, data collection standards, and communication enhances quality of care, which leads to better health outcomes while containing costs. The RBHAs are to expand their provider networks capability of providing a full array of crisis services geared toward members, with the expectation that this will maintain health and enhance member quality of life. The use of crisis service data for crisis services delivery and coordination of care is critical to the effectiveness of the overall crisis delivery system.

The following are some highlights of what the RBHAs are contractually required to meet for crisis services:

Stabilize members as quickly as possible and assist them in returning to their pre-crisis level of functioning.

Provide solution-focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more segregated setting.

Assess the individual's needs, identify the supports and services necessary to meet those needs, and connect the individual to those services.

Develop and Maintain collaborative relationships with fire, police, emergency medical services, hospital emergency departments, AHCCCS Acute Care Health Plans and other providers of public health, and safety services to provide information about the crisis response system; and

Strategies for crisis service care coordination and strategies to assess and improve the Contractor's crisis response services.

Establish and maintain a twenty-four (24) hours per day, seven (7) days per week, crisis response system.

Establish and maintain a single toll-free crisis telephone number.

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 to make sure the caller has stabilized.

Establish and maintain mobile crisis teams with the following capabilities:

The team must have the ability to travel to the place where the individual is experiencing the crisis.

Crisis services for the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress.

Establish and maintain crisis stabilization settings with the following capabilities:

Offer twenty-four (24) hour substance use disorder/psychiatric crisis stabilization services including twenty-three (23) hour crisis stabilization/observation capacity.

Provide short-term crisis stabilization services (up to seventy-two (72) hours) to resolve the crisis and return the individual to the community instead of transitioning to a more restrictive level of care.

Please indicate areas of technical assistance needed to this section.

Technical Assistance is not being requested at this time.

Footnotes:

AHCCCS COVERED BEHAVIORAL HEALTH SERVICES GUIDE

Revision Date July 2017

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

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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.

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.

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*
- *First Data Bank (i.e., pharmacy information)*
- *Physicians' Current Procedural Terminology (CPT) Manual*
- *Healthcare Procedure Coding System (HCPCS) Manual*

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

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.

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.

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.

AHCCCS has updated the code set (B2 Matrix) to be linked to the new AHCCCS provider type for BCBA 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 | 16 – Outpatient Facility |
| 06 – Physical Therapy | Fees |
| 09 – Pharmacy | 26 – Respite Care Services |
| 10 – Inpatient Hospital | 31 – Non-Emergency |
| 12 – Pathology & | Transportation |
| Laboratory | 39 – Habilitation |
| 13 – Radiology | 47 – Mental Health |
| 14 – Emergency | Services |
| Transportation | |

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).

- 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 BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 406, Community Service Agencies-Title XIX Certification available on line at <http://www.azdhs.gov/bhs/policy/index.php>.

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 COS 47 and COS 26 codes are available to Provider Type 39:

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

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.

Reference tables are provided by AHCCCS to AHCCCS BEHAVIORAL HEALTH SERVICES and the T/RBHAs 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:

(1.) CPT

- Physicians' Current Procedural Terminology (CPT) contains nationally recognized service codes. For more information regarding these codes see the *Physicians' Current Procedural Terminology (CPT) Manual*, which contains a systematic listing and coding of procedures and services, such as surgical, diagnostic or therapeutic procedures.

(2.) HCPCS

Healthcare Procedure Coding System (HCPCS) contains nationally recognized service codes. For more information regarding these codes see the *Healthcare 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/Appendix B2.xls](http://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. Information regarding these pharmacy-related codes can be found in the *First Data Bank*.

(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/AppendixB2.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 | 87 – Licensed Professional Counselor* |
| 03 – Pharmacy | 97 – Air Transport Providers |
| 04 – Laboratory | A3 – Community Service Agency |
| 06 – Emergency Transportation | A4 – Licensed Independent Substance Abuse Counselor* |
| 08 – Physician (Allopathic)* | A5 – Behavioral Health Therapeutic Home |
| 11 – Psychologist* | A6 – Rural Substance Abuse Transitional Agency |
| 12 – Certified Registered Nurse Anesthetist* | B1 – Level I Residential Treatment Center – Secure (IMD) |
| 18 – Physician Assistant* | B2 – Level I Residential Treatment Center – Non-Secure (non-IMD) |
| 19 – Nurse Practitioner* | B3 – Level I Residential Treatment Center – Non-Secure (IMD) |
| 28 – Non-emergency Transportation | B5 – Level I Subacute Facility (non-IMD) |
| 29 – Rural Health Clinics (RHCs) | B6 – Level I Subacute Facility (IMD) |
| 31 – Physician (Osteopathic)* | B7 – Crisis Services Provider |
| 39 – Habilitation Provider | B8 – Behavioral Health Residential Facility |
| 71 – Level I Psychiatric Hospital (IMD) | C2 – Federally Qualified Health Centers (FQHCs) |
| 72 – Tribal Regional Behavioral Health Authority/Regional Behavioral Health Authority (T/RBHA) | IC – Integrated Clinics |
| 73 – Out-of-state, One Time Fee For Service Provider | BC – Board Certified Behavioral Analysts |
| 77 – Behavioral Health Outpatient Clinic | |
| 78 – Level I Residential Treatment Center – Secure (non-IMD) | |
| 85 – Licensed Clinical Social Worker* | |
| 86 – Licensed Marriage/Family Therapist* | |

* These individuals are referred to as “Independent Billers.”

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 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

* 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

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-9-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-9 diagnosis code describing the person's condition, there are a number of very general ICD-9 codes that can be used for those cases in which no specific diagnosis has been established at the time of the service.

If a code of 799.9 is assigned under the DSM-IV criteria and is not changed to a more specific diagnostic or descriptive “V” code before a claim is submitted to AHCCCS BEHAVIORAL HEALTH SERVICES, the AHCCCS PMMIS data system reads it as if it were an ICD-9-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 is 799.9.

Providers are strongly encouraged to limit the use of 799.9 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 “V” code (e.g., V61.20, counseling for parent-child problem, unspecified; V61.21, 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-9 mental health or substance abuse diagnosis (see Appendix B-3: Encounter/Claims Principle Behavioral Health ICD-9 Diagnostic Codes). Although a patient may have other diagnosis codes (e.g., a “V” code or other ICD-9 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-9 diagnostic codes 648.33 and 648.43 as principle diagnoses for complications of pregnancy while an individual is receiving inpatient psychiatric services.

Although ICD-9 and DSM-IV diagnosis codes are substantially alike, DSM-IV codes must not be used. Areas of differences include:

- Two ICD-9 codes (i.e., 312.8 and V61.) require a 5th digit. See ICD-9-CM manual to determine appropriate 5th digit.

ICD-9 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 code within the coding category.
- Use a four-digit code only if there is no fifth digit subclassification for that category.
- Use a five-digit code for those categories where the fifth digit subclassification exists.

ICD-9 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 only bill for their time spent in providing the actual service. For all services, the provider may not 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 face-to-face direct contact; however, when providing assessment or case management services, the provider may also bill indirect contact. 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 may not 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 may not 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 (H2011) on the same day of admission to Inpatient Hospital (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 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.

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>.

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.

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.

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)
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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

- **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:

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, Rorschach 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, Rorschach 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, Rorschach, 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.

- 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.

- 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

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

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.

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

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.

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-Acupuncture, 1 or 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)**

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)

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

- **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.

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.

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

- **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.

Billing Unit: 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.

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, techniques and materials which meet the individual's needs and are appropriate for the person's age and mental and physical status. While the goal may be for persons to achieve full time employment in a competitive, integrated work environment, there may be persons for whom this goal is not applicable. 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. Some individuals may desire to focus on socialization goals, which should also be addressed in rehabilitation services, 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:

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

For Community Service Agencies, please see AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 406, Community Service Agencies-Title XIX Certification AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 406, Community Service Agencies-Title XIX Certification 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 BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 406, Community Service Agencies-Title XIX Certification 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 BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 406. Community Service Agencies-Title XIX Certification 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.

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)

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

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

care physician (PCP) may prescribe psychotropic medications (For the treatment of mild 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.

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.

- 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,

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

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

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

- 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

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-

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.

- 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

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

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

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

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

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.

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

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)

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.

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

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

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.

- 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

- **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.

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.

II. D. 2. Personal Care Services

General Information

General Definition

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.

Service Standards/Provider Qualifications

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 9 A.A.C. 10.

Code Specific Information

HCPCS Codes

- **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).

Billing Unit: 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.

Billing Unit: 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)..

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

General Information

General Definition

Home care training family services (family support) involve face-to-face interaction 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

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.

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 certified 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

- **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.

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.

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

Code Specific Information

HCPCS Codes

- **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**

Billing Unit: 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.

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.

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

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

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.

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.

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).

II. D. 10. Transportation

General Information

General Definition

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.

Service Standards/Provider Qualifications

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 (A.R.S. 36-2233).

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.

Record Keeping for Non-Emergency Transportation Providers

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**
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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.

- **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**
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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

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.

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.

- 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.

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.

Code Specific Information

HCPCS Codes

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

Billing Unit: 15 minutes

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

Billing Unit: 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.

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.

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.

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.

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

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

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

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

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

(RTC) may both bill revenue code 0114, the fee-for-service rate will be different depending on the provider type billing the service.

HCPCS Codes

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.

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

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

- 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

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.

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

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

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.

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.

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

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.

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.

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.

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.

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

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.

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).

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.

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.

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: his 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>

A-4 Case Management

<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA4.pdf>

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. Encounter/Claims Principle Behavioral Health ICD-9 Diagnostic Codes (COVER SERVICES PRIOR TO 09/30/2015)

<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB3.pdf>

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>

B-5. Billing Limitations Matrix

<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB5.pdf>

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health 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 behavioral health 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, 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. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|---|--|--|
| • Clubhouses | Peer-run respite services | Whole Health Action Management (WHAM) |
| • Drop-in centers | • Peer-run crisis diversion services | • Shared decision making |
| • Recovery community centers | • Telephone recovery checkups | • Person-centered planning |
| • Peer specialist | • Warm lines | • Self-care and wellness approaches |
| • Peer recovery coaching | • Self-directed care | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching | • Supportive housing models | • Room and board when receiving treatment |
| • Peer health navigators | • Evidenced-based supported employment | |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) | |
| • Peer-delivered motivational interviewing | | |

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,

i. The AHCCCS Office of Individual and Family Affairs (OIFA) hosts a monthly meeting with an Advisory Council. This Advisory Council is composed almost exclusively of peers (MH and SUD) and family members of adults and/or children receiving services. Many of these members are actively working within the state's Behavioral Health System, while others are current or former utilizers of behavioral health services.

ii. OIFA is facilitating and coordinating a workgroup of the Advisory Council. This workgroup is focusing on targeted outcomes to demonstrate the efficacy of peer and family run organizations. Sub-workgroups are focusing on:

- 1. Employment
- 2. Housing
- 3. Education
- 4. Health Promotion/Disease Prevention
- 5. Criminal Justice
- 6. Family Stabilization
- 7. Hospitalization
- 8. Connectedness
- 9. Social Determinants of Health, and
- 10. Crisis Utilization

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.

For adults with SMI, recovery, and recovery support services are available in a variety of settings. Peer/Recovery support services are available in stand-alone Peer-Run Organizations and traditional mental health clinics. These are services provided in 1:1 or in group interactions. AHCCCS has recently approved for 1:1 Peer Support services delivered via telephone for use in more remote/rural areas.

For children with SED, there are up-and-coming peer support programs provided by credentialed peer supports working in Family-Run Organizations. A multi-disciplinary workgroup dedicated to developing a program for "Foster Youth Peer Support" is meeting to create a vision that would mentor foster youth past their time into the system and serve as a conduit to achieve full independence.

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

Members with substance use disorders (SUDs) have access to the same recovery support services as members with SMI/SED. The only difference being the location at which they receive them. Some agencies specialize more in the field of SUD treatment, and members needing support for SUDs will seek out support services in those settings.

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

For the past several years, the State of Arizona has partnered with Arizona State University to operate the Peer and Family Career Advancement Academy. This academy is a "grad-school" for credentialed peer supports to further their education into other areas of health services.

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

No technical assistance is requested at this time.

Footnotes:

Environmental Factors and Plan

18. 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 behavioral health 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 behavioral health 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.

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 20 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 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. 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 Active Assertive Community Treatment (ACT) case management teams in Maricopa County, and initiated the development of teams statewide that are monitored for adherence to SAMHSA fidelity standards.
- Distribution, management, and monitoring of the Serious Mental Illness (SMI) Housing (state funded) Trust Fund to support acquisition and renovation of new housing stock for members determined to have SMI.
- Provide state-funded housing and utility subsidies for members determined to have an SMI in concert with the provision of Medicaid funded housing supportive services following Permanent Supportive Housing standards to support members to live in their own home.

- Developed a system that monitors fidelity to the SAMHSA Consumer Operated Services evidenced-based practice.
- Established a peer training credentialing process that creates a workforce of individuals with lived experience to address the needs of the behavioral health community. To date over 2,000 individuals have credentials as peer support specialists and 1,100 of those individuals are currently working in the publically funded behavioral health system. Arizona has also contracted with Arizona State University to advance the Peer and Family Career Academy that offers a professional development path to those with lived experience working in Arizona’s publicly funded behavioral health system.
- Trained the behavioral health workforce (MCOs, providers, peer support specialists, etc.) on work incentives (both Social Security and Medicaid) and the Arizona Disability Benefits 101 website (www.az.db101.org) to demonstrate how work and benefits go together for individuals starting to or returning to work.

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

In 2014 – 2015, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) established the Olmstead Policy Academy to provide a number of technical assistance and learning opportunities to help inform a collaborative process by all the relevant state agencies and stakeholders to update the state’s Olmstead Plan. The process resulted in a joint draft Olmstead Plan for ADHS/DBHS, Arizona Health Care Cost Containment System (AHCCCS), and the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD). Each state agency (ADHS/DBHS, AHCCCS, and DES/DDD) underwent a plan development and review process with both internal and external stakeholders. Each agency has a member advisory board engaged in providing input on the agency specific action plans.

In 2016, the final draft continued to undergo a review by each of the state agency partners. On July 1, 2016, the ADHS/DBHS merged with AHCCCS in an effort to streamline monitoring and oversight of the Regional Behavioral Health Authorities (RBHAs) throughout Arizona. Prior to finalizing the current draft of the Olmstead Plan, the Plan must reflect changes as a result of the aforementioned state agency merger. It is projected the final draft will be completed in 2017. Once a final draft is completed, each state agency will initiate their respective public input processes to garner input from the public and inform the final revisions to the plan.

Subsequent to the approval of the final and updated plan, each state agency agreed to participate in quarterly Olmstead Policy Academy meetings. The primary purpose of the meetings will be to inform one another of progress made on the agency specific action plans, identify strategies to address any implementation barriers and discuss strategies for collaboration. In addition to the Olmstead Policy Academy meetings, each state agency has developed, at a minimum, annual review processes to monitor and receive input on the plan implementation from both internal and external stakeholders.

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

The state does not require any technical assistance on the Olmstead Plan at this time, but rather is working toward allocating internal personnel resources to ensure the state agency partners are meeting on a quarterly basis, the Plan is updated (at a minimum) on an annual basis and appropriate measures are in place to solicit, monitor and receive public input on the Plan from external stakeholders.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health 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 community⁶⁶. 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 24⁶⁷. 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 death⁶⁸.

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 21⁶⁹. 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 costs⁷⁰.

According to data from the 2015 Report to Congress⁷¹ 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 behavioral health 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).

⁶⁶Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁷Kessler, 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.

⁶⁸Centers 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.

⁶⁹The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁷⁰Department 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 <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>

⁷¹http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? Yes No
 - The recovery and resilience of children and youth with SUD? Yes No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
 - Child welfare? Yes No
 - Juvenile justice? Yes No
 - Education? Yes No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? Yes No
 - Costs? Yes No
 - Outcomes for children and youth services? Yes No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - Mental health treatment and recovery services for children/adolescents and their families? Yes No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult behavioral health system? Yes No
 - 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.)

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

Developed in 2001, Arizona's Olmstead Plan provided a comprehensive approach to demonstrating the State of Arizona's historical emphasis on principles found in the Olmstead Decision and its desire to continue to ensure persons who are elderly and persons with disabilities have appropriate access and choice regarding community-based services and placements.

Although the Supreme Court did not require states to develop a plan, Arizona believed this was an opportunity for advocates, agencies, members, and community stakeholders to collaborate on a plan that would guide the State toward improving access to

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

In January 2014, the ADHS/DBHS initiated a plan calling for an increase of services in four areas: Assertive Community Treatment (ACT), Supported Employment, Supportive Housing, Peer, and Family Services. The initiative also provides for the use of several tools to evaluate services provided in Maricopa County, including a quality service review (QSR), network capacity analysis, and SAMHSA fidelity tools. The strengthening of ACT in Arizona, along with the well-established Child and Family Team (CFT) practice, has been important to improving outcomes for children and adults when they transition from hospitals to community based care.

In the Children's System, this expansion is supported by the collaborative efforts of the Arizona Children's Executive Committee (ACEC). The ACEC brings together multiple state and government agencies, community advocacy organizations, and family members of children/youth with behavioral health needs to collectively ensure behavioral health services are being provided to children and families according to the Arizona Vision and 12 Principles. The Arizona Vision describes a System of Care in which all our state agencies work collaboratively to insure four key functional outcomes:

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

The 12 Principles further outline our System of Care Values and closely align with the 13 System of Care Principles described by Dr. Bob Friedman and Shelia Pires in the SAMSHA sponsored "System of Care" approach. The collaboration exemplified by the ACEC drives our System of Care to view a family holistically, working from a family systems approach, which does not identify the child as a "presenting problem," but utilizes the family strengths and culture to develop a plan which may include specific services for the parents (i.e. parenting and life skills training), in addition to services for the child. In an upcoming initiative, AHCCCS will be collaborating with the Child Welfare system to identify children at risk of removal from their homes and provide such services to the parent in order to support them and, potentially, prevent removal.

AHCCCS has built a statewide system of care utilizing an individualized, family centered, youth-guided, community-based, and culturally competent approach to meet the needs of children and families. Policies, practice protocols, a covered services guide, and contract language provide guidance and direction to those working with children and families. Besides the Arizona Vision and 12 Principles, statewide policies regarding the Children's System of Care include the AHCCCS Covered Behavioral Health Services Guide (CBHSG), which includes one of the widest arrays of services and supports available to Title XIX and XXI members in the country. As mentioned earlier, the CBHSG includes a wide array of supports and services for the entire family in order to help maintain the child in the family. The Child and Family Team (CFT) Clinical Guidance Tool 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. The High Needs Case Management Initiative provides funding specifically for cadres of case managers with reduced caseloads (1 to 20) in order to work with the most complex child and family needs; the Meet Me Where I Am Campaign (MMWIA) provides specific funding and direction for development and provision of generalist direct support programming (available 24 hours per day, 7 days per week), and helps to maintain the most complex, high needs youth in their homes and communities, and out of residential placements. AHCCCS monitors the statewide policies and activities originally developed by ADHS/DBHS, and they are written into the Regional Behavioral Health Authorities (RBHAs) contracts.

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

System of care monitoring happens in multiple ways, including Children's System of Care Plans developed annually to incorporate current goals and initiatives, and reported by the RBHAs on a quarterly basis. Additionally, for the past nine years Arizona has utilized the System of Care Practice Review (SOCPR) Tool, developed by University of South Florida, to measure CFT practice fidelity to system of care values and principles. Each year approximately 200 children with complex needs, as well as over 800 telephonic Brief Practice Reviews (BPR) for children with standard 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.

Arizona monitors and tracks service utilization, costs, and outcomes for children and youth with mental, substance use, and co-occurring disorders through the encounter system. Specific service codes are monitored in order to understand what services are being provided. For example, the use of generalist direct supports is of particular interest because of the state's investment in the MMWIA initiative. When the initiative rolled out, there was a requirement for providers to use a special modifier to their

encounters so they could track increases in service utilization. This monitoring continues to be required at the RBHA level, and overseen by AHCCCS in order to monitor service availability and prioritize services to families most in need.

Annually updated collaborative protocols are in place with most child and youth serving agencies in Arizona. These protocols describe mutual support for the system of care vision and values, as well as support for provision of services through the CFT process. In addition, collaborative protocols define how the behavioral health system and its partners will work together, communicate, and problem-solve. These protocols are developed at the local level so the RBHA and the system partners in their respective geographic service area (GSA) shape the protocol to meet the specific needs of the service area. Collaborative protocols are contract requirements monitored at the state and local level via regular and ongoing meetings of providers and stakeholders.

Co-located and agency-specific liaison roles further enhance collaboration in the provision of children's services. RBHAs and their providers maintain co-located positions at juvenile courts and Department of Child Safety (DCS) offices. Liaison positions are maintained at parole offices and juvenile courts to establish single points of contact for system partners to navigate the behavioral health system and resolve case-specific concerns. Although there is no official designee to the Arizona Department of Education (ADE) from AHCCCS, the two agencies and other state agencies participate, in two statewide groups that have the goal of enhancing collaboration between the entities. The Arizona Community of Practice on Transition (AzCoPT) and the Positive Behavioral Interventions and Supports Advisory Committee (PBIS-AZ) both work to identify school-aged children and youth with mental health/substance abuse needs, and provide them with appropriate services.

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

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

Transitional Aged Youth (TAY):

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 Clinical Guidance Tool "Transition to Adulthood" (see attached). This document provides instruction to provider agencies regarding the State's expectations with respect to the transition process and it includes detailed guidance for the transition of youth in foster care. In addition, AHCCCS provides guidance for working with foster youth in the Clinical Guidance Tool "The Unique Behavioral Health Service Needs of Children, Youth, and Families involved with the Department of Child Safety (DCS)" (see attached).

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

None at this time.

Footnotes:



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 unless 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

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.

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.

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.),

- 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.

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.

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.azed.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>



**UNIQUE BEHAVIORAL HEALTH
SERVICES FOR NEEDS OF CHILDREN,
YOUTH AND FAMILIES INVOLVED WITH
DEPARTMENT OF CHILD SAFETY
PRACTICE TOOL**

Effective Date: 10/01/16



**UNIQUE BEHAVIORAL HEALTH SERVICE NEEDS OF CHILDREN,
YOUTH AND FAMILIES INVOLVED WITH DCS PRACTICE TOOL****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

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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,

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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. Addressing Needs in the Context of Each Child's Family

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. When the Child Remains with His/Her Own Family

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.

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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. When the Child Is Removed to Out-Of-Home Placement

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

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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

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- 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. When the Child Returns to His/Her Family of Origin from Out-of-Home Placement

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

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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. When the Child Achieves Permanency through Adoption or Guardianship

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.

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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),

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- 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,

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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

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- e. Coordinated planning between behavioral health and Department of Child Safety to ensure seamless transitions for children involved with DCS

Bibliography

^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 und 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 Michael Lahti, *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

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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 Foster 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 1/4 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

20. Suicide Prevention - Required 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 behavioral health 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 through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health 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.

We have identified six priority populations to work with to reduce Arizona's rate of suicide:

- veterans,
- those age 65 and older,
- American Indians,
- medical examiners,
- first responders, and
- gun vendors.

We selected veterans; those age 65 and older, and American Indians because they are disproportionately represented in the 1400 deaths by suicide in Arizona in 2016. Our outreach to these groups includes working closely with the state's VA hospitals, veteran service organizations, and being a key partner in the state's Be Connected Program, created by Senator John McCain's Clay Hunt legislation. We also work closely with the state's 22 tribal populations to provide resources and support. We coordinate a quarterly Four Corners phone call of suicide prevention efforts in the four states, including tribal entities, community, and government employees. We also collaborate with the state's Area Agency on Aging to address suicide among elders.

We selected medical examiners because in Arizona, death certificates start at the county medical examiner office. We have 15 counties in the state, and the resources and populations vary significantly by geography. We are working to standardize language on death certificates to improve data quality.

We work with first responder organizations state-wide because this profession is the first on scene to address a suicide, or suicide attempt. Additionally, first responders have a high rate of suicide themselves. One of our goals in 2018 is to develop further the LOSS program alongside first responders to provide better care to family members. More information on LOSS can be found at: https://afsp.org/support_group/loss-loving-outreach-to-survivors-of-suicide/

We also would like to work with gun vendors in Arizona to encourage suicide prevention materials be provided at the point of sale. Research shows when suicide prevention materials are given at the time of purchasing a gun, the firearm is less likely to be used in a suicide.

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 2016-FFY 2017 plan was submitted? Yes No

If so, please describe the population targeted.

We have begun several statewide initiatives regarding suicide prevention since the last fiscal year. Please see the aforementioned details (in the answer to question #2) regarding Be Connected, Four Corners calls, and medical examiner work.

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

None at this time.

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

None at this time.

Footnotes:

An End to Suicide in Arizona

2017 State Plan

EXECUTIVE SUMMARY

According to officials at the World Health Organization (WHO), more than 800,000 people die by suicide annually; many more make an attempt. Suicide was the second leading cause of death among 15-29 year olds globally in 2012. It is a global phenomenon in all regions of the world and accounted for 1.4% of all deaths worldwide, making it the 15th leading cause of death in 2012.

In Arizona, the latest data shows some 1320 Arizonans died by suicide in 2015.

From 2009-2013, Arizona had more than 5,500 suicides, 2,000 homicides, and another almost 900 undetermined deaths. Many of those undetermined deaths were ruled unintentional poisonings; 750 Arizonans died by taking too much of one medication in 2012.

Suicide is not just a behavioral health concern. Suicide may be linked to depression and other mental 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, at 8.7%. Also of grave concern are suicides among our increasing populations of retirees and veterans. The 2015 state plan is a guideline for activities to prevent suicide in Arizona. This plan has been created with guidance and using the framework from the Substance Abuse and Mental Health Administration (SAMHSA) and the National Action Alliance’s plan for Zero Suicide. Special thanks to the authors of the Texas State Plan for Suicide Prevention 2014. Its comprehensive plan served as the framework to create a similar strategy for Arizona.

HISTORY

The 2017 *End to Suicide in Arizona State Plan* follows the changes incorporated in the recommendations from the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, a joint report from the U.S. Surgeon General and the National Action Alliance for Suicide Prevention: http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

Also of note, on July 1, 2016, all behavioral health services in the state of Arizona were transferred from the Arizona Department of Health Services (ADHS) to the Arizona Health Care Cost Containment System (the state Medicaid agency.) Suicide prevention is now managed by AHCCCS staff in partnership with Arizona Department of Health Services (ADHS.)

2017 STATE PLAN

The *2017 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.

The 2015 Arizona State Plan was based on the same model; the 2017 goals and objectives have been modified slightly to meet more current issues, as decided by suicide data. ADHS leadership conducted extensive community outreach for the 2015 plan; this plan is an extension of that work, along with additional conversations with stakeholders.

Also, AHCCCS is outreaching recipients of funding provided by the Garrett Lee Smith Memorial Act for suicide prevention. This federal funding to campuses can fund education and outreach activities related to mental health and substance abuse prevention, while funding to states and tribes can develop and implement youth suicide prevention and early intervention strategies. This federal suicide funding can be used toward government, university, and tribal projects. Previous recipients include:

- Arizona Department of Health Services
- Arizona State University
- Gila River Health Care Corporation
- Havasupai Tribal Government Office
- Native Americans for Community Action, Inc.
- Navajo Nation Dept. of Behavioral Health Services
- Tohono O'odham Nation
- University of Arizona
- White Mountain Apache/Johns Hopkins University

The following Arizona grantees have active funding:

- The White Mountain Apache/Johns Hopkins collaborative:
http://www.sprc.org/grantees/listing?title=&field_grant_type_value_many_to_one=All&field_program_status_value_many_to_one=All&province=Arizona
- Native Americans for Community Action, Inc.,: <http://www.sprc.org/grantees/native-americans-community-action-inc-5>

AHCCCS will also assess other community resources for partnership, especially in rural communities. When appropriate, faith organizations and libraries may be excellent partners to disseminate suicide prevention education materials and hold trainings.

This plan was submitted to the Arizona Coalition for Suicide Prevention and other community partners for 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 2017 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 to zero through coordinated prevention activities
2. Develop broad-base support for the Zero Suicide model
3. Reduce stigma related to suicide
4. Promote responsible media reporting of suicide
5. Promote efforts to reduce access to lethal means of suicide among those with identified suicide risk
6. Provide training to schools, community, clinical, and behavioral health service providers on the prevention of suicide and related behaviors
7. Promote suicide prevention as a core component of health care services
8. Promote suicide prevention best practices among Arizona's largest health care providers for patients and staff
9. Provide care and support to individuals affected by suicide deaths or suicide attempts and implement community best practice-based post-vention strategies to help prevent further suicides
10. 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
11. Improve timeliness of data collection and analysis regarding suicide deaths
12. Evaluate the impact and effectiveness of suicide prevention interventions and systems, and synthesize and disseminate findings
13. Coordinate statewide calendar of suicide prevention activities, fostering a collaborative community of support

GOAL 1. Reduce the number of suicides in Arizona to zero through coordinated prevention activities

OBJECTIVE 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.

STRATEGY 1.1.1: Implement programs and policies to build social connectedness and promote positive mental and emotional health.

STRATEGY 1.1.2: Implement organizational changes to promote mental and emotional health in the workforce.

STRATEGY 1.1.3: Increase the number of local, state, tribal, professional, and faith-based groups that integrate suicide prevention activities into their programs.

OBJECTIVE 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state, county, tribal, and local levels.

STRATEGY 1.2.1: AHCCCS, in collaboration with the Arizona Coalition for Suicide Prevention, will coordinate and convene public and private stakeholders, assess needs and resources, and update and implement a comprehensive strategic state suicide prevention plan annually.

STRATEGY 1.2.2: Through the support AHCCCS, in collaboration with the Arizona Coalition for Suicide Prevention, county health departments and representatives from each RBHA will participate in local coalitions of stakeholders to promote and implement comprehensive suicide prevention efforts at the community level.

OBJECTIVE 1.3: Sustain and strengthen collaborations across agencies and organizations to advance suicide prevention.

STRATEGY 1.3.1: Strengthen partnerships with agencies that serve individuals at higher risk of suicide, such as military, veterans, substance abuse, foster care, juvenile justice, youth, elderly, American Indian, middle-aged white males, mental health consumers, suicide attempt survivors, those bereaved by suicide, GLBTQ2S (gay/lesbian/bisexual/transgender/questioning/two-spirited people), and other higher risk groups.

STRATEGY 1.3.2: Educate local, state, professional, volunteer and faith-based organizations about the importance of integrating suicide prevention activities into their programs, and distribute specific suggestions and examples of integration.

STRATEGY 1.3.3: Collaborate with ADHS' injury and violence prevention committee

OBJECTIVE 1.4: Integrate Zero Suicide into all relevant health care policy efforts.

STRATEGY 1.4.1: Encourage businesses and employers to ensure that mental health services are included as a benefit in health plans and encourage employees to use these services as needed.

AHCCCS 2017 Actions: AHCCCS will organize regional meetings of suicide prevention stakeholders to discuss the Zero Suicide model and successful prevention activities. This will include coordination of Zero Suicide prevention plans by the regional behavioral health authorities, veteran groups, 22 American Indian tribes in Arizona, state universities, hospital systems, faith organizations, and major employers. AHCCCS will work with each of these entities to create and manage such plans.

GOAL 2. Develop broad-base support for the Zero Suicide model.

OBJECTIVE 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.

STRATEGY 2.1.1: Develop and implement an effective communications strategy for defined higher risk audiences and school personnel promoting suicide prevention, mental health, and emotional well-being, incorporating traditional and new media.

OBJECTIVE 2.2: Reach policymakers with dedicated communication efforts.

STRATEGY 2.2.1: Increase policymakers' understanding of suicide, its impact on constituents and stakeholders, and effective suicide prevention efforts.

OBJECTIVE 2.3: Increase communication efforts in mass and social media that promote positive messages and support safe crisis intervention strategies.

STRATEGY 2.3.1: Incorporate emerging technologies in suicide prevention programs and communication strategies, using best practices guidelines, and link to Teen LifeLine.

STRATEGY 2.3.2: Incorporate positive messages and safe crisis intervention information in suicide prevention communication programs.

OBJECTIVE 2.4: Increase knowledge of risk factors and warning signs for suicide and how to connect individuals in crisis with assistance and care.

STRATEGY 2.4.1: Increase public awareness of the role of the national and local crisis lines in providing services and support to individuals in crisis.

STRATEGY 2.4.2: Increase the use of new and emerging technologies such as tele-health, chat, text services, websites, mobile applications, AHCCCS social media, and online support groups for suicide prevention communications.

AHCCCS 2017 Actions: AHCCCS will report on state Zero Suicide prevention efforts using the AHCCCS website and will report activities from partners statewide.

GOAL 3. Reduce stigma related to suicide

OBJECTIVE 3.1: Promote effective programs and practices that increase protection from suicide risk. STRATEGY 3.1.1: Provide opportunities for social participation and inclusion for those who may be isolated or at risk.

STRATEGY 3.1.2: Implement programs and policies to prevent abuse, bullying, violence, and social marginalization or exclusion.

STRATEGY 3.1.3: Encourage individuals and families to build strong, positive relationships with family and friends.

STRATEGY 3.1.4: Encourage individuals and families to become involved in their community's volunteer efforts (e.g. mentor or tutor youth, join a faith or spiritual community, reach out to older adults in the community.)

OBJECTIVE 3.2: Reduce prejudice, discrimination or stigma associated with suicidal behaviors, and mental health and substance use disorders.

STRATEGY 3.2.1: Promote mental health, increase understanding of mental and substance abuse disorders and eliminate barriers to accessing help through broad communications, public education, and public policy efforts.

STRATEGY 3.2.2: Increase funding and access to mental health services in an effort to reduce suicide attempts, hospitalizations, or incarcerations due to mental health related behaviors.

OBJECTIVE 3.3: Promote the understanding that recovery from mental health illness and substance use disorders is possible for all.

STRATEGY 3.3.1: Communicate messages of resilience, hope, and recovery to communities, patients, clients, and their families with mental health and substance use disorders.

<http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/>

AHCCCS 2017 Actions: AHCCCS will coordinate suicide stigma reduction activities during the month of September—suicide prevention month. AHCCCS will also reach out to media to discuss suicide in our community and share effective prevention mechanisms. AHCCCS staff will be counseled in using the word “suicide” in lieu of softer language.

AHCCCS will also work with the Spanish-speaking population for the creation of Spanish support groups for survivors and loss survivors.

GOAL 4. Promote responsible media reporting of suicide

OBJECTIVE 4.1: 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.

STRATEGY 4.1.1: Disseminate *Recommendations for Reporting on Suicide* to news and online organizations. <http://reportingonsuicide.org>

STRATEGY 4.1.2: Encourage communication and feedback to news and online organizations in response to stories related to suicide, noting when they are appropriate and/or inappropriate, utilizing a variety of communications such as letters to the editor, op-eds, articles, online article comments, personal contacts, and phone calls.

STRATEGY 4.1.3: Develop a sample response template for recommendations to media and a procedure for dissemination of the recommendations.

STRATEGY 4.1.4: Recognize selected members of the news media industry who follow safe messaging guidelines at suicide prevention symposiums and regional meetings/summits.

OBJECTIVE 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the appropriate representation of suicide and other related behaviors. STRATEGY 4.2.1: Develop a sample response template for recommendations to the entertainment industry and a procedure for dissemination of the recommendations.

OBJECTIVE 4.3: Promote and disseminate national guidelines on the safety of online content for new and emerging communication technologies and applications.

STRATEGY 4.3.1: Encourage statewide groups, local coalitions, and gatekeepers to monitor and respond to the safety of online content and encourage the use of national guidelines on safe messaging and suicide prevention.

OBJECTIVE 4.4: Disseminate national guidelines for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.

STRATEGY 4.4.1: Develop a distribution list of journalism and mass communications schools in Arizona and disseminate the national guidelines.

AHCCCS 2017 actions: AHCCCS will work with and look for opportunities to discuss suicide prevention efforts with local and national media.

GOAL 5. Promote efforts to reduce access to lethal means of suicide among those with identified suicide risk

OBJECTIVE 5.1: Encourage providers who interact with individuals and groups at risk for suicide to routinely assess for access to lethal means.

STRATEGY 5.1.1: Sponsor trainings and disseminate information on means restriction to mental health and healthcare providers, professional associations, patients, and their families.

STRATEGY : 5.1.2: Incorporate lethal means counseling into suicide risk assessment protocols and address means restriction in safety plans.

STRATEGY 5.1.3: Sponsor medication take-back days and ongoing methods for the disposal of unwanted medications (e.g. secure collection kiosks at police departments or pharmacies).

STRATEGY 5.1.4: Encourage individuals and families to dispose of unused medications, particularly those that are toxic or abuse-prone, and take additional measures (e.g. medication lock box) if a member of the household is at high risk for suicide.

STRATEGY 5.1.5: Educate clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, healthcare providers, and others about the importance of promoting efforts to reduce access to lethal means among individuals at risk for suicide.

STRATEGY 5.1.6: Encourage all individuals and families to store household firearms locked and unloaded with ammunition locked separately.

STRATEGY 5.1.7: For households with a member at high risk for suicide, take additional measures such as recommendations in the Means Matter website

hsph.harvard.edu/means-matter/

OBJECTIVE 5.2: 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.

STRATEGY 5.2.1: Develop a list of potential firearm suicide safe advocacy groups in Arizona, such as gun retailers, shooting clubs and ranges, manufacturers, firearm retail insurers, concealed handgun instructors, law enforcement, farm and ranch associations, and veterans groups.

STRATEGY 5.2 .2: Initiate partnerships with firearm advocacy groups (e.g. retailers, shooting clubs, manufacturers, firearm retail insurers, concealed handgun instructors, law enforcement, farm and ranch associations and veterans groups) to increase suicide prevention awareness.

STRATEGY 5.2.3: Develop and implement pilot community projects to promote gun safety and suicide safe homes, incorporating the National Action Alliance's Zero Suicide recommendations.

<http://zerosuicide.actionallianceforsuicideprevention.org>

OBJECTIVE 5.3: Encourage the implementation of safety technologies to reduce access to lethal means.

STRATEGY 5.3.1: Promote safety technologies to reduce access to lethal means (e.g. reducing carbon monoxide, restricting medication pack sizes, pill dispensing lockboxes, barriers to bridges.)

AHCCCS 2017 Actions: AHCCCS will work with community partners to advertise medication take-back days and the dangers of prescription medications left unattended. Additionally, AHCCCS supports community partners working with firearm vendors and advocacy groups to provide suicide prevention materials and education.

GOAL 6. Provide training to schools, community, clinical, and behavioral health service providers on the prevention of suicide and related behaviors

OBJECTIVE 6.1: Provide training to community groups in the prevention of suicide and related behaviors.

STRATEGY 6.1.1: AHCCCS will promote the use of best practice programs and the Zero Suicide model.

STRATEGY 6.1.2: AHCCCS will support the Arizona Coalition for Suicide Prevention and Teen Lifeline on their work with schools in Arizona concerning suicide prevention, including helping to provide technical assistance to interested school districts in the creation of suicide prevention plans. store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669

OBJECTIVE 6.2: 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.

STRATEGY 6.2.1: Increase the capacity of health care providers to deliver suicide prevention services in a linguistically and culturally appropriate way.

STRATEGY 6.2.2: Increase the capacity of healthcare providers to deliver routine suicide prevention screening and services using best practice guidelines.

OBJECTIVE 6.3: 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. STRATEGY 6.3.1: Integrate core suicide prevention competencies into relevant curricula and continuing education programs (e.g. nursing, medicine, allied health, pharmacy, social work, education, counseling, therapists.)

OBJECTIVE 6.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

STRATEGY 6.4.1: Review current core requirements for credentialing and accreditation bodies and make recommendations regarding suicide prevention and intervention guidelines to their curricula. **OBJECTIVE 6.5:** 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.

STRATEGY 6.5.1: Add suicide risk-specific protocols to programs and policies for mental health clinicians, supervisors, first responders, and their support staff.

STRATEGY 6.5.2: Enhance effective communication and coordination among mental health clinicians, supervisors, first responders, their support staff, and others on responding to clients at imminent risk.

AHCCCS 2017 Actions: AHCCCS will provide support to behavioral health providers concerning recognizing suicide behaviors in members and how to prevent suicide. AHCCCS will encourage behavioral health providers and integrated health providers to ask specific questions about depression and suicidal thoughts. AHCCCS and community partners will also ask behavioral health providers to ask their members who are veterans, to better coordinate services with veteran service organizations (including the VA.)

GOAL 7. Promote suicide prevention as a core component of health care services

OBJECTIVE 7.1: Promote the adoption of Zero Suicide as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

STRATEGY 7.1.1: AHCCCS will develop a pilot program and Zero Suicide Toolkit on how to implement suicide safe care centers in communities.

STRATEGY 7.1.2: Promote zerosuicide.com website in publications and communications about treatment and support services.

STRATEGY 7.1.3: Educate providers of health care and community support systems about adopting zero suicide as an aspirational goal, and promote the organizational readiness survey of the National Action Alliance for Suicide Prevention.

OBJECTIVE 7.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.

OBJECTIVE 7.3: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

STRATEGY 7.3.1: Advocate for funding for prevention and postvention for clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

OBJECTIVE 7.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.

STRATEGY 7.4.1: Promote the use of safety planning and other best practices for emergency department care as highlighted in the Suicide Prevention Resource Center's Best Practices Registry sprc.org/bpr

OBJECTIVE 7.5: Encourage healthcare delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

OBJECTIVE 7.6: Establish linkages among providers of primary care, mental health and substance abuse services and community-based programs, including peer support programs.

STRATEGY 7.6.1: AHCCCS and the Arizona Coalition for Suicide Prevention will promote suicide prevention regional summits to enhance linkages among providers of primary care, mental health and substance abuse services and community-based programs, including peer support programs.

OBJECTIVE 7.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.

OBJECTIVE 7.8: Develop collaborations between emergency departments and other health care providers to provide safe alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up and ongoing care after discharge.

STRATEGY 7.8.1: Promote rapid enhanced programs for immediate care after discharge, such as caring letters, postcards, texts, and letters.

AHCCCS 2017 Actions: AHCCCS will work with healthcare entities statewide to provide training for staff concerning suicide prevention among patients and staff. AHCCCS will also help to develop suicide prevention materials for healthcare settings and materials for loss survivors upon a suicide death. AHCCCS will encourage healthcare providers to have policies on the discharge of suicidal patients.

GOAL 8. Promote suicide prevention best practices among Arizona's largest health care providers for patients and staff

OBJECTIVE 8.1: Promote national guidelines for the assessment of suicide risk among persons receiving care in all settings.

STRATEGY 8.1.1: Educate providers about best practice-based toolkits and ways to implement the national guidelines for the assessment of suicide risk among persons receiving care in all settings, which can be found on the Suicide Prevention Resource Center's Best Practices Registry, sprc.org/bpr

OBJECTIVE 8.2: Disseminate and implement best practice-based guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk, such as guidelines posted on the best practices registry at sprc.org/bpr

STRATEGY 8.2.1: Educate providers about the best practice-based national guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk, which can be found on the Suicide Prevention Resource Center's Best Practices Registry, sprc.org/bpr

OBJECTIVE 8.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.

STRATEGY 8.3.1: The Arizona Coalition for Suicide Prevention will advocate to eliminate penalties for suicide attempts from insurance providers.

STRATEGY 8.3.2: AHCCCS and community partners will educate providers about safe and effective guidelines for conducting safe suicide risk assessments such as the Chronological Assessment of Suicide Events (CASE approach - suicideassessment.com), Columbia Suicide Severity Rating Scale (CSSRS - cssrs.columbia.edu/), Assessing and Managing Suicide Risk (AMSR - sprc.org/training-institute/amr), Collaborative Assessment and Management of Suicidality (CAMS - psychology.cua.edu/faculty/jobes.cfm), and other programs identified on the Suicide Prevention Resource Center's best practice registry, <http://www.sprc.org/bpr>, beginning with local mental health authorities, by 2017.

OBJECTIVE 8.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.

STRATEGY 8.4.1: Engage families and those at risk of suicide about the importance of including families and concerned others in the safety planning process.

OBJECTIVE 8.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental health and/or substance use disorders.

STRATEGY 8.5.1: Promote best practice risk stratification systems and pathways of clinical care.

OBJECTIVE 8.6: Promote standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

OBJECTIVE 8.7: Promote guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

STRATEGY 8.7.1: Promote best practice-based recommendations such as those identified in suicide prevention and resources for primary care by the Suicide Prevention Resource Center (sprc.org) and SAMHSA (samhsa.gov) related to assessment and treatment of those identified with suicidal thoughts and behaviors. Example: Recognizing and Responding to Suicide Risk in Primary Care, sprc.org/bpr/section-III/recognizing-and-responding-suicide-risk-primary-care-rrsr-pc.

AHCCCS 2017 Actions: AHCCCS will reach out to Arizona's largest employers to determine what policies are currently in place for helping suicidal employees and help create an appropriate plan for referring employees for further care. AHCCCS will also continue to support the use of SafeTalk and ASSIST, so all community members are aware of the warning signs of suicide and how to get help.

GOAL 9. Provide care and support to individuals affected by suicide deaths or suicide attempts and implement community best practice-based post-vention strategies to help prevent further suicides

OBJECTIVE 9.1: Promote guidelines for effective comprehensive support programs for individuals with lived experience, including those bereaved by suicide and survivors of suicide attempts, and promote the full implementation of these guidelines at the state, county, tribal, and community levels.

actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf

STRATEGY 9.1.1: AHCCCS will add links and/or information on best-practice support programs or guidelines for postvention strategies to the state website.

OBJECTIVE 9.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

STRATEGY 9.2.1: Disseminate guidelines on trauma informed care to clinicians, agencies, and first responders. samhsa.gov/traumajustice/traumadefinition/guidelines.aspx

STRATEGY 9.2.2: AHCCCS will collaborate with state initiatives on trauma informed care and systems of care to include suicide prevention and postvention.

OBJECTIVE 9.3: Engage suicide attempt survivors and those bereaved by suicide in suicide prevention planning, including support services, treatment, community suicide prevention education, and promote guidelines and protocols for support groups for suicide attempt survivors and those bereaved by suicide.

STRATEGY 9.3.1: AHCCCS will promote the development of follow-up services for attempt survivors, and those bereaved by suicide, in emergency departments and other community

providers after a suicide attempt or death by suicide. Follow-up may include phone calls, post cards, email, or texts at intervals with caring messages and contact information for help.

STRATEGY 9.3.2: AHCCCS will promote inclusion of people with lived experience, including suicide attempt survivors and those bereaved by suicide, in local, regional, and state initiatives.

OBJECTIVE 9.4: Promote community postvention best practice-based policies and programs to help prevent suicide clusters and contagion.

STRATEGY 9.4.1: Inform communities and school districts about support for postvention including how to address suicide clusters and contagion through the local mental health authority suicide prevention coordinator, local suicide prevention coalitions, and the state suicide prevention coordinator.

OBJECTIVE 9.5: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.

STRATEGY 9.5.1: Support and encourage communities to develop a LOSS Team (Local Outreach to Suicide Survivors), trainings, support groups, and offer best practice-based bibliotherapy and other resources. lossteam.com/About-LOSSteam-2010.shtml

STRATEGY 9.5.2: Provide support for open and direct talk about suicide postvention through best practice-based presentations, debriefing, and counseling.

STRATEGY 9.5.3: Provide support to schools and school districts for training and facilitated discussions with teachers, administrators, support staff, and parents after a suicide loss.

STRATEGY 9.5.4: Provide support to students after a suicide loss in one-to-one or small group discussions only.

STRATEGY 9.5.5: Provide awareness about the need for best practice supports to medical examiner officers, victim services groups, first responders, funeral homes and faith-based organizations for those bereaved by suicide deaths or affected by suicide attempts.

STRATEGY 9.5.6: Disseminate guidelines about best practices for online and social media after suicide attempt or loss.

STRATEGY 9.5.7: Develop or disseminate best practice based support materials targeted to youth after a suicide loss.

STRATEGY 9.5.8: Encourage safe messaging training for all individuals and organizations involved in prevention, intervention and postvention activities. SuicidePreventionMessaging.org

OBJECTIVE 9.6: Provide health care providers, first responders, and others with best practice-based care and support when a patient under their care, or a colleague, dies by suicide.

STRATEGY 9.6.1: Provide support (including training, facilitated discussions, and counseling support) to professional caregivers in communities and schools after a patient or a colleague dies by suicide.

STRATEGY 9.6.2: Consider utilizing hospital or health care organizations' regular communications to inform other providers about increased suicide risk and potential clusters.

AHCCCS 2017 Actions: AHCCCS' Contractors will reach out to healthcare providers to see what information is being provided to loss and attempt survivors. AHCCCS will partner with Arizona Coalition for Suicide Prevention to develop appropriate resources and materials. AHCCCS will encourage healthcare providers to reach out to both groups within 24 hours after the event. AHCCCS will encourage loss and attempt survivor participation in suicide prevention policy creation and at the quarterly suicide prevention meetings statewide.

GOAL 10. 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 10.1: Improve the timeliness of reporting vital records data at state, county, local, school, and higher education levels.

STRATEGY 10.1.1: Improve capacity for state epidemiologists and the state suicide prevention coordinator to review and report suicide data

OBJECTIVE 10.2: Improve the usefulness and quality of suicide related data, including death, attempt, ideation, and exposure to suicide.

STRATEGY 11.2.1: Promote a mechanism in Arizona to collect and disseminate suicide attempt data. **OBJECTIVE 10.3:** Improve and expand state, county, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.

STRATEGY 10.3.1: As allowed by law, encourage government entities to enter into memorandums of understanding to share suicide data that does not name a deceased person.

OBJECTIVE 10.4: Increase the number of national and state representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.

STRATEGY 10.4.1: AHCCCS will review and make recommendations for the addition of questions to the Arizona Behavioral Risk Factor Surveillance System Survey related to suicide prevention and gay/lesbian/bisexual/transgender/two-spirited adults.

STRATEGY 10.4.2: AHCCCS will collaborate with Arizona State University on the state's data included in the National Violent Death Reporting System.

AHCCCS 2017 Actions: AHCCCS will encourage the White River Apache Reservation to provide technical assistance to other Arizona American Indian tribes concerning suicide surveillance.

GOAL 11. Improve timeliness of data collection regarding suicide deaths

OBJECTIVE 11.1: Develop an Arizona suicide prevention research agenda with comprehensive input from multiple stakeholders.

STRATEGY .11 .1.1: Form partnerships with higher education to promote and support suicide prevention research, including support of the National Violent Death Reporting System (NVDRS) -- new to Arizona: <http://www.cdc.gov/violenceprevention/nvdrs/stateprofiles.html>

STRATEGY 11.1.2: Consult with the research prioritization task force of the National Action Alliance for Suicide Prevention on how Arizona can develop a mechanism to prioritize state research.

OBJECTIVE 11.2: Disseminate national and Arizona-based suicide prevention research agenda. STRATEGY 11.2.1: Encourage Arizona researchers to apply for national grants and research opportunities on suicide prevention, intervention, and postvention.

STRATEGY 11.2.2: Encourage suicide prevention researchers to inform the AHCCCS about their articles and research projects so that their results can be shared statewide.

Objective 11.3: Promote the timely dissemination of suicide prevention research findings.

STRATEGY 11.3.1: Provide timely dissemination of suicide research findings through links on the AHCCCS website, Facebook, newsletters, Twitter, and other social media.

OBJECTIVE 11.4: Support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

STRATEGY 11.4.1: Provide links to repositories of national suicide prevention, intervention and postvention toolkits and websites.

OBJECTIVE 11.5: Encourage Arizona foundations to support suicide prevention research.

AHCCCS 2017 Actions: AHCCCS will foster relationships with state and private universities in Arizona to promote the research of suicide prevention and will support the work of ASU with the NVDRS. AHCCCS will outreach medical examiners and funeral home directors to have conversations about accuracy of death data and will encourage and promote grant writing technical assistance for those needing help in applying for suicide research funding.

GOAL 12. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

OBJECTIVE 12.1: Evaluate the effectiveness of suicide prevention interventions in Arizona.

STRATEGY 12.1.1: AHCCCS will publicize evaluation results of best practice-based suicide prevention projects, including the Zero Suicide pilot project.

OBJECTIVE 12.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions in Arizona.

OBJECTIVE 12.3: 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.

AHCCCS 2017 Actions: AHCCCS will work with other SAMHSA region 9 state suicide prevention coordinators to share information about state plans, successful programming and noted trends.

GOAL 13. Coordinate a statewide calendar of suicide prevention activities, fostering a collaborative community of support.

OBJECTIVE 13.1: Organize a statewide calendar, promoted by AHCCCS.

STRATEGY 13.1.1: Collaborate with as many community stakeholders as possible to keep an up-to-date calendar of community events related to suicide prevention and awareness.

WHAT COMMUNITIES CAN DO TO ADVANCE THE STATEWIDE GOALS

STRATEGIC DIRECTION 1—HEALTHY AND EMPOWERED INDIVIDUALS, FAMILIES AND COMMUNITIES

- Participate in local coalitions of stakeholders to promote and implement comprehensive suicide prevention efforts at the community level. For more information, email: kelli.donley@azahcccs.gov
- Develop and implement communication strategies that convey messages of help, hope, and resiliency. suicidepreventionmessaging.org/
- Provide opportunities for social participation and inclusion for those who may be isolated or at risk.
- Include those with lived experience such as attempt survivors and those bereaved by suicide for planning and implementation of programs.
- Consider sharing recommendations for reporting on suicide and safe messaging to media and encourage communication and feedback to news and online communities in response to local stories related to suicide. suicidepreventionmessaging.org/

STRATEGIC DIRECTION 2—CLINICAL AND COMMUNITY PREVENTIVE SERVICES

- Implement suicide prevention programs that address the needs of groups at risk for suicide and that are culturally, linguistically, and age appropriate.
- Initiate partnership with firearm advocacy groups (e.g. retailers, shooting and hunting clubs, manufacturers, firearm retail insurers) to increase suicide awareness. hsph.harvard.edu/means-matter/examples-of-means-restriction-programs/
- Educate first responders, clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, and others about the importance of promoting efforts to reduce access to lethal means among individuals at risk for suicide. hsph.harvard.edu/means-matter/ and sprc.org/search/apachesolr_search/means%20matters?filters=
- Advocate with your local hospital, emergency departments and other health care providers to provide follow up connections through rapid enhanced programs for immediate care after discharge, such as caring letters, postcards, texts and letters. bjp.rcpsych.org/content/197/1/5.full

STRATEGIC DIRECTION 3—TREATMENT AND SUPPORT SERVICES

- Coordinate the services of community-based and peer-support programs with the support available from local providers of mental health and substance abuse services to better serve individuals at risk for suicide.
- Consider providing support services for those with lived experience such as suicide attempt survivors and those bereaved by suicide.

STRATEGIC DIRECTION 4 —SURVEILLANCE RESEARCH, AND EVALUATION

- Work with a local university to evaluate your suicide prevention program

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/amr>

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-](http://www.lossteam.com/About-LOSsteam-2010.shtml)

[2010.shtml](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/The-Way-Forward-Final-2014-07-01.pdf>

Zero Suicide in Health and Behavioral Health Care

<http://zerosuicide.actionallianceforsuicideprevention.org>

PARTNERS:

- Area Agency on Aging
- Arizona Coalition to End Sexual and Domestic Violence
- Arizona Coalition for Military Families
- Arizona Criminal Justice Commission
- Arizona Coalition for Suicide Prevention
- Arizona Department of Veteran Services
- ASU – Center for Applied Behavioral Health Policy
- ADHS Bureau of Public Health Statistics
- ADHS Office of Injury Prevention
- First Things First
- Gila River Indian Community Police Department
- Glendale Police Department
- Goodyear Police Department
- Pasadera Behavioral Health Network
- Phoenix Police Department
- Phoenix VA Hospital administration
- Pima County Administrator's Office
- Pima County Medical Society
- Senator John McCain's staff
- St. Joseph's Hospital and Medical Center
- Teen Lifeline
- Tucson Police Department
- Maricopa County Justice System Planning and Information
- Mercy Maricopa Integrated Care
- Health Choice Integrated Care
- Cenpatico Integrated Care
- University of Arizona Medical Center

2017 CALENDAR OF EVENTS:

AHCCCS Regional Suicide Prevention Community Conversations

Tucson, Phoenix, Flagstaff

February May August November

Locations to be determined

Arizona Suicide Prevention Coalition: Second Tuesday of the month

JFCS

2033 N. 7th St. Phoenix, AZ

Dial in: 1-619-326-2772 #5131264

Verde Valley Suicide Prevention Coalition Second Wednesday of the Month

3:30-4:30 pm

Location varies

September:

Suicide Prevention Month

December:

Out of Darkness Suicide Prevention walk, Phoenix

Environmental Factors and Plan

21. Support of State Partners - Required 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 behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

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?

We have added a new partnership with the Arizona Department of Education (ADE) since the last planning period as explained in the second bullet point under question number three below.

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 Disabilities Education Act.

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

- An Intergovernmental Agreement (IGA) between AHCCCS and the Department of Economic Security, Rehabilitation Services Administration (DES/RSA) exists to increase coordination and facilitate the expansion of vocational rehabilitation services between the agencies.

- An ISA between AHCCCS and ADE 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, AHCCCS behavioral health staff is involved in two committees whose goal is to strengthen the relationship between behavioral health and education. These are the Arizona Community of Practice on Transition and the Arizona Positive Behavioral Interventions and Supports Advisory Council. These collaborative efforts, including the ISA, support local schools provision of services under the Individuals with Disabilities Education Act (IDEA).
- In an 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 a serious mental illness (SMI) who are residing in Pima County.
- There is an IGA for behavioral health services between AHCCCS and the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) established to help ensure appropriate coordination between individuals enrolled with both DDD and behavioral health.
- The ISA between AHCCCS and the Arizona Department of Housing (ADOH) was developed with the purpose of outlining duties to be performed by ADOH, provide technical assistance, project underwriting, and risk assessment analysis, as well as making final recommendations to ADHS/DBHS on the feasibility of funding particular housing projects for members with SMI.
- An IGA also exists between AHCCCS and 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.
- 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.
- The Arizona Children's Executive Committee (ACEC) brings together multiple state and government agencies, community advocacy organizations, and family members of children/youth with behavioral health needs to ensure behavioral health services are being provided to children and families according to the Arizona Vision and 12 Principles. ACEC strives to create and implement a successful system of behavioral health care in Arizona by serving as a state-level link for local, county, tribal, and regional teams.

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

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 impact in a positive way, 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.

Deferred until receiving recommendations from SAMHSA following the site visit in May of 2017.

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or 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 a Behavioral Health Advisory/Planning Council (BHPC). 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 BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**⁷²

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 behavioral health 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.

⁷²<http://beta.samhsa.gov/grants/block-grants/resources>

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

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

The Behavioral Health Planning Council was involved in the development and review of the State Plan and report by reviewing the plan and providing feedback to AHCCCS that was incorporated into the final draft of the plan.

a) AHCCCS includes the council in the planning and implementation of substance abuse prevention, Substance Use Disorder (SUD) treatment, and recovery services in regular council meetings that include staff from AHCCCS. There, the council and the State review and discuss any concerns the council has identified through their involvement with local stakeholders.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i 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 indicate 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.

Council members represent our states mental health population including GMH/SA, Substance Use Disorders, and individuals who are diagnosed as seriously mentally ill (SMI). The Council regularly collaborates with AHCCCS on program funding matters. 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 and have their voices heard.

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

Not at this time.

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

Ongoing technical assistance is being received to enhance the collaboration of the Planning Council and the state.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁷³

⁷³There 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.

Footnotes:



**ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
PLANNING COUNCIL**

**March 17, 2017
9:00 am – 2:30 pm**

MEETING LOCATION	TELEMED AVAILABILITY
AHCCCS 701 E. Jefferson Street Grand Canyon Room, 701-4 Phoenix, AZ 85034	None
Call In Number Host Code/Guest Code 1-877-820-7831- Host Code: 6017439 ; Guest Code: 976852	

AGENDA ITEM

ANTICIPATED ACTION

I. Call to Order & Introductions	Michael Carr, Chair	
II. Review of Agenda		Discussion
III. Approval of Meeting Minutes	Michael Carr, Chair	Action
IV. AHCCCS Reports	Kathy Bashor, AHCCCS	Discussion
V. Arizona State Hospital Report	Dr. Aaron Bowen, AZSH	Discussion
VI. State Agency Update:		
A. ADOH	Joy Johnson, ADOH	Update/Discussion
B. ADCS	Michael Carr, ADCS	Update/Discussion
C. DES/RSA	Alicia Ruiz, DES/RSA	Update/Discussion
VII. Committee Reports		
A. Community Advisory Committee	Dan Haley	Report/Discussion
B. Planning and Evaluation Committee	Vicki Johnson/Dawn Abbott, Co- Chairs	Report/Discussion
C. Executive Committee:	Michael Carr, Chair	Report Discussion
1. Election of Chair/Vice Chair		Action
2. Leadership		
3. Board Organization		
4. Leadership Training		
X. Other Business/Announcements	Michael Carr, Chair	Discussion
XI. Next Meeting/Agenda	Michael Carr, Chair	Discussion
XII. Call to the Public	Michael Carr, Chair	Discussion
XIII. Adjournment	Michael Carr, Chair	Action

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(Public Laws 99-660, 100-639, and 102-321)**

BEHAVIORAL HEALTH PLANNING COUNCIL

Advocacy and Legislation Committee	Date: March 17, 2017	Called to Order: 9:08 am Adjourned:

Members Present:	Dan Haley; Vicki Johnson; Kathy Bashor; Michael Carr; Dawn McReynolds; Joy Johnson, Akia Compton, Dawn Abbott, Lynette Toliver and Jane Kallal via phone
Members Absent:	
Non-Members Present:	Sherri Moncayo
Guests:	

Agenda Item	Notes	Follow-up/Next Steps
I. Call to order and Introductions	Meeting was called to order by Vicki Johnson at 9:08 am. Introductions around the room and the phone.	
II. Review of Agenda	NA	
III. Approval of Meeting Minutes	NA	
IV. AHCCCS Report – Kathy Bashor, AHCCCS	•	
V. Arizona State Hospital – Dr. Aaron Bowen	•	
VI. State Agency Updates	ADOH: • ADCS: • DES/RSA:	
VII. Committee Reports	<p>Community Advisory – Dan Haley Dan called the meeting to order at 10:16 am. Dan gave Suzanne the wrong time to come to the meeting. He told her 12:00 instead of 10:00. Will close the meeting and reconvene when Suzanne comes with her presentation. Went to Executive meeting.</p> <p>Planning & Evaluation – Vicki Johnson/Dawn Abbot, Co-Chairs</p> <ul style="list-style-type: none"> • Reviewed and discussed the Integrated RBHAS Statewide Statement of Activities for both SABG and MHBG with emphasis on the 	Need to ask Alex O’Hannon at the Governors’ office to present at an upcoming meeting. Need to

	<p>SED information.</p> <ul style="list-style-type: none"> • How does AHCCCS determine the amounts of money distributed to the RBHA's, Prevention, and Peer & Family run organizations from the Governors' office? • How are the funds split between adults and adolescents? • Would like a 12 month report instead of a 3 month report. • Can we get documents to the people calling in? • Discussed MHBG expenditures regarding Peer & Family run. Cenpatico gets SMI and GMHA funding; MMIC only gets SMI, no GMHA. BH Planning Council needs to be involved with protocols and how money should be distributed and to which providers. • Need clarification of what happens to funds that are not utilized during fiscal year. Is it returned or rolled over to the next year? Report shows Cenpatico paid taxes on their "profit" being portrayed in the report. <p>Executive – Michael Carr</p> <ul style="list-style-type: none"> • Discussed new Planning Council membership. Dan as Chair and Dawn Abbott as Co-Chair. Vicki motioned to approve; Kathy seconds. All in favor. Sherri sent out an email to all Committee members for voting. • Would like Chris Vinyard, AHCCCS Legislative liaison, to attend some of these meetings. • State agencies will present every other month. 	<p>stress collaboration between the Council and Governors' office. What are the internal processes AHCCCS uses?</p> <p>Sherri sent the report via email to those on the phone. Can we set up a GoToMeeting or email to everyone prior to a meeting if needed?</p> <p>Need to set up concrete responsibilities for each Council member and a consistent contact person for the community.</p> <p>Need to clarify the time frame for each committee. Executive needs to have a set time and the others can be more flexible. Ended meeting at 10:35 to be reconvened at 12:30.</p>
VIII. T/RBHA Updates	NA	
IX. Other Business/Announcements	<ul style="list-style-type: none"> • 	

X. Next Meeting	April 21, 2017 9:00 am – 2:30 pm AHCCCS 701 E. Jefferson St., Phoenix, AZ 85034 Grand Canyon conference room.	
XI. Call to Public	NA	
XII. Adjournment		

Discussion with Council Members only
prior to the Advocacy and Legislation Committee meeting.

Members Present:	Mike Carr; Dan Haley; Vicki Johnson; Alida Montiel (via phone); Akia Compton (via phone); Joy Johnson, Kathy Bashor; James Hargrave
Guests Present:	Dawn McReynolds; Camilla Parker; Chaz Longwell

Council frustrations:

- Requests for documentation which is never received. This issue dates back to ADHS.
- Lack of support from the right areas.

Council feels they give broader view of the system which needs to be heard.

Previously looked at MHBG, 90% of funds went to SED kids which was requested by Dr. Nelson. Dr. Nelson requested to change the formatting to 50% adult/child.

Historical relationship: There has been a recent breakdown in communication. Council was not requested to provide nor informed about input. Council has valuable information and has a broader view of the system and it needs to be shared with AHCCCS. Council wants to be productive and is willing to look at how to do things differently. The Council wants to develop a structure where their voice is incorporated.

BEHAVIORAL HEALTH PLANNING COUNCIL

Advocacy and Legislation Committee	Date: May 18, 2017	Called to Order: 1:00 pm
		Adjourned: 2:05 pm

Members Present:	Dan Haley; Michael Carr; Kathy Bashor; Vicki Johnson; Alida Montiel; Lynette Tolliver; Jane Kallal; Dawn McReynolds; Steve Tyrrell (via phone)
Members Absent:	Asim Varma; Dawn Abbott; Akia Compton; John Baird; Joy Johnson; Alicia Ruiz
Guests:	Sherri Moncayo; Chaz Longwell

Agenda Item	Notes	Follow-up/Next Steps
I. Call to order and Introductions	Meeting called to order by Dan at approximately 1:00 pm	
II. Debrief of Joint Monitoring Visit	<ul style="list-style-type: none"> • SAMHSA was very engaged but the Council discussions went off subject for quite a bit of the meeting. • The Council needs to be proactive and work with another entity to help with technical assistance to get AHCCCS engaged with the Behavioral Health Planning Council. • Who are the block grant dollars for? SAMHSA to the State > to RBHAs > to providers. At what point does the BHPC get involved? In 2008 the allocation of funds changed from 90% children / 10% adults to 50/50. The Council has not been asked for input since then. • What do the responsibilities/authority of Behavioral Health Planning Councils in other states look like? Need to be able to see the budget prior to implementation. Are there any line items to cover travel and administrative support for the Council in the budget? • Seek an invitation to the June 8th meeting and put a delegation together after approval. • SA and SED funds are not getting spent. Need to get the RBHAs introduced to the BH Planning Council. Possibly invite a representative from each of the RBHAs who is in a position to make decisions. 	

	<ul style="list-style-type: none"> • Vicki Johnson is resigning from the Planning & Evaluations Committee. 	
III. AHCCCS Information Request Form	<ul style="list-style-type: none"> • Would like additional information from AHCCCS regarding the AHCCCS Information Request Form. • Meet with an AHCCCS representative every other month. The Executive Committee will decide who to invite and the agenda will be sent a month in advance. Use questions, purpose and recommendations to determine which AHCCCS personnel to invite to the meetings every other month. 	
IV. Adjournment	Meeting was adjourned at approximately 2:05 pm.	



ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
PLANNING COUNCIL
 MEETING OF MAY 18, 2017
 1PM-2PM

MEETING LOCATION	TELEMED AVAILABILITY
AHCCCS 701 E. Jefferson – 3rd Floor Prickly Pear Room Phoenix, Arizona 85034	None
Call In Number Moderator Code/Participant Code 1-877-820-7831- moderator code 9895417# /participant code 906422#	

<u>AGENDA ITEM</u>	<u>FACILITATOR</u>	<u>ANTICIPATED ACTION</u>
I. Call to Order & Introductions	Dan Haley, Chair	Action
II. Debrief of Joint Monitoring Visit	Dan Haley, Chair	Discussion
III. AHCCCS Information Request Form	Albert Rock, AHCCCS	Discussion
IV. Adjournment	Dan Haley, Chair	Action

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(Public Laws 99-660, 100-639, and 102-321)

ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
701 E. Jefferson St. MD 6500
Phoenix, AZ 85034

August 23, 2017

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 2017. This must occur before it is submitted to the United States Department of Health and Human Services (DHHS) so that Arizona may receive the federal Mental Health Block Grant and the federal SABG for 2017. The Planning Council is submitting this letter to the Center for Mental Health Services with comments and recommendations regardless of whether they have been accepted by the State.

The Planning Council has included integrated representation between mental health and substance abuse since 1999, with the participation of several substance abuse providers. The Council recognizes the importance of increasing its expertise of substance abuse, particularly with the integration of mental health and substance abuse funding through the Block Grant. 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 and continually strives to improve representation among its members.

The Council ensures its membership is reflective of 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 SED child. There are also older adults, and individuals with SMI designation in the behavioral health system, family members of young children and a member of the LGBT community. Additionally, the Council recruits and retains individuals throughout the state, including individuals from Tucson, Southern Arizona (San Manuel), and Northern Arizona (Lake Havasu City, Kingman, Bullhead City). In the past year the Planning Council, at the suggestion of AHCCCS, had eliminated travel to other locations around Arizona. The Council had agreed to this on a trial basis with the understanding that it would allow AHCCCS leadership to participate and provide more detailed guidance and date for the Council. The Executive Committee continues its efforts to further diversify membership by recruiting transition-age youth/young adults, representatives from the educational and correctional systems, and individuals with personal

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experience in the behavioral health system, specifically mental health and drug courts. The 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.

As part of its discussion on membership recruitment, the Executive Committee identified the need to develop a training manual and orientation process that provides candidates with basic information on the Council and committees' functions, as well as a high level overview of what the Council and each committee has been working on for the past six (6) months. The Executive Team completed the training manual and it is issued to all new candidates who express an interest in joining the Council and/or its' supporting committees. To further ensure the orientation process is a smooth one, a candidate will also be partnered with an existing member/mentor to help navigate the membership process. The current Council members are given a training manual to use as a reference and refresher. The Executive Committee has begun to explore different options in committee and Council structure and meeting times to facilitate recruitment of Council members. The Executive Committee has discussed using an internet based conferencing system and different meeting times to facilitate community engagement and recruitment.

The "Administrative Simplification" ordered by Arizona Governor has been completed. This process, duties performed by the Division of Behavioral Health Services (DBHS) were moved under the Arizona Health Care Cost Containment System (AHCCCS), which is the State's Medicaid agency. This transition has been completed and the Council has prepared a guidance document which identifies what the Council will need from AHCCCS to meet its responsibilities. It also outlines what an advisory role for the Council regarding the Substance Abuse Block Grant might entail. These were discussed and finalized over the summer and fall of 2016. This document included proposed timelines for review and feedback of the various elements needed in the grants. Once finalized, the Planning Council bylaws will be updated to reflect any changes. The Council did not make as much progress on this area as it had originally planned. There has been more difficulty in the transition and the loss of historical knowledge and expertise within the state agency which has been difficult to overcome. There were communication problems and initially there was not a single point of contact at AHCCCS for the Council to work with. The Council was asked for ideas of how to utilize some of the SED funding. One of the areas which community stakeholders had identified is that if teens that were enrolled and receiving behavioral health services, often would lose that eligibility when they were detained for crimes. The behavioral health providers are unable to maintain its provision of needed behavioral health services and is unable to assist in the transition planning for the adolescent. The Planning Council agreed with the recommendation that some of the block grant monies would be used to assist in the transition planning for youth whose Medicaid funding has been suspended.

Arizona is experiencing significant increases in opioid overdoses and deaths. In 2016 two or more Arizonans died from opioid overdoses each day. Several taskforces have been created by the

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Governor to address this issue and members of the Planning Council have served or are serving on these additional taskforces. The AHCCCS Medical Director served as co-chair of Substance Abuse Task Force which the Governor created in 2016 and one of the Planning Council members also served on this task force which provided the Governor with 104 recommendations to consider regarding prevention and early intervention programs, access to treatment, medication-assisted treatment and neonatal abstinence syndrome. The Council was asked to support the purchase of additional naloxone kits to be provided to first responders. The Council agreed. From June 15, 2017 to August 17, 2017 1339 naloxone doses were administered outside of the hospital by emergency medical services, law enforcement and others. 1,533 naloxone kits were distributed to the public by pharmacies.

The Arizona Behavioral Health Planning Council meets monthly, with the exception of July and August. Typically, the Planning & Evaluation Committee meets during the summer to complete the Mental Health Plan portion of the Block Grant application. This year, the Council was not able to conform to this process because the format for the Block Grant application was received late from SAMSHA and this left little time for the Council to review the Arizona Plan. Meetings are held in the state capitol (Phoenix). The Council's standing committees also meet regularly and are used to assist the Council in its responsibilities by reviewing specific issues or concerns and by developing recommendations.

Through its Advocacy and Legislative Committee, the Council is active in reviewing and tracking state and federal legislation pertaining to mental health services. Should an issue of concern be presented, the Committee works to develop and disseminate position papers, provides testimony at legislative hearings, and advocates for the populations the Council is appointed to serve.

The Council is also kept abreast of current issues, programs, upcoming grants, and other topics in the behavioral health field, and acts as an advisory body to the State. Reports on the Block Grant are discussed by the Planning and Evaluation Committee, as well as included in the full Council agendas for discussion and feedback to the State.

The Community Advisory Committee is currently working with AHCCCS to identify issues with the transition of adolescents to the adult mental health system. The Committee met with several children's services providers and the Maricopa and Pima County Regional Behavioral Health Authority (RBHA) to discuss their process for ensuring children transition without an interruption in services. It has been determined that the encounter data for youth in the child welfare system will be the data tables used for analysis. This group was chosen as it is a separate data set and these youth would automatically qualify for Medicaid as they turn 18. The Committee is awaiting encounter data for this population and if negative trends are identified, the Committee will work with AHCCCS to develop and implement a resolution.

The Council meets with AHCCCS staff who are directly involved in the statistical and financial data collection, and subsequent Block Grant development. This happens during regularly scheduled Council meetings as well as specially scheduled sessions to develop the Community Mental Health Services (MHBG) and Substance Abuse Block Grant (SABG). These meetings provide an opportunity to share updates and feedback on priorities, issues, and other relevant topics related to the Block Grant.

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System of Care Plans provide a mechanism for planning and implementation of mental health and substance abuse services within the state. Annual plans are developed and updates are submitted to AHCCCS staff quarterly. The Planning Council is included in this process with the AHCCCS System of Care Plan being disseminated for review and feedback. The process allows the Council, AHCCCS, and RBHAs to develop effective and efficient plans through a series of reviews and feedback provisions. Information gathered from the review and planning process is shared with the Planning Council; any requests for recommendations, comments, and concerns from the Council are made by AHCCCS.

AHCCCS staff meets with the Council's Planning and Evaluation Committee to discuss programs and activities related to the Block Grants. AHCCCS staff receives feedback from the Committee regarding new priorities and data needed to respond to them. During the past year, the Planning Council requested a report from Terros, which is one of Arizona's largest behavioral health providers and provides a wide range of behavioral health services from crisis to substance abuse residential treatment. It also, is a recipient of both Substance Abuse Block Grant and Community Mental Health Block Grant monies. They were able to provide to the Council, their process of identification of eligibility and utilization of both streams of grant money. They identified that the category of monies designated for SED children is the most difficult and often under used stream of monies. They explained that the population of children which they typically serve in crisis and ongoing process are eligible for Medicaid so the block grant monies are not utilized.

The Planning Council has identified areas of focus for the 2017-2018 grant years. The Council:

- Will become more involved with the expenditure of the set-aside monies for an evidence-based program addressing first episode psychosis.
- Plans to recruit representatives from programs that are awarded block grant funds. Although the Council is well represented in the number of members who are impacted by, or provide services related to substance use and abuse, the Council is not well represented by providers who are receiving the block grant dollars for the provision of the services. Recruiting a provider that receives block grant funds will allow the Council to better understand how the dollars are used.
- Will focus on training and educating the RBHAs on how to maximize the use of SED dollars.

The Council will seek information to understand how the Mental Health Parity and Addiction Act and the Affordable Care Act are working in Arizona by collaborating with established workgroups which have been monitoring and collecting information regarding this legislation.

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.

Sincerely,



Daniel Lee Haley
Chair Planning Council

**“...to advise, review, monitor, and evaluate all aspects of the development of the State Plan”
(Public Laws 99-660, 100-639, and 102-321)**

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Dawn Abbott	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1743 Sycamore Avenue Kingman AZ, 86409 PH: 928-681-5990	dabbott@mmhc-inc.org
John Baird	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1036 W. 3rd Avenue San Manuel AZ, 85631 PH: 520-385-2667	johnbaird1@hotmail.com
Kathy Bashor	State Employees	AHCCCS - State Mental Health Agency		
Leon Canty III	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Michael Carr	State Employees	DCS - State Social Service Agency	400 N. Central Avenue Phoenix AZ, 85012 PH: 602-771-3631	MCarr@azdes.gov
Akia Compton	Parents of children with SED		2642 E. Thomas Rd Phoenix AZ, 85016 PH: 480-414-4879	akiac@mikid.org
Daniel Haley	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		H.O.P.E. Inc. Tucson AZ, 85716 PH: 520-869-6263	danielhaley@hopetucson.org
Joy Johnson	State Employees	ADOH - State Housing Agency	1110 W. Washington st., Ste. 310 Phoenix AZ, 85007 PH: 602-771-1026	joy.johnson@azhousing.gov
Vicki Johnson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		5409 W. Siesta Way Laveen AZ, 85339 PH: 480-236-2552	Vlj30@cox.net
Jane Kallal	Providers		5333 N. 7th Street, A -100 Phoenix AZ, 85014 PH: 602-412-4070	Jane@Familyinvolvementcenter.org
Dawn McReynolds	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4350 E Cotton Center Blvd Phoenix AZ, 85040	a2zdawn727@gmail.com
Alida Montiel	Parents of children with SED		2214 N. Cnetral Avenue Phoenix AZ, 85004 PH: 602-258-4822	Alida.Montiel@itcaonline.com

Alicia Ruiz	State Employees	DES - State Vocational Rehabilitation Agency	1789 W. Jefferson St., 2NW Phoenix AZ, 85007 PH: 602-542-3792	AliciaRuiz@azdes.gov
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			

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	16	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	3	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	10	62.50%
State Employees	4	
Providers	1	
Vacancies	1	
Total State Employees & Providers	6	37.50%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Persons in recovery from or providing treatment for or advocating for substance abuse services	2	
Federally Recognized Tribe Representatives	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Update: Behavioral Health Advisory Council Members :

The State has recently clarified the roles of members currently sitting on the Council and has identified the members from State agencies still required. AHCCCS is working closely with the Behavioral Health Planning Council to reach out to potential candidates and will be sending a letter from the Assistant Director to both the Criminal Justice and Education State agencies to formally request representation from their agencies to sit on the council and offer their perspectives going forward. AHCCCS feels confident that this issue is being addressed by both the State and the Council and will be resolved in the coming months.

The Planning Council was involved in the review of the application upon receiving a copy of the application draft with and without attachments. The Planning Council invited AHCCCS staff to provide an overview of the application. The Planning Council asked questions about the application and was provided with details in response to their questions.

The deadline to have the application completed by 9/1/17 does not allow the Planning Council to do as thorough of a review of the application as they would like, so they were encouraged to do a preliminary review within the time available and do a more comprehensive review so their recommendations can be incorporated into the 2019 update and 2020 application.

The Planning Council provided recommendations for the activities of the Council throughout the coming year, but did not provide any modification requests to the application (see attached letter). The Planning Council did provide information on new Council Members who are in the process of becoming appointed. They are:

- Leon Canty, an adult recipient of mental and substance services;
- Brenda Vittatoo, an adult family member;
- Lisa St. George, an adult recipient of mental health services; and
- Mary Ann Page, a Criminal Justice Representative.

Footnotes:

Environmental Factors and Plan

23. 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

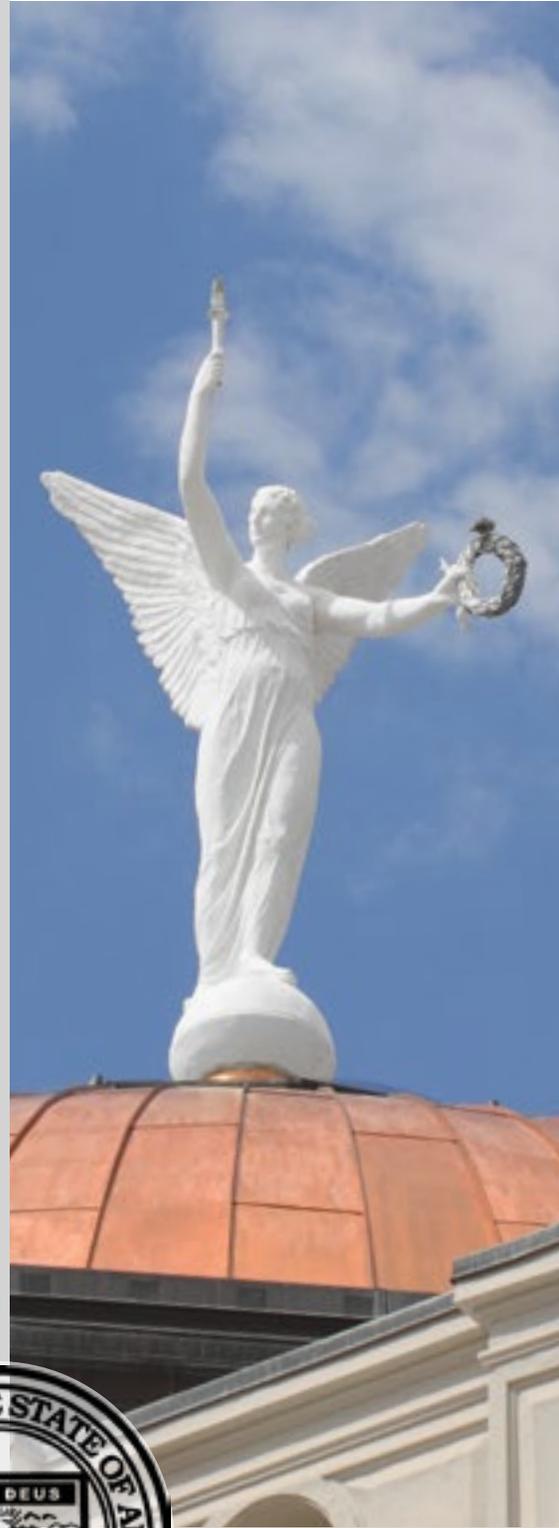
Footnotes:

The draft block grant application was posted to the URL listed above on 8/18/2017. The final draft of the application will be posted at the website for following year for public comments to be considered in the 2019 application and going forward.

Arizona Substance Abuse Recommendations

Arizona Substance Abuse Task Force

October, 2016



Governor Ducey's Office of Youth, Faith and Family



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Acknowledgements

This document was developed by the Arizona Substance Abuse Task Force convened by Governor Doug Ducey through the Governor's Office of Youth, Faith and Family.

Arizona Substance Abuse Task Force:

Debbie Moak, Co-Chair

Governor's Office of Youth, Faith and Family

Dr. Sara Salek, MD, Co-Chair

Arizona Health Care Cost Containment System

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Executive Summary

Convened by the Arizona Governor's Office on Youth, Faith and Family (GOYFF), the Arizona Substance Abuse Task Force met from March through October 2016. Through facilitated in-depth discussion, consideration of information from topic area experts, and consensus building, the Task Force developed the following positions and recommendations:

- The use of evidence-based and data-driven substance use disorder (SUD) prevention, early intervention, and treatment approaches, as well as the exploration and consideration of promising and emerging practices, encourages the development, refinement, and evaluation of practices to identify and build an evidence base for best practices.
- All SUD approaches, strategies, interventions, and treatments must be culturally sensitive and competent.
- Primary, secondary, and tertiary prevention efforts should be conducted in family, educational, faith-based, community, health care, and medical practice settings before substance use begins, and early intervention should take place at the first sign of substance use.
- SUD is a chronic, relapsing brain disease that is characterized by compulsive drug and/or alcohol seeking and use, despite harmful consequences. Stigma is often grounded in misunderstandings about the nature of addiction. Reducing stigma and working together collaboratively is our best opportunity to assist more people into long-term treatment and recovery.
- Investing in prevention is essential to mitigate the human suffering, social problems, and financial costs of substance abuse. Increased funding is recommended to support prevention and early intervention activities directed at middle and high school students, families, educators, addiction specialists, medical and behavioral health providers, law enforcement, criminal justice, and others in the community.
- Multiple entities should work in partnership to eliminate system silos and develop system-wide, collaborative mechanisms for prevention, intervention, and treatment strategies. Collaborating entities should include schools; medical and behavioral health providers; the Department of Corrections; the Department of Juvenile Corrections; county, juvenile, and adult probation; the Department of Child Safety; the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program; commercial health plans; charity and faith-based services.
- Additional provider and public education is needed to reduce the number of prescriptions written for dangerous opioids and to increase the use of evidence-based alternative, non-opioid pain management modalities.
- To support SUD data collection, jurisdictions should instruct medical examiners to appropriately and consistently specify the drug(s) identified through a toxicology analysis for inclusion on the death certificates of individuals who die from a drug overdose.
- Because 90 percent of all addiction begins with drug use during the teen years, Arizona schools should be supported with drug education programs and resources. The "Healthy Families – Healthy Youth" substance abuse prevention pilot should be scaled up and made available to all 7th grade students, parents, and faculty in the state.
- Treatment of overdoses in hospital emergency departments (EDs) is inefficient and incomplete without a referral to further treatment. It is essential to provide additional education to ED physicians on addiction and resources for timely referrals to appropriate SUD treatment providers.
- Addiction is a health issue. Arizona communities should expand programs such as the Juvenile Deten-

tion Alternatives Initiative (JDAI) and the Arizona Angels Initiative (AAI), which can reduce the need for detention or incarceration for individuals with SUD who have not committed a violent crime.

- Grant funding should be explored in order to pay providers to deliver SUD treatment services in jails and prisons.
- The Arizona Substance Abuse Partnership (ASAP) Committee's Department of Corrections Advisory Work Group should be asked to ensure that the Department of Corrections immediately and fully implements the four re-entry strategies presented to the Task Force.
- The GOYFF should convene a group to develop regional protocols and criteria for sober living homes and to address the problem of illegal referrals. The group should explore the merits of reinstating the sober living home criteria that were in place in Arizona prior to 2013. Treatment facilities and sober living homes should be held accountable to an evidence-based best practice standard of care.
- Providers should be educated about the importance of social supports and encouraged to involve the family, if appropriate, and/or other relational supports in the treatment process. Lack of social supports is a core issue that can lead to substance abuse. A support system should be developed to help families navigate the systems involved with SUD intervention and treatment.
- Access to medication-assisted treatment (MAT) should be expanded. While SUD treatment is not "one size fits all," the full continuum of MAT, including the non-opioid drug naltrexone, should be considered as an effective treatment option and used as part of a comprehensive treatment plan that includes counseling and participation in social support programs. MAT is one of the most effective strategies for preventing relapse for opioid use disorders.
- Scalable strategies should be developed to address the shortage of providers who are willing, qualified, and licensed to administer MAT so that it is available in a timely and appropriate way similar to other chronic conditions, such as congestive heart failure and diabetes.
- All detox and treatment programs should have the resources needed to test for communicable diseases, including Hepatitis C virus (HCV), HIV, AIDS, sexually transmitted diseases (STDs), and the Zika virus. Addressing this significant public health issue requires the availability of patient education materials that can help individuals with SUD understand the importance of screening tests.
- Neonatal Abstinence Syndrome (NAS), the withdrawal from a drug following birth, is a serious and growing problem in Arizona and throughout the U.S. Mothers using substances may avoid prenatal care because of shame, guilt, and/or stigma. It is important to reduce the stigma associated substance use and to provide the mother with resources for treatment, counseling, and support services.
- The earlier a practitioner is able to intervene in the prenatal care of a mother using a drug that endangers the baby and/or alcohol, the better for both the mother and the baby. All prescribers should be educated about the potential danger of prescribing opiates to women of childbearing age, NAS, and mitigation tactics. Pediatricians, family physicians, obstetricians, and other providers should be educated about the ongoing health and developmental problems associated with NAS.
- The Arizona Perinatal Trust should be encouraged to develop, promote, and ensure compliance with standardized best practice protocols for newborn NAS treatment and maternal interventions.
- Health plans, AHCCCS, and the Health Information Exchange should be encouraged to enhance data tracking of NAS babies, using consistent data collection tools, to monitor progress and outcomes.
- Because hospitals are required to report NAS and at-risk children to the Arizona Department of Child Safety (DCS), training should be made available to hospital nurses, social workers, and providers on how to effectively interact with DCS. DCS should provide hospitals statewide with DCS hospital liaisons who are specifically trained to assess newborn safety and to connect families to resources for

- The efforts of the Industrial Commission of Arizona to prevent future opioid addiction among Worker's Compensation beneficiaries and to obtain treatment for individuals who already have SUD should be supported.
- Arizona agencies should continue to seek federal grant monies to support substance abuse prevention, early intervention, and treatment efforts in Arizona.

Task Force Goals

The goals of the Arizona Substance Abuse Task Force were to:

- Address and seek to reverse the growing epidemic of substance abuse and addiction in Arizona communities by finding the best treatments and reducing barriers to care.
- Provide recommendations on a variety of substance abuse related issues, including:
 - Prevention and early intervention
 - Access to treatment
 - Neonatal Abstinence Syndrome (NAS)
 - Medication-Assisted Treatment (MAT)
- Across all areas, consider evidence-based, promising, and emerging prevention, intervention, and treatment practices.

Methodology

The Governor's Office on Youth, Faith and Family (GOYFF) convened the Arizona Substance Abuse Task Force in Spring 2016. Debbie Moak, GOYFF Director, and Dr. Sara Salek, Arizona Health Care Cost Containment System (AHCCCS) Chief Medical Officer, co-chaired the Task Force. A professional facilitator, Sharon Flanagan-Hyde, Flanagan-Hyde Associates, LLC, facilitated the Task Force and Work Group meetings.

Twenty-nine individuals were appointed to serve as Task Force members, and several additional people with special expertise were invited to participate in Work Groups. The Task Force and Work Group rosters are included in Appendix A.

The full Task Force conducted its work during six two-hour meetings in March, April, May, June, August, and October 2016. Four Work Groups also met for six two-hour sessions: Early Intervention and Prevention, Access to Treatment, Medication-Assisted Treatment (MAT), and Neonatal Abstinence Syndrome (NAS). All Task Force members were asked to participate in at least one Work Group.

The Task Force and Work Groups abided by the following group norms:

- *Help create an environment that allows all to speak candidly;*
- *Listen with an open mind and a collaborative mindset.*
- *Speak concisely and respectfully.*
- *One person speaks at a time, as called upon by the facilitator.*
- *The full Task Force focuses on the overall goals—details and tactics will be handled by Work Groups.*
- *Stay focused on the topic at hand and self-monitor to avoid tangents.*

- *Work toward consensus on recommendations.*

In response to Task Force requests for additional information, experts offered presentations at Task Force and Work Group meetings. A list of presenters and topics is included in Appendix B. Task Force members developed the recommendations in this report through in-depth discussion and consensus.

A Table of Acronyms is provided as Appendix C.

Evidence-Based, Emerging, and Promising Practices

For the purpose of developing recommendations, the Task Force used the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) definition as a foundation and added emerging and promising practices. Task Force members said that many tactics that are known to be effective have not been formally studied. In addition, since data collection and sharing on tribal lands has been difficult, the needs of tribal members may not be fully represented in evaluation studies. Consequently, the Task Force took the stance that evidence-based practices (EBPs) are not limited to data-driven or data-supported initiatives; rather, they are the intersection of research, clinical expertise, and the needs and desires of the individual. The decision about using an evidence-based, emerging, or promising practice for a given individual should be left to the discretion of the prescribing provider.

The Task Force's position is aligned with that of the Centers for Disease Control and Prevention (CDC): How can we encourage ongoing development, refinement, and evaluation of practices to identify and build an evidence base for best practices? . . . At the intersection of public health impact and quality of evidence, a continuum of evidence-based practice emerges, representing the ongoing development of knowledge across 4 states: emerging, promising, leading, and best.¹

The purpose of NREPP is to help people learn more about available evidence-based programs and practices and determine which of these may best meet their needs. NREPP does not endorse or approve interventions, but instead 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. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. Task Force members noted that in practice, staff and cost limitations sometimes make it challenging to implement models with fidelity.

The Task Force agreed that substance abuse prevention and treatment cannot be addressed with a "one size fits all" approach.

¹ Spencer LM, Schooley MW, Anderson LA, Kochtitzky CS, DeGross AS, Devlin HM, et al. Seeking Best Practices: A Conceptual Framework for Planning and Improving Evidence-Based Practices. *Prev Chronic Dis* 2013;10:130186.

Cultural Competency

The Task Force and Work Groups agreed that all approaches, strategies, interventions, and treatments must be culturally sensitive and competent. SAMHSA defines cultural competence as “the ability to interact effectively with people of different cultures to help ensure that the needs of all community members are met. In practice, both individuals and organizations can be culturally competent. Culture must be considered at every step of the Strategic Prevention Framework (SPF).

‘Culture’ is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. Cultural competence means to be respectful and responsive to the health beliefs and practices—and cultural and linguistic needs—of diverse population groups. Developing cultural competence is also an evolving, dynamic process that takes time and occurs along a continuum.”²

Prevention and Early Intervention

Working Definition of Prevention

The Prevention and Early Intervention Task Force developed the following working definition of prevention:

Prevention is a set of actions that are designed to avert the onset of substance use or limit the development of problems associated with using psychoactive substances. Prevention efforts should focus on the individual, the family, and their surroundings, including schools and workplaces, and should be culturally sensitive and appropriate. Prevention programs often include monitoring and evaluation to improve their effectiveness.

Task Force members noted that primary, secondary, and tertiary prevention must be addressed. Prevention should take place in family, educational, faith-based, community, health care, and medical practice settings before substance use begins, and early intervention should be initiated at the first sign of substance use.

Reducing Stigma

Addiction is a chronic medical disease with the potential for life-threatening emergent crises. The National Center on Addiction and Substance Abuse (CASA) report found that of nearly \$500 billion in current federal and state spending only 2 percent goes to prevention and treatment.³ The National Institute on Drug Abuse defines addiction as a chronic, relapsing brain disease that is characterized by compulsive drug and/or alcohol seeking and use, despite harmful consequences. It is considered a brain disease because drugs and/or excessive alcohol change the brain’s structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.⁴ Stigma is often grounded in misunderstandings about the nature of addiction.

² <http://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence>

³ <https://www.centeronaddiction.org>

⁴ Adapted from <https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics>

Recommendation

1. The Task Force urges collaborative efforts among state officials and agencies, nonprofit organizations, professionals, and the public to decrease the stigma associated with SUD and eliminate moral judgments and shaming of individuals living with an addiction. This requires shifting from a culture of shaming to one of support for recovery. Reducing stigma and working together collaboratively is our best opportunity to assist more people into long-term treatment and recovery.

Prevention

Substance abuse is a critical public health issue in Arizona and throughout the United States. Investing in prevention is essential to mitigate the human suffering, social problems, and financial costs of substance abuse. This point was driven home by the powerful personal stories that community members shared about the impact of substance abuse on their children and families. Focused efforts to decrease the illicit use of opioids and stimulants are critical. It is also essential to address problems with alcohol: underage use, excessive use by adults, and use by women during pregnancy. Additional physician education is needed to discourage inappropriate prescriptions for opioids to treat pain.

Ninety percent of all addiction begins with drug use during the teen years. We must educate youth before and during these years in order to better prevent first drug use. Supporting Arizona schools with drug education and resources can go a long way toward addressing early substance use and school culture. Schools need our collective support to prevent first drug use.

Recommendations

2. Increase funding to support prevention and early intervention activities. Investing in evidence-based prevention and early intervention improves public safety and decreases dollars spent on incarceration and long-term treatment.
3. Fund, develop, and implement an intensive, effective, and evidence-based media campaign that uses clear, engaging, easy-to-remember, non-stigmatizing, culturally appropriate messages for Arizona’s diverse populations, e.g., specific ethnicities, youth of various ages, the LGBT community, veterans, etc. Essential messages include:
 - a. Prescription pain medications can be addictive and should only be used as prescribed.
 - b. Addiction is a brain disease, not a personal failure.
 - c. Here is where to go and what to do when substance abuse occurs (with specific, up-to-date information listed.)
 - d. Substance use/abuse during pregnancy can lead to neonatal abstinence syndrome (NAS) and other developmental and health issues for babies.
4. Educate the community—families, educators, addiction specialists, medical and behavioral health providers, law enforcement, criminal justice, and others—on how to identify early symptoms of substance abuse and how to respond (e.g., referrals to counseling and support groups, frequent drug testing, etc.). Emphasize the importance of responding in a supportive and not punitive manner.

5. Use the powerful personal stories shared by community members with the Task Force as part of educational messages.
6. Engage children and adolescents in building social skills, character, and coping skills, so they have the tools needed to decline when offered substances.
7. Engage youth to take the lead in educating their peers about the consequences of drug use by connecting them with education and supportive resources such as “Safe Talk for Teens.”
8. Thoroughly train teens to deliver peer-to-peer prevention and early intervention messages through evidence-based programs. Address vaping (inhaling substances through e-cigarettes and other devices) as part of these programs.
9. Encourage use of the websites *substanceabuse.az.gov*, *overcomeawkward.org*, and *ivegotsomethingbetter.org* and *ReThinkRxAbuse.org*
10. Scale prevention programs throughout Arizona in schools to develop drug-free school cultures.
11. Investigate if the Adolescent ASAM (American Society of Addictive Medicine) Screening & Assessment Tool is the most efficacious tool for use in adolescents as well as the most cost effective option for the State.
12. Support the GOYFF’s plan to build a Youth Treatment Locator.
13. Disseminate drug abuse prevention/resource toolkits to schools, primary care providers, faith-based groups, parent groups, and others who interact with young people.
14. Develop a flyer on substance abuse treatment services and disseminate to pharmacists and providers.
15. Address core substance abuse/mental health issues that exacerbate the challenges faced by someone who is living with SUD: homelessness, the inability to get or keep a job, and inadequate social supports.
16. Support efforts to improve the screening and treatment of mental illness, and to screen and treat mental illness at earlier ages.
17. Develop a centralized “depot” of resources on substance abuse and prevention and disseminate information statewide.
18. Educate providers, health plans, and the general public about effective alternative pain management modalities for acute and chronic pain in order to decrease the use of opioids and unintended addiction.
19. Address the specific needs of the elderly population in terms of pain management modalities.
20. Eliminate system silos and develop system-wide collaboration mechanisms for schools; medical and behavioral health providers; the Department of Corrections; the Department of Juvenile Corrections; county, juvenile, and adult probation; the Department of Child Safety, AHCCCS, commercial health plans, and charity and faith-based services in prevention, intervention, and treatment strategies.
21. Leverage the positions of Governor Doug Ducey and GOYFF on substance abuse prevention to garner engaged support from other champions who are willing to publicly address substance abuse.
22. Partner with corporations, private foundations, the faith-based community, and other partners in order to effectively scale statewide prevention programming.

Prescriber Education and Guidelines

The National Safety Council (NSC) recommends that states require continuing medical education (CME) on pain management for prescribers of controlled substances.⁵ Further, NSC states that:

Sound, evidence-based prescribing guidelines encourage physicians to incorporate alternative, non-opioid treatments for pain and provide the lowest effective doses and the fewest number of pills when prescribing dangerous opioid medications. The recently released CDC [Centers for Disease Control and Prevention] guideline on opioid treatment for chronic pain should be adopted as the state prescribing guideline, but states should also consider the risks for acute pain patients.⁶

Prescribers in Arizona are required to access and update the Controlled Substance Prescription Monitoring Program (CSPMP) database before prescribing a controlled substance to a patient. This new legislation—SB 1283, signed by Governor Ducey on May 12, 2016—targets “doctor shopping” by individuals seeking controlled substances.

The concept of pain assessment as the “fifth vital sign” came into use in the late 1990s. The Joint Commission put in place pain management standards. The Centers for Medicare and Medicaid Services (CMS) uses patient satisfaction questions about pain as part of its reimbursement procedures. A number of groups, including the Physicians for Responsible Opioid Prescribing (PROP), believe that the standards have contributed to opioid overprescribing and subsequent addictions.⁷

Recommendations

23. Expand the number of prescribers receiving “report cards” from the Board of Pharmacy comparing their prescribing habits to similar clinicians.
24. Require and expand prescriber education regarding opioid use for pain management. Standardized resources for Arizona providers should include information on the dangers of prescribing opioids, SB 1283 and the CSPMP database, and recent federal legislation. These resources should be available online.
25. The CSPMP should continue to be enhanced to be robust and user-friendly, with multi-state capabilities. Clear information should be provided on how to use the CSPMP.
26. Promote prescriber guidelines to reduce the number of opioid prescriptions written by providers.
27. Promote and educate providers on the use of alternative methods of treating acute and chronic pain.
 - a. Educate patients and the general public on non - narcotic options, including Complementary and Alternative Medicine (CAM) to manage pain.
 - b. Encourage providers to seek information from pain management centers of excellence to learn about non-opioid pain management modalities, including CAM.
 - c. Educate insurers about the long-term cost-savings of reimbursements for evidence-based non-narcotic pain management options
 - d. Educate providers on how to appropriately document recommended non-narcotic pain management approaches when submitting reimbursement claims to insurers.

⁵ National Safety Council. (2016) Prescription Nation 2016: Addressing America’s Drug Epidemic, 16.

⁶ National Safety Council. (2016) Prescription Nation 2016: Addressing America’s Drug Epidemic, 4.

⁷ <http://www.medpagetoday.com/publichealthpolicy/publichealth/57336>

28. Engage medical schools, dental schools, veterinarian schools, and higher education programs for nurse practitioners and physician assistants to increase required curricula on substance abuse prevention and treatment.
29. Educate and re-culture the profession for ICD-10. (The International Statistical Classification of Diseases and Related Health Problems 10th Revision [ICD-10] is a coding of diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization [WHO]). Unless doctors begin coding appropriately, specific missed in data collection and treatment. For example, F1117 is an opiate dependent person. When an opiate dependent person comes to an emergency department, practitioners need to be trained to diagnose, code, and refer appropriately.
30. Support CMS efforts to eliminate pain management from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) payment score.
31. Support efforts to request that the Joint Commission, which accredits and certifies health care organizations, re-examine its pain management standards.

Data Collection on Overdose Deaths

The scope of overdose deaths from various drugs is difficult to ascertain because death certificates often do not indicate the drug(s) used by the decedent. A 2013 study found that in 21 states, more than 25 percent of overdose death certificates did not specify the drugs involved in the death.⁸ Collecting and tracking data through death certificates can guide public policy, prevention, and intervention efforts.

Recommendation

32. Encourage jurisdictions to specify the drug(s) identified through a toxicology analysis for inclusion on the death certificate of individuals who die from a drug overdose. Have medical examiners (MEs) appropriately and consistently identify drug use overdose as the cause of death. (Frequently MEs are reluctant to do so, and identify UNK (unknown), as cause of death.)

School-based Prevention Programs

Evidence-based, age-appropriate prevention programs have been developed for students in elementary, middle, and high school. The National Council of State Legislatures reported that the School Health Policies and Practices Study (SHPPS), conducted by the Centers for Disease Control and Prevention in 2014, found that 66.7 percent of middle schools and 86.9 percent of high schools require that students receive instruction on alcohol or other drug use prevention. The National Association of State

⁸ Warner, M., Paulozzi, L. J., Nolte, K. B., Davis, G. G., & Nelson, L. S. (2013). State Variation in Certifying Manner of Death and Drugs Involved in Drug Intoxication Deaths. *American Forensic Pathology*, 231-236.

Boards of Education (NASBE) provides a State School Health Policy Database with information on state policy for Alcohol, Tobacco and Drug Use Education.⁹

Knowing that 90 percent of all addiction begins with drug use during the teen years and that the average age of first alcohol experience in Arizona is 12 years 9 months, we must educate Arizona's youth and parents earlier. A key to reducing the state's substance abuse lies in funding and scaling early prevention programs.

The "Healthy Families – Healthy Youth" substance abuse prevention pilot for seventh grade youth and their families in Arizona was launched in September 2016 by the GOYFF. It was funded through a SAMHSA Substance Abuse Prevention Block Grant.

Educators are increasingly aware that suspension for substance use is not an effective disciplinary measure and does not reduce future drug use. For example, a 2015 study showed that the likelihood of student marijuana use was higher in schools in which administrators reported using out-of-school suspension and students reported low policy enforcement. Student marijuana use was less likely where students reported receiving abstinence messages at school and students violating school policies were counseled about the dangers of marijuana use. Researchers concluded that schools might reduce student marijuana use by delivering abstinence messages, enforcing nonuse policies, and adopting a remedial approach to policy violations rather than use of suspensions.¹⁰

Because parents play the number one role in preventing teen drug use, we must educate both parents and their children. School faculties play a major role in both preventing and especially intervening in a student's early drug use. Therefore, we must require substance use education and identification along with resources.

Recommendations

33. Scale the "Healthy Families – Healthy Youth" substance abuse prevention pilot and ensure its availability to all 7th grade students, parents, and faculty in the state.
34. Engage the Arizona Board of Education to consider a mandate that substance abuse be a part of the required health curriculum.
 - a. Utilize specialists and peers to assist in the delivery of evidence-based curricula.
 - b. Develop school-based drug prevention programming that builds drug-free culture.
 - c. As a part of the required health curriculum, prescreen for potential substance use precursors using the Adverse Childhood Experiences (ACEs) questionnaire and screen for substance abuse using the adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT) process.

⁹ Memorandum from Emily Heller, National Council of State Legislatures, to Claire Scheuren, Task Force Member, June 13, 2016.

¹⁰ Tracy J. Evans-Whipp, Stephanie M. Plenty, Richard F. Catalano, Todd I. Herrenkohl, and John W. Toumbourou. Longitudinal Effects of School Drug Policies on Student Marijuana Use in Washington State and Victoria, Australia. *American Journal of Public Health*: May 2015, Vol. 105, No. 5, pp. 994-1000.

35. Discourage schools from suspending children and youth for using substances. Instead, encourage schools to implement programs such as SBIRT and “Teen Intervene” and student assistance programs.

Access to Treatment

Arizonans in need of substance abuse treatment face substantial challenges. Barriers to treatment include lack of available treatment beds, delays in receiving appointments, lack of insurance or insurance restrictions, gaps in treatment services, lack of childcare, lack of transportation, and lack of culturally and linguistically appropriate treatment, among others.

Overdose Treatment

Treatment of overdoses in hospital emergency departments (EDs) is inefficient and incomplete without a referral to further treatment. It is essential to provide additional education to ED physicians on addiction and resources for timely referrals to appropriate SUD treatment providers.

In Arizona, HB 2355, signed by Governor Doug Ducey on May 12, 2016, allows a pharmacist to dispense naloxone without a prescription to a person at risk of experiencing an opioid-related overdose, a family member, or community member in a position to assist that person. It also protects prescribers from certain liabilities to encourage widespread prescriptions for the medication.

Pregnant women can be safely given naloxone in limited doses under the supervision of a doctor.

A doctor or pharmacist can show patients, their family members, or caregivers how to administer naloxone. Administration of the medication, whether intranasal or intramuscular, every two to three minutes is recommended during a suspected opioid overdose. Patients who have naloxone should keep the item available at all times in case of emergency. Medication should be replaced when the expiration date passes.

Naloxone is not effective in treating overdoses of benzodiazepines, alcohol, or stimulant overdoses involving cocaine or amphetamines.

Recommendations

36. One of the National Safety Council's six key indicators of state progress in addressing the drug epidemic is mandatory provider education.¹¹ All medical providers should participate in continuing education (CE) on addiction and the range of available treatments.
37. Increase access to the overdose antidote naloxone (Narcan™).
 - a. Conduct a needs assessment regarding the distribution of naloxone kits in Arizona and create strategies to support harm reduction.
 - b. Conduct community overdose education and prevention programs and distribute naloxone overdose prevention kits. Distribution must be accompanied with appropriate training on how to recognize the signs of an overdose, when and how to administer naloxone, the

¹¹ National Safety Council. (2016). Prescription Nation 2016: Addressing America's Drug Epidemic, 4-5.

importance of calling 911, and how to administer rescue breathing until 911 first responders arrive.

38. Promote greater use of naloxone, especially in populations that are prone to fatal overdose such as people getting out of jail or prison, veterans, and individuals leaving the emergency department or a treatment program.
39. Determine medical best practices in treating overdoses of benzodiazepines, alcohol, and stimulants and include those in medical provider continuing education (CE) and with family members or caregivers.
40. Engage hospitals to ensure that adequate information on referral options are available for patients being treated for drug overdoses.

Addiction Treatment

Individuals who experience a drug- or alcohol-related crisis and intervention are often willing, within a short window of time, to engage in a conversation about entering treatment. However, for many individuals with SUD, Arizona lacks the capacity to provide immediate treatment. There is a shortage of available beds and providers.

Delays in connecting an individual with services due to lack of capacity result in lost opportunities to get the person into treatment. One Task Force member talked about times when 50 percent of emergency room patients have a substance abuse and/or mental health issue; one patient was in the hospital for 14 days without treatment while waiting for a bed in a treatment facility. This highlights the need for additional collaboration between hospitals and treatment providers. We must make treatment readily available when individuals have their “moment of clarity.”

SAMHSA supports a trauma-informed approach to the treatment of SUD, saying:

A program, organization, or system that is trauma-informed:

- Realizes the widespread impact of trauma and understands potential paths for recovery;
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively resist re-traumatization.

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.¹²

Vista Thompson, Associate General Counsel, Blue Cross Blue Shield of Arizona, offered a presentation to the Task Force on mental health parity and commercial insurance. She noted that parity legislation does not force a health plan to cover mental health or substance abuse treatment. Instead, the law mandates that if a plan elects to cover such treatments, they must cover it as equally as they cover medical and surgical

¹² <http://www.samhsa.gov/nctic/trauma-interventions>

benefits. Insurers may implement a number of restrictions on services.¹³

Recommendations

41. Develop resources and communication mechanisms after the initial assessment to support a “no wrong door” and “warm hand-off” approach when an individual seeks treatment. A care coordinator, case manager, or navigator from the entity that conducts the assessment should stay with the person until the next phase of the treatment process begins, using an online treatment locator if necessary.
42. Provide assistance in navigating the system to individuals seeking treatment.
43. Assess the 24/7 availability of appropriate treatment levels and increase treatment capacity throughout Arizona as needed to ensure that appropriate services are available immediately when an individual seeks treatment. This includes early intervention, inpatient and outpatient detox, inpatient treatment beds, intensive outpatient (IOP) treatment, and outpatient treatment.
44. Expand the number of one-stop, comprehensive programs. The integration of physical and behavioral health care provides multiple benefits for patients as well as cost savings.
45. Design and implement, with consistent funding and appropriate staffing, an effective information disbursement system so that information about substance abuse treatment gets to communities throughout the state, including rural, frontier areas and tribal lands. This might be incorporated into one provider by combining multiple resources such as Arizona 2-1-1 Community Information and Referral Services, Crisis Response Network, and others. The Arizona Substance Abuse Locator (<http://substanceabuse.az.gov>) lists prevention, treatment, and recovery providers and is searchable by ZIP code.
46. Encourage providers to use a Trauma-Informed approach when assessing and interacting with individuals with SUD and their families.
47. Encourage the use of motivational interviewing by treatment providers.
48. Provide training and education for law enforcement professionals on SUD and treatment options
49. Encourage providers to offer after-school IOP programs for school-age youth.
50. AHCCCS should consider contractual requirements that facilitate additional options for treatment availability.
51. Encourage the Regional Behavioral Health Authorities (RBHAs) to share best and promising practices with the other RBHAs, the AHCCCS managed care organizations (MCOs), and commercial health plans.
52. AHCCCS should consider opening up Screening, Brief Intervention and Referral to Treatment (SBIRT) codes. This may require an additional appropriation to AHCCCS to cover the associated costs
53. Put in place programs for early screening of youth for both substance abuse and mental health in order to connect youth to help.
54. Design and implement a statewide messaging campaign that incorporates the SBIRT program into all appropriate settings.
55. Increase affordable and readily available services for children, adolescents, and adults in need of treatment through expanding public education, implementing public policies that support access, and addressing workforce shortages.

¹³ Vista Thompson, Associate General Counsel, Blue Cross Blue Shield of Arizona, presentation to Task Force, April 27, 2016.

56. Increase both awareness of and the capacity of crisis stabilization recovery centers in Arizona.
57. Develop and disseminate scripts for professionals, families, and friends to talk with individuals who are not ready for treatment, but may be in the future.

Criminal Justice System

Criminal justice issues were discussed in several of the Work Groups and in response to requests for information, presentations were offered on a number of topics and programs. A recurring theme was the importance of understanding addiction as a health issue, not a criminal issue.

Youth Detention

Both the Yuma County Juvenile Court and the Pima County Juvenile Court Center have engaged with the Juvenile Detention Alternatives Initiative (JDAI), a project of the Annie E. Casey Foundation designed to reduce the negative impacts of youth detention. The likelihood of future success for youths who experience detention is bleak, according to the Justice Policy Institute:

A recent literature review of youth corrections shows that detention has a profoundly negative impact on young people’s mental and physical well-being, their education, and their employment. One psychologist found that for one-third of incarcerated youth diagnosed with depression, the onset of the depression occurred after they began their incarceration, and another suggests that poor mental health, and the conditions of confinement together conspire to make it more likely that incarcerated teens will engage in suicide and self-harm. Economists have shown that the process of incarcerating youth will reduce their future earnings and their ability to remain in the workforce, and could change formerly detained youth into less stable employees. Educational researchers have found that upwards of 40 percent of incarcerated youth have a learning disability, and they will face significant challenges returning to school after they leave detention. Most importantly, for a variety of reasons to be explored, there is credible and significant research that suggests that the experience of detention may make it more likely that youth will continue to engage in delinquent behavior, and that the detention experience may increase the odds that they will recidivate, further compromising public safety.¹⁴

Since 1992, JDAI has demonstrated that jurisdictions can safely reduce reliance on secure confinement and generally strengthen their juvenile justice systems through a series of interrelated reform strategies. JDAI is now being applied in almost 200 jurisdictions in 39 states and the District of Columbia, including highly successful implementation in a few places in Arizona. Outcomes demonstrate that the use of detention can be reduced through eight interrelated, core reform strategies: Community Collaboration, Data Driven Decisions, Objective Admission Criteria, Alternatives to Detention, Expedited Case Processing, Special Detention Cases, Reducing Racial Disparity, and Conditions of Confinement.¹⁵

For example, the Hope Assessment Center in Yuma, which uses the JDAI model, offers a welcoming atmosphere and is available 24/7. Minors can be referred by police, parents/guardians, teachers, or can walk into the center on their own. The goal is to front-load services in the community before problems

¹⁴ Holman, Barry & Jason Ziedenberg, Justice Policy Institute, The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities, 2006, 2-3.

¹⁵ <http://www.jdaihelpdesk.org/default.aspx>.

escalate to the need for detention. Of 194 youth who went into the Center, only 16 came back on another referral.¹⁶

Police Department Support for People Living with SUD

The Gloucester, MA Police Department developed a policing program designed to help people living with substance addiction to receive help. The model uses volunteer “Angels,” who guide individuals through the process, and created a partnership of treatment providers to ensure that people receive immediate care and treatment. Police do not arrest people who come to the police station and ask for help. The police also dispose of drugs and drug paraphernalia.¹⁷

The Arizona Angel Initiative (AAI) is now being piloted in the Maryvale precinct of the Phoenix Police Department. Citizens are able to walk into the police precinct, turn in their drugs, and request treatment without fear of arrest. Police check applicants to make sure they do not have pending charges for crimes that involve violence, arson, sex, children, or the elderly. Peer-support “Angels” have been trained and the network of volunteer providers is growing. Other sites in Arizona, for example, Chandler, are getting ready to launch the program.

Recommendations

58. Encourage police departments throughout Arizona to implement an Angel Initiative program.
59. Scale the AAI to interested counties to better assist individuals into treatment during their “moment of clarity” while reducing costs to law enforcement.
60. Expand the AAI to include street outreach in identified high drug distribution areas to expedite connection to treatment and reduction of criminal activities.

Prison Transition and Recidivism Prevention

A barrier to SUD treatment for incarcerated individuals is that Medicaid dollars cannot be used to provide services in jails and prisons.

The Arizona Department of Corrections presented four re-entry strategies to the Task Force: utilizing risk/need assessments to ensure the right people are receiving the most appropriate programs to maximize resources, capitalizing on alignment of inmate programs to proactively support successful re-entry and transition, focusing on strategies for strengthening community re-entry and transition efforts, and relying on community partner collaboration.¹⁸

Individuals face multiple barriers to success after incarceration, including getting a job and finding an apartment. Examples of re-entry services include assessment, case management, mentoring, and counseling. Agencies may provide assistance with employment, educational/vocational training, obtaining food boxes, mental health/medical services, medication needs, public assistance programs, faith-based

¹⁶ Presentation to Prevention and Early Intervention Work Group by Jennifer Ortiz & Steve Tyrrell, Arizona Supreme Court, Administrative Office of the Courts, May 11, 2016.

¹⁷ <http://gloucesterpd.com/addicts/>

¹⁸ Presentation to Task Force by Karen Hellman, Arizona Department of Corrections, May 25, 2016.

services, twelve-step groups, housing needs, literacy tutoring, and transportation support.¹⁹

Steve Grams presented on SAGE Counseling’s transition program, which allows an offender to be released 90 days earlier than their court-ordered sentence. The offender is provided with both counseling and case management services, and 75 to 80 percent of participants successfully finish the program. Recidivism is low—approximately 16 percent. Some Work Group members expressed concern that jails and prisons have financial motivations to block early release.

Best outcomes are achieved when the transitional process starts prior to release.

The Bridging the Gap Offender Re-entry (BTG-OR) Program pilot is designed to provide clients with the tools they need to avoid recidivism. The pilot targets men designated by the Maricopa County Adult Probation Department (MCAPD) as medium- to high-risk of reoffending and with a co-occurring substance abuse or mental health diagnosis. The program is able to provide wrap-around services and supports such as housing, employment, food, residential substance abuse treatment, primary health care, and HIV education, counseling, and testing.

BTG-OR is a collaboration of Terros Health, MCAPD, the Arizona Department of Corrections, Crossroads, and St. Joseph the Worker, with funding from SAMHSA. Because the pilot is still underway final analysis is not yet available. However, about 138 individuals have completed the program and fewer than 10 percent were incarcerated for new offenses within the first six months after release. Programs like BTG-OR can provide substantial financial savings to the state: BTG-OR costs \$415,000 per year for services for 50 people, compared to the cost of \$1.75 million annually to keep 50 inmates in prison. Reduced recidivism also improves public safety and reduces crime.²⁰

Access to Treatment Work Group member Doray Elkins shared information about numerous models and programs that are experiencing positive results in treating addiction and reducing recidivism through the use of the injectable form of naltrexone, Vivitrol®. She provided statistics from the Sacramento (CA) County Sheriff’s Department, Barnstable County (MA) Sheriff’s Office, Nassau County (NY) Opiate Treatment Program, and Partners for Progress (AK), among others.

Recommendations

61. Recognize substance abuse disorder as a disease. Shift substance abuse from a criminal issue to a health issue through public health campaigns and policy changes. Destigmatize substance abuse and focus on treatment.
62. Change the culture of over-institutionalization of individuals with SUD. Offer mandatory treatment as an option in lieu of incarceration for an individual who is not a fugitive from justice and does not have prior or pending charges for crimes involving violence, arson, sexual offenses, children, or the elderly. Scale JDAI and the Arizona Angel Initiative throughout the state.
63. With 77 percent of incarcerated males and 89 percent of incarcerated females reporting an SUD, ensure treatment for all who will at some future date be released. Explore grant funding in order to pay providers to deliver treatment services in jails and prisons.

¹⁹ Presentation to Task Force by Steve Grams, SAGE Counseling, May 25, 2016.

²⁰ Presentation to Prevention and Early Intervention Work Group by Andrea Smiley & John Greenawalt, Terros, June 29, 2016.

64. Ensure access to intervention and treatment, and create a safe environment for recovery in jails and prisons. A full range of MAT and counseling should be available.
65. Allow diversion and transitional program providers to have access to clients in jails and prisons. Most county jails allow access (although access is very limited for some); the Department of Corrections historically has not allowed providers into prisons.
66. Ask the Arizona Substance Abuse Partnership (ASAP) Committee's Department of Corrections Advisory Work Group to ensure that the Department of Corrections immediately and fully implements the four re-entry strategies presented to the Task Force.
67. Ask the GOYFF to convene a group to further discuss and define what Arizona's version of "Ban the Box" might be.
68. Support and expand programs that connect offenders who have a bond release with high-quality case quality transition, step-down, or comprehensive treatment that includes case management, counseling, and support, as appropriate for the individual.
69. Include families in transition programs to the extent possible.
70. Provide assistance with applications for AHCCCS coverage.
71. Encourage counties and the state to work more closely in order to leverage resources.

Sober Living Homes

Some Access to Treatment Work Group members expressed concern about sober living homes, which are not regulated or licensed in Arizona. Homes are able to avoid licensure requirements because they send patients to other licensed providers for treatment, and the home essentially functions only in the capacity of sleeping quarters. Staff often has little experience in working with substance abuse and some residents bring illegal substances into the home, which challenges residents' ability to maintain sobriety. Homes are often poorly maintained and located in areas where drugs are readily available.

This may change somewhat as a result of HB 2107, signed by Governor Doug Ducey on May 17, 2016. This legislation permits a city, town, or county to adopt ordinances regulating health and safety standards and enforcement mechanisms for a structured sober living home.

Access to Treatment Work Group members also expressed concern about treatment programs that illegally seek referrals by contracting with individuals who search for people living with SUD on the facility's behalf. Programs enroll patients in insurance upon admission and drop the insurance policy when patients leave the program.

Recommendations

72. Encourage cities, towns, and counties to make use of the provisions of HB 2107 to improve the safety and effectiveness of sober living homes.
73. Convene a group to develop regional protocols and criteria for sober living homes and to address the problem of illegal referrals. The group should explore the merits of reinstating the sober living home criteria that were in place in Arizona prior to 2013.
74. Treatment facilities and sober living homes should be held accountable to an evidence-based best practice standard of care.

Supporting Families/Caregivers

Providers know the importance of involving families and caregivers in treatment programs. However, the Health Information Portability and Accountability Act (HIPAA) prevents medical providers from sharing information with family members without the permission of the patient/client. Nonetheless, programs that provide support for families and caregivers during the treatment process are often welcomed and effective.

Recommendations

75. Educate providers about the importance of social supports and involve the family, if appropriate, and/or other relational supports in the treatment process. Lack of social supports is a core issue that can lead to substance abuse.
76. Develop a support system to help families navigate the systems involved with substance abuse intervention and treatment.

Medication-Assisted Treatment

MAT Modalities

Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral health therapy and medications to treat substance abuse disorders. Comprehensive treatment plans include counseling and social support programs. SAMHSA describes MAT as follows:²¹

Buprenorphine

Buprenorphine is an opioid partial agonist. This means that, like opioids, it produces effects such as euphoria or respiratory depression. With buprenorphine, however, these effects are weaker than those of full drugs such as heroin and methadone and it effectively blocks the effects of those drugs. Buprenorphine has unique pharmacological properties that help:

- Lower the potential for misuse
- Diminish the effects of physical dependency to opioids, such as withdrawal symptoms and cravings
- Increase safety in cases of overdose
- The U.S. Food and Drug Administration (FDA) has approved:
 - Bunavail® (buprenorphine and naloxone) buccal film
 - Suboxone® (buprenorphine and naloxone) film
 - Zubsolv® (buprenorphine and naloxone) sublingual tablets
 - Buprenorphine-containing transmucosal products for opioid dependency

Buprenorphine's opioid effects increase with each dose until at moderate doses they level off, even with further dose increases. This "ceiling effect" lowers the risk of misuse, dependency, and side effects. Also, because of buprenorphine's long-acting agent, many patients may not have to take it every day.

²¹ Adapted by Task Force from <http://www.samhsa.gov/medication-assisted-treatment>

Limited information exists on the use of buprenorphine in women who are pregnant and have an opioid dependency. There have been studies that have shown the safety of buprenorphine use during pregnancy. The FDA, however, classifies buprenorphine products as Pregnancy Category C medications, indicating that the risk of adverse effects has not been ruled out. If used during pregnancy, it should be used by itself rather than in combination with naloxone.

To prescribe, physicians must qualify and apply for a waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000). Qualified physicians may provide treatment in a variety of settings, including in an office, community hospital, health department, and correctional facility. SAMHSA-certified OTPs may dispense buprenorphine.

Methadone

Methadone works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opiate drugs such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. It can be addictive so it must be used exactly as prescribed. Taking more can cause unintentional overdose.

Methadone is offered in pill, liquid, and wafer forms and is taken once a day. Pain relief from a dose of methadone lasts about four to eight hours. Methadone treatment should ideally last a minimum of 12 months. Some patients may require treatment for years. Treatment must be stopped gradually to prevent withdrawal.

Methadone as an opioid use disorder treatment is carefully regulated. It can only be dispensed through an OTP certified by SAMHSA. MAT services professionals are required to acquire and maintain certifications to legally dispense and prescribe opioid dependency treatments. After a period of stability (based on progress and proven, consistent compliance with the medication dosage), patients may be allowed to take methadone at home between program visits.

SAMHSA says that women who are pregnant or breastfeeding can safely take methadone. When withdrawal from an abused drug happens to a pregnant woman, it causes the uterus to contract and may bring on miscarriage or premature birth. Methadone's ability to prevent withdrawal symptoms helps pregnant women better manage their addiction while avoiding health risks to both mother and baby. Undergoing methadone maintenance treatment while pregnant will not cause birth defects, but some babies may go through withdrawal after birth. This does not mean that the baby is passively dependent. Infant withdrawal usually begins a few days after birth but may begin two to four weeks after birth.

Mothers taking methadone can still breastfeed. Research has shown that the benefits of breastfeeding outweigh the effects of the small amount of methadone that enters the breast milk. A woman who is thinking of stopping methadone treatment due to breastfeeding or pregnancy concerns should speak with her doctor first.

Naltrexone

Naltrexone blocks the euphoric and sedative effects of drugs such as heroin, morphine, codeine, and alcohol. It is non-narcotic and non-addictive. It works differently in the body than buprenorphine and methadone, which activate opioid receptors in the body that suppress cravings. Naltrexone binds to and blocks opioid receptors, and is reported to reduce opioid cravings. There is no abuse and diversion potential with naltrexone. If a person relapses and uses the problem drug, naltrexone prevents the feeling of getting high.

The pill form of naltrexone (ReVia®, Depade®) can be taken at 50 mg once per day. The injectable extended-release form of the drug (Vivitrol®) is administered at 380 mg intramuscular once a month. Any health care provider who is licensed to prescribe medications can prescribe naltrexone and special training is not required.

Medically managed detoxification is required before initiating or resuming treatment with naltrexone. Patients must abstain from illegal opioids and opioid medication for a minimum of 7-10 days before starting naltrexone. If switching from methadone to naltrexone, the patient has to be completely withdrawn from the opioids.

Patients on naltrexone may have reduced tolerance to opioids and may be unaware of their potential sensitivity to the same, or lower, doses of opioids that they used to take. If patients who are treated with naltrexone relapse after a period of abstinence, it is possible that the dosage of opioid that was previously used may have life-threatening consequences, including respiratory arrest and circulatory collapse.

Naloxone

Naloxone (sold under the brand name **Narcan®**) is a medication approved by the FDA to prevent overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection. Naloxone is also added to buprenorphine to decrease the likelihood of diversion and misuse of the combination drug product. (See "Overdose Treatment" on pages 14-15 for details and recommendations.)

MAT Issues

The Task Force recognizes that there is a divide in the treatment community concerning MAT. It can be difficult for some providers to accept new and innovative practices. Additionally, stigmas within and outside the treatment arena may make it difficult to accept MAT. Some treatment programs and sober living homes require individuals to be off MAT to be admitted, which may not be in the best interest of the individual. The Task Force is clear that there is not a "one size fits all" treatment and that each person seeking treatment for SUD must be treated as an individual. As one Work Group member said, "MAT Work Group is not a magic bullet."

However, MAT should be seriously considered as an effective treatment option and should always be

used as part of a comprehensive treatment plan that includes counseling and participation in social support programs. Consistent communication and coordination of care among providers greatly enhances treatment. MAT may be a lifelong need to prevent relapse because some people never recover the endorphin physiology they had before the addiction.

Adolescents and Young Adults

An August 2016 American Academy of Pediatrics policy statement said: “Opioid use disorder is a leading cause of morbidity and mortality among U.S. youth. Effective treatments, both medications and substance use disorder counseling, are available but underused, and access to developmentally appropriate treatment is severely restricted for adolescents and young adults. Resources to disseminate available therapies and to develop new treatments specifically for this age group are needed to save and improve lives of youth with opioid addiction.”²² There are numerous opportunities for youth to develop leadership skills through peer prevention, early intervention, and treatment programs.

Medicaid Coverage

The AHCCCS Pharmacy and Therapeutics Committee (P&T) reviewed the substance use disorder class at the May 2016 P&T meeting and will be re-reviewing annually moving forward. Decisions from the May 2016 P&T for this class include removal of prior authorization for long-acting injectable naltrexone (Vivitrol®) and adding naloxone (Narcan®) without prior authorization. Additionally, the P&T will be reviewing the long-acting narcotic analgesics class at the October 2016 P&T and will consider abuse-deterrent options to be added to the AHCCCS Drug List at that time. (Note that the AHCCCS P&T only applies to medication coverage through Medicaid, i.e., does not apply to private/commercial medication coverage.)

Increasing the Availability of MAT Providers

The number of physicians who provide MAT is not adequate to address the level of need in Arizona. Some MAT Work Group members reported that the mechanics of licensure are very onerous and the current situation scares off providers who might be interested in providing substance abuse treatment. The National Safety Council (NSC) recommends that “physician patient caseload limits be raised for buprenorphine-waivered physicians and that advanced practice nurses are allowed to obtain DATA-2000 waivers to prescribe buprenorphine. NSC also recommends that federal and state-funded substance abuse services offer MAT, the most effective methods of opioid dependence treatment. Care should be coordinated and MAT provided in conjunction with counseling and recovery support services.”²³

On July 6, 2016, the Department of Health and Human Services (HHS) released a final rule (effective August 8, 2016) to increase access to MAT with buprenorphine products in the office setting by allowing eligible practitioners to request approval to treat up to 275 patients. The final rule also includes requirements to ensure that patients treated by these practitioners receive high-quality care.

To be eligible for a patient limit increase to 275, a physician must possess a current waiver to treat up to

²² <http://pediatrics.aappublications.org/content/early/2016/08/18/peds.2016-1893>

²³ National Safety Council. (2016). Prescription Nation 2016: Addressing America’s Drug Epidemic, 26.

100 patients, must have maintained that waiver without interruption for at least one year, and meet one of the following requirements:

- Hold “additional credentialing,” meaning board certification in addiction medicine or addiction psychiatry by the American Board of Addiction Medicine (ABAM) or the American Board of Medical Specialties (ABMS) or certification by the American Osteopathic Academy of Addiction Medicine, ABAM or ASAM; or
- Practice in a “qualified practice setting,” meaning a practice that:
 - Provides professional coverage for patient medical emergencies during hours when the practitioner’s practice is closed.
 - Provides access to case-management services for patients including referral and follow-up services for programs that provide, or financially support, the provision of services such as medical, behavioral, social, housing, employment, educational, or other related services.
 - Uses health information technology (health IT) systems such as electronic health records, if otherwise required to use these systems in the practice setting. Health IT means the electronic systems that health care professionals and patients use to store, share, and analyze health information.
- Is registered for their State prescription drug monitoring program (PDMP) where operational and in accordance with Federal and State law
- Accepts third-party payment for costs in providing health services, including written billing, credit, and collection policies and procedures, or federal health benefits.

Additionally, practitioners may not have had Medicare enrollment and billing privileges revoked under 42 CFR 424.535 nor have been found to have violated the Controlled Substances Act pursuant to 21 U.S.C. 824(a) to be eligible for the higher limit.

The rule does not extend prescribing authority to clinicians other than physicians as the original DATA 2000 statute limits the practitioners eligible for the waiver to physicians. As such, HHS does not have the authority to extend prescribing privileges to other clinicians.²⁴

In response to public comments, the rule notes: “Questions related to expanding eligible prescribers are outside the scope of this rulemaking; the statute limits who is eligible to prescribe buprenorphine for MAT. 21 U.S.C. 823(g)(2) limits the practitioners eligible for waiver in this context to physicians, and, therefore, HHS is not authorized to include other types of providers in this rule. However, HHS recognizes the issues raised by commenters and the President’s FY 2017 Budget proposes a buprenorphine demonstration program to allow advanced practice providers to prescribe buprenorphine. This would allow HHS to begin testing other ways to improve access to buprenorphine throughout the country.”²⁵

A Task Force member talked about the success of Project Extension for Community Care Outcomes, known as Project ECHO, which helps rural doctors and nurses in New Mexico address substance abuse and other issues. It links primary care clinics in rural areas with the University of New Mexico’s School of Medicine in Albuquerque over an Internet-based, audio-visual network. Unlike most telehealth initiatives,

²⁴ <http://www.asam.org/magazine/read/article/2016/07/06/summary-of-the-major-components-of-the-hhs-final-rule-which-will-be-effective-on-august-5-2016>

²⁵ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-16120.pdf>

which mainly connect patients with doctors, Project ECHO focuses on training rural doctors, nurses, physician's assistants, and other clinicians, and helping them stay current with advances in treating chronic disease and addressing other specialized health conditions. It is funded by the Agency for Health-care Research and Quality (AHRQ).²⁶

Katherine Cates-Wessel, Executive Director, American Academy of Addiction Psychiatry, presented to the MAT Work Group on the Providers Clinical Support System for Medication-Assisted Treatment (PCSS-MAT) and the Providers Clinical Support System for Opioid Therapies (PCSS-O). Both evidence-based programs are internet-based and free of charge. Mentors are provided without charge. The PCSS-MAT coalition is based on integrated health and interdisciplinary collaboration. Partner groups receive dollars to support trainings directed toward various constituencies.

The American Osteopathic Academy of Addiction is a partner organization and provides waiver training in rural communities that have a hard time finding resources and experts. The American Psychiatric Association offers "hot topic" webinars each month on topics such as preparing for Drug Enforcement Administration (DEA) inspection and working with pregnant women using Suboxone®. The American Society of Addiction Medicine (ASAM) provides training in collaboration with the American Congress of Obstetricians and Gynecologists (ACOG) that focuses on pregnant women.

Comprehensive Addiction and Recovery Act (CARA)

The Comprehensive Addiction and Recovery Act (CARA) (P.L. 114-198) was signed into law by President Barack Obama on July 22, 2016. It authorizes over \$181 million each year in new funding to fight the opioid epidemic; however, monies must be appropriated every year through the regular appropriations process in order for it to be distributed in accordance with the law. Components include the following:

- Expand prevention and educational efforts—particularly aimed at teens, parents and other caretakers, and aging populations—to prevent the abuse of methamphetamines, opioids, heroin and to promote treatment and recovery.
- Expand the availability of naloxone to law enforcement agencies and other first responders to help in the reversal of overdoses to save lives.
- Expand resources to identify and treat incarcerated individuals suffering from addiction disorders promptly by collaborating with criminal justice stakeholders and by providing evidence-based treatment.
- Expand disposal sites for unwanted prescription medications to keep them out of the hands of our children and adolescents.
- Launch an evidence-based opioid and heroin treatment and intervention program to expand best practices throughout the country.
- Launch a medication assisted treatment and intervention demonstration program.
- Strengthen prescription drug monitoring programs to help states monitor and track prescription drug diversion and to help at-risk individuals access services.²⁷

²⁶ <https://healthit.ahrq.gov/ahrq-funded-projects/transforming-healthcare-quality-through-health-it/project-echo-bringing>

²⁷ <http://www.cadca.org/comprehensive-addiction-and-recovery-act-cara>

CARA also includes a provision that permits nurse practitioners and physician assistants to prescribe buprenorphine for the first time.²⁸

Worker's Compensation and Prescriptions

Jacqueline Kurth of the Industrial Commission of Arizona presented to the MAT Work Group on Workers' Compensation and Prescriptions. Over the last few years, the Commission has seen an increase in narcotic use for back pain and other chronic pain. People may see multiple physicians and receive prescriptions for multiple medications. She provided a copy of ARS 23-10062, which regulates off-label and prescription use of controlled substances. She talked about the committee of physicians, attorneys, payors, and staff who met for more than two years, starting in 2012, to reach agreement on the use of the Official Disability Guidelines (ODG). A pilot implementation of ODG failed. New medical treatment guidelines, Arizona Rules R20-5-1301 through R20-5-1312, were recently approved, with an effective date of 10/1/2016 to implement changes. This will include a closed drug formulary with preauthorization needed for all drugs classified as opioids and all drugs prescribed for claims that relate to chronic pain management. There will also be changes to medical treatment guidelines.

The Commission has an electronic portal so that physicians, workers, or payers can submit a request for a peer review, with physicians reviewing other physicians' recommendations for treatment. The hope is to have quality decisions that resolve problems faster than litigation. Going forward, with newly injured workers, the Commission hopes the rules will prevent future problems with opioid addiction. There is a statute in place (231062.02f) that prevents payers from not authorizing opioids. The Commission is working on a report with steps for transitions such as weaning off drugs and detox.

Example of an Outpatient MAT Protocol

MAT Work Group member Dr. Rick Sloan provided a summary of the treatment protocol he uses at his Glendale, Arizona, outpatient clinic. His approach, developed by Dr. Peter Coleman of The Coleman Institute, starts with a full physical exam followed by detoxification using multiple medications (olanzapine, tramadol, clonidine, diazepam, and baclofen) to block withdrawal symptoms. A reliable support person, usually a family member or friend, administers the medications at home. The detox process takes 3-9 days plus a 5-7 day taper-off period. He does an IV Narcan® challenge to check for the presence of opioids before starting naltrexone. His preferred form of naltrexone is an implant. Patients receive counseling three times per week for at least one year. He reported a high success rate. The clinic's patient population ranges from ages 18-79. This approach has not yet been published in peer-reviewed journals and it not considered evidence-based at this time. It is considered to be an emerging practice.

Recommendations

77. Increase the number of providers who are trained and licensed to provide MAT in Arizona. The Task Force recognizes that people with SUD are a high-risk population with a high rate of

²⁸ <http://www.drugpolicy.org/news/2016/07/congress-passes-landmark-opioid-bill-comprehensive-addiction-and-recovery-act-cara>

comorbidities and many physicians are risk averse. Nonetheless, we must develop scalable strategies to address the shortage of providers who are willing, qualified, and licensed to administer MAT so that it is available in a timely and appropriate way similar to other chronic conditions, such as congestive heart failure and diabetes. Tactics include the following:

- a. Recognize the importance of MAT as one of the most effective strategies for preventing relapse for opioid use disorders.
 - b. Streamline the licensure process and DEA oversight procedures.
 - c. Increase awareness and trainings for doctors not currently utilizing MAT in order to fill the void in available services.
 - d. Educate medical providers on how and why to use the full continuum of MAT, including, but not limited to, methadone, buprenorphine/naloxone (Suboxone®), and naltrexone (Vivitrol®).
 - e. Encourage physicians to obtain a waiver to prescribe or dispense buprenorphine with approval to treat the highest number of patients allowed by federal regulations.
 - f. Encourage the federal government to lift the cap on the number of patients that a provider can treat on specific MAT drugs such as buprenorphine.
 - g. Support the ability of nurse practitioners and physician assistants to prescribe buprenorphine as allowed under the Comprehensive Addiction and Recovery Act.
 - h. Explore the feasibility of Arizona being one of the PCSS-MAT waiver training sites.
 - i. Identify ways to magnify the impact of existing providers, for example, using telemedicine, or adopting ambulatory detox protocols.
 - j. Develop an extensive system of educational resources aimed at increasing the knowledge base and training of prescribers from diverse, multidisciplinary health care backgrounds.
 - k. Encourage a broad range of providers to complete the Relias Medication-Assisted Treatment in Opioid Addiction module.
 - l. Educate primary care physicians about the recent American Academy of Pediatrics policy statement “Medication-Assisted Treatment for Adolescents with Opioid Use Disorders.” The policy statement calls on pediatricians to consider offering medication-assisted treatments to their adolescent and young adult patients with opioid use disorders or refer them to other providers who can.²⁹
 - m. Develop an educational loan repayment program for MAT-qualified providers working with low-income, rural, and/or underserved populations.
 - n. Create an addiction medicine fellowship in Arizona.
78. Implement the recommendations related to naloxone as described on pages 14-15.
79. Create a system of needs assessments for detoxification services, identify gaps, and increase capacity as needed so that appropriate levels of residential detox, inpatient detox, and outpatient detox services are readily available throughout Arizona.
80. Encourage the use of evidence-based tools to help determine whether residential, inpatient, or outpatient detoxification is the best choice for a given individual, followed by appropriate assessment and treatment.
81. Create and maintain a real-time statewide locator for available detox service providers that incorporate appropriate assessment modalities and the provision of or referrals for treatment.
82. Educate providers on the appropriate use of non-opioid MAT and expand non-opioid treatment programs to meet the level of need.

²⁹ <http://pediatrics.aappublications.org/content/early/2016/08/18/peds.2016-1893>

83. Create targeted strategies for MAT for special populations, for example, individuals involved with the Department of Corrections, pregnant women, Native American communities, and rural communities.
84. Ensure that all detox and treatment programs have the resources needed to test for communicable diseases, including Hepatitis C virus (HCV), HIV, AIDS, sexually transmitted diseases (STDs), and the Zika virus. Addressing this significant public health issue requires the availability of patient education materials that can help individuals with SUD understand the importance of screening tests. One example of a potential grant funded resource is the Gilead Sciences, Inc. FOCUS (Frontlines of Communities in the United States) program, which provides funding for HIV and HCV testing as a standard testing protocol in the integrated care setting.
85. Support the efforts of the Industrial Commission of Arizona to prevent future opioid addiction among Worker’s Compensation beneficiaries and to obtain treatment for individuals who already have SUD.
86. Continue to seek federal grant monies to support prevention, early intervention, and treatment efforts in Arizona.

Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome (NAS) is a serious and growing problem in Arizona and throughout the U.S. The rate of NAS increased by 235 percent in Arizona from 2008 to 2014 and 27 percent since 2013. AHCCCS was the payer in 79 percent of NAS cases overall from 2008 to 2014. The number of newborns with Fetal Alcohol Syndrome (FAS) increased 67 percent from 2013 to 2014. There were 1,374 Arizona newborns identified during 2015 with presence of a substance exposure at birth. The median cost for a NAS hospital stay is approximately \$31,000 versus \$2,500 for non-NAS related births.³⁰ Average hospital stay is 13 days compared to two days for non-NAS related births.³¹

There is a difference between NAS and SEN (substance-exposed newborns). NAS is withdrawal from a drug following birth. It is primarily caused by maternal opiate use (e.g., heroin, methadone, hydrocodone, oxycodone, Suboxone®, fentanyl) and also can be caused by use of amphetamines, barbiturates, benzodiazepines, marijuana, alcohol, and cocaine. Substance exposure leads to an infant being at risk for NAS, but not all exposed babies develop NAS. Mothers who test positive for opioids represent a wide spectrum in terms of the impact on babies: some babies never display effects of exposure, while others show symptoms immediately or soon after birth and may face ongoing health and/or developmental challenges.

Mothers using substances may avoid prenatal care because of shame, guilt, and/or stigma. It is important to reduce the stigma associated substance use and to provide the mother with resources for treatment, counseling, and support services. The earlier a practitioner is able to intervene in the mother’s prenatal care, the better for both the mother and the baby. A complicating factor is that due to the loss of the menstrual cycle when using heroin, the mother may not know that she is pregnant until twenty-four weeks. The American Congress of Obstetricians and Gynecologists (ACOG) reaffirmed the following Committee opinion in 2016:

³⁰ Median cost estimated from data collected from ADHS Hospital Discharge Database and reflect hospital charges and not actual reimbursement.

³¹ All data in this paragraph are from Arizona Department of Health Services, Office of Injury Prevention, July 2015 statistics. Presentation by Jennifer Dudek, MPH, ADHS to NAS Work Group, May 12, 2016.

Opioid use in pregnancy is not uncommon, and the use of illicit opioids during pregnancy is associated with an increased risk of adverse outcomes. The current standard of care for pregnant women with opioid dependence is referral for opioid-assisted therapy with methadone, but emerging evidence suggests that buprenorphine also should be considered. Medically supervised tapered doses of opioids during pregnancy often result in relapse to former use. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise. During the intrapartum and postpartum period, special considerations are needed for women who are opioid dependent to ensure appropriate pain management, to prevent postpartum relapse and a risk of overdose, and to ensure adequate contraception to prevent unintended pregnancies. Patient stabilization with opioid-assisted therapy is compatible with breastfeeding. Neonatal abstinence syndrome is an expected and treatable condition that follows prenatal exposure to opioid agonists.³²

NAS Work Group members said that identifying drug use and drug abuse early in pregnancy is as important as identifying venereal diseases, for which screens are part of the standard of care. Work Group members also said that prenatal and postnatal approaches to NAS are fragmented in Arizona; some protocols are good, but there is not consistency among providers or facilities. Not all obstetricians or hospitals have the capacity and capability to treat pregnant women who are using/abusing substances. There is a statewide need for a clear standard of care for providers and health plans, and for a robust network of resources. Work Group members said that the largest hurdle to the advancement of standardized practice will be the private/commercial medical providers; AHCCCS is already standardizing best practices of care for NAS babies.

The Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs is revising its identification of best practices among AHCCCS providers and is developing a protocol for use with all mothers. This will include a tool kit to screen, identify, and treat women using substances (The Arizona Health Plans Best Practice and Guidelines for Identifying Substance Exposed Newborns is included in Appendix D).

The Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs goals for 2015-2020 include:

- Work with providers and stakeholders to appropriately identify substance-exposed newborns in an effort to obtain a more accurate baseline of the incidence of SEN.
- Raise awareness and understanding of the risks and effects of prenatal exposure to alcohol and other drugs for families and communities.
- Create optimal opportunity for engagement in effective interventions and services for all women of reproductive age in Arizona.
- Promote successful outcomes for those individuals affected by SEN in Arizona.
- Strengthen the Task Force and elevate its standing so it can better carry out its mission and achieve its goals.³³

³² The American Congress of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women and the American Society of Addiction Medicine, Committee Opinion, Opioid Use, Dependence, and Addiction in Pregnancy, 524, May 2012, reaffirmed 2016, <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Opioid-Abuse-Dependence-and-Addiction-in-Pregnancy>

³³ Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs, Guidelines for Identifying

Critical factors hindering statewide efforts include:

- Raise awareness and understanding of the risks and effects of prenatal exposure to alcohol and other drugs for families and communities.
- Create optimal opportunity for engagement in effective interventions and services for all women of reproductive age in Arizona.
- Promote successful outcomes for those individuals affected by SEN in Arizona.
- Strengthen the Task Force and elevate its standing so it can better carry out its mission and achieve its goals.

Critical factors hindering statewide efforts include:

- There is evidence that the incidence of substance exposed newborns and NAS is rising.
- Lack of awareness and understanding of the impact of prenatal exposure.
- Lack of coordinated care for youth with prenatal exposure to alcohol and other drugs across the life span.³⁴

The hospital where a mother delivers is part of and often times the starting place for the continuum of care for NAS cases. Women tend to be more open to treatment in the hours following childbirth, which presents an opportunity to get the mother substance abuse care. However, there is no standardized policy or best practice for approaching the mother during this time period, and typically mothers spend a relatively short amount of time in the hospital.

Health care professionals are required to report substance exposure in infants to DCS. In SFY 2016, the Child Abuse Hotline received 4,059 reports with a substance-exposed newborn tracking characteristic. When DCS determines that a family needs intervention, options include out-of-home dependency, voluntary placement (out of home 90 days), or home with parents (with or without a safety monitor). Home options include in-home intervention, in-home dependency, or the Substance-Exposed Newborns Safe Environment (S.E.N.S.E.) program. S.E.N.S.E. includes a coordinated system of care for substance-exposed newborns and their families. This comprehensive program allows all agencies to share information, develop one comprehensive service plan, coordinate treatment schedules, and regularly share the family's ongoing progress. The greatest program emphasis is on the vulnerable infant, but the program also helps to preserve the family and treat the mother's drug or alcohol addiction. S.E.N.S.E. is available only in Maricopa, Mohave, Yuma, and Pima counties. Programs like S.E.N.S.E. in Arizona can provide resources and support to the mother, newborn, and the family after the neonate is discharged from NAS treatment.

Calm, gentle care in a quiet environment supports NAS babies during the withdrawal period. In contrast, the typical site of care for babies experiencing withdrawal is a Neonatal Intensive Care Unit (NICU), which is busy and noisy. Many NAS Work Group members expressed strong interest in a proposal presented by NICU nurse practitioners Kelly Woody, RN, NNP-BS, and Tara Sundem, MSN, RN, NNP-BS. They hope to replicate a model of care for babies suffering from NAS developed by Lily's Place in Huntington, WV. Caring for NAS babies in a residential treatment facility instead of the NICU provides a quieter, more therapeutic environment, cuts costs by as much as 75 percent, and better meets the needs of families.

³⁴ Substance-Exposed Newborns, 2016.

³⁴ A Report of the Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs, Prenatal and Other Drug Exposure in Arizona, prepared April 2015, updated February 2016, 12.

Tucson Medical Center (TMC) initiated a new treatment approach for NAS babies in Spring 2016: “Thanks to a TMC nursing task force, TMC in April opened an annex just outside the intensive care unit to provide [NAS] babies with a calming, quiet room featuring cycled lighting and fewer visitors to reduce overstimulation. Importantly, it also assigns specialized staff members who care just for these infants, who can be hard to console and who need significant time being swaddled and rocked to feel more secure. To expand care for these babies, volunteer coverage has doubled on shifts.”³⁵

Work Group members were supportive of an alternative model of care for NAS babies, in a calm, secure and quiet environment, that would allow the mother to stay onsite with her baby 24/7. Accommodations could be made for foster parents as necessary. Such a model could be implemented in a hospital or a freestanding facility with the mother (and father, if feasible) and baby rooming in together. The Children’s Hospital at Dartmouth-Hitchcock in New Hampshire found that costs dropped from \$19,700 to \$8,700 per baby for NAS babies treated with medicine and using the rooming in model.³⁶

Recommendations

87. Educate all prescribers about the potential danger of prescribing opiates to women of childbearing age, NAS, and mitigation tactics, including:
 - a. Using the CSPMP every time they prescribe an opiate.
 - b. Practitioners prescribing any medication to women of childbearing years, including opioids, should utilize evidence-based guidelines, which may include screening for pregnancy.
 - c. Conducting SBIRT when prescribing opiates to women of childbearing age. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with SUD, as well as those who are at risk of developing these disorders.³⁷
88. Work with the Arizona Perinatal Trust to develop, promote, and ensure compliance with standardized best practice protocols for newborn NAS treatment and maternal interventions.
89. Utilize existing codes and, if needed, ask CMS to establish a new reimbursement code and rate for alternative treatment facilities that provide a level of care for NAS babies that is less intensive and therefore less costly than the NICU, but more than the cost of care allowed for a well-child without a NAS diagnosis.
90. Collaborate with the Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs to update the Perinatal Substance Use and Abuse Among Women: A Task Force Report prepared in April 2015 and updated in February 2016.
91. Educate pediatricians, family physicians, obstetricians, and other providers about the ongoing health and developmental problems associated with NAS. Provide resources to support early intervention and appropriate treatment.
92. Increase awareness of NAS among people and agencies that interact with pregnant women. It is important to understand what the mother is going through and offer positive, long-term interventions to support the mother and child.
93. Train a broad range of health providers and provide tool kits to help them identify at-risk women before pregnancy.
94. Provide first responders with resources they can offer to pregnant women who are abusing

³⁵ <https://tmcaznews.com/2016/06/15/babies-experiencing-withdrawal-receive-specialized-care/>

³⁶ Children’s Hospital Association, Strategies to Care for Babies Born Drug Dependent, April 25, 2016, <https://www.childrenshospitals.org/Newsroom/Childrens-Hospitals-Today/Spring-2016/Articles/Caring-for-Babies-Born-Drug-Dependent>

³⁷ Substance Abuse and Mental Health Services Administration, <http://www.samhsa.gov/sbirt/about>

substances.

95. Educate women of childbearing age about the consequences of substance use/abuse during pregnancy and about NAS.
96. Allow health plans to provide case management for mothers and NAS babies during the first year of the baby’s life when feasible through reimbursement. This would include engagement, education, and support; coordination of care; and referral to community programs, state agencies, wrap-around services such as Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Arizona Early Intervention Program (AzEIP), home visiting programs, the Birth to 5 Hotline, developmental/behavioral health services for the child, and continued behavioral health/addiction services for the mother.
97. Encourage the health plans, AHCCCS, and the Health Information Exchange to enhance data tracking of NAS babies, using consistent data collection tools, to monitor progress and outcomes.
98. Because hospitals are required to report NAS and at-risk children to the Arizona Department of Child Safety (DCS), train hospital nurses, social workers, and providers need training on how to effectively interact with DCS. Require DCS to provide hospitals statewide with DCS hospital liaisons who are specifically trained to assess newborn safety and to connect families to resources for treatment and support. Liaisons are focused on prevention and provide triage and referral services.
99. Require DCS, in its supportive prevention and early intervention role, to function as a partner with providers in obtaining treatment and support for the mother and child. DCS can help to evaluate family-support tools and to ensure that every family has access to the necessary tools and resources to succeed.
100. Prohibit providers from using DCS as a threat against women. Educate providers about the resources that DCS offers and encourage them to talk about DCS as a source of support rather than a “stick” or punitive entity. DCS could play an interventionist role and connect the family to services, if eligible.
101. Establish a case code for DCS so that cases may remain open longer to ensure compliance and provide needed support for families that are reunified or kinship placements.
102. Secure funding to expand the S.E.N.S.E. program statewide.
103. Engage First Things First as a partner in SEN and NAS prevention.
104. Scale and fund the following evidence-based prevention and early intervention programs and incentivize involvement while a woman is pregnant:
 - a. Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together), also known as AFF, is a partnership of DCS, ADHS, and DES. The AFF program helps parents address substance abuse issues that are affecting their ability to care appropriately for their children or to get and keep a job. It provides the opportunity for families to overcome the barrier of substance abuse in order to reach the outcomes of permanency for children, family reunification, and self-sufficiency. The goal of the program is to reduce or eliminate abuse of and dependence on alcohol and other drugs and to address other adverse conditions related to substance abuse.
 - b. Healthy Families Arizona (HFAz) is a voluntary home visitation program that serves pregnant women and families of newborns. It is designed to help expectant and new parents get their children off to a healthy start. Families are screened according to specific

criteria and participate voluntarily in the program. Families that choose to participate receive home visits and referrals from trained staff. Program services are designed to strengthen families during the critical first years of a child's life – the time when early brain development occurs, laying the foundation for a lifetime of memories, behaviors and outcomes. Through its efforts to support and educate families, the program has shown to reduce incidences of child abuse and neglect, provide stability for at-risk families, and has grown a new generation of healthy families in the state. Intensity of services is based on each family's needs, beginning weekly and moving gradually to quarterly home visits as families become more self-sufficient. Healthy Families services may continue if needed until the child turns five years old.

Appendix A: Substance Abuse Task Force Roster

Debbie Moak, Director, Governor's Office of Youth, Faith and Family, Task Force Co-Chair
Dr. Sara Salek, MD, Chief Medical Officer, Arizona Health Care Cost Containment System (AHCCCS), Task Force Co-Chair
Cindy Beckett, PhD, RNC-OB, LCCE, CHRS, Director, Office of Research & Research Compliance, Northern Arizona Healthcare; Co-Chair Task Force of the Prevention of Prenatal Exposure to Alcohol and Other Drugs
Eddy Broadway, CEO, Mercy Maricopa Integrated Care
Kate Brophy McGee, Arizona State Representative, LD 28
Sherry Candelaria, Community Member, REACH Family Services, Inc. (Alcanza Servicios de Familia)
Michael Carr, Statewide Behavioral Health and Appeals Coordinator, Arizona Department of Child Safety
Jennifer Carusetta, Executive Director, Health System Alliance of Arizona
Reuben Howard, Health Director, Pascua Yaqui Tribe
Peggy Chase, President and CEO, Terros Health
Haley Coles, Community Member
Denise Dain, Director of Case Management, St. Luke's Behavioral Health Center
Doray Elkins, Community Member
Elaine Ellis, MD, Phoenix Children's Hospital
Deb Gullett, Executive Director, Arizona Association of Health Plans
Mary Hunt, Manager of Care Management, Maricopa Integrated Health System
Robert Johnson, MD, Director of Maternal Fetal Medicine, Arizona Perinatal Care Center
Susan Junck, Healthcare Advocacy Coordinator, Office of Individual and Family Affairs (OIFA), Arizona Health Care Cost Containment System (AHCCCS)
Jonathan Maitem, DO, Pre-hospital Medical Director, HonorHealth Deer Valley
Lee Pioske, Executive Director, Crossroads
Dennis Regnier, President and CEO, CODAC Health Recovery & Wellness
Thelma Ross, CEO, National Council on Alcoholism and Drug Dependency
Dawn Scanlon, Community Member
Frank Scarpati, President and CEO, Community Bridges
Claire Scheuren, Executive Director, Pima Prevention Partnership
Gagandeep Singh, MD, Chief Medical Officer, Behavioral Health, Banner Health
Jeff Taylor, The Salvation Army Phoenix Advisory Board Member
Glenn Waterkotte, MD, Retired Medical Director, Neonatal Intensive Care Unit, Cardon Children's Medical Center
Michael White, Director of Community Programs, Community Medical Services

Work Group Rosters

Prevention and Early Intervention

Debbie Moak, Task Force Co-Chair
Cindy Beckett
Rep. Kate Brophy-McGee
Sherry Candelaria
Michael Carr
Deb Gullett
Mary Hunt
Dr. Jonathan Maitem
Dawn Scanlon
Claire Scheuren
Jeff Taylor

Access to Treatment

Debbie Moak, Task Force Co-Chair
Eddy Broadway
Sherry Candelaria
Michael Carr
Jennifer Carusetta
Peggy Chase
Haley Coles
Denise Dain
Doray Elkins
Reuben Howard
Mary Hunt
Dr. Robert Johnson
Susan Junck
Dr. Jonathan Maitem
Lee Pioske
Dawn Scanlon
Frank Scarpati
Jeff Taylor
Dennis Regnier
Michael White

Medication-Assisted Treatment

Debbie Moak, Task Force Co-Chair
Dr. Sara Salek, Task Force Co-Chair
Peggy Chase
Haley Coles
* Christina Corieri, Health and Human Services
Senior Policy Advisor to Governor Doug Ducey
* Lenn Ditmanson, MD, Medical Director of
Medically Assisted Treatment, Cope Community
Services, Inc.
Doray Elkins
Reuben Howard
Dr. Gagandeep Singh
* Rick Sloan, MD, Compassionate Care Centers
* Michel Sucher, MD, Chief Medical Officer,
Community Bridges, Inc.
Michael White

* Member of Work Group only (not a Task Force member)

Neonatal Abstinence Syndrome

Debbie Moak, Task Force Co-Chair
Cindy Beckett
Rep. Kate Brophy McGee
Jennifer Carusetta
Elaine Ellis
Deb Gullett
Thelma Ross
* Dr. Rick Sloan
Dr. Glenn Waterkotte
Michael White

Appendix B: Task Force and Work Group Presenters

Date and Group	Medication-Assisted Treatment	Topic
5/11/16 Prevention & Early Intervention Work Group	Jennifer Ortiz, Detention Specialist/ JDAI Coordinator & Steve Tyrell, AZ Supreme Court, Administrative Office of the Courts	Juvenile Detention Alternatives Initiative (JDAI)
5/11/16 Access to Treatment Work Group	Doray Elkins & Dawn Scanlon, Work Group members	Our Stories: Lives Impacted by Substance Abuse
5/12/16 Neonatal Abstinence Syndrome Work Group	Jennifer Dudek, MPH, AZ Dept. of Health Services	Arizona Neonatal Abstinence Syndrome (NAS) Data
5/12/16 Medication-Assisted Treatment Work Group	Dr. Rick Sloan & Dr. Len Ditmanson, Work Group members	Medication-Assisted Treatment (MAT) Modalities
5/25/16 Task Force	Steve Grams, Sage Consulting	Prison Transition
5/25/16 Task Force	Karen Hellman, AZ Dept. of Corrections	Prison Transition
5/25/16 Task Force	Vista Thompson, Associate General Counsel, Blue Cross Blue Shield of AZ	Parity and Commercial Insurance
6/8/16 Prevention & Early Intervention Work Group	Colby Bower & Shannon Whittaker, AZ Dept. of Health Services	Licensing Substance Abuse Providers
6/9/16 Neonatal Abstinence Syndrome Work Group	Tara Sundem, MSN, RN, NNP-BS & Kelly Woody, RN, NNP-BS	Neonatal Abstinence Syndrome (NAS) Facility for Newborns
6/9/16 Medication-Assisted Treatment Work Group	Jacqueline Kurth, Industrial Commission of AZ	Workers' Compensation and Prescriptions
6/22/16 Task Force	Kristin Crowley, Lori Hennesy & Michelle Hamby, Community Members	Our Stories: Lives Impacted by Substance Abuse
6/22/16 Task Force	Tory McJunkin, MD & Paul Lynch, MD, Arizona Pain Specialists	Pain Management
6/28/16 Access to Treatment Work Group	Todd Nichols & Mike Zipprich, Program Developers	Treatment Provider Brainstorm

Appendix C: Table of Acronyms

Date and Group	Medication-Assisted Treatment	Topic	Acronym	Name
6/30/17 Neonatal Abstinence Syndrome Work Group	Rene Bartos, MD, Medical Director, Mercy Care Plan and Cindy Beckett, Work Group member	NAS Initiative and Long-Term Outcomes of Substance Abuse	AAI	Arizona Angel Initiative
6/30/16 Medication-Assisted Treatment Work Group	Katherine Cates-Wessel, Executive Director, American Academy of Addiction Psychiatry Providers Clinical Support System (PCSS) for Medication-Assisted Treatment		ABAM	American Board of Addiction Medicine
			ABMS	American Board of Medical Specialties
			ACOG	American Congress of Obstetricians and Gynecologists
			ADHS	Arizona Department of Health Services
			AFF	Arizona Families F.I.R.S.T.
			AHCCCS	Arizona Health Care Cost Containment System
			AHRQ	Agency for Healthcare Research and Quality
			AIDS	Acquired Immune Deficiency Syndrome
			ASAM	American Society of Addictive Medicine
8/24/16 Task Force	Sara Salek, MD, Chief Medical Officer, Arizona Health Care Cost Containment System (AHCCCS), Task Force Co-Chair	Overview of the Medicaid Service Delivery System for Substance Use Disorders in Arizona	ASAP	Arizona Substance Abuse Prevention
			AzEIP	Arizona Early Intervention Program
			BTG-OR	Bridging the Gap Offender Re-entry
			CARA	Comprehensive Addiction and Recovery Act
			CDC	Centers for Disease Control and Prevention
8/24/16 Task Force	Michelle Skurka, MSW, System of Care and Grants Administrator, AHCCCS	Substance Abuse Block Grant Overview	CE	Continuing Education
			CME	Continuing Medical Education
			CMS	Centers for Medicare and Medicaid Services
			CSPMP	Controlled Substance Prescription Monitoring Program
8/24/16 Task Force	Gabriella Guerra, MSW, Head of Crisis, Cultural and Clinical Services Mercy Maricopa Integrated Care; Ryan Kivela, Adult and Crisis Administrator, Health Care Integrated Care; & Terry Stevens, MA, LPC, Centpatico Integrated Care	Regional Behavioral Health Authorities	DATA 2000	Drug Addiction Treatment Act of 2000
			DCS	Department of Child Safety
			DEA	Drug Enforcement Administration p 23 33
			EBP	Evidence-Based Practice
			ED	Emergency Department
			F.I.R.S.T.	Families in Recovery Succeeding Together
			FAS	Fetal Alcohol Syndrome
			FDA	U.S. Food and Drug Administration
			GOYFF	Governor's Office on Youth, Faith and Families
			HB	House Bill
			Health IT	Health Information Technology
			HFAz	Healthy Families Arizona
			HHS	Department of Health and Human Services
			HIPAA	Health Information Portability and Accountability Act
			HIV	Human Immunodeficiency Virus
			ICD-10	The International Statistical Classification of Diseases and Related Health Problems 10th Revision
			IOP	Intensive Outpatient
			JDAI	Juvenile Detention Alternatives Initiative
			LGBT	Lesbian, Gay, Bisexual and Transgender
			MAT	Medication-Assisted Treatment
			MCAPD	Maricopa County Adult Probation Department
			MCOs	Managed Care Organizations
			NAS	Neonatal Abstinence Syndrome
			NASBE	National Association of State Boards of Education
			NICU	Neonatal Intensive Care Unit

Acronym

Name

NREPP	National Registry of Evidence-based Programs and Practices
NSC	National Safety Council
ODG	Official Disability Guidelines
OTP	Opioid Treatment Program
P&T	Pharmacy and Therapeutics
PCSS-MAT	Providers Clinical Support System for Medication-Assisted Treatment
PCSS-O	Providers Clinical Support System for Opioid Therapies
PDMP	Prescription Drug Monitoring Program
Project ECHO	Project Extension for Community Care Outcomes
PROP	Physicians for Responsible Opioid Prescribing
RBHA	Regional Behavioral Health Authority
S.E.N.S.E.	Substance-Exposed Newborns Safe Environment
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SEN	Substance-Exposed Newborns
SHPPS	School Health Policies and Practices Study
SPF	Strategic Prevention Framework
STDs	Sexually Transmitted Diseases
SUD	Substance Use Disorder
TMC	Tucson Medical Center
WHO	World Health Organization
WIC	Women, Infants, and Children

Appendix D: Guidelines for Identifying Substance-Exposed Newborns



<http://azprenatal.wixsite.com/taskforce>

Guidelines for Identifying Substance-Exposed Newborns

**A Publication Of:
The Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs**

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Letter from the Chair

September 12, 2016

To: Chairman, Obstetrics Department Chairman, Pediatric Department Chairman, Neonatology Department

RE: Statewide Initiative to Identify Substance – Exposed Newborns

There is a growing concern for the care and safety of substance-exposed newborns in Arizona and nationwide. The care and safety of this vulnerable population has a profound effect on the medical community and the child welfare system.

The Arizona Task Force for the Prevention of Prenatal Exposure to Alcohol and Other Drugs, in collaboration with Governor Douglas Ducey's 2016 Task Force on Substance Abuse has reviewed and revised the 2008 Guidelines for Identifying Substance- Exposed Newborns (SEN).

An extensive review of the medical, nursing, substance abuse and mental health literature provided the evidence for revision of this document. The SEN work group (Appendix B) has worked closely with professional organizations and agencies to revise and update the guidelines.

These Guidelines support the state law requirement that a health care professional, who reasonably believes that a newborn infant may be affected by the presence of alcohol or a drug, to immediately report this information, or cause a report to be made, to the Arizona Department of Child Safety (DCS). For reporting purposes, "newborn infant" means a newborn infant who is under thirty days of age (A.R.S. §13- 3620).

These Guidelines have been posted for Public Comments, and reviews have been requested from the following organizations: American Academy of Pediatrics-Arizona Chapter, (AzAAP), Arizona Medical Association (ArMA)-Maternal Child Health Committee, Arizona Perinatal Trust, and the American College of Obstetrics and Gynecologists-Arizona Chapter prior to the implementation in early 2017. The Guidelines will be disseminated to providers across Arizona with the collaboration of the Arizona Perinatal Trust.

Including these Guidelines in your policies and procedures for nursing staff, social services, and medical staff will provide a consistent approach and avoid potential bias in the identification of these newborns.

Introduction

The attached documents will be maintained and updated on the Arizona Department of Health Services website: www.azdhs.gov.

Any questions related to these *Guidelines* may be directed to Cindy Beckett, PhD, RNC-OB, Chair of the Arizona Task Force for the Prevention of Prenatal Exposure to Alcohol and Other Drugs, via the email address: Cynthia.Beckett@nahealth.com

Sincerely,



Cindy Beckett, PhD, RNC-OB, LCCE, CHRC
Chair-AZ Task Force for the Prevention of Prenatal Exposure to Alcohol & Other Drugs
Substance Abuse Task Force member
Neonatal Abstinence Syndrome sub-committee member
Prevention and Intervention sub-committee member

Substance use during pregnancy is a complex public health problem often resulting in multiple consequences for a woman and her newborn. Alcohol, cocaine, hallucinogens including marijuana, prescription or nonprescription narcotics/opioids, and certain non-narcotic medications during pregnancy may result in adverse effects on the health and well-being of the newborn, in addition to the woman's health. Accurate and consistent diagnoses of exposed births allow for early intervention services for the newborn and mother. These services are critical in minimizing the acute and long-term effects of prenatal substance exposure. It is also important to provide appropriate preconception health education and screening, counseling, and referrals for women planning pregnancies, and all women of childbearing age, in order to prevent exposed births from ever occurring.

Stakeholders in Arizona came together in 2002 to develop guidelines to assist health care providers in understanding their role in the identification of substance-exposed newborns (SEN), and again in 2008 to revise the guidelines to reflect advances in understanding. The Arizona Department of Health Services (ADHS) conducted a Neonatal Abstinence Syndrome Conference in July 2015 which brought together physicians, hospital systems, health plans and other stakeholders from around the state to discuss the problem of substance exposed newborns as well as next steps for Arizona. One of the key recommendations was to update the Guidelines for Identifying Substance Exposed Newborns and to work with the Arizona Perinatal Trust (APT) to encourage hospitals to have protocols and policies in place. Since the 2008 revision the number of exposed newborns has continued to increase as the state, as well as the rest of the nation, continues to face an opioid epidemic.

When a woman uses substances regularly during pregnancy, the baby may go through withdrawal after birth leading to a condition called neonatal abstinence syndrome (NAS). Research has shown that NAS is primarily associated with the maternal use of opiates (heroin, methadone, hydrocodone or oxycodone). Other non-opiate drugs such as benzodiazepines, SSRI's, barbiturates, alcohol, hallucinogens, cocaine, methamphetamine, marijuana, and ecstasy, can also cause NAS symptoms (See Table 1 for a list of non-narcotic drugs that cause neonatal psychomotor behavior consistent with withdraw). Newborns diagnosed with the presence of substance such as narcotics, cocaine and/or alcohol in certain biological specimens such as urine and meconium, may or may not exhibit withdrawal symptoms. The type and severity of a newborn's withdrawal symptoms depend on the drug(s) used, how long and how often the mother used, and how the mother's body breaks down the drug.

Between 2008 and 2014 the rate of Neonatal Abstinence Syndrome (NAS) has increased by 235%. Additionally, the rate of newborns exposed to narcotics has increased more than 219%. Between 2013 and 2014 the number of newborns diagnosed with Fetal Alcohol Syndrome (FAS) has increased 67% (Arizona Hospital Discharge Data, 2014). A recent study authored by researcher Dr. Phil May and published in Pediatrics in 2014 concluded that the rate of FAS was found to be 6-9 cases per 1,000 children, and the total cases of any form of FASD ranged from 24 to 48 cases per 1,000 or 4% (May, et.al., 2014). Many studies have highlighted a prevalence of substance exposed newborns (SEN) far higher than that captured through diagnostic records. Missed diagnoses remain a serious issue that confounds accurate data collection, hindering trend analysis and evaluation of interventions, and ultimately endangers the health

Table 1: Non-narcotic drugs that cause neonatal psychomotor behavior consistent with withdraw. Source: Hudak et al. Neonatal Drug Withdraw. Pediatrics 2012, 129(2):e542

Drug	Signs	Onset of Signs	Duration of Signs*	Ref. No.
Alcohol	Hyperactivity, crying, irritability, poor suck, tremors, seizures; onset of signs at birth, poor sleeping pattern, hyperphagia, diaphoresis	3-12 h	18 mo	14,15
Barbiturates	Irritability, severe tremors, hyperacusis, excessive crying, vasomotor instability, diarrhea, restlessness, increased tone, hyperphagia, vomiting, disturbed sleep; onset first 24 h of life or as late as 10-14 d of age	1-14 d	4-6 mo with prescription	12,13
Caffeine	Jitteriness, vomiting, bradycardia, tachypnea	At birth	1-7 d	161
Chlordiazepoxide	Irritability, tremors; signs may start at 21 d	Days-weeks	9 mo; 11/2 mo with prescription	11
Clomipramine	Hypothermia, cyanosis, tremors; onset 12 h of age		4 d with prescription	162
Diazepam	Hypotonia, poor suck, hypothermia, apnea, hypertonia, hyperreflexia, tremors, vomiting, hyperactivity, tachypnea (mother receiving multiple drug therapy)	Hours-weeks	8 mo; 10-66 d with prescription	10
Ethchlorvynol	Lethargy, jitteriness, hyperphagia, irritability, poor suck, hypotonia (mother receiving multiple drug therapy)		Possibly 10 d with prescription	163
Glutethimide	Increased tone, tremors, opisthotonus, high-pitched cry, hyperactivity, irritability, colic		6 mo	164
Hydroxyzine	Tremors, irritability, hyperactivity, jitteriness, shrill cry, myoclonic jerks, hypotonia, increased respiratory and heart rates, feeding problems, clonic movements (mother receiving multiple drug therapy)		5 wk with prescription	58
Meprobamate	Irritability, tremors, poor sleep patterns, abdominal pain		9 mo; 3 mo with prescription	165
SSRIs	Crying, irritability, tremors, poor suck, feeding difficulty, hypertonia, tachypnea, sleep disturbance, hypoglycemia, seizures	Hours-days	1-4 wk	31-33,35

* Prescription indicates the infant was treated with pharmacologic agents, and the natural course of the signs may have been shortened.

newborns diagnosed with Fetal Alcohol Syndrome (FAS) has increased 67% (Arizona Hospital Discharge Data, 2014). A recent study authored by researcher Dr. Phil May and published in *Pediatrics* in 2014 concluded that the rate of FAS was found to be 6-9 cases per 1,000 children, and the total cases of any form of FASD ranged from 24 to 48 cases per 1,000 or 4% (May, et.al., 2014). Many studies have highlighted a prevalence of substance exposed newborns (SEN) far higher than that captured through diagnostic records. Missed diagnoses remain a serious issue that confounds accurate data collection, hindering trend analysis and evaluation of interventions, and ultimately endangers the health and wellbeing of exposed newborns. Many lacking an initial diagnosis may receive inappropriate care and experience difficulty later accessing services in childhood and adolescence when developmental delays may be evident.

To address this growing epidemic of prenatal exposure to alcohol and other drugs, the Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs, with input from key stakeholders, has revised Arizona's Guidelines for Identifying Substance-Exposed Newborns.

The updated 2016 guidelines:

- Provide best practices resources for combatting a complex and worsening public health issue;
- Improve the ability of health care providers to effectively identify at-risk pregnancies and substance-exposed newborns;

- Standardize recommendations and guidelines for maternal and neonatal medical screening, treatment and management in Arizona; and
- Reaffirm the state's commitment to improving the health and well-being of women and their at-risk newborns.

State and National Data Overview

In addition to the direct toxic effects of the drugs to the newborn, continued substance abuse by the mother increases the risk for child abuse and neglect. Indeed, reports of child abuse and neglect have increased dramatically over the past decade and are correlated with an increase in drug use among primary caregivers. In 2014, 85 infant deaths were categorized as Sudden Unexplained Infant Deaths (SUID) and 75 were categorized as child fatalities due to maltreatment. Tobacco exposure or substance use/misuse has been associated with many of these preventable deaths (Arizona Child Fatality Report, 2015).

Prenatal substance abuse is a condition that crosses all social, racial and ethnic groups. The National Institute on Drug Abuse estimated that 15.8 million women (12.9%) ages 18 or older have used illicit* drugs in the last year (SAMHSA, 2014). According to the Arizona Department of Health Services, in 2014, there were 86,648 births in Arizona. In this same year, the SAMHSA National Survey on Drug Use and Health reported that 5.4% of pregnant women were current illicit drug users and 18% of women reported using alcohol in the first trimester. The Centers for Disease Control (CDC) report that 1 in 10 pregnant women used alcohol and that up to 1 in 20 United States school children may have FASDs (CDC BRFSS, 2011-2013). Smoking during pregnancy was also reported by 3.9% of women giving birth in 2014. The most widely utilized illicit substances were marijuana and non-medical use of prescription drugs. There were a total of 2,373 cases of newborns diagnosed with NAS during 2008-2015; 3,771 cases of newborns diagnosed with narcotics; 592 cases of newborns diagnosed with cocaine; 459 cases of newborns diagnosed with hallucinogens and 205 cases of newborns diagnosed with effects of prenatal exposure to alcohol also referred to as Fetal Alcohol Spectrum Disorder (FASD) during 2008-2015. In total, there were 1,374 Arizona newborns identified during 2015 with presence of a substance exposure (See Table 2 for a complete table of newborns with a diagnostic code at discharge of NAS and other drug exposures in Arizona). Other information about maternal drug use during pregnancy is not reported on the Arizona birth certificates; however it can be obtained from the hospital discharge database by searching for several diagnostic codes which identify exposure of the fetus or newborn to narcotics, hallucinogens, alcohol and cocaine.

Table 2: Number of Newborns with a Diagnostic Code at Discharge of Neonatal Abstinence Syndrome (NAS) and Other Drugs Exposures in Arizona, 2008-2015.

Number of Newborns with NAS and Drug Exposures in Arizona, 2008-2015*							
Year	NAS	Narcotics	Cocaine	Hallucinogens	Alcohol	Other Drugs of Addiction	# of Hospital Births
2008	145	234	161	35	22		95,420
2009	154	410	99	51	25		89,115
2010	223	414	79	46	15		84,069
2011	300	424	68	46	30		81,988
2012	304	531	59	47	27		82,905
2013	339	646	55	68	20		82,338
2014	438	650	34	93	33		83,427
2015	470	462	37	73	33	299	85,514**
Total	2,373	3,771	592	459	205	299	684,776

Source: Arizona Department of Health Services, Public Health Vital Statistics, Hospital Discharge Data Base, 2008-2015.

(*2015 NAS Counts include a change in reporting using the ICD10-cm codes)

**Preliminary counts

Key Data to Inform Practice

- U.S. - NAS increased to 3.39 per 1,000 hospital births from 1.20 per 1,000 hospital births in 2000 (*JAMA*, 2012)
- U.S. - Drug overdose death rates increased over five-fold between 1980 and 2008 making drug overdose the leading cause of injury deaths over car crashes (NCHS Data Brief, no 81. National Center for Health Statistics; 2011)
- Arizona - NAS has increased by 235% from 2008 to 2014 and 27% from 2013-2014; The rate of Arizona NAS was 5.25 per 1,000 hospital births in 2014 (ADHS, Hospital Discharge Database 2014)
- Arizona - The number of newborns diagnosed with Fetal Alcohol Spectrum Disorders (FASD) increased 67% from 2013-2014 (ADHS, Hospital Discharge Database 2014)
- Arizona - The rate of newborns exposed to narcotics has increased more than 218% since 2008 (ADHS, Hospital Discharge Database 2014)
- Arizona - White non-Hispanics made up 68% of the total number of NAS cases (2008-2014) (ADHS, Hospital Discharge Database 2014)
- AHCCCS was the payer in 76% of the newborns exposed to narcotics (2008-2014) (ADHS, Hospital Discharge Database 2014)
- U.S. - Medicaid covers the majority of mothers with opiate exposure during pregnancy (60%) and infants diagnosed with NAS (78%) (*JAMA*, 2013)

Substance use by pregnant mothers can lead to long-term and even fatal effects for the child including: low birth weight, birth defects, small head size, premature birth, Sudden Unexpected Infant Death (SUID), developmental delays, and problems with learning,

memory, and emotional control. In addition to individual negative outcomes, societal impact related to prenatal substance abuse profoundly affects many facets of our communities. Successful identification and intervention may result in substantial cost savings in health care, foster care, special education and incarceration.

Health care professionals have an important role in identifying substance-exposed newborns. These guidelines have been developed to assist in:

- Improving effective identification of substance-exposed newborns;
- Implementation of educational programs to assure consistent assessment and scoring using the NAS scoring tool;
- Standardizing guidelines for maternal and neonatal screening in Arizona;
- Improving the health and well-being for women and their at-risk newborns; and
- Creating standardized evidence-based protocols for treating infants with NAS scores requiring pharmacological interventions.

In addition, health professionals are bound by **Arizona Revised Statutes § 13-3620 which requires a health care professional, who reasonably believes that a newborn infant may be affected by the presence of alcohol or a drug, to immediately report this information, or cause a report to be made, to Child Protective Services.** For reporting purposes, "newborn infant" means a newborn infant who is under thirty days of age.

Overview of the Arizona State Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs

The **Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs** is an entity comprised of professionals representing various sectors of the community, focused on ensuring the health and wellness of women and children. Its purpose is to focus statewide attention and resources on the issue of prenatal exposure to alcohol and other drugs in an effort to improve health outcomes for Arizona's children.

Task Force Vision

To live in a time when all Arizonans will know and understand the emotional, physical and social costs of prenatal exposure to Alcohol and Other Drugs; where all babies have the chance to be born free of any substance abuse; where women, children and families live safely and have ready access to necessary resources; and where there is ample assistance for children already born exposed, and their caregivers, to ensure the best possible outcomes.

Task Force Mission

To improve the health and wellness of Arizona families by creating and implementing data driven, evidence-informed solutions to reduce prenatal exposure to alcohol and others drugs through a coordinated, effective and viable public-private state wide partnership that is both accountable and transparent.

2015-2020 Goals

Goal 1: Work with providers and stakeholders to appropriately identify substance exposed newborns in an effort to obtain a more accurate baseline of the incidence of Substance Exposed Newborns (SEN)

Goal 2: Raise awareness and understanding of the risks and effects of prenatal exposure to alcohol and other drugs for families and communities

Goal 3: Create optimal opportunity for engagement in effective interventions and services for all women of reproductive age in Arizona

Goal 4: Promote successful outcomes for those individuals affected by SEN in Arizona

Goal 5: Strengthen the Task Force and elevate its standing so it can better carry out its mission and achieve its goals

<http://azprenatal.wixsite.com/taskforce>



Rising Opioid Abuse Trends

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that prescription drug abuse is the fastest growing drug problem in the United States. Prescription drugs are essential to relieving acute or chronic pain for many individuals. However, the misuse, abuse, addiction and overdoses of prescription drugs have increased to become a serious and devastating public health problem.

The rising opioid abuse trends can be partially attributed to the increasing number of prescriptions written in recent years. According to data from Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), there were 9.6 million Class II-IV prescriptions written and 575 million pills dispensed in Arizona in 2013. This equates to 87.4 Schedule II-IV controlled substance pills for every person, adults and children, living in Arizona. Prescription pain relievers accounted for 51.2% of these prescriptions, with Hydrocodone and Oxycodone accounting for the majority (~80.9%) of all pain relievers. According to experts, recent prescribing practices in Arizona places our state as the 5th highest opioid prescribing state in the country.

Rates of adult prescription drug misuse in Arizona are alarmingly high, with 50% of adults reporting misuse in the past 12 months and 13% of adults reporting misuse in the past 30 days. Although rates of adult prescription drug misuse traverse all age categories and regions in Arizona, significantly higher rates were reported among individuals living in the Southeastern region of the state and for individuals 45 years and older. The majority of the misuse involved pain relievers (47%) (ADHS Injury Prevention, 2016).

In 2011, the Arizona Criminal Justice Commission and the Governor's Office for Children, Youth and Families, along with many state and local partners including the Arizona Department of Health Services, launched a multi-systemic effort to reduce prescription drug misuse and abuse in Arizona. The Arizona Prescription Drug Misuse and Abuse Initiative team formulated a set of data-and-research-driven strategies to be used in a multi-systemic, multi-agency **collaborative approach to reduce prescription drug misuse in Arizona**. Resources developed include:

- The Arizona Opioid Prescribing Guidelines
<http://azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opiod-prescribing-guidelines.pdf>
- The Controlled Substance Prescription Monitoring Program (CSPMP)- Healthcare Prescribers Registration and Use: www.pharmacympm.az.gov
- The Arizona RX Drug Misuse and Abuse Initiative Toolkit
<http://azcjc.gov/ACJC.Web/Rx/toolkit.asp>
- Online Prescribing Course for Arizona DEA prescribers:
www.VLH.com/AZPrescribing

Women of Childbearing Age Who Have Addiction Issues

According to the National Institute on Drug Abuse, when it comes to substance use women face special issues that are influenced by biological differences, pregnancy, breastfeeding and culturally defined roles.

The Centers for Disease Control (CDC) estimates that 3.3 million women between ages 15-44 are at risk of exposing a developing fetus to alcohol because they drink, are sexually active and are not using birth control. Even when women are actively trying to get pregnant, three out of four women continue to drink after they have stopped using birth control.

The CDC recommends that young women should avoid alcohol unless using birth control since about half of all pregnancies in the United States are unplanned, and even if planned, many women don't know they are pregnant until after 4-6 weeks and they may still have been drinking during those weeks.

The American College of Obstetricians and Gynecologists (ACOG) recommends women abstain completely from alcohol, tobacco and other drugs while pregnant.

A woman who is prescribed opioids and becomes pregnant will need to be managed by her healthcare provider. Opioid abuse during pregnancy includes the use of heroin and the misuse of prescription opioid medications. The current standard of care for pregnant women with opioid dependence is a referral for opioid-assisted therapy with methadone.

Early detection and treatment of an alcohol or drug problems by a health care professional is more effective and less costly than addressing a chronic substance use disorder. Primary prevention during the preconception period is the ideal point to intervene and prevent a substance-exposed pregnancy. ACOG has recommended universal screening of all women of reproductive age by a healthcare provider using an evidenced based screening tool at every healthcare visit as a step towards primary prevention.

Guidelines

Prevention

Neonatal Abstinence Syndrome (NAS) is a growing problem in the United States. Fortunately, NAS is preventable if an expectant mother receives proper care and treatment. Prevention begins with preconception health care and continues as this education geared towards both patients and providers is reinforced throughout a woman's entire pregnancy. The following are ways to enforce prevention:

- Education about drug/alcohol use in pregnancy
- Pregnancy testing prior to prescribing
- Recommend providers to check CSPMP (Controlled Prescription Monitoring Program) prior to distributing and/or prescribing medications
- Any providers taking care of, dispensing, or prescribing medication to women of childbearing age need to counsel/educate women prior to prescribing
- Engage member's health plan case management program as appropriate

Identification & Screening – Maternal

Prenatal screening begins initially with the maternal interview. The following screening criteria may identify substance use/abuse, which can impact the health of the mother and the newborn. Two basic methods are used to identify drug users: self-report or laboratory testing of biological specimens. Screening is recommended to include self-reporting by the mother, followed by laboratory testing if any of the following occur:

- History of previous or current substance use by mother and/or significant others living in the home, or history of a previous delivery of a substance-exposed newborn.
- Current CPS involvement; suspected or reported domestic violence
- Non-compliance with prenatal care (late entry to care, multiple missed appointments, or no prenatal care).
- Evidence of unexplained poor weight gain during the pregnancy.
- Medical non-compliance.
- Medical symptoms of withdrawal in the mother.
- Physical or behavioral signs of substance use/abuse.
- Maternal medical history of Hepatitis B or C, HIV infection, or two or more sexually transmitted diseases.
- Previous or current history of placental abruption or unexplained vaginal bleeding.
- Cardiovascular accident of the mother.
- Unexplained intrauterine growth restriction
- Pre-term labor may be seen in association with substance use or abuse as reported in the literature. It may be considered prudent to screen, if any of the above factors exist in association with pre-term labor.

If positive for one or more of the above screening criteria, recommend:

- **Testing of the mother***; and
- **A referral for further assessment, including possible treatment services.**

***Toxicology Consideration**

Maternal urine toxicology will generally identify only common drugs of abuse (e.g. cocaine, marijuana, opiates, barbiturates, benzodiazepines, amphetamines, and PCP) that have been used within the last 24 to 48 hours and will be negative if drugs were used earlier in the pregnancy. Alcohol use is best identified by blood or saliva testing and some drugs such as volatile inhalants can only be identified by special testing. You may wish to consult with a toxicologist to determine the best way to screen for drugs that are not included in routine urine drug screening.

To reduce the incidence of substance exposed newborns, screen women at risk of addiction. This document provides samples of interview screening tools for drugs and alcohol (See Appendix C).

Information About Other Screening Tools Can Be Found:

- <http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs>

- DAST- a 28 item self-report scale that will take at least eight minutes to complete www.uspreventiveservicestaskforce.org
- DAST 10- a revised, 10 item self-report tool that (Skinner, H. A. (1982). The Drug Abuse Screening Test. Addictive Behavior, 7 (4),363–371.) <https://www.drugabuse.gov/sites/.../DAST-10.pdf>
- SBIRT (Screening, Brief Intervention, and Referral to Treatment)- "a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders for use in community settings". AZ SBIRT is sponsored by the AZ Governor's Office and AZ Department of Health Services under contract with NARBHA and funded by SAMHSA.

Identification & Screening – Neonates

Although no single approach can accurately determine the presence or amount of drug used by the mother during pregnancy, it is more likely that fetal exposure will be identified if a biological specimen is collected along with a structured maternal interview.

Medical care providers may choose to use a standardized and validated scoring tool that is accurate in assessing infants for signs of NAS. The most widely recommended tool to examine infants for signs of NAS in the hospital setting is the Finnegan Scoring Tool (See Appendix D). Other NAS scoring tools include the Lipsit, Neonatal Withdrawal Inventory and the Neonatal Narcotic Withdrawal Index. The nursing staff provide the scoring assessment. It is important that the scoring frequency be consistent and occurs initially after transition which is 2-4 hours after birth, then score again after 3-4 hours. Treatment begins when score is 8 or greater on the tool. If no treatment is required by 72 hours scoring can be discontinued and baby discharged after 24 hours.

Identification of substance-exposed newborns is determined primarily by clinical indicators in the prenatal period including maternal and newborn presentation, history of substance use/abuse, medical history, and/or toxicology results. Newborn toxicology screening should be performed if the results will influence management of medical care for the mother and newborn, including treatment options, and/or to confirm the maternal pattern of drug use.

The three most commonly used specimens to establish drug exposure during the prenatal and perinatal period are urine, meconium, and hair. However, none is accepted as a “gold standard.”

Newborn toxicology screening may:

- Confirm presence of substance of use and abuse.
- Determine use of multiple substances, which were not identified during the maternal interview.
- Identify the newborn that is at risk for withdrawal.
- Identify substances or drugs that may be contraindicated in breastfeeding.

- Identify newborns that may need protective services, and/or developmental follow-up.
- Identify the mother who may need treatment services.

The recommended screening criteria for the newborn includes:

- Signs of neonatal abstinence syndrome which may include marked irritability, high-pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea, or diaphoresis.
- Unexplained apnea in newborn.
- Microcephaly (when accompanied by additional symptoms).
- Birth weight <5th percentile for gestational age (unexplained intrauterine growth restriction, or newborns who are small for gestational age).
- Cerebral vascular accident in the newborn (not otherwise considered at-risk).
- Other vascular accident in the newborn.
- Necrotizing enterocolitis (NEC) in the full-term newborn (or newborn not otherwise considered at-risk for NEC).

If positive for one of more of the above screening criteria, recommend:

- **Testing of the newborn* and a social service referral to identify potential accompanying diagnosis; and**
- **Consider testing of the mother.**

***Toxicology Consideration**

Urine Testing: The first urine contains the highest concentration of drug or metabolites. If this urine sample is missed, a confirmatory test is less likely, even in the presence of intrauterine drug exposure. A negative urine toxicology result is common even in the presence of substance use or abuse.

Limitations of newborn urine testing include:

- The first urine sample may be easy to miss.
- Bag urine collections for newborns are difficult to collect.
- Positive drug threshold values have not been scientifically determined.
- The threshold values for the newborn have been arbitrary set at the adult reference range.
- False negative urine toxicology may be the result of using a higher adult reference range in the newborn population.
- Threshold levels of drug metabolites generally can be detected in urine only for several days.

Meconium Testing: Meconium testing is the most reliable and comprehensive toxicology screen in the newborn. Meconium formation starts between 16 to 20 weeks gestation, and continues until birth, and thus it is hypothesized that meconium will reflect exposure during the second and third trimester of pregnancy. Newborn meconium testing is noninvasive and will identify most substance used by the mother after 20 weeks, such as: cocaine, marijuana, opiates, barbiturates, benzodiazepines,

amphetamines, and PCP. Best results are obtained by collecting multiple meconium specimens. In addition, meconium is easier to collect.

Fatty acid ethyl esters (FAEEs) have been identified as an important biomarker of alcohol consumption. They are formed by esterification of ethanol with free fatty acids. High levels of FAEEs in meconium are a “direct biomarker reflective of true fetal exposure to ethanol in-utero”. Supplemental meconium testing can identify FAEEs, by gas chromatography/mass spectrometry (GC/MS) analysis and provides a 99% level of sensitivity in identifying FAEEs. If the level is in the 3rd or 4th quartile, this is indicative of heavy alcohol exposure, which would identify the infant at higher risk for effects from alcohol exposure.

However, use of meconium to determine the timing or extent of exposure during pregnancy is controversial because of a lack of studies regarding the effects of the timing and quantity of the postpartum specimen collection as well as the effects of urine or transitional stool contamination of the meconium samples for several days.

Other Forms of Testing: Hair is easy to collect, although some people decline this sampling method because of cosmetic concerns and societal taboos. Drugs become trapped within the hair and, thus, can reflect drug use over a long period of time. Unfortunately, using hair to determine timing and quantity of exposure also is controversial. In addition, environmental contamination, natural hair colors and textures, cosmetic hair processing, and volume of the hair sample available all affect the rational interpretation of the results. Other biological specimens have been studied for use in the detection of in utero drug exposure but are not commonly used in the clinical setting. These include such specimens as cord blood, human milk, amniotic fluid, and umbilical cord tissue.

Further recommendations if the above screening criteria are positive:

- Consider maternal and newborn testing for identification of related infections (Syphilis, Hepatitis B or C, HIV).
- If maternal or newborn toxicology is positive for opiates, watch for onset of abstinence syndrome in the newborn.
- Counsel mother that breastfeeding is contraindicated in the presence of a positive history of cocaine, heroin, methamphetamine, PCP, or marijuana use.
- If the medical provider reasonably believes that a newborn infant may be affected by the presence of alcohol or a drug, (per A.R.S. § 13-3620) immediately report this information, or cause a report to be made, to Arizona Department of Child Safety (DCS) at 1-888-767-2445 (1-888-SOS-CHILD).
- Consider consultation with DCS prior to the newborn’s discharge.
- Consider Home Health nursing visit(s).
- The Primary Care Provider should notify DCS if there is poor follow-up with recommended medical care, or if the newborn’s medical needs are being neglected.

Treatment & Management – Maternal

Drugs of abuse alter the brains structure and function causing changes that last long after drug use has ceased. This can explain why drug users are at risk of relapse even after long periods of abstinence.

All treatment and management of pregnant women should follow evidence based practice. Treatment needs to be readily available, but does not need to be voluntary to be successful - (individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily). Effective treatment addresses the entire individual and not just her drug use, and incorporates not only medical management but other services as appropriate.

- Refer women to appropriate gender-specific obstetric, addiction, and behavioral health treatment services.
- Appropriate counseling services may include: psychotherapy, family therapy, parenting instruction, vocational rehabilitation, social services, and legal services.
- Provide women with access to psychiatry consultation for assessment and treatment options for co-occurring disorders.
- Coordination of care among providers, treatment services, and health plans.
- Medically assisted opioid withdrawal (“detoxification”) **IS NOT** recommended in pregnancy and is associated with high maternal relapse rates.
- Opioid agonist treatment (OAT) remains the standard of care for treating opioid use disorder in pregnancy.
 - OAT has been shown to reduce illicit drug use, increase adherence to prenatal care, improve maternal nutrition, improve neonate birth weight, and reduce the chance of infection exposure secondary to Intravenous Drug Use (IVDU), (Saia, et. Al, 2016). Methadone is the gold standard, but there is supporting evidence of buprenorphine being an effective therapeutic option as well.
- Develop enhanced postpartum care with close follow up (within 2 weeks of delivery) and option for multiple postpartum visits.
- Ongoing monitoring of drug use. Once detoxification (management of acute withdrawal symptoms) is achieved, continued drug treatment and support following detoxification to support long term functioning and prevention of future relapse, must be available.
- Breastfeeding with OAT is safe and beneficial for the mother and infant.

Treatment & Management – Neonate

Both medical and nonmedical treatment options exist for infants with NAS.

Neonatal abstinence syndrome (NAS) includes a combination of physiologic and neurobehavioral signs that include such things as sweating, irritability, increased muscle tone and activity, feeding problems, diarrhea, and seizures. Although nonpharmacological care is the initial treatment options, infants with NAS can often require prolonged hospitalization and treatment with medication.

Nonpharmacological care for the infant with NAS includes minimizing light and noise, swaddling, breastfeeding, and providing skin-to-skin contact with the mother. Breastfeeding is not contraindicated unless the mother is infected with HIV or involved in polydrug abuse or street drugs. Mothers may need extra guidance, and can benefit from programs that improve the bond between mother and child. Pharmacological treatment is recommended if the infant does not show signs of improvement after nonpharmacological care. Morphine is the most commonly used drug for the treatment of NAS secondary to opioids. For neonates, therapy is aimed at rapid clinical stabilization of opioid-exposed infants followed by gradual reduction of the medication under careful medical supervision. The average newborn will recover from NAS in 5 to 30 days with these treatments. The best practice is to have a consistent protocol in place.

Best practice protocols from the research evidence provide clinical highlights in managing NAS newborns.

- Each nursery caring for NAS newborns should develop a protocol that defines indications and procedures for screening for maternal substance abuse.
- Maternal screening for substance abuse should incorporate multiple methods, including maternal history, maternal urine testing, and testing of newborn urine and/or meconium specimens.
- Drug withdrawal should be considered in differential diagnosis in newborns who develop compatible signs.
- Nonpharmacological support measures should be part of the initial approach to therapy and should include: measures to minimize environmental stimuli, adequate rest and sleep, and sufficient caloric intake to promote weight gain.
- Use of a published NAS scoring tool to assess signs of withdrawal. Infants with confirmed exposure, but who are unaffected or demonstrating minimal signs of withdrawal DO NOT require pharmacologic therapy. Use caution prior to instituting pharmacologic therapies. These will increase length of stay and interfere with maternal-infant bonding.
- Even using published NAS scoring tools, there are unknown optimal thresholds for pharmacologic therapies.
- If not contraindicated, encourage breastfeeding and the provision for expressed human milk.
- Pharmacologic therapy for withdrawal-associated seizures is indicated, but also evaluate for other causes of neonatal seizures.
- Relative indicators for NAS treatment are vomiting, diarrhea, or both in association with dehydration and poor weight gain in the absence of other diagnoses.
- Limited evidence from controlled trials of NAS support the use of oral morphine and methadone with pharmacologic treatment is indicated.
- Severity of withdrawal signs including seizures had not been proven to be associated with differences in long-term outcomes of SEN newborns.
- Neonates with a known antenatal exposure to opioids and benzodiazepines should be observed for 4 to 7 days. Early follow-up after discharge is indicated for further assessment for the risks of late withdrawal.

- Neonates who have been treated in NICUs for extended durations can be converted to equivalent regimens of oral methadone and lorazepam. The medications can be reduced by 10% to 20% of the initial dose every 1 to 2 days on the basis of clinical response and serial assessments using an NAS scoring tool (Hudak & Tan, 2016).

In order for the neonate to receive appropriate services it is recommended that there be

- Appropriate documentation of prenatal exposure.
- Positive drug screen documentation.
- Life-long follow up for congenital, behavioral, and developmental abnormalities.

Long-term Follow-up – Maternal

Women who enter into treatment or are in treatment programs for opioid addiction will in all likelihood need to continue in their treatment programs in order to successfully strive for, achieve, and maintain productive functioning in the family workplace and society.

Treatment programs have to be available for long term follow up and support, and need to be specific to the needs of the childbearing woman and her children. Programs like the Substance Exposed Newborn Safe Environment Program (SENSE) in Arizona can provide resources and support to the mother, newborn and family after the neonate is discharged from NAS treatment.

For women to be successful in managing their own drug or alcohol problems, they need to have integrated services that will address their physical needs, emotional/mental health needs, and personal/family needs for safety, shelter, food, clothing, and transportation. By providing case management and social supports she will be able to focus on treatment and recovery.

Long-term Follow-up – Babies and Children

Little is known about the long-term effects of in-utero exposure on the newborns, however, it is known that substance use during pregnancy has long-term effects that manifest long after the newborn period. Early in pregnancy, fetal malformations may occur while, later in pregnancy, it is the developing fetal brain that is more vulnerable to injury. The effects of fetal substance exposure may include stunted growth or more subtle findings like alterations in neurobehavioral functions. Alcohol is the most-often studied drug of abuse and can cause several fetal problems including restricted fetal growth, congenital anomalies, behavior problems, poor memory and intellectual disabilities. Prenatal nicotine exposure has been associated with brain development issues, cognition, language, achievement, and long-term behavior.

Infants with NAS are more likely to be admitted to the NICU and to be hospitalized longer than infants without NAS. Additionally, when there are exposures to other substances in supplement to opioids, there is evidence that the risk of antenatal complications is higher. In mothers and infants enrolled in the Tennessee Medicaid program, antenatal cumulative prescription opioid exposure, opioid type, tobacco use,

and selective serotonin reuptake inhibitor (SSRI) use increased the risk of NAS (Patrick, et.al., 2015).

The consequences for children who were prenatally exposed to drugs go beyond the immediate neonatal period. A study by Uebel et. al. (2015) in PEDIATRICS found that children with NAS were more than twice as likely to require hospitalization, to die in hospital, and be admitted for maltreatment, visual, mental, and behavioral problems. According to the study, this increase continues to adolescence, and emphasizes the critical need for continued support for children after resolution of NAS.

Physicians should maintain documentation of substance use during pregnancy and be vigilant in following the child for potential long term physical and cognitive consequences. Even after accounting for prematurity, it is likely that children with NAS will be hospitalized again throughout childhood for maltreatment, trauma, and mental and behavioral disorders. This pattern can continue into adolescence and highlights the critical need for continued support of this vulnerable group after resolution of NAS.

For a summary of effects of prenatal drug exposure of the fetal growth, abnormalities, withdraw, neurobehavioral, and growth refer to Table 3.

TABLE 3
Summary of Effects of Prenatal Drug Exposure

Short-term effects/ birth outcomes	Nicotine	Alcohol	Marijuana	Opiates	Cocaine	Methamphetamine
Fetal growth	Effect	Strong effect	No effect	Effect	Effect	Effect
Anomalies	No consensus on effect	Strong effect	No effect	No effect	No effect	No effect
Withdrawal	No effect	No effect	No effect	Strong effect	No effect	
Neurobehavioral	Effect	Effect	Effect	Effect	Effect	Effect
Long-term effects						
Growth	No consensus on effect	Strong effect	No effect	No effect	No consensus on effect	
Behavior	Effect	Strong effect	Effect	Effect	Effect	
Cognition	Effect	Strong effect	Effect	No consensus on effect	Effect	

Behnke, Marylou & Smith, Vincent C., (Committee on Substance Abuse, Committee of Fetus and Newborn), March 2013, Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus, from the American Academy of Pediatrics Technical Report, *Pediatrics*, vol. 131:3.

Ethical considerations

The subject of testing for drugs of abuse, particularly testing for those that are illegal, presents ethical dilemmas for health professionals. On the one hand, the screening for the detection of substances of abuse holds the promise of benefit to the mother with addiction problems that may be remedied by treatment. On the other, the detection of illegal substances may lead to the discovery of information that may require reporting to authorities. Reporting of detected illegal substances in the mother may lead to criminal prosecution and incarceration as a form of punishment. Similarly, detection in the infant may lead to mandated reporting to child protection service agencies and lead to custodial litigation, prosecution, or other disruptions to the mother and infant relationship.

Punitive approaches and incarceration have not been demonstrated to be beneficial in improving health for mothers and infants. Foster placement of children and mandated entry to complex child welfare systems with limited resources and capabilities may also lead to sub-optimal outcomes for both mother and infant. This may be especially true in our own State of Arizona, where many of our child protective organizations and agencies are undergoing dynamic change and development to improve the delivery of services for children. Hence, as is the case with all decisions in medicine, practitioners are often faced with dichotomous choices, each carrying broad implications that must be carefully weighed before potentially causing harm to mothers and infants under their care.

Although there may be punitive consequences of reporting the detection of illegal substances, there may be benefits as well. Testing may be beneficial in providing clinical information and identifying the need for services. Various programs across the state can help the mother receive treatment and maintain their sobriety while keeping their children in the home. The SENSE (Substance Exposed Newborn Environment) program provides services for families referred by the Department of Child Safety (DCS) after the birth of a substance exposed infant. The program develops and implements a coordinated Family Service Plan with the family and with staff from Intensive In-Home services, Arizona Families FIRST, Healthy Families, and DCS case management. This program aims to keep the infant in the home while the parent works with service providers to learn new skills and works to maintain their sobriety. The SENSE program is currently only offered in Maricopa, Mohave, Yuma, and Pima counties. With the increasing number of NAS babies in Arizona it has been recommended that this program be expanded to meet this growing need. Other programs that offer home visiting services, such as Arizona Health Start Program, are also beneficial to these families. Strong Families AZ is a network of free home visiting programs that helps families raise healthy children ready to succeed in school and in life. Many of these services offer treatment that incorporate evidence based programs that have shown effective implementation of services for children and families involved with the child welfare system.

Health professionals, when entering into a relationship with a patient, are bound by duty to act in their best interest. Hence, the decision to obtain information through the use of

body fluids or tissues should be carefully weighed with an anticipated expectation of benefit for infant and mother. As with any other medical intervention, drug, or treatment, the provider should weigh the anticipated benefits carefully against the potential risks. For a health professional to do otherwise is unethical.

Another dilemma involves the patient's right to privacy. Recent Supreme Court actions suggest that collection of health information without the express consent of the patient, such as that obtained during urine drug screening for other than directly medical indications represents unreasonable search and seizure. Thus, health professions organizations, including the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Department of Health and Human Services generally recommend that drug screening for substances of abuse be obtained on mother and infant only with the consent of the mother, unless the medical situation demands otherwise.

These considerations demand care and thoughtfulness in the decision by health professionals or institutions to implement procedures that involve the use of drug screening.

In an effort to maintain the interests of the pregnant woman and the newborn foremost in the delivery of their care, the following guiding principles are suggested:

- Health professionals should be knowledgeable about state and local laws regarding mandatory reporting of illegal drug detection in pregnant women and infants.
- Health professionals should be knowledgeable regarding the resources and facilities available for treatment and management of substance abuse in their communities.
- Health providers should remain cognizant of the duty they assume when engaged in the delivery of care to their patients. This duty requires their actions to be performed in the best interest of the patient.
- Medical decision-making requires an assessment of risk and benefit to mother and newborn. The potential risk and adverse consequences of screening and identification of substance-exposed newborns should be weighed against the potential benefits in a manner no different than as applied to other medical interventions.
- Health providers should be aware of the legal implications of their actions in the context of recent court decisions that uphold the rights of mothers against unlawful search and seizure.
- In keeping with recommendations by health professions organizations, health providers should obtain informed consent from patients (or the mother of an infant) before chemical drug screening procedures except where this is not possible for medical reasons.

Disclaimer These guidelines are not an exclusive course of management. Variations that incorporate individual circumstances or institutional preferences may be appropriate.

Referral list

Regional Behavioral Health Authorities

Maricopa County

Mercy Maricopa Integrated Care

500 West Thomas Road
Phoenix, AZ 85013
Customer Service Number: **1-800-564-5462, 602-586-1841**

Apache, Coconino, Gila, Mohave, Navajo & Yavapai Counties

Health Choice Integrated Care

1300 South Yale Street
Flagstaff, AZ 86001

410 North 44th Street, Suite 900

Phoenix, AZ 85008

Customer Service Number: **1-800-640-2123**

Cochise, Graham, Greenlee, La Paz, Pinal, Santa Cruz and Yuma Counties

Cenpatico Integrated Care

333 E Wetmore Road Suite 500
Tucson, AZ 85705
Customer Service Line: **1-866-495-6738**

Statewide for children in the CRS program

Children's Rehabilitative Services (CRS) Program

United Health Care Customer Service
PO Box 29675
Hot Springs, AR 71903-9802
Customer Service Line: **1-800-348-4508**

Community Information and Referral

Yuma, La Paz, Cochise, Maricopa, Mohave, Coconino, Apache, Navajo, Yavapai, Pinal and Gila counties
1-800-352-3792 or (602) 263-8856

Information and Referral

Pima, Graham, Greenlee, Cochise & Santa Cruz counties
1-800-362-3474 or (520)-881-1794

AHCCCS Substance Abuse Treatment Providers in the Northern 5 Counties:

West Yavapai Behavioral Health Locations:

643 Dameron Drive
Prescott, AZ 86302
928-445-5211 or 1-800-293-7730
555 W Road 3 North
Chino Valley, AZ 86323
928-445-5211 or 1-800-293-7730

3345 N Windsong Drive
Prescott Valley, AZ 86314
928-445-5211 or 1-800-293-7730

Spectrum Healthcare Locations:

8 E Cottonwood Street
Cottonwood, AZ 86326
928-634-2236

452 Finnie Flat Road
Camp Verde, AZ 86323
928-567-4026

2880 Hopi Drive
Sedona, AZ 86336
928-282-4357

Little Colorado Behavioral Health Center Locations:

50 N Hopi Drive, PO Box 699
Springerville, AZ 85938
928-333-2683

470 W Cleveland, PO Box 579
St Johns, AZ 85936
928-337-4301

Specialty Programs for Mothers and Infants

Casa de Amigas (no children)
1648 W Colter #8
Phoenix AZ
(602) 265-9987

Center for Hope (owned and operated by Community Bridges)
554 S. Bellview
Mesa, AZ 85204
(480) 461-6984

Elba House (owned and operated by Ebony House)
6222 S. 13th Street Phoenix AZ
(602) 276-4288

Hacienda Healthcare-Hacienda Children's Hospital
Drug Dependent Newborn Program
610 W. Jerome Ave
Mesa, AZ 85210
(480) 579-2400

Maricopa County Value Options

Native American Connections
609 N 2nd Avenue, #120 Phoenix AZ
(602) 424-2060

New Arizona Family, Inc.
3301 E. Pinchot
Phoenix AZ (602) 553-7300

**Pima, Graham, Greenlee, Santa Cruz & Cochise counties
Community Partnership of Southern Arizona (CPSA)**

CODAC Behavioral Health Services

333 W Ft. Lowell #219
Tucson, AZ 85705
(520) 327-4505
Fax: (520) 792-0033

Las Amigas
502 Silverbell Road
Tucson, AZ 85745
(520) 882-5898

The Haven
1107 E. Adelaide
Tucson, AZ 85719
(520) 623-4590

Amity Foundation
Robin Rettmer
Director of Family Services
(520) 749-5980
Fax: (520) 749-5569

Family Supports/Resources

Arizona Department of Health, Office of Women's and Children's Health
150 North 18th Ave.
Suite 320
Phoenix, AZ 85008
Phone: (602) 364-1400 Fax: (602) 364-1495 Toll Free: (602) 542-1200
www.azdhs.gov/phs/owch/

Children's Health Center of St. Joseph's Hospital
350 West Thomas Rd
Phoenix, AZ 85013
Phone: (602) 406-3000 Fax: (602) 406-6135
www.stjosephs-phx.org/index.htm

Emily Anderson Family Learning Center
1919 East Thomas Road
Phoenix, AZ 85016
Phone: (602) 546-1400 Fax: (602) 546-1409
www.phoenixchildrens.com/health-information/the-emily-center/

FAS Arizona
Tucson, AZ
www.fasarizona.com/

March of Dimes
3550 North Central Avenue, Suite 610
Phoenix, AZ 85012
Phone: (602) 266-9933 Fax: (602) 266-9793
www.marchofdimes.com/arizona/arizona.asp

NAFACES- Northern Arizona Fetal Alcohol Spectrum Disorders Center for Education and Support
77 West Forest Ave, Suite 110
Flagstaff, AZ 86001
For more information, contact:
Jean Richmond-Bowman (928)214-3747
Cindy Beckett (928)773-2307

Native American Community Health Center
4520 North Central Avenue

Suite 620
Phoenix, AZ 85012
Phone: (602) 279-5262
www.nativehealthphoenix.org/

Native American Connections Inc., Guiding Star Lodge
3424 E Van Buren
Phoenix, AZ 85008
Phone: (602) 254-5805
www.nativeconnections.org/about/locations/guiding-star

Parker Indian Health Service Hospital
12033 Agency Road
Parker, AZ 85344
Phone: (520) 669-2137

Pilot Parents
2600 North Wyatt Drive
Tucson, AZ 85712
Phone: 520-324-3150
www.pilotparents.org/

Raising Special Kids
5025 East Washington Street
Suite #200
Phoenix, AZ 85034
Phone: (602) 242-4366 Fax: (602) 242-4306 Toll Free: (800) 237-3007
www.raisingpecialkids.org/

Spectrum Disorders (FASD).
FAS Community Resource Center
4710 E. 29th St.
Tucson, AZ 85710
Fax: 520-296-9172
Contact: Teresa Kellerman
www.come-over.to/FASCRC

The Arc of Arizona
PO Box 90714
Phoenix, AZ 85066
Phone: (602) 234-2721
www.arcarizona.org/

Websites

American Academy of Pediatrics
www.aap.org

American College of Nurse-Midwives (ACNM)
www.midwife.org

American Congress of Obstetricians and Gynecologists (ACOG)
www.acog.org

American Society of Addiction Medicine
www.asam.org

Arizona Department of Economic Security
<https://des.az.gov>

Arizona Department of Health Services
www.azdhs.gov

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)
www.awhonn.org

Centers for Disease Control and Prevention (CDC)
www.cdc.gov/fasd

Family Empowerment Network (FEN)
www.pregnancyandalcohol.org

National Institute for Alcohol Abuse and Alcoholism (NIAAA)
www.hiaaa.nih.gov

National Institute on Drug Abuse
www.drugabuse.gov

National Organization on Fetal Alcohol Syndrome (NOFAS)
www.nofas.org

Northern Arizona Fetal Alcohol Spectrum Disorders Center for Education and Support
www.NAFACES.org

Pacific Southwest Technology Transfer Center
www.psattc.org

Physicians and Lawyers for National Drug Policy: A Public Health Partnership
www.plndp.org

Southwest Human Development Birth to Five Helpline
<https://www.swhd.org/programs/health-and-development/birth-to-five-helpline/>

Substance Abuse and Mental Health Services Administration (SAMHSA)
Substance Abuse Treatment Facility Locator
www.samhsa.gov
www.findtreatment.samhsa.gov

The American College of Obstetrics and Gynecologists Women and Alcohol
www.womenandalcohol.org

The Arc
www.thearc.org

The Governor's Office of Youth, Faith, and Family (treatment locator website)
<http://substanceabuse.az.gov/substance-aabuse/arizona-substance-abuse-partnership>

The Governor's Office (Program Inventory July 2015)
http://www.azcjc.gov/cdc_site/Resource.aspx

Reference Articles (Historical and Current)

- American Academy of Pediatrics, Committee on Drugs. (2001) The transfer of drugs and other chemicals in human milk. *Pediatrics*; 108(3):776-789.
- American Academy of Pediatrics, Committee on Drugs. (1998) Neonatal drug withdrawal. *Pediatrics*, June; 101(6):1079-1088.
- American Academy of Pediatrics, Committee on Fetus and Newborn. (1995) Hospital stay for healthy term newborns. *Pediatrics*, Oct; 96(4):788-790.
- American Academy of Pediatrics, Committee on Fetus and Newborn. (1998).Hospital discharge for the high-risk neonate--proposed guidelines. *Pediatrics*, Aug; 102(2):411-417.
- American Academy of Pediatrics, Committee on Substance Abuse. (1993) Drug-exposed infants. *Pediatrics*; 96:364.
- American College of Obstetricians and Gynecologists. (1995) Substance abuse in pregnancy. *Technical Bulletin #195*: July.
- Anonymous. (2000). Prenatal Exposure to Alcohol. *Alcohol Research and Health* 24: 32-41.
- Anonymous (2004). Fetal Alcohol Syndrome Is Still a Threat, Says Publication. *Science Letter* September 28, 2004: 448.
- Artigas, V. (2014). Management of Neonatal Abstinence Syndrome in the Newborn Nursery. *AWHONN*. Vol.18, Issue 6, December 2014/January 2015. 509-514.
- Arizona Child Fatality Review Program, 22nd Annual Report, Nov 15, 2015. * The term "illicit" refers to the use of illegal drugs, including marijuana according to federal law and misuse of prescription medications
- Arizona Department of Health Services. (2011) Arizona Health Status and Vital Statistics. Incidence of Prenatal Alcohol Exposure. Retrieved from <http://www.azdhs.gov/plan/report/ahs/ahs2011/toc11.htm>
- Arizona Department of Health Services. (2015). Women's Directory: A Guide to Substance Abuse and Mental Health Services for Women. LeCroy & Milligan Associates, Inc.
- Arizona Hospital Discharge Data 2014. Hospital cases of exposure were identified by one of the following ICD9 codes: 779.5,760.75,760.73,760.72,760.71.
- Bada, HS. (2015) Neurodevelopmental Outcomes of Children with Prenatal Opiate Exposure. NAS Conference. July 2015.
- Bauer CR, Shankaran S, Bada HS, et al. (1996) Maternal Lifestyles Study (MLS): Effects of substance abuse exposure during pregnancy on acute maternal outcomes. *Pediatric Res*; 39:257A.
- Behavioral Risk Factor Surveillance System. . (2013)Behavioral Surveillance Branch, Centers for Disease Control and Prevention. Alcohol Use and Smoking in Arizona. Retrieved from <http://www.marchofdimes.com/peristats>
- Burgos, A. & Burke, B.L., (2009). Neonatal Abstinence Syndrome. *NeoReviews*, vol.10, no. 5, May, e222-e229.

Callahan CM, Grant TM, Phipps P, Clark G, Novack AH, Streissguth AP, Raisys VA, et.al. (1992). Measurement of gestational cocaine exposure: Sensitivity of infants' hair, meconium, and urine. *J Pediatrics*;120:763-768.

Catlin, A. (2012). Call for Improved Care for the Substance –Positive Mother. *Advances in Neonatal Care*, Vol. 12, No. 5, 286-287.

CDC Behavioral Risk Factor Surveillance System (BRFSS), United States, 2011-2013 <http://azdhs.gov/prevention/womens-childrens-health/injury-prevention/>

Centers for Disease Control. (September 10, 2013). Facts about FASD. Retrieved from <http://www.cdc.gov/NCBDDD/fasd/facts.html>

Centers for Disease Control and Prevention (CDC). (2011). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Chasnoff, IJ, et.al. (2003). Prenatal substance exposure: Maternal screening and neonatal identification and management. *NeoReviews*; 4(9) 228-234.

Clinical Report American Academy of Pediatrics (2012). Neonatal Drug Withdrawal. *Pediatrics*. Online www.pediatrics.org/cgi/doi/10.1542/peds.2011-3212. e540-e558.

Committee on Health Care for Underserved Women and the American Society of Addiction Medicine (Reaffirmed 2014). Opioid Abuse, Dependence, and Addiction in Pregnancy: Committee Opinion. *The American College of Obstetrics and Gynecologists*. Number 524. May 2012.

Committee of Substance Abuse and Committee on Children with Disabilities. (2000).Fetal Alcohol Syndrome and Alcohol-Related Neurodevelopmental Disorders. *Pediatrics* 106 (August): 358-361.

Controlled Substance Prescription Monitoring Program (CSPMP) <https://pharmacypmp.az.gov/>

Coonrod, D. (2012). Preconception Health – A Life Course Perspective. Conference Presentation, November 29, 2012.

Cramer, C. & Davidhizar, F. (1999). FAS/FAE: Impact on Children. *Journal of Child Health Care*, 3 (Autumn): 31-34.

D'Apolito, K. (2013). Breastfeeding and Substance Abuse. *Clinical Obstetrics and Gynecology*. Vol. 56. No. 1, 202-211.

D'Apolito, K.C. (2014). Assessing Neonates for Neonatal Abstinence: Are You Reliable? *Journal of Perinatal & Neonatal Nursing*. Vol. 28, No. 3, 220-231.

Drinking and your pregnancy. (1996). National Institute on Alcohol Abuse and Alcoholism; 96:4101.

Drugs and pregnancy. (1999). American Council for Drug Education's Facts for Parents.

Dudeck, J. (2015). Neonatal Abstinence Syndrome and Newborn Drug Exposures, Arizona Births, 2008-2014. Office of Injury Prevention. Arizona Department of Health Services.

Gillogley KM, Evans AT, Hansen RL, Samuels SJ, Batra KK, et.al. (1990) The perinatal impact of cocaine, amphetamine, and opiate use detected by universal intrapartum screening. *Am J Obstetrics Gynecology*; 163:1535-1542.

Graham K, Koren G, Klein J, Scheiderman J, Greenwald M. et.al. (1989). Determination of gestational cocaine exposure by hair analysis. *JAMA*; 262:3328-3330.

Gregory, K. (2014). Caring for the Infant with Neonatal Abstinence Syndrome in a Community-Based Setting. Expert Opinion, Neonatal. *The Journal of Perinatal & Neonatal Nursing*. July/September. 161-163.

Hale's Medications and Mother's Milk (2004). 119, 198-199, 405.

Hannigan, J. H., and D. R. Armant. (2000). Alcohol in Pregnancy and Neonatal Outcome. *Seminars in Neonatology* 5 (August): 243-54.

Hansen RL, Evans AT, Gillogley KM, Hughes CS, Krener PG, et.al. (1992). Perinatal Toxicology Screening. *Journal of Perinatology*; XII:220-224.

Hayes, M.J. & Brown, M.S. (2012). Epidemic of Prescription Opiate Abuse and Neonatal Abstinence. *Journal of the American Medical Association*. Published online April 30, 2012, E1-E2.

Holmes, A.V. (2016). Dartmouth study offers hope for babies exposed to drugs in womb. Downloaded 6/21/16, <http://www.unionleader.com/apps/pbcs.dll/article?AID=/20160524/NEWS12/160529711&...>

Howard CR, Lawrence RA. (1998) Breast-feeding and drug exposure. *Obstetrics and Gynecology Clinics of North America*; 25(1), 195-217.

Hudak, M.L. & Tan, R.C. (2012). Neonatal Drug Withdrawal. *Pediatrics*. The Committee on Drugs and the Committee on Fetus and Newborn. 129, e540; originally published online January 30, 2012.

Intermountain Healthcare (2013). Fact Sheet for Patients and Families: Newborn Withdrawal. www.Intermountainhealthcare.org

Jansson, L.M. & Velez, M. (2012). Neonatal Abstinence Syndrome. *Current Opinions in Pediatrics*. Vol. 24, No. 2, 252-258.

Kellerman, T. (2013). Presentation Fetal Alcohol Spectrum Disorders Screening and Intervention Strategies.

Kocherlokata, P. (2014). Neonatal Abstinence Syndrome. *Pediatrics*. 134, e547; originally published July 28, 2014 online, -DOI: 10.1542/peds.2013-3524.

Kraft, W.K., Stover, M.W., & Davis, J.M. (2016). Neonatal Abstinence Syndrome: Pharmacologic Strategies for the Mother and Infant. *Seminars in Perinatology*. Online <http://dx.doi.org/10.1053/j.semperi.2015.12.007>

Kandall, SR (1999). Treatment strategies for drug-exposed neonates. *Clinics in Perinatology*; 231-243.

Kocherlakota P. (2014). Neonatal Abstinence Syndrome. *Pediatrics*; 134:e547-e561.

Kwong TC, Ryan RM. (1997). Detection of intrauterine illicit drug exposure by newborn drug testing. *Clinical Chemistry*; 43:235-242.

Lucas, K. & Knobel, R.B. (2012). Implementing Practice Guidelines and Education to Improve Care of Infants with Neonatal Abstinence Syndrome. *Advances in Neonatal Care*. Vol. 12, No. 1, 40-45.

Madden JD, Payne TF, Miller S. (1986). Maternal and fetal effect on the newborn. *Pediatrics*, 77:209-211.

Maguire, D. (2014). Care of the Infant with Neonatal Abstinence Syndrome: Strength of the Evidence. *The Journal of Perinatal & Neonatal Nursing*. Vol. 28. No.3, 204-211.

March of Dimes NAS information
[http://www.marchofdimes.org/baby/neonatal-abstinence-syndrome-\(nas\).aspx](http://www.marchofdimes.org/baby/neonatal-abstinence-syndrome-(nas).aspx)

May, Philip PhD, Baete, Amy, MBA, et al. Prevalence and Characteristics of Fetal Alcohol Spectrum Disorders, *Pediatrics*. 2014; 2013-3319.

Maynard EC, Amoruso LP, Oh W, et.al. (1991). Meconium for drug testing. *AJDC*. June; 145:650- 652.

McCarthy, J.J., Leamon, M.H., Parr, M.S., & Anaia, B. (2005). High-dose Methadone Maintenance in Pregnancy: Maternal and Neonatal Outcomes. DOI: 10.1016/j.ajog.2005.03.072.

Millard D: Toxicology testing in neonates: Is it ethical, and what does it mean? *Clinics in Perinatology* 1996; 23:491.

Mitchell JL: Pregnant, substance-using women, treatment improvement protocol. U.S. Department of Health and Human Services 1993; DHHS Publication No. (SMA) 95-3056.

Mittal, L. (2014). Buprenorphine for the Treatment of Opioid Dependence in Pregnancy. *The Journal of Perinatal & Neonatal Nursing*. Vol. 28, No. 3,178-184.

MMIC Guidance on drug and alcohol treatment programs
<http://www.mercymaricopa.org/members/resources/substance> provides members with information on the dangers of drug and alcohol abuse, crisis hotline information, and the government health links *Drugabuse.gov* and the *U.S. Department of Health Services*

National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control. (September 10, 2013) Guidelines for FAS Diagnosis and Referral. Retrieved from
<http://www.cdc.gov/ncbddd/fas>

Neonatal Abstinence Syndrome State of the Art Review Article
<http://pediatrics.aappublications.org/content/pediatrics/134/2/e547.full.pdf>

Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care
<http://www.astho.org/Prevention/NAS-Neonatal-Abstinence-Report>

NIH. (2012). Principles of Drug Addiction Treatment: Principles of effective Treatment. A research- based Guide (Third Edition). December.

Opioid Abuse, Dependence, and Addiction in Pregnancy - American College of Obstetricians and Gynecologists. (2016) <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Opioid-Abuse-Dependence-and-Addiction-in-Pregnancy>

Organization of Teratology Information Specialists. (August 20, 2013) Fact Sheets. Retrieved from
<http://www.mothers-to-baby.org/fact-sheets-s13037>

Orlando, S. (2014). An Overview of Clinical Tools Used to Assess Neonatal Abstinence Syndrome. *The Journal of Perinatal & Neonatal Nursing*. Vol. 28, No. 3, 212-219.

Oro AS, Dixon SD. (1987). Perinatal cocaine and methamphetamine exposure: Maternal and neonatal correlates. *J Pediatrics*; 111:571-578.

Osterloh JD, Lee L, et.al. (1989). Urine drug screening in mothers and newborns. *AJDC*. July;143:791-793.

Ostrea EM, Welch RA, et.al. (1991) Detection of prenatal drug exposure in the pregnant woman and her newborn infant. *Clinics in Perinatology*. September;18: 629-645.

Prescription Opioids Epidemic and Infant Outcomes
<http://pediatrics.aappublications.org/content/pediatrics/early/2015/04/08/peds.2014-3299.full.pdf>

Pritham, U.A, Paul, J.A., & Hayes, M.J. (2012). Opioid Dependency in Pregnancy and Length of Stay for Neonatal Abstinence Syndrome. *JOGNN*. 41, 180-190, DOI: 10.1111/j.1552-6909.2011.01330.x.

Puckett, David. American Association of Neurological Surgeons. (November 13, 2010). Retrieved from
<http://www.aans.org/>

Reasons for Re-hospitalization in Children Who Had Neonatal Abstinence Syndrome
<http://pediatrics.aappublications.org/content/136/4/e811>

Robakis, T. & Williams, K.E. (2013). Atypical Antipsychotics during Pregnancy. *Current Psychiatry*. Vol. 12, No. 7, 13-20.

Rowe, H., Baker, T., & Hale, T.W. (2013). Maternal Medication, Drug Use, and Breastfeeding. *Pediatrics Clinics of North America*. Vol. 60, 275-294. <http://dx.doi.org/10.1016/j.pcl.2012.10.009>.

Russell, M. (1994). New assessment tools for drinking in pregnancy: T-ACE, TWEAK, and others. *Alcohol Health and Research World*, 18(1), 55-61. retrieved from -
http://pubs.niaaa.nih.gov/publications/assessingalcohol/InstrumentPDFs/74_TWEAK.pdf

Saia, K.A., Schiff, D., Wachman, E.M. et al. (2016) *Current Trends in Obstetrics & Gynecology Rep*, 5: 257. DOI:10.1007/s13669-016-0168-9

Saunders, C., King, T., Smith, S., Buchheit, J., Cook, K., Edds, J., & Mefford, L. (2014). Neonatal Abstinence Syndrome. *The Journal of Perinatal & Neonatal Nursing*. Vol. 28, No. 3, 232-240.

SAMHSA (2016). Pocket Guide: Medication-Assisted Treatment of Opioid Use Disorder. Online:
<http://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf>.

Schiller, J.H. & Stojan, J. (2013). Index of Suspicion in the Nursery. *NeoReviews*. Vol. 14. No. 1. E32-e34.

State of Kentucky Prevention Enhancement Site. (July, 2013). Baby Love Power Point. Retrieved from
<http://www.come-over.to/FASCRC/>

Substance Abuse Mental Health Services Administration, Office of Applied Studies, National Survey on Drug Use & Health. (September 23, 2013) Illicit Drug Use in Arizona. Retrieved from
<http://www.marchofdimes.com/peristats>

Sutter, M.B., Leeman, L., & Hsi, A. (2014). Neonatal Opioid Withdrawal Syndrome. *Obstetrics & Gynecology the Clinics of North America*, 41: 317-334.

Uebel H, Wright IM, et. Al. (2015) Reasons for Rehospitalization in Children Who Had Neonatal Abstinence Syndrome. *Pediatrics*, October; 4:136: e811-e820.

United States Government Accountability Office (2015). Prenatal Drug Use and Newborn Health: Federal Efforts Need Better Planning and Coordination. GAO-15-203.GAO Highlights.

Virginia Department of Health Services, Division of Women and Infant's Health. (2003) Perinatal substance use: A guide for hospitals and health care providers.

Wesson, D.R. & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *Journal Psychoactive Drugs*, 35 (2), 253-259.

Woolf AD, Shannon MW, et.al. (1995) Clinical toxicology for the pediatrician. *Pediatric Clinics of North America*, April;42:317-333.

Worley, J. (2014). Identification and Management of Prescription Drug Abuse in Pregnancy. *The Journal of Perinatal & Neonatal Nursing*. Vol. 28, No. 3, 196-203.

Young, M.E, Hager, S.J., & Spurlock, D. (2015). Retrospective Chart Review Comparing Morphine and Methadone in Neonates Treated for Neonatal Abstinence Syndrome. *American Journal of Health-Systems Pharmacy*. Vol. 72, Dec. 2015-Supplement 3. S162-S167.

Appendix A 2008 Committee Members

The Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs would like to recognize the following original committee members:

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2016 Committee Members for SEN Guidelines**

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Pamela Tom - Medical Director, DDD of Arizona

Joanna Kowalik - CMO, DDD of Arizona

Erin Phillips – AmeriCorps VISTA, Easter Seals Blake Foundation

Appendix C Screening Tools

To reduce the incidence of substance exposed newborns, screen women at risk of addiction. Samples of interview screening tools for drugs and alcohol include:

CAGE

- C** Have you ever felt you ought to **cut down** on your drinking or drug use?
- A** Have people **annoyed** you by criticizing your drinking or drug use?
- G** Have you ever felt bad or **guilty** about your drinking or drug use?
- E** **Eye opener:** Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover?

The CAGE can identify alcohol or drug problems over the lifetime. Two positive responses are considered a positive test and indicate further assessment is warranted. *National Institute on Alcohol Abuse and Alcoholism*

4 P's

This screening device is often used as a way to begin discussion about drug or alcohol use. Any woman who answers yes to one or more questions should be referred for further assessment.

1. Have you ever used drugs or alcohol during this **pregnancy**?
2. Have you had a problem with drugs or alcohol in the **past**?
3. Does your partner have a **problem** with drugs or alcohol?
4. Do you consider one of your **parents** to be an addict or alcoholic?

Ewin H, Born Free Project, Martinez California

T-ACE

A score of 2 or more is considered positive. Affirmative answers to questions A, C, or E = 1 point each. Reporting tolerance to more than two drinks (the T question) = 2 points.

- T** **Tolerance:** how many drinks does it take to make you feel high?
- A** Have people **annoyed** you by criticizing your drinking or drug use?
- C** Have you ever felt you ought to **cut down** on your drinking or drug use?
- E** **Eye opener:** Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover?

Sokol RJ, et al. (1989) The T-ACE questions: Practical prenatal detection of risk drinking. AM Journal of Obstetrics and Gynecology, 160(4).

Chang G. (2001) Alcohol-Screening Instruments for Pregnant Women, Alcohol Research and Health, 25 (3), 204-209.

TWEAK is a five-item scale developed originally to screen for risk drinking during pregnancy. It is an acronym for the questions below (Russell, 1994):

- T** **Tolerance*** "How many drinks can you hold?"
- W** **Worried** "Have close friends or relatives worried or complained about your drinking in the past year?"
- E** **Eye-opener** "Do you sometimes take a drink in the morning when you first get up?"
- A** **Amnesia (stands for blackouts)** "Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?"
- K** **K/Cut Down** "Do you sometimes feel the need to cut down on your drinking?"

Russell, M. (1994). New assessment tools for drinking in pregnancy: T-ACE, TWEAK, and others. Alcohol Health and Research World, 18(1), 55-61.

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 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.