Arizona

UNIFORM APPLICATION
FY 2022/2023 Block Grant Application

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

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/19/2021 12.23.53 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 2022

End Year 2023

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 Kristen

Last Name Challacombe

Agency Name Arizona Health Care Cost Containment System

Mailing Address 801 East Jefferson MD4100

City Phoenix

Zip Code 85034

Telephone 602-417-4000

Fax

Email Address kristen.challacombe@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 Kristen

Last Name Challacombe

Agency Name Arizona Health Care Cost Containment System (AHCCCS)

Mailing Address	801 E Jefferson MD4100
City	Phoenix
Zip Code	85034
Telephone	602-417-4000
Fax	
Email Address	kristen.challacombe@azahcccs.gov

III. Third Party Administrator of Mental Health Services

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

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

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

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	
Last Name	
Telephone	
Fax	
Email Address	

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

Footnotes:

State Information

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

Fiscal Year 2022

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
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Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

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

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

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

Footnotes:

State Information

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

Fiscal Year 2022

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

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

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

Footnotes:

Planning Steps

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

Narrative Question:

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

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

Footnotes:

SABG/MHBG Combined Application
FY2022-23
Planning Step 1

September 1, 2021

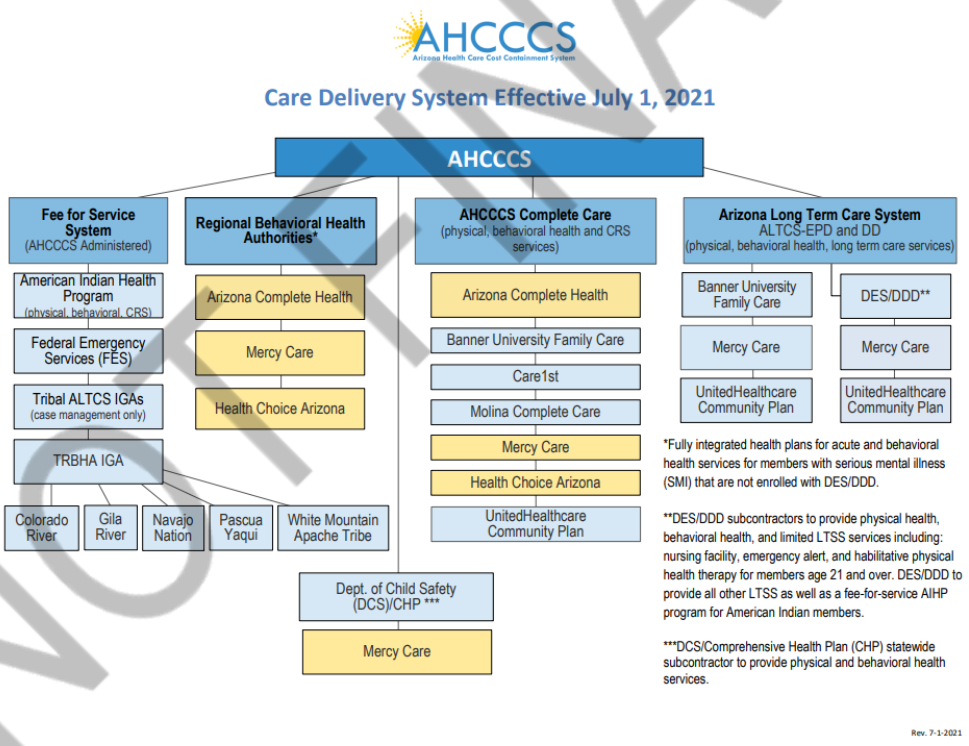
AHCCCS Overview

Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid agency for the State of Arizona. In that capacity, it is responsible for operating the Title XIX and Title XXI programs through the State's 1115 Research and Demonstration Waiver, which allows for the operation of a total managed care model.

AHCCCS' mission "reaching across Arizona to provide comprehensive, quality health care to those in need" is implemented through the vision of "shaping tomorrow's managed care…from today's experience, quality, and innovation." Built on a system of competition and choice, AHCCCS' $14 billion program operates under an integrated managed care model.

Arizona Complete Care (ACC) Plans

On October 1, 2018, AHCCCS took the largest step to date toward this strategic goal of fully integrated care delivery when 1.6 million members were enrolled in one of AHCCCS' Complete Care (ACC) health plans and American Indian Health Plans (AIHP). ACC plans and AIHP provide a comprehensive network of providers to deliver all covered physical and behavioral health services to child and adult members without a Serious Mental Illness (SMI) designation. The ACC plans and AIHP also provide services for members with Children's Rehabilitative Services (CRS) conditions. ACC plans and AIHP address the whole health needs of our state's Medicaid population which is vitally important to improving service delivery for AHCCCS members and reducing the fragmentation that has existed in our healthcare system. The YH19-0001 AHCCCS Complete Care Request for Proposal [ACC RFP (Request for Proposals)] awarded in March of 2018 resulted in seven awarded ACC plans across the state in three Geographic Service Areas: north, central, and south.



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

Contracted health plans coordinate and pay for physical and behavioral health care services delivered by more than 104,000 health care providers. According to the *Behavioral Health Enrolled and Served Report* required by Arizona Revised Statute 36-3450(D), as of June 2021, 1,814,108 members were enrolled in in Medicaid Title XIX/XXI, including 269,543 (15 percent) who received behavioral health services.

Regional Behavioral Health Authorities (RBHAs)

Three of the ACC plans are affiliated with current AHCCCS Regional Behavioral Health Authorities (RBHA) and were required to align the RBHA and ACC contracts under one organization. The following link shows the contracted ACC plans and RBHAs and the different Geographic Service Areas (GSAs) served (https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/).

A RBHA is a contracted Managed Care Organization (also known as a health plan) responsible for the provision of comprehensive behavioral health services to all eligible individuals assigned by the administration and provision of comprehensive physical health services to eligible persons with a Serious Mental Illness enrolled by the Administration. The function of the RBHAs include:

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

Arizona's three Regional Behavioral Health Authorities (RBHAs) are required to maintain comprehensive networks of behavioral health providers to deliver prevention, intervention, treatment, and rehabilitation services to members enrolled in AHCCCS.

- Mercy Care – RBHA serving central Arizona, including Maricopa County
- Arizona Complete Health – RBHA serving southern Arizona, including Tucson
- Health Choice Arizona – RBHA serving northern Arizona

Tribal Behavioral Health Authorities (TRBHAs)

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

- White Mountain Apache – TRBHA serving the White Mountain Apache Nation
- Gila River – TRBHA serving the Gila River Indian Community
- Pascua Yaqui – TRBHA serving the Pascua Yaqui Tribe
- Navajo Nation – TRBHA serving the Navajo Nation

The ACCs, MCOs, RBHAs, and TRBHAs are required to maintain a comprehensive network of behavioral health providers to deliver prevention, intervention, treatment, and rehabilitative services to members enrolled in the AHCCCS system. This structure allows communities to provide services in a manner appropriate to meet the unique needs of members and families residing within their local areas.

Single State Authority (SSA) and State Mental Health Authority (SMHA)

In addition to overseeing the managed care organizations that provide Medicaid-funded health care services, AHCCCS serves as the Single State Authority on substance use, and as the State Mental Health Authority (SMHA) responsible for the state public mental health service delivery system administration. AHCCCS is the agency responsible for mental health and substance use and provides oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona.

Service Delivery System

Regardless of the type, amount, duration, scope, service delivery method, and population served, AHCCCS requires all MCOs ensure that their service delivery system:

- Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines in a cost-effective manner,
- Coordinate and provide access to high-quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and incorporate a trauma-informed care approach,
- Coordinate and provide access to preventive and health promotion services, including wellness services,
- Coordinate and provide access to comprehensive care coordination and transitional care across settings; follow-up from inpatient to other settings; participation in discharge planning, and facilitating transfer from the children's system to the adult system of health care,
- Coordinate and provide access to chronic disease management support, including self-management support,
- Conduct behavioral health assessment and service planning following a Health Home model,
- Coordinate and provide access to peer and family delivered support services, based on member's needs, voice, and choice,
- Provide covered services to members in accordance with all applicable Federal and State laws, regulations, and policies,
- Coordinate and integrate clinical and non-clinical health care related needs and services across all systems,
- Implement health information technology to link services, facilitate communication among treating professionals and between the health team and individual and family caregivers, and
- Deliver services by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider.

AHCCCS further requires that at all MCOS work in partnership to meet, agree upon, and reduce to writing joint collaborative protocols with each county, district, or regional office of:

- Administrative Office of the Courts,
- Juvenile Probation and Adult Probation,
- Arizona Department of Corrections and Arizona Department for Juvenile Corrections,
- Arizona Department of Child Safety (DCS),
- Tribal Nations and Providers (Refer to this section above),
- The Veterans' Administration, and
- The county jails.

Continuum of Care (Adult and Child Systems)

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 fosters an environment of person-centered planning that includes the voice and choice of the person being served, their family, identified persons of support, advocates (as designated) and service providers, as identified. The Individual Service Planning (ISP) progress is transparent, fluid and the ISP is a living and breathing document that can change as a persons' choices and treatment needs change. AHCCCS has an Adult System of Care (ASOC) that is a continuum of coordinated community and facility-based services and support for adults with, or at risk for, behavioral health challenges. The ASOC is organized into a comprehensive network to create opportunities to foster recovery and improve health outcomes by:

- Building meaningful partnerships with individuals served,
- Addressing the individuals' cultural and linguistic needs and preferences, and
- Assisting the individual in identifying and achieving personal and recovery goals.

The ASOC developed the following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness:

Nine Guiding 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 underscore one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism are 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.

In addition, AHCCCS collaborated with the child, family, and others to provide services that are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family, and their cultural heritage.

Arizona/AHCCCS developed **The Twelve (12) Principles** for Children's in the Behavioral Health Service Delivery System:

Twelve (12) Guiding Principles:

1. COLLABORATION WITH THE CHILD AND FAMILY: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. FUNCTIONAL OUTCOMES: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. COLLABORATION WITH OTHERS: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DES/DDD caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.

4. ACCESSIBLE SERVICES: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.
5. BEST PRACTICES: Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.
6. MOST APPROPRIATE SETTING: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.
7. TIMELINESS: Children identified as needing behavioral health services are assessed and served promptly.
8. SERVICES TAILORED TO THE CHILD AND FAMILY: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
9. STABILITY: Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.
10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.
11. INDEPENDENCE: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.
12. CONNECTION TO NATURAL SUPPORTS: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parent's own network of

associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Overall, the Person-Centered Planning and Service Plan reflects the individual's strengths and preferences that meet the person's social, cultural, and linguistic needs and includes individualized goals and desired outcomes. Additionally, the planning process also identifies risk factors (includes risks to member rights) and puts measures in place to minimize them with individual back-up plans and other strategies as needed.

Arizona Behavioral Health Planning Council (BHPC)

AHCCCS utilizes the Arizona Behavioral Health Planning Council to advise the state in planning and implementing a comprehensive community-based system of behavioral health and mental health Services.

Division of Grants Administration (DGA)

The Division of Grants Administration (DGA) is the point of contact related to the pursuit, implementation and oversight of grants administered by the agency. DGA is inclusive of both programmatic and financial teams. Together, the teams work closely with each other to ensure the effective communication, oversight and implementation of all grants management for the agency. In 2019, AHCCCS recruited an Assistant Director to lead the unit, who reports to the Deputy Director of Business Operations within the Office of the Director. DGA staff positions include the State Opioid Treatment Authority/Opioid Treatment Network, Women's Treatment Network, National Prevention Network and National Treatment Network representatives, Grant Managers and Project/Grant Coordinators.

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

Substance Abuse Block Grant (SABG) Primary Prevention

To streamline prevention services, AHCCCS made the decision to administer the prevention contracts directly. This decision was effective as of July 1, 2021, and AHCCCS procured 20 local community-based coalitions through a competitive Request for Proposal (RFP) process. In addition to the administration of funding for local community-based prevention coalitions, AHCCCS has Intergovernmental Agreements (IGAs) with two of the state's TRBHAs, the Pascua Yaqui Tribe and the Gila River Indian Community, to administer SABG primary prevention funding to tribal populations within the state. AHCCCS also has a relationship with the Governor's Office of Youth, Faith, and Family (GOYFF) to provide substance abuse prevention services through Evidence Based Practices (EBPs) and community-based organizations.
All SABG Primary Prevention efforts are administered utilizing the Strategic Prevention Framework (SPF) Model from the Substance Abuse and Mental Health Services Administration (SAMHSA) with these funds. AHCCCS currently utilizes a variety of providers to implement prevention services, including community-based coalitions, schools, and various state agencies. AHCCCS prevention efforts

currently focus on several substances, including alcohol, tobacco, prescription drugs, and opioids. AHCCCS prevention efforts include focusing on a Risk and Protective Factor Theory, which includes reducing risk factors, and increasing protective factors, in a variety of settings. To address the unique needs of the state with these funds, AHCCCS will also address Adverse Childhood Experiences (ACEs) and trauma to ensure all high-risk individuals are receiving the appropriate types of services. AHCCCS will continue to support all prevention providers in offering services virtually, as appropriate, to ensure the health and safety of all participants. All primary prevention services will serve populations according to the Institute of Medicine (IOM) categories as follows: Universal (Indirect and Direct), Selective, and Indicated.

All primary prevention activities are quantified into the six Center for Substance Abuse Prevention (CSAP) strategies. It should be noted that AHCCCS requires the utilization of all strategies, as each strategy alone has not been proven to be effective in the reduction of substance use, misuse, and/or abuse. Some strategies to be used by AHCCCS prevention providers as part of this funding include, but are not limited to:

AHCCCS currently requires the use of Evidence Based Practice (EBP), Research Based Practice (RBP), or Promising Practice (PP) and allows providers to utilize Promising and Innovative Interventions at a ratio of one Evidence, Research and/or Promising Intervention to every Innovative Intervention. AHCCCS currently accepts the guidance provided by the SAMHSA document “Selecting Best-fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners” as the standard to follow when selecting programs and practices, including the best practices lists and resources. AHCCCS is aware that every community is unique and has unique needs to be addressed with prevention programming. To support innovation within communities to meet these unique needs, AHCCCS has developed parameters regarding the use of these interventions. AHCCCS utilizes the “AHCCCS Innovative Prevention Program Intervention Protocol” for all SABG Primary Prevention Activities that are not currently designated as Evidence or Research Based. The protocol, developed by AHCCCS staff, requires the prevention providers to formally submit documentation related to the intervention they are proposing to use, prior to the use of the intervention, for review and approval by AHCCCS. Upon review, AHCCCS designates an evidence-based status to the proposed intervention and provides feedback to the prevention provider regarding implementation.

AHCCCS currently employs a variety of methods to ensure primary prevention activities are equitable and include a focus on those at greater risk for health disparities. All AHCCCS primary prevention activities follow the SPF model, which requires the infusion of “cultural competence” into each phase of the SPF model. AHCCCS prevention efforts are currently moving to a “culturally responsive” approach in lieu of “cultural competency,” but the premise of the strategies remain the same. As part of the SPF model, all AHCCCS prevention providers are required to utilize a local primary prevention needs assessment that must be completed or renewed every three years. Mandatory data to be collected within the target communities include, but are not limited to, total population level, ages, educational attainment, housing, income level, poverty level, business/economical information, race and Hispanic origin, immigrant status, and veteran status. In addition to the needs assessment, each provider is also required to utilize a prevention strategic plan that is to be updated every three years. This plan must include the provider’s plan to address equity within their target populations through cultural responsiveness, which include engaging stakeholders from various backgrounds in the planning and implementation of prevention efforts, representation on the coalition, and to identify any barriers in existence that will impede the provider’s ability to provide culturally responsive services and a plan to address said barriers, as needed.

AHCCCS is aware that every community is unique and has unique needs to be addressed with prevention programming. Current evidence-based programming can be dated, and as was reported in the 2018 AHCCCS Statewide Primary Prevention Needs Assessment, youth expressed how current programming does not speak to them, feels dated, and does not keep them engaged. This was corroborated by local substance abuse providers and stakeholders. Arizona's populations and demographics are changing and has required the state to develop systems to enhance culturally responsive and equitable approaches to substance abuse prevention. To support innovation within communities to meet these unique needs, AHCCCS has developed parameters regarding the use of these interventions. As discussed previously, AHCCCS utilizes the "AHCCCS Innovative Prevention Program Intervention Protocol" for all SABG Primary Prevention activities that are not currently designated as evidence or research based. AHCCCS currently contracts with community based coalitions and local providers that tailor primary prevention efforts directly towards populations at high risk, with coalitions serving and focusing efforts on LGBTQ+ youth, Hispanic populations, refugee populations, border populations where health literacy and outcomes are low when compared to other areas of the state, border cities where illegal drug trade/activities are impacting youth, as well as focusing on areas of prevention deserts that historically have not had substance abuse prevention infrastructure present within the community.

AHCCCS also utilizes a "culture as prevention" framework when it comes to Arizona's indigenous and diverse populations. Primary prevention services are currently being implemented within two of AHCCCS' Tribal Regional Behavioral Health Authorities (TRBHAs), the Pascua Yaqui Tribe, and the Gila River Indian Community. Because the pandemic impacted Arizona's tribal communities at a rate disproportionate to other communities, AHCCCS met with these TRBHAs to develop and research dedicated substance abuse prevention strategies to help mitigate the impact on these communities. Primary prevention interventions that included multiple outcomes in substance abuse prevention, mental health promotion, suicide prevention, and domestic violence/intimate partner violence prevention were explored to ensure that the tribal communities could select substance abuse primary prevention interventions that had a larger impact on other community needs during the pandemic. AHCCCS' tribal partners lead the way to develop the prevention strategies that work best within their communities, focusing on cultural values, teaching of traditions, and spiritual practices.

AHCCCS maintains a strong presence within the community to ensure all backgrounds and voices of Arizonans are represented within primary prevention program assessment, planning, implementation, and evaluation. AHCCCS has demonstrated this through various ways, including holding statewide primary prevention focus groups discussing future SABG prevention planning/efforts in July 2020, the facilitation of a statewide substance abuse prevention plan that includes data and stakeholders' feedback from over 40 local, regional, and state level prevention providers, and through regular participation and attendance at the Substance Abuse Coalition Leaders of Arizona meetings.

Substance Abuse Block Grant (SABG) Treatment

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

1. Pregnant women (including teenagers) who use drugs by injection,
2. Pregnant women (including teenagers) who use substances,
3. Other persons who use drugs by injection,
4. Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children, and

5. All other individuals with a substance use disorder, regardless of gender or route of use, (as funding is available).

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

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

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

- Childcare
- Case management
- Transportation

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

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

Interim Services are required for those who meet the priority populations of pregnant women, women with dependent children, or intravenous drug users if there is a waitlist to engage in services. The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the member, and reduce the risk of transmission of disease. The minimum required interim services include:

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

AHCCCS Contracts ensure services covered through the AHCCCS Medical Policy Manual are provided in a culturally competent manner utilizing evidence-based practices. The services are geared towards members and individuals who have a behavioral health diagnosis and identify as being a part of an identified group with norms not always addressed through traditional treatment modalities, including, but not limited to veterans, LGBTQ+, elderly, homeless, rural, and diverse populations. The Managed Care Organizations (MCOs) 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.

Mental Health Block Grant (MHBG)

The MHBG is allocated to provide mental health treatment services to adults with a Serious Mental Illness (SMI) designation, children with Serious Emotional Disturbance (SED), and individuals with an Early Serious Mental Illness (ESMI) including first episode of psychosis (ESMI/FEP). The program makes funds available to Arizona to provide community mental health services. The program's objective is to support the grantees in carrying out plans for providing comprehensive community mental health services.

MHBG funds are used to provide treatment services in accordance with AHCCCS Medical Policy Manual (AMPM) 300-2B and AMPM 320-T1 and to ensure access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental, and health services as well as mental health services and supports.

Adults with a Serious Mental Illness (SMI) designation includes persons aged 18 and older who have a diagnosable behavioral, mental, or emotional condition as defined by the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM) of *Mental Disorders*.
Serious Emotional Disturbance (SED) includes persons up to age 18 who have diagnosable behavioral, mental, or emotional issues (as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM)). Their condition results in a functional impairment that substantially interferes with, or limits, a child's role or functioning in family, school, or community activities.

First Episode Psychosis (FEP) services are supported by the 10 percent set aside for ESMI/First Episode of Psychosis (FEP) and support evidence-based programs that provide treatment and support services for those who have experienced a first episode of psychosis within the past two years. Psychosis is a brain condition that disrupts a person's thoughts and perceptions, making it difficult to differentiate between what is real and what is not. FEP Program models may include principles or core components identified by National Institute of Mental Health (NIMH) via the Recovery After an Initial Schizophrenia Episode (RAISE) initiative.

Five percent of the MHBG was set aside for crisis services to support an evidence-based crisis system. This funding is to support evidence-based crisis care programs to address the needs of individuals with an SMI designation and SED. Current projects include a pilot initiative to increase outreach and identification of under and uninsured individuals with Serious Emotional Disturbance (SED) who are experiencing crisis. This project will also support crisis providers in the provision of intensive wraparound crisis intervention services in the community to maintain children and adolescents in their homes. The goal of the program is to decrease hospitalizations and out of home placements through the provision of in-home supports to the family in both the immediate crisis resolution, and coordination of

ongoing supports through outpatient providers in the community. Services may include outreach, referrals, screening/evaluation/assessment, and crisis intervention services.

AHCCCS is the designated unit of the executive branch that is responsible for administering the MHBG. AHCCCS ensures the following performance requirements are met:

- Subrecipients must submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with serious mental illnesses and children with serious emotional disturbances,
- Subrecipients to provide annual reports on their plans,
- Subrecipients may distribute funds to local government entities and non-governmental organizations,
- Subrecipients must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs,
- Subrecipients must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, CMHS conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to assess how they are using the funds to benefit the population. These evaluations include careful review of the following:
    - How the grantees are tracking use of MHBG funds and their adult and child mental health programs,
    - Data and performance management systems,
    - Collaboration with consumers and the grantees' mental health planning council, and
    - Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.
    - Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
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, SUD prevention, and SUD treatment goals at the state level.

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Footnotes:

SABG/MHBG Combined Application
FY2022-23
Planning Step 2

September 1, 2021

Contents

Overview

The Arizona Health Care Cost Containment System (AHCCCS) utilizes several 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, intervention, 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.

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

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

    - Intensive Outpatient,
    - Partial Hospitalization, and
    - Residential Inpatient.
- A description of subcontracts for substance abuse prevention and treatment through the Substance Abuse Block Grant (SABG) Block Grant utilizing capacity data including wait list management methods for SABG Block Grant Priority populations.

As the designated unit of the executive branch that is responsible for administering the MHBG (Mental Health Block Grant), AHCCCS ensures the following performance requirements are met:

- Subrecipients must submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with serious mental illness (SMI) designation and children with serious emotional disturbances.
- Subrecipients to provide annual reports on their plans.
- Subrecipients may distribute funds to local government entities and non-governmental organizations.
- Subrecipients must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs.
- Subrecipients must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, CMHS conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to assess how they are using the funds to benefit the population. These evaluations include careful review of the following:
    - How the grantees are tracking use of MHBG funds and their adult and child mental health programs,
    - Data and performance management systems,
    - Collaboration with consumers and the grantees' mental health planning council, and
    - Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.
- Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.

The National Survey on Drug Use and Health (NSDUH), prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA) provides the underlying methodology used by AHCCCS to quantify the need for substance abuse treatment in Arizona. On an annual basis, prevalence information from the NSDUH compares census data, both actual and estimated, for the State of Arizona. The results outlined treatment needs based on race/ethnicity, gender, and age group for the state, and then for each county and/or sub-state planning area.

AHCCCS policy requires that members with behavioral health needs undergo a clinical assessment, administered by a clinician through a mental health or substance use treatment program. The information gathered during this assessment process includes several identifiable factors, such as race

and ethnicity, gender, and reasons for seeking treatment. According to AHCCCS' Annual Report: Substance Use Treatment Programs State Fiscal Year 2019, between July 1, 2018, and June 30, 2019:

- 100,528 members were served with a substance use disorder,
- 15 percent were served by the northern GSA, 28 percent by the southern GSA, and 56 percent by the central GSA,
- 54.7 percent were male; 45.3 percent were female,
- 55.6 percent were white, 6.9 percent African American, 7.9 percent American Indian,
- 13.3 percent were under the age of 25; 4.1 percent were over the age of 65, and
- 19.4 percent used opiates, 18.8 percent alcohol, 19 percent marijuana, and 19.8 percent methamphetamines.

The Arizona Substance Abuse Partnership (ASAP) Epidemiology Workgroup was created in 2004 as a requirement of the Strategic Prevention Framework State Incentive Grant (SPF SIG) and continues to serve as an invaluable resource. 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 provides data management and analytics related to substance use and impacts within Arizona. The objective is data-driven analytics to inform decision-making to prevent, assess risks, evaluate treatments, and develop priorities. The analysis integrates, links, and associates data from multiple sources in Arizona for a comprehensive view of status and trends.

In 2017, the ASAP launched an interactive data dashboard to provide timely data about the opioid epidemic in Arizona. The dashboard is a tool that the Arizona Department of Health Services (ADHS), Governor's Office of Youth, Faith, and Families (GOYFF), and AHCCCS use to develop interventions that will keep Arizona's communities safe. 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.

According to a February 2021 publication from the Arizona Public Health Association, the rates of opioid and other drug related deaths have accelerated over the past year, particularly in the synthetic opioid category that includes fentanyl.

AHCCCS also relies on the results of data management and numerous qualitative surveys to determine need and direct 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 AHCCCS Office of Data Analytics (AODA) within the Division of Health Care Management (DHCM). Data management and analysis on impact and outcome measures 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. Qualitative surveys are critical to identifying potential service gaps, as they capture the human component and the effect a lack of services can have on a community which quantitative analysis cannot adequately determine.

Needs and Gaps of Arizona's Substance Use Disorder Primary Prevention Continuum

AHCCCS finalized a statewide substance abuse prevention needs assessment in September 2018 that highlighted areas of needs in the current statewide primary prevention system structure. The assessment generated a community prevention inventory, conducted focus groups throughout AZ, conducted key informant interviews throughout AZ, conducted an online Substance Use Prevention Workforce survey, and synthesized secondary data analysis for a multitude of data sources. In response to the completed needs assessment and following the Strategic Prevention Framework (SPF) model, AHCCCS began a Strategic Planning process utilizing an outside vendor. More than 40 stakeholders representing statewide prevention efforts were a part of the planning process, including but not limited to the following entities: local community coalitions. RBHAs, TRBHAs, Governor's Office of Youth, Faith, and Family (GOYFF), Drug Enforcement Agency (DEA), High Intensity Drug Trafficking Area (HIDTA), Arizona National Guard Counter Drug Task Force, Arizona State University (ASU), and University of Arizona (UA) were involved in the planning efforts within the development of the Strategic Plan. "Individuals, families and communities across Arizona are informed, connected, engaged, and health" was the vision developed during the planning process, the following items identified as the purpose for AHCCCS prevention services:

- Engage stakeholders to minimize duplication, ensure efficiency, and build capacity,
- Assess strengths and needs to address root problems and ensure all communities are served,
- Respect and engage different cultures and perspectives to ensure an inclusive process and equitable outcomes,
- Educate and inform stakeholders to increase understanding and buy-in, and
- Collect and monitor data on implementation and outcomes to guide continuous quality, improvement and ensure program effectiveness.

The data collected as part of the 2018 needs assessment contributed to the following 10 major findings related to substance use and mental health needs:

- An increasing number of Arizonans of all ages and in all regions are suffering from untreated mental health issues that are leading to substance use and/or misuse.
- LGBTQ+ identified individuals in all regions are experiencing significantly more risk factors for, consequences of, and issues with substance use and/or misuse as compared to non-LGBTQ+ identified individuals.
- Vaping (e-cigarettes, etc.) is increasing in Arizona for youth in middle and high schools and is significantly higher than national averages.
- The counties that are experiencing the most severe consequences of substance use in Arizona are: (1) Gila County, (2) Navajo County, (3) Mohave County, and (4) Pima County.
- A lack of social support and/or someone to turn to/talk to is a protective factor for substance use and/or misuse to which many Arizonans do not have access.
- The normalization of marijuana and other substances may be leading to increased substance use.

- Reductions in funding and resources for schools prohibit effective prevention programs from being delivered to high needs communities.
- Recent efforts to combat the prescription drug opioid crisis in Arizona are leading to increased street drug use.
- Prevention programs that are culturally competent, engaging, and up to date are more effective and should be prioritized.
- If basic needs are not being met (e.g., shelter, food, safety, physical health, mental health, social support, etc.) then prevention programs and efforts often fail.

While this assessment was completed prior to the onset of the COVID-19 pandemic, AHCCCS has noted an increase in related substance use and mental health needs among Arizonans through both administrative and anecdotal data sources. Statewide data sources and survey implementations have been impacted and/or delayed by COVID-19 but preliminary data indicates an increased need for additional services within the state due to the pandemic.

The Arizona Department of Health Services (ADHS) recently released Opioid related death data, and 2020 numbers show that the state has seen an increase in Opioid deaths since the onset of the pandemic (confirmed through death certificate data reported to ADHS Vital Records). Figure 1 shows the increase based on current numbers:

Figure 1. Arizona Opioid Deaths 2019 & 2020 (ADHS, 2021)

Month	2019	2020*
January	105	142
February	81	118
March	105	159
April	103	144
May	110	181
June	89	212
July	133	224
August	128	196
September	129	136
October	128	159
November	118	165
December	130	124
TOTAL Year to Date	**1359**	**1960**

The counties that have seen the highest increased rates of opioid deaths per 100,000 citizens are Maricopa (30.59), Pima (30.25), and Yavapai (27.54). (ADHS, 2021) The age group experiencing the highest rates of opioid deaths continues to be Arizonans aged 25-34, with this age group reporting 603 deaths in 2020, and 362 deaths in 2019. (ADHS, 2021) Arizona's youth have shown an uptick in opioid-related deaths, with 14 deaths in the under 15 years age group (data suppressed in 2019 due to less than 10 occurrences), and 361 deaths in the 15-24 age groups (reported 227 deaths in 2019). (ADHS, 2021) In terms of substances involved within verified opioid overdoses, fentanyl was the outlier

reported in 42.4 percent of overdoses. Oxycodone was the second highest substance reported at 15.2 percent. Heroin and benzodiazepines each reported at 10.7 percent of Arizona's overdoses. (ADHS, 2021)

The 2020 Arizona Youth Survey administered by the Arizona Criminal Justice Commission (ACJC) during the COVID-19 pandemic shows that alcohol, e-cigarettes, and marijuana use are the top three substances used by Arizona youth in grades eight through 12 for more than 30 days. When asked for the reasons for using substances, youth cited the following reasons, in order of prevalence:

1. To have fun,
2. To get high or feel good,
3. To deal with the stress from my school,
4. To deal with the stress from my parents and family, and
5. I was feeling sad or down.

It should be noted that each of these reasons for use have increased by approximately 4-5 percentage points from the previous survey administration in 2018. The reason for use with the largest increase in 2020 was "I was feeling sad or down." This preliminary data corroborates anecdotal data AHCCCS has received from stakeholders and contractors stating that Arizona's youth are experiencing increased mental health needs that lead to increased substance misuse, especially in the wake of isolation resulting from COVID-19. The closure of schools, after school activities, youth groups, sports, and faith-based activities has contributed to the feelings of isolation and the reduction of protective factors for substance abuse and mental health needs among Arizona youth. Efforts have been made statewide to continue services virtually using teleconferencing, social media, and various online platforms, yet access to reliable internet connections and the necessary technological infrastructure continue to be an issue, especially in rural and remote areas within the state.

Through a collaboration with the Arizona National Guard's Counter Drug Task Force and other stakeholders including the Governor's Office of Youth, Faith and Family (GOYFF); Arizona Department of Health Services (ADHS); local substance abuse prevention leaders; and Banner Health Poison and Drug Information Center, Arizona has begun identifying areas of "prevention deserts'' within the state. These are areas of high need based on substance abuse rates, substance abuse related consequences, rate of population growth in the last 10 years, and location within the state. For example, border towns or regions considered frontier (meaning the location is sparsely populated and is geographically isolated from population centers and services) have little or no prevention services or infrastructure such as community mobilization(e.g., coalition development). Through the development of a mapping tool that includes the identification criteria listed above, Arizona has identified and prioritized the following areas as prevention deserts that must be targeted for enhanced development and prevention service infrastructure building:

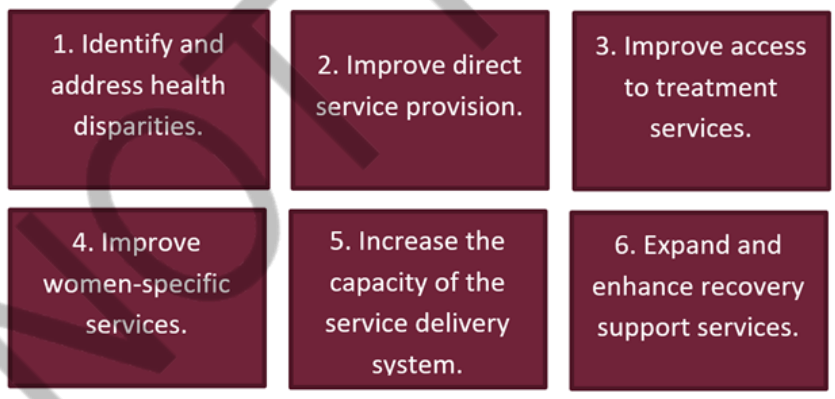
- Avondale,
- Casas Adobes,
- Gilbert,

- Goodyear,
- Queen Creek,
- San Tan Valley,
- Surprise,
- Winslow/Holbrook, and
- Yuma.

While AHCCCS has made SABG prevention services available to the entire state, it should be noted that the areas identified above did not submit a bid for prevention services during the last procurement opportunity in December 2020. Through fact-finding meetings with local stakeholders, it was discovered that while the need for services is apparent within these communities, they do not have the basic infrastructure to complete a grant application. This fact is driven by a lack of prevention champions and organizations, which are critical and necessary to lead mobilization efforts; and lack of mentoring from nearby established coalitions to build local prevention efforts, hold town hall meetings, and mobilize training for active community members. Adding these infrastructure building activities will lead to the formation of coalitions and /or community-based organizations that can lead prevention efforts in their areas.

Needs and Gaps of Arizona's Substance Use Disorder Service Continuum

Arizona has identified six key areas of need and gaps related to intervention, treatment, and recovery services.



1. Identify and Address Known Health Disparities Related to Substance Use Disorder (SUD).

- SUD treatment and recovery needs of Arizonans have changed significantly due to the COVID-19 pandemic. There is a need to gather meaningful, reliable data on the current needs of the "new normal" so that the service delivery system is adaptive to changing community needs. AHCCCS seeks to identify prominent health disparities among gender, age, race/ethnicity, sexual orientation, and geography based on data, establish baseline data, and track measurable outcomes, and determine where resources are inadequate or inaccessible to meet SUD intervention, treatment, and recovery needs.

- With additional funding opportunities, more direct communication regarding the unique needs of local communities, particularly rural and remote communities, is necessary. This relationship and information are required to strategically direct critical resources to expand broad-based state and local community strategies and approaches to address SUD prevention, intervention, treatment, and recovery support services.
- Alcohol-induced deaths are more prevalent in rural and remote counties, signaling a need for additional innovations and interventions. According to 2019 data released by the Arizona Department of Health Services (ADHS), the mortality rate for alcohol-induced deaths was 17.7 per 100,000 statewide, and there are astounding discrepancies in Apache (72.4), Navajo (71.8), La Paz (58.9) and Gila (52.6) counties. Alcohol-induced deaths comprised 2.1 percent of the statewide total deaths with a disproportionate prevalence of 7.2 percent in Apache, 5.7 percent in Coconino, 4.2 percent in La Paz and 6.8 percent in Navajo counties.

2. Improve Direct Service Provision Among SUD Treatment Providers.

The following treatment needs and gaps emerged from results of the 2020 Independent Case Review of the current service delivery continuum.

- Statewide, screening for tuberculosis was documented in only 57 percent of cases, and screening for hepatitis C, human immunodeficiency virus (HIV), and other infectious diseases was present in only 45 percent of cases.
- Utilization of natural supports in the development of individual service plans (ISPs) was significantly lower than expected. Only 14 percent of cases document the inclusion of family or other supports in treatment planning.
- AHCCCS' Fiscal Year 2022 Strategic Plan includes the objective, "Standardize treatment planning and placement for individuals with substance use disorder." AHCCCS has been promoting the use of the ASAM (American Society of Addiction Medicine) Continuum Tool and will be requiring its use statewide by October 2022. While a high percentage (86 percent) of SUD treatment providers use the ASAM criteria as part of the initial assessments according to 2020 ICR results, only 42 percent of cases documented the use of ASAM criteria during treatment to reassess the appropriate level of care. It is expected that ASAM criteria be used to reassess levels of care during treatment.
- In 2020, 81 percent of providers used social determinants of health (SDOH) information from the initial assessments to inform treatment decisions, yet most providers did not incorporate SDOH issues during treatment (other than transportation), even when SDOH concerns were identified in the initial assessment. AHCCCS' Whole Person Health Initiative includes addressing the SDOH while accessing care, including SUD treatment. Health Current, the state's designated Health Information Exchange (HIE), is implementing a closed loop referral system in partnership with AHCCCS and Soleri. This will streamline referrals from health services to social services, which will be new to the SUD provider community.
- Most cases (66 percent) failed to provide any documentation as to whether the client was attending self-help recovery groups. To maximize recovery efforts, it is critical that treatment providers discuss, offer, and connect individuals to self-help recovery groups as part of

treatment planning and relapse prevention. There is a need to strengthen the relationships between SUD treatment providers and self-help recovery groups.

- In only 55 percent of the reviewed cases, providers documented completion of a relapse prevention plan prior to discharge. There is a clear need to improve discharge planning to include an array of recovery and relapse prevention services/supports.
- Once individuals disengaged from services, providers had difficulty re-engaging them. There is a need to increase the use of scientifically based outreach strategies and low barrier programming to engage and re-engage individuals.

3. Improve Access to SUD Treatment Services, Particularly for Underserved and High-risk Populations.

- There is a need to develop the use of digital therapeutics as a part of addiction treatment. Leveraging computer-based and mobile technologies improves access to evidence based medical and psychological treatments. Because most people have a mobile phone, this is an effective way to reach underserved and rural or frontier areas/communities. The Arizona Department of Health Services (ADHS) and AHCCCS jointly identified the need to expand the use of telehealth for Medication Assisted Treatment (MAT) treatment as a key recommendation within the Arizona Opioid Action Plan. Arizona has made progress towards this goal by developing the use of FDA-approved medications and digital therapeutics as a part of addiction treatment that will improve the effectiveness of interventions.
- There continue to be needs related to information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and remote areas, and use of Global Positioning System (GPS) to expedite response times and to remotely meet with the individual in need of services. Broadband is being addressed statewide by another state agency. More information is needed to determine the equipment and network gaps provider agencies have to improve their service delivery and accessibility.
- Advance telehealth opportunities to expand services (i.e., counseling, assessment, case management, care coordination, intake, medication management, recovery coaching, peer services, etc.) for hard-to-reach locations, especially rural and remote areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Treatment providers have indicated a need for webcams, tablets, headsets, offline capabilities for Electronic Health Records, Wi-Fi connectivity improvements, satellite phones for remote areas, and mobile technology infrastructure to enable telehealth appointments during outreach efforts.
- AHCCCS is expanding harm reduction contracts and evidence-based supports to ensure comprehensive programming statewide, including remote and rural areas. Naloxone distribution, education, and training have been key components of AHCCCS' harm reduction contracting and will remain primary areas of focus. According to a February 2021 publication from the Arizona Public Health Association, the rates of opioid and other drug related deaths have accelerated over the past year, particularly in the synthetic opioid category that includes fentanyl. In the last legislative session, the Arizona State Legislature passed legislation and Governor Ducey signed into law public policy allowing the use of fentanyl testing strips and

syringe service programs (including access to and disposal of sterile syringes and injection equipment). AHCCCS will procure services for a comprehensive harm reduction contract to begin on January 1, 2022. There is a need for funding to expand contract requirements to include a statewide evidence-based harm reduction program inclusive of scientifically based outreach, education, training, naloxone distribution, fentanyl testing strips, and a syringe service program (once approved by the Centers for Disease Control (CDC) and SAMHSA).

- Based on current data related to health disparities, there is a need to continue the development and implementation of culturally appropriate approaches to substance use and alcohol use treatment for American Indian/ Alaska Native (AI/AN) in Arizona.

4. Improve Women-specific Services.

The number of women with substance use disorder accessing services has increased by more than 10 percent since the COVID-19 pandemic. In 2018, 125,065 women diagnosed with substance use disorder were enrolled in services for nine months or more. By 2020, that number increased to 140,539. Expenditures increased from $69.88 per woman, per month to $99.64 per woman, per month, indicating an increase in utilization of higher cost services.

- Recent 2020 file review results indicate that only 28 percent of women statewide had access to women-specific SUD treatment services. For the same year, the Operational Review conducted by AHCCCS with all three regional behavioral health authorities resulted in identification of concerns related to gender specific treatment. Using SAMSHA's Treatment Improvement Protocol (TIP) 51, there is a need to increase the continuum of treatment and recovery options available to women (including pregnant and parenting women) that are tailored to their needs. Currently, there is little evidence of SUD treatment providers addressing healthy relationships, sexual and physical abuse, reproductive wellness, and other culturally responsive treatment services.
- The Steering Committee of Arizona's Pregnant and Postpartum Women Pilot Project (PPW-PLT) has identified several systems-level needs, such as training and screening for postpartum depression, identifying peers and providers who are trained and willing to work with pregnant women with substance use disorder, and integrating services among SUD treatment providers and family service agencies.
- AHCCCS' fiscal year 2022 Strategic Plan includes an objective to "reduce health disparities." AHCCCS needs to improve care for American Indian/Alaska Native (AI/AN) women. AI/AN women are more likely to have substance use disorder, have access to fewer services, and have higher utilization costs than women of other races. According to Census data, American Indians comprise 5.3 percent of the Arizona population, yet 11 percent of the Arizona women with substance use disorder are American Indians. In contrast, 82.6 percent of the Arizona population is Caucasian, and 50 percent of the Arizona women with SUD are Caucasian. In an analysis of 2018-2020 medical claims data of women with substance use disorder accessing medical services, for outpatient services, AI/AN women were below the statewide average in four of seven of the highest use categories, indicating they have access to fewer services than women

of other races. Expenditures per Caucasian woman averaged $90.73 per woman, per month in 2020, yet the cost per AI/AN woman was $207.37 for the same year, nearly double.

5. Increase the Capacity of the Service-delivery System to Meet the Evolving Needs.

- AHCCCS seeks to increase network capacity for existing substance use disorder detox facilities to allow for same-day or next-day appointments, and low barrier approaches.
- AHCCCS seeks to increase network capacity for existing substance use disorder outpatient clinics in areas of greatest need. Expanding the hours of operation to evenings and weekends will enable Arizonans to see their care team on the same day. Evening and weekend availability will prevent crisis intervention and facilitate access to timely lower levels of care. Teams can respond to situations with a community-based response, providing Arizonans services where they are to address their behavioral health and treatment service needs.

6. Expand and Enhance a Range of Recovery Support Services.

- Arizona's epidemiological profile suggests a lack of affordable recovery housing throughout the state due to increased substance use during the COVID-19 pandemic. The demands for treatment services, recovery services/supports, and affordable housing have escalated in the past year. There is a need to create additional recovery housing options and sustain these options over time.
- According to 2020 ICR results, only 36 percent documented that peer support services were offered as part of the treatment plan. While the network of peer support specialists for SUD populations has increased in Arizona, those seeking these services are often unaware of how to access them, particularly in rural and remote areas of the state. Given the identified stigma challenges and the number of individuals with SUD who do not receive treatment, there is a need to increase public awareness of peer services and reduce barriers to entering and retaining in treatment services.

Needs and Gaps of Arizona's Mental Health Services Continuum

AHCCCS assesses the mental health services continuum needs and gaps through multiple means, including qualitative feedback from ongoing stakeholder engagement efforts, needs assessments, tracking of mental health service utilization trends, and assessment of quality metrics. Based on the review of these data sources, the mental health services continuum needs in Arizona include:

1. The need to develop standardized processes to identify, refer, and assess children for an SED designation.

To address the mental health needs of children in Arizona, the appropriate identification and referral mechanisms for assessment of SED must exist for child-serving systems. The systems that most commonly interface with children are the education system as well as primary care providers. Informing and providing the education system and primary care providers with a user-friendly interface for referral for SED assessment will improve early identification and initiation of service delivery for children

designated as SED. This strategy will also augment the current behavioral health in schools initiative in Arizona as well as the Targeted Investments efforts to improve access to mental health care in educational and primary care settings.

In addition, Arizona will benefit from standardization of the functional impairment criteria for an SED designation as well as an assessment process. Based on a recent Statewide analysis conducted, there is variation of how functional impairment is defined and applied for SED designation.

2. The need to expand access to evidence-based mental health care for justice-involved youth with an SED designation.

Minority youth in Arizona's juvenile justice system are disproportionately represented when compared to the general youth population. For example, in 2020, of the youth committed to the Arizona Department of Juvenile Corrections (ADJC), 15 percent were African American, 13.5 percent bi-racial, and 44.9 percent Hispanic. The most recently available Arizona census data for 2019 demonstrates that 5.2 percent of Arizona youth are African American, 2.9 percent biracial, and 31.7 percent. Addressing the mental health needs of youth in the juvenile justice system is a critical component to reducing the risk of recidivism and thus addressing these disparities.

During conversations with peer and family support providers, needs identified included:

- Parent peer support services to assist parents with navigating the behavioral health system,
- Reach-in services to assist juveniles exiting detention to facilitate and connect to services immediately upon release, and
- Increased technological infrastructure to conduct virtual services during the COVID-19 pandemic.

AHCCCS conducted a targeted needs assessment for justice-involved youth with an SED designation. Overall findings of this needs assessment, which included data gathering from key informant interviews and focus groups with youth currently in detention facilities, demonstrates the need for improved coordination of care with the outpatient mental health provider prior to release through reach-in activities and improved access to mental health care for youth on probation or parole. Additionally, based on ongoing justice system collaboration efforts and lessons learned from the AHCCCS Targeted Investments (TI) co-located behavioral health model for adults, co-location of behavioral health providers within juvenile probation and parole offices will increase access to mental health services for children with an SED designation who are involved with the juvenile justice system.

Coupled with the efforts of reach-in programs for juvenile detention and co-location with juvenile probation or parole, there is an ongoing need to increase the behavioral health system capacity to implement evidence-based treatment for justice-involved youth with an SED designation. For example, currently Arizona only has one behavioral health provider certified in Multisystemic Therapy® (MST®). Expanding the behavioral health provider system capacity to implement MST and other evidence-based treatments for justice-involved youth will be an important strategy to reduce the risk of recidivism and improve prosocial behaviors including school attendance and living at home.

3. The need to expand the primary care workforce capacity to serve children designated with SED through access to child and adolescent psychiatrists and other mental health specialists.

Arizona, like other states, has a shortage of child and adolescent psychiatrists and other licensed mental health professionals to serve children designated with SED. Although AHCCCS has made progress with expanding access to mental health care through primary care providers based on integration efforts, including the Targeted Investment Program, additional capacity is necessary to serve the increasing number of children who present with mental health needs in light of the COVID-19 pandemic. One model that has demonstrated success in other states is the Child Psychiatry Access Program (CPAP), which provides primary care providers with direct access to child and adolescent psychiatrists and other pediatric mental health specialists.

4. The need to expand evidence-based practices for adults designated with SMI (Seriously Mental Illness) including Assertive Community Treatment (ACT), Supportive Housing, Supported Employment, and Peer Support.

Historically, the development and fidelity monitoring of these services focused on Maricopa County, the most populous county in Arizona. Efforts to expand this work into Northern and Southern Arizona have shown promise despite multiple challenges, including behavioral health provider shortages and the rural nature of many of these regions. Existing service providers in these regions benefit from extensive technical assistance to develop the infrastructure and provide services that meet fidelity to criteria established by SAMHSA.

Considering the additional difficulties in accessing affordable housing brought forth during the COVID-19 pandemic, there is a critical need to expand upon the supportive housing services available, while also ensuring that housing, once located, can be maintained. Housing maintenance needs include intensive supportive services focused on individuals at risk of eviction to ensure that they are not displaced from their homes. While there have been multiple programs recently established to provide monetary support to acquire and maintain housing, individuals require additional support in learning how to furnish their home, pay for groceries and utilities, and to budget, to make their housing stable and sustainable.

During conversations with peer and family support providers, the following needs were also identified:

- Reach-in services to individuals exiting the justice system to facilitate and connect to support services immediately upon release,
- Transitional housing and services/support continues to be a need,
- Workforce development and capacity building to enhance/increase current peer support capacity, as well as to train new peer paraprofessionals to meet the increased demand for services,
- Intensive transitional step-down programming for individuals transitioning from inpatient settings, and
- Increased technological infrastructure to conduct virtual services during the COVID-19 pandemic.

Additionally, individuals with an SMI designation, including those who experience homelessness, may not have the proper identification documents that are required for social security applications, applying for benefits, and/or are required for access to housing, social, medical, and financial services. Mobile digital identity solutions using digital wallet technology will assist individuals with applying for these benefits and/or services.

5. **The need to expand and enhance service delivery for individuals with intellectual and developmental disabilities (IDD) and an SMI designation.**

Individuals with an IDD and have an SMI designation are at risk of delayed identification and treatment of their co-occurring mental illness, which may result in higher levels of care utilization including extended hospitalization while awaiting appropriate treatment service availability. Factors contributing to the delayed identification and treatment include a limited mental health workforce with the expertise necessary to effectively identify and implement pharmacologic and non-pharmacologic treatment. The COVID-19 pandemic exacerbated these challenges, as social distancing and change in day treatment programming to limit the spread of COVID-19 has resulted in increased community isolation for these individuals.

Needs and Gaps of Arizona's Crisis Continuum

Consistent with AHCCCS efforts to identify needs and gaps within the mental health services continuum, AHCCCS also assesses the crisis services continuum needs and gaps through multiple means, including the completion of a crosswalk between Arizona's current crisis system infrastructure against SAMHSA best practice, qualitative feedback from ongoing crisis stakeholder engagement efforts, and tracking of crisis service utilization trends. Based on the review of these data sources, the crisis services continuum needs in Arizona consist of the need to further develop a comprehensive 24/7 crisis continuum for children with an SED designation and their families.

Arizona, like other states, is seeing an increase in emergency department boarding for children. This trend is due to multiple factors, including the additional stressors brought upon by the COVID-19 pandemic, coupled with the lack of the availability of 23-hour crisis stabilization units, short-term residential treatment options, and intensive specialized wraparound. Children that are particularly at risk of extended emergency department boarding include children with an SED designation under the age of 12, children with co-occurring IDD, and children with multi-system involvement. Currently, only southern Arizona (Pima County) has a designated 23-hour crisis stabilization unit for children, which further exacerbates emergency department boarding.

The availability of the full continuum of crisis services for children designated with an SED designation is compounded by the shortage of mental health providers in the public behavioral health system. Although this issue is not new in Arizona, it has been further exacerbated by the COVID-19 pandemic as behavioral health providers report loss of workforce due to family commitments (e.g., parents staying home to support their child with at-home learning), the availability of other job opportunities, and other factors. Specific models of care that support the behavioral health workforce, including professional

development opportunities, access to technology to ease workflow, and coaching are critical to maintain the public behavioral health system workforce.

Lastly, although the coverage of telehealth for behavioral health service delivery is robust in Arizona, many of the services and supports through the crisis continuum cannot be appropriately provided via telehealth modalities. For example, mobile teams and the higher levels of care such as inpatient hospital and residential must be provided in-person. Additionally, while creative hybrid telehealth and in-person models for wraparound exist, children with an SED designation and their families in crisis often benefit from in-person support. Thus, further professional development opportunities for the behavioral health workforce, including parent and family support services to provide both in-person and virtual care are essential for crisis stabilization for youth and families.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Youth Underage Alcohol (Prevention)

Priority Type: SAP

Population(s): Other (LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Decrease the percentage of youth reporting past 30-day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 7.0% of those in the 8th grade, 17.6% to 15.6% of those in the 10th grade, and 27.3% to 25.3%% of those in the 12th grade, as measured by the 2024 Arizona Youth Survey.

Strategies to attain the goal:

Provide education on available evidence based practices related to addressing underage alcohol use, and provide training on how to choose EBPs based on community need. Increase the use of Evidence Based Programs (EBP) with activities to include:

Enhancing the ability of local community coalitions to more effectively provide prevention services for alcohol including organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking.

Provide alternatives for underage drinking for youth including drug free dances and parties, Youth/adult leadership/mentor activities, community drop-in centers and community service activities.

Establish or change written and unwritten community standards and codes and attitudes that factor into underage alcohol use, including promoting the establishment or review of alcohol, tobacco and drug use policies in schools, technical assistance to communities to maximize local enforcement, procedures governing availability and distribution of alcohol, tobacco, and other drug use, modifying alcohol and tobacco advertising practices, and product pricing strategies.

Provide underage alcohol use education and educational opportunities that involve two-way communication and is distinguished from the Information Dissemination by the fact that interaction between the educator/facilitator and the participants is the basis of its activities, including education to affect critical life and social skills, decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Provide awareness and knowledge of the nature and extent of local and state underage alcohol use, abuse and addiction and their effects on individuals, families and communities, and increase awareness of available prevention programs and services through clearinghouse/information resource center(s), resource directories, media campaigns, brochures, radio/TV public service announcements, speaking engagements, and health fairs/health promotion.

Identify those who have indulged in illegal/age-inappropriate use of alcohol in order to assess if their behavior can be reversed through education, including student assistance programs, and driving while under the influence/driving while intoxicated education programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: The percentage of Arizona students reporting past 30 day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 7.0% of those in the 8th grade, 17.6% to 15.6% of those in the 10th grade, and 27.3% to 25.3%% of those in the 12th grade, as measured by the 2024 Arizona Youth Survey.

First-year target/outcome measurement: Reduce the amount of Arizona students reporting past 30 day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 8.0% of those in the 8th grade, 17.6% to 16.6% of those in the 10th grade, and 27.3% to 26.3%% of those in the 12th grade, as measured by the 2024 Arizona Youth Survey.

Second-year target/outcome measurement: The percentage of Arizona students reporting past 30 day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 7.0% of those in the 8th grade, 17.6% to 15.6% of

those in the 10th grade, and 27.3% to 25.3%% of those in the 12th grade, as measured by the 2024 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 2021 numbers will be difficult to evaluate until 2020.

https://www.azcjc.gov/Programs/Statistical-Analysis-Center/Arizona-Youth-Survey

Priority #: 2

Priority Area: Youth Underage ATOD (Prevention)

Priority Type: SAP

Population(s): Other (LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 32.0% in 2020 to 30.0%, as measured by the 2024 Arizona Youth Survey.

Strategies to attain the goal:

Provide education to increase awareness of available evidence based practices that address community, family, school, and peer/individual risk factors, and provide training on how to choose EBPs based on community need. Activities to include:

Enhancing the ability of local community coalitions to more effectively provide prevention services for ATOD including organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking

Provide alternatives of ATOD use for youth including drug free dances and parties, Youth/adult leadership/mentor activities, community drop-in centers and community service activities.

Establish or change written and unwritten community standards and codes and attitudes that factor into ATOD use, including promoting the establishment or review of alcohol, tobacco and drug use policies in schools, technical assistance to communities to maximize local enforcement, procedures governing availability and distribution of alcohol, tobacco, and other drug use, modifying alcohol and tobacco advertising practices, and product pricing strategies.

Provide ATOD education and educational opportunities that involve two-way communication and is distinguished from information dissemination by the fact that interaction between the educator/facilitator and the participants is the basis of its activities, including education to affect critical life and social skills, decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Provide awareness and knowledge of the nature and extent of local and state ATOD use, abuse and addiction and their effects on individuals, families and communities, and increase awareness of available prevention programs and services through clearinghouse/information resource center(s), resource directories, media campaigns, brochures, radio/TV public service announcements, speaking engagements, and health fairs/health promotion.

Identify those who have indulged in illegal/age-inappropriate use of ATOD in order to assess if their behavior can be reversed through education, including student assistance programs, and driving while under the influence/driving while intoxicated education programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: The percentage of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8

or more risk factors, 10th & 12th grades: 9 or more risk factors) is 32.0%, according to the 2022 Arizona Youth Survey.

First-year target/outcome measurement: Reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 32.0% in 2020 to 31.0%, as measured by the 2024 Arizona Youth Survey.

Second-year target/outcome measurement: Reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 31.0% in 2020 to 30.0%, as measured by the 2024 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 2021 numbers will be difficult to evaluate until 2020.

https://www.azcjc.gov/Programs/Statistical-Analysis-Center/Arizona-Youth-Survey

Priority #: 3

Priority Area: Tuberculosis

Priority Type: SAT

Population(s): TB

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: FY 2020 data on the number of members receiving substance abuse treatment with documentation of TB services documented in their chart. Current baseline for SFY 2020 is 57%.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2021), 60%.

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2022), 65%.

Data Source:

Independent Case Review (ICR)

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:

None noted.

Priority #: 4

Priority Area: Suicide

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Reduce the Arizona Suicide Rate to 18.0% per 100,000 by the end of calendar year (CY) 2021. The rate is currently 18.7%.

Strategies to attain the goal:

HCCCS will continue to work collaboratively with other state agencies and stakeholders to implement suicide prevention strategies for all Arizonans, but specifically to address priority populations including: American Indians, those age 65 and older, the LGBTQI community, veterans, and teens. . Strategies will include but are not limited to community and conference presentations, social media messaging, social marketing/public awareness campaigns, youth leadership programs, gatekeeper trainings, improved data surveillance, and ongoing collaboration with stakeholders for 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 CY2020 was 18.7 per 100,000 population 1419 suicide deaths/population.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of CY 2021), 18.0 per 100,000.

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of CY 2022), 17.8 per 100,00.

Data Source:

The Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/nchs/pressroom/states/arizona/az.htm

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 2021 data will be made available in Fall 2022). Aggregated across the general population, this number establishes a suicide rate per 100,000 persons.

Data issues/caveats that affect outcome measures:

AHCCCS and ADHS do not have a current data sharing agreement. AHCCCS suicide prevention team members have to wait for ADHS to publish their annual suicide data to understand what is happening statewide.

Priority #: 5

Priority Area: Engaging youth with substance use disorder in treatment

Priority Type: SAT

Population(s): PWID, Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice)

Goal of the priority area:

To increase the participation of youth with substance use disorder in appropriate intervention, treatment, and recovery services.

Strategies to attain the goal:

1. Pilot a pre-peer support program for youth in recovery.
2. Arizona Health Care Cost Containment System (AHCCCS) Managed Care Organizations (MCOs) lines of business will continue to collaborate and meet regularly with child/adolescent providers to share information on substance abuse screening, trends, and best practices.

3. Require contractors to provide and promote access to substance abuse training initiatives among child/adolescent providers including those employed though other agencies such as the OJJDP Detention Centers.
4. Pursue a standardized, parent-friendly, screening tool to identify substance use/abuse in the children and adolescents.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In the last 12 months, the percentage of minors in the behavioral health system with a diagnosis of substance use disorder who received a substance use-related treatment service.

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

AHCCCS recipient data

Description of Data:

Denominator is the number of youth under the age of 18 diagnosed with any substance use disorder (need not be primary diagnosis) in the past 12 months.

Data issues/caveats that affect outcome measures:

Priority #: 6

Priority Area: Social determinants of health for individuals with substance use disorders

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

Address the social determinants of health for individuals with substance use disorders to support stable, long term recovery.

Strategies to attain the goal:

1. Increase the funding invested in Oxford Houses.
2. Educate and encourage the participation of service providers in the Closed Loop Referral System.
3. Leverage supported housing opportunities provided through the Statewide Housing Administrator.
4. Alleviate barriers to accessing childcare.
5. Expand capacity for supported independent living programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of Oxford Houses operating in the state of Arizona.

Baseline Measurement: For SFY2021, there were 41 houses.

First-year target/outcome measurement: By the end of SFY2022, there will be 50 houses.

Second-year target/outcome measurement: By the end of SFY2023, there will be 55 houses.

Data Source:

Contract deliverable to AHCCCS

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: The number of non Title XIX childcare claims coded T1009 and/or funded alternatively through SABG.

Baseline Measurement: For SFY2021, there were 0 documented requests for reimbursable childcare services.

First-year target/outcome measurement: By the end of SFY2022, there will be 25 documented requests for reimbursable childcare services.

Second-year target/outcome measurement: By the end of SFY2023, there will be 100 documented requests for reimbursable childcare services.

Data Source:

AHCCCS claims and encounter data, and contract deliverable to AHCCCS

Description of Data:

Requests for reimbursable childcare services maybe documented in claims data or other contract deliverables.

Data issues/caveats that affect outcome measures:

Priority #: 7

Priority Area: Integration of family care and substance use treatment

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Coordinate prenatal care, postpartum care, and substance use treatment.

Strategies to attain the goal:

1. Leverage the PPW-PLT Learning Collaborative to identify opportunities for cross sector collaboration, education, and referrals.
2. Identify a SUD screening tool or tools for providers of prenatal and postpartum treatment services that considers gender and cultural specific needs of pregnant and postpartum women.
3. Provide gender specific substance use disorder training to provider networks of both substance use disorder treatment, prenatal care, and postpartum treatment.
4. Conduct an environmental scan of providers (including peers) trained to address perinatal and postpartum depression among women with substance use disorder and develop an online resource guide.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In last 12 months, percent of pregnant women enrolled in a SUD treatment program who accessed outpatient primary medical care within 3 months prior to the delivery of a baby.

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

AHCCCS recipient, claims and encounter data

Description of Data:

Denominator is the number of pregnant women enrolled to a SUD treatment service in the last 12 months.

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: In last 12 months, percent of pregnant women admitted to SUD treatment service who accessed outpatient care within 3 months after the delivery of a baby.

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

AHCCCS recipient, claims and encounter data

Description of Data:

Denominator is the number of pregnant women admitted to a SUD treatment service in the last 12 months.

Data issues/caveats that affect outcome measures:

Priority #: 8

Priority Area: Retention in SUD treatment services

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

Provide support to individuals receiving community SUD treatment services early in the treatment process that is gender specific and culturally responsive to improve completion rates of treatment programs.

Strategies to attain the goal:

1. Require contractors to plan to document in each individual service plan the individual's natural supports.
2. Require contractors to plan to increase the use of peer support services throughout the treatment and recovery processes.
3. Require contractors to document in the individual service plan when an individual declines peer support services and the reasons for declining.
4. Revise the Independent Case Review evaluation tool to reflect changes in requirements.
5. Require contractors to provide training and support to providers on evidence-based engagement strategies by providing training.
6. Identify providers to engage in developing a range of Practice-Based Evidence engagement strategies as defined by SAMHSA to support the positive culture and traditions of local communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In last 12 months, percent of individuals receiving an SUD treatment service who continue to receive a SUD service every month for at least 3 consecutive months after enrollment in a SUD treatment program.

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

AHCCCS recipient data

Description of Data:

Denominator is all (unduplicated) individuals admitted to SUD treatment in the previous 12 months receiving a SUD service the month following admission.

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: In last 12 months, percent of files including documentation of natural supports.

Baseline Measurement: In the FY20 ICR, 14% of the files documented the inclusion of family or other supports in treatment planning.

First-year target/outcome measurement: By the end of SFY2022, 18% of the files reviewed will document the inclusion of family or other supports in treatment planning.

Second-year target/outcome measurement: By the end of SFY2023, 20% of the files reviewed will document the inclusion of family or other supports in treatment planning.

Data Source:

Independent Case Review

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 3

Indicator: In last 12 months, percent of files including documentation that peer or family support was offered as part of the treatment plan.

Baseline Measurement: In the FY20 ICR, 36% of the files documented that peer support services were offered as part of the treatment plan.

First-year target/outcome measurement: By the end of SFY2022, 45% of the files reviewed will document that peer support services were offered as part of the treatment plan.

Second-year target/outcome measurement: By the end of SFY2023, 55% of the files reviewed will document that peer support services were offered as part of the treatment plan.

Data Source:

Independent Case Review

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 9

Priority Area: Substance use treatment that addresses the specific needs of women

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

To improve treatment engagement, retention, and outcomes for women with substance use disorder

Strategies to attain the goal:

1. Implement a training collaborative for service providers focused on the unique needs of women with substance use disorder.
2. Formalize processes for monitoring gender specific treatment among contractors, including the use of the annual Independent Case Review, Operational Review, and Secret Shopper program.
3. Provide ongoing training through a learning management system on gender specific treatment for women with substance use disorder.
4. Leverage the PPW-PLT Learning Collaborative to identify emerging needs and address them.
5. Leverage opportunities in new contracts to require evidence-based and practice-based gender-specific treatment.
6. Revise Measure V of the Independent Case Review to collect more specific information on gender-specific treatment.
7. Define gender-specific treatment in contract and policy.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Percentage of clinical files for women which include evidence that gender specific treatment (GST) was offered.
Baseline Measurement:	For SFY2021, 28% of the files reviewed documented access to GST.
First-year target/outcome measurement:	By the end of SFY2022, 35% of the files reviewed documented access to GST.
Second-year target/outcome measurement:	By the end of SFY2023, 40% of the files reviewed documented access to GST.

Data Source:

Independent Case Review

Description of Data:

Data issues/caveats that affect outcome measures:

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$60,887,470.00		$983,946,072.00	$31,443,639.00	$16,213,182.00	$0.00	$0.00		$28,419,171.00	$18,407,872.00
a. Pregnant Women and Women with Dependent Children[c]	$7,001,554.00								$3,500,777.00	$2,625,583.00
b. All Other	$53,885,916.00		$983,946,072.00	$31,443,639.00	$16,213,182.00				$24,918,394.00	$15,782,289.00
2. Primary Prevention[d]	$16,236,658.00		$0.00	$0.00	$0.00	$0.00	$0.00		$7,578,446.00	$4,908,767.00
a. Substance Abuse Primary Prevention	$16,236,658.00								$7,578,446.00	$4,908,767.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services	$0.00									
5. Early Intervention Services for HIV	$0.00									
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$4,059,164.00			$2,105,577.00					$1,894,611.00	$1,227,191.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$81,183,292.00**	**$0.00**	**$983,946,072.00**	**$33,549,216.00**	**$16,213,182.00**	**$0.00**	**$0.00**	**$0.00**	**$37,892,228.00**	**$24,543,830.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

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

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Footnotes:
8/19/2021 - Arizona plans to expend 75% ($24,543,830) of the ARP Award ($32,725,106) during the timeframe 7/1/21 - 6/30/23 .

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]		$0.00						$0.00		$0.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$3,952,442.00						$2,271,157.00		$2,942,180.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care		$2,529,563.00	$788,961,262.00		$35,106,056.00			$1,453,540.00		$1,691,947.00
8. Ambulatory/Community Non-24 Hour Care		$29,089,973.00	$3,545,401,951.00		$157,758,163.00			$16,715,712.00		$19,457,389.00
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$1,976,221.00	$0.00	$274,275.00				$1,135,578.00		$1,471,090.00
10. Crisis Services (5 percent set-aside)[g]		$1,976,221.00						$1,135,578.00		$3,859,194.00
11. Total	**$0.00**	**$39,524,420.00**	**$4,334,363,213.00**	**$274,275.00**	**$192,864,219.00**	**$0.00**	**$0.00**	**$22,711,565.00**	**$0.00**	**$29,421,800.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:
8/19/2021 - Arizona plans to expend 75% ($29,421,800) of the ARP Award ($39,229,067) during the timeframe 7/1/21 - 6/30/23 .

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	4,133	986
2. Women with Dependent Children	24,340	5,574
3. Individuals with a co-occurring M/SUD	69,739	24,335
4. Persons who inject drugs	502	358
5. Persons experiencing homelessness	13,237	6,892

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

Not applicable

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$30,443,735.00	$28,419,171.00	$18,407,872.00
2 . Primary Substance Use Disorder Prevention	$8,118,329.00	$7,578,446.00	$4,908,767.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Administration (SSA Level Only)	$2,029,582.00	$1,894,611.00	$1,227,191.00
6. Total	**$40,591,646.00**	**$37,892,228.00**	**$24,543,830.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

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

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Footnotes:

8/18/2021 - Arizona plans to expend 75% of the ARP Award during the timeframe 10/1/21 - 9/30/23 ($32,725,106).

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal	$2,111,062	$753,446	$562,500
	Selective	$68,571	$400,000	$375,000
	Indicated	$19,025	$100,000	$127,500
	Unspecified	$1,846	$0	$0
	Total	**$2,200,504**	**$1,253,446**	**$1,065,000**
2. Education	Universal	$1,155,987	$700,000	$525,000
	Selective	$318,266	$400,000	$318,766
	Indicated	$123,648	$250,000	$112,500
	Unspecified	$1,615	$0	$0
	Total	**$1,599,516**	**$1,350,000**	**$956,266**
3. Alternatives	Universal	$637,802	$650,000	$562,500
	Selective	$114,332	$400,000	$225,000
	Indicated	$34,075	$175,000	$75,000
	Unspecified	$1,615	$0	$0
	Total	**$787,824**	**$1,225,000**	**$862,500**
4. Problem Identification and Referral	Universal	$132,363	$500,000	$262,500
	Selective	$89,416	$250,000	$131,250
	Indicated	$94,976	$100,000	$56,250
	Unspecified	$585	$0	$0
	Total	**$317,340**	**$850,000**	**$450,000**
	Universal	$1,169,832	$500,000	$375,000

	Selective	$180,350	$250,000	$206,250
5. Community-Based Process	Indicated	$36,475	$100,000	$93,750
	Unspecified	$1,238	$0	$0
	Total	**$1,387,895**	**$850,000**	**$675,000**
6. Environmental	Universal	$505,586	$650,000	$525,000
	Selective	$36,536	$450,000	$262,500
	Indicated	$9,071	$100,000	$56,250
	Unspecified	$377	$0	$0
	Total	**$551,570**	**$1,200,000**	**$843,750**
7. Section 1926 Tobacco	Universal	$12,866	$100,000	$56,250
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$12,866**	**$100,000**	**$56,250**
8. Other	Universal	$0	$0	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$6,857,515**	**$6,828,446**	**$4,908,766**
Total SABG Award[3]		**$40,591,646**	**$37,892,228**	**$24,543,830**
Planned Primary Prevention Percentage		**45.81 %**	**49.07 %**	**75.76 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct	$3,516,544	$1,926,723	$1,637,500
Universal Indirect	$2,179,668	$1,926,723	$1,637,500
Selective	$833,674	$2,150,000	$1,905,021
Indicated	$327,629	$825,000	$695,000
Column Total	**$6,857,515**	**$6,828,446**	**$5,875,021**
Total SABG Award[3]	**$40,591,646**	**$37,892,228**	**$24,543,830**
Planned Primary Prevention Percentage	**16.89 %**	**18.02 %**	**23.94 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☑	☑
Heroin	☑	☑	☑
Inhalants	☑	☑	☑
Methamphetamine	☑	☑	☑
Bath salts, Spice, K2)	☑	☑	☑
Targeted Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQ	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑
Hispanic	☑	☑	☑
Homeless	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☑	☑	☑
Asian	☑	☑	☑
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Footnotes:

Planning Tables

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

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$0.00	$226,677.00		$75,000.00	$37,500.00
2. Infrastructure Support	$0.00	$112,162.00		$250,000.00	$150,000.00
3. Partnerships, community outreach, and needs assessment	$0.00	$351,298.00		$100,000.00	$75,000.00
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00		$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$159,882.00		$25,000.00	$15,000.00
6. Research and Evaluation	$0.00	$134,915.00		$100,000.00	$75,000.00
7. Training and Education	$0.00	$275,880.00		$200,000.00	$150,000.00
8. Total	**$0.00**	**$1,260,814.00**	**$0.00**	**$750,000.00**	**$502,500.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Footnotes:

Planning Tables

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

MHBG Planning Period Start Date: 10/01/2021 MHBG Planning Period End Date: 09/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4. Planning Council Activities (MHBG required, SABG optional)	$5,000.00	$0.00	$0.00	$5,000.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
7. Training and Education	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
8. Total	**$5,000.00**	**$0.00**	**$0.00**	**$5,000.00**	**$0.00**	**$0.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:

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

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

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

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

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

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

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

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[26] **https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.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**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://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/home**; National Telehealth Policy Resource Center, **https://www.cchpca.org/topic/overview/**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] 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**

[34] 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); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] 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**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

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[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/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.

AHCCCS provides coverage of integrated health care services through Managed Care Organizations (MCOs). Most AHCCCS members receive all integrated health services through their chosen acute care program, one of seven AHCCCS Complete Care (ACC) plans. Services include, but are not limited to, primary health care, mental health counseling, psychiatric and psychologist services, and treatment for substance use disorders, including Opioid Use Disorder. The Regional Behavioral Health Authorities (RBHAs) continue to serve most individuals with a Serious Mental Illness designation, while continuing to provide crisis, grant-funded and state-only funded services. Additionally, the Arizona Long Term Care System (ALTCS) program provides health insurance for individuals who are age 65 or older or who have a disability. American Indians and Alaska Natives (AI/AN) enrolled in AHCCCS or CHIP (KidsCare) may choose to receive their coverage through the AHCCCS fee-for-service program (American Indian Health Program (AIHP), Tribal ALTCS, or Tribal RBHAs (TRBHAs enter into Intergovernmental Agreements with AHCCCS for behavioral health care management)) or one of the AHCCCS-contracted managed health plans. The fee-for-service program provides medically necessary services for enrolled members, including physical preventive and behavioral health care services.?

AHCCCS MCOs are required to develop processes to identify Health Homes within their network and assign members with an SMI designation to a Health Home within five days of enrollment.? The Health Home is then responsible for either providing, or coordinating the provision of, all covered health services. In order to treat the whole person, the Health Home is also responsible to provide or coordinate a range of recovery-focused services to members, such as medication services, substance use disorder treatment, medical management, case management, transportation, peer and family support services, and health and wellness groups. Additionally, to support continuity of care and ensure coordination across systems, the Health Home is required to ensure follow up and continuing care post-crisis engagement.?

Additionally, AHCCCS' Division of Fee for Service Management (DFSM) has been targeting improvement in care coordination within the tribal health care delivery system over the past five years. This has included, but is not limited to, the establishment of the American Indian Medical Home, investing in the Health Information Exchange to implement notifications related to admissions, discharges and transfers (ADTs), and working to coordinate with TRBHAs regarding Emergency Department (ED) and inpatient admissions for care management follow-ups.??

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

AHCCCS MCOs function as the single entity responsible for administrative and clinical integration of health care service delivery

for members with an SMI designation, which includes coordinating Medicare and Medicaid benefits for these members who are dually eligible. Coordinating and integrating physical and behavioral health care produces improved access to primary care services, increased prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease. Increasing and promoting the availability of integrated, holistic care for members with chronic behavioral and physical health conditions helps members to achieve better overall health and an improved quality of life.?

The core principles of AHCCCS' system of care are based on the concepts of recovery, member input, family involvement, person-centered care, communication, and commitment. AHCCCS MCOs are expected to demonstrate an unwavering commitment to these principles, while demonstrating creativity and innovation in their oversight and management of an integrated service delivery system. MCOs are required to develop and promote care integration activities, such as establishing integrated settings which serve members' primary care and behavioral health needs and encouraging member utilization of these settings. MCOs are also required to consider the entirety of the member population's health needs during network development and provider contracting to ensure member access to care, care coordination, and management, and to reduce duplication of services.?

AHCCCS MCOs are required to maintain and execute policies and procedures describing the implementation of comprehensive and coordinated delivery of integrated physical and behavioral health services, including administrative and clinical integration of health care service delivery. Integration strategies and activities are expected to focus on improving individual health outcomes, enhance care coordination (including care coordination for Medication Assisted Treatment (MAT)), and increase member satisfaction.?

AHCCCS MCOs are also contractually required to report on performance measures that consider underlying performance, performance gaps, reliability and validity, feasibility, and alignment. These performance measures are also evaluated based on several demographics to reduce, to the extent practical, health disparities based on age, race, ethnicity, sex, primary language, and disability status. These measures are used to evaluate whether MCOs are fulfilling key contractual obligations and are an important element of the agency's approach to transparency in health services and Value Based Purchasing (VBP). MCO performance is publicly reported on the AHCCCS website (e.g., report cards and rating systems), as well as other means, such as the sharing of data with state agencies and other community organizations and stakeholders. MCO performance is compared to AHCCCS requirements, with the national NCQA Medicaid Mean (for NCQA HEDIS ® measures) and the CMS Medicaid Median (for CMS Core Set Only measures) for the associated measurement period serving as the performance target for each contractually required performance measure.?

AHCCCS is pursuing long-term strategies that bend the cost curve while improving member health outcomes. The overall mission is to leverage the AHCCCS managed care model toward value-based health care systems where members' experience and population health are improved through aligned incentives with MCOs and provider partners, and a commitment to continuous quality improvement and learning. One critical tool, VBP, encompasses a variety of initiatives for payment reform, including Alternative Payment Models (APMs), Differential Adjusted Payments (DAP), Directed Payments and Targeted Investments (TI). Through VBP, AHCCCS is committing resources to leverage the state's successful managed care model to address inadequacies of the current health care delivery system, such as fragmentation and paying for volume instead of quality.?

AHCCCS also requires that all contracted health plans have an Office of Individual and Family Affairs (OIFA) as a counterpart to the AHCCCS OIFA.? The health plan OIFAs are contractually required to collaborate and participate in various initiatives and activities with AHCCCS OIFA and with their counterparts across health plans.??

Health plans are contractually required to have peer and family member participation on internal decision-making committees.? This representation must reflect all populations served by the contractor including members with SUD.??

Health plans are contractually required to maintain a network of providers including Peer-Run Organization (PRO) and Family-Run Organizations (FRO) serving all populations, including members with SUD. Health plan OIFAs take an active role by providing technical assistance to existing PROs and FROs; and by identifying new agencies wishing to be recognized by AHCCCS as PROs and FROs?

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? (●) Yes ( ) No

b) and Medicaid? (●) Yes ( ) No

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

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

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

a) Prevention and wellness education (●) Yes ( ) No

b) Health risks such as

ii) heart disease (●) Yes ( ) No

iii)	hypertension	(•) Yes ( ) No
iv)	high cholesterol	(•) Yes ( ) No
v)	diabetes	(•) Yes ( ) No
c)	Recovery supports	(•) Yes ( ) No

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

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

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

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

Please indicate areas of technical assistance needed related to this section

Technical assistance is not being requested at this time.

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

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

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

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

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

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

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

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

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

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

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

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

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

Please respond to the following items:

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

a) Race	○ Yes ◉ No
b) Ethnicity	○ Yes ◉ No
c) Gender	○ Yes ◉ No
d) Sexual orientation	○ Yes ◉ No
e) Gender identity	○ Yes ◉ No
f) Age	◉ Yes ○ No

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

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

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

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

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

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

The AHCCCS Health Equity Committee is currently evaluating available data, and determining how to enhance equity-related analyses and address any identified disparities.

Please indicate areas of technical assistance needed related to this section

Technical assistance is not being requested at this time.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.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 focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

1. AHCCCS Differential Adjusted Payment (DAP) Activity CYE 2022 Final Public Notice Originally Posted April 29, 2021.

The purpose of the notice was to provide the following Differential Adjusted Payment decisions:

For the contracting year October 1, 2021 through September 30, 2022 (CYE 2022), select AHCCCS-registered Arizona providers which meet agency established performance criteria will receive Differential Adjusted Payments (DAP).

AHCCCS is implementing these DAP rates to assure that payments are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. AHCCCS requests provider and Managed Care Organization (MCO) feedback on current and future DAP initiatives each year.

2. AHCCCS Contractor Operations Manual/Chapter 300 Finance/ 306 – Alternative Payment Model Initiative – Withhold and Quality Measure Performance Incentive

The purpose of the policy applies to all Acute Care and Arizona Long Term Care System (ALTCS) /Elderly and Physically Disabled (EPD) Contractors. The purpose of the AHCCCS Alternative Payment Model (APM) Initiative – Withhold and Quality Measure Performance (QMP) Incentive is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings by aligning the incentives of the contractor and provider

through APM strategies.

3. AHCCCS Contractor Operations Manual/Chapter 300 Finance/307– Alternative Payment Model Initiative – Strategies and Performance-Based Payment Incentive

The purpose of the Alternative Payment Model (APM) Initiative - Strategies and Performance-Based Payments Incentive Policy applies to Acute Care, Arizona Long Term Care System Elderly and Physical Disability (ALTCS/EPD), Children's Rehabilitative Services (CRS), Regional Behavioral Health Authority (RBHA), ALTCS Division of Economic Security/Developmental Disabilities (DDD) Contractors and DDD Sub-contractors. The purpose of this initiative is to encourage contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the contractor and provider through APM strategies. AHCCCS requires a specified percentage of spend in Value Based Purchasing (VBP) arrangements. AHCCCS requests provider and MCO feedback on current and future VBP initiatives each year.

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

Technical Assistance is not being requested at this time.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

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

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

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

Evidence-based practices (EBPs) implemented in Arizona for early serious mental illness (ESMI) including first episode of psychosis include: The Coordinated Specialty Care (CSC) model, OnTrackNY, NAVIGATE, including the NAVIGATE Staying Well and Achieving Goals (SWAG), Cognitive Behavior Therapy (CBT) for psychosis, Systemic Family Therapy, Acceptance and Commitment Therapy (ACT), Internal Family Systems (IFS), Multifamily Group, Motivational Interviewing (MI), Cognitive Remediation, Personal Medicine, Certified Clinical Trauma Specialist–Individual (CCTSI), Cognitive Enhancement Therapy, mindfulness meditation, and peer support.

The MHBG funds 9 early intervention programs for ESMI and first episode psychosis (FEP). Below are descriptions of each program.

Banner Early Psychosis Intervention Center (EPICenter), located in Tucson, AZ, was developed from the CSC model and is the only 5-year program of its kind in the nation, providing evidence-based and intensive stage-specific treatment

including wrap-around services for adolescents and young adults (aged 15 to 35) in the early stages of a psychotic illness. The program offers members three core functions: (a) Early detection, (b) Acute care during and immediately following a psychiatric crisis, and (c) Recovery-focused continuing care, featuring multimodal 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.

Resilient Health's FEP program, located in Phoenix, AZ, is a CSC approach that is 18 to 24 months in duration and serves ages 15 to 30. It is composed of a clinical director, three masters level counselors, and one case manager/employment specialist. The team has received formal training in the CSC model.. Using a team-based, multi-element approach to treating FEP, the program focuses on early intervention services and works to prevent future symptomatic relapses. The program includes rapid service engagement to reduce duration of untreated psychosis, assertive case management, patient psychoeducation, family psychoeducation, low dose pharmacologic treatment, Cognitive Remediation, and vocational and education support. Resilient Health serves members ages 15-30 who are within the first 2 years of their first psychotic episode, and have a qualifying diagnosis.
For nearly two years, the Connections REACH program worked diligently to engage community partners and increase referrals to the program, having recently worked collaboratively with Pima County Crisis Response Center, behavioral health hospitals, emergency departments, and primary care physicians. However, these efforts did not result in successful intakes to the program and census remained low. Connections will no longer provide FEP services. Instead, there is coordination work occurring to bring a new FEP provider on board under the grant.

Valleywise Health FEP program, located in Avondale, AZ, serves ages 15 to 30 implements a CSC model with the team consisting of the following members: Team Specialist, Education and Employment Specialist, Peer Support Specialist, Recovery Coach, Program Supervisor, Program Assistant, Registrar, Psychiatrist, Nurse, and a Medical Assistant. Certain FEP team members are certified in Personal Medicine and as Clinical Trauma Specialist–Individual (CCTSI). The team implements strategies and modalities such as Shared Decision Making, Cognitive Enhancement Therapy, mindfulness meditation, integrated care, and more. The team uses the CSC to provide support to help divert the usual trajectory of a diagnosis of a primary psychotic disorder. The program focuses on educating members about their diagnosis, learning about the tools and resources available to them overcoming the derailment caused by psychosis symptoms can cause in a young person's life. Services members age 15-25 with a diagnosis of a primary psychotic disorder, diagnosed within the last 12 months, and the person or guardian is in agreement with the referral.

In the Northern region of Arizona, 5 health homes are funded to implement ESMI and FEP programming: Mohave Mental Health Center (MMHC) in Kingman, AZ, Spectrum Healthcare Group (SHG) in Cottonwood, AZ, Child and Family Support Services (CFSS) in Flagstaff, AZ, The Guidance Center (TGC) in Flagstaff, AZ, and West Yavapai Guidance Clinic (WYGC) in Prescott Valley, AZ. They implement a program called Fast Forward, using the CSC model, and also utilize curriculum directly from the NAVIGATE program. Although they are all structured similarly, each Health Home adjusts the program to meet their unique model and staffing structure. Each program consists of a Fast Forward Service Provider, a Behavioral Health Medical Professional, a nurse, a therapist, and other staff unique to each agency. They also operate under the empowerment model, meaning clients have the opportunities to set their own goals to work towards while in treatment, and have an active role in treatment plans and approaches.
Each of the five health homes' Fast Forward Service Providers are responsible for all aspects of case management, therapy, nursing, and coordinating with other health home staff. These providers ensure all services are provided based on the needs of the individual and family.
TGC utilizes a model similar to the high needs case management model. TGC also has a designated BHP and therapist to work with FEP participants. In addition, TGC has recently added a Youth in Transition Case Manager to the Fast Forward Team to help members transition from the children's system to the adult system of care and to provide sustainability to the FEP program.
SHG and WYGC operate a similar model to TGC, and have a dedicated Fast Forward Service Provider who functions as a high needs case manager while also providing skills training, vocational and educational services, and psychoeducation services. However, WYGC has also included a Peer Support as a member of their Fast Forward Team.

CFSS employs a Fast Forward Supervisor, who provides treatment services and coordinates care for FEP members. The Supervisor provides education on psychosis and appropriate interventions to staff working with members experiencing psychosis or identified as early SMI. CFSS also has a dedicated BHP who provides services to members and coordinates with the Supervisor.
Finally, the Connections REACH Program for FEP, which was located in Tucson, AZ, was based on the Coordinated Specialty Care model. This was a new program developed in the last 2 years and was operating with a Team Lead, a Family Education and Employment Support Specialist and a Psychiatrist. The Team Lead served as the primary clinician, individual, group, and family therapist, and case management provider. The Family Education and Employment Support Specialist provided vocational and educational goal setting, liaison with family and community groups, and peer support. The Psychiatrist was responsible for diagnosis, medical care needs, and medication management.

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

AHCCCS promotes the use of EBPs for ESMI and FEP through the inclusion of requirements in policy and deliverable templates.

The AHCCCS Medical Policy Manual (AMPM) 320-T1 defines an FEP Program as "a program focused on the early identification and provision of evidence-based treatment and support services to individuals, who have experienced a first episode of psychosis (FEP) within the past two years. Evidence-based FEP programs have been shown to improve symptoms, reduce relapse, and lead to better outcomes. A commonly used evidenced based model is Coordinated Specialty Care, which is a recovery-based approach that uses shared decision making and offers case management, psychotherapy, medication management, family education and support, and supported education or employment." Once the MHBG FEP allocations are released by AHCCCS, each contractor that receives MHBG FEP funds is required to submit budgets and program plans for the dollars. AHCCCS MHBG staff conduct both programmatic and financial reviews to ensure the budgets and plans meet the requirements set forth in the MHBG and are appropriate under ESMI/FEP. Finally, contractors are required to report back on their use of EBPs to fidelity in their quarterly and annual FEP Program Status Reports, including service utilization by members to ensure members are offered and receive the services prescribed under the CSC model. Additionally, contractors report on the use of EBPs by FEP providers and what is done to monitor fidelity to the model.

AHCCCS implements an integrated model of health care, combining coverage of medical and behavioral health under one managed care health plan. Contracted health plans coordinate and pay for physical and behavioral health care services delivered by more than 104,000 health care providers to more than two million Arizonans. Three of the seven AHCCCS Complete Care Plans are designated as Regional Behavioral Health Authorities (RBHAs) which are fully integrated health plans for acute and behavioral health services for members with serious emotional disturbance (SED) and serious mental illness (SMI) that are not enrolled with DES/DDD. The RBHAs are responsible for the coordination of care for members with behavioral health needs which includes those with ESMI and FEP. AHCCCS Complete Care encourages more coordination between providers within the same network which can reduce fragmentation and lead to better health outcomes for members.

In addition to the requirements for FEP providers to implement EBPs for FEP, the recent integration of physical, dental, and behavioral health under one plan for children in foster care, helps to ensure these children, who are at increased risk for psychosis, have access to comprehensive individualized treatment and integrated care. The earlier children in foster care, especially those who may be experiencing psychosis, receive integrated physical and behavioral health care, the better their health outcomes may be.

Further, the use of Child and Family Teams (CFT) for children and Assertive Community Treatment (ACT), and Adult Recovery Teams (ART) for adults ensure that children, youth, and young adults with psychosis receive integrated health care through the use of EBPs, not just for the treatment of early psychosis but for their other mental health needs as well as physical health.

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

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

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

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

The state's ESMI programs are various versions of the CSC model and related programs such a the Fast Forward CSC Program, the NAVIGATE, OnTrackNY, the Connections REACH CSC program, and training and consultation from the OnTrack program.

CSC is an evidence based model studied and shown effective in the Recovery After an Initial Schizophrenia Episode (RAISE) project. CSC focuses on offering psychotherapy, medication management, family education and support, case management, supported education and employment, in a recovery-oriented manner, with an emphasis on shared decision making. Each member works with the team of specialists and the family as much as is possible and appropriate to create an individualized treatment plan that works best for the individual. Each team of specialists is comprised of professionals to meet the key roles and functions, although the staffing in each program may vary based on local needs.

These CSC programs are currently implemented in Arizona under Resilient Health, Valleywise Health First Episode Center, Banner EPICenter, Mohave Mental Health Center, Spectrum Healthcare Group, Child and Family Support Services, The Guidance Center, and West Yavapai Guidance Clinic.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

Each year, AHCCCS develops an allocation schedule for all funding sources, including MHBG and also the ESMI/FEP set aside. Once published, AHCCCS informs the Regional Behavioral Health Authorities (RBHAs) of their respective allocations, and requests they submit program plans and budgets for the ESMI/FEP dollars for the RBHA as well as the direct service providers as subcontractors. Once submitted, AHCCCS then reviews from both a programmatic and a fiscal lens and works with the RBHAs to make revisions until AHCCCS is able to approve the program plans and budgets. This process occurs throughout August and September with the goal to approve all program plans and budgets by September 30, 2021.

Although this process has not yet begun for FY 2022 and FY 2023, AHCCCS does not anticipate major variances from previous years, as each RBHA and provider are likely to continue current efforts and build upon the successes of previous years and to sustain and expand ESMI/FEP services. Major activities under the ESMI/FEP dollars are as follows:
Clinical, support, and administrative personnel to support the ESMI/FEP program
Outreach, education, and supplies including art/journaling supplies, social media campaigns, posters, brochures, parent guides,

recovery guides, office supplies
Equipment such as electronic tablets
Video education for clients, family members, and community members
Training and consultations for Coordinated Specialty Care programs, clinical treatment modalities for psychosis, related conferences
Early Psychosis Intervention (EPI) Project ECHO implementation
Maintaining certifications, memberships and required software
One difference AHCCCS anticipates is the addition of a new FEP provider in the Southern region to replace Connections REACH program that was not able to successfully launch in the last two years. The RBHA that was contracted with the Connections REACH program provided ample support and technical assistance to the provider, but it was mutually agreed to discontinue the contract. A budget revision for this RBHA is already in process. As such, a new provider will come in to provide ESMI/FEP services and it is anticipated that the RBHA will have significant plans for program capacity building and start up such as training and technical assistance (TTA) for evidence-based practices to treat ESMI/FEP, best practices for serving members with ESMI/FEP, reporting and other relevant TTA.

In light of the unprecedented environment caused by the COVID-19 pandemic, the need for continued and additional services for First Episode Psychosis (FEP) is greater than ever. Utilizing additional block grant funding granted by SAMHSA, AHCCCS will be enhancing current and adding additional services through the following projects:

Support for additional FEP positions to provide outreach and treatment services;
Support the training and staff time to participate in evidence-based practices;
Provide FEP services to individuals impacted by the COVID-19 Pandemic;
Provide support for additional workforce development activities to enhance current provider capacity to address the needs of this populations; and
Funding of supplies and outreach materials.

These proposed programs and projects will allow for increased service capacity and improved access to mental health care for individuals designated with FEP to aid in the unprecedented behavioral health needs experienced due to the impact of COVID-19.

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

RBHAs are required to submit FEP Program Status Reports to AHCCCS on a quarterly and annual basis regarding the ESMI/FEP 10% set aside. In order to complete this deliverable, the RBHAs may use the FEP providers' monthly or quarterly reports to the RBHA and other efforts to collect information directly from the FEP providers, and also compile information from the RBHA level. As a result, the following information is compiled at the clinic, RBHA, and state level:
Quarterly: enrollment, referral sources, discharge reasons, outreach efforts, service utilization, psychotropic medication prescribed and taken, implementation of EBPs to fidelity, barriers, successes, plans to address barriers and sustain/build successes, expenditures according to approved budget.
Annually: all the information requested in the quarterly report, plus member demographics (age, gender, race, ethnicity), employment or education status, living situation, engagement in physical health services/activities, referrals made to crisis, ED, inpatient, medication compliance, medication side effects, court and IEP status, at-risk member behavior, inpatient hospitalizations, substance use, engagement in meaningful activities, housing barriers, efforts to address housing barriers, successes and plans to build/sustain successes in housing, SAMHSA snapshot information, and planning items including baseline enrollment (previous fiscal year) versus current enrollment.[Text Wrapping Break][Text Wrapping Break]The clinics and RBHAs may also have additional clinical information, not requested by AHCCCS at this time. The MHBG Grant Coordinator reviews these quarterly and annual deliverables, meets with the RBHAs and works with them to identify any gaps, issues, or concerns in the data.

Throughout the report period of October 1, 2019 to September 30, 2020, a total of 368 members were reported to be enrolled in FEP programming. A few highlights of aggregate data reflecting reports from all three RBHAs include the following:

Out of 257 recorded, 92 (35.8%) reported attending school, 79 (30.74% were employed, and 86 (33.46%) were employed through Vocational Rehabilitation, receiving employment/education supports.

Out of 297 recorded, 237 (79.80%) reported living with family or friends and 36 (12.12%) reported independent living (paying for own housing).

Out of 271 recorded, 163 were taking oral psychotropic medications with 96 (58.9%) were compliant, 20 were taking long acting psychotropic injectables with 14 (70%) compliant.

Out of the 368 enrollees, 31 were in court ordered treatment, 12 on probation, and 12 in an individualized education program, with all but 1 being in good standing with their program/plan.

Out of the 368 enrollees, 39 (10.60%) were reported as persistently acutely disabled, 726 (7.07%) were reported a danger to self, 10 (2.72%) were reported a danger to others, while only 1 (0.27%) was gravely disabled.

Out of 228 recorded, 163 (71.49%) were reported as not engaged in substance use/abuse, 33 (14.47%) were reported as being engaged with recreational use(less than once a week), 21 (9.21%) with regular use (at least once a week), and 11 (4.82%) as using/abusing substance and seeking substance abuse treatment.

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

Per AHCCCS Medical Policy Manual (AMPM) 320-T1, the following are diagnoses that qualify under ESMI/FEP. These are not intended to include conditions that are attributable to the physiologic effects of an SUD, are attributable to an intellectual/developmental disorder, or are attributable to another medical condition:

a. Delusional Disorder,
b. Brief Psychotic Disorder,
c. Schizophreniform Disorder,
d. Schizophrenia,
e. Schizoaffective Disorder,
f. Other specified Schizophrenia Spectrum and Other Psychotic Disorder,
g. Unspecified Schizophrenia Spectrum and Other Psychotic Disorder,
h. Bipolar and Related Disorders, with psychotic features, and
i. Depressive Disorders, with psychotic features.

The members served in the ESMI/FEP programs have diagnoses that fall within these diagnostic categories.

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

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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

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

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

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

AHCCCS has implemented person-centered planning for all populations that we serve.?This has been a collaborative effort and partnership with the individuals we serve, family members, advocates, and community stakeholders.? An essential part of person-centered planning is that the person drives the process.?They are at the center of the "person-centered planning" process, and it is essential to gather their input, hear their voice and choice of treatment/services, who they want involved in their treatment planning process and ensure access to care is timely and efficient.? Arizona's model is based upon the premise that people want and deserve dignity, respect, inclusion, and safety.
?
Person-Centered Planning is based upon a foundation of Person-Centered Thinking (PCT), which inspires and guides respectful listening leading to actions, resulting in individuals who:

Have positive control over the life they desire and find satisfying
Are recognized and valued for their contributions to their journey toward recovery and to their families, people of support and their community/ies
Are supported by a network of relationships, both natural and paid, within their community

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

Person-centered service planning supports AHCCCS Aging and Long Term Care Services (ALTCS) members in planning and creating the life they want through services and supports to ensure all members are integrated into their communities and have full access to the benefits of community living. ALTCS case managers play a significant role in assessing needs and addressing barriers and challenges that our members face, through a person-centered approach.??
?
The AHCCCS Person-Centered Service Plan (PCSP) is a requirement for the ALTCS population, and is a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid, including behavioral health) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP also reflects the member's strengths and preferences that meet the member's social, cultural and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize risk, including the development of individualized back-up/ contingency plans and other strategies as needed.
?
The person-centered service planning process ensures a standardized method for assessing and documenting discussions with members during assessment and service planning meetings for all ALTCS members; promotes and support discussions with members around key indicators that help assess an individual's integration experience and access to rights afforded to them; and helps
to document information shared during conversations with the members, which help to inform
personal goal development and service planning.
?
AHCCCS fosters an environment of person-centered planning that includes the voice and choice of the person being served, their family, identified persons of support, advocates (as designated) and service providers, as identified.? The planning?process is transparent, fluid and is a living and breathing document that can change as a persons' choices and treatment needs change.?

?
In addition to Person-Centered Planning requirements in the ALTCS population, AHCCCS' Adult System of Care (ASOC) is a continuum of coordinated community and facility based services and supports for adults with, or at risk for, behavioral health challenges.? The ASOC is organized into a comprehensive network to create opportunities to foster recovery and improving health outcomes by:
?
Building meaningful partnerships with individuals served
Addressing the individuals' cultural and linguistic needs and preferences
Assisting the individual in identifying and achieving personal and recovery goals
?
The ASOC developed the following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness:
?
Nine Guiding 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 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.
In addition, Arizona/AHCCCS collaborated with the child, family and others to provide services that are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family and their cultural heritage.??
?
Arizona/AHCCCS developed The Twelve (12) Principles for Children's in the Behavioral Health Service Delivery System:
?

Twelve (12) Guiding Principles:

?

1. COLLABORATION WITH THE CHILD AND FAMILY:? Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

?

2. FUNCTIONAL OUTCOMES:? Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

?

3. COLLABORATION WITH OTHERS:? When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DDD caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.?

?

4. ACCESSIBLE SERVICES: ?Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

?

5. BEST PRACTICES: ?Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.?

?

6. MOST APPROPRIATE SETTING: ?Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

?

7. TIMELINESS: Children identified as needing behavioral health services are assessed and served promptly.?

?

8. SERVICES TAILORED TO THE CHILD AND FAMILY: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.?

?

9. STABILITY:? Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.?

?

10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE: ?Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

?

11. INDEPENDENCE:? Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.?

?

12. CONNECTION TO NATURAL SUPPORTS: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

?

Overall, the Person-Centered Planning and Service Plan reflects the individuals' strengths and preferences that meet the persons'

social, cultural and linguistic needs and includes individualized goals and desired outcomes.? Additionally, the planning process also identifies risk factors (includes risks to member rights) and puts measures in place to minimize them with individual back-up plans and other strategies as needed.

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

None.

Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

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

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

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

Please respond to the following items:

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

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

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

AHCCCS contracts with three Regional Behavioral Health Authorities (RBHAs) for the provision of SAMHSA Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) services and funding. These Contracts delineate the requirements of the RBHAs, including their responsibilities for implementing and monitoring subcontractors who are the providers of direct care services and treatment. Notwithstanding any relationship(s) the RBHA may have with any subcontractor, the RBHA maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. RBHAs subcontract with providers in their Geographic Service Area (GSA) to ensure members may access services within their communities. Provider networks must meet access-to-care standards for the populations served.

AHCCCS also holds Intergovernmental Agreements (IGAs) with three Tribal Regional Behavioral Health Authorities (TRBHAs) for the provision of MHBG and SABG services and funding. The TRBHA IGAs ensures that services and treatment funded under the federal block grants meet all the legal requirements of the respective block grant. The TRBHAs are responsible for implementing and monitoring direct care services and treatment; and as funds are available, are responsible for the development, and implementation of primary substance abuse prevention services.

Contracts/IGAs are updated and amendments are executed as needed to revise and implement reporting, monitoring, evaluation,

and compliance requirements. Additionally, RBHAs are required to align their programs and activities with the following AHCCCS System Values and Guiding Principles:
Timely access to care,
Culturally competent and linguistically appropriate care,
Identification of the need for and the provision of comprehensive care coordination for physical and behavioral health service delivery,
Integration of clinical and non-clinical health care related services,
Education and guidance to providers on service integration and care coordination,
Provision of disease/chronic care management including self-management support,
Provision of preventive and health promotion and wellness services,
Adherence with and continuing education and guidance to physical and behavioral health providers on the Adult Behavioral Health Service Delivery System-Nine Guiding Principles,
Promotion of evidence-based practices through innovation,
Expectation for continuous quality improvement,
Improvement of health outcomes,
Containment and/or reduction of health care costs without compromising quality,
Engagement of member and family members at all system levels,
Collaboration with the greater community,
Maintains, rather than delegates, key operational functions to ensure integrated service delivery,
Embraces system transformation, and
Implementation of health information technology to link services and facilitate improved communication between treating professionals, and between the health team, the member, and member caregivers.

Monitoring
Within AHCCCS, many divisions collaborate to ensure compliance with block grant program integrity responsibilities. The Division of Health Care Management (DHCM), the Office of the Director (OOD), the Division of Community Advocacy & Intergovernmental Relations (DCAIR), and the Division of Fee for Service Management (DFSM) play an integral role in the ongoing monitoring for programmatic compliance, including promoting the proper expenditure of block grant funds, improving block grant program compliance, and demonstrating the effective use of block grant funds. RBHAs and TRBHAs are required to ensure reporting requirements and deliverables outlined in their contract/IGA are met.

Corporate Compliance/Fraud, Waste, and Abuse
AHCCCS has established a comprehensive Corporate Compliance Program to achieve the goals of preventing and detecting fraud, waste, and abuse of the program. The program ensures Contractor compliance with applicable laws, rules, regulations, and contract requirements. Continued collaboration efforts include regularly scheduled meetings held to share information with RBHAs and TRBHAs regarding their Corporate Compliance Program that includes all program integrity activities.

Operational Reviews
AHCCCS conducts annual SABG/MHBG Operational Reviews to verify Contractor performance which include review of internal monitoring of grant activities; verification of timely and accurate notifications to providers of sub-awards, funding, and audits; verification of tracking and implementation of decisions regarding provider audit findings; and appropriate tracking of grant funding.

Reporting Requirements
Regular deliverable submissions to AHCCCS by each RBHA and TRBHA are required and analyzed to ensure program integrity efforts are met. These include at a minimum: annual Independent Case Reviews; annual MHBG and SABG Activities and Expenditures Plans and Reports; quarterly Grievance and Appeal reporting; and annual/quarterly/monthly Financial Reporting. A brief description of each is provided below:

1. AHCCCS oversees the Independent Case Reviews (ICRs) to meet the Peer Review requirement of the block grant to ensure the quality and appropriateness of treatment services and indications of treatment outcomes. An ICR interdisciplinary team from an independent agency completes case reviews.

2. RBHAs and TRBHAs must provide information regarding MBHG and SABG activities and expenditures outlining use of funds, strategies for monitoring expenditures, and make adjustments in a timely manner to best meet the needs of the community.

3. RBHAs and TRBHAs must for all members, subcontractors, and providers administer all Grievances and Appeal System processes competently, expeditiously, and equitably. RBHAs and TRBHAs are required to report provider claim disputes, member grievances, SMI Grievances and SMI Appeals as delineated in Arizona Administrative Code Title 9, Chapter 21, Article 4.

4. RBHAs and TRBHAs are required to submit financial statements and reporting packages, which must comply with contractual requirements for management of federal block grant funds.

Policies and Procedures
In addition to the Contracts/IGAs, multiple policies and procedures are developed and implemented for RBHAs and TRBHAs to

ensure operational and programmatic compliance and appropriate service delivery. Two priority manuals are the AHCCCS Contractor Operations Manual (ACOM) and the AHCCCS Medical Policy Manual (AMPM). Policies within these manuals are written with input from multiple divisions at AHCCCS with revisions completed as needed due to Federal or State legislation, contractual requirements, operational changes, monitoring requirements, benefit coverage, etc. All applicable policies are incorporated by reference in the Contracts/IGAs.

Listed below are several policies important to note which relate to RBHA grant services and funding; member and provider notifications; and access to care requirements (this is not an all-inclusive list):
ACOM Policy 103, Fraud, Waste, and Abuse
ACOM Policy 323, RBHAs Title XIX/XXI Reconciliation and Non-Title XIX/XXI Profit Limit
ACOM Policy 404, Contractor Website and Member Information
ACOM Policy 406, Member Handbook and Provider Directory
ACOM Policy 416, Provider Information
ACOM Policy 436, Provider Network Requirements
ACOM Policy 444, Notice of Appeal Requirements (SMI Appeals)
ACOM Policy 446, Grievances and Investigations Concerning Persons with Serious Mental Illness
ACOM Policy 448, Housing
AMPM Policy 310-B, Title XIX/XXI Behavioral Health Services Benefit
AMPM 310-V, Prescription Medications-Pharmacy Services
AMPM 320-V, Behavioral Health Residential Facilities
AMPM Policy 320-T1, Block Grants and Discretionary Grants
AMPM Policy 580, Behavioral Health Referral and Intake Process
AMPM Policy 650, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening, Application for Public Health Benefits Provider Eligibility
AMPM Policy 960, Quality of Care Concerns
AMPM Policy 961, Incident, Accident, and Death Reporting
AMPM Policy 962, Reporting and Monitoring of Seclusion and Restraint
AMPM Policy 963, Peer and Recovery Support Service Provision Requirements
AMPM Policy 964, Credentialed Parent Family Support Requirements
AMPM Policy 1040, Outreach, Engagement, Re-Engagement and Closure for Behavioral Health
Contractors, providers, and members have full access to the ACOM, AMPM, and other Guides and Resources via the AHCCCS website. Policies are made available to stakeholders for a 45-day Tribal Consultation/Public Comment period and revision memos accompany each policy revision explaining the changes and notification of changes is sent via email. Additionally, AHCCCS hosts the AHCCCS Managed Care Organization (MCO) Update Meetings with contracted health plans, state agencies, and TRBHAs; these meetings are typically held every two months. AHCCCS also holds quarterly Tribal Consultation meetings to consult with tribes, Indian Health Service, tribal health programs operated under P.L. 93-638, and urban Indian health programs in Arizona on policy and programmatic changes that may significantly impact members. Individualized communication with each RBHA formally occurs in person during regular meetings with AHCCCS to review issues, concerns, and new information. If an improvement plan is established, oversight, and communication from AHCCCS occurs more frequently.
RBHAs and TRBHAs are responsible for ensuring that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals. In the event of a modification to AHCCCS Policy, guidelines, and manuals and are required to issue a notification of the change to its affected subcontractors within 30 calendar days of the published change and ensure amendment of any affected subcontracts. Additionally, RHBAs are contractually required to hold provider forums semi-annually to improve communication between the Contractor and providers and to address issues (or to provide general information, technical assistance, etc.).

As stated in Contracts and IGAs respectively, RBHAs and TRBHAs shall comply with all reporting requirements contained in Contract/IGA and Policy.

Please indicate areas of technical assistance needed related to this section
Technical assistance is not being requested at this time.

AHCCCS OIG Program Integrity Statement
The Office of Inspector General (OIG) is responsible for the Program Integrity for the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program. The OIG is also responsible for handling reports of fraud, waste, and abuse of the AHCCCS program. All suspected fraud, waste, or abuse must be reported to the AHCCCS OIG. Anyone can report Arizona Medicaid fraud, waste, or abuse. There are no restrictions. To report suspected fraud by an AHCCCS medical provider, please call in Maricopa County: 602-417-4045, outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686. To report suspected fraud by an AHCCCS member, please call in Maricopa County: 602-417-4193, outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686. Additionally, provider and member fraud can be reported online at https://www.azahcccs.gov/Fraud/ReportFraud/onlineform.aspx. Questions can also be emailed to the AHCCCS OIG at AHCCCSFraud@azahcccs.gov.

TRBHA Block Grant Oversight

AHCCCS Division of Fee forService Management (DFMS) monitors the Tribal Regional Behavioral Health Authority (TRBHA) block grant services by conducting biennial Operational Reviews (OR). Block grant general requirements and prohibitions are outlined in the TRBHA Intergovernmental Agreements (IGA), along with associated deliverables. DFSM looks to the IGA, as well as collaborates with the Division of Grants Administration (DGA) for required standards which are incorporated into the OR Tool for review and monitoring. During the OR, records of members who received block grant services are reviewed according to the individual grant requirements. The OR also includes ensuring the funds are expended on appropriate activities such as services for the priority population and intervention and prevention services and that the services meet the legal requirements of each respective block grant. The audit ensures that block grant funds are the payor of last resort. Upon completion of the OR, work plans are created with each TRBHA to address any findings or standards which were not met. AHCCCS DFSM collaborates with DGA on reviewing and monitoring the work plan or providing technical assistance, as needed.

In addition to the OR, DFSM collaborates with DGA in providing additional TRBHA oversight through a variety of methods, including receiving and reviewing reports and deliverables, monitoring and reviewing spend through Contract Expenditure Reports (CERs), conducting site visits, providing technical assistance and training to the TRBHAs as needed, and holding routine finance meetings. DFSM monitors deliverables for timely submission and assists DGA when additional information from the deliverables is needed. DFSM and DGA hold monthly coordination meetings to discuss any issues or block grant opportunities for the TRBHA and to identify any need for technical assistance or training opportunities, in addition to responding to TRBHA requests for additional block grant funding.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

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

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

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

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

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

Please respond to the following items:

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

   Between August 2019 – July 2021 there were 25 tribal consultation sessions.
   https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html

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

   There were several areas of discussion or concern covered at the consultation meetings throughout the year, including: the physical and behavioral health care coordination for tribal members; non-emergency transportation services; pharmacy benefits; State Plan Amendments, including traditional healing, dental benefits, and differential adjusted payments; 1115 waivers, including AHCCCS Works/community engagement requirement and prior quarter coverage ; housing; funding and payment details; Indian Health Services (IHS) 638 funding; Value Based Purchasing; legislative actions; best practices; and policy implications.

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

   In addition to Tribal Consultation, AHCCCS holds quarterly meetings with the Tribal Regional Behavioral Health Authorities (TRBHAs). There were four meetings conducted in both State Fiscal Years (SFY) 2020 and 2021. Additionally, the TRBHA Intergovernmental Agreements (IGA) were set to expire June 30, 2021. During SFY 2021, AHCCCS spent six months in negotiation with the TRBHAs to draft new IGAs. In preparation for this process, AHCCCS also convened TRBHA IGA Listening Sessions. These discussions included feedback and recommendations related to the TRBHAs' scope of work and implementation of the block grants.

   The Tribal Regional Behavioral Health Authorities (TRBHAs) continue to be actively involved in partnering with AHCCCS programmatic staff in regular meetings and conference calls to coordinate the efforts of substance use disorder prevention and treatment services, and to receive technical assistance related to the block grant reporting requirements. The State has identified a

process for which the TRBHAs can request additional block grant dollars, if needed. This process has been clearly communicated to them as well as posted to the AHCCCS website.

AHCCCS has also implemented its American Indian Medical Home Program for IHS/638 facilities for enhanced primary care case management and care coordination, as well as the implementation of Care Coordination Agreements between IHS/638 facilities and non-IHS/638 facilities to improve the delivery system for American Indians by increasing access to care and strengthening the continuity of care.

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

Technical assistance is not being requested at this time.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

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

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

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

Please respond to the following items

Assessment

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

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

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

Major substance use issues in the community

Substances causing the most harm

Causes of substance use

Effectiveness of prevention efforts

Recommendations for prevention approaches

Gaps in prevention efforts

Community strengths that prevent substance use

Subgroup differences

Medical profession changes that reduce risk for prescription drug misuse

Types of access to substances

Types of substance use prevention efforts

Challenges on implementation

Training access/availability by county

Training needs

Efforts to evaluate impact

Demographics/information on communities served

Evaluation methods used

Evaluation needs

Resource adequacy

Addressing root causes

Efforts to consider special populations

Challenges

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

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

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

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

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

If yes, (please explain)

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

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

Results of the needs assessment continue to inform AHCCCS planning and implementation. Findings included:
A lack of resources to address untreated mental health concerns,
Health disparities facing the LGBTQ population,
Reductions in local funding for prevention activities, and
The unintended consequence that recent efforts to combat the prescription drug opioid crisis in AZ are leading to increased street drug use.

AHCCCS is addressing these findings by:
Including these gaps and priorities in the scope of work and request for proposals for prevention services, and evaluating proposals accordingly,
Highlighting identified target populations for providers,
Comparing identified needs to current resources available to that population and working to fill the gaps
Increasing utilization of prevention interventions with dual outcomes in both mental health and substance use,
Providing education of those available interventions,
Increasing collaborations statewide within other agencies or entities that can lead to more effective state funding spending,
Meeting with agency level decision makers discuss the current substance abuse prevention system structure and recommendations for improvement, and
Coordinating services across federal and state funding sources.

Since the needs assessment was published, AHCCCS instituted changes to strengthen the prevention system. AHCCCS contractually required SABG-funded primary prevention providers to develop and submit several deliverables that improve the science base of funded activities. This includes AHCCCS templates for deliverables such as logic models, needs assessments, and strategic plans, and mandates of basic prevention training, requiring evidence-based practices but also allowing the use of innovative practices with written review and approval by AHCCCS.

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

Local providers may also use the Arizona Statewide Prevention Needs Assessment, along with other sources of data, to inform their work. SABG Prevention providers are required to develop and submit to AHCCCS a prevention needs assessment at least once every three years. It must include information on existing prevention efforts in resources, gaps, risk and protective factors, and consequences related to substance use, trends, training capacity, prevalence of substance use issues, treatment resources, demographics, and sustainability. Additionally, the Arizona Youth Survey (AYS), administered by the Arizona Criminal justice Commission once every two years to students in grades eight, 10, and 12, is widely used data source for AZ prevention providers that gives county, city/town, and even school level data that providers use to inform their program planning, implementation, and evaluation.

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

Narratve Question

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

Capacity Building

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

If yes, please describe

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

If yes, please describe mechanism used

Arizona Health Care Cost Containment System (AHCCCS) is committed to advancing Arizona's Prevention System and has several mechanisms for learning about training and technical assistance (TTA) needs and providing TTA. AHCCCS is in the process of developing a statewide prevention training plan and resource guide for the statewide prevention workforce. AHCCCS is in regular communication with Arizona's designated Prevention Technology Transfer Center (PTTC) to inform the state of upcoming training and technical assistance opportunities, as well as discuss statewide training needs that the PTTC can help address. 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.

In 2020, AHCCCS contracted with LeCroy & Milligan Associates (LMA) to complete a Strategic Plan, and as part of the process, LMA collected updated information that was originally collected in the needs assessment, including TTA needs of the prevention field. Additionally in August 2020, AHCCCS conducted 3 substance use prevention focus groups among prevention stakeholders to inform AHCCCS in many areas, including prevention field TTA needs. Examples of questions that solicited answers to inform TTA needs include:
What Center for Substance Abuse Prevention (CSAP) strategy/strategies do you feel have the most influence on preventing substance abuse problems in your community?
What level of experience does the field have in competing for prevention funding and what types of resources would be helpful in writing a successful proposal?
What proportion of prevention professionals currently have some level of Prevention certification or credential?
Would the prevention specialist certification requirements be feasible, and helpful and/or useful for your everyday work in prevention?
What training requirements are in place in the current systems in which you work?
What current training opportunities are you finding to be most valuable and should continue to be offered?
What additional training does the field need to be successful with implementing primary prevention activities?
What formats of technical assistance and training is the best for the field?
What subcontractors or subcontractors are you currently utilizing to implement prevention services?

How are you currently evaluating your prevention programs for effectiveness?

Both of these data collection opportunities informed the direct service scope of work and request for proposals.

AHCCCS also meets with all prevention contractors once every 2 months to provide and request updates, which is a platform by which AHCCCS staff may learn about TTA needs or provide TTA. As of July 1, 2021, AHCCCS no longer administers SABG Prevention set aside funds through the RBHAs. Though the Governor's Office of Youth Faith and Family and the Tribal Regional Behavioral Health Authorities still receive SABG Prevention allocations, AHCCCS now also directly contracts with 19 prevention service providers. This new administrative structure allows AHCCCCS to be in closer contact with the providers, to provide direct TTA, and to solicit information on TTA needs in real time. Each AHCCCS Prevention Grant Coordinator meets with the prevention providers monthly, and communicates via email more frequently to address TTA needs. AHCCCS continues to provide TTA to GOYFF and the TRBHAs as well, whether directly or through partners such as the PTTC, Wellington Consulting Group, or LeCroy & Milligan Associates.

Some recent and upcoming examples of TTA provision to prevention contractors include Logic Model training in September through November 2020, a Primary Prevention Contractor Kick Off Meeting on July 7, 2021, several recent TTA on required report deliverables since July 1, 2021, and upcoming Prevention Evaluation training.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

The AHCCCS funded prevention system follows the Strategic Prevention Framework (SPF) model, which includes the development and implementation of a statewide needs assessment at least every 3-5 years. The most recent Needs Assessment, finalized in September 2018, included a community readiness assessment that allowed AHCCCS to see the state's capacity to address current prevention needs on a large scale.

Additionally, until July 1, 2021, AHCCCS ensured RBHAs performed a community readiness assessment to determine workforce capacity and the level of community readiness to implement appropriate strategies. Now, the directly contracted providers are required to conduct a substance abuse prevention needs assessment at least once every 3 years. The TRBHAs who receive SABG Prevention funds are also required to conduct regular substance abuse prevention needs assessments, which would include a community readiness section. These assessments at the community level are required to identify and address those factors contributing to substance use problems. Prevention efforts are purposefully designed to meet the communities' needs and consider the community's readiness for prevention services and activities.

Narratve Question

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Planning

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

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

Please see attached plan.

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

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

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

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

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

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

Until recently, AHCCCS participated in the Evidence Based Practice Workgroup through the Pacific Southwest Prevention Technology Transfer Center (PTTC). As of July 2021, the PTTC informed AHCCCS that the workgroup will be transitioned instead into a network of prevention Subject Matter Experts (SMEs).

AHCCCS participates in and collaborates with other state, federal, and community entities through the Arizona Substance Abuse Partnership (ASAP), which is the single statewide council on substance abuse prevention, treatment and recovery efforts. In 2020,

ASAP had two workgroups: the Arizona Substance Abuse Epidemiology Workgroup, and the Program Inventory Workgroup. AHCCCS Prevention staff participated in the Program Inventory Workgroup as well. The group reviewed a broad range of programming and strategies in prevention, identified promising practices, and provided recommendations to ASAP.

Further, AHCCCS currently accepts guidance set forth from SAMHSA in the document "Selecting Best-fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners" as the standard to follow when selecting programs and practices, including the best practices lists and resources. Directly contracted prevention providers are required to implement comprehensive evidence-based programs, utilizing all 6 Center for Substance Abuse Prevention (CSAP) strategies, and serving each Institute of Medicine (IOM) Category per community need. Evidence-based programs or practices are interventions that fall into one or more of the following categories:

1. The intervention is included in a federal registry of evidence based interventions, or
2. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer reviewed journal, or
3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which shall be followed. These guidelines require interventions to be:
a. Based on a theory of change that is documented in a clear logic or conceptual mode,
b. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals,
c. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects, and
d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

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

Narratve Question

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Implementation

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

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

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

a) Information Dissemination:

This strategy provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.??
Tabling/Booth events at Health Fairs, School Parent Nights, and local community events?
Dissemination of prevention flyers, posters, brochures, and other informational media at local grocery stores, doctor's offices, schools, etc.??
Media campaigns aimed at increasing knowledge of local substance use and abuse trends and data, as well as focusing on risk and protective factors to reduce substance use and abuse within high-risk populations.??

b) Education:

This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.?
Parenting/Family Education curriculum, such as Strengthening Families, Guiding Good Choices, and Triple P. These

programs aim to enhance parenting behaviors and skills, enhance effective child management behaviors and parent-child interactions and bonding, to teach children skills to resist peer influence, and reduce adolescent problem behaviors.??
Curriculum that teaches youth life skills, such as LifeSkills, which are designed to prevent teenage drug and alcohol abuse, tobacco use, violence and other risk behaviors by teaching students self-management skills, social skills, and drug awareness and resistance skills.?

c) Alternatives:

This strategy provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol and drugs and would, therefore, minimize or obviate resort to the latter.??
Drug-free community and/or youth events, including drug-free dances, sports tournaments, after-school youth groups/programs/clubs, etc.??
Connection and engagement in cultural activities, tribal practices, and learning cultural and/or tribal ways.??

d) Problem Identification and Referral:

This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.?
Programs/classes for youth who have broken school campus rules regarding alcohol, tobacco, and other drugs (ATOD), such as being in possession of ATOD or related paraphernalia. Classes aim to educate youth about the dangers of ATOD use, offer alternatives to substance use, and prevent future infractions.??

e) Community-Based Processes:

This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.?
Building and sustaining of community-based coalitions (there are currently 20 SABG Prevention-funded coalitions within the state).??
Strategic planning at state and local levels, which includes bringing together key stakeholders from the following sectors to the table to engage in effective planning:?
Youth,?
Parents,?
Law enforcement,?
Schools,?
Businesses,?
Media,?
Youth-serving organizations,?
Religious and fraternal organizations,?
Civic and volunteer groups,?
Healthcare professionals,?
State, local, and tribal agencies with expertise in substance abuse, and;?
Other organizations involved in reducing substance abuse.?

f) Environmental:

This strategy establishes, or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.?
The passing of local ordinances that affect the sale, manufacturing, or availability of ATODs, including alcohol tax increases, moratoriums on alcohol/marijuana advertising around schools, parks, or places where youth are present, and moratoriums on the establishment or placement of medical marijuana stores in local areas.?
The review of current ATOD policies within schools and/or communities, including the review of policies related to prevention of ATOD use amongst youth, review of policies regarding "punishment" of youth who use or are caught, what prevention strategies are used to decrease repeat behavior, and the eventual revision of policies to be prevention focused, rather than punishment focused.?

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

If yes, please describe

AHCCCS collaborates closely with several other state agencies and entities to ensure there is communication regarding which primary prevention services are being funded and implemented throughout the state. Examples include the Substance Abuse Coalition Leaders of Arizona (SACLAz), Governor's Office of Youth Faith and Family (GOYFF), National Guard Counter Drug Task Force, Arizona Substance Abuse Partnership (ASAP), AHCCCS staff overseeing other prevention initiatives.

These collaborations allow AHCCCS to ensure there is no service duplication, and for AHCCCS to gather information regarding any

gaps and additional needs in services throughout the state. AHCCCS is also aware of the location and strategies of current Drug Free Communities (DFC) coalitions throughout the state to address this as well.

Additionally, primary prevention providers submit contracted-required prevention deliverables to AHCCCS that allow AHCCCS to assess the use of SABG dollars against other funds. These deliverables include planning deliverables such as provider budgets, logic models, strategic plans, action plans, and evaluation plans as well as Contractor Expenditure Reports (CERs) showing actual expenditures under SABG prevention. AHCCCS staff reviews CERs from a programmatic and fiscal lens to ensure appropriateness and allowability under the grant.

In addition, AHCCCS' use of the Strategic Prevention Framework (SPF) model allows for comprehensive statewide assessment of prevention needs, resources, and capacity that helps AHCCCS identify gaps, duplications, and other prevention needs.

Narratve Question

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Evaluation

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

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

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

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

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

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☑ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use
- ☑ Binge use
- ☑ Perception of harm
- **c)** ☑ Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

AHCCCS is the agency responsible for matters related to behavioral health and substance use, and provides oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona. AHCCCS contracts with Regional Behavioral Health Authorities (RBHAs) and Managed Care Organizations (MCOs) to oversee the provision of comprehensive physical and behavioral health services to eligible persons with a Serious Mental Illness (SMI) designation or Serious Emotional Disturbance (SED).

AHCCCS also operates the American Indian Health Program (AIHP), a Fee-For-Service program that is responsible for care for American Indian members who select AIHP. AHCCCS has intergovernmental agreements with the Tribal Regional Health Authorities (TRBHAs) for the coordination of behavioral health services for American Indian members enrolled with the TRBHA.

There is an array of outpatient covered health services for individuals diagnosed with a SMI, SED, general mental health (GMH) disorders, substance use disorders (SUDs), and those individuals with co-occurring mental health and substance use disorders. A vast majority of the outpatient services are delivered at Integrated Health Homes/Integrated Clinics, Outpatient Treatment Clinics, Outpatient Substance Use Clinics, Medication Assisted Treatment (MAT) Clinics, and Federally Qualified Health Clinics. The goal is to serve the whole person and to provide behavioral, medical, and physical health services. Most of the facilities have primary care physicians on site to address physical health needs; this also includes pharmacy and laboratory services. If a clinic/facility site does not have integrated care or primary care services on site, it is the expectation that staff provide coordination of care between behavioral, medical, and physical health providers to ensure the needs of the whole person are addressed. This integrated system allows for reduced fragmentation and improved health outcomes for members.

AHCCCS has participated in the Targeted Investment Program which has driven the implementation of integrated care across the State of Arizona. Individuals with an SMI designation or SED are offered an array of covered health and community based services, including, but not limited to:

For adult members:
Case Management
Assertive Community Treatment (ACT) as determined by need
Supportive Level of Care as determined by need
Connective Level of Care as determined by need
Psychiatric services and assignment to a Behavioral Health Medical Provider
Evaluation and assessments
Medication/Medication Management
Nursing Services
Rehabilitation Services
Employment Services
Educational Services
Housing Services and Community Living Support
Applications, rental assistance
Primary Care Services and coordination of care between behavioral health and medical/physical providers
Substance Use services, referrals, and coordination of care
MAT as indicated
Substance Use Counseling (both individual and group as indicated) provided by Substance Use Specialists/Counselors
Coordination of crisis services as determined by need

As an example: a Crisis Mobile Team visits/Well Watch if a person is experiencing symptoms of their illness
Crisis Mobile Team visits/Well-Watch can occur during the day, evenings, weekends and can be coordinated 24/7 to ensure a person has the supports to assist them through a challenging time.
Counseling services
Individual
Group
Non-emergent transportation and/or coordination of transportation services
Peer Support Services
Family Support Services
Assistance with applying for benefits
AHCCCS/Medicaid benefits
Social Security
Food Stamps
Public Assistance
Evidenced Based Practices (EBP) coordination of care/referrals, as indicated
Assertive Community Treatment (ACT)
Cognitive Behavioral Therapy (CBT)
Dialectical Behavior Therapy (DBT)
Applied Behavior Analysis (ABA)
Trauma Informed Care
American Association of Addiction Medicine/ASAM CONTINUUM assessment for persons with substance use challenges to determine levels of care
Motivational Interviewing
Other EBP's as indicated by assessments and treatment planning
Coordination of care and referrals to community based services and natural supports
Overall development of an Individual Services Plan (ISP) to address the unique needs of the whole person

For children/adolescents, including those with a SED, AHCCCS has implemented the Child and Family Team (CFT) practice. The CFT practice is utilized with all Medicaid eligible children, adolescents and young adults under the age of 21, who are receiving services through the children's T/RBHA system. The CASII is implemented with all children and adolescents ages six to 18 who are receiving services through the T/BRHA system.

The behavioral health services provider is responsible for facilitating a CFT practice; the CFT facilitator for a child and family with complex needs has the specialized training and skill set to perform this function. The CFT is meant to facilitate a consensus in the development of the child's/adolescents' service plan goals and interventions. The child/adolescent, their family members (biological, foster parents, other individuals of support, as determined), Department of Child Safety (DCS) case manager/s, behavioral health case manager/s, advocates can also learn to lead CFTs.

In the Arizona CFT practice 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), Department of Economic Security/Division of Developmental Disabilities (DES/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 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 Behavioral Health Medical Practitioner (BHMP) and/or primary care physician (PCP). 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 Individual Service Plan (ISP). Several stressors/risk factors are considered by the CFT when reviewing the child's and family's level of complexity, including environmental stressors such as changes in primary caregiver, inadequate social support, housing problems, mental health or substance use concerns. The team also considered out-of-home setting (group home, therapeutic foster care, etc.) and use of crisis or inpatient services.

One method for determining complexity of needs and intensity of service delivery is through the application of the CALOCUS for children ages 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.

For individuals with co-occurring mental health and substance use disorders, outpatient providers provide MAT services, prevention, treatment, ongoing SUD counseling, coordination of care, and referrals to community based services; this also includes natural supports and resources such as Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, etc.

MAT is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use

disorders. For those with an opioid disorder (OUD), medication addresses the physical challenges that one experiences when they stop taking opioids. MAT can help to re-establish normal brain function, reduce substance cravings, and prevent relapse. The longer a person engages in the treatment, the more the individual will be able to manage their dependency and move forward toward recovery.

An important piece of the MAT approach is that the medications are "assisting" other components of treatment. To increase the benefit that individuals receive from psychosocial intervention, services should be best practice. Some examples of best practice for persons who have substance use disorders include, Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Moral Reconation Therapy, Peer and Recovery Support Services, Twelve Step Facilitation, and Contingency Management. Arizona has 24/7 Access Point Locations providing opioid treatment services 24 hours a day, seven days a week to serve individuals seeking treatment.

MAT services are offered in various settings including Opioid Treatment Programs (OTPs) and Office-Based Opioid Treatment (OBOTs). An OTP is any treatment program certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide medication-assisted treatment for persons diagnosed with OUD. These programs are authorized to administer and distribute all forms of MAT: methadone, buprenorphine (Suboxone/Subutex) and naltrexone. Additional support services within the OTP may include case management, peer support, individual counseling, group counseling, and other types of support services.

An OBOT program allows for a qualified primary care physician (PCP) to provide opioid treatment services in their office based settings. Federal guidelines allow qualified physicians in the OBOT to prescribe medications for OUD in their office setting although it is required that the physician has the ability to connect their patients to the appropriate level of counseling and other appropriate services, as indicated by the needs of the individual and their treatment plan.

AHCCCS also supports evidence-based Permanent Supportive Housing (PSH) models, including Housing First, for serving persons experiencing homelessness, persons with behavioral health needs including mental illness or substance use disorders (SUD) and/or other hard to serve populations is premised on: 1) access to and availability of both affordable housing subsidies and capacity, and 2) individualized wrap around housing focused supportive services to support housing placement, stability and coordination with member's other service goals and resources.

AHCCCS addresses transitions from the Arizona State Hospital, through the screening of members to be 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.

AHCCCS has partnerships and an Interagency Service Agreements(ISA) with the Rehabilitation Services Administration (RSA) Vocational Rehabilitation (VR) to connect members to employment and educational support and opportunities. The VR program provides a variety of services to persons with disabilities and, with the ultimate goal to prepare for, enter into and/or retain employment. The VR program is a public program funded through a federal/State partnership and administered by the RSA, which in Arizona falls under the Arizona Department of Economic Security (DES).

Additionally and not related to the ISA, RSA/VR has assigned one of their offices to work with individuals transitioning to the community from the Arizona State Hospital and also has a VR Counselor assigned to the Human Services Campus. The VR Counselor at the Human Services Campus assists people who are experiencing homelessness and housing insecurity and wanting to re-enter the workforce. The Human Services Campus is Maricopa's largest homeless services provider.

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

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

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

AHCCCS' System of Care is a spectrum of effective community-based services and supports for individuals with, or at risk for, mental health or other challenges and their families that is organized into a coordinated network, builds meaningful partnerships with members and their families, and addresses their cultural and linguistic needs, in order to help them to a function better at home, in school, in the community, and throughout life.

Providers, MCOs and FFS Programs are required to ensure delivery of services is consistent with the following values, principles, and goals:
1. Timely access to care,
2. Culturally competent and linguistically appropriate care,
3. Identification of the need for and the provision of comprehensive care coordination for health service delivery,
4. Integration of clinical and non-clinical health care related services,
5. Education and guidance to providers on service integration and care coordination,
6. Provision of chronic disease management including self-management support,
7. Provision of preventive and health promotion and wellness services,
8. Adherence with the Adult Behavioral Health Service Delivery System-Nine Guiding Principles, and the Arizona Vision and Twelve Principles for Children Behavioral Health Service Delivery,
9. Promotion of evidence-based practices through innovation,
10. Expectation for continuous quality improvement,
11. Improvement of health outcomes,
12. Containment and/or reduction of health care costs without compromising quality,
13. Engagement of member and family members at all system levels,
14. Collaboration with the greater community,
15. Maintenance, rather than delegation of, key operational functions to ensure integrated service delivery,
16. Embrace of system transformation, and
17. Implementation of health information technology to link services and facilitate improved communication between treating.

AHCCCS has developed an Adult System of Care (ASOC) following the Nine Guiding Principles to promote a recovery focused continuum of coordinated community and facility based services and supports for adults with, or at risk for, behavioral health challenges. The ASOC is organized into a comprehensive network to create opportunities to foster recovery and improving health outcomes by:

Building meaningful partnerships with individuals served,
Addressing the individuals' cultural and linguistic needs and preferences, and
Assisting the individual in identifying and achieving personal and recovery goals.

Within the Children's System of Care, Arizona's Child and Family Team (CFT) practice model blends shared concepts of the 12 Arizona 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. The CFT considers involvement of the child in Juvenile Justice (Probation or Parole), Department of Economic Security/Division of Developmental Disabilities (DES/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, contributes to the level of service coordination required, as well as consideration by team members of the individual mandates for each agency involved. Providers are required to incorporate the Arizona Model in all aspects of service delivery to children and families at all levels of need/acuity as well as children with complex needs or who are determined to have a SED.

In collaboration with the child and family and others, MCOs are required to 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 are tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.

AHCCCS further requires that MCOs develop, manage, and monitor provider use of Evidence Based Programs and Practices (EBPP) including, but not limited to:
1. Intake, assessment, engagement, treatment planning, service delivery, inclusion of recovery interventions, discharge planning, relapse prevention planning, harm reduction efforts, data and outcome collection, and post-discharge engagement,
2. EBPPs used by all providers for the treatment of SUD, including MAT, integrated into services as appropriate,
3. Trauma Informed Care,
4. Gender based treatment,
5. LGBTQIA+,
6. Culturally appropriate,
7. Criminal Involvement,

8. Adolescent specific, and
9. Development and use of Promising Practices, if no EBPP is available.

3. Describe your state's case management services

AHCCCS covers provider case management as a supportive service intended to improve treatment outcomes and meet individuals' Service or Treatment Plan goals. Examples of case management activities include but are not limited to:
Assistance in maintaining, monitoring, and modifying behavioral health services.
Assistance in finding necessary resources other than behavioral health services.
Coordination of care with the individual/Health Care Decision Maker (HCDM), designated representative (DR), healthcare providers, family, 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 care services, nursing services, and family counseling) and providers.
Assisting individuals in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach.
Outreach and follow-up of crisis contacts and missed appointments.
Provider case managers are responsible for monitoring the individual's current needs, services, and progress through regular and ongoing contact with the individual. The frequency and type of contact is determined during the treatment planning process, and is adjusted as needed, considering clinical need and individual preference, though generally falls within one of the following categories
1. Assertive Community Treatment (ACT) Case Management (Adult): One component of a comprehensive model of treatment based upon fidelity criteria developed by the Substance Abuse and Mental Health Services Administration. ACT case management focuses upon individuals with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems (e.g., social services, housing services, health care).
2. High Needs Case Management (Children/Adolescents): Focuses upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvements for whom less intensive case management would likely impair their functioning. Children with high service intensity needs who require the assignment of a high needs case manager are identified as:
a.
Children 0 through five years of age with two or more of the following:
i. Other agency involvement; specifically: Arizona Early Intervention Program (AzEIP), DCS, and/or DES/DDD, and/or
ii. Out of home placement for behavioral health treatment (within past six months), and/or
iii. Psychotropic medication utilization (two or more medications), and/or
iv. Evidence of severe psycho-social stressors (e.g., family member serious illness, disability, death, job loss, eviction), and
b. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.
3. Medium Level of Intensity Case Management (Adult): Focuses upon individuals for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance, support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.
4. Low Level of Intensity Case Management (Adult): Focuses on individuals who have largely achieved recovery and who are maintaining their level of functioning. Case management involves careful monitoring of the individual's care and linkage to service. Caseloads may include both individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.
In addition to the levels of Case Management, as listed above, Forensic Assertive Community Treatment Teams (FACT) were also created in Maricopa County, Arizona. The FACT teams address the unique needs of people who have been diagnosed with a SMI and are justice involved and have had involvement with the criminal justice system. The goal of the FACT teams is to reduce recidivism and assist members with high needs through an array of community based services, resources and supports.
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, and
Reduce hospitalizations and contact with the criminal justice system, improve health outcomes, and help establish and strengthen natural community supports.
FACT team employees have experience in psychiatry, nursing, social work, rehabilitation services, substance-abuse interventions, employment support, independent-living skills, and housing. A key member of the team is a peer who has lived experience with behavioral health challenges and prior interaction with the criminal justice system. The team assists members with adhering to treatment plans, activities of daily living, employment-related services, finding and maintaining affordable housing, budgeting, obtaining benefits, and engaging in community activities through delivering services in accordance with SAMHSA evidence-based practices (EBP/s).

AHCCCS/Maricopa County also developed Medical Assertive Community Treatment Teams (MACT). MACT employees have experience in psychiatry (Behavioral Health Medical Provider), nursing, social work, rehabilitation services, substance use specialists (licensed) who provide individual and group counseling, interventions/supports, employment support, independent living skills, and

housing supports. The difference between a regular ACT team and the MACT team is that the individuals not only have an SMI designation but also have significant medical comorbid conditions. The MACT team employs a Primary Care Medical Provider and monitors closely the medical and physical condition of the member along with their behavioral health condition.

MCOs are required to submit an annual Provider Case Management Plan that addresses how the Contractor will implement and monitor provider case management standards and caseload ratios for adult and child individuals. The Provider Case Management Plan includes performance outcomes, lessons learned, and strategies targeted for improvement.

MCOs must also ensure that provider sites where provider case management services are delivered have regular and ongoing member and/or family participation in decision making, quality improvement, and enhancement of customer service.

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

AHCCCS' System of Care includes a comprehensive continuum of coordinated community and facility based services and supports for adults with, or at risk for, behavioral health challenges and for children with a SED. Case managers are responsible for monitoring the individual's current needs, services, and progress through regular and ongoing contact with the individual. The frequency and type of contact is determined during the treatment planning process, and is adjusted as needed, considering clinical need, and individual preferences. The goal is to provide services in the least restrictive environment/setting and to provide outpatient services and community supports to divert crisis presentations and inpatient admissions.

Case management services, home visits (face -o-face depending on the situation and virtual due to COVID-19), appointments with the Behavioral Health Medical Provider, counseling, and other supports are available. These services are intended to address the treatment needs of a person to assist them in the community and have an impact on reduced hospitalizations and crisis situations. Regular and ongoing contact with the person, their family or other persons of support is essential to assisting them during their recovery journey.

In the event of a hospitalization, MCOs, RBHAs, and providers are required to track inpatient admissions, lengths of stay, and discharge dates. MCOs and RBHAs have care managers that track and monitor the status of individuals in hospitals/inpatient facilities to ensure coordination of care and discharge planning occurs to reintegrate back to the community. There are inpatient protocols in place for case managers/providers to have ongoing contact with the inpatient social workers and Behavioral Health Medical Providers, while the person is inpatient, to ensure coordination of care, and appropriate discharge planning occurs.

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

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

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	0.26%	0.07%
2.Children with SED	1.17%	0.61%

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.

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.

Statewide Prevalence (B):

To calculate the Statewide Prevalence (B) of Adults with SMI, the following formula was used:

Prevalence Rate = (All new and pre-existing cases of a specific disease during a given time period) / (Total Population during the same time period) and expressed as a %.

Where the numerator (All new and pre-existing cases of a specific disease during a given time period) is equal to all individuals age 18 or older who had an SMI designation (case) during the time period of 7/1/2020 - 6/30/2021. And the denominator (Total Population during the same time period), is equal to the total state population of individuals 18 or older during the same time period.

Therefore, the Statewide Prevalence Rate (B) of Adults with SMI is equal to (The total number of individuals 18 or older identified with a new/pre-existing SMI case between 7/1/2020 - 6/30/2021) over (The total state population of individuals 18 or older during the same time period) expressed as a %.

To calculate the Statewide Prevalence (B) of Children with SED, the following formula was used:

Prevalence Rate = (All new and pre-existing cases of a specific disease during a given time period) / (Total Population during the same time period) and expressed as a %.

Where the numerator (All new and pre-existing cases of a specific disease during a given time period) is equal to all individuals age younger than 18 who had an SED diagnosis (case) during the time period of 7/1/2020 - 6/30/2021. And the denominator (Total Population during the same time period), is equal to the total state population of individuals younger than 18 during the same time period.

Therefore, the Statewide Prevalence Rate (B) of Children with SED is equal to (The total number of individuals younger than 18 identified with a new/pre-existing SED case between 7/1/2020 - 6/30/2021) over (The total state population of individuals younger than 18 during the same time period) expressed as a %.

Statewide Incidence (C):

To calculate the Statewide Incidence (C) of Adults with SMI, the following formula was used:

Incidence Rate = (Total number of new cases of specific disease during a given time period) / (Total population at risk during the same time period) and expressed as a %.

Where the numerator (Total number of new cases of a specific disease during a given time period) is equal to all individuals age 18 or older who had an SMI designation (case) during the time period of 7/1/2020 - 6/30/2021. And the denominator (Total Population at risk during the same time period), is equal to the total state population of individuals 18 or older during the same time period.

Therefore, the Statewide Incidence Rate (C) of Adults with SMI is equal to (The total number of individuals 18 or older identified with a new SMI case between 7/1/2020 - 6/30/2021) over (The total state population of individuals 18 or older at risk during the same time period) expressed as a %.

To calculate the Statewide Incidence (C) of Children with SED, the following formula was used:

Incidence Rate = (Total number of new cases of specific disease during a given time period) / (Total population at risk during the same time period) and expressed as a %.
Where the numerator (Total number of new cases of a specific disease during a given time period) is equal to all individuals age younger than 18 who had an SED diagnosis (case) during the time period of 7/1/2020 - 6/30/2021. And the denominator (Total Population at risk during the same time period), is equal to the total state population of individuals younger than 18 during the same time period.
Therefore, the Statewide Incidence Rate (C) of Children with SED is equal to (The total number of individuals younger than 18 identified with a new SED case between 7/1/2020 - 6/30/2021) over (The total state population of individuals younger than 18 at risk during the same time period) expressed as a %.

Criterion 3

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

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

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

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

Criterion 4

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

AHCCCS contracts with Regional Behavioral Health Authorities (RBHAs) to cover over one million Arizonans throughout the state including rural and tribal areas. For the purposes of RBHA coverage, Arizona is divided into three Geographic Services Areas (GSAs) to serve the unique needs of each region of the state. While all three GSAs include rural areas, the northern and southern GSAs include most of the rural counties and regions characterized by low general population and population densities. A significant portion of Arizona's geography consists of reservation and tribal lands and similar to the RBHA structure, there are four Tribal Regional Behavioral Health Authorities (TRBHAs) that fulfill similar roles for their designated tribal groups. Each of these groups is responsible under contract with AHCCCS to establish a services network that meets the contractual requirements for all RBHAs while allowing the RBHA or TRHBA to address the specific needs of their GSA including delivery of services in a rural context. Within this service network, AHCCCS has Non-Title XIX/XXI state general funds to provide housing subsidies for persons experiencing homelessness who have a Serious Mental Illness (SMI) designation. As with other AHCCCS programs and services, these housing subsidies and supports are also allocated to each GSA and provide housing to both urban and rural populations. Homeless coordination is one way in which the RBHA/TRBHA structure meets the needs of rural communities and how collaboration and coordination with other systems have directly improved care and services for members in rural areas. AHCCCS Contractor Operations Manual Policy 448 (Housing) policies require all RBHA and TRBHA contractors and their networks of clinics, services, and housing programs to participate in the local HUD Continuum of Care (CoC) for their jurisdiction. This includes participation, when possible, in local case conferencing, homeless coordinated entry systems, care coordination, and regional homeless planning efforts. For RBHAs and TRBHAs serving rural or tribal Arizona areas, participation is in the Balance of State CoC (BoSCoC covers the 13 rural counties of Arizona outside of Maricopa County/Phoenix and Pima County/Tucson) and HMIS system. In addition to the aforementioned participation in regional planning and other coordination efforts, RBHA and their providers have established innovative partnerships to increase services to SMI and other persons with behavioral health needs in rural areas. For example, in many rural southern Arizona counties, there are no homeless service sites, shelters, or facilities to serve as HUD CoC Coordinated entry sites for purposes of connecting homeless persons, including those with mental health needs, to HUD homeless programs and housing. To address this, the southern RBHA, Arizona Complete Health (AZCH) required all of their health homes and housing providers to serve as CoC Coordinated Entry sites for persons with behavioral health needs. This includes conducting CoC required housing assessments, HMIS data entry, and enrollment on the local by name list of persons seeking CoC housing. The site can also enroll the individual, if eligible, in AHCCCS housing programs in addition to other Medicaid covered services. AHCCCS is currently working with its northern RBHA, and the BoSCoC to replicate the southern structure in its northern RBHA and network. Similarly, rural communities and counties in Arizona have had the opportunity to apply for Project for Assistance to Transition from Homelessness (PATH) grants during open procurement opportunities as administered by AHCCCS. PATH teams serving the BoSCoC also coordinate with the regional CoCs and serve as coordinated entry points to enroll members in CoC services and housing lists especially in rural areas where homeless shelters, service sites, or access points may be limited.

PATH utilizes federal and state funding dollars to contractors who serve as a point of contact for food, clothing, water, blankets, shelter, and other basic living skills individuals require to reduce homelessness for individuals with an Serious Mental Illness (SMI) designation. PATH funding is critical in creating linkages with the behavioral health crisis system, aiding enrollment into the behavioral health system, obtaining medical records, picture ID, and social security cards. PATH funding also allows for affordable housing options and conducting outreach and in-reach to adults 18 and over who are chronically homeless and have a Serious Mental Illness diagnosis.

PATH services are provided in Coconino, Mohave, and Yavapai counties through Catholic Charities; in Maricopa County through Community Bridges Inc; Cochise County through Good Neighbor Alliance; and in Pima County through La Frontera. Of those counties where services are provided, the majority of the population served is rural. The targeted services provided by PATH providers are outreach services (i.e., case management, peer support, housing services, individual living skills, etc.); Screening and diagnostic treatment (i.e. SMI determinations); Habilitation and rehabilitation; community mental health (i.e., create linkages with behavioral health system); Substance use treatment; Referrals for primary healthcare, job training, educational services, and housing services, and SOAR.

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

The Arizona Health Care Cost Containment System (AHCCCS) is awarded the Project for Assistance to Transition from Homelessness (PATH) funding from SAMHSA. Arizona finalized a competitive Request for Proposal (RFP) to PATH contractors in May 2020. These current contracts are for three initial years with two one-year options to extend, not to exceed a total contracting period of five years.

AHCCCS receives the PATH grant to provide outreach services to persons who are homeless, at risk of becoming homeless, and those with an SMI designation, including those with a co-occurring substance use disorder to six out of the fifteen counties in

Arizona; Maricopa, Pima, Cochise, Coconino, Yavapai, and Mohave. For Fiscal Year (FY) 2021 Arizona was allotted $1,349,288 with a minimum match of $449,763. The PATH grant provides an array of services, which include; community health screening, case management, and outreach to locations where homeless individuals commonly gather, (i.e., food banks, parks, vacant buildings, and the streets). PATH staff provides community education, field assessments and evaluations, hotel vouchers in emergent situations, assistance in meeting basic needs such as: food stamps, health care, and applying for Medicaid and/or SSI/SSDI. Additionally, PATH staff can assist individuals in obtaining behavioral health case management, medications, moving assistance, and referrals for transitional and permanent housing. Services are documented within each individual's case plan and the case plan is updated as needed, or every six months.

AHCCCS works with the aforementioned state partners, health plans and other stakeholders to provide needed services to homeless individuals. Statewide PATH teams are integrated into CoC HMIS coordination activities including coordinated entry, case conferencing, and use of By Name List to prioritize housing for most vulnerable at risk persons. On an annual basis, funded contractors, volunteers perform a point-in-time street shelter count to determine the number of individuals in Arizona, those with an SMI designation, or co-occurring illness substance disorder.

The table below is 2020 broken out by each county within Arizona.

County/Total Homeless Count/Unsheltered
Maricopa (Phoenix): 7,419/3,767
Pima (Tucson): 1,1660/579
Balance State: 1,175/1,061

The PATH contractors utilize best or promising practices to target street outreach and case management to serve the most vulnerable adults who are literally or chronically homeless. Once the individual is enrolled into the PATH program, the PATH Contractor will assist with applying for mainstream services such as SSI/SSDI, housing, Temporary Assistance for Needy Families, food stamps, medical resources, etc. Services are documented within the individual's case plan and the case plan will be updated as needed or every three (3) months.

AHCCCS has recognized the importance of housing not only in solving homelessness, but as a social determinant and key factor in improving member health outcomes and reducing health care costs, especially for persons experiencing homelessness with physical or mental health issues. Through state XIX/XXI funds, AHCCCS is able to provide housing subsidies for approximately 2,800 persons each year. These housing subsidies are targeted primarily to serve homeless persons with an SMI designation, although limited subsidies are also available for homeless persons identified with General Mental Health/Substance Use Disorders. All AHCCCS housing funds are currently administered through the RBHAs for each GSA, but beginning in October of 2021, AHCCCS housing will be managed by a contracted statewide Housing Administrator to standardize processes and increase programmatic effectiveness.

AHCCCS also received limited Non-Title XIX/XXI state capital funding to allow it to acquire additional SMI homeless housing capacity. Despite these resources, current statewide housing waitlists of homeless persons with an SMI designation average between 2,800 to 3,000 persons at any given time due to need. AHCCCS endorses evidence-based permanent supportive housing (PSH) and "Housing First '' approaches in its housing programs. To this end, members receiving housing subsidies to address their homelessness also receive individualized wrap- around supportive services to assist members in attaining and maintaining housing. To this end, most wrap-around supportive services are Medicaid reimbursable through AHCCCS's Managed Care Organizations (MCOs).

To evaluate the efficacy of AHCCCS housing programs, AHCCCS compared health care utilization and expenditures of members placed in its housing programs a year prior to their housing placement while homeless to their utilization and costs in the year subsequent to their housing placement. Data showed significant decreases in crisis and inpatient health and behavioral health utilization including a 31 percent reduction in emergency department visits, 44 percent reduction in inpatient admissions, and an 89 percent reduction in behavioral health residential facility admissions. Overall, members in housing showed a 45 percent reduction in total cost of care for an average cost reduction of $5,563 per month per member across the 3,040 persons in the evaluation. In recognition of the impact of housing and housing services, housing is a major focus of AHCCCS current Whole Person Care Initiative to address social risk factors to health. As part of this initiative, AHCCCS has submitted an amendment to its 1115 Medicaid waiver renewal to CMS.

The Housing and Health Opportunities (H2O) proposal seeks to further expand Medicaid reimbursable housing supports and wrap around services to persons with an SMI designation as well as other homeless sub populations including persons with physical disabilities and physical health care conditions, young adults, and others with frequent inpatient or crisis utilization. Key waiver amendment service enhancement proposals include allowing for additional homeless transitional settings to expedite persons moving out of homelessness and into permanent housing, one-time housing supports including rent deposits, move-in assistance and eviction prevention services, increase of eligible populations for wrap around housing supports and increased outreach capacity to expand coverage. AHCCCS anticipates CMS response to its amendment in the current waiver renewal process. AHCCCS is also working closely with the local Continua of Care in Arizona, its sister state agencies, and other key stakeholders to expand homeless services and housing options.

AHCCCS is also involved in a number of data sharing efforts to increase coordination with the homeless system. In June, AHCCCS began a HMIS/AHCCCS data share to better serve homeless persons with potential COVID-19 infections. Names and locations of individuals screened and identified with COVID-19 in HMIS experiencing homelessness, including those with an SMI determination, were provided to their MCOs and providers for follow up. This resulted in significant care coordination improvement and follow up including clinical re-engagement, housing placement, and outreach. Based on this and other homeless collaborations and data sharing efforts, AHCCCS is part of a collaborative effort funded by charitable sources to integrate data from all three Arizona CoC HMIS systems, AHCCCS and the Arizona Department of Economic Security (DES). The goal of this sharing is to further understand Arizona's homeless population and needs and to improve coordination between the homeless provider system, AHCCCS/Medicaid resources and mainstream homeless programs. The goal of the grant funding and pilot is to have a functional data sharing infrastructure and system in place by the end of 2022.

AHCCCS' MHBG efforts work in tandem with PATH efforts to ensure PATH enrollees receive the entire continuum of services they may need for recovery. PATH subrecipients are required to have Memorandums of Understanding (MOUs) with local RBHAs and TRBHAs to ensure information sharing, and referral resources as needed between the PATH subrecipients and other administrators of Arizona's behavioral health systems. MHBG subrecipients are held to contractual and policy language regarding the outreach of homeless populations to ensure services are being provided to Arizona's most vulnerable populations. AHCCCS monitors the adherence and compliance to these parameters through various reporting mechanisms, including annual Operational Reviews (ORs). If subrecipients do not meet the requirements through the OR process, AHCCCS develops a Corrective Action plan for the subrecipients and offers technical assistance as needed to the subrecipients.

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

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

MHBG subrecipients are held to contractual and policy language regarding the outreach of older adult populations to ensure services are being provided to Arizona's most vulnerable populations. AHCCCS monitors the adherence and compliance to these parameters through various reporting mechanisms, including annual Operational Reviews (ORs). The OR includes the submission of all documentation from the subrecipient to show the progress made, as well as any administration policies, to outreach and engage this population. If subrecipients do not meet the requirements through the OR process, AHCCCS develops a Corrective Action plan for the subrecipients and offers technical assistance as needed to the subrecipients.

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 leverages several financial resources and funding streams to provide a well-supported network of behavioral health providers to deliver covered services under the various contracted health plans. Although the Division of Grants Administration oversees the administration of grants and other Non-Title XIX/XXI funding, staff work collaboratively across divisions to leverage county, state, and federal dollars (Title XIX/XXI and Non-Title XIX/XXI) effectively and appropriately for services included in the state plan. Title XIX/XXI funds provide care for members' physical and behavioral health care needs, including behavioral health prevention/promotion, treatment, recovery, and other support services under a single one managed care or fee-for-service health plan. Non-Title XIX/XXI funds provide coverage for additional mental health services not covered by Title XIX/XXI, and for certain members who are not eligible for Title XIX/XXI but who meet other eligibility criteria. These other funding sources may include:
the Children's Behavioral Health Fund for children's services including SED,
the Mental Health Block Grant for SED, SMI, and ESMI/FEP,
Maricopa County, Pima and Coconino County funds for certain children's or SMI services and/or Court Ordered Evaluation/Pre-Petition Screening,
SMI General Fund,
SMI Housing General Fund,
Supported Housing General Fund,
SMI Housing Trust Fund,
Emergency COVID-19 grant for members with co-occurring illness,
COVID-19 Emergency Response for Suicide Prevention, and
state crisis service dollars.

Each funding source may have its own staffing or training requirements. Larger system training requirements are described below.

In accordance with ACOM Policy 407, AHCCCS requires that Contractors establish and maintain a Workforce Development Operation (WFDO) and employ a Workforce Development Administrator. The WFDO works together with the MCO's Network and Quality Management functions to ensure the provider network has sufficient workforce capacity, and is staffed by a workforce that is interpersonally, clinically, culturally, and technically competent in the skills needed to provide services. The WFDO is the organizational structure MCOs utilize to monitor and assess current workforce capacity and capability, forecast and plan future workforce capacities and capabilities, and, when indicated, deliver technical assistance to provider organizations to strengthen their Workforce Development (WFD) programs. AHCCCS further requires all MCOs to participate in a Single Learning Management System (LMS), and to collaborate with all other AHCCCS MCOs to use the LMS to administer the delivery, documentation, tracking and reporting of all required education and training programs.

AHCCCS requires that Contractors provide, at a minimum, annual training/s to support and develop law enforcement agencies' understanding of behavioral health emergencies and crises. Contractors are also contractually required to have regular and ongoing training for providers to assist members with how to access both Medicaid compensable services as well as Non-Medicaid funded services.

AHCCCS is committed to workforce development and support of the medical residency and dental student training programs in the State of Arizona and expects MCOs to support these efforts. AHCCCS also requires that MCOs attempt to contract with graduating residents and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas. AHCCCS encourages MCOs to contract with or otherwise support the many Graduate Medical Education (GME) Residency Training Programs currently operating in the State and to investigate opportunities for resident participation in medical management and other committee activities.

In 2018, AHCCCS required all seven new ACC health plans and the three RBHAs to jointly fund a contract between the AZ Association of Health Plans (AzAHP) and an LM) provider who would be responsible for operating a single, statewide LMS for physical and behavioral health workforce training. RELIAS was the selectedLMS provider and remains under contract to provide LMS support to the MCOs, RBHAs and providers whose workforces use the system to deliver physical and behavioral health services training.

AHCCCS requires the use of an LMS in order to accomplish three goals:

To disseminate computer assisted policy and best practice education and training content to provider organizations across Arizona,
To collect and store training program transcripts and skill competency evaluations for provider staff and to ensure the transcripts and evaluations are available to staff and their employers upon request, and

To report training or competency requirements compliance for all AHCCCS policies or mandated practices requiring specific staff training or competency demonstrations.

The RELIAS LMS automatically collects and stores individual staff training and evaluation records. In addition, the LMS has the capability of supporting traditional in-person training and evaluation events and generating required compliance reporting. Included in the Relias LMS platform are training opportunities for the staff employed at the MCOs, RBHAs and providers to learn about the Mental Health Block Grant and services for members with SED, SMI, and/or ESMI/FEP.

AHCCCS divisions are sensitive and responsive to staffing and training needs for mental health services providers. For example, the AHCCCS Division for Fee for Service Management (DFSM) employs staff responsible for provider trainings, inclusive of behavioral health trainings. Some behavioral health trainings are posted online for ease of access for providers. If a provider has questions regarding billing and coding, they are then routed to the AHCCCS coding team. Additionally, the AHCCCS Division of Community Advocacy and Intergovernmental Relations (DCAIR) conducts educational sessions for individuals in the system, Regional Behavioral Health Authorities (RBHA) staff/provider staff and other stakeholders on various topics. AHCCCS DCAIR and the Office of Individual and Family Affairs (OIFA), have also established training requirements and credentialing standards for Peer and Recovery Support Service (PRSS) providing Peer Support within the AHCCCS programs, including qualifications, supervision, continuing education, and training. These are a few examples of additional mechanisms by which AHCCCS may ensure training for mental health providers.

Additional training is available at the health plan level through their Workforce Development Administrators, and other staff or departments. Some Contractors utilize Project ECHO for optimizing performance and spreading new medical knowledge throughout the provider network in a manner allowing community providers to learn from specialists, from each other, and for specialists to learn from community providers as well. One known example of this is the Early Psychosis Intervention (EPI) Project ECHO in the Northern region of Arizona, where project staff are responsible for providing training and education to community and system partners about the first episode of psychosis, facilitating monthly EPI ECHO sessions around cases and brief lectures. In the Southern region, contractors and providers have used Project ECHO to provide workshops on working with Black, Indigenous, and People of Color (BIPOC) persons and providing trauma-informed and culturally competent care.

CALOCUS/LOCUS/ECSII

AHCCCS is currently in the process of implementing the Child and Adolescent Level of Care Utilization System (CALOCUS) as the standardized mechanism for determining the level of intensity in case management supports necessary for children age 6-18. Service intensity assessment and planning is a critical independent element of overall person and family-centered service planning and is a collaborative process between the person or family served and their service providers. Cultural considerations and social determinants of health impact all these dimensions, and the CALOCUS systematically matches individuals and families' dimensional ratings to specific defined levels of case management support to ensure that their needs are met.

The CALOCUS is considered best practice for assessment of service intensity across multiple dimensions, as follows:
1. Risk of Harm
2. Functional Status
3. Medical, Addictive and Psychiatric Co-Morbidity as well as Developmental Disabilities
4. Recovery Environment:
O A-Stressors
O B-Supports
5. Treatment and Recovery History
6. Engagement and Recovery Status

ASAM

AHCCCS is in the process of implementing the ASAM CONTINUUM® assessment tool across the state of Arizona to improve treatment outcomes with greater assessment fidelity and proper level of care placement. This assessment tool provides the entire treatment team with a computerized clinical standard decision support system for assessing members with substance use disorders and co-occurring conditions. This is an evidenced based practice (EBP) established by the American Society of Addiction Medicine (ASAM) to assist clinicians in determining levels of care for persons who have substance use disorders.

AHCCCS has collaborated with the with the Managed Care Organizations (MCO) Workforce Development Administrators, ASAM, FEI Systems and the Arizona Association of Health Plans (AzAHP) to have the ASAM CONTINUUM® assessment training videos hosted on the Relias Learning Management System (LMS) platform. This will assist with "ease of access/use" for clinicians and providers and allow for standardized training reports.

Mental Health First Aid

AHCCCS has also implemented Mental Health First Aid Training in Arizona. Statistics show that approximately one (1) million people suffer a heart attack every year and teaching Cardiopulmonary Resuscitation (CPR) has become an important public health education initiative. Meanwhile, one (1) in four (4) Americans experience depression, anxiety and other mental health illnesses and

challenges. Mental Health First Aid may not be a bandage although it is an appropriate and critical part of training and education.

Mental Health First Aid is an eight (8) hour training that is available to anyone age 16 and older interested in learning about mental health. Each session can accommodate 25-33 participants. Participants learn a valuable five (5) step process to assess a situation, select and implement appropriate interventions and help a person experiencing a crisis or who may be exhibiting the signs and symptoms of mental illness.

AHCCCS is offering the training for employees at AHCCCS and there are also several trainings available in the community.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

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

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

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

b) Services for special populations:

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

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

Criterion 2

Criterion 3

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

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

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

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

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

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

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

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

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

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

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

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

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

i) Educational assistance (●) Yes ( ) No

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

Secret Shopper Surveys

AHCCCS conducts an annual, anonymous, secret shopper campaign that examines three contact points: access to care, adherence to state and federal regulations, and how to improve an individual/support networks experience.

AHCCCS internal staff anonymously call agencies that have frequent customer contact, such as the Medicaid Agency Applicant and Member Service Department, crisis agencies, health plans and a sample of individual providers who receive SABG funding. ? Each call captures the following items in an evaluation tool:
Caller Information,
RBHA,
Provider Information (i.e address, phone number,,
Level of Care,
Scenario,
Detail of call (i.e date, beginning and end time of call, wait time, name of person answering the phone, etc),
Were services answered within 48 hours,

Was the called offered an assessment, waitlist, transportation, childcare, treatment services, and
The culture of the call

The call data is aggregated to identify patterns and trends. ? The AHCCCS call team and subject matter experts debrief and determine a course of action to address opportunities for improvement.? AHCCCS provides feedback and data to contractors who receive SABG funding, who then work with their contracted service providers to improve access to care, adherence to state and federal regulations, and how to improve an individual/support networks experience.

Independent Case Review

CFR 45 § 96.136 requires an annual independent peer review process referred to as the Independent Case Review (ICR) which reviews the quality and appropriateness of SABG-funded treatment services. The review focuses on treatment programs and the substance abuse service system within each Geographic Service Area, rather than on the individual practitioners. The intent of the ICR process is to continuously improve the treatment services to alcohol and drug users within the state system. “Quality,” for purposes of this section, is the provision of treatment services which, within the constraints of technology, resources, and

individual/member circumstances, will meet accepted standards and practices which will improve individual/member health and safety status in the context of recovery. “Appropriateness,” for purposes of this section, means the provision of treatment services consistent with the individual's identified clinical needs and level of functioning.

On an annual basis, AHCCCS contracts for ICR through a competitive process.? A contractor is selected to review at least 200 case files with adequate sample sizes to meet the requirements for SABG.? The project reviewers are individuals with expertise in the field of alcohol and drug use treatment. Because treatment services may be provided by multiple disciplines, AHCCCS makes every effort to ensure that individual case reviewers are representative of the various disciplines utilized by the SABG. Individual case reviewers are also knowledgeable about the modality being reviewed and its underlying theoretical approach to addictions treatment, and are sensitive to the cultural and environmental issues that may influence the quality of the services provided.

As part of the ICR, a representative sample of individual/member records are reviewed to determine quality and appropriateness of treatment services, while adhering to all federal and state confidentiality requirements, including 42 CFR part 2. The reviewers examine the following:
Admission criteria/intake process,
Assessments,
Treatment planning, including appropriate referral, e.g., prenatal care and tuberculosis and HIV services,
Documentation of implementation of treatment services,
Discharge and continuing care planning, and
Indications of treatment outcomes.

Data is aggregated and published in a formal report used for quality improvement efforts.? Information specific to each contractor is provided, highlighting both strengths and opportunities for improvement.? Contractors are expected to respond with an actionable plan to address areas of concern.? AHCCCS compares data year over year to identify trends and patterns emerging for each contractor and statewide.??

Operational Review

AHCCCS regularly reviews its Contractors to ensure that their operations and performance are in compliance with federal and state law; rules and regulations; and the AHCCCS contract. The reviewers use a process approved by the Centers for Medicare and Medicaid Services (CMS) based upon the terms of the contract with AHCCCS.

The primary objectives of the Operational Review are to:
Determine if the Contractor satisfactorily meets AHCCCS’ requirements as specified in Contract, AHCCCS policies, Arizona Revised Statute, the Arizona Administrative Code and 42 CFR Part 438, Managed Care,
Increase AHCCCS knowledge of the Contractor’s operational encounter processing procedures,
Provide technical assistance and identify areas where improvements can be made, and identify areas of noteworthy performance and accomplishments,
Review progress in implementing recommendations made during prior reviews,
Determine if the Contractor is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures,
Perform Contractor oversight as required by the CMS in accordance with the AHCCCS 1115 Waiver, and
Provide information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR 438.364.

Contractors must complete a Corrective Action Plan (CAP) for any standard where the total score is less than 95 percent.

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, if applicable	( ) Yes (•) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

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

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

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

AHCCCS contracts with Regional Behavioral Health Authorities (RBHAs) to administer behavioral health services. RBHAs contract with a network of service providers similar to health plans to deliver a comprehensive array of services as outlined in the AHCCCS Medical Policy Manual (AMPM) detailing prevention, treatment, and recovery support services 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 PWID. It also ensures that sufficient outreach, specialized treatment, and recovery supports are available to this population. Contracts between AHCCCS and the RBHAs include language for preferential access to care and provision of interim services, as needed. 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 through contracts between AHCCCS and the RBHAs and referenced in the AHCCCS Contractors Operations Manual (ACOM), and AMPM.

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

The SABG supports treatment services for persons with substance use disorders, and is used to plan, implement, and evaluate activities to prevent and treat substance use. SABG treatment services must support the long-term treatment and substance-free recovery needs of eligible persons. Behavioral health providers must also submit specific data elements to identify special populations and record specified clinical information. In addition to the compliance related activities mentioned above, AHCCCS monitors program compliance through the following mechanisms:

Operational Review: An annual requirement to ensure Contractors satisfactorily meet AHCCCS' requirements as specified in contract.

AHCCCS Medical Policy Manual (AMPM): Manual for covered services for NT-XIX/XXI populations, referenced by AHCCCS and Providers to ensure appropriate use of services. Updated annually.

Contracts & Deliverables: AHCCCS employs multiple contracts and service agreements to ensure appropriate use of SABG funds. Providers are required to regularly submit deliverables related to program progress, financial standing, and/or ad-hoc information as requested by AHCCCS.

Secret Shopper: Annually, designated staff at AHCCCS will conduct "secret shopper" calls,

Independent Peer Review: An annual requirement of the SABG, the Independent Peer Review assesses the quality, appropriateness, and efficacy of treatment services provided in the State.

Tuberculosis (TB)

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

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

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

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

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

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

AHCCCS tracks and ensures compliance with all identified TB strategies utilizing a variety of compliance monitoring tools. These tools include annual/ad hoc list of tuberculosis cases annually to determine if any individuals received substance use disorder or treatment or mental health services during the reporting fiscal year. This deliverable(s) from the Arizona Department of Health Services (ADHS) is specified through an Interagency Service Agreement (ISA). Additionally, AHCCCS utilizes the Independent Case Review (ICR) to review the quality, appropriateness, and efficacy of treatment services as documented in the client records. The intent of the independent peer review process is to continuously improve the treatment services provided to individuals diagnosed with substance use disorder (SUD) within the State (45 CFR § 96.136) in order to ultimately improve client outcomes and recovery. The ICR process examines multiple aspects of the treatment records as part of the review process, including treatment planning, including reviewing if the appropriate referrals, such as tuberculosis services, were included.

Utilizing the AHCCCS Medical Policy Manual Policy (AMPM) 302-T1, Block Grants and Discretionary Grants, subrecipients of SABG are held to the following standards for TB procedures:

As specified in 45 CFR Part 96 Sect. 127, providers shall routinely make available tuberculosis services as defined in 45 CFR 96.121 to each individual receiving treatment for substance use, implement infection control procedures including the screening of patients, and identify those individuals who are at high risk of becoming infected. As per 45 CFR 96.121, TB services include:
Counseling the individual with respect to tuberculosis,
Testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment for the individual, and
Providing for or referring the individuals infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.

The Contractor shall submit the SABG TB Services Treatment Procedure and Protocol as specified in Contract. This deliverable shall include the following information items:

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

If compliance issues are identified through AHCCCS monitoring and reporting, AHCCCS initiates technical assistance sessions with sub-recipients to identify gaps, barriers, and/or any training needs that may need to be addressed. If warranted, AHCCCS will utilize procurement policies related to Corrective Action Planning (CAPs) and Corrective Action Letters to document deficiencies and identify steps to bring subrecipients back into compliance.

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

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

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

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

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

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

Syringe Service Programs

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

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

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

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

Criterion 8,9&10

Service System Needs

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

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

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

Service Coordination

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

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

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

Charitable Choice

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

2. Does your state provide any of the following:

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

Referrals

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

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

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

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

Patient Records

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

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

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

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

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

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including 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.

To assess the quality and appropriateness of treatment services throughout Arizona, AHCCCS identified 63 block grant subrecipients to undergo the Independent Peer Review for State Fiscal Year 2020. The block grant subrecipients submitted a total of 310 treatment records for review, of which 200 were randomly selected to be included in the final review.

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

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

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

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

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

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

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

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

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

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

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an 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. Has your state identified a need for any of the following:

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

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

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

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

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

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ◉ Yes ○ No

Waivers

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

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

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

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

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

https://www.azleg.gov/arsDetail/?title=36

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? (●) Yes ( ) No

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

Technical assistance is not being requested at this time.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

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

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

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

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

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

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

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

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

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

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

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

AHCCCS has developed and modified policies as necessary to guide how we address individuals with trauma-related issues. There are multiple policies that address the use of trauma informed care and appropriate trauma focused treatment. In particular, AHCCCS' policy to address processes for assessment and service planning requires that these activities be conducted utilizing trauma informed principles. Further, there are policies that focus on early intervention strategies and psychiatric best practices for infants and toddlers. While the policies covering treatment guidelines for infants and toddlers may not specifically stipulate their use for parents or caregivers with substance use disorders, these policies can be utilized alongside parents in substance use programs, or to ameliorate the negative effects on children that may have developed while parents or caregivers were utilizing

substances. Not only do they offer clinical best practice guidelines for improving parent/caregiver knowledge and skills, but they also provide a table of nationally recognized tools for assessment of trauma and other potential developmental risk factors.

Managed Care Organizations (MCOs) are contractually required to ensure their behavioral health providers follow evidence-based practices, which include use of SUD treatment, Medication Assisted Treatment (MAT), and Trauma Informed Care. Further, they are obligated to ensure their provider networks include certified trauma informed behavioral health professionals and utilize routine trauma screenings. The MCOs are also required to ensure that their network of primary care physicians (PCPs) utilized standardized tools for identification of the need for trauma-informed care and treatment of substance use disorders within their scope of practice.

Current contracts require that MCOs implement standardized SUD assessments as identified within AHCCCS policy. Additionally, there is an existing requirement for a phased-in approach to implement the American Society of Addiction Medicine (ASAM) criteria (Third Edition, 2013) in substance use disorder assessments, service planning, and level of care placement. However, as of October 1 2022, MCOs will be required to utilize the complete ASAM Continuum for SUD assessment for members 18 and older, who also have co-occurring SUD and mental health needs. The ASAM Continuum provides counselors, clinicians, and other treatment team members with a computer-guided, structured interview for assessing and caring for patients with addictive, substance-related, and co-occurring conditions. The decision engine is based on the ASAM Criteria® and uses research-quality questions (including tools such as the ASI, CIWA, and CINA instruments) to generate a comprehensive patient report that details DSM SUD diagnoses, severity, and imminent risks as well as a recommended level of care determination.

Operational reviews (ORs) are a required component of regularly scheduled AHCCCS monitoring activities to ensure appropriate implementation of contract and policy requirements. Under the OR structure, MCOs are monitored for compliance with implementation of both trauma informed care and substance use treatment and services. Specifically, there are two standards under Medical Management that evaluate compliance with implementation of trauma informed care principles demonstrable evidence of trauma informed care practices, screenings, treatment, and network sufficiency. An additional standard exists for substance use disorder screening and treatment practices, which focuses on identification of youth needing SUD services.

AHCCCS gives MCOs the option of choosing from evidence-based standardized assessment tools, based on their community needs and population served. AHCCCS also prescribes tools for specific uses (e.g., ACES, ASAM, etc.). More specifically, under the Targeted Investment (TI) Primary Care Behavioral Health component, milestones were created that incentivized pediatric, primary care practitioners to utilize ACES or other evidence-based screening tools to identify potential evidence of trauma in children. As part of the milestone guidelines, pediatric practices developed collaborative protocols, which outline their screening and referral processes, as needed for trauma informed care under the behavioral health system. These collaborative protocols also enabled pediatric practitioners to identify children at high risk for chronic physical, developmental, behavioral, or emotional conditions and track them through a high risk registry. The registry tracks patients of highest risk that can be positively affected with appropriate interventions. These targeted milestone activities work in tandem with contractual and policy requirements to help identify children at risk for and in need of substance use services. Under these milestones, pediatric practitioners and care managers also received education and training related to trauma informed care principles.

AHCCCS plans the implementation of a standardized assessment tool on October 1, 2021, known as the CALOCUS, or Child and Adolescent Level of Care Utilization System. This tool is designed to identify appropriate levels of need and intensity of both services and resources to meet the behavioral and/or physical health needs of children aged six to 18. The CALOCUS assessment tool is designed to assess children and adolescents for for four essential activities: (1) identification of immediate needs, especially if there is potential for risk of harm, (2) treatment planning processes, (3) establishment of medical necessity criteria for level of care and treatment, and (4) techniques and services for moving through the course of recovery. At a systemic level, the CALOCUS offers opportunities for identifying resource needs for complex populations (that can include children with SUD) and there are also offers a detailed tool that can facilitate cross system communication.

AHCCCS is considering utilization of the LOCUS (Level of Care Utilization System) for adults, as well as the Early Childhood Service Intensity Instrument (ECSII). Both tools evaluate level of need, resources, and protective factors for individuals needing services. The utilization of all three tools would allow AHCCCS to have a standardized continuum of assessments each of which is based on similar guidelines and evaluation criteria.

Additionally, workforce development activities for MCOs are guided by policy and contract. Each MCO is given the opportunity to identify their workforce development needs for trauma informed care and substance use diagnosis and treatment. There are contractual requirements as part of new employee orientation that focus on ensuring staff is aware of the principles of trauma informed care. Further, MCOs are required to ensure their networks have the capacity of appropriately licensed and trained professionals to deliver SUD assessment and treatment, as well as trauma-informed care, screening, and treatment to AHCCCS members.

Furthermore, AHCCCS not only encourages employment of peers, but MCOs are required to have locally established, Arizona-based, independent peer-run and family-run organizations within their network.

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

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

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

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

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

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

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

Please respond to the following items

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

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

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

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

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

The Arizona Health Care Cost Containment System (AHCCCS) continues to lead 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 health plans to work together. Regularly occurring meetings take place at the state and local levels to focus on policy development, implementation, improving communication, identifying system barriers, and problem-solving. Collaborative development activities such as Drug Courts, Mental Health Courts, and Juvenile Detention Alternatives Initiative (JDAI) are examples of some of the work occurring in Arizona.?

While Arizona does not have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions, screening and treatment are provided prior to adjudication and/or sentencing for individuals with mental health and substance use disorder (SUD) screening as a part of their intake protocols.?

AHCCCS Complete Care (ACC) Managed Care Organizations (MCOs) 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 who

come in contact with the justice system, to the extent possible, have their mental health, SUD treatment needs, and physical health needs assessed and addressed, and that relevant issues are communicated and coordinated with the judiciary and justice partners. MCOs maintain co-located staff at both Juvenile and Adult Courts and Detention Centers to provide coordination of care between the acute, behavioral health system and the justice systems in meeting the enrolled members' needs. Staff is available to assist in enrolling members if they have not previously been identified as having physical/mental health, SUD treatment needs.??

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

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

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

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

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

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

Technical assistance is not being requested at this time.

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Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

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.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

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

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

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

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

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

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

MAT Services

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

In addition to the Substance Abuse Block Grant (SABG), AHCCCS is allocated other state and federally funding to treat Opioid Use Disorder (OUD). Some of the funding sources include various SAMHSA grants: State Opioid Response (SOR), State Opioid

Response II (SORII), the Emergency COVID-19 and Supplemental Grant, and the State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT). AHCCCS also receives state funding such as the Governor's Substance Use Disorder funding.

Various OUD treatment options are available through these funding sources; most involve a team of professionals including social workers, doctors, nurse practitioners, psychologists, and other behavioral health clinicians. Treatment begins with a clinical assessment to determine which treatment method is best for the individual. AHCCCS has worked collaboratively with state and federal partners including the community to identify the needs and gaps to overcome the opioid epidemic. The treatment system for opioid use disorder and other substance use disorders is comprised of multiple service components, including:

Individual and group counseling,
Medication Assisted Treatment Programs (MAT),
Residential Treatment,
Intensive Outpatient Treatment,
Partial Hospital Programs,
Case or Care Management,
Recovery Support Services,
12-Step Fellowship, and
Peer support Services.

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

improving access to naloxone in our communities to reverse overdoses,
expanding access to treatment, especially 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.

Some of AHCCCS' initiatives to address the identified priority areas are as follows:

Improving access to Naloxone

In efforts to improve access to naloxone in Arizona's communities and reverse opioid overdoses, the SABG funds a statewide Overdose Education and Naloxone Distribution (OEND) program serving all SABG priority populations, community-based organizations, and multiple cross-sector partners including law enforcement, faith-based communities, and corporate partners to educate, train, distribute naloxone, and reduce stigma associated with substance use. In 2020, the OEND contractor distributed 148,371 doses of naloxone, reported 4,282 reversals, connected 1,106 individuals to treatment related to substance use and/or necessary medical care, and conducted 351 overdose education trainings throughout Arizona.

Expanding Access to Treatment

Certified SAMHSA Opioid Treatment Programs

AHCCCS recognizes the important role medication-assisted treatment (MAT) plays in the treatment of OUD and access to treatment. Arizona has a total of 66 certified SAMHSA Opioid Treatment Programs (OTPs) and two medication units. Of the 66 OTPs, one is located on tribal land, Pascua Yaqui Tribe's Health Department, and six are located within the Maricopa Correctional Health Facilities.

24/7 Access Points

AHCCCS recognizes the important role MAT plays in the treatment of SUD and access to treatment. Arizona has four 24/7 access points to serve individuals who need immediate access to treatment services and connections to ongoing services. These 24/7 access points are located throughout Arizona (one in Tucson, one in Mesa, and two in Phoenix).

Mid Level Exemptions

AHCCCS recognizes the need for Mid-Level Practitioners and developed a process to allow those practitioners to dispense opioids within a MAT setting for individuals with opioid use disorder, as outlined in the AHCCCS Medical Policy Manual (AMPM) 660: Opioid Treatment Program. This exemption process follows the requirements specified in 42 CFR Part 8.11 for Opioid Treatment Programs (OTPs).

Collaboratively, AHCCCS and SAMHSA have approved 24 OTPs for the requested exemption to utilize 33 Mid-Level Practitioners since January 2021.

Opioid Treatment Services Locator

AHCCCS is funding Carahsoft, through the State Opioid Response II grant, to develop the Opioid Services Locator, a "one stop" portal that houses a daily census and capacity for available OUD treatment options and naloxone availability. The intent of this project is to eliminate "wrong doors" for individuals seeking OUD treatment, recovery, and ancillary services. The contractor will be responsible for building an electronic system for treatment providers to update their available capacity in real-time (e.g., number of available slots in local OTPs or Office Based Opioid Treatment (OBOT) facilities, number of available residential beds, and naloxone availability). The locator will be available to the general public and the Opioid Assistance and Referral Line will use the repository to create a "no wrong door" approach to navigating individuals with OUD to timely treatment options.

Educating Arizonans

AHCCCS and other community stakeholders educate and raise awareness within the community regarding what MATs are, the services provided within the MAT setting, facility locations, and their availability throughout the state. As the SSA, AHCCCS continues to cite research about the importance of utilizing evidence-based MAT treatment in the community and have contract terms that require the Managed Care Organizations (MCOs) to maintain a network of MAT providers for their geographic service areas (GSAs).

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

Footnotes:

Environmental Factors and Plan

15. Crisis Services - Required for MHBG

Narrative Question

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

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

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

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

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

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

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

2. Crisis Intervention/Stabilization

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

3. Post Crisis Intervention/Support

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

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

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

AHCCCS supports a coordinated system of entry into crisis services that are community based, recovery-oriented, person focused, and work to stabilize the individual as quickly as possible to assist them in returning to their baseline of functioning. Collaboration, the improvement of data collection standards, and communication are integral in enhancing quality of care leading to better health care outcomes, while containing cost. Expanding provider networks capable of providing a full array of crisis services geared towards the individual is expected to maintain a person's health and enhance quality of life. The collection, analysis, and use of crisis service data for crisis service delivery and coordination of care is critical to the effectiveness of the overall crisis delivery system.?

AHCCCS utilizes the Regional Behavioral Health Authorities (RBHAs) as the Managed Care Organizations (MCOs) responsible for the full array of crisis services in their designated Geographical Service Area (GSA). The RBHAs are required to:?

1. Maintain responsibility for the provision of a full continuum of crisis services to all individuals, within their GSA(s), including individuals in the Federal Emergency Services Program (FESP). Crisis services include but are not limited to; crisis telephone response, mobile crisis teams, and facility-based stabilization (including observation and detox), and all other associated covered services delivered within the first 24 hours (for Title XIX/XXI members) of a crisis episode.?

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

3. Provide solution-focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more segregated setting, utilizing a trauma-informed and responsive care approach.?

4. Utilize the engagement of peer and family support services in providing crisis services.?

5. Immediately assess the individual's needs, identify the supports and services that are necessary to meet those needs, and connect the individual to those services.?

6. Not require prior authorization for emergency behavioral health services, including crisis services (A.A.C. R9-22-210.01),?

7. Require subcontracted providers that are not part of Contractor's crisis network to deliver crisis services or be involved in crisis response activities during regular business operating hours.?

8. Coordinate with all clinics and case management agencies to resolve crisis situations for assigned members.?

9. Develop local county-based stabilization services to prevent unnecessary transport outside of the community where the crisis is occurring.?

10. Ensure individuals are connected through warm handoffs throughout the crisis care continuum, to support the coordination of crisis services and connection to ongoing care.

11. Provide crisis services on tribal lands as dictated by each tribe within the Contractor's assigned GSAs:?

a. Annually, the Contractor shall contact each tribe within the Contractor's GSAs to offer a full range of crisis services to establish agreements for the provision of crisis services on tribal lands, per the discretion and needs of the tribe,?

b. Report annually the status of tribal agreements for the provision of crisis services on tribal lands in the Tribal Coordinator Report, and?

c. Develop a process where tribal liaisons and appropriate clinical staff coordinate crisis services on tribal lands with crisis providers.?

12. Provide non-emergency transportation for continuing care and/or for connection to community resources for immediate crisis stabilization.?

13. Implement core and essential system requirements detailed in SAMHSA's National Guidelines for Behavioral Health Crisis Care.?

14. Coordinate benefits and required payments of Liable Third Parties as specified in Arizona Contractor Operations Manual (ACOM) Policy 434.?

15. Participate in a data and information sharing system, connecting crisis providers and member physicians through a health information exchange.?

16. AHCCCS will provide the Contractor necessary access to member data, which shall be used to support crisis services care coordination for members receiving general mental health and substance use services through an AHCCCS Complete Care Contractor or AIHP.?

17. Analyze, track, and trend crisis service utilization data to improve crisis services. Maintain data and be able to report information that contains, but is not limited to:?

a. Telephone call volume and metrics, calls resolved by phone, calls made in follow up to a crisis to ensure stabilization, and call dispositions including triage to Nurse-On Call services, referral, and dispatch of service providers, community and collaborative partners, and health plan notification for dual eligible members,

b. Mobile team dispositions to include response timeframes, transports to crisis stabilization units and other facilities, initiation of court ordered evaluation/court order treatment COE/COT process, and coordination with collaborative partners, and?

c. Submit a Crisis Call Report of the total volume and disposition of crisis calls, and disposition of mobile team dispatch and outcomes received by local and toll-free Crisis Line numbers.?

18. Provide the community information about crisis services and develop and maintain collaborative relationships with community partners including: fire, police, emergency medical services, hospital emergency departments, other AHCCCS MCOs, and other providers of public health and safety services, and:?

a. Have active involvement with local police, fire departments, and first responders, and other community and statewide partners in the development and maintenance of strategies for crisis service care coordination and strategies to assess and improve crisis response services,?

b. Provide, at a minimum, annual training to support and develop law enforcement agencies' understanding of behavioral health emergencies and crises, and?

c. Utilize and train tribal police to be able to assist in behavioral health crisis response on tribal land.?

19. Develop a collaborative process to ensure information sharing for timely access to Court Ordered Evaluation (COE) services, and

20. Notify the MCO of enrollment within 24 hours of a member engaging in crisis services (telephone response, mobile crisis teams and/or stabilization services) and provide clinical recommendations for the individual's continuing care, so subsequent services can be initiated by the Contractor of enrollment.?

RBHAs must also? establish and maintain crisis stabilization settings that offer 24 hour substance use disorder/psychiatric crisis stabilization services including 23 hour crisis stabilization/observation capacity, for Individuals with Substance Use Disorders (SUDs), offer crisis stabilization services that provide access to all FDA approved Medication Assisted treatment (MAT) options covered under the AHCCCS Drug List, and provide short-term crisis stabilization services in an effort to successfully resolve the crisis and return the individual to the community instead of transitioning to a higher level of care. Crisis Stabilization settings must accept all crisis referrals, adhere to a "no wrong door" approach for referrals, and ensure streamlined practices for swift and easy transfer of individuals from law enforcement and public safety personnel. Crisis assessment and stabilization services may be provided in settings consistent with requirements to have an adequate and sufficient provider network that includes any combination of the following:?

Licensed Level I acute (Behavioral Health Inpatient Facility) and sub-acute facilities (Behavioral Health Observation/Stabilization Service),?

Behavioral Health Residential facilities,?

Outpatient clinics (Outpatient Treatment Centers) offering 24 hours per day, seven days per week access, and

Opioid Treatment Program (OTP).

RBHAs also have the discretion to include home-like settings such as apartments and single-family homes where individuals experiencing a psychiatric crisis can stay to receive support and crisis respite services in the community before returning home.?

Further, RBHAs are also required to establish and maintain mobile crisis teams with the following capabilities:?

1. Ability to travel to the place where the individual is experiencing the crisis.?

2. Ability to assess and provide immediate crisis intervention.?

3. Provide mobile teams that have the capacity to serve specialty populations including youth and children, hospital rapid response, and those who live with a developmental disability.

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

5. Employ reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop individualized plans to meet the person's needs.

6. When clinically indicated, transport the individual to a more appropriate facility for further care.?

7. Require mobile crisis teams to respond on site within the average of 60 minutes of receipt of the crisis call as calculated by utilizing the monthly average of all crises call response times.

8. Prioritize and incentivize expeditious response of mobile crisis teams that occur below established performance thresholds.

9. Prioritize law enforcement requests for mobile team dispatch with a target response time of 30 minutes or less.?

10. Work collaboratively with law enforcement/public safety personnel and develop strategies to ensure mobile team response is effective and tailored to specific needs, and

11. Utilize credentialed peers or family support specialists for mobile crisis team response.

Finally, RBHAs must establish and maintain a 24 hours per day, seven days per week crisis response system. This requirement includes that each RBHA:

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

2. Publicize its single toll-free crisis telephone number throughout its assigned GSA(s) and include it prominently on the Contractor's website, the Member Handbook, member

newsletters, and as a listing in the resource directory of local telephone books.

3. Have a sufficient number of staff to manage the telephone crisis response line.

4. Answer calls to the crisis response line within three telephone rings, with a call

abandonment rate of less than 3 percent.

5. Include triage, referral, and dispatch of service providers and patch capabilities to and

from 911 and other crisis providers or crisis systems, as applicable.

6. Provide telephone support to callers to the crisis response line including a follow-up call within 72 hours to make sure the caller is stabilized.

7. Offer interpretation or language translation services to persons who do not speak or

understand English and for the deaf and hard of hearing.

8. Provide Nurse On-Call services 24 hours per day, seven days per week to answer general healthcare questions.

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

Law enforcement (LE) callers to the crisis lines are prioritized, receive direct access to crisis call supervisors, priority dispatch of crisis mobile teams. In addition, LE are able to drop off individuals at any crisis facility with a "no refusal" policy, with a target drop-off time at 23-hour observation units of 10 minutes or less.

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

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

Since September 2018, AHCCCS has held regular behavioral health roundtable collaborations with statewide crisis providers, RBHA,s and other AHCCCS health plans to address system issues and develop strategies to enhance the delivery of crisis services throughout Arizona.?

In continuing with system integration principles and streamlining the delivery system, AHCCCS will be integrating standalone RBHA services into its existing managed care organization structure in October 2022. In early 2019, AHCCCS released a request for information to solicit feedback regarding suggestions for integrating crisis services into the AHCCCS delivery system, in addition to requesting stakeholder feedback regarding crisis system enhancements and delivery of crisis services on tribal lands.??

AHCCCS is in the process of developing a new standalone crisis policy expected to be released in August 2022.?

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

Technical assistance is not being requested at this time.

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

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

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

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

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

Please respond to the following:

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

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

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

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

In Arizona, we have Peer-Run Organizations, Family-Run Organizations, and Specialty Providers that provide services to these populations based on the principles of recovery and resiliency. AHCCCS Policy AMPM 100 establishes the 9 Guiding Principles of Adult System of Care and Arizona Vision and 12 Principles for Children's System of Care. These principles came directly from members and family members to guide us as the State Medicaid Authority in the fundamental values of recovery in the adult system and resiliency in the children's system.

Recovery support services are for all AHCCCS members including adults with a serious mental illness designation. These services are provided to many specialty populations including members involved in the justice system, dual diagnosis, in tribal communities, and faith- based organizations. All individuals providing this service are credentialed as Peer Recovery Support Specialists (PRSS) through an AHCCCS approved training program.

Credentialed family support training elements for children with SED are established in AHCCCS Policy. Credentialed family support (CFSS) is provided by family members of children with SED who have completed training and credentialing with state approved curricula. This applies the peer principle to family support which traditionally can be provided by individuals without "lived experience." CFSS ensures that those providing the service can relate to those they are serving as peers with shared lived experience of raising children with SED.

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

As stated above, recovery support services are available to all AHCCCS members, including those with substance use disorders, with specialty training and support specifically to members with opioid use disorders. PRSS serving members with SUD, have substantial representation within Arizona's recovery support workforce. PRSS servicing members with SUD are employed in many settings including medication assisted services (MAT programs).

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

The policies overseeing these services are informed and guided directly by stakeholders, including those receiving these services. In response to the public health emergency, the State began a program offering personal support to PRSS and CFSS to prevent burnout and compassion fatigue at no cost. Those providing this direct personal support are persons currently employed as a PRSS and CFSS, and are volunteering their time to support their colleagues. This program is operated by the Arizona Peer and Family Career Academy under contract with the State of Arizona.

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

Technical assistance is not being requested at this time.

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Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

Please respond to the following items

1. Does the state's Olmstead plan include :

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

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

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

Technical Assistance is not being requested at this time.

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

Footnotes:

ARIZONA'S OLMSTEAD PLAN

Arizona Health Care Cost Containment System
Arizona Department of Economic Security
Arizona Department of Health Services

August 2001
Revised Workplans: March 2003

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STATE OF ARIZONA

Jane Dee Hull
Governor

August 27, 2001

Dear Interested Parties:

We are pleased to provide you with a copy of *Arizona's Olmstead Plan.* This plan represents a collaborative effort by consumers, providers and advocacy groups to improve opportunities for the elderly and persons with disabilities to access community based services.

Input from individual consumers and advocacy groups has clearly shaped the vision and spirit of this document and served as an impetus for us to look critically at the strengths and limitations in our existing service system. *Arizona's Olmstead Plan* will serve as a blueprint for AHCCCS, ADHS and ADES to enable the elderly and persons with disabilities to live in integrated, community settings appropriate to their needs.

In summary, we acknowledge the dedication and commitment of all the participants who contributed to *Arizona's Olmstead Plan.* The development of this plan ensures that Arizona has a continuous quality improvement process in place for providing services to consumers.

Sincerely,

Phyllis Biedess
Director

Catherine R. Eden
Director

John L. Clayton
Director

AHCCCS

Arizona Department of Health Services

DES

PREFACE

Providing treatment in the most integrated setting is an underlying principle of the Arizona Health Care Cost Containment System/Arizona Long Term Care System (AHCCCS/ALTCS), Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) and Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) systems. As such, many aspects of the State's compliance with the Olmstead Decision are already incorporated in the rules, policies, and practices of these agencies. This document is not a comprehensive statement of every implementation of the community integration requirement of the Americans with Disabilities Act.

This document was drafted in the spirit of continuous quality improvement. We recognize that there are always opportunities to provide services to the citizens of the State in ways that better serve their needs and are consistent with self-determination even when the State complies with the mandates of federal law. The interest of the U. S. Department of Health and Human Services/ Centers for Medicare and Medicaid Services (DHHS/CMS)[1] in the Olmstead Decision came about because the CMS funds many of the services that are impacted by the Olmstead Decision both in Arizona and nationwide. Arizona believes it is in substantial compliance with the mandates of the Olmstead Decision, and statements contained in this document are not admissions by any of the Arizona agencies that they are not in compliance with the requirements of the Americans with Disabilities Act. The direction from the CMS simply provided Arizona with another vehicle for critical self-examination.

Readers should also note that improving community integration is a "living process." This document is a snapshot of the current state of the agencies and the challenges they face. It expresses potential solutions based on information and resources currently available. It attempts to plan for improvement in community integration and to assist agencies in establishing their priorities in the context of other critical issues that each of the State agencies face. As resources and competing priorities change, so will this plan. Changes may not always be reflected in a revised version of this plan even though the involved agencies intend to review and update this document (with community input) as time and resources permit.

[1] As of July 2, 2001 the Health Care Financing Administration (HCFA) changed its name to the Centers for Medicare and Medicaid Services (CMS)

EXECUTIVE SUMMARY

Background

Why Did Arizona Prepare a Plan?

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 that it would be appropriate, and in the consumers' best interest, to convene a public planning process that would review the accomplishments of the state to date and identify areas for future endeavors to improve opportunities for consumers to live in the most appropriate integrated setting possible. The state agencies recognize that this is part of a continuous improvement process in which each agency was already involved prior to the Olmstead Decision and will continue to engage in. The preparation of the plan is also consistent with the Executive Order issued by President George W. Bush on June 18, 2001 in support of the Olmstead Decision.

The Process of the Plan Development

AHCCCS, ADES/DDD and ADHS/DBHS convened an initial meeting in June 2000 to discuss the Supreme Court decision and subsequent information from the Centers for Medicare and Medicaid Services. In August 2000, the state agencies identified the process to encourage consumer involvement in the plan development process. This has included the convening of four regional stakeholder meetings, including one that was conducted via videoconference, one subcommittee for document review and several additional agency specific planning meetings. In September 2000, the state invited representatives from each of the statewide councils to meet and provide recommendations on how to best secure additional consumer participation. The statewide councils recommended that the agencies first develop draft plans that could be presented to consumers for input. In November and December 2000, the state held statewide meetings to present these preliminary plans and receive input. The consumers recommended that the agencies develop a single, consolidated plan because of the issues common to all of the consumers and the three agencies. Based on this input, the state developed the draft consolidated plan and requested review by a group of volunteers from the stakeholder community. This review occurred in March 2001. During April and May 2001, the state revised the consolidated plan, again based on the consumer responses, and posted a copy of the revised plan on the AHCCCS website in early June. Additional stakeholder meetings occurred in late June to receive comments on this plan. The final plan was published and posted on the AHCCCS website in August 2001.

The agencies will periodically review and update the final plan and continue to seek consumer input as to the status of the recommendations.

Results and Conclusions

AHCCCS, ADES/DDD and ADHS/DBHS have identified, with assistance and input from consumers, the priority issues for future development. These are:

AHCCCS and ADES/DDD

- Consumer Directed Service: Develop and implement a plan to allow consumers to take a stronger role regarding the hiring and directing of their personal care attendants.
- Consumer Pay Increases for Home and Community Based Providers: Begin the process of increasing pay for home and community based workers; analyze current reimbursement rates to determine if an increase is appropriate, conduct a cost study, obtain necessary appropriations if necessary, and ensure the increase, if received, is passed through to direct care providers.

ADHS/DBHS

- Re-evaluate the current service matrix that includes services and service reimbursement rates.
- Conduct ongoing analysis of the service network through the Regional Behavioral Health Authorities (RBHA).
- Continue with ongoing improvements through the collaborative effort of the RBHAs, Arizona State Hospital, ADHS/DBHS, AHCCCS, and ADES/DDD to meet the needs of special populations.

About the Content

This document is organized to allow consumers, advocates and providers easy access to specific areas of interest.

Part I provides general background on the Olmstead Decision and Arizona's philosophical base and consumers served.

Part II, Common Elements, provides a brief description of the system. This includes a discussion of the common components of the community based Medicaid programs in Arizona and the common themes on which the agencies are working. Labor force, education and consumer information, consumer-centered care management, and network development are the issues that are common to all of the agencies serving the populations in home and community based environments.

Part III, Agency Specific Actions, provides information about how each agency is addressing the six Olmstead Principles.

Services provided by the Arizona Health Care Cost Containment System/Arizona Long Term Care System for persons who are elderly and/or have a physical disability.

Services provided by the Arizona Department of Economic Security/Division of Developmental Disabilities to children and adults with a developmental disability.

Services provided by the Arizona Department of Health Services/Division of Behavioral Health Services to children and adults with behavioral health needs.

Part IV, Appendices, provides the reader with more detail regarding the Olmstead Decision principles, populations and programs, services and settings, definitions and acronyms, the work plans for each of the state agencies, and people and organizations that were involved in the development and/or review of this plan, including:

Appendix A: CMS Olmstead Principles

Appendix B: Program Descriptions and Populations Served

Appendix C: Services and Settings

Appendix D: Timeframe for Plan Development

Appendix E: Acronyms and Definitions

Appendices F, G, and H: The Work Plans for AHCCCS, ADES/DDD and ADHS/DBHS

Appendix I: Persons and Organizations Invited to Participate in the Planning Process

Appendix J: Links to Other Resources for Consumers

This Plan demonstrates the State of Arizona's historical and current emphasis on the same principles that are found in the Olmstead Decision. The State will look at system improvements so that it can continue to strive to ensure that persons with disabilities have appropriate access to and choice regarding community based services and placements.

PART I: BACKGROUND AND INTRODUCTION

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

Olmstead Overview

Supreme Court Decision

In June 1999, the United States Supreme Court rendered a decision, Olmstead v L.C., 119 S.Ct. 2176 (1999), which provides an important legal framework for the efforts of the federal and state governments to integrate individuals with disabilities into the communities in which they live. The Court's decision issues a challenge to all of us, the public sector, private sector, advocates, consumers and families, to improve opportunities for individuals with disabilities to access systems of cost-effective community based services.

Under the Court's decision, States are required to provide community based services for persons with disabilities who would otherwise be entitled to institutional services when:

> (a) The State's treatment professionals reasonably determine that such placement is appropriate;
>
> (b) The affected person is in agreement with the decision; and
>
> (c) The placement can be reasonably recommended, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services.[2]

A state may be able to meet its obligation under the Americans with Disabilities Act by demonstrating that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in the most integrated setting appropriate, and a waiting list that moves at a reasonable pace not controlled by a State's objective of keeping its institutions fully populated.[3]

Executive Order

On June 18, 2001, President George W. Bush issued an Executive Order on Community Based Alternatives for Individuals with Disabilities. This Executive Order reconfirmed the Federal Government's support of the Olmstead Decision. It directed the United States Office of the Attorney General; the Secretaries of Health and Human Services, Education, Labor, and Housing and Urban Development; and the Commissioner of the Social Security Administration to "work cooperatively to ensure that the Olmstead Decision is implemented in a timely manner". These departments are directed to work with the States to "help them assess their compliance with the Olmstead Decision and the ADA in providing services to qualified individuals with disabilities

[2] CMS Letter to State Medicaid Directors; January 14, 2000
[3] CMS Letter to State Medicaid Directors; January 14, 2000

in community based settings, as long as such services are appropriate to the needs of those individuals."

Arizona's Philosophy

Although the Court did not require states to develop a plan, Arizona believes that this is an opportunity for advocates, agencies, consumers and community stakeholders to collaborate on a plan that will 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 – the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Department of Economic Security (ADES) and the Arizona Department of Health Services (ADHS), have a history of working under the premise that people should live in an appropriate integrated setting in the community.

Olmstead Principles

The ***principles*** of the Olmstead Decision, which this Plan addresses, are:

- Principle 1 -- Plan: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community based settings.
- Principle 2 -- Involvement: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.
- Principle 3 -- Assessment: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities.
- Principle 4 – Availability: Ensure the availability of community-integrated services.
- Principle 5 – Informed Choice: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.
- Principle 6 – State and Community Infrastructure: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan.

A detailed description of the Olmstead Decision Principles is included in Appendix A.

Arizona's Purpose, Principles, Goals and Outcomes to Meet Olmstead

Purpose

The ***purpose*** of this Plan is to provide an opportunity for the public agencies, provider agencies, consumers, families and advocates to collectively comment on the success that Arizona has demonstrated in meeting the principles of the Olmstead Decision and to identify and plan for improvements to the current community based system.

Guiding Principles

The ***guiding principles*** of the state programs were in place prior to the Olmstead Decision and continue to guide the planning and delivery of services. Although the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Department of Economic Security (ADES) and the Arizona Department of Health Services (ADHS) may state the specifics of these principles differently, they all essentially espouse:

- *Person-Centered Care Management* – Belief that the consumer is the primary focus and that the consumer, along with family and significant others, as appropriate, is an active participant in planning, delivery and evaluation of services. This also means that if a team approach is used that the team also should be "person-centered."
- *Consistency of Services* -- Service systems are developed to ensure that consumers can rely on services being provided as agreed to by the consumer and the program representative. This means that the services are timely, consistent, dependable and appropriate.
- *Available and Accessible Services* -- Access to services is maximized when services are developed to meet the needs of the consumer. Service provider restrictions, limitations or assignment criteria are clearly identified to the consumer and family and significant others, as appropriate.
- *Most Integrated Setting* -- Consumers should be able to reside in the most integrated setting. To that end, consumers are afforded choice in remaining in their own home or choosing an alternative residential setting versus entering into an institution.
- *Collaboration with Stakeholders* -- The appropriate mix of services will continue to change. Resources should be aligned with identified consumer needs and preferences. Efforts are made to include consumers and families or other significant persons, service providers and related community resources, to assess and review the change of the service spectrum. Changes to the service system are planned, implemented and evaluated for continuous improvement.

Goals

The ***goals*** of this Plan are to:

- Address the recommendations of the Centers for Medicare and Medicaid Services (CMS) and the Office of Civil Rights in meeting the principles embedded in the Olmstead Decision.
- Demonstrate the progress that Arizona has made in meeting these principles.
- Identify areas for improvements in the delivery of home and community based settings and services.
- Ensure that consumers, advocates and other stakeholders are included in the planning process.
- Identify the data that must be collected to achieve the goals.

- Evaluate the progress that the State of Arizona is making toward meeting the goals and revising them, as needed.

Outcomes

The ***outcomes*** from this Plan are to provide a map to:

- Strengthen informed decision making and choice for consumers.
- Improve community service systems.
- Improve administrative processes to support community integration.
- Monitor the overall capacity of the service system to provide services and supports that improve access to community integration.

The planning process has provided an excellent opportunity for the public agencies, provider agencies, consumers, families and advocates to collaborate regarding improvement strategies that will assist Arizona in maintaining the principles of the Olmstead Decision.

Populations and Programs

The long term care and home and community based programs in Arizona are the responsibility of three state agencies and are differentiated by population and fund source. Because Medicaid is a significant funder of home and community based services and placements, it is the primary focus of this document. The populations and programs that are addressed in this plan are described in more detail in Appendix B, and include:

- **Elderly and persons with a physical disability**

  Arizona Health Care Cost Containment System/Arizona Long Term Care System for persons who are Elderly and/or have a Physical Disability (AHCCCS/ALTCS/EPD)

- **Children and adults with developmental disabilities**[4]

  Arizona Department of Economic Security/Division of Developmental Disabilities/ Arizona Long Term Care System for Persons with Developmental Disabilities (ADES/DDD/ALTCS/DD)

  Arizona Department of Economic Security/Division of Developmental Disabilities/State Funded Program for Persons with Developmental Disabilities (ADES/DDD/DD)

- **Children and adults with behavioral health needs**

  Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) through the Regional Behavioral Health Authorities (RBHAs).

Arizona recognizes that there are other programs and funds that provide additional supports to the same populations. These supports and services also enable people to live more independently in their own homes and communities, and, in some cases, prevent or delay the need for more intensive services through the Medicaid programs. These programs include:

[4] In this document the ALTCS/DDD and the State-Funded DDD program will be discussed together as the DDD program.

Arizona Department of Economic Security/Aging and Adult Administration/Non-Medical Home and Community Based System (ADES/A&AA/NMHCBS)

Arizona Department of Economic Security/Rehabilitative Services Administration (ADES/RSA)

The three state agencies – AHCCCS, ADES, and ADHS -- have historically engaged in planning that involves local communities and constituencies. Arizona is the only state in which the Home and Community Based System has no limits on the number of consumers who can live in the community. The state has also underscored the importance of community based settings by expanding the living arrangements and options available to the consumer. Arizona's model for persons with disabilities and the elderly is founded on principles that stress choice, dignity, independence, individuality, privacy and self-determination.

Arizona's Olmstead Plan and Its Implementation

The state expects that the Plan will be a document that the state agencies will periodically monitor and update. Comments from the public are welcome at anytime. Once the Plan is completed, copies will be provided to members of the public and the Statewide Councils. The state agencies will transmit the Plan to the Governor and the Arizona State Legislature, and will post a copy on the AHCCCS website. The ADES and ADHS websites will contain a link to the AHCCCS website that will take the consumer directly to the document.

This Plan identifies both issues that are common to all of the state agencies and programs and issues that are specific to a particular population, agency or program. The work plans for monitoring and review are included in Appendices F (AHCCCS/ALTCS), G (ADES/DDD) and H (ADHS/DBHS) and with each agency being responsible for monitoring its own work plan. In addition, each agency will be responsible for addressing issues specific to them as well as collaborating on common issues as appropriate. Work plans will be updated by the agencies as needed.

Accomplishment of the strategies and goals will take the effective partnering of the agencies, consumers, providers, and, in some cases, permission of the federal government.

PART II: COMMON ELEMENTS

Common Components of Community Based Medicaid Programs in Arizona

The Arizona Health Care Cost Containment System/Arizona Long Term Care System AHCCCS/ALTCS) is the Medicaid program serving elderly, physically disabled (EPD) and developmentally disabled (DD) persons at risk of institutionalization in Arizona. In addition, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) provides Medicaid and state-funded behavioral health services to children and adults with behavioral health needs. The Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) also has a State Only funded program. Other non-Medicaid programs, such as the Non-Medical Home and Community Based System (NMHCBS) and the Rehabilitation Services Administration (RSA), also offer other supportive services to the same populations – either prior to enrolling in a Medicaid program, in lieu of a Medicaid program if the person is not eligible, or as an additional support to a Medicaid program.

The Medicaid programs include the following common components for all of the identified populations (elderly, physically disabled, developmentally disabled and persons with behavioral health needs), with exceptions as noted. A complete listing of all services and placements is provided in Appendix C.

Home and Community Based Services (HCBS)

Consumers may remain in their own homes or in alternative home settings. Support services are available to assist consumers to remain in the community.

There is no limit on the number of elderly, physically disabled and developmentally disabled consumers who can reside outside of institutions. Medicaid does limit expenditures to no more than the amount that would have been spent on individuals in institutions. Members' options and choices are based on need.

Alternative Residential Settings Under HCBS

These settings provide a more community-integrated setting for persons who might otherwise need to reside in an institution. A variety of types of settings are available, based on the consumer's need. By having a variety of alternative settings with differing levels of care available consumers are able to delay institutionalization, or, in some cases, transfer from a nursing facility into an HCBS setting. More important than the savings experienced by using HCBS, this alternative to institutionalization provides consumers with a degree of independence and control that might not be available in an institutional setting.

The three State agencies realize that a person's own home is the most optimal setting. The State, however, tries to ensure that the Alternative Residential Settings, when they are needed, are the most home-like atmosphere possible.

Institutional Care

Institutional care in either a Medicare and/or a Medicaid approved institution is available to consumers.

Behavioral Health Services

These are services provided to eligible consumers either through the ALTCS/EPD and ALTCS/DD program or separately through the ADHS/DBHS for children and adults with behavioral health needs.

Acute Medical Care

Acute medical care is available for all Medicaid eligible consumers.

Early Periodic Screening, Diagnosis and Treatment Program (EPSDT)

This program is available for Medicaid eligible persons from birth to 21 years of age to provide early detection and treatment of medical and behavioral conditions.

Common Themes for All State Agencies

Just as there are common philosophies and common components across the home and community based programs and services, there are also common themes which all of the involved State agencies' programs address. Some of these common themes are more easily addressed and improved – such as education to consumers and development of advisory councils. Others, like the labor force issue, are more complicated and require creative solutions.

Labor Force

Although the Olmstead Decision does not specifically mandate states to address labor force issues, Arizona is, nonetheless, concerned about the impact on its ability to support people in the most appropriate community-integrated setting. There are labor shortages throughout the nation. This includes many human service and health care/direct care industries, including workers that support the long term care industry and community-integrated services. Many experts have examined and reported on the reasons for the current and future shortages. Their analyses find similar causes: retirement of baby boomers; better opportunities in other fields in a robust economy; and a shortage of individuals entering the human service and health care/direct care fields. This is a complex issue that will take creativity from many different fronts at the federal, state and local levels.

The State believes that it will take a community coalition of education, employment development industries, commerce, providers and consumers to successfully address these labor force issues. The Arizona Health Care Cost Containment System (AHCCCS), the Arizona Department of Economic Security (ADES), and the Arizona Department of Health Services (ADHS) encourage advocates, providers and consumers to continue to support the recognition that care provided in a person's home is a valued profession to ensure that these types of jobs are considered by both potential and current employees and employers as work worthy of adequate pay and benefits – regardless of whether it is in the public or private arena. Solutions to labor force issues will

come about only by a combination of legislative support, fiscal support, changes in credentialing and scope of practice limitations and an adequate labor market. These solutions will take the combined efforts of all parties.

Labor force issues, however, are further complicated by the fact that state law and regulation govern "scope of practice" issues for many professions while prohibiting others who are not members of that particular profession from performing activities that are considered within a professional scope of practice. In addition, the diversity of Arizona's population can result in the inappropriate matches of direct care workers with clients, particularly if the providers experience difficulties in recruiting and retaining persons with a similar language or cultural background as the clients for whom they work.

AHCCCS, ADES/DDD and ADHS/DBHS, all address labor force issues through analyzing network capacity and gaps, exploring issues related to licensure and scope of practice that may limit the ability to provide services to certain professionals, and identifying appropriate standards of care in the various programs. AHCCCS, ADES/DDD and ADHS/DBHS encourage providers to identify gaps and barriers to having an adequate and qualified workforce and to bring these issues forward. The State agencies will continue to monitor their contractors regarding the identification and filling of gaps.

In addition to encouraging community participation in addressing labor force issues, each of the state agencies continues to review and act upon specific labor force issues:

AHCCCS/ALTCS/EPD and ADES/DDD

AHCCCS along with ADES/DDD has identified the following areas where it can be of assistance:

- Personal Care Attendants -- AHCCCS will evaluate the possibility of using Medicaid ALTCS funds in the ALTCS program to pay spouses and parents. This will expand the network and make it easier for people to move back into their homes.
- Interim Pay for Personal Care Attendants -- AHCCCS will submit a State Plan Amendment requesting the Centers for Medicare and Medicaid Services approval to allow payment for a personal care attendant under the ALTCS program for a specified period of time when the consumer may be out of the home or in an alternative setting (e.g. hospitalization). This change will enable the consumer to keep the same personal care attendant.
- Pay Increases for Home and Community Based Providers -- AHCCCS recently completed a study on reimbursement rates for home and community based providers. The study resulted in an average increase, effective October 1, 2001, of 15.3% for the ALTCS/EPD program. Recently passed legislation requires each agency (AHCCCS, ADES/DDD and ADHS/BHS) to contract with an independent consulting firm for an annual study of the appropriateness of reimbursement rates to service providers. A complete study of reimbursement rates will be completed no less than once every five years. In addition, the State Agencies encourage providers and contractors to address the salaries of direct care workers with increases in budgets.
- Consumer Directed Services – AHCCCS along with ADES/DDD will develop and implement a plan to allow consumers to take responsibilities for recruiting, hiring,

training, scheduling, directing and firing their personal care attendant workers. This includes the possibility of allowing the consumer to delegate skilled tasks to Personal Care Attendants. AHCCCS and ADES/DDD remain committed, however, to ensuring that clients have sufficient information to make appropriate decisions and to understand that choosing consumer directed care is a voluntary act.

ADHS/DBHS

ADHS/DBHS, to address labor issues, is re-evaluating its current service matrix that includes the types of services and the recommended service reimbursement rates. A consultant has been contracted to propose additional service types and facilitate the evaluation process. Services are being reviewed and revised based on the gap analysis data provided by the Regional Behavioral Health Authorities (RBHA). Recommendations are being made for an increase in service reimbursement rates where appropriate. ADHS/DBHS will need to implement proposed changes and provide training to providers on any enhancements to the service matrix. It is anticipated that these changes will increase reimbursements and expand the types of reimbursable services in the community.

Education and Information to Consumers

One of the most difficult tasks for an agency is developing strategies in order to get the right information at the right time for consumers. For all of the programs, there are councils that include consumers and families. These organizations, working in collaboration with the state agencies, assist in the development, review and/or distribution of educational and informational materials to interested parties. In addition, for all programs, case managers and support coordinators work with consumers to assist them to understand the choices that they have for services and settings and the implications of those choices.

Informational Material

AHCCCS, in cooperation with ADES/DDD and ADHS/DBHS, will explore the possibility of developing and disseminating informational materials to help consumers make informed choices. One of the examples of current information that is provided is the ADHS/DBHS publication of the "Arizona Behavioral Health Systems - Guide to Services" handbook and "Your Rights and Self Advocacy" guidebook. These are distributed statewide to assist consumers with information about the service delivery system. The RBHAs are also required to provide a consumer's handbook to all enrolled consumers. AHCCCS requires ALTCS Program Contractors and ADES/DDD to provide a member handbook to all ALTCS consumers.

Member/Provider Councils

Currently, several advocacy groups including member/provider councils, such as Advocates for the Seriously Mentally Ill, the Arizona Mental Health Association, the Arizona Alliance for the Mentally Ill, Mentally Ill Kids in Distress (MIKID), the ADHS/DBHS Consumer Advisory Board, the RBHA's Human Rights Committee, the DDD Human Rights Committee, the Developmental Disabilities Advisory Council, the DDD Family Support Council, and the Arizona Center for Disability Law, provide exceptional supports to consumers and potential consumers through advocacy and information sharing. The Yavapai County Long Term Care System began operating its Member/Provider Council in July 2000. Beginning October 1, 2001, all ALTCS/EPD Program Contractors will convene member/provider councils that are

representative of the ALTCS/EPD consumers and the providers within a given geographic area. These councils are available to provide a forum for discussions and feedback on the Plan and any revisions. In addition, AHCCCS will require that member/provider councils include family members and other types of advocates.

Consumer Advocacy

ADHS/DBHS has partnered with the University of Arizona to provide training on the philosophy of recovery to consumers and providers throughout Arizona and to staff from the Arizona State Hospital. This philosophy supports consumer choice that often includes obtaining employment. ADHS/DBHS will verify that trainings have occurred throughout the state and will also encourage the RBHAs to develop training programs for consumers interested in providing behavioral health services such as peer mentoring and peer advocacy. Currently, licensure standards related to experience and education have posed a barrier to consumers who are interested in providing direct care. Expanding training programs for peer mentors and revising current regulations will positively impact labor force issues.

Consumer Centered Care Management

Consumer Centered Care Management is at the heart of the philosophical base of the programs offered in Arizona. Care management and support coordination is provided for consumers to ensure that their care is integrated and appropriate to their level of need and potential. The programs offer advocacy and case management to assist the consumer in directing his/her own care by providing information, education and support throughout the planning and service delivery process. State agencies realize that there is a need for ongoing training of this philosophy/approach for care managers.

The State also encourages consumers and their advocates or designated representatives to advocate for their own individual needs. This may include consumers identifying and developing, on a more informal basis, their own "circle of friends" as a way of being more active and integrated in their own communities. In addition, more training is needed because the more specialized people can be, the more effective they will be in working with others who have unique needs. The consumer must have the ability to initially identify and change the designation of their advocates and designated representatives, as needed.

Examples of the activities for self advocacy, in which consumers of behavioral health services are encouraged to participate, include completing Advance Directives (a well developed crisis plan) which identifies the service preferences if and when they are unable to make their own decisions due to their behavioral health symptoms. Another example is the Wellness Recovery Action Plan (WRAP) where personal goals related to recovery are identified. The plan has action steps determined by the consumer that they would need to complete in order to achieve the goals.

Case manager caseloads should also contain a mix of clients in both HCBS and institutional settings. However, when caseloads are exclusively made up of institutionalized consumers, ALTCS Program Contractors will be encouraged to have systems in place that will ensure institutionalized consumers are being appropriately assessed for community placement.

Provider Networks

AHCCCS, ADES/DDD and ADHS/DBHS conduct ongoing analysis of the service networks in Arizona. AHCCCS and ADHS/DBHS require contractors to provide an Annual Provider Network Status Report and Quarterly Updates. ADES/DDD, as an AHCCCS contractor for ALTCS, provides this information for the members they serve.

Beginning October 1, 2001, all AHCCCS/ALTCS Program Contractors are required to have formal Network Development and Management Plans. The purpose of the plan is to identify the current status of the network at all levels and to project future needs based upon membership growth. The plans will, at a minimum, include: current status of the network; current network gaps; immediate short-term interventions when a gap occurs; interventions to fill network gaps, and barriers to those interventions; outcome measures/evaluations of interventions; ongoing activities for network development; specialty population; and membership growth/changes. AHCCCS reviews these plans and requires contractors to implement corrective actions when indicated.

ADHS/DBHS is in the process of implementing a new system for monitoring service networks. The policies were recently revised and now require additional elements that must be reported. In addition, ADHS/DBHS has set up a cross-functional team , including the Quality Management, Financial, and Clinical Bureaus, to conduct reviews of the Network Analysis Reports. The team is also in the process of identifying additional information that will be incorporated into the network analysis review process, such as problem resolution and consumer satisfaction data. This information will assist in evaluating the provider network including any material gaps. The Regional Behavioral Health Authorities may be required to develop corrective action plans to address any issues identified.

PART III: AGENCY SPECIFIC ACTIONS

AHCCCS/ALTCS/EPD

The Arizona Long Term Care System Elderly and Physically Disabled (ALTCS/EPD) program for persons that are elderly and persons with a physical disability has accomplished many milestones that support and maintain consumers in the most integrated settings. These requirements are codified in contracts with the Program Contractors and AHCCCS policy and procedures that are available on the Arizona Health Care Cost Containment System (AHCCCS) website (www.ahcccs.state.az.us). A work plan can be found in Appendix F.

Comprehensive Effective Working Plan (Principle 1)

This is a core principle since it suggests that states should develop a comprehensive, effective plan to provide services to individuals with disabilities in more integrated, community based settings. Through the Olmstead Plan (Plan), Arizona has an opportunity to build upon a model that incorporates many of the elements embodied in the first principle. For example, the ALTCS program has a wide spectrum of home and community based services (HCBS) and a solid range of alternative residential settings in the community (See Appendix C). The emphasis on HCBS is reflected in the high percentage of consumers living in the community. For example, nearly 50 percent of the elderly or persons with physical disabilities reside in the community and receive HCBS. Building upon this foundation, AHCCCS is working with the community to develop a comprehensive working plan.

AHCCCS will continue to support the principles of the Olmstead Decision in making reasonable efforts to ensure that potential and current consumers are assessed, provided information, and offered an array of services and settings that can enhance the consumer's opportunity to live in the most community-integrated setting possible. As part of that effort, AHCCCS will periodically monitor and update the Work Plan found in Appendix F of this document.

Plan Development and Implementation Process (Principle 2)

The Centers for Medicare and Medicaid Services (CMS) has suggested that states should provide an opportunity for interested persons to be involved in the plan development. AHCCCS has involved key stakeholders and will continue to involve consumers, program contractors, advocates, community stakeholders and all other interested parties in formulating its portion of Arizona's Olmstead Plan. A listing of persons and organizations that were invited to participate in the development, review and comment on the Plan is included in Appendix I.

AHCCCS will post the completed Plan on its website and will invite all interested members of the community to provide written comments to AHCCCS at any time throughout the year. AHCCCS will periodically review, with interested parties, the status of the work plan, and continue to refine the document. AHCCCS will continue to include the consumers, program contractors, advocates, community stakeholders and all other interested parties in these ongoing review and update activities.

Assessment on Behalf of Potentially Eligible Populations (Principle 3)

This principle is designed to prevent or correct current and future unjustified institutionalization of individuals with disabilities. Many states must begin their planning process by correcting unwarranted nursing facility placements. Arizona is fortunate that we are not starting from that point and can build on a philosophy that stresses independence in the most integrated setting. Planning for community integration begins before the consumer enters the nursing facility and a more collaborative approach is required between case managers and the HCBS system. Because Arizona does not provide prior period coverage for HCBS, there is no funding available to engage in early planning that would allow for an easier transition from the institution to home. To correct this, AHCCCS is reviewing the possibility of providing prior period coverage for HCBS.

AHCCCS monitors the system to ensure that this principle is met by:

- Reviewing the outcome of assessments made by the program contractors to ensure that consumers are placed in the most integrated and most appropriate placement.
- Redesigning the ALTCS computer system to improve data collection capabilities.
- Reviewing the current level of care assessment tools utilized by program contractors to evaluate if changes should be made to the tool. In addition, AHCCCS will require a standard assessment be used by the Elderly and Physically Disabled (EPD) Program Contractors throughout the state to ensure uniformity in each geographic region.
- Providing incentives to ALTCS/EPD Program Contractors for appropriate placement in home and community settings allowing consumers to reside in the most integrated environment.

Advocacy agencies can also assist in ensuring appropriate and early assessment and discharge planning occur. The State encourages advocacy groups to meet with nursing facility resident councils and program contractors to negotiate and ensure the availability of timely and accurate information for consumers.

Availability of Community-Integrated Services (Principle 4)

AHCCCS provides a wide range of services and settings to assist people with integration into their communities, and because this is an entitlement program, there is no waiting list for the ALTCS/EPD program. The enrollment increases in the ALTCS HCBS program, as well as increases in the utilization of services, are reflective in the increases of expenditures for the program.

CHANGE IN ALTCS EXPENDITURES BY SERVICE CATEGORY FEDERAL FISCAL YEAR 1996 - 1999	
ALTCS SERVICE (EXCLUDING CASE MANAGEMENT)	**ALTCS % OF EXPENDITURE GROWTH FFY 1996 – FFY 1999**
Home Health Services (RN and HHA)	**+89%**
Attendant Care	**+47%**
Home-Delivered Meals	**+83%**
Housekeeping	**+13%**
Personal Care	**-18%** **(Attributable to increase in Attendant Care)**
Other (Adult Day Health, Environmental Modification, Alternative Residential Settings)	**+680%** **(Attributable to Alternative Residential Settings)**
Respite Care	**+138%**

Please refer to Appendix C for a complete listing of the ALTCS/EPD services and settings that are available.

Principle 4 stresses the importance of making HCBS accessible. Since the AHCCCS program was founded on this principle, the focus is on how to improve accessibility. Complete accessibility to HCBS is not always possible in rural areas or when there is a lack of providers. The goal, however, is still appropriate and AHCCCS and its Program Contractors must identify the gaps and quantify the problems to begin finding solutions. Some of the strategies that AHCCCS uses to measure accessibility are:

- Annual operational and financial reviews of the Program Contractors conducted by AHCCCS to determine areas of best practices and areas that need improvement.
- The Community Based Services and Settings Report. It will be updated every two years and will help identify and quantify gaps in service.
- An ALTCS Member Survey to solicit consumer ideas about what works, where attention should be focused for the future and what needs to be improved, has recently been completed. AHCCCS/ALTCS will share the results with the community and analyze the findings to determine possible steps to implement for program improvement.
- Periodic assessment of the accessibility and availability of services with the primary care providers, through communication with consumers and Program Contractors; and by measuring general member satisfaction with the ALTCS program.
- Review of annual general or focused member surveys performed by Program Contractors. The results of these surveys are communicated to AHCCCS/ALTCS and the Member/Provider Councils and provide a measurement of satisfaction as well as case

manager performance, appointment waiting time, transportation wait times and culturally competent treatment.

Recently, the CMS removed the limit on the number of consumers who can reside in HCBS. Although the ALTCS/EPD program had never met the HCBS limitation in the past several years, it was critical for AHCCCS to have this perceived barrier removed.

The two critical coordination activities for the AHCCCS/ALTCS program are case management and ongoing coordination and planning at the state and local levels. Case management provides assistance to individuals at all stages of the eligibility and service delivery process and local providers and planning bodies meet regularly to improve linkages among services.

As an entitlement program, AHCCCS/ALTCS must continue to grow to meet the increasing population needs of Arizona's eligible populations. In 2000, there were 110,000 non-institutionalized Arizonans age 65 or older in need of some type of assistance with mobility or self-care. By 2014, the number of persons 85 and older will double to approximately 149,000. Not all of the elderly will require assistance; however, the rapid population growth of elderly persons is one indicator of the type of expansion that the community based services and settings may require.

AHCCCS/ALTCS has in place or will research concepts that can improve the availability of community-integrated services.

Financial Incentives

AHCCCS will continue to offer financial incentives to program contractors who exceed the targets set for HCBS.

Reimbursement for Home and Community Based Placements and Services

AHCCCS is exploring the financial impact of paying for HCBS and placements from the time that an applicant applies for ALTCS rather than from the day the individual is found eligible for ALTCS. This arrangement should support community placements and may reduce costs if individuals do not need to go to a nursing facility in order to have their bills paid from the day they apply and are found eligible for ALTCS.

Transition Funds

In response to comments from the public hearings, AHCCCS will review the potential to provide funding to assist people in transitioning into their own homes, including providing deposit funds for rental apartments and houses, utilities and telephones, and providing start-up funding for household items and furniture.

Assistive Technology

In addition, the state is encouraging the Arizona Technology Access Program, which is federally funded, to develop recommendations and training modules to provide additional training to clients, case managers and direct care providers for the improved use of assistive technology. This should include the development of a comprehensive strategy for assistive technology to ensure a successful placement, including adequately trained personnel to assist a person with his/ her assistive technology needs.

Informed Choice (Principle 5)

The principle of Informed Choice underscores the purpose of a home and community based program that gives individuals with disabilities and their families an opportunity to make informed choices about how their needs can be met in the community. A basic tenet of the ALTCS/EPD program is to involve consumers in decision making about what services they want and where they want to live. For consumers to be able to make informed choices, they must have information about the available range of living arrangements, types of services, methods of service delivery, and the likely benefits, disadvantages and risks of each option. For example, people who are participating in the ALTCS/EPD program in Maricopa County should receive information about the three program contractors for acute and long term care services so that they can make an informed choice. The participants also need to receive a thorough explanation of the array of services and settings available so that they have informed choice and decision-making abilities relative to their care plan. To achieve that goal, each consumer is assessed to determine the most integrated placement for that consumer when considering the individual's medical and support needs. The case manager is responsible for facilitating placement/services based primarily on the consumer's choice. In addition:

1. Program Contractors prepare informational materials (i.e., consumer handbooks, newsletters, and brochures) and submit them to AHCCCS/ALTCS for prior approval.
2. Applicants are given information about available ALTCS services and settings during the eligibility process and advised of their rights and responsibilities.
3. AHCCCS/ALTCS is conducting focus groups with "baby boomers" to determine what long term care information would be beneficial and how best to distribute the information.

For individuals who cannot communicate their needs and choices, the Planning Team must develop a plan that is in the individual's best interest. The Team may include the individual, the family, the guardian, the case manager, the service provider, the residential provider, friends and any others chosen by the individual.

AHCCCS will work collaboratively with consumers, advocates and the Program Contractors to identify effective approaches to ensure that current and potential consumers are provided the necessary information to make informed choices.

State and Community Infrastructure (Principle 6)

The CMS advised states to ensure that quality assurance, quality improvement and sound management principles support the plan. Some of the strategies that AHCCCS has in place are:

1. A requirement that all program contractors have an annual Quality and Utilization Management Plan that evaluates the quality of care. The program contractors must document the results and explain how the goals were met or unmet, document and trend quality management activities that have occurred and suggest what needs to be changed for the next year. AHCCCS reviews each program contractor's plan.
2. AHCCCS continually re-evaluates what is needed for a good management structure and incorporates those tenets in the contracts.

3. The Program Contractors' network and infrastructure are monitored in an annual operational review.
4. AHCCCS staff address all complaints or concerns referred to the agency. All complaints/concerns/quality of care issues are logged in, tracked and maintained in a centralized database. The allegations are identified and research is performed by obtaining and reviewing documentation from the numerous sources (e.g. Arizona Department of Health Services, Adult/Child Protective Services, Arizona State Board of Nursing, providers, program contractors and other regulatory agencies). Referrals are made to AHCCCS' Office of Program Integrity and shared with the Attorney General's Office, as appropriate. Findings are reviewed and discussed for actions taken on the case which may include policy and procedure changes, educational or in-services training, plans of correction, prosecution, bed holds and/or suspension or termination of the contracts.
5. Annual Operational and Financial reviews are performed by AHCCCS to ensure program compliance (Case Management, Network, Behavioral Health, Quality Utilization Management, Grievance and Requests for Hearing, Financial and Administrative). The reviews will identify areas where improvements can be made and recommendations are made to the program contractors. AHCCCS monitors the program contractor's progress on implementing the changes and provides the program contractor with technical assistance if necessary.

The AHCCCS/ALTCS program will continually look at ways to improve the ALTCS program. The addition of Network Management and Development Plans and Member/Provider Councils (see Principle 5) are two additional approaches to ensure the ALTCS program continues to improve and meet the needs of the consumers that it serves. The Member/Provider Councils also include consumer advocacy groups.

ADES/DDD

Comprehensive, Effective Working Plan (Principle 1)

The Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) State and Federal Funded Program for Persons with a Developmental Disability (DD) supports this core principle since it suggests that states should develop a comprehensive, effective plan to provide services to individuals with disabilities in more integrated, community based settings. ADES/DDD has historically worked to ensure that consumers are provided with assessments, information and services that will support them in the most integrated community setting that is appropriate. Through the Olmstead Plan (Plan), ADES/DDD has the opportunity to continue to build upon this model. ADES/DDD offers an array of community-integrated settings and services to support those settings. ADES/DDD also encourages consumers and their families to be active participants in service decisions. The emphasis on home and community based services (HCBS) is reflected in the high percentage of consumers living in the community. For example, over 99 percent of persons with developmental disabilities live in the community.

ADES/DDD will continue to support the principles of the Olmstead Decision in making reasonable efforts to ensure that potential consumers and consumers are assessed, provided information, and offered an array of services and settings that can enhance the individual's opportunity to live in the most community-integrated setting possible. As part of that effort, ADES/DDD will periodically monitor and update the Work Plan found in Appendix G of this document.

Plan Development and Implementation Process (Principle 2)

The Centers for Medicare and Medicaid Services (CMS) has suggested that states should provide an opportunity for interested persons to be involved in the Plan development. ADES/DDD has involved key stakeholders and will continue to involve consumers and their families, providers, advocates, other community stakeholders and all other interested parties in formulating its portion of the Plan. A listing of persons and organizations that were invited to participate in the development, review and comment on this Plan is included in Appendix I.

ADES/DDD will provide a link to the completed Plan on its website and will invite all interested members of the community to provide written comments to ADES/DDD at any time throughout the year. ADES/DDD will periodically review, with interested parties, the status of the work plan, and continue to refine the document. ADES/DDD will continue to include consumers and their families, providers, advocates, other community stakeholders and all other interested parties in these ongoing review and update activities.

Assessment on Behalf of Potentially Eligible Populations (Principle 3)

ADES/DDD has determined that existing assessment and planning procedures are adequate to identify individuals currently in institutionalized settings, to identify institutionalized individuals who could benefit from more integrated community settings and to identify individuals in the community who are at risk of placement in an unnecessarily restrictive setting.

Individual planning processes include the Individual and Family Service Plan (IFSP) for children under age three, the Individual Service Plan (ISP) for individuals over age three, and the Person-Centered Planning process which is being pilot tested at this time. All plans are reviewed annually as part of the current planning process. An annual Arizona Health Care Cost Containment System/Arizona Long Term Care System (AHCCCS/ALTCS) review of Medicaid eligible individuals is also conducted. Assessments from therapists and psychologists as well as functional assessments and employment assessments are also reviewed as part of this process.

Decisions to move an individual to the most integrated setting must include an assessment of their ability to live in the setting. There must be agreement to the move by the individual and the team of system representatives, professionals, and family members or other persons who are significant to the individual. Service plans and the planning process should be long term and anticipate future needs as well as current needs. On an individual basis, the planning process and overall philosophy support placement in the most appropriate integrated setting chosen by the individual.

Family members and others are currently being trained as part of the Person-Centered Planning Process to facilitate plan development focusing on the individual's goals including the long term needs to reach those goals. Addressing the service system changes needed to prepare for these trends will provide more options and choices for the individuals.

For special populations, such as persons with developmental disabilities who also are receiving services at the Arizona State Hospital, there is a special joint discharge planning process that occurs prior to enrollment of the individual with a Program Contractor or Regional Behavioral Health Authority (RBHA).

The ADES/DDD is planning a number of improvements to assessment and planning, including:

- Taking steps to ensure quality implementation of the IFSP and the ISP. The process and tools have been developed and work well.
- Taking actions to enhance the system's responsiveness to service changes/changes in need.
- Improving the identification of persons at risk of moving to more restrictive settings.
- Expanding the Person-Centered Planning process to other locations in the state after the pilot is completed.

Availability of Community-Integrated Services (Principle 4)

ADES/DDD has a wide range of community-integrated settings and support services available for consumers who have a developmental disability. Among the current initiatives that ADES/DDD is pursuing to further improve community integration are Home of Your Own and Family Support. The Home of Your Own program assists individuals with disabilities in determining if they are interested in becoming homeowners and in assessing the financial viability of home ownership, and may provide up to $10,000 per person to be used for a down payment or closing costs on the purchase of a home. Family support groups, and educational support for them, continue to grow throughout the state including an increasing number of self-advocates.

Integrated services can be provided in every residential setting to varying degrees. ADES/DDD is planning a number of improvements to promote integrated services in each setting, including increasing the opportunities for and knowledge about community services in settings, increasing opportunities for individuals to engage in community activities, improving learning skills, establishing an information contact, expanding transportation opportunities, and addressing best practices.

For individuals who cannot fully participate and individuals without family or other informal caregivers, ADES/DDD will ensure that the individual's team knows the person and has a commitment to their well being, uses volunteers and mentors, and has access to legal advocacy and individual opportunities.

In order to address gaps in services, ADES/DDD plans to address the issues of the following support services: transportation, skill levels of residential providers, creating meaningful day activities, and increasing availability of therapies, home nursing, respite, habilitation, and transition services. The degree to which there is a shortage of the service varies in different parts of the state.

ADES/DDD will also address employment services, networks and assistive technology.

Informed Choice (Principle 5)

ADES/DDD affords individuals with developmental disabilities and their families with the opportunity to make informed choices regarding how their needs can best be met in the community or institutional settings. In addition to providing consumers and their families with written and verbal information and with information on how to access other family advocacy and support groups, ADES/DDD has a number of initiatives in progress, including:

Case Management Options – a pilot project in Districts VI, II and part of District I that allows individuals and families to make choices on case managers, including contracted agencies or individuals, parents, family members, consumers or Division staff.

Person-Centered Planning – which supports ADES/DDD's direction of self-determination by ensuring more family/consumer control of the services they need. It allows for families/consumers to control their own budget and select services and providers when and as they need them. The pilot will be evaluated and will become available statewide depending upon the results of the evaluation.

Core Indicators Project – a project that pilots a set of quality indicators. Consumers are surveyed to determine the extent of community integration, choice and self determination, independence, quality of relationships, quality of life, satisfaction with service coordination, access to supports and services, safety, health, respect and rights and satisfaction with providers. Results will allow Arizona, and the other states that are participating, to develop practical strategies to improve quality of supports and services.

Voucher Program – the opportunity for over 1,000 people to use vouchers to purchase services. This empowers families and individuals to choose providers and streamlines the service delivery system.

Partners in Policymaking – a Pilot Parents of Southern Arizona initiative, supported by ADES/DDD, which promotes opportunities for individuals with developmental disabilities to become more involved in planning and decision making. The initiative is an innovative leadership-training program that teaches people to be community leaders and to affect systems and policy change at the local, state and national levels.

In order to support and ensure that individuals and their families have the information needed and the ability to make decisions based on accurate information, the following overall concepts need to be incorporated into all levels of service planning and delivery.

- Information that supports individuals and families making informed choices needs to be readily and comprehensively available.
- Individuals and families need to know that they do have choices and they need to know how to exercise those choices and decision-making rights. Individuals need to be provided opportunities to learn decision-making skills, and to understand that they have the right to change their minds.
- For individuals who cannot communicate their desires/choices, the Planning Team must develop a plan that is in the individual's best interest. The Team may include the individual, the family, the guardian, the support coordinator, the service provider, the residential provider, friends and any others who know the individual.

In addition, ADES/DDD will develop written materials and explore options for various forms of delivery. This will include a 1-800 number, a website, connections with current clients or families of clients for peer support and strengthening peer support networks. ADES/DDD will also explore additional opportunities to inform individuals about choice and consequences.

The Rehabilitation Council, Independent Living Centers and the Governor's Council on Developmental Disabilities are reviewing the decision-making process for employment. Their recommendations, which will support individual choice and informed decision making, should be implemented.

State and Community Infrastructure (Principle 6)

ADES/DDD engage in continuous improvement processes that include quality assurance reviews and enhancement of sound management practices. There are two mechanisms currently in place that will provide information for monitoring the overall system responsiveness to integrated services.

The Core Indicators Project: Arizona, along with over 20 other states is piloting a set of quality measures - Core Indicators. Consumers are surveyed to determine the extent of community integration, choice and self determination, independence, quality of relationships, quality of life, satisfaction with service coordination, access to supports and services, safety, health, respect and rights and satisfaction with providers. Results allow states to develop practical strategies to improve quality of supports and services. Specific areas included in the indicators related to community integration are:

- People are receiving supports to find and maintain employment in integrated settings and earn increased wages.

- People use integrated community services and participate in everyday community activities.
- People make life choices and participate actively in planning their services and supports.
- People are satisfied with the services and supports they receive – The proportion of people who report satisfaction with where they live.

Waiting List Tracking -- Program Managers in each ADES/DDD District of the State track the number of persons waiting for a less-restrictive setting or service – residential and/or employment. Based on information available as of August 15, 2000, there are nine (9) individuals who are working in sheltered employment settings that are prepared to move to employment in a more integrated setting. There are fifty-four (54) individuals prepared to move to a more integrated residential setting. Twenty two of the clients reside at the Arizona Training Program at Coolidge (ATPC) in the larger cottages and are willing to move to smaller settings if they can remain on the ATPC campus. The 54 individuals represent only 2 percent of those who are living out of home. In each case, the availability of appropriate options is delaying the changes.

The combination of information from the core indicators, AHCCCS/ALTCS audits and Program Manager tracking provides a very specific means of monitoring improvement in providing integrated service settings and services.

To ensure that the contracting and resource development functions support placement in integrated settings, the ADES/DDD will review the contracting process, identify additional methods to support consumers in the community, and promote creativity among providers in serving clients.

ADHS/DBHS Children and Adults with Behavioral Health Needs

Comprehensive, Effective Working Plan (Principle 1)

The strategic plan for the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) strives to promote healthy development and provide effective prevention, evaluation, treatment, and rehabilitation for those individuals in need of behavioral health services. A successful system allows for personal empowerment and can assist the individual in leading a responsible, productive and meaningful life. Therefore, Arizona's Olmstead Plan (Plan) includes principles that are consistent with the guiding Olmstead Decision principles.

Foremost is preventing the unnecessary institutionalization of children and adults whose behavioral health needs can be met in more appropriate integrated settings. Arizona has successfully met this objective as evidenced by the decline in the average daily census and the average length of stay at the Arizona State Hospital since 1997. The Regional Behavior Health Authorities (RBHAs) expenditure reports indicate that inpatient hospitalization costs have been decreasing and expenditures for community supports have been increasing significantly during this same time period. This success has been greatly due to the RBHAs' increased utilization of community based mental health services. Currently, 99 percent of children and adults with behavioral health needs are residing in the community utilizing community based services. Services such as case management, in-home supports and respite care have expanded and continued expansion in these areas is anticipated, as ADHS/DBHS continues to assure that the behavioral health needs of the consumers are met in integrated settings when appropriate.

ADHS/DBHS, in conjunction with the RBHAs, have historically believed that consumer(s) and those significant to the consumer(s) should have a voice and actively participate in their care and/or the care of those close to them. The goal is to continue striving to include individuals in their service provision. This is best done by providing information to consumers regarding all aspects of the behavioral health service delivery system, including but not limited to, assessment, available services, treatment and after-care. Provision of complete and accurate information allows for responsive, comprehensive, and when appropriate community based services tailored to the individual, family, community, and culture.

To ensure that the principles set forth in this document are adhered to, ADHS/DBHS will periodically monitor and update the Work Plan found in Appendix H. The Plan will be reviewed bi-annually by the ADHS/DBHS management team and annually with the other agencies participating in this Plan.

Plan Development and Implementation Process (Principle 2)

ADHS/DBHS has involved key stakeholders and will continue to involve consumers and their families, the RBHAs, providers, advocates, other community stakeholders and all other interested parties in formulating its portion of Arizona's Olmstead Plan. A listing of persons and organization that were invited to participate in the development, review and comment on this Plan is included in Appendix I.

ADHS/DBHS will provide a link on its website to the completed Plan and will invite all interested members of the community to provide written comments to ADHS/DBHS at any time throughout the year. ADHS/DBHS will periodically review, with interested parties, the status of the Work Plan, and continue to refine the document.

Assessment on Behalf of Potentially Eligible Populations (Principle 3)

A critical ADHS/DBHS responsibility is to provide oversight and regulation to the RBHAs. This is demonstrated in a variety of forms. ADHS/DBHS develops policies and procedures regarding the assessment of service delivery, including the utilization of community based services and systemic needs and provides the RBHAs with a Quality Management/Utilization Management Plan (QM/UM). The RBHAs, as indicated in ADHS/DBHS policy, are responsible for conducting service delivery assessments according to the QM/UM Plan and determining service needs in their region. The RBHAs develop area-specific policies and procedures consistent with the guidelines set forth by ADHS/DBHS and ensure adherence by the area providers. Annual reviews of the RBHA's adherence to the QM/UM Plan, policies and procedures, and practices, as well as their monitoring activities of area providers are conducted by ADHS/DBHS and feedback is provided to enhance service delivery. A cross-functional monitoring team consisting of representatives from the Quality Management and Financial Departments and the Clinical Bureaus conduct these reviews (Operational and Financial Reviews) so that it is comprehensive in nature. These annual Operational and Financial Reviews include reviewing service delivery assessment methods (data systems), case files, and adherence to mandates.

On a practical level, the behavioral health system in Arizona requires prior authorization for inpatient hospitalization or residential treatment to ensure that such restrictive placements are necessary to address individual needs and could not be addressed in less restrictive settings. Long term inpatient placements are periodically reviewed to determine if the individual has achieved maximum benefit and to ensure the placement should continue. RBHAs are required to report quarterly (to ADHS/DBHS) on data (i.e., average length of stay, admission information, and discharge data) verifying that institutional placements and acute care is monitored and not over-utilized.

An additional safeguard to prevent against the over-utilization of long term restrictive placements has been developed to ensure that individuals being hospitalized at the Arizona State Hospital have been appropriately assessed. All pending Arizona State Hospital admissions must be reviewed by the RBHA of jurisdiction and Arizona State Hospital representatives prior to hospitalization. Both authorities review severity of referring illness, expected outcome, and the identification of discharge goals. If admission is determined necessary, a discharge plan is initiated upon admission outlining goals for transitioning back into the community as quickly as appropriate. Additionally, incentives for the RBHAs have been developed by ADHS/DBHS to maintain the Arizona State Hospital census at predicable levels, to promptly place patients who are ready for discharge and to prevent readmission by providing appropriate monitored community services.

ADHS/DBHS will continue to coordinate and assure that meetings take place to allow for collaboration with other agencies regarding service delivery. The current monthly meetings held

with representatives from ADHS/DBHS, ADES/DDD, the RBHAs, and the Arizona State Hospital to coordinate discharge for persons with multiple service needs, will continue. Any barriers identified in these meetings will be addressed through the development of workgroups, and if necessary, ADHS/DBHS will revise or write policies to address the issue. ADHS/DBHS will also be developing on-going collaborative meetings with stakeholders, representatives from ADHS/DBHS, ADES/Division of Children, Youth and Families, ADES/DDD, Arizona Department of Juvenile Corrections, RBHAs and the Arizona Administrative Office of the Courts to decrease barriers to services for children and families served by the state agencies. ADHS is in the process of developing strategies to improve the assessment of and provision of services to children who are served by multiple agencies.

Availability of Community-Integrated Services (Principle 4)

ADHS/DBHS mission is to provide a comprehensive array of services to meet a person's behavioral health needs in community based settings. The RBHAs are responsible for determining the service needs in their region and developing a plan to meet those identified needs. As indicated earlier, ADHS/DBHS monitors the RBHAs to ensure that the service needs identified are being addressed and that multiple services exist. Currently, RBHAs deliver a full range of behavioral health services including prevention programs for adults and children, a full continuum of services for adults with substance abuse and general behavioral health disorders, adults with serious mental illness (SMI), and children with serious emotional disturbances (SED). The RBHAs accomplish this either directly or by developing a network of providers to deliver the services. A list of available services is included in Appendix C.

Service delivery options are expected to increase in the near future in Arizona. ADHS/DBHS has Intergovernmental Agreements with other state agencies to expand the provision of integrated community services. There are two initiatives currently underway which will additionally increase the utilization of integrated services within the state. They are as follows:

1. House Bill 2003 – This provides additional funding for services such as housing and vocational rehabilitation services to improve integration at the community level.

2. Proposition 204 – The implementation of Proposition 204 allows for matching funds for identified consumers thereby requiring the development of additional community based services.

In addition to the above, a provision from the State's Tobacco Settlement of $50 million for adults with SMI diagnoses and $20 million for children has been appropriated to increase community services. Finally, the Centers for Medicare and Medicaid Services (CMS) waiver which raises Medicare eligibility, will be used to expand community behavioral health services.

ADHS/DBHS is currently participating in a rate review with AHCCCS to expand Medicaid funding to include vocational services and personal assistance. Also being evaluated is a prospective rate that will include providers' development/start-up costs. RHBAs are focusing on developing housing and residential support services that have been identified through gap analysis data.

Other activities underway to enhance community based services include the development of Active Community Treatment (ACT) case management teams for adults. The ACT model of case management has, in other states, proven successful in supporting individuals upon their discharge from state institutions. The model provides a clinical team whose members have expertise in housing, vocational rehabilitation, substance abuse, medication management, and symptom management. These teams have been quite successful in other states assisting consumers with community integration. ADHS/DBHS has also sponsored an Integrated Treatment Consensus and Statewide Advisory Panel to establish best practice guidelines, training and improved methods for service delivery to persons with co-occurring mental health and substance abuse disorders. ADHS will continue to facilitate these discussions and support development of integrated community services for individuals with mental health and substance abuse issues.

Additionally, the ADHS/DBHS and the RBHAs, in collaboration with ADES, and Rehabilitative Services Administration (RSA) are developing peer mentor trainings and additional supported employment opportunities to increase available services. The RBHAs are also encouraged to expand consumer run programs including drop-in centers, clubhouses, and peer counseling.

The Bureau of Children's Services, in partnership with other child-serving agencies, has been involved in the implementation of a number of projects to coordinate services to children served by the RBHAs. Single Purchase of Care (SPOC), is a joint process developed in collaboration with the Department of Economic Security, the Department of Juvenile Corrections, and the Administrative Office of the Courts to provide a streamlined purchasing system of behavioral health care for children. The Early Childhood Behavioral Health Task Force was developed to define a system that provides access to comprehensive infant mental health services from trained and qualified practitioners in community based settings. Interagency Case Management Projects (ICMP) are currently being implemented and designed to centralize, coordinate and manage the services for children and youth. In addition to the above collaboration efforts, the Bureau of Children's Services also collaborates in other programs which include: Model Court, No Wrong Door, 300 Kids Project, and area Children's Coordinating Councils. The ADHS/DBHS has also added respite care for family members as a service covered by AHCCCS for children and adults with behavioral health needs.

Informed Choice (Principle 5)

ADHS/DBHS have developed policy requirements to ensure that individuals (including children and their families) are informed about their treatment options, including medications. Consumers are required and encouraged to take part in the service planning process and service plan reviews and can also identify any additional persons they may wish to be a part of their clinical team. These individuals may be family members, designated representatives, friends, etc. who can assist them in making informed choices about their treatment. Additionally, persons with a serious mental illness who are assessed as being unable to participate in treatment decisions and therefore are in need of special assistance, are referred for advocacy services as required by ADHS/DBHS policy.

A variety of methods to increase client awareness to available treatment options include meetings held with consumers at drop-in centers to assist and support the development of

recovery plans such as the Wellness Recovery Action Plan (WRAP). These plans clearly state the consumer's choices regarding treatment. In addition, a Recovery Training program will be provided at the Arizona State Hospital by the University of Arizona to educate consumers who are currently hospitalized on their treatment options to allow for more informed choices. Representatives from the ADHS/DBHS Bureau for Adult Services and Bureau for Children's Services attend the Arizona Behavioral Health Planning Counsel and the Children's Planning Counsel meetings to increase knowledge and information sharing regarding available services. This exchange of information provides a greater opportunity for consumers to be educated about how to make informed treatment choices.

State and Community Infrastructure (Principle 6)

ADHS/DBHS has the responsibility for direct oversight, both financially and programmatically for the activities of each of the RBHAs that sub-contract with provider networks including more than 1,300 service providers throughout the state. Monitoring for contract compliance, adherence to Medicaid regulations, fiscal accounting, program design, delivery, and effectiveness, as well as client satisfaction, occurs in a structured manner and on a periodic basis as indicated in previous sections. If necessary, additional monitoring may occur throughout the year based on outcome of the yearly monitoring reviews. Also included in the review process is data provided regarding the availability of and timeliness of appointments and if the consumer's presenting problems are being adequately addressed by the services designated in the service plan.

Consumer satisfaction surveys are completed biannually. Additional surveys to be implemented in the future include: the Mental Health Statistical Improvement Project (MHSIP) Youth Services Survey, MHSIP Youth Service Survey for Families, MHSIP (Adapted) Family Survey, and a Recovery Survey. This data will be analyzed as part of the quality improvement process for monitoring the service delivery system.

ADHS/DBHS initiatives focusing on expansion of community based services include:

1. Implementation of the recent changes to the behavioral health covered services array including the addition of new services (i.e. peer and family support) and provider types (i.e. Community Service Agencies and Rural Substance Abuse Transitional Center).

2. Integrated treatment for persons with co-occurring disorders.

3. A new process and policy for analyzing the sufficiency of the provider networks and identifying service gaps so they can be addressed in a timely manner.

PART IV: APPENDICES

APPENDIX A: CENTERS FOR MEDICARE AND MEDICAID SERVICES OLMSTEAD PRINCIPLES

Principle 1 -- Plan: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community based settings. When effectively carrying out the principle:

- The State develops a plan or plans to ensure that people with disabilities are served in the most integrated setting appropriate. It considers the extent to which there are programs that can serve as a framework for the development of an effectively working plan. It also considers the level of awareness and agreement among stakeholders and decision makers regarding the elements needed to create an effective system, and how this foundation can be strengthened.

- The plan ensures the transition of qualified individuals into community based settings at a reasonable pace. The State identifies improvements that could be made.

- The plan ensures that individuals with disabilities benefit from assessments to determine how community living might be possible (without limiting consideration to what is currently available in the community). In this process, the individuals are provided the opportunity for informed choices.

- The plan evaluates the adequacy with which the State is conducting thorough objective and periodic reviews of individuals with disabilities in institutional settings (such as State institutions, ICFs/MR, nursing facilities, psychiatric hospitals and residential services facilities for children) to determine the extent to which they can and should receive services in a more integrated setting.

Principle 2 -- Involvement: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up. When effectively carrying out this principle:

- The State involves people with disabilities (and their representatives, where appropriate) in the plan development and implementation process. It considers what methods could be employed to ensure constructive, on-going involvement and dialogue.

- The State assesses what partnerships are needed to ensure that any plan is comprehensive and works effectively.

Principle 3 -- Assessment: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities. When effectively carrying out this principle:

- The State has a reliable sense of how many individuals with disabilities are currently institutionalized and are eligible for services in community based settings. The plan considers what information and data collection systems exist to enable the State to make this determination. Where appropriate, the State considers improvements to data collection systems to enable it to plan adequately to meet needs.

- The State evaluates whether existing assessment procedures are adequate to identify institutionalized individuals with disabilities who could benefit from services in a more integrated setting.

- The State also evaluates whether existing assessment procedures are adequate to identify individuals in the community who are at risk of placement in an unnecessarily restrictive setting.

- The plan ensures that the State can act in a timely and effective manner in response to the findings of any assessment process.

Principle 4 -- Availability: Ensure the Availability of Community-Integrated Services. When effectively carrying out this principle:

- The plan identifies what community based services are available in the State. It assesses the extent to which these programs are able to serve people in the most integrated setting appropriate (as described in the ADA). The State identifies what improvements could be accomplished including the information systems, to make this an even better system, and how the system might be made comprehensive.

- The plan evaluates whether the identified supports and services meet the needs of persons who are likely to require assistance in order to live in the community. It identifies what changes could be made to improve the availability, quality and adequacy of the supports.

- The State evaluates whether its system adequately plans for making supports and services available to assist individuals who reside in their own homes with the presence of other family members. It also considers

whether its plan is adequate to address the needs of those without family members or other informal caregivers.

- The State examines how the identified supports and services integrate the individual into the community.

- The State reviews what funding sources are available (both Medicaid and other funding sources) to increase the availability of community based services. It also considers what efforts are under way to coordinate access to these services. Planners assess the extent to which these funding sources can be organized into a coherent system of long term care that affords people with reasonable, timely access to community based services.

- Planners also assess how well the current service system works for different groups (e.g. elderly people with disabilities, people with physical disabilities, developmental disabilities, mental illness, HIV-AIDS, etc.). The assessment includes a review of changes that might be desirable to make services a reality in the most integrated setting appropriate for all populations.

- The plan examines the operation of waiting lists, if any. It examines what might be done to ensure that people are able to come off waiting lists and receive needed community services at a reasonable pace.

Principle 5 – Informed Choice: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.

- The plan ensures that individuals who may be eligible to receive services in more integrated community based settings (and their representatives, where appropriate) are given the opportunity to make informed choices whether and how their needs can best be met.

- Planners address what information, education, and referral systems would be useful to ensure that people with disabilities receive the information necessary to make informed choices.

Principle 6 – State and Community Infrastructure: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan. When effectively carrying out this principle:

- Planners evaluate how quality assurance and quality improvement can be conducted effectively as more people with disabilities live in community settings.

The State also examines how it can best manage the overall systems of health and long term care, so that placement in the most integrated setting appropriate becomes the norm. It considers what planning, contracting and management infrastructure might be necessary to achieve this result at the State and community level.

APPENDIX B: BRIEF PROGRAM DESCRIPTIONS

Programs that support the target populations in community settings are defined according to the population that they serve. Some programs, such as Rehabilitative Services, Non-Medical Home and Community Based Service System and other types of services are available to more than one population group.

AHCCCS/ALTCS/EPD

Arizona Health Care Cost Containment System/Arizona Long Term Care System for Persons who are Elderly and/or have a Physical Disability (AHCCCS/ALTCS/EPD)

ALTCS/EPD services are provided either directly or indirectly, in the 15 Arizona counties, by Program Contractors under contract with AHCCCS, to persons who are elderly or who have a physical disability. Program Contractors coordinate, manage and provide acute care, institutional care, home and community based care, behavioral health and case management services to ALTCS/EPD consumers. The typical ALTCS/EPD consumer is a white female between 80 and 89 years of age, and 18 percent of the EPD consumers are over 90 years of age.

As of May 1, 2001, there were 19,515 elderly and physically disabled persons enrolled in the ALTCS/EPD program. The number of consumers currently residing in nursing facilities is 9,953. The home and community based population is divided into "own home" and "alternative residential settings." As of May 1, 2001, 8,196 consumers lived in their own home and 1,366 lived in Alternative Residential settings.

Table 1 shows the change from January 1997, through January 2001, in the proportion of ALTCS/EPD members who reside in their own home, alternative residential settings and nursing facilities. Nearly 50 percent of the consumers in the ALTCS/EPD program reside in home and community based settings (own home and alternative residential settings). The proportion of nursing facility residents has declined from 62.1 percent in 1997 to 50.5 percent in 2001.

Table 2 takes this same data that made up Table 1 and shows the percentage of growth that has occurred in members who reside in their own homes, alternative residential settings and nursing facilities for the same time period. Nursing facility growth has essentially remained flat or decreased over this time period. The largest proportion of growth is with those members residing in alternative residential settings. Those members residing in their own homes or alternative residential settings continue to grow at a rate greater than the overall ALTCS/EPD growth.

For more information call 1-(800) 654-8713, extension 4614 or visit the AHCCCS web site at www.ahcccs.state.az.us.

Table 1: Increases in the Proportion of ALTCS/EPD Consumers Who Live in the HCBS

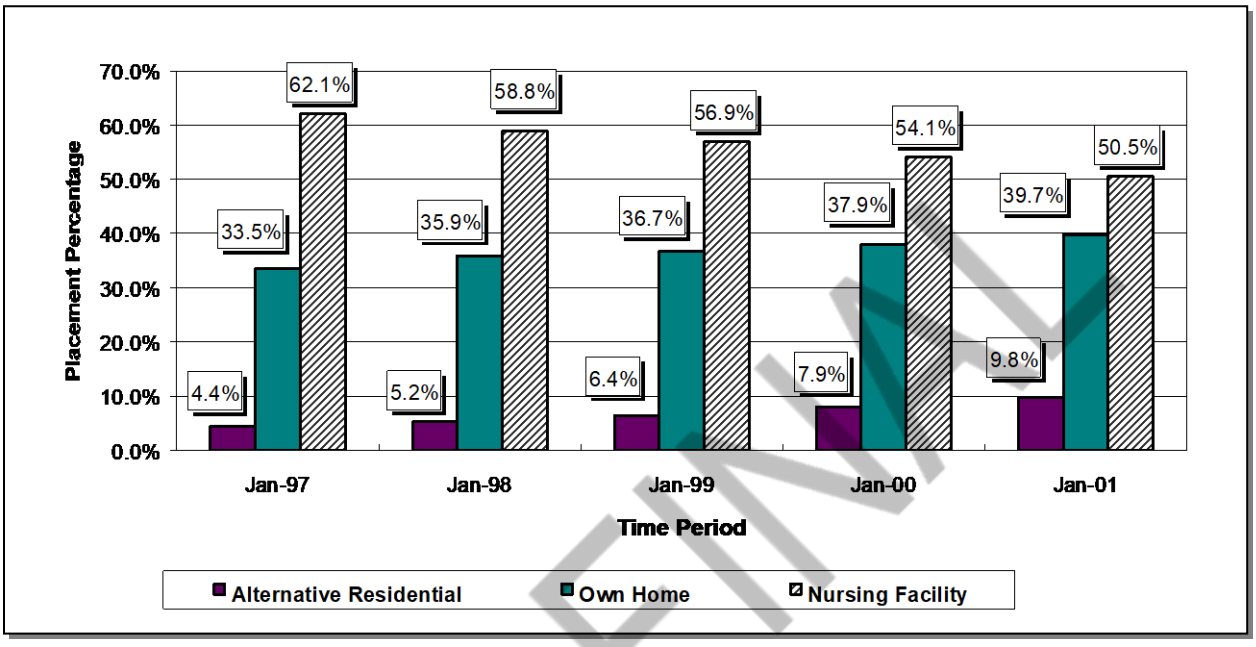
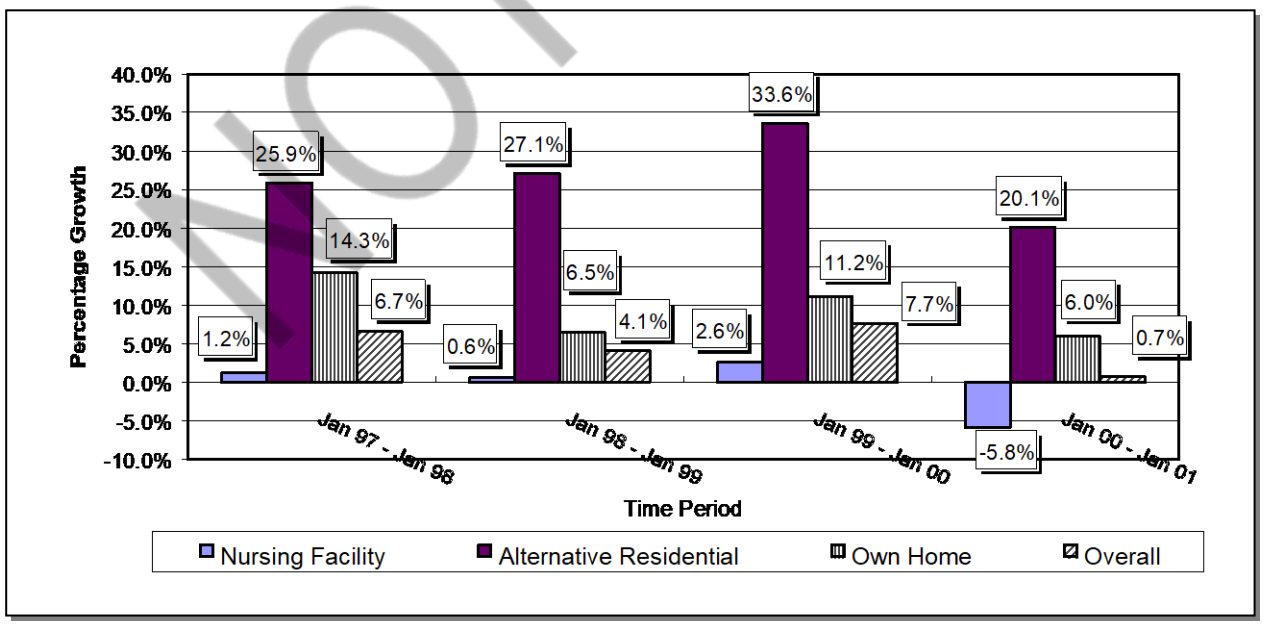


Table 2: Growth in Own Home and Alternative Residential Compared with Growth in Overall ALTCS/EPD Population



ADES/DDD

Arizona Department of Economic Security/Arizona Long term Care System for Persons with Developmental Disabilities (ADES/ALTCS/DD) and the Arizona Department of Economic Security/State-Funded Program for Persons with Developmental Disabilities (ADES/DDD/DD) [5]

The Medicaid-funded ALTCS/DD program for consumers with a developmental disability provides acute health, behavioral health, in home, alternative residential and institutional services. The DD State-Funded program offers essentially the same services as does the ALTCS/DD program except for acute and behavioral health services. The state-funded program is limited in the amount of services that it can provide because it is limited to appropriated State funds. Some DD State-Funded consumers can qualify for the Acute Medicaid program and thus obtain their acute and behavioral services from this source.

Over the past five years, the trend toward placement in integrated community settings has remained constant for persons with developmental disabilities.

LIVING LOCATIONS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES AS OF APRIL 30, 2001

Settings	Title XIX	State Funded
• ICF-MR (Coolidge, Windsor, Pinchot, Campbell, Earll and Hacienda)	166	28
• Skilled Nursing Facility (SNF & ICF)	58	3
• Group Homes	1,964	192
• Adult Developmental Homes	276	40
• Home with Community Based Services (Independent Settings and With Family)	9,717	6,944
Total	12,181	7,207

For more information call 1-866-229-5553 or visit the ADES website at www.de.state.az.us.

[5] In this document the ALTCS/DD and the State-Funded DD program will be discussed together as the ADES/DDD program.

ADHS/DBHS

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) for children and adults with behavioral health needs.

The ADHS/DBHS serves as the single state authority to provide coordination, planning, administration, regulation and monitoring of the state behavioral health system. Behavioral heath services include alcohol, drug and mental health services. ADHS/DBHS contracts with intermediary organizations, known as the RBHAs, to administer behavioral health services in the state. RBHAs are responsible for the development of regional provider networks that deliver effective services, develop services in response to client needs, coordinate care within the provider network, and continually seek to improve client outcomes.

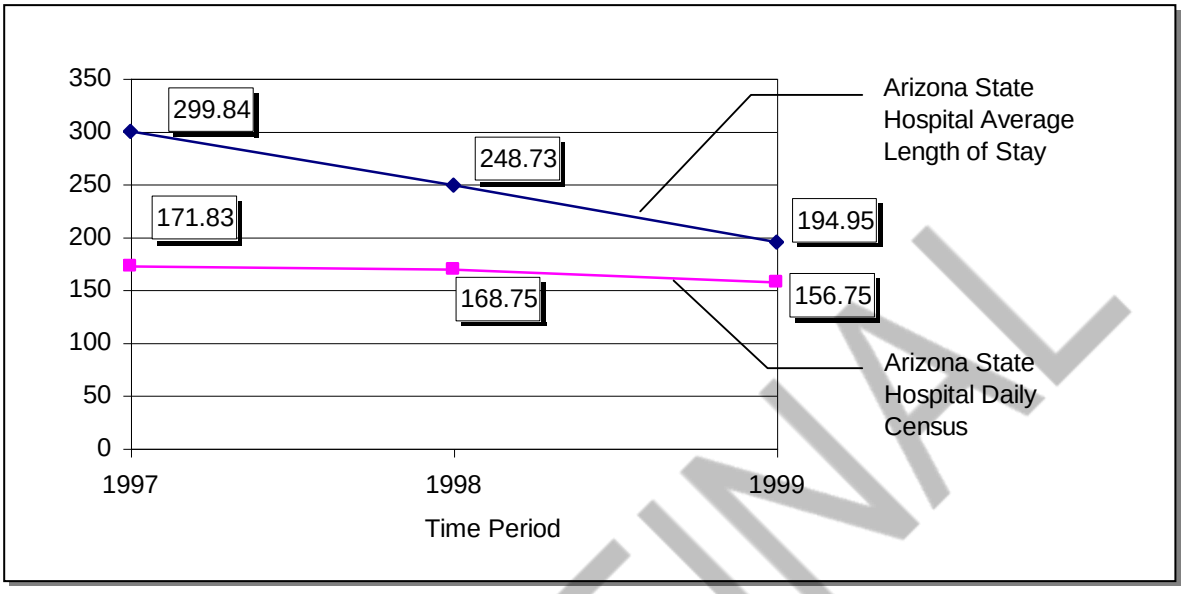
The ADHS/DBHS, through the RBHAs, served a total of 30,907 Title XIX and Title XXI children, adults with general mental heath needs, adults with a serious mental illness and adults with substance abuse issues during calendar year 2000.

Approximately 99 percent of these individuals are receiving community based services. Children and adults who are at risk of institutionalization may require higher levels of care including acute hospitalization when community services are not available or are inadequate to meet their needs.

ADHS/DBHS has identified the need for community based services and was ranked first in the nation in a 1997 evaluation of state mental health spending priorities conducted by the International Association of Psychosocial Rehabilitation Services (IAPRS). Concerned over some states' reliance on expensive psychiatric hospitals in an era of scarce behavioral health resources, the IAPRS awarded Arizona top honors for overall progress in moving from an institutionally-based mental health system to a community based system of behavioral health care. Overall, the study found that Arizona expended 83 percent of its mental health budget on community programs, compared with 73 percent in California and 67 percent in Wisconsin, the second and third ranked states.

As indicated in the following chart, the average daily census and the average length of stay at the Arizona State Hospital has decreased steadily since 1997. Aggressive discharge planning which begins upon admission to the Arizona State Hospital has assisted in the successful transition to home and community based services upon discharge.

Table 3: Arizona State Hospital Length of Stay and Admissions/Discharge Trends[6]



For more information call 1-(800)-867-5808 or visit the Department of Health Services website at www.hs.state.az.us.

Supporting Community Agencies

ADES/A&AA/Non-Medical HCBS

Arizona Department of Economic Security/Aging and Adult Administration/Non-Medical Home and Community Based System (ADES/A&AA/NMHCBS)

The Non-Medical Home and Community Based Service System (NMHCBS) offers an array of services designed to assist individuals to live as independently as possible in their homes or communities. Services are provided through a comprehensive case managed system. This single point of entry is provided by the Area Agencies on Aging and their provider network.

This program is a support to the Arizona Long Term Care System (ALTCS) program as it assists those who do not meet ALTCS eligibility criteria (financial and medical). This program does not provide institutional services, and it is not an entitlement program. "Anecdotally, the NMHCBS program may keep consumers from entering into the

[6] Statewide Average Length of Stay (LOS) and Statewide Average Daily Census is broken down by year for all civilly committed adults (SMI and Non-SMI). LOS was determined on the month of admission regardless of the date of discharge and the date of discharge had to have been by 12/31/00. Statewide Average Daily Census is determined by taking the census on the last day of each month of the year and then averaging for that year.

ALTCS program by quickly providing services that help them maximize their independence at an earlier stage in the need for assistance."[7] The services provided through the NMHCBS program to maintain people in their own homes includes: Adult Day Health Care, Case Management, Home-Delivered Meals, Housekeeping; Home Health Aid, Personal Care, Respite Care, Home Nursing, Congregate Meals in Senior Centers, Outreach, Transportation, Home Repair, Recreation/Socialization, Legal Assistance, Advocacy, Ombudsman, and Information and Referral.

There are three major focuses of the NMHCBS System. First, the system provides an array of services to prevent inappropriate or premature institutionalization. Second, the system allows an individual to live independently in his/her home or community setting as long as possible. Third, the system strengthens the informal supports created by families and caregivers of older Arizonans and Arizonans with disabilities.

For more information call 1-602-542-4446, the Elder Line at 1-800-686-1431, Adult Protective Services at 1-877-767-2385 or the State Health Insurance Assistance Program at 1-800-432-4040.

ADES/RSA

Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)

Several programs are provided through ADES/RSA in support of persons with disabilities becoming or remaining independent in their homes and communities. As with the Non-Medical Home and Community Based Services program, the people who participate in these programs may not necessarily be at risk of institutionalization; however, participation in these programs further enhances their independence and are, therefore, important components of a community integration approach.

These programs include Vocational Rehabilitation (VR), Independent Living Rehabilitation Services (ILRS), Employment Support Services (ESS), Arizona Industries for the Blind (AIB) and Vocational Services for the Seriously Mentally Ill.

Vocational Rehabilitation (VR): Helps people with disabilities become or remain economically independent through work by decreasing or eliminating their need for ongoing government supports through integrated, meaningful, and sustained work.

Independent Living Rehabilitation Services (ILRS): Facilitates the integration and full inclusion of individuals with significant disabilities into the mainstream of American society. Core services include: information and referral; independent living skills training; peer counseling, and self-advocacy. In addition, funds are used in part to support the Statewide Independent Living Council (SILC).

Employment Support Services (ESS): Assists individuals with the most significant disabilities to maintain successful employment. Extended employment support

[7] Arizona's Community-Based Services and Settings Report; October 2000; AHCCCS & ADES; page 1.

services are provided by Community Rehabilitation Program (CRP) providers under contract with RSA.

Arizona Industries for the Blind (AIB): Provides employment and training opportunities for Arizonans who are legally blind.

Interagency Service Agreement (ADHS/DBHS and ADES/RSA) for Vocational Services for the Seriously Mentally Ill. The overall goal of the agreement is to ensure that each program performs its job and coordinates to improve services to persons who have a serious mental illness.

For more information call 1-(800) 563-1221 or visit the Department of Economic Security website at www.de.state.az.us.

APPENDIX C: SERVICES AND SETTINGS

For more detailed information, please contact the specific state agency or visit their websites.

Elderly, Physically Disabled and Developmentally Disabled

The services an ALTCS consumer receives may include:

- Home and Community Based Services (HCBS)
- Institutional Care Services
- Acute Care Services
- Early Periodic Screening, Diagnosis and Treatment (birth to 21 years of age)
- Behavioral Health Care

Home and Community Based Services (HCBS) are services that prevent institutionalization and are provided in the consumer's home or in a residential setting such as a foster care home or group home for the people with a developmental disability.

In-Home Services:

- Adult Day Care
- Attendant Care
- DD Day Care
- Habilitation
- Home-Delivered Meals
- Home Health Aid
- Homemaker Services
- Hospice
- Nursing Services
- Personal Care
- Respite
- Therapies
- Transportation
- Environmental Modifications

Alternative Residential Services:

- Adult Foster Care
- Assisted Living Home
- Assisted Living Center – Unit Only
- Developmental Group Home
- Behavioral Health Level I
- Behavioral Health Level II
- Behavioral Health Level III

Institutional Care Services

- Nursing Facilities - Care for consumers who require round-the-clock skilled nursing care and related services but do not require hospitalization. The care is needed to ensure the individual receives treatments, medications, a therapeutic diet and rehabilitative nursing under the direction of a physician.
- Intermediate Care Facilities for the Mentally Retarded - Specialized care centers designed to meet the specific needs of the mentally retarded or persons with related conditions.
- Other Institutional Settings - Include residential treatment facilities for individuals under age 21, institutions for mental disease for individuals under age 21 or 65 and older, or hospice.

Acute Care Services

- Well-baby care (free check-ups and immunizations)
- Doctors' office visits
- Complete physical examinations
- Emergency dental care
- Immunizations
- Hospital
- Nutritional information
- Speech testing
- Lab and X-rays
- Prescriptions and medical supplies
- Substance and drug services
- 24-hour emergency medical care
- Durable medical equipment
- Transportation, if no public, private or free transportation is available

Behavioral Health Services

- Screening and Evaluation
- Counseling & Other Therapies
- Doctor Services
- Medicine
- Emergency/Crisis Services
- Inpatient Hospital
- Transportation

Early Periodic Screening, Diagnosis and Treatment Program

(EPSDT). The services listed below are covered for eligible persons from birth to 21 years of age:

- Health screening services
- Complete physical exams
- Immunizations
- Eye testing and glasses
- Dental exams and treatment
- Hearing tests and hearing aids
- Behavioral health services
- Other necessary health care, diagnostic services, treatment and measures required by section 1905(r) (5) of the Social Security Act

Children and Adults with a Behavioral Health Needs

These services may include:

- Behavioral Health Care
  - Screening and Evaluation
  - Counseling & Other Therapies
  - Doctor Services
  - Medicine
  - Emergency/Crisis Services
  - Inpatient Hospital
  - Transportation
- Alternative Residential Behavioral Health Levels I, II and III
- Institutions for Mental Disease (i.e., Arizona State Hospital)

If the client is also Medicaid eligible, he/she will receive Acute Care and EPSDT services as identified in the previous section.

APPENDIX D: ARIZONA'S OLMSTEAD PLAN TIMEFRAME FOR DEVELOPMENT

The key milestones in the development of the Arizona's Olmstead Plan were:

June 28, 2000 - Representatives from the three agencies met to discuss the Supreme Court decision, the Centers for Medicare and Medicaid Services (CMS) letter regarding Olmstead and how the state might proceed in the development of Olmstead Plans.

August 23, 2000 - Representatives from Arizona Department of Economic Security (ADES), Arizona Health Care Cost Containment System (AHCCCS) and Arizona Department of Health Services/Department of Behavioral Health Service (ADHS/DBHS) discussed concepts for a plan, identified a process to encourage consumer involvement and acknowledged the value to this process of Statewide Councils and public forums throughout the state.

September 20, 2000 - The state invited two representatives from each of the statewide councils to meet with the state agencies. A summary of the Olmstead Decision and its implications were presented and an update was given to the representatives. The group discussed how to best proceed with consumer participation. The preference of the group was to have some level of draft material so there would be a basis to begin the dialogue. As a result of this input, AHCCCS, ADES/Division of Developmental Disabilities (DDD) and ADHS/DBHS each developed a preliminary plan.

November 29 and December 5, 2000 -.Public Meetings The state agencies hosted a Video Conference in Phoenix and a public meeting in Tucson to seek further input from the public on the preliminary plans. The public had access to the draft plans for approximately one month prior to the meetings via mailed hard copy and the AHCCCS website.

February 8, 2001 - AHCCCS transmits Arizona's Olmstead Plan Draft to stakeholders.

March 1, 2001 - The state agencies and selected volunteer stakeholders meet to discuss revisions to the Draft Plan.

June 21 and June 22, 2001 - Second set of meetings for public comment on Arizona's Olmstead Plan Draft.

August 2001 - The final Arizona's Olmstead Plan is published.

APPENDIX E: ACRONYMS AND KEY DEFINITIONS

- ADES – Arizona Department of Economic Security: The state agency responsible for human service programs and services, including programs and services to persons with a developmental disability.
- ADHS – Arizona Department of Health Services: The state agency responsible for the delivery of public health and mental health services is the Arizona Department of Health Services (ADHS). The Department is comprised of five service areas with the Division of Behavioral Health Services (DBHS) being the largest service area, comprising about 75 percent of the agency's personnel and budget.
- AHCCCS – Arizona Health Care Cost Containment System: Arizona's state agency responsible for Medicaid and Health Care programs for people who meet the eligibility requirements.
- ALTCS – Arizona Long Term Care System – the AHCCCS program for persons who are elderly and persons with disabilities and at risk of an institutional level of care.
- DBHS - Division of Behavioral Health Services -- The ADHS division responsible for planning, administering and monitoring a comprehensive system of services for children, individuals with drug and alcohol problems, individuals with general mental health issues and adults with a serious mental illness (SMI). ADHS/DBHS also provides prevention services and inpatient services at the Arizona State Hospital.
- DDD – The Division of Developmental Disabilities in the ADES that serves as a Program Contractor to AHCCCS for home and community based and long term care services for persons with a developmental disability.
- EPD – Persons who are elderly and/or persons with a physical disability.
- GMH – General Mental Health.
- Prior Period Coverage – The period of time from the 1st day of the month of application or the 1st eligible month whichever is later to the day a member is enrolled with the contractor.
- Program Contractor -- The managed care organizations that contract with AHCCCS to deliver long term care services, behavioral health services, and case management and home and community based services to ALTCS consumers.
- RBHAs – Regional Behavioral Health Authorities – The contractors under the ADHS/DBHS that plan and administer all behavioral health services in Arizona, including TRBHAs (Tribal Regional Behavioral Health Authorities).

APPENDIX F: WORK PLAN – AHCCCS/ALTCS

ACTIONS	END DATE	AGENCY COMMENT
1. Arizona's Olmstead Plan: AHCCCS will post the completed Plan on its website and will invite all interested members of the community to provide written comments to AHCCCS at any time throughout the year. AHCCCS will periodically review, with interested parties, the status of the work plan, and continue to refine the document. Hard copy will also be distributed to Advocacy Councils and others upon request. *Principles 1 & 2*	Ongoing	Initial plan distributed August 2001. 02/2003: Workplan reviewed and updated.
2. Member/Provider Councils: Beginning October 1, 2001, all AHCCCS ALTCS program contractors will convene member/provider councils that are representative of the ALTCS consumers, family, advocates and the providers within a given geographic area. Purpose of the councils is to promote a collaborative effort to enhance the service delivery system in local communities. These councils will also be able to provide a forum for discussions and feedback on the Plan and any revisions. *Principles 2, 5 & 6*	October 2001	02/2003: Incorporated into all Elderly and Physically Disabled (EPD) program contractor contracts as of October 2001.
3. Informed Choices by Consumers: AHCCCS, in cooperation with ADES/DDD and ADHS/DBHS, will explore the possibility of developing and disseminating informational materials to help consumers make informed choices. *Principles 3 & 5*		2/2003: No action taken. The interagency workgroup is no longer active. AHCCCS will consider other approaches to address this item.

ACTIONS	END DATE	AGENCY COMMENT
4. Continue to offer financial incentives to the AHCCCS/ALTCS/EPD program contractors who exceed the targets set for the number of people receiving home and community based services. *Principles 3 & 6*	Not applicable	Ongoing. 02/2003: Program Contractors continue to develop the services and settings so that the percentage of people placed in HCBS programs continues to increase. AHCCCS has made no changes to the financial incentives.
5. "Prior Period Coverage" for Home and Community Based Services: Explore possibility of paying for home and community based (in-home and alternative residential settings) from the time that an applicant applies for ALTCS rather than from the day the individual is found eligible for ALTCS (Prior Period Coverage). • Determine financial impact; Centers for Medicare and Medicaid Services (CMS) approval; implement. *Principle 4*		02/2003: No plans to implement at this time because it may require a budget increase.
6. Spouses and Parents as Paid Caregivers: Explore possibility of a waiver from the CMS to pay spouses and parents. • Determine financial impact; waiver request to CMS; implement. *Principle 4*		02/2003: AHCCCS requested CMS approval but the request was not approved.

7. Payment to Assist Transition From Institutional to Home and Community Based Settings: Review the potential to provide funding to assist people to transition into their own homes, including providing deposit funds for rental and utilities and providing start up funding for household items and furniture. • Determine financial impact; CMS approval; implement. *Principle 4*		02/2003: The CMS recently informed AHCCCS that approval of this service would require our ALTCS Medicaid waiver to be renegotiated for cost neutrality. If AHCCCS amends the ALTCS waiver at a later time, this recommendation will be considered.
8. Interim Pay for Personal Care Attendants: Develop and implement plan to pay for a personal care attendant for a specified period of time when the consumer may be out of the home or alternative setting (e.g. hospitalization). • Determine financial impact; CMS approval; implement. *Principle 4*		02/2003: AHCCCS requested CMS approval but the request was not approved.
9. Pay Increases for Home and Community Based Providers: Implement the approximately 15.3% pay increase for ALTCS/EPD home and community based providers that will be effective October 1, 2001. *Principle 4*	October 2001	Implemented the October 2001 rate increases. 02/2003: Rates are reviewed annually for adjustments. An inflationary adjustment was made effective October 1, 2002.

10. Consumer Directed Services: Develop and implement plan to allow consumers to take responsibilities for recruiting, hiring, training, scheduling, directing and firing their personal care attendant workers. This includes the possibility of allowing the consumer to delegate skilled tasks to Personal Care Attendants. • Assess liability issues for State agencies and managed care organizations, determine scope of consumer direction (skilled vs. non-skilled); receive CMS approval; implement. *Principles 4 & 5*		02/2003: No formal activity to date. However, under the existing policies and practice ALTCS members are able to accept or refuse caregivers sent to their home. Also, if they are able to identify a potential caregiver they can refer this person to the provider agency to be hired. The potential caregiver must meet the training and other requirements of the hiring agency.
11. Network Development and Management Plans: Beginning October 1, 2001, all AHCCCS/ALTCS program contractors are required to have formal Network Development and Management Plans. AHCCCS will review and monitor the plans annually and as needed. *Principles 4 & 6*	October 2001	02/2003: This requirement was incorporated into all program contractor contracts as of October 2001. Plans are reviewed and acted on as needed.
12. Request the Arizona Technology Access Program (AzTAP) to develop recommendations and a training module to provide additional training to consumers, case managers and direct care providers for the improved use of assistive technology. *Principle 5*	February 2003	02/2003: AHCCCS has requested AzTAP to address.

13. Assess during the annual Operational and Financial Reviews – Are Program Contractor provider networks being affected by labor issues. Does the Program Contractor have plans to address any identified labor issue. How are program contractors involving their Member/Provider Councils in dealing with any identified labor issues? *Principles 4 & 6*	Ongoing beginning October 2001	02/2003: Labor issues have become less of an issue because of increases to provider reimbursement rates over the current and past two contract years and because of a downturn in the economy. Program contractors have discussed labor issues with their Councils as needed. In general Program contractors state that their providers are able to find the needed caregivers. Continue to monitor.
14. Update the Community Based Report every two years. *Principle 6*	2004	02/2003: An updated report was published 05/2002. It is available at: http://www.ahcccs.state.az.us/publications/commrpt/2002/hcbsannual2002a.pdf

APPENDIX G: WORK PLAN – ADES/DDD

UPDATED 1/15/03

ACTIONS	END DATE	AGENCY COMMENT
1. Arizona's Olmstead Plan: Link the DDD website to the AHCCCS website which will contain the completed Plan. Invite all interested members of the community to provide written comments to DDD at any time throughout the year. DDD will periodically review, with interested parties, the status of the work plan, and continue to refine the document. *Principles 1 & 2*	10/2001	The DDD web page is linked to the AHCCCS Website containing the Olmstead plan.
2. Include in the Best Practice Program, a category that would highlight program innovations in community integration for each type of setting. *Principle 4*		The Division conducts an annual workshop showcasing the best practices across the state and will be including community integration in the 2002 workshop.
3. Encourage the Arizona Technology Access Program, which is federally funded, to develop recommendations and a training module to provide additional training to clients, case managers and direct care providers for the improved use of assistive technology. This should include the development of a comprehensive strategy for assistive technology to ensure a successful placement, including adequately trained personnel to assist a person with his/her assistive technology needs. *Principle 4*	1/22/2002	Letter sent to Jill Oberstein regarding implementation of the objective January 22, 2002. Meeting was held between the Division and Jill Oberstein on 9/3/2002. The Arizona Technology Access Program trained Division training team on November 1, 2002.

4. Integration: Improve access to services and opportunities in the community, including employment and training *Principle 4*		Various activities are being implemented to improve access including the use of a Fiscal Intermediary, Member Directed Supports, Person Centered Planning and the Case Management pilot. The DES is also reviewing the provision of employment services. Retroactive to 10/1/2001, employment services have been added to the Arizona Medicaid Long Term Care program.
5. Labor Force: Develop a statewide initiative to address the shortage of therapists, nurses, home and community based providers and other direct care staff. *Principles 4 & 5*		The Division has looked at new and innovative approaches to increase the network of providers. The Division held a "roundtable" discussion on provider network issues in January 2002. Four priority strategies were developed out of this process and management staff were identified as leads on each of the strategy areas. The Arizona Legislature approved an allocation to increase rates of providers receiving below average negotiated rates, beginning July 2002. In late 2002, a new rule was promulgated to institute a Qualified Vendor system for procuring providers. This new process will begin on July 1, 2003.
6. Access to services and community: Find residential providers with skills and interest in serving people with serious problems – such as behavior problems. *Principles 4 & 5*		The Division has implemented an initiative named the Community Protection Project to increase the focus of placing individuals with significant behavior challenges into the community. Beginning August 2002 the Division has initiated new behavioral health services designed to support individuals in

		the community and reduce/prevent inpatient placements. The Division held a special forum on autism and has developed a work plan for improvements based on the recommendations.
7. Information: AHCCCS, in cooperation with ADES/DDD and ADHS/DBHS, will explore the possibility of developing and disseminating informational materials to help consumers make informed choices. *Principle 5*		The Division is exploring the option of using a self-advocate as a consultant and the Arizona People First organization to address this objective.[Due to a lack of funds this has been put on hold] The Division has initiated a Self-Determination Council with the State People First organization. The Council will assist the Division to communicate with self-advocates.
8. Person Centered Planning: Complete pilot and evaluation and develop detail plans for expansion, including options to promote community integration and improve services. *Principle 5*		The Division implemented a pilot. Evaluation of the pilot was completed and recommendations for statewide implementation have been articulated.
9. Person-Centered Planning: Complete improvements to the Individual Family Service Plan (IFSP) and Individual Service Plan (ISP) processes to include ensuring individuals facilitating and participating have information and training, establish process to ensure clear expectations for facilitators, include mechanism to include all relevant persons. *Principle 5*		This is an on-going effort to improve the planning processes and training to further integrate person centered planning into the various planning processes.
10. Choice: Continue implementation of the Options for Case Management Services that will provide individuals and families with choices in case management personnel, and develop plans for nursing home residents, and use of mentors. *Principle 5*		The Division piloted Private Case Management, providing families and members with choices. The pilot was evaluated and a recommendation made to deploy the options statewide on July 1, 2003.

11. Access to Services and Community: Increase services and supports to prevent unnecessary institutionalization and to improve the integration of people who do reside in institutions. *Principle 5*		As noted above in item 4, the Division continues to look at ways to improve access to services. In addition the Division is working to improve and increase opportunities for integration for those individuals who continue to reside in institutional settings. (Memo from Assistant Director to ATPC regarding semi-annual reports of integrative activities-January 15, 2002)
12. Skills: Ensure support coordinators have the information and can and do review it with individuals and families, and other staff have appropriate interview, assessment and service planning skills, and provide educational opportunities for direct care staff. *Principle 5*		The Division is increasing the communication options to better inform support coordinators and families about services and supports. The Division has been actively involved in working with the Glendale Community College on a curriculum for direct care staff.
13. Access to Services: Prepare a Network Plan that will identify gaps in services and action steps to fill those gaps. Include responsiveness to changes and needs. Develop the Network Plan with local stakeholders - families, individuals, providers, and advocacy groups. Coordinate the Network Plans with other funders and programs; Rehabilitative Services Administration, Behavioral Health, School Systems, Arizona Department Of Transportation for transportation and providers of services. Ensure staff orientation and training always includes philosophy of individual choice and decision making. Promote individual choice of providers as a means for supporting providers being innovative in creating options for individuals. *Principles 4, 5 & 6*		The Division created a Network Plan for each District and a combined plan for the entire state beginning in 2001. The second iteration was completed in 2002 and includes a quarterly reporting mechanism with review by the senior management group for actions to be identified and addressed. In addition, a behavioral health network plan was developed in 2002. The plans include a regular review process by each District and a quarterly review by the Statewide Management Team.

14. Develop information and options for methods of delivery to describe the system, inform individuals about the right to make decisions and have choices, identify the choices and options, provide qualitative information about services and providers and demonstrate the interrelationship of choices. *Principle 5*		As noted above, the Division is exploring the option of using a self-advocate as a consultant and the Arizona People First organization to address this objective. [Due to a lack of funds this has been put on hold] The Division has initiated a Self-Determination Council with the State People First organization.
15. Complete implementation of the following: - A 1-800 phone number. - Website with information about the system, services, providers and individual rights. - Connections for new families and individuals to people with expertise in system. - Supporting peer networking opportunities through projects such as the independent living centers, Arizona Bridge to Independent Living (ABIL) and DIRECT Center for Independence, Inc. *Principle 5*		• 1-800 numbers have been implemented for each District and for Central Office. • The Division has implemented a website with information. This will continually be refined and improved. The address is: http://www.de.state.az.us/ddd/ • The Division piloted a chat room but believes this was not the most effective means for communicating directly with families. Other options such as "list servers" are being explored. • The Division continues to fund and contract for a "mentor" program. • The Division has completed a guide for families called "Navigating the System"

16. Encourage Rehabilitation Services Administration to review and implement the recommendations from the Rehabilitation Council, Independent Living Centers and Governor's Council on Developmental Disabilities on decision-making process for employment. *Principle 6*		As noted above, the Department is looking at the future of employment services for persons with developmental disabilities. AHCCCS has agreed to include employment services under the ALTCS program retroactive to October 2001. The Department is considering a possible transfer of these services from the Rehabilitation Services Administration to the Division of Developmental Disabilities.

APPENDIX H: WORK PLAN – ADHS/DBHS

ACTION	END DATE	COMMENT
1. AHCCCS, in cooperation with ADES/DDD and ADHS/DBHS, will explore the possibility of developing and disseminating informational materials to help consumers make informed choices. *Principle 1*	Ongoing	
2. Arizona's Olmstead Plan: Link the DHS website to the AHCCCS website which will contain the completed Plan. Invite all interested members of the community to provide written comments to DHS at any time throughout the year. DHS will periodically review, with interested parties, the status of the work plan, and continue to refine the document. *Principles 1 & 2*	Oct. '01	Link is operational. No comments have been received as of 12/02.
3. Establish Service Planning Guidelines and post on website. *Principle 3*	Ongoing	DBHS currently reviewing Service Planning Guidelines posted on the Web Site and proposing revisions if needed. Additional guidelines may be added in the future.
4. Revise DBHS Discharge Policy. *Principle 3*	2/1/03	Policy committee has determined that this policy will be deleted and replaced with an Assessment and Treatment Planning Policy that is currently in draft form.
5. Establish monthly meeting of representatives from ADHS/DBHS, ADES/DDD, RBHAs, and Arizona State Hospital to coordinate discharge planning. *Principle 3*	Ongoing	Meetings are scheduled every 6wks. Next meeting 1/03. Meeting also includes representatives from AHCCCS Health Plans.

ACTION	END DATE	COMMENT
6. Ad Hoc workgroup including RBHAs, Arizona State Hospital, ADHS/DBHS, ASMI, AHCCCS, ADES/DDD meets to review results of pilot assessment tools, how to implement, and description of placements that would meet the needs of special populations. *This workgroup is now focusing on similar issues for people diagnosed with Borderline Personality Disorder. *Principle 3*	July 2002 Ongoing	The group has divided into three sub-committees that include technical assistance, education, and advocacy. This group also has access to the Olmstead consultant, Clarence Sundram.
7. Implement the components of the Children's Intergovernmental Agreement, as new issues are addressed and developed. *Principles 3 &,4*	10/31/03	J-K lawsuit settled. Children's Behavioral Health Annual Action Plan 11/1/01-10/31/02 implemented. Plan is revised and updated yearly. Family and Child Teams developed/statewide training provided.
8. Implementation of Proposition 204 including an aggressive outreach plan is being implemented to assist consumers and family members in completing applications for these benefits from AHCCCS. The RBHAs anticipate hiring staff to assist in this process. Ongoing assessment will be needed to determine what community based services will be needed to serve this population. Ongoing assessment will be needed to determine what community based services will be needed to serve this population. *Principle 4*	9/02 Ongoing	T/RBHA AHCCCS Eligibility Representative Workgroup meets on an as needed basis. Manual was revised and statewide "retraining" completed 9/02. ASSESSMENT DBHS has assigned a Network Development Clinical Team to each RBHA to assist RBHAs in assessing service gaps and providing TA for network development.
9. Require review of all pending RBHA or Arizona State Hospital admissions to Arizona State Hospital.	July '01	

ACTION	END DATE	COMMENT
Principle 4		
10. Complete the annual revision of the agreement regarding the Arizona State Hospital Community Placement Fund. *Principle 4*	July '03	Arizona State Hospital staff revise agreement every fiscal year and provide it to RBHA CEOs.
11. Implement Active Community Treatment (ACT) case management teams. *Principle 4*	6/03	ACT teams have been est. in all 5 RBHAs. Network development plans include the addition of more teams in all RBHAs in 2003.
12. Oversight of House Bill 2003 implementation that provides additional funding for services such as housing and vocational rehabilitation services. *Principle 4*	6/03	Initial Data Validation completed; 6 mo. reviews scheduled Fidelity measures being scored on a regular basis and programs being reviewed as part of the monitoring process.
13. Expand consumer run programs (RBHAs). *Principle 4*	Ongoing	Covered Services Policy implemented 10/3/01 provides additional options for Consumer Run Programs. NARBHA, CPSA, ValueOptions, and PGBHA currently have programs. DBHS has assigned a Network Development Clinical Team to each RBHA to provide to assist RBHAs in assessing service gaps and providing TA for network development.
14. Complete and implement the best practice guidelines, training and improved methods for service delivery to persons with co-occurring mental health and substance abuse disorders developed by the Integrated Treatment Consensus Panel.	Ongoing	Best Practice Guidelines on Web Site, U of A conducted Training of the Trainers, Local and State panels meet on a regular basis. ValueOptions has Monthly trainings with

ACTION	END DATE	COMMENT
Principles 4 & 6		National Expert. Other RBHAS have training dates scheduled with National Experts during 2002.
15. ADHS/DBHS will verify that trainings have occurred throughout the state and will also encourage the RBHAs to develop training programs for consumers interested in providing behavioral health services such as peer mentoring and peer advocacy. *Principle 5*	July 2002	Training coordinators workgroup met monthly to develop training modules to be implemented statewide.
16. Re-evaluate the current service matrix that includes types of services and service reimbursement rates. *Principle 6*	10/03/01	Re-evaluation completed and statewide trainings conducted for Covered Services Policy. Policy implemented 10/03/01. *Additional training will be provided to Frontline Service Providers in January 2003.
17. Conduct ongoing analysis of the service network through the RBHAs; and provide an Annual Provider Network Status Report and Quarterly Updates on their provider network status including any material gaps in the network and how they plan to address any issues identified. *Principle 6*	Ongoing	DBHS has assigned a Network Development Clinical Team to each RBHA to provide to assist RBHAs in assessing service gaps and providing TA for network development. Quarterly reports are reviewed by T/RBHA teams.

APPENDIX I: PERSONS AND ORGANIZATIONS INVITED TO PARTICIPATE IN ARIZONA'S OLMSTEAD PLANNING PROCESS

AGENCIES/ORGANIZATIONS/ASSOCIATIONS

- Alzheimer's Association
- Area Agency on Aging, - Region I
- Area Agency on Aging, Region II, Pima Council on Aging
- Arizona Alliance for the Mentally Ill (AAMI) -- NAMI Arizona
- Arizona Assisted Living Federation of America
- Arizona Association for Home Care
- Arizona Association for Homes and Housing for the Aging
- Arizona Behavioral Health Planning Council
- Arizona Bridge to Independent Living
- Arizona Center for Disability Law
- Arizona Civil Rights Advisory Board
- Arizona Commission for the Deaf and Hard of Hearing
- Arizona Council for the Hearing Impaired
- Arizona Department of Economic Security
- Arizona Department of Health Services
- Arizona Early Intervention Program (AZEIP)
- Arizona Health Care Association
- Arizona Health Care Cost Containment System
- Arizona Office for Americans with Disabilities
- Arizona State Hospital Advisory Board
- Arizona Technology Access Program
- Behavioral Health Consumers in Action
- Carondelet Home Health
- Central Arizona Council on Developmental Disabilities
- City of Holbrook, City Council
- Cochise Health Systems

AGENCIES/ORGANIZATIONS/ASSOCIATIONS

- Community Partnership of Southern Arizona (CPSA)
- Developmental Disabilities Advisory Council
- DIRECT Center for Independence, Inc.
- Division of Developmental Disabilities District Councils
- Eden Center
- Foundation For Senior Living
- Four County Conference on Developmental Disabilities
- Freedom Manor
- Gila River Indian Community
- Good Shepherd
- Governor's Advisory Council on Aging
- Governor's Committee on Employment of People with Disabilities
- Governor's Council on Blindness & Visual Impairment
- Governor's Council on Developmental Disabilities
- Governor's Council on Spinal & Head Injuries
- Heritage Home Healthcare
- Interagency Council of Infants and Toddlers
- Intertribal Council of Arizona (ITCA)
- John C. Lincoln Hospital
- Lifemark Health Plans (now Evercare)
- Maricopa Advisory Council
- Maricopa Home Health
- Maricopa Managed Care Systems
- Mental Health Association of Arizona
- Mercy Care Plan
- Moore Advocacy Consulting
- Native American Community Health
- Navajo Nation
- Northern Arizona Regional Behavioral Health Association
- Office of the Attorney General
- Office of the Governor

AGENCIES/ORGANIZATIONS/ASSOCIATIONS

- Parent and Friends of Arizona Training Program at Coolidge
- Pascua Yaqui Tribe
- People First
- Pima Council on Developmental Disabilities
- Pima Health Systems
- Pinal/Gila County Long Term Care
- Pinal Gila Behavioral Health Association
- Sage Employment and Community Services – Division of the Blake Foundation
- San Carlos Apache Tribe
- St. Luke's Health Initiatives
- State Rehabilitation Council
- Statewide Independent Living Council
- Statewide Medicaid Advisory Council
- The ARC of Arizona, Inc.
- The ARC of Tucson
- The EXCEL Group (BHS Yuma)
- Tohono O'odham
- ValueOptions
- White Mountain Apache Tribe
- Yavapai County Long Term Care

PARTICIPANTS

- Pam Allan
- Karen Barno
- Lynn Bejnar
- Skip Bingham
- Edna Bonham
- Keith Bonham
- Nancy Boyle
- Kathy Byrne
- Marcella Cardone
- Sue Clift
- Leslie Coney
- Marge Cook-Dixon
- Jozef de Groot
- Martha J. Dennler
- Matt Devlin
- Cam Dibiase
- Max Dine
- Patricia Dominguez
- Dana Evans
- Stew Grabel
- Jeannie Harmon
- Robert Harmon
- Paul Harrington
- Scott Gardner
- Li-Su Javedan
- Helena Kalmis
- Diane King
- Diane Krenn
- Vicki A. Kronabetter
- Lynn Larson
- Brian Lensch
- Donna Lerma
- Dina Lesperance
- Dave Maass
- Liana Martin
- Kelly McLear
- Robert McMorran
- Teresa McMorran
- Ann Meyer
- Susan Michael
- Teresa Moore
- Sandra Pahl
- Edie Petersen
- Arathi Premkamur
- Jill Preston
- Debbie Quinn
- Laura Teike
- John Rosa
- Patsy Rosa
- Virginia Roundtree
- Alan Schafer
- Tim Sikkema
- Claire Sinay
- Karen Smith
- Vicky Staples
- Sondra Stauffacher
- Dan Steffy
- Heather Steiner
- Mary Tatom
- Len Trainor
- Gene van den Bosch
- Michael Ward
- Kay Wingate

APPENDIX J: RESOURCES FOR CONSUMERS

THE ELDERLY

- Arizona Health Care Cost Containment System/Arizona Long- Term Care System Administration (AHCCCS/ALTCS); 1-800-654-8713, ex. 4690; www.ahcccs.state.az.us
- Arizona Department of Economic Security/Aging and Adult Administration; 1-602-542-4446; Elder Line 1-800-686-1431; Adult Protective Services 1-877-767-2385
- State Health Insurance Assistance Program 1-800-432-4040
- Area Agency on Aging - Region I – Maricopa

  Mary Lynn Kasunic – Phone: 1-602-264-2255; Fax: 1-602-264-2299; E-mail: Kasunic@aaaphx.org
- Area Agency on Aging - Region II - Pima Council on Aging

  Marian Lupu – Phone: 1-520-790-7262; Fax: 1-520-790-7577; E-mail: Mlupu@pcoa.org
- Area Agency on Aging - Region III – Northern Arizona Council of Governments

  Louise Wolverton – Phone: 1-520-774-1895; Fax: 1-520-214-7235; E-mail: lwolverton@nacog.org
- Area Agency on Aging – Region IV – Western Arizona Council of Governments

  Jill Harrison – Phone: 1-520-782-1886; Fax: 1-520-329-4248; E-mail: jillh@wacog.com
- Area Agency on Aging – Region V – Pinal/Gila Council for Senior Citizens

  Olivia Guerrero – Phone: 1-520-836-2758; Fax: 1-520-421-2033; E-mail: pgcse@casagrande.com
- Area Agency on Aging – Region VI – Southeastern Arizona Government Organization

  Kathleen Heard – Phone: 1-520-432-5301; Fax: 1-520-432-5858; E-mail: kheard@seago.org

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THE ELDERLY (CONTINUED)
• Area Agency on Aging – Region VII – Navajo Area Agency on Aging LaVerne Wyaco – Phone: 1-520-871-6797; Fax: 1-520-871-6255; E-mail: laverne.wyaco@nndoh.org • Area Agency on Aging – Region VIII – Intertribal Council of Arizona Lee Begay – Phone: 1-602-258-4822; Fax: 1-602-258-4825; E-mail: lbegay@itcaonline.com
PERSONS WITH A DEVELOPMENTAL DISABILITY
• Arizona Department of Economic Security/Division of Developmental Disabilities; 1-866-229-5553; www.de.state.az.us • Arizona Department of Economic Security/Rehabilitation Services Administration, 1-800-563-1221; www.de.state.az.us
PERSONS WITH A PHYSICAL DISABILITY
• Arizona Health Care Cost Containment System/Arizona Long Term Care System Administration (AHCCCS/ALTCS); 1-800-654-8713, ex. 4690; www.ahcccs.state.az.us • Arizona Department of Economic Security/Rehabilitation Services Administration, 1-800-563-1221; www.de.state.az.us
PERSONS WITH BEHAVIORAL HEALTH NEEDS
• Arizona Department of Health Services/Division of Behavioral Health Services; 1-800-867-5808; www.hs.state.az.us • Arizona Department of Economic Security/Rehabilitation Services Administration, 1-800-563-1221; www.de.state.az.us • Advocates for the Seriously Mentally Ill; 1-800-421-2124 • Mental Health Association; 1-800-MHA-9277; www.mhaaz.com • MIKID Mentally Ill Kids in Distress; 1-800-35-MIKID; www.accessarizona.com/community/groups/mikid

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Please respond to the following items:

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

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

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

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

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

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

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

b) Costs? (●) Yes ( ) No

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

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

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

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

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

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

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

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

Regardless of the type, amount, duration, scope, service delivery method, and population served, the Arizona Health Care Cost Containment System (AHCCCS) requires all health plans to ensure that their service delivery system:
1. Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines in a cost-effective manner,?
2. Coordinate and provide access to high-quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and incorporate a trauma-informed care approach,
3. Coordinate and provide access to preventive and health promotion services, including wellness services,
4. Coordinate and provide access to comprehensive care coordination and transitional care across settings; follow-up from inpatient to other settings; participation in discharge planning; and facilitating transfer from the children's system to the adult system of health care,
5. Coordinate and provide access to chronic disease management support, including self-management support,
?6. Conduct behavioral health assessment and service planning following a Health Home Model,
7. Coordinate and provide access to peer and family delivered support services, based on member's needs, voice, and choice,
8. Provide covered services to members in accordance with all applicable federal and State laws, regulations, and policies,
9. Coordinate and integrate clinical and non-clinical health-care related needs and services across all systems,
10. Implement health information technology to link services, facilitate communication among treating professionals and between

the health team and individual and family caregivers, and
11. Deliver services by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider.?

AHCCCS further requires that at all MCOS work in partnership to meet, agree upon, and reduce to writing joint collaborative protocols with each county, district, or regional office of:?
1. Administrative Office of the Courts,?
2. Juvenile Probation and Adult Probation,?
3. Arizona Department of Corrections and Arizona Department for Juvenile Corrections,?
4. Arizona Department of Child Safety (DCS),?
5. Tribal Nations and Providers (Refer to this section above),?
6. Veterans Affairs, and?
7. The county jails.?

MCOs must ensure that each collaborative protocol addresses, at a minimum, the procedures for each entity to coordinate the delivery of covered services to members served by both entities.

MHBG-Specific Examples
For the youth population identified as experiencing First Episode Psychosis (FEP), or experiencing Serious Emotional Disturbances (SED), AHCCCS ensures providers are coordinating with an array of community services, including but not limited to: treatment services, medical services, Federally Qualified Health Centers (FQHCs), school-based service programs, case management, suicide prevention and ideation services, skills training and development, and family preservation services.

AHCCCS providers also focus on services and programs that address school violence related to mental health through Youth Engagement Specialists that are trained to outreach and assess the needs of these youth populations and ensure refer to services are occurring as needed. The Youth Engagement Specialists are trained in assessment and suicide prevention and have been and will continue working with students referred by schools for behavioral health services. These supportive services have continued to be offered to students through telehealth and in-person appointments. Even with the virtual schooling that has taken place over the last year due to the pandemic, these referrals and appointments continue to be well attended. AHCCCS providers continue to build relationships with school districts within each Geographic Service Area (GSA), with many partnerships within local schools already in place to ensure coordination of services between youth identified as at risk.

AHCCCS is currently utilizing supplemental MHBG funding to expand services within these vulnerable populations through the building and identification of additional services and providers for children and adolescents. AHCCCS will ensure providers are building partnerships with key stakeholders for these populations to ensure youth services are inclusive of all areas of need. These additional projects include the following items:

Children/Adolescents with SED
Implementation of a statewide standardized process for early identification and referral for SED assessment,
Implementation of co-located models of care and strengthening of evidence-based practice delivery for justice involved youth,
Implementation of a Child Psychiatry Access Program (CPAP) to expand access to child and adolescent psychiatrists for Primary Care Providers (PCPs), and
Expansion of the availability of parent and family support services, Child and Family Team (CFT) coaches, and professional development opportunities to support the behavioral health workforce.

Children/Adolescents experiencing FEP
Support for additional FEP positions to provide outreach and treatment services,
Support the training and staff time to participate in evidence-based practices, and
Funding of supplies and outreach materials.

SABG-specific examples
To better serve youth who are most at risk for substance use disorder, AHCCCS is utilizing SABG funding to launch several new projects within the continuum of care that target adolescents.
Service providers are developing opportunities to cultivate youth with lived experience to serve as peer support as adults. AHCCCS is referring to this as pre-peer support. Programming includes mentorship programs, youth-led community projects, and youth development programs collaboratively implemented with American Indian tribes, justice system partners, and youth diversion.?
Detention Centers employ Behavioral Health Technicians and Clinicians to administer assessments for youth without an existing community-based treatment relationship. This improves continuity of care for youth in detention settings.
AHCCCS is submitting plans to SAMHSA to potentially expand the number of Juvenile Justice Engagement Team (JJET) Liaisons to include services for juveniles in qualified detention facilities. JJETs primary purpose is to resolve service barriers and other concerns for Probation, families, or other treatment stakeholders while juveniles temporarily reside in detention facilities.
AHCCCS' plan also includes non-billable outreach and coordination staff for qualified detention centers and billable Covered Services to include substance use disorder treatment and support services. Individual therapy, case management, and Teen AA classes are most offered to juveniles in a detention setting.
Building upon the work of the PPW-PLT learning collaborative, AHCCCS is using SABG funding to support programs that integrate

SUD treatment with health and family service agencies with a focus on pregnant and postpartum women and their babies and children.

Service providers are offering maternal mental health programs that support the complex OB and substance use disorder needs of pregnant and postpartum women in recovery. Services include the provision of MAT (Medication Assisted Treatment) modalities through data-waivered, office-based opioid treatment counselors, expanding both perinatal and postpartum depression programs and family support services.

Detoxification programs for substance-exposed newborns and supportive services to their mothers are being offered together, serving the mother/baby dyad. Parenting courses are a key component of programming.

Supported independent living programs utilize outpatient services for women in substance use disorder who are living with their children while in recovery. In these programs, treatment is designed to replicate a full-time job. Women are engaged in services 40 hours per week and childcare is provided. Case management, group processing, individual counseling, life skills (budgeting, scheduling, meal planning, etc.), vocational services, and 12 step meetings are offered.

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

None additional.

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

Technical assistance is not being requested at this time.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

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

Please respond to the following items:

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

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

The goals of our state plan to address suicide in Arizona include:
1. Improve the mental health of individuals and communities,
2. Perform surveillance to monitor suicide in Arizona and identified targeted demographic groups, and
3. Ensure treatment and support services are available to clinicians, communities, families, and survivors.

Activities to meet these goals include:
1. Develop and disseminate information on suicide prevention resources and training,
2. Increase the resilience and well-being of Arizona youth,
3. Increase awareness of available financial opportunities to improve the stability of families and reduce financial stressors,
4. Improve social connectedness and help seeking behavior,
5. Increase access to mental health care for Arizonans by adopting the Zero Suicide model statewide,
6. Provide recommendations regarding mental health treatment parity,
7. Perform a gap analysis on suicide related data and implement a surveillance system for suicide related events in Arizona,
8. Conduct surveillance on Protective Factors in Arizona,
9. Conduct a 50-state review to inform Arizona suicide prevention efforts,
10. Increase access to the crisis system,
11. Increase access to resources and services for individuals and communities that have experienced suicide and increase access to prevention materials,
12. Increase access and awareness to support of suicide survivors, and
13. Increase access and awareness to targeted resources in the community for high-risk populations.

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 2020-FFY 2021 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

AHCCCS manages the COVID-19 Emergency Response Suicide Prevention (ERSP) Grant, which provides suicide screening and follow-up services in Pima County to those uninsured and underinsured with suicidal ideation and who are 25 years of age and older. This occurs primarily through emergency departments, psychiatric facilities, and crisis line referrals. Through Arizona Complete Health (AzCH) and a contract with CODAC,?CODAC Behavioral Health Technicians (BHTs) will screen individuals in emergency departments and inpatient psychiatric facilities for suicidal ideation and identify/screen those persons who may have been or are at risk of domestic violence.?

AHCCCS works closely with the Arizona Coalition for Military Families and their Secure Your Weapon campaign. The statewide Secure Your Weapon campaign was launched in 2021 to encourage gun owners (primarily veterans and first responders) to have a gun safety plan in place, recognize the signs of behavioral health crises, and know how to receive behavioral health services. The AHCCCS suicide prevention team serves as the subject matter experts for the campaign.

Also, AHCCCS is in the process of becoming a Zero Suicide organization with an emphasis on training opportunities available to all staff. Further, suicide prevention messaging is regularly included in agencywide updates. The suicide prevention team hosts a quarterly Zero Suicide taskforce meeting of statewide stakeholders, including other state agencies who are also adopting the

model.

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

Technical assistance is not being requested at this time.

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

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

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

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

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

If yes, with whom?

AHCCCS' commitment to collaborative efforts begins at its administrative level, where mental health, substance use services, and acute care are administered out of one agency. Both the Single State Authority (SSA) and State Mental Health Authority (SMHA) designation is held by a representative of the AHCCCS Executive Team. AHCCCS partners with numerous Arizona state agencies, including the Department of Economic Security (DES), Arizona Department of Juvenile Corrective (ADJC) and Arizona Department of Corrections (AzDOC), Department of Education (ADE), the Administrative Office of the Courts (AOC), the Department of Housing, the Governor's Office of Youth, Faith and Family, and the Department of Child Safety (DCS), to provide a comprehensive array of publicly funded services to children and adults through memorandums of understanding (MOUs), contractual agreements, and/or informal relationships. Formal partnerships include:
A partnership with the Arizona Department of Economic Security/Rehabilitation Services Administration (DES/RSA) through an Interagency Service Agreement (ISA), AHCCCS and RSA work together to provide specialty employment services and supports for enrolled members who have a Serious Mental Illness (SMI) designation.

AHCCCS requires, through contract and policy, that all Managed Care Organizations (MCOs) providing behavioral health services develop Collaborative Protocols or MOUs with system stakeholders including; the Department of Child Safety, Administrative Office of the Courts (juvenile and adult probation), Department of Corrections (adult and juvenile), and the Veterans' Administration.

Related to SABG Primary Prevention efforts, AHCCCS requires through contract that all contracted coalitions develop a Memorandum of Understanding (MOU) with the AHCCCS Complete Care (ACC) Health Plan, the American Indian Health Program (AIHP), Regional Behavioral Health Authority (RBHA), and/or Tribal Regional Behavioral Health Authority (TRBHA), in their

respective Local Jurisdiction(s) providers and/or agencies necessary to facilitate information sharing, resources sharing, and to provide services for any referrals for individuals within primary prevention programming. This is done to ensure service availability and referrals as needed for primary prevention activity participants, as well as to ensure that primary prevention coalitions are not operating in silos within the behavioral health system.

An Interagency Service Agreement (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, in August 2018 the Arizona Legislature allocated $7 million to be utilized by behavioral health agencies to provide behavioral health services to school-aged children specifically in a school setting. An associated allocation of $3 millions was given directly to the schools for them to provide Mental Health First Aid Training to school personnel. These collaborative efforts, including the ISA, support local schools' provision of services under the Individuals with Disabilities Education Act (IDEA).

In an Intergovernmental Agreement (IGA) between AHCCCS and Pima County Board of Supervisors, AHCCCS is tasked with providing a comprehensive, community-based system of mental health care for persons with an SMI designation who are residing in Pima County.
AHCCCS and the DOH developed an Interagency Service Agreement (ISA) which ADOH provided specialized real estate technical assistance for AHCCCS housing development projects, including project underwriting, risk assessment analysis, and providing recommendations to AHCCCS on the feasibility of funding particular housing projects for members with an SMI designation. AHCCCS also entered into agreements with ADOH to leverage its SMI Housing Trust Funds into ADOH administered Low Income Tax Credit Projects in exchange for a set-aside of units for SMI members in two new affordable housing projects, resulting in additional SMI housing capacity.

An IGA also exists between AHCCCS and the Maricopa County Board of Supervisors. This agreement ensures service provision for remanded juveniles as well as for members with an SMI designation, 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. AHCCCS' Chief Medical Officer (CMO) Dr. Sara Salek is currently the Vice-Chair of the ASAP.

AHCCCS regularly attend and are members of the Substance Abuse Coalition Leaders of Arizona (SACALAz), a community organization that educates and raises awareness about substance abuse issues, and advocates for policy change. SACLAz was developed to strengthen and support the collective impact of substance abuse coalitions in Arizona.

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

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

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

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

None.

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Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

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

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

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

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

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

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

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

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DATE: August 11, 2020

TO: Substance Abuse and Mental Health Services (SAMHSA)

FROM: Ali De La Trinidad, Project Manager, Arizona Behavioral Health Planning Council

SUBJECT: Arizona Behavioral Health Planning Council Minutes

In July 2019, the Arizona Behavioral Health Planning Council (BHPC) agreed to record each of their meetings in lieu of written minutes. The BHPC follows the Arizona Open Meeting Law and minutes are uploaded to AHCCCS' website within 3 working days after the meeting.

These recordings are available on AHCCCS' website at https://www.azahcccs.gov/Resources/Grants/CMHS/.

If you have any questions or concerns regarding these recordings, please contact me at 602-417-4706 or ali.delatrinidad@azahcccs.gov.

Thank you.

Environmental Factors and Plan

Advisory Council Members

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

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

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
David Delawder	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Jane Kallal	Youth/adolescent representative (or member from an organization serving young people)			
John Baird	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kathy Bashor	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Greg Billi	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kathryn Blair	Providers	Yavapai County Public Fiduciary		
Richard Brubaker	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Kim Foy	State Employees	Arizona Department of Economic Security		
Bill French	Persons in recovery from or providing treatment for or advocating for SUD services			
Olivia Gutzman	State Employees	Arizona Department of Housing		
Daniel Haley	Persons in recovery from or providing treatment for or advocating for SUD services			
Vicki Helland	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Allie Hesketh	State Employees	Arizona Department of Child Safety		
Vicki Johnson	Parents of children with SED/SUD			

Susan Kennard	State Employees	Arizona Health Care Cost Containment System (AHCCCS)		
Scott Lindbloom	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Alida Montiel	Representatives from Federally Recognized Tribes			
Stacy Paul	State Employees	Arizona Department of Corrections		
Teresa Pena	Providers	Valle Del Sol		
Aayna Rispoli	State Employees	Arizona Department of Education		
Alicia Ruiz	State Employees	Arizona Department of Economic Security		

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Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**20**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	1	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	1	
Total Individuals in Recovery, Family Members & Others	**11**	**55.00%**
State Employees	7	
Providers	2	
Vacancies	0	
Total State Employees & Providers	**9**	**45.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**1**	
Youth/adolescent representative (or member from an organization serving young people)	1	

* 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?

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Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

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

a) Public meetings or hearings? ○ Yes ○ No

b) Posting of the plan on the web for public comment? ○ Yes ○ No

If yes, provide URL:

c) Other (e.g. public service announcements, print media) ○ Yes ○ No

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Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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